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PROJECT PROPOSAL

Parental support and parental attitudes to mental health in relation to help-seeking behaviours in young Black British adults

According to the World Health Organisation (WHO), mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community", making ill mental health a potentially devastating cause of detrimental psychological and emotional well-being in an individual. Common mental disorders include generalised anxiety disorder, depression, phobias, OCD and panic disorder, but there is also a prevalence of severe mental health problems, such as psychotic disorders, bipolar disorder, ADHD, personality disorders and autistic spectrum disorder (Fundamental Facts about mental health, 2016).

The topic of mental health in black, Asian and minority ethnic groups is under-researched, even though BAME groups are at higher risk of developing mental ill health (Bhui & McKenzie, 2008). Statistics from the US show that although African Americans display similar rates of mental illness in comparison to the general population (Primm et al, 2010), only one in three receive mental health care (Dalencour et al, 2017). This difficulty in accessing healthcare is also reported in UK BME communities, causing concern (The Sainsbury Centre for Mental Health, 2002) and the development of briefs into race equality in mental health (Mental Health Network, 2012). However, black men in the UK are more likely to be treated under a section of the Mental Health Act and offered medication rather than talking treatments such as Psychotherapy, leading to a reluctance to engage with professional services for mental health, increasing the likelihood of any present mental illnesses becoming more prominent.

HELP-SEEKING BEHAVIOUR

According to Rickwood & Thomas (2012) "In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern". External assistance can either be in the form of mental health care professionals, such as a counsellor/therapist, psychologist or psychiatrist, or informal support such as family, peers and religious leaders.

Brown, Evans-Lacko, Aschan, Henderson, Hatch & Hotopf (2014) found that 33.6% of individuals that had indicated suffering from a common mental disorder had sought out informal help alone, 11.1% sought formal help alone and 26.3% sought no help. They also found that men were less likely to seek help than women, particularly informal help. Similar results were found in black men by Woodward, Taylor & Chatters (2011). Additionally, Black Caribbeans were shown to rather seek help from friends (77.9%) than family members, and Black Africans were most likely to use religious leaders (17.8%).

A survey carried out by the Mental Health Foundation found that men are less likely to look for professional help than women, with 28% of men revealing they haven't pursued medical help when it was needed, compared with only 19% of women. Men were also reported to be less likely to divulge information about problems with mental health to family and friends, with 15% of women receiving treatment compared to 9% of men. Only 6.2% of people that received treatment were from black ethnic minority groups, compared to 13.3% of white British people. These statistics highlight the disparities in help-seeking behaviours between gender and racial groups and indicate particular concern for help seeking within black men.

There are many theories that can help explain why people either choose to seek help for health issues, or not to. These theories can be applied to mental health. As one of the most dominant theories of help seeking behaviour, the Health Belief model (REF), originally developed for public health is based on the concepts of: *(i) the desire to avoid illness or to get well (value);* and *(ii) the belief that a specific health action available to a person would prevent (or ameliorate) illness (expectation).* The key variables of the HBM have three categories:

Individual perceptions

- Perceived susceptibility/perceived severity of disease

Modifying factors

- Variables such as age, sex, ethnicity, knowledge, etc.
- Perceived threat of disease
- Cues to action, e.g. education, symptoms/illness, information

Likelihood of action

- Perceived benefits minus perceived barriers to behaviour change
- Likelihood of behaviour change

This model is based on the beliefs and attitudes of an individual regarding their health state and can therefore not only explain why an individual may be reluctant to seek help for mental health issues, but also the factors that alter their mindset. Perceived barriers and benefits of

seeking help were also shown to be direct predictors of help seeking behaviour in young people with mental health issues, particularly the 'perceived benefits' variable (O'Connor, Martin, Weeks and Ong, 2014).

MENTAL HEALTH STIGMA/ATTITUDES IN THE BLACK COMMUNITY

Mental illness stigma has been identified as a concerning matter for mental health advocates (Wahl, 1999) and negative responses to mentally ill individuals is found as a considerable obstacle to recovery, limits opportunities and undermines self esteem (Fink & Tasman, 1992). Stigma is highlighted as potentially more significant treatment barrier in black populations (Alvidrez, Snowden, Rao & Boccellari, 2009), due to more stigmatizing perceptions of the mentally ill than Whites (Whaley, 1997; Corrigan & Watson, 2007) which leads to a decreased likelihood of mental health help-seeking (Snowden, 1999). Alvidrez, Snowden and Kaiser (2008) found that African American participants grew up learning that the topic of mental health was not to be talked about and any issues with mental health should not be talked about outside of the family. Because they grew up believing that having mental illness or seeking help about it was a sign of weakness, black men tend not to seek professional help until the symptoms are overly pronounced. The lack of early access to support services leads to declined mental health outcomes and an increased likelihood of involuntary admission (Mclean, Campbell and Cornish, 2003).

PARENTAL SUPPORT

According to Thomas, Gecas, Weigert & Rooney (1974) parental support is defined as "behavior manifest by a parent toward a child that makes the child feel comfortable in the presence of the parent and confirms in the child's mind that he is basically accepted and approved as a person by the parent." Support is identified as a critical component of parenting, coming in the form of nurturance, attachment, acceptance and love (Barnes and Farrell, 1992). Parental support has been shown to be a protective factor against mental illness in transgender adolescents (Simons, Schrager, Clark, Belzer & Olson, 2013) and gay, lesbian and bisexual youth (Eisenberg & Resnick, 2006). The lack of it on the other hand can lead to negative outcomes on their well-being (Ruholt, Gore and Dukes, 2015).

A relationship has also been found between parenting styles and help-seeking behaviours, with Puustinen, Lyyra, Metsäpelto & Pulkkinen (2008) finding that warm, child-centered parenting styles led to more positive help-seeking styles in girls. Parental influence has also

been identified as an important factor in other types of decision making, such adolescent sexual activity (Hutchinson, 2002), contraception decision making (Commendador, 2010) and career choice (Palos & Vîşcu, 2010). Therefore, Links can be created between the HBM and parental support by understanding how parental perceptions about their child's mental health may influence the child's individual perception about their own condition. Modifying factors such as knowledge and education can be influenced by parents. If a parent holds negative stereotypes about mental illness, this can influence what the child hears about mental health and cause them to feel shame about their own state of health. This shame can impact the likelihood of action variables, and potentially cause a reduced likelihood of help-seeking behaviour.

Within the African-Caribbean community there is a low awareness and considerable stigma around mental health issues, with the term 'mental health' being associated with words such as 'madness' (NSMC, 2010). There is potential for these negative views to be passed down onto children, and when this is combined with a lack of parental support, this can have a detrimental impact on a person's ability to seek help for ill mental health.

Most of the research on the relationship between support and mental have defined support as a 'social' factor, in which this includes parents, as well as other family members, friends, teachers, etc. Although studies such as these provide evidence of a significant association between social support and well-being/mental health symptoms (Kessler and McLeod, 1985; Lee, Koeske and Sales, 2004), the lack of studies looking at parental support as a specific protective factor against mental health problems paves the way for research that may help close the gap in the field, and on this particular ethnic group. Although poor relationship with peers, teachers and other family members may also impact an individual's mental health and psychological well-being, it is important to single out parental support for exploration due to its significance in an individual's life.

MENTAL HEALTH STIGMA/ATTITUDES AND SOCIAL SUPPORT

Lindsey, Joe and Nebbitt (2010) found that in African American adolescent boys, social support was negatively associated with symptoms of depression and enhanced the negative relationship between mental health stigma and reduced symptoms of depression when present.

Other studies found that stigma negatively impacts on psychological well-being and is a dominant barrier to help-seeking, whilst social support can be a protective factor against depression and assists help-seeking behaviours (Li, Lee, Thammawijaya, Jiraphongsa and Rotheram-Borus, 2008; Gulliver, Griffiths and Christensen, 2010).

AGE

Most mental health issues develop in childhood or young adulthood, and three-quarters of all mental health issues are formed by the age of 24 (Mental Health Taskforce, 2016), as well as 16-24-year old's being least likely to receive treatment for mental health issues and an overrepresentation of young Black men in inpatient mental health services in the UK. On black populations, older black male students were inclined to have more positive views about professional psychological help-seeking behaviour than younger students (Duncan, 2003). Factors such as the influence of religion and traditional masculine ideals were identified as barriers to seeking help in young men (Lynch, Long & Moorhead, 2018), as well as a need for easier access to professional help and mental health literacy (Rickwood, Deanne, Wilson & Ciarrochi, 2005).

It is important to note that whilst a substantial amount of research has been done into mental health illness in African American men, there has been less so on the Black British population, particularly from the Afro-Caribbean perspective of mental health. Previous research on African American men have focused mainly on factors such as socio-economic status, racism and sexual orientation as a predictor of mental ill health. There is no study that has explored the role of parental support and stigmatised mental health attitudes on help seeking behaviours of black individuals, especially men in the UK. Therefore, this piece of research is important in helping to improve help-seeking behaviours and combat the disproportionate number of black men in psychiatric settings in the UK. The hope is that this piece of research can open conversation within the racial group and raise awareness in parents on the importance of supporting children with ill mental health or mental wellbeing issues. This can potentially lead to a less stigmatized view of mental health within parents of young black men and the young men themselves, as well as an increase in parental support for young black men suffering from mental wellbeing issues or ill mental health.

RESEARCH QUESTIONS

Question 1

Is there an association between the level of perceived parental support, parental attitudes to mental health, and their own attitudes to seeking help for mental health issues in young Black British adults?

Question 2

Is there an association between the level of perceived parental support, parental attitudes to mental health, and actions of help-seeking behaviour in young Black British adults who have sought mental health support?

RESEARCH METHODS

Participants

Black British young people who were born and raised in the UK to African or Caribbean immigrant parent(s)/guardian(s) and are currently living in the UK. The age range is between 16 and 25 years. Given the limited attention to men's mental health and low response rate from male participants, more effort will be put into inviting men to participate. Those that do not meet the criteria will be excluded from the study. Non-respondents/ participants that do not complete all measures will also be excluded from the study. According to sample size calculation completed using GPower 3.1.9.2, the number of participants is estimated to be 68 for those who have not sought professional help for mental health and a further 68 for those who have. This is based on a linear multiple regression: fixed model, linear multiple regression ($\alpha = 0.05$, effect size = 0.15). A power of 0.8 was chosen as this is the first study exploring parental support with parental attitudes to mental health and its relationship with and actions of help-seeking behaviour within the UK black male population.

Procedure

Research has shown that testing the influence of two or more different independent variables at the same time is an advantage, as this allows the researcher to recognize the mediator and moderator effects (Ellen and Fitzgerald, 2015). This is supported by various studies that utilize this design (Dunn, Trivedi, Kampert, Clark and Chambliss, 2005; Ahluwalia, Okuyemi, Nollen. Choi, Kaur, Pulvers and Mayo, 2006). The biggest limitation to using this design is the difficulty of having more than two factors/levels in a study, and the diligent planning that is involved, as an error in a level or the general practicality may critically influence the work.

Participants will be recruited using social media and an approved recruitment website (Facebook, twitter, callforparticipants) to advertise the research. University of Nottingham Department administrators, Student Union and BME-related societies will also be contacted for permissions to distribute the survey on our behalf. Potential participants will be invited to read the information sheet and have to indicate informed consent, which will be presented

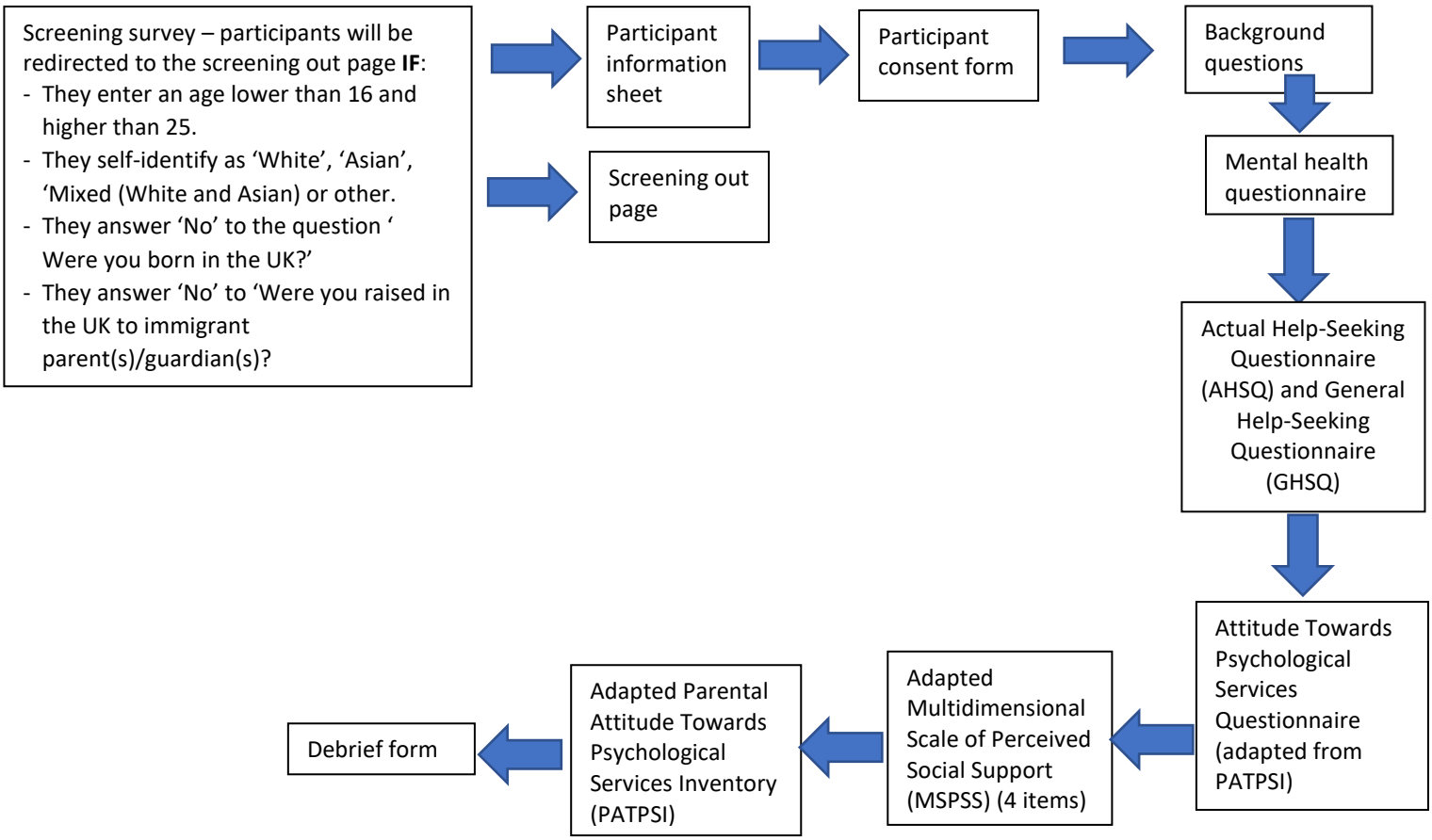
using a consent form before participating. After completion of the study, participants will be presented with a debrief form, explaining the aims of the study and giving information on support organisations.

Data collection will take place online using JISC online surveys, with participants required to complete a screening survey, followed by reading the information sheet, completing the consent form, and a total of seven questionnaires. Data collection is estimated to start in March 2019 and finish in May 2019.

Materials

The materials used in this online study will include a screening survey, participant information sheet, participant consent form, debrief form, and 13 tools.

1. Socio-demographic information about the participants was collected in the beginning, which included age, gender, race, geographical region, relationship status, education level, religion and employment status.
2.



3. A brief questionnaire on common mental health symptoms was adapted from the Mayo Clinic website (2015). This 15 item questionnaire is used to identify respondents who may have felt experienced mental health issues in the last 12 months rather than a definite mental health assessment.
4. Participants' own attitudes to and actions of help-seeking behaviour will be assessed using the General Help-Seeking Questionnaire (GHSQ) and Actual Help-Seeking Questionnaire (AHSQ). The GHSQ and AHSQ show satisfactory reliability and validity, and flexibility when measuring previous experiences with help seeking and help seeking intentions (Wilson, Deane, Ciarrochi and Rickwood, 2005`) as well as cross-cultural validity and reliability with Chilean adolescents (Olivari and Guzmán-Gonazález, 2017).
5. Parental support will be assessed with the family subscale of the Multidimensional Scale of Perceived Social Support (MSPSS) (4 items; α=0.93), substituting "family" for "parent(s)" (e.g., "My parent(s) really try to help me"). The MSPSS has been found to have good internal and test-retest reliability, moderate construct validity and discriminant validity and offers a moderating effect (supporting the buffering hypothesis) when tested on several different populations (Dahlem, Zimet and Walker, 1991; Zimet, Dahlem, Zimet and Farley, 2010) including a largely African-American adolescent population (Zimet, Canty-Mitchell and Zimet, 2000).
6. Parental attitudes to mental health and participant's own attitudes towards mental health will be assessed using two adapted versions of the Parental Attitude Towards Psychological Services Inventory (PATPSI). For assessing parental attitudes, the substitutions will be as follows: "I" and "my" for "my parent(s)", "they" and "their" where applicable and "my child" for "I" and "me" where applicable (e.g., "My parent(s) would not want others (friends, family, teachers, etc.) to know if I had a psychological or behaviour problem"). For assessing participant own attitudes towards mental health, the substitutions will be as follows: "I" and "my" for "my parent(s)", "they" and "their" where applicable and "my child" for "I" and "me" where applicable (e.g., "I would not want others (friends, family, teachers, etc.) to know if I had a psychological or behaviour problem"). The PATPSI shows adequate internal consistency and test-retest reliability, as well as discriminate validity (Turner, 2011).

Proposed analytical methods

All completed data sets will be analysed using linear multiple regression analysis. The statistical analysis will be carried out using IBM Statistics SPSS 24, with the alpha set at .05.

To answer Question 1

Multiple regression will be run on the completed data sets. The predictor variables are the level of perceived parental support and perceived parental attitudes towards mental health. The criterion variable is likelihood of help-seeking. Background variables such as age, gender, education, employment, living status and their own attitude towards mental health will be controlled for.

To answer Question 2

Multiple regression will be run on the completed data sets. The predictor variables are the level of perceived parental support and perceived parental attitudes towards mental health. The criterion variable is actual help-seeking behaviour. Background variables such as age, gender, education, employment, living status and their own attitudes towards mental health will be controlled for.

Estimated timescale

Data collection is estimated to start in April 2019, with the estimated end date in July 2019.

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ETHICS APPLICATION

1 Title of Project: Parental support and parental attitudes to mental health in relation to help-seeking behaviours in young Black British adults

Short title for use in footers of documents (ie Dynamic study): Quantitative study

2 Names, Qualifications ,Job Title, School/Divisional/Unit/Address, email of all Researchers:

Chief Academic/Supervisor:
Dr Shihning Chou
Associate Professor
Centre for Forensic & Family Psychology
Faculty of Medicine & Health Sciences

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NG8 1BB
shihning.chou@nottingham.ac.uk

Other key researchers/collaborators:

Students name and course:
Olivia Kwakyewaa-Gyamfi
Forensic and Criminological Psychology MSc
olivia.kwakyewaa-gyamfi@nottingham.ac.uk

3 Type of Project:
Masters project, Survey-based study

4 Location of study:

School of Medicine,
University of Nottingham,
Medical School,
Nottingham,
NG7 2UH

Start date: April 2019
End date: July 2019
Length of study: 3 months

5 Description and number of participants to be studied:

Black British young adults who were born and raised in the UK to immigrant parent(s)/guardian(s) and currently living in the UK. Criteria includes age between 16 and 25 years. According to sample size calculation, the number of participants is estimated to be 68 for those who have not sought professional help for mental health and a further 68 for those who have.

6 Summary of Experimental Protocol

Background

Mental health in black, Asian and minority ethnic groups is under-researched, even though BAME groups are at higher risk of developing mental ill health (Bhui & McKenzie, 2008). Statistics from the US show that although African Americans display similar rates of mental illness in comparison to the general population (Primm et al, 2010), only one in three receive mental health care (Dalencour et al, 2017). This difficulty in accessing healthcare is also reported in UK BME communities, causing concern (The Sainsbury Centre for Mental Health, 2002) and the development of briefs into race equality in mental health (Mental Health Network, 2012). However, black men in the UK are more likely to be treated under a section of the Mental Health Act and offered medication rather than talking treatments such as Psychotherapy, leading to a reluctance to engage with professional services for mental health, increasing the likelihood of any present mental illnesses becoming more prominent.

Aims

To explore the association between

1. the level of perceived parental support, parental attitudes to mental health, and their own attitudes to seeking help for mental health issues in young Black British adults.
2. the level of perceived parental support, parental attitudes to mental health, and actions of help-seeking behaviour in young Black British adults who have sought mental health support.

Research protocol and methods

Participants will be recruited using social media and an approved recruitment website (Facebook, twitter, callforparticipants) to advertise the research. University of Nottingham Department administrators, Student Union and BME-related societies will also be contacted for permissions to distribute the survey on our behalf. Potential participants will be invited to read the information sheet and have to indicate informed consent, which will be presented using a consent form before participating. After completion of the study, participants will be presented with a debrief form, explaining the aims of the study and giving information on support organisations.

Data collection will take place online, with participants required to complete a screening survey, followed by seven questionnaires.

Measurable end points/statistical power of the study

Participants' attitudes to help-seeking behaviour
Participants' actions of help-seeking behaviour

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7 Lay Summary of project (in lay words): (maximum 200 words) ***Summaries which include language which is too technical for lay members of the Committee will be rejected.***

Mental health in black, Asian and minority ethnic groups in the UK is under-researched, even though BAME groups are at higher risk of developing mental ill health (Bhui & McKenzie, 2008). The existing research is mostly on African Americans and the focus has been on the association between socio-economic status, racism or sexual orientation and their mental health. No research has explore the role of parental support and parental attitudes around mental health issues.

The aims of this project are to explore the association between

- the level of perceived parental support, parental attitudes to mental health, and their own attitudes to seeking help for mental health issues in young Black British adults.
- the level of perceived parental support, parental attitudes to mental health, and actions of help-seeking behaviour in young Black British adults who have sought mental health support.

Participants will be recruited using social media and an approved recruitment website (Facebook, twitter, callforparticipants) to advertise the research. University of Nottingham Department administrators, Student Union and BME-related societies will also be contacted for permissions to distribute the survey on our behalf. Data collection will take place online, with participants required to complete a screening survey, followed by seven questionnaires.

8 Will written consent be obtained from all volunteers? No

No, as because this is an online study, written consent cannot be collected from each participant. Instead, participants will read the information page, followed by a consent page that will explain what they are consenting to and what their data will be used for. On this page, they can either consent and continue to the study, or decline and not take part.

9 Will an inconvenience allowance be offered

No

If Yes, give rate (*delete as appropriate)

*Per day:
*Per Study:
*Per procedure:
Give the maximum allowance payable to a participant:
Pro rata if a participant withdraws part way through?

10 FUNDING

Will there be any material benefits from the study for the Department or individual investigator? (E.g. equipment, research salaries, consumables etc)

No

If yes please specify in general terms what the benefits will be:

11 Studies involving NHS Staff, organisations, Services

Does the study involve any premises, services staff who hold a contract with a hospital, Primary Healthcare or Social Care Trust? No

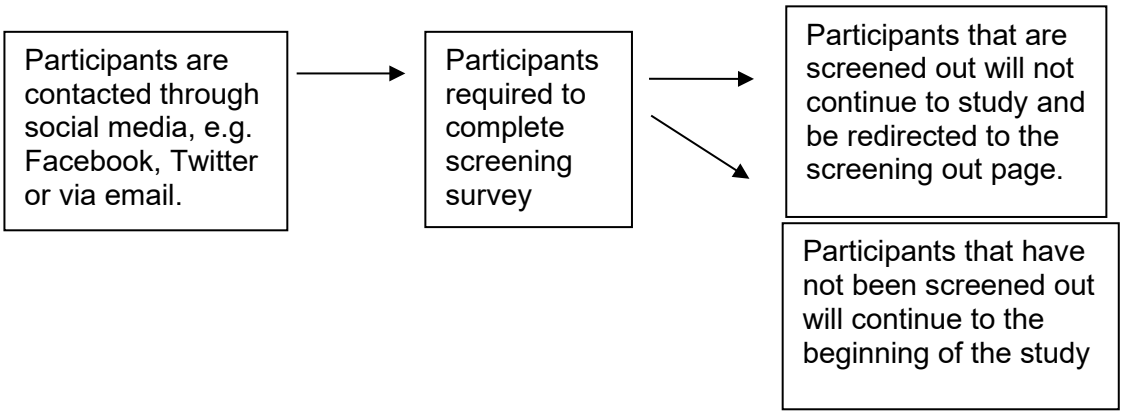
If you answer yes please contact the University Sponsor Office before you start and submit your application to this Committee: Please e-mail sponsor@nottingham.ac.uk who will advise you where you need to apply to for approvals i.e. HRA/Hospital Trust R&D approval which is a University research governance requirement.

12 How will the subjects be chosen?

Participants will be recruited using social media and an approved recruitment website (Facebook, twitter, callforparticipants) to advertise the research. University of Nottingham Department administrators, Student Union and BME-related societies will also be contacted for permissions to distribute the survey. All potential participant will first be required to complete a screening survey. Those that do not meet the requirements for the study will be screened out – remaining participants will continue to the beginning of the study.

Please include a copy (as a separate attachment) of your proposed poster or advert, e-mail/letter of invitation text to be posted on social media sites and in an email.

13 Describe how possible participants will be approached.



14 What sources of information will be included? i.e, pre-existing research database, student records, visits to other organisation, online resource

Participants will be provided with an information sheet, which will inform them about the study, their rights as a participant, and what the data will be used for. They will also be provided with a debrief form, which states the aims of the study, along with contact details of charities/ mental health groups to contact if they suffer any distress from participation.

15 Whose permission will be sought to access this information (eg GP, consultant Head of Organisation)? Please submit copies of letters/emails giving permission/support
N/A

16 For interview/focus groups:
N/A

17 Data Storage and Data management
Research data will be collected through JISC online surveys, stored in a password-protected computer file for security and initially handled only by the lead researcher and supervisor. Participants are not required to give any details that could potentially identify them, such as a name or address, and their IP address will not be stored. This insures that the data collected is completely anonymous. No personal data will be collected. The lead researcher will be responsible for the collected data. Data will be stored for 5 years after completion of study.

18 What ethical problems do you foresee in this project?

To ensure confidentiality and anonymity no personal identifiable information is collected.

Due to the sensitivity of topic and potential vulnerability of the participant, the language in the questionnaires has been carefully considered and the information of several support organisations is provided in the debriefing sheet.

18. What are the possible limitations of the proposed design of this study?

Using a regression design is difficult when there are two or more factors, as an error in one of the factors could critically impact the work. Also, if the practicality of the study is too difficult, this could also influence the study. The use of an online survey for data collection is fast, but opens the door for participants to falsify answers, which potentially reduces the validity of the results.

DECLARATION: I will inform the Medical School Ethics Committee as soon as I hear the outcome of any application for funding for the proposed project and/or if there are any significant changes to this proposal. I have read the notes to the investigators and clearly understand my obligations as to the rights, welfare and dignity of the subjects to be studied, particularly with regard to the giving of information and the obtaining of consent.

Signature of Lead Investigator:  **Date: 11/03/19**

Name and address for correspondence with applicant:

Olivia Kwakyewaa-Gyamfi
84 Rothesay Avenue
Nottingham
Nottinghamshire
NG7 1PW

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences Research Ethics Committee
Faculty Hub
Room E41, E Floor, Medical School
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Nottingham University Hospitals
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21 May 2019

Olivia Kwakyewaa-Gyamfi
Forensic and Criminological Psychology
Dr Shihning Chou
Associate Professor
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Dear Ms Kwakyewaa-Gyamfi

Ethics Reference No: 216-1903 **– please always quote**	
Study Title: Parental support and parental attitudes to mental health in relation to help-seeking behaviours in young Black British adults.	
Chief Investigator/Supervisor: Dr Shihning Chou, Associate Professor, Centre for Forensic & Family Psychology, School of Medicine.	
Lead Investigators/student: Olivia Kwakyewaa-Gyamfi, Forensic and Criminological Psychology MSc.	
Proposed Start Date: 01/04/2019	**Proposed End Date:** 31/08/2019

Thank you for submitting the above application and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 11.03.2019

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion has been given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Perceived parental support and parental attitudes towards mental health help-seeking in relation to help-seeking behaviours and attitudes of Black and Black Mixed ethnicity young people in the UK

Research evidence from various populations has shown parental support and parental stigma towards mental health and help-seeking to influence individual's attitudes towards and actions of help seeking. This study explores perceived parental support and parental attitudes towards mental health help-seeking in relation to help-seeking behaviours and attitudes in Black and Black Mixed ethnicity young people in the UK. This was an online study, using a correlational-predictive design. Participants were required to fill out six questionnaires that measured levels of perceived parental support, parental attitudes towards mental health help-seeking, their own attitudes towards mental health help-seeking, likelihood of general help-seeking and actions of help-seeking. Results showed a significant relationship between parental support and likelihood of general help-seeking, as well as a significant relationship between parental attitudes towards mental health help-seeking and all three of the outcome variables. These findings both support and contradict previous research in this field and offer an alternative perspective on the role of stigma/negative attitudes towards mental help-seeking in the likelihood and actions of help-seeking behaviour. Interpretation of the results, limitations of the study and implications of the findings in practice and future research are considered in the discussion.

RESEARCH BACKGROUND

According to the World Health Organisation (WHO), mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community", making ill mental health a potentially devastating cause of detrimental psychological and emotional well-being in an individual. Common mental disorders include generalised anxiety disorder, depression, phobias, OCD and panic disorder, but there is also a prevalence of severe mental health problems, such as psychotic disorders, bipolar disorder, ADHD, personality disorders and autistic spectrum disorder (Fundamental Facts about mental health, 2016).

The topic of mental health in Black, Asian and minority ethnic groups is under-researched, even though there is higher risk of ill mental health in BAME groups (Bhui & McKenzie, 2008). Although African Americans display similar rates of mental illness in comparison to the general population (Primm et al., 2010), only one in three receive mental health care (Dalencour et al., 2017). This difficulty in accessing healthcare is also reported in UK BME communities, with black adults having the lowest treatment rate of any ethnic group (Lubian et al., 2016) with concerns noted (The Sainsbury Centre for Mental Health, 2002) and the development of briefs into race equality in mental health (Mental Health Network, 2012). However, Black British people are still most likely to report a common mental disorder (Mental Health

Statistics for England, 2018), three to five times more likely than other ethnic groups to receive a diagnosis or admittance to hospital for schizophrenia (Mental Health Foundation, 2014) and are most likely to be detained under the Mental Health Act (GOV.UK, 2019). This suggests that there are underlying factors that prevent Black British individuals from engaging in help-seeking behaviours for mental health issues. Identifying and exploring these factors can help to reduce the racial disparities in mental health care and prevent further disadvantages.

With most mental health issues developing in childhood or young adulthood and three-quarters of all mental health issues being formed by the age of 24 (Mental Health Taskforce, 2016), studying the help-seeking behaviours of young adults is particularly important to halting this growing problem. Surveys have identified the 16-24 age group as least likely to receive treatment for mental health issues. As well as this, evidence shows that younger adults report more negative attitudes towards seeking mental health treatment than older adults (Gonzalez, Alegria & Prihoda, 2005) and in black populations, older students were inclined to have more positive views about professional psychological help-seeking behaviour than younger students (Duncan, 2003). Because of this, investigating the factors that influence the help-seeking behaviours of young Black and Black Mixed adults is important for this area of knowledge.

THE ROLE OF STIGMA/NEGATIVE ATTITUDES TOWARDS MENTAL HEALTH HELP-SEEKING ON HELP-SEEKING BEHAVIOUR

As one of the most regarded definitions of stigma, Goffman (1963) defined the concept as “an attribute that is deeply discrediting”, that which diminishes an individual “from a whole and usual person to a tainted, discounted one”, therefore producing a “spoiled identity” in a person. In relation to mental illness, stigma is often related to context rather than personal appearance and identified as “a powerful negative attribute in all social relations” (Bryne, 2000). Because of this, it can be suggested that stigma is important for perceptions of self and others.

Mental illness stigma has been singled out as a concerning matter for mental health advocates (Wahl, 1999) and negative responses to mentally ill individuals is found as a considerable obstacle to recovery, limiting possible opportunities and undermining one's self-esteem (Fink & Tasman, 1992). Stigma is highlighted as a potentially more significant barrier to help-seeking and treatment in black populations (Alvidrez, Snowden & Kaiser, 2008; Alvidrez, Snowden, Rao & Boccellari, 2009), due to more stigmatizing perceptions of the mentally ill than Whites (Whaley, 1997; Corrigan & Watson, 2007) which leads to a decreased likelihood of mental health help-seeking that has been found in both general and institutionalized populations (Snowden, 1999). The lack of early access to support services has been linked to declined mental health outcomes and increased likelihood of involuntary admission (Mclean, Campbell & Cornish, 2003), highlighting stigma and negative attitudes towards help-seeking as important factors in influencing help-seeking behaviours. However, there is evidence that suggests no relation between perceived stigma of mental illness and treatment engagement (Alvidrez, Snowden & Patel, 2010), indicating that negative attitudes towards mental illness may not have as large an impact on help-seeking as previously thought. Studies on other foreign populations have found that stigma negatively impacts psychological well-being and is a dominant barrier to help-seeking (Li, Lee, Thammawijaya, Jiraphongsa & Rotheram-Borus, 2008) with similar findings established through robust systematic reviews (Gulliver, Griffiths & Christensen, 2010). Therefore, it is possible to conclude that negative attitudes towards mental health and help-seeking play an important role in an individual's likelihood of seeking help for emotional problems and actions of help-seeking behaviour.

In relation to individual's own attitudes towards mental health and help-seeking, vigorous research evidence has found low levels of perceived stigma to be positively associated with general attitudes towards seeking professional psychological help (Wrigley, Jackson, Judd & Komiti, 2005), indicating that stigma can affect individual's own perceptions of help-seeking. However, opposing research based on a rural community sample has shown perceived stigma to not influence help-seeking. Instead, positive attitudes towards professional help-seeking were found to be a significant predictor of mental health help-seeking (Komiti, Judd & Jackson, 2006). As well as this, large European samples have found evidence that attitudes towards mental health help-seeking were significantly related to service

use (ten Have et al., 2010), with perceived stigma for seeking psychological help being linked with negative help-seeking attitudes in Asian American students (Shea & Yeh, 2008). This highlights the cross-cultural relevancy of stigma as a predictor of negative help-seeking attitudes and a barrier to actions of help-seeking.

THE ROLE OF PARENTAL SUPPORT IN MENTAL HEALTH AND HELP-SEEKING BEHAVIOUR

According to Thomas, Gecas, Weigert & Rooney (1974) parental support is defined as a "behaviour manifest by a parent toward a child that makes the child feel comfortable in the presence of the parent and confirms in the child's mind that he is basically accepted and approved as a person by the parent." Support is identified as a critical component of parenting, coming in the form of nurturance, attachment, acceptance and love (Barnes & Farrell, 1992), meaning that a lack of support can have a detrimental impact on the parent-child relationship and the child's emotional well-being.

Parental support has been shown to be a protective factor against mental illness in transgender adolescents (Simons, Schrager, Clark, Belzer & Olson, 2013) and gay, lesbian and bisexual youth (Eisenberg & Resnick, 2006), with a lack of parental support leading to negative outcomes on an individual's well-being (Ruholt, Gore & Dukes, 2015). In African American populations, social support has been found to enhance the negative relationship between mental health stigma and reduced symptoms of depression (Lindsey, Joe & Nebbitt, 2010), emphasizing the importance of family support. Social support has also been found to assist help-seeking behaviours in foreign populations (Li, Lee, Thammawijaya, Jiraphongsa & Rotheram-Borus, 2008), establishing social support as an ecologically valid construct that can be applied to different populations in regard to help-seeking behaviour. Vigorous research evidence also identifies warm, child-centred parenting styles as a strong indicator of more positive help-seeking styles in girls, and parental influence as an important factor in other types of decision making (Hutchinson, 2002; Commendador, 2010; Palos & Vîşcu, 2010).

Whilst there is little research relating parental support and attitudes toward help-seeking behaviours, there is evidence that parental support plays a significant role in reducing stigma of gay, lesbian and bisexual issues (Goldfried & Goldfried, 2001), as well as buffering the negative outcomes produced by perceived discrimination in socio-economically disadvantaged Irish children (Bradshaw, Jay, McNamara, Stevenson & Muldoon, 2016). Although not mental health focused, this evidence demonstrates the effects of parental support in different contexts and in different populations.

Within the African-Caribbean community there is a low awareness and considerable stigma around mental health issues, with the term 'mental health' being associated with words such as 'madness' (NSMC, 2010). There is potential for these negative views to be passed down onto children, and when this is combined with a lack of parental support, this can have a detrimental impact on a person's ability to seek help for ill mental health. The lack of studies looking at parental support as a single factor related to help-seeking paves the way for research that may help close the gap in the field, and on this particular ethnic group. It is important to single out parental support for exploration due to its significance in an individual's life.

THE HEALTH BELIEF MODEL AS A FRAMEWORK FOR HELP-SEEKING BEHAVIOUR

According to Rickwood & Thomas (2012) "In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern". External assistance can either be in the form of mental health care professionals, such as a counsellor/therapist, psychologist or psychiatrist, or informal support such as family, peers and religious leaders.

As one of the most dominant theories of help-seeking behaviour, the Health Belief model (REF) was originally developed for public health and is based on the concepts of: *(i) the desire to avoid illness or to get well (value);* and *(ii) the belief that a specific health action available to a person would prevent (or ameliorate) illness (expectation).* The key variables of the HBM have three categories:

Individual perceptions

- Perceived susceptibility/perceived severity of disease

Modifying factors

- Variables such as age, sex, ethnicity, knowledge, etc.
- Perceived threat of disease
- Cues to action, e.g. education, symptoms/illness, information

Likelihood of action

- Perceived benefits minus perceived barriers to behaviour change
- Likelihood of behaviour change

Stigma towards mental health help-seeking may influence individual's perceptions of their perceived susceptibility to/severity of ill mental health, as well as being a modifying factor for actions of help-seeking alongside parental support. As previous research suggests, parental support can positively influence help-seeking behaviours (Li et al., 2008). Hence, it can be hypothesised that low parental support may reduce the likelihood of said actions. Mental health stigma can be developed through interactions with parents/guardians who hold negative attitudes towards mental health and help-seeking. This stigma can cause individuals to anticipate the negative consequences (e.g. perceptions of help-seeking as a sign of weakness or being crazy) and deter them from help-seeking behaviours (Clement et al., 2015). Therefore, whilst there is a desire to get well, the lack of parental support and increased mental health stigma act as barriers towards actions of help-seeking and reduce the belief that these actions would prevent ill mental health.

This model is based on the beliefs and attitudes of an individual regarding their health state and can therefore not only explains why an individual may be reluctant to seek help for mental health issues, but also the factors that alter their mindset. Critical review of HBM-related studies (Janz & Becker, 1984), as well as recent research on Asian American and White American students (Kim & Zane, 2015) provide strong empirical support for the different dimensions of the HBM. This research highlights the dimensions as key contributors in the explanation and prediction of health-related behaviours in

individuals and supports the use of the HBM as framework for explaining differences in the mental health help-seeking intentions.

RESEARCH RATIONALE

This piece of research seeks to improve understanding of the factors involved in attitudes and actions of help-seeking behaviour in young Black and Black Mixed ethnicity people in the UK. Identifying and addressing significant risk factors may help to reduce the difference in the number of reports of common mental disorders, hospital diagnoses/admittances for mental health issues and detentions under the Mental Health Act between ethnic groups. This research can also raise awareness in the importance of parental support for black emotionally troubled or mentally ill individuals, as well as the implications of negative help-seeking attitudes. This can potentially lead to a less stigmatized view of mental health and help-seeking within parents of young black people and themselves and increase parental support for individuals suffering from emotional issues or ill mental health.

RESEARCH AIM

To explore if perceived parental support and parental attitudes towards mental health help-seeking are significantly related to help-seeking behaviours and attitudes in Black and Black Mixed ethnicity young people in the UK.

RESEARCH QUESTIONS

1 a) Is there an association between the level of perceived parental support and participant's own attitudes towards seeking help for mental health issues?

b) Is there an association between parental attitudes towards mental health/help-seeking and participant's own attitudes towards seeking help for mental health issues?

2 a) Is there an association between the level of perceived parental support and the likelihood of help-seeking behaviours in young Black British adults?

b) Is there an association between parental attitudes towards mental health/help-seeking and the likelihood of help-seeking behaviour in young Black British adults?

3 a) Is there an association between the level of perceived parental support and actions of help-seeking behaviour in young Black British adults who have sought mental health support?

b) Is there an association between parental attitudes towards mental health/help-seeking and actions of help-seeking behaviour in young Black British adults who have sought mental health support?

RESEARCH METHODS

PARTICIPANTS

140 datasets were collected for use in this study. However, five respondents did not fully complete the consent form and were therefore excluded from the study. The final sample used Black and Black Mixed young people (*N*=135) who were born and raised in the UK to immigrant parent(s)/guardian(s) and are currently living in the UK. The age range is between 16 and 25 years. Those that did not meet the criteria were excluded from the study.

PROCEDURE

Participants were recruited using social media platforms (Facebook, Twitter, Reddit) to advertise the research. University of Nottingham Department administrators and BME-related societies were also contacted for permissions to distribute the survey on our behalf. Potential participants were invited to read the information sheet and indicate informed consent, which was presented using a consent form before participation. After completion of the study, participants were presented with a debrief form, explaining the aims of the study and giving information on support organisations. Data collection took place online using JISC online surveys and lasted for approximately seven days, with participants required to complete a total of six questionnaires.

MEASURES

The materials used in this online study included a participant information sheet, consent form, screening survey, debrief form, and six questionnaires (See Appendix for full information). The information collected was as follows:

1. Socio-demographic information about the participants, which included age, gender, race, geographical region, relationship status, education level, religion and employment status.
2. A brief questionnaire on common mental health symptoms was adapted from the Mayo Clinic website. This 18-item questionnaire is used to identify respondents who may have experienced symptoms of ill mental health within the last five years, rather than a definite mental health assessment. Higher scores on the questionnaire indicate more symptoms of ill mental health.
3. Parental support was assessed with the family subscale of the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988) (4 items; α=0.93), substituting "family" for "parent(s)" (e.g., "My parent(s) really try to help me"). Scores between 1 and 2.9 indicate low support, 3 to 5 indicate moderate support and 5.1 to 7 indicate high support. The MSPSS has good internal and test-retest reliability, moderate construct validity and discriminant validity, and offers a moderating effect when tested on several different populations (Zimet, Dahlem, Zimet & Farley, 1988; Dahlem, Zimet & Walker, 1991) including a largely African American adolescent population (Canty-Mitchell & Zimet, 2000).
4. Parent and participant's attitudes towards mental health help-seeking were assessed using two adapted versions of the Parental Attitude Towards Psychological Services Inventory (PATPSI) (Turner, 2011). For assessing parental attitudes, the substitutions were as follows: "I" and "my" for "my parent(s)", "they" and "their" and "my child" for "I" and "me" where applicable (e.g., "My parent(s) would not want others (friends, family, teachers, etc.) to know if I had a psychological or behaviour problem"). For assessing participant own attitudes towards mental health, the substitutions were as follows: "my child" for "I", "me" and "myself" where applicable (e.g., "It would be relatively easy for me to take myself to see a professional for help"). This study used 12 items from the PATPSI scored from 0 to 5, with a possible minimum score of 0 and maximum score of 60. Higher scores indicate more negative attitudes towards help-seeking. The PATPSI shows adequate internal consistency and test-retest reliability, as well as discriminate validity (Turner, 2011).
5. Participants' own attitudes to and actions of help-seeking behaviour was assessed using the General Help-Seeking Questionnaire (GHSQ) and Actual Help-Seeking Questionnaire (AHSQ)

(Rickwood, Deane, Wilson & Ciarrochi, 2005). Participants were first asked if they had been previously diagnosed with a mental health issue by a professional. If they answered 'yes', they were asked to complete both the AHSQ and GHSQ. If they answered 'no' they were only asked to complete the GHSQ. This study used 9 items from the GHSQ scored from 1 to 7, with a possible minimum score of 9 and maximum score of 63. Higher scores indicate higher intentions of help-seeking. The possible total score for the AHSQ is 10, with higher scores indicating higher levels of help-seeking behaviour. The GHSQ and AHSQ show satisfactory reliability and validity, flexibility when measuring previous experiences with help seeking and help seeking intentions (Wilson, Deane, Ciarrochi & Rickwood, 2005`) and cross-cultural validity and reliability with Chilean adolescents (Olivari & Guzmán-Gonazález, 2017).

ETHICS

This study was reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine & Health Sciences Research Ethics Committee (FMHS REC ref no: 216-1903).

- All participants were required to complete a consent form before starting the survey.
- To prevent bias in responses, participants were only told the full aim of the study in the debrief form upon completion.
- Participants were given a right to withdraw at any point during the online study, as well as after data submission.
- Participants were informed that their data will remain anonymous and confidential, and that their IP address would not be stored.
- There were no known risks associated with this research study. However, participants were presented with various charities and support groups upon completion of the study.

Whilst there were a number of approaches that could have been utilized for data collection (e.g. in-person interviews, postal questionnaires, etc.), an online survey was chosen due to fast distribution, reduced data collection times and easy obtainment of a large sample size (Evans & Mathur, 2005). The use of systems such as JISC Online Surveys allows for the implementation of advanced options, such as required answers and control of answer order, that ensure non-responses and improper answers are not accepted, reducing the likelihood of erroneous data. There is evidence that online surveys have a higher completion rate than postal surveys (Ilieva, Baron & Healey, 2002). Online surveys are also convenient, as they can be completed by respondents at any time, in any place with internet connection, and in as much time necessary. This is noted as an advantage of this method (Hogg, 2003). However, the use of online surveys comes with limitations as well. There are potential problems in regard to sample implementation due to unintended participants completing the survey. Additionally, due to the self-administration nature of online surveys, instructions may not always be as clear to the potential participant as other approaches, e.g. face to face interviews. This can cause individuals to become frustrated and exit the survey without completing it (Ray & Tabor, 2003).

RESULTS

Table 1 present sample characteristics. The age of participants ranged from 16 to 25 years. Participants were both female (n= 114, 84.4%) and male (n= 21, 15.6%), predominantly of fully black origin (n= 123, 91.1%), single/never married (n= 70, 51.9%), university undergraduate students (n= 75, 55.6%), from the Greater London area (n= 79, 58.5%) and currently living with parents (n= 112, 83.0%). See Table 1 for full information on sample characteristics.

Table 1. *Sample Characteristics for the Study (N=135)*

Demographics	N	%
Gender		
Male	21	15.6
Female	114	84.4
Age		
16	6	4.4
17	4	3.0
18	11	8.1
19	15	11.1
20	16	11.9
21	21	15.6
22	14	10.4
23	20	14.8
24	13	9.6
25	15	11.1
Race		
Black	123	91.1
Mixed (Black and White)	7	5.2
Mixed (Black and Asian)	3	2.2
Mixed (Other)	2	1.5
Relationship Status		
Single/ Never married	70	51.9
Dating	18	13.3
In a serious relationship	19	14.1
I have never gone out with anyone	27	20.0
Married/ Domestic partnership	1	0.7
Education Level		
Secondary school	5	3.7
College/ Sixth form	34	25.2
Vocational training	1	0.7
University/ Undergraduate degree	75	55.6
Master's/ Postgraduate degree	19	14.1
Other	1	0.7
Geographical Area		
Bedfordshire	1	0.7

Berkshire	1	0.7
Buckinghamshire	1	0.7
Cambridgeshire	1	0.7
Clackmannanshire	1	0.7
Dorset	1	0.7
Essex	7	5.2
Greater London	79	58.5
Hertfordshire	5	3.7
Kent	8	5.9
Lancashire	1	0.7
Leicestershire	2	1.5
Londonderry	2	1.5
Middlesex	5	3.7
Northumberland	1	0.7
Nottinghamshire	5	3.7
Somerset	1	0.7
Staffordshire	3	2.2
Surrey	3	2.2
Sussex	1	0.7
Warwickshire	2	1.5
Yorkshire	4	3.0
Employment Status		
Employed (full time)	40	29.6
Employed (part time)	19	14.1
Self-employed	2	1.5
Student	64	47.4
Unemployed	6	4.4
Prefer not to say	1	0.7
Other	3	2.2
Religion		
Christianity	113	83.7
Islam	9	6.7
None	11	8.1
Other	2	1.5
Living with parent(s)/guardian(s)?		
Yes	112	83.0
No	23	17.0

Notes. There were 5 respondents excluded across all categories.

Table 2 presents the mean scores and standard deviations for each measure, including interpretation of the scores.

Table 2. *Mean Scores and Standard Deviations for Variables*

Variable	Mean (M)	Standard Deviation (SD)	Interpretation
Emotional Problem	6.95	3.75	Moderate
Parental Support	4.32	1.51	Moderate
Parent Attitudes – Mental Health/Help-Seeking	40.76	7.01	Moderate/High
Participant Attitudes – Mental Health/Help-Seeking	40.69	7.42	Moderate/High
General Help-Seeking Behaviour	34.57	6.29	Moderate
Actual Help-Seeking Behaviour	1.13	2.01	Low

Notes. There were 5 excluded respondents across all categories.

Before data analysis was conducted, histograms were created for each variable and checked for normality of distribution. All of the variables, excluding 'Actual Help-Seeking Behaviour' were found to be normally distributed through visual analysis of histograms provided in the SPSS output (See Appendix K for histograms). For large sample sizes, visual assessment of data distribution is said to be adequate, with formal significant testing rarely necessary (Kirkwood & Sterne, 2003). As the variable 'Actual Help-Seeking Behaviour' was not normally distributed, it could not be used in the linear regression analysis. Although Pearson's correlation was run and shows a weak, non-significant relationship between the two predictor variables, visual analysis of their scatterplot indicates linearity between them (See Appendix L for scatterplot).

After completion of tests for normality on the dataset, each of the predictor variables were tested for correlation and significance to the outcome variable used in each question. Subsequently, simple linear regression was chosen as the appropriate analysis to conduct for research Question 1 and 2. For Question 3, scatterplots were created for the outcome variable against the predictor variables and Spearman's Rank correlation was conducted to check for correlation and significance of the relationship. The results were as follows:

Question 1

a) Is there an association between the level of perceived parental support and participant's own attitudes towards seeking help for mental health issues?

Pearson's correlation shows a weak, non-correlational, non-significant relationship between perceived parental support and participant's attitudes towards mental health/help-seeking (See Appendix L for scatterplot of variables). Results of linear regression analysis indicate that for every one unit of change in the parental support score, participant's attitudes increased by .22, with 95% confidence that this increase is actually somewhere between -.62 and 1.06. With a p-value of .60, perceived parental support and participant's own attitudes towards mental health/help-seeking do not have a statistically significant relationship when fitted into this model. These findings are consistent when the model is adjusted for age, gender and race.

b) Is there an association between parental attitudes towards mental health/help-seeking and participant's own attitudes towards seeking help for mental health issues?

Pearson's correlation shows a moderate, positive, significant relationship between perceived parental attitudes towards mental health/help-seeking and participant's attitudes towards mental health/help-seeking. Results of linear regression analysis indicate that for every one unit of change in parental attitudes, participant's attitudes increased by .57, with 95% confidence that this increase is actually somewhere between .43 and .73. With a p-value of <.001, parental attitudes towards mental health/help-seeking and participant's own attitudes towards mental health/help-seeking have a high statistically significant relationship when fitted into this model. These findings are consistent when the model is adjusted for age, gender and race.

Table 3. *Results of Linear Regressions for Participant Attitudes towards Mental Health/Help-Seeking (N = 135)*

	Unadjusted β (95% CI)	*P*	Age, Gender & Race adjusted β	*p*
Parental Attitudes	0.57 (.42, .73)	<.001	0.57 (.41, .72)	<.001
Parental Support	0.22 (-.62, 1.06)	.60	0.35, (-.50, 1.19)	.42

Question 2

a) Is there an association between the level of perceived parental support and the likelihood of help-seeking behaviours in young Black British adults?

Pearson's correlation shows a weak, positive, highly significant relationship between perceived parental support and participant's likelihood of general help-seeking. Results of linear regression analysis indicate that for every one unit of change in parental support, participant's likelihood of general help-seeking increased by 1.80, with 95% confidence that this increase is actually somewhere between 1.15 and 2.44. With a p-value of <.001, level of perceived parental support and participant's likelihood of general help-seeking have a high statistically significant relationship when fitted into this model. These findings are consistent when the model is adjusted for age, gender and race.

b) Is there an association between parental attitudes towards mental health/help-seeking and the likelihood of help-seeking behaviour in young Black British adults?

Pearson's correlation shows a weak, non-correlational, significant relationship between perceived parental attitudes towards mental health/help-seeking and participant's likelihood of general help-seeking. Results of linear regression analysis indicate that for every one unit of change in perceived parental attitudes, participant's likelihood of general help-seeking increased by .19, with 95% confidence that this increase is actually somewhere between .04 and .34. With a p-value of < .05, parental attitudes towards mental health/help-seeking and participant's likelihood of general help-seeking have a statistically significant relationship when fitted into this model. These findings are consistent when the model is adjusted for age, gender and race.

Table 4. *Results of Linear Regression for General Help-Seeking Intentions (N = 135)*

	Unadjusted β (95% CI)	*P*	Age, Gender & Race adjusted β	*p*
Parental Attitudes	.19 (.04, .34)	<.05	.19 (.03, .34)	<.05
Parental Support	1.80 (1.15, 2.44)	<.001	1.80 (1.14, 2.46)	<.001

Question 3

a) Is there an association between the level of perceived parental support and actions of help-seeking behaviour in young Black British adults who have sought mental health support?

Results of the Spearman's Rho correlation shows a correlation coefficient of .07, which indicates an almost non-existent relationship between perceived parental support and actual help-seeking behaviour. This is a statistically non-significant relationship, with $p = .43$. Visual analysis of the scatterplot of the two variables shows no linearity between the two variables.

b) Is there an association between parental attitudes towards mental health/help-seeking and actions of help-seeking behaviour in young Black British adults who have sought mental health support?

Results of the Spearman's Rho correlation shows a correlation coefficient of .17, which indicates a very weak relationship between perceived parental attitudes towards mental health/help-seeking and actual help-seeking behaviour. This is a statistically significant relationship, with $p < .05$. Visual analysis of the scatterplot of the two variables shows no linearity between the two variables.

Table 5. *Results of Pearson's Correlation for Actual Help-Seeking Behaviour (N = 135)*

	p	*α*
Parental Attitudes	.17	<.05
Parental Support	.07	.43

DISCUSSION

The aim of this study was to explore if parental support and parental attitudes towards mental health help-seeking were related to attitudes and actions of help-seeking behaviour in young Black and Black Mixed ethnicity people in the UK. This piece of work contains six research questions, which ask if levels of perceived parental support and parental attitudes towards help-seeking are related to participant attitudes towards help-seeking, likelihood of and actions of help-seeking behaviour.

INTERPRETATION OF RESULTS WITHIN THE STUDY CONTEXT

Based on the results of this present study, a conclusion could not be made on whether levels of perceived parental support has any relation with attitudes towards mental health help-seeking or actions of help-seeking behaviour in young Black and Black Mixed British adults, therefore not providing support for questions 1a and 2a. Perceived parental support was found to have a high statistically significant relationship with the likelihood of general help-seeking behaviour. Although the relationship is weak, the results indicate that as perceived parental support goes up, so does the likelihood of help-seeking behaviour. Because of this, it is concluded that there is a relationship between the two variables, answering research question 2a.

Parental attitudes towards mental health help-seeking was found to have a statistically significant relationship with all three of the outcome variables, answering questions 1b, 2b, and 3b. The findings suggest that whilst an increase in parents' negative attitudes towards help-seeking is related to an increase in negative attitudes towards help-seeking in young Black adults, there is also a slight increase in the likelihood of general help-seeking intentions. Whilst a significant relationship was found between parental attitudes towards mental health and actual help-seeking behaviour, the limitations of the chosen analysis means there is uncertainty surrounding the nature of this relationship.

INTERPRETATION OF RESULTS IN RELATION TO PREVIOUS RESEARCH

The finding that increased parental support is related to an increased likelihood of general help-seeking supports the previous literature in this area that highlights parental support as a protective factor against mental illness (Eisenberg & Resnick, 2006; Simons et al., 2013). However, the lack of a statistically significant relationship with participant's attitudes towards mental health help-seeking and actions of help-seeking behaviour in the sample does not support the literature presented which shows parental support as significant in reducing stigma in LGBT communities (Goldfried & Goldfried, 2001) and an aid for help-seeking behaviours (Li et al., 2008).

In regards to parental attitudes towards mental health and help-seeking, the finding of a significant positive relationship with participant attitudes towards mental health/help-seeking is consistent with previous research that highlights levels of perceived stigma and attitudes towards help-seeking as being associated or predictors of mental health help-seeking (Wrigley, Jackson, Judd & Komiti, 2005; Komiti, Judd & Jackson, 2006), further supporting the belief that stigmatised views of mental health and help-seeking from family or loved ones can influence individual's own views of mental health and help-seeking. The findings of the linear regression indicate that increases in negative parental attitudes towards mental health help-seeking is related to an increase in the likelihood of general help-seeking, which is inconsistent with the literature presented. However, this provides a different perspective in understanding the relationship between perceived mental health stigma and help-seeking. One explanation is that stigma could play a positive role by increasing thoughts about seeking help in those suffering from emotional wellbeing or mental health issues.

Although finding a significant correlation between parental attitudes towards mental health/help-seeking and actions of help-seeking behaviour, the limitations of the data analysis used for these two variables means that there is uncertainty over whether this finding fully supports the current literature in the field.

LIMITATIONS OF THE STUDY

Whilst this study produced some significant results, there are a number of limitations that may have prevented the discovery of further significant findings. One of the shortcomings with this present study was the choice of measures used for data collection. In particular, the four-item family subscale from the Multidimensional Scale of Perceived Social Support (MSPSS) can be highlighted for its inability to produce significant results. Because only four items were used, it is possible that this scale was too small to accurately represent perceived parental support in relation to the other variables used in the study. For future replications of this research, researchers may look to use alternative measures that may be more appropriate against the other examined variables.

Another limitation of this study is the lack of diversity within the sample used. Sample characteristics show that the majority of participants were from London and female. Because of this, it is difficult to make broader generalisations from the results as the sample is not representative of the entire UK black population. However, putting a limit of the number of participants from each geographical region or gender would have made data collection slower and potentially led to a considerably smaller sample for this study. Therefore, in order to obtain a large sample size, restrictions such as these were not applied. Whilst an adequate sample size was accumulated, allowing more time for data collection may have provided a more representative sample and increased accuracy in the generalisation of results to the target population.

Nonetheless, the significant relationships found are valid for the purpose of answering the intended research questions.

HOW DO THE FINDINGS DEVELOP AREA KNOWLEDGE IN THE WIDER CONTEXT?

The current literature in this area shows parental support and mental health stigma/negative parental attitudes towards mental health and help-seeking to have a negative effect on individual's attitudes

and actions of help-seeking behaviour in various populations. The findings of this study reinforce this in the Black British population for the first time, but also indicate that negative parental attitudes can increase both likelihood and actions on help-seeking behaviour in the target population. These are findings which although inconsistent with the current area knowledge, provide new insight into the relationship between stigma/negative attitudes towards mental health and help-seeking attitudes and behaviours. The results of the present study offer a new role to stigma, as a prompt for help-seeking likelihood and actions.

IMPLICATIONS OF THE FINDINGS IN PRACTICE AND FOR FUTURE RESARCH

It can be questioned if the design of this study is powerful enough to influence practice and future research. Therefore, we can only speculate about the potential implications of this work. With levels of perceived parental support being related to likelihood of general help-seeking in the young Black British population, greater efforts can be made within schools, communities and from mental health organisations to provide knowledge to black parents on the importance of supporting children with emotional wellbeing and mental health issues. This can encourage more involvement in the help-seeking process, shed light on how negative attitudes can impact their children's mental well-being and help-seeking abilities, as well as helping to reduce mental health stigma in the Black British population, disparities in reports of common mental disorders between the ethnic groups and detentions under the Mental Health Act.

This finding can also encourage the implementation of family therapy groups that focus on those suffering with mental health issues within the Black community, offering a safe space for parents and children to discuss their thoughts on mental health and gain information on how to support children/family members. By doing so, this can also help to reduce reports of mental health symptoms and hospital admissions for Black British people, as well as increase treatment rates.

The finding of a relationship between parental negative attitudes towards help-seeking and likelihood/actions of help-seeking behaviour is new and can encourage further study into these variables. The use of different research designs may produce further information that can aid understanding of the relationship between these variables. For example, a longitudinal study can explore the effects of perceived parental support and parental attitudes towards help-seeking over time in the Black population, revealing whether the impact is more prominent in young people or consistent with age. Qualitative research, such as a thematic analysis, could explore the relationship between these variables deeper, and improve understanding of why Black individuals feel that parental support aids the likelihood of help-seeking, or why negative parental attitudes towards mental health and help-seeking may be related to their own attitudes and actions of help-seeking.

CONCLUSION

This aim of this project was to explore whether levels of perceived parental support and parental attitudes towards mental health help-seeking were related to attitudes and actions of help-seeking behaviour in young Black and Black Mixed ethnicity people in the UK. The findings show that parental support is related to likelihood of general help-seeking, and parental attitudes towards mental health help-seeking is related to participant attitudes towards mental health help-seeking, likelihood of general help-seeking and actions of help-seeking. The implications of these findings can provide knowledge to black parents on the importance of mental health support, lead to the implementation of family therapy groups within the Black community and the use of different research designs that can produce further information to aid understanding of the relationship between these variables.

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APPENDICES

Appendix A: Screening/Background Questions

Screening questions

Please specify your gender
- Male
- Female
- Other (please specify)

Please enter your age _____

What race are you?
- White
- Black
- Asian
- Mixed (Black and White)
- Mixed (Black and Asian)
- Mixed (White and Asian)
- Other (please specify)

Were you born in the UK?
- Yes
- No

Are you currently living in the UK?
- Yes
- No

Were you raised by immigrant parent(s)/guardian(s)?
- Yes
- No

Background / demographic questions

What is your relationship status?
- Single/ never married
- Dating
- In a serious relationship
- I have never gone out with anyone
- Married/ Domestic partnership
- Divorced
- Widowed
- Separated
- Prefer not to say

What is your highest level of education?

- No formal education
- Secondary school
- College/sixth form
- Vocational training
- University/Undergraduate degree
- Master's/Postgraduate degree
- Doctorate/ PHD
- Other (please specify)
- Prefer not to say

Which geographical area do you live in at the moment?
[A dropdown menu of all the UK counties]

What is your current employment status?

- Employed (full time)
- Employed (part time)
- Self-employed
- Student
- Retired
- Unemployed
- Other (please specify)
- Prefer not to say

What religion do you identify with? If none, which religion were you raised in?

- Christianity
- Islam
- Buddhism
- Sikhism
- Hinduism
- Judaism
- None
- Other (please specify) _____

Are you currently living with your parent(s)/guardian(s)?

- Yes
- No

Have you been diagnosed with a mental health issue by a professional, such as GP or psychiatrist?

- Yes
- No

Appendix B: Mental Health Questionnaire

Have you ever had any of the following experiences for over 4 consecutive weeks in the last 5 years? (Please select all that applies)

- Feeling sad or down
- Feeling confused or finding it hard to concentrate
- Excessive fears, worrying a lot or feeling extremely guilty
- Extreme mood changes of highs and lows
- Detachment from reality
- Paranoia or hallucinations (e.g. seeing or hearing things that are not there)
- Unable to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Thinking about ending my own life
- Not going out and seeing friends, or doing so less often
- Significant tiredness, low energy or problems sleeping
- Using a lot of alcohol or drug to the point where I cannot get on with what I need to do in everyday life
- Major changes in eating habits
- Increase or decrease in sex drive
- Feeling very angry
- Hurting others physically such as hitting, pushing, punching or kicking etc.
- Shouting at others or saying mean things to them
- None

Appendix C: Adapted Multidimensional Scale of Perceived Social Support (MSPSS)

Below are some statements about your relationship with your parent(s)/guardian(s). Please answer each statement based on your feelings and thoughts about this relationship.

1 = **Very Strongly Disagree**
2 = **Strongly Disagree**
3 = **Somewhat Disagree**
4 = **Neutral**
5 = **Somewhat Agree**
6 = **Strongly Agree**
7 = **Very Strongly Agree**

a) My parent(s)/guardian(s) really try to help me.
b) I get the emotional help and support I need from my parent(s)/guardian(s).
c) I can talk about my problems with my parent(s)/guardian(s).
d) My parent(s)/guardian(s) are willing to help me make decisions.

Appendix D: Adapted Parental Attitude Towards Psychological Services Inventory (PATPSI)

Below are some statements about your parent(s)/guardian(s) feelings towards your mental wellbeing and help-seeking behaviours. Please answer each statement based on how you think your parent(s)/guardian(s) would act and feel in relation to your mental wellbeing and help-seeking behaviours.

0 = ***Strongly Disagree***
1 = ***Disagree***
2 = ***Somewhat Disagree***
3 = ***Somewhat Agree***
4 = ***Agree***
5 = ***Strongly Agree***

a) My parent(s)/guardian(s) would not want others (friends, family, teachers, etc.) to know if I had a psychological or behaviour problem.
b) If I were experiencing a serious psychological or behaviour problem at this point in my life, my parent(s)/guardian(s) would be confident that they could find relief in professional help.
c) If I were to experience a psychological or behaviour problem, my parent(s)/guardian(s) would get professional help if they wanted to.
d) Important people in my parent(s)/guardian(s) life would think less of me if they were to find out that I had a psychological or behaviour problem.
e) It would be relatively easy for my parent(s)/guardian(s) to take me to see a professional for help.
f) My parent(s)/guardian(s) would want to get professional help if I were worried or upset for a long period of time.
g) My parent(s)/guardian(s) would be uncomfortable seeking professional help for me because people (friends, family, co-workers, etc.) might find out about it.

h) My parent(s)/guardian(s) would not want to take me to a professional because of what people might think.
i) If my parent(s)/guardian(s) believed I was having a mental breakdown, their first decision would be to get professional help.
j) My parent(s)/guardian(s) would feel uneasy going to a professional because of what some people would think.
k) Had I received treatment for a psychological or behaviour problem, my parent(s)/guardian(s) would feel that it should be "kept secret".
l) My parent(s)/guardian(s) would be embarrassed if their neighbour saw me going into the office of a professional who deals with mental health concerns.

Appendix E: Attitude Towards Psychological Services Questionnaire

Below are some statements about your feelings towards your mental wellbeing and help-seeking behaviours. Please answer each statement based on how you think you would act and feel in relation to your mental wellbeing and help-seeking behaviours.

0 = ***Strongly Disagree***
1 = ***Disagree***
2 = ***Somewhat Disagree***
3 = ***Somewhat Agree***
4 = ***Agree***
5 = ***Strongly Agree***

a) I would not want others (friends, family, teachers, etc.) to know if I had a psychological or behaviour problem.
b) If I were experiencing a serious psychological or behaviour problem at this point in my life, I would be confident that I could find relief in professional help.
c) If I were to experience a psychological or behaviour problem, I would get professional help if I wanted to.
d) Important people in my life would think less of me if they were to find out that I had a psychological or behaviour problem.
e) It would be relatively easy for me to go and see a professional for help.
f) I would want to get professional help if I were worried or upset for a long period of time.
g) I would be uncomfortable seeking professional help for myself because people (friends, family, co-workers, etc.) might find out about it.
h) I would not want to take myself to a professional because of what people might think.
i) If I believed I was having a mental breakdown, my first decision would be to get professional help.
j) I would feel uneasy going to a professional because of what some people would think.
k) Had I received treatment for a psychological or behaviour problem, I would feel that it should be "kept secret".
l) I would be embarrassed if my neighbour saw me going into the office of a professional who deals with mental health concerns.

Appendix F: Actual Help-Seeking Questionnaire (AHSQ)

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem. Tick any of these who you have gone to for advice or help in the past five years for a personal or emotional problem.

3a) Partner (e.g., significant boyfriend or girlfriend)
3b) Friend (not related to you)
3c) Parent
3d) Other relative / family member
3e) Mental health professional (e.g., school counsellor, psychologist, psychiatrist)
3f) Phone help line
3g) Family doctor / GP
3h) Teacher (year advisor, classroom teacher)
3i) Someone else not listed above (please describe who this was)
_____
3j) I have not sought help from anyone for my problem

If you selected 'Someone else not listed above', please describe who this person was.

Briefly describe the type of problem you went to the selected person(s) about.

Appendix G: General Help-Seeking Questionnaire (GHSQ)

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem. Please select the number that shows how likely is it that you would seek help from each of these people for a personal or emotional problem during the next year?

1 = Extremely Unlikely
2 = Very Unlikely
3 = Unlikely
4 = Neutral
5 = Likely
6 = Very Likely
7 = Extremely Likely

1a) Partner (e.g., significant boyfriend or girlfriend)
1b) Friend (not related to you)
1c) Parent
1d) Other relative / family member
1e) Mental health professional (e.g., school counsellor, psychologist, psychiatrist)
1f) Phone help line

1g) Family doctor / GP
1h) Minister or religious leader (e.g. Priest, Rabbi, Chaplain)
1i) Someone else not listed above (please describe who this was)
_____
1j) I would not seek help from anyone

2a) Have you seen a mental health professional within the last five years (e.g., school counsellor, counsellor, psychologist, psychiatrist) to get help for personal problems?

Yes / No

Appendix H: Participant information form

School of Medicine
University of Nottingham
Medical School
Nottingham, NG7 2UH

Research study into the help-seeking behaviours of Black British young people.

Research Ethics Ref: 216-1903

Researcher: Olivia Kwakyewaa-Gyamfi (Olivia.Kwakyewaa-Gyamfi@nottingham.ac.uk)
Supervisor: Dr Shihning Chou (shihning.chou@nottingham.ac.uk)

General Information

Thank you for your interest in taking part in this online survey. You have been invited to participate as you are a black person aged 16-25 years old. Please read through this information before agreeing to participate by clicking 'next' and checking all boxes on the consent form.

This survey should take no more than 15 minutes to complete, with seven short questionnaires. The information collected will be analysed and discussed in a dissertation, with potential for future journal publication.

How will your data be used?

Your data will remain anonymous and confidential. Your participation in this study is entirely voluntary. You can withdraw at any point during the survey for any reason, before submitting your answers by clicking the Exit button/closing the browser. Your data will only be uploaded on completion of the questionnaire by clicking the SUBMIT button. If you wish to withdraw your data after submission, please post the randomly assigned study number at the top of the debrief page to Olivia Kwakyewaa-Gyamfi, B22 Yang Fujia Building, University of Nottingham, Wollaton Road, Nottingham, NG8 1BB.

Your data will be stored in a password-protected file and may be used in academic publications. Your IP address **will not** be stored.

Who will have access to your data?

The University of Nottingham is the data controller for the purposes of the Data Protection. Your data may be shared with other senior staff within the School of Medicine, for inspection upon marking.

As with any online related activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous. We will minimize any risks by using a password-protected file. The results of the study may be published in scientific journals and presented at

scientific conferences. The data will be reported anonymously, with any identifying information removed. This anonymous data will be kept for 7 years.

If you have any questions about this project, you may contact the Lead Researcher: Olivia Kwakyewaa-Gyamfi (olivia.kwakyewaa-gyamfi@nottingham.ac.uk) or if you have any concerns about any aspect of this study please contact the Research Supervisor: Dr Shihning Chou (shihning.chou@nottingham.ac.uk). If you remain unhappy and wish to complain formally, you should then contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk

This study has been reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine & Health Sciences Research Ethics Committee (FMHS REC ref no: 216-1903).

Appendix I: Participant consent form

Olivia Kwakyewaa-Gyamfi

School of Medicine
University of Nottingham
Medical School
Nottingham, NG7 2UH

Ethics ref no: 216-1903

Consent Form

Thank you for participating!

Please, tick each box to continue:

- ○ I confirm that I have read and understood the information on the previous page
- ○ I am 16 years old and/or older
- ○ I understand that my participation is voluntary, and I can end the study at any time and withdraw my data by clicking the EXIT button.
- ○ I understand that my answers will be anonymous.
- ○ I understand the overall anonymized data from this study may be used in the future for research (with research ethics approval) and teaching purposes.
  NEXT – to be taken to the survey.

I have read and understood the above information and consent form, I confirm that I am 16 years old or older and by clicking the NEXT button to begin the online questionnaire, I indicate my willingness to voluntarily take part in the study.

NEXT – I consent to take part EXIT - I do not give consent

Appendix J: Debrief form

The aim of this study is to find out if parental support and parental attitudes to mental health are associated with how Black British young people seek help when they experience emotional or mental health issues.
By submitting your data, you are acknowledging that you understand the research aims and are happy to include your data in this study. You may withdraw your data, without reason, up until the point of submission by exiting the survey. After this point, if you wish for your data to be withdrawn, you will have to send an anonymous post with your receipt number – this can be found at the top of the page – to Olivia Kwakyewaa-Gyamfi, B22 Yang Fujia Building, University of Nottingham, Wollaton Road, Nottingham, NG8 1BB. If you wish to obtain general information about your results, you may do so by contacting the researcher after July 2019.

We believe there are no known risks associated with this research study; however, if you experience any distress as a result of your participation in this study, please seek advice from:

Depression Alliance
Charity for sufferers of depression. Has a network of self-help groups.
Website: www.depressionalliance.org

Mental Health Foundation
Provides information and support for anyone with mental health problems or learning disabilities.
Website: www.mentalhealth.org.uk

Mind
Promotes the views and needs of people with mental health problems.
Phone: 0300 123 3393 (Mon to Fri, 9am to 6pm)
Website: www.mind.org.uk

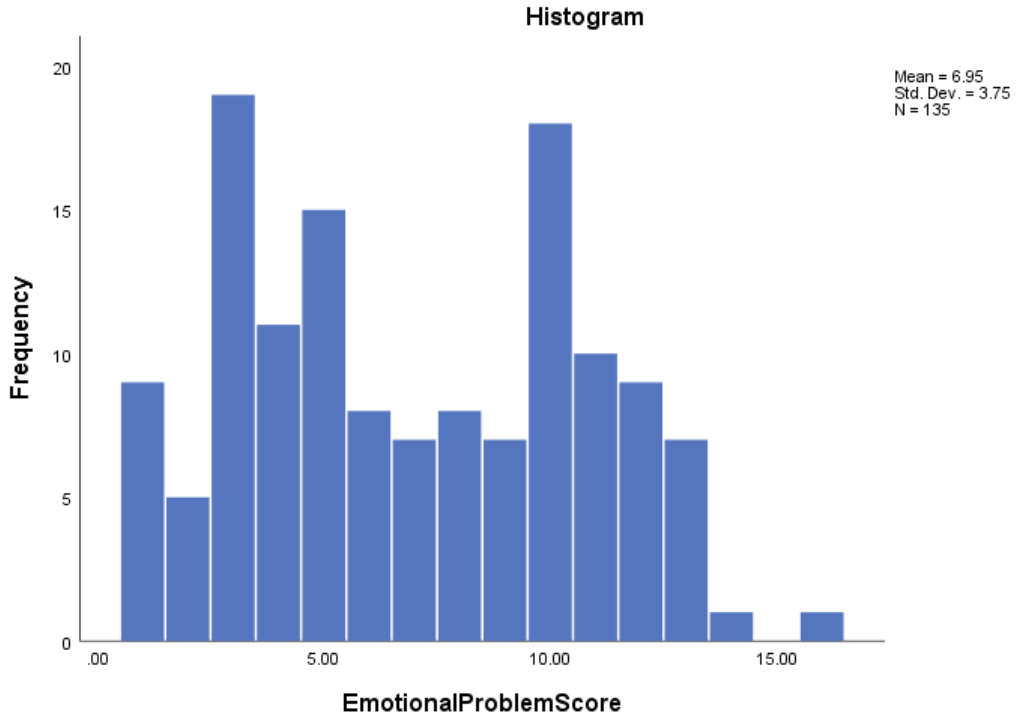
PAPYRUS
Young suicide prevention society.
Phone: HOPElineUK 0800 068 4141 (Mon to Fri,10am to 5pm & 7 to 10pm. Weekends 2 to 5pm)
Website: www.papyrus-uk.org

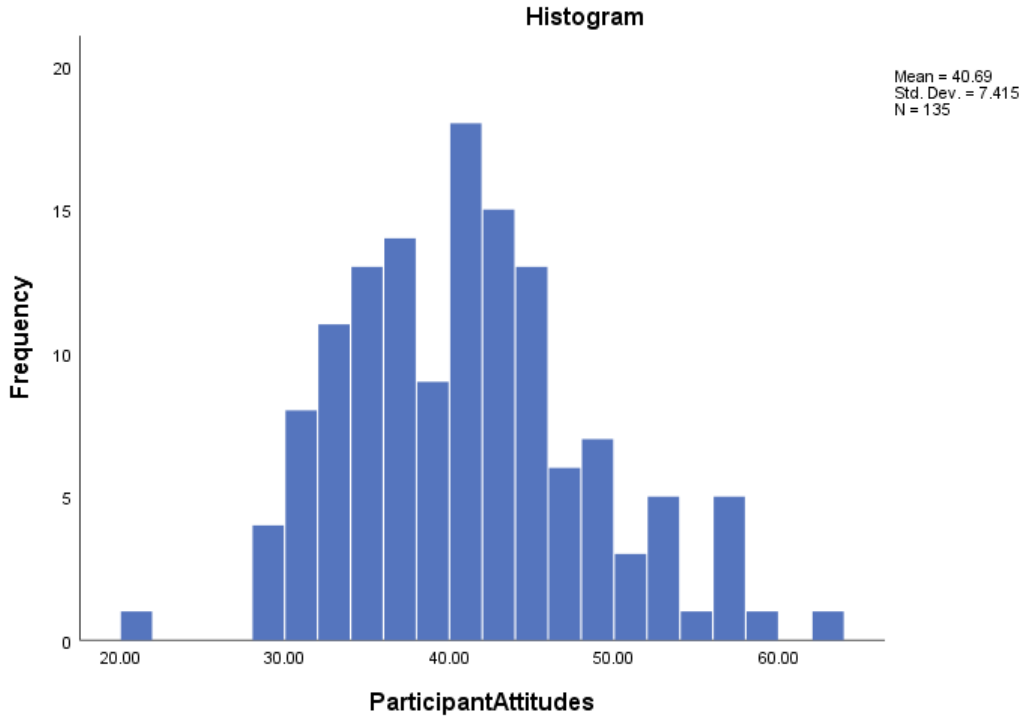
Samaritans
Confidential support for people experiencing feelings of distress or despair.
Phone: 116 123 (free 24-hour helpline)
Website: www.samaritans.org.uk

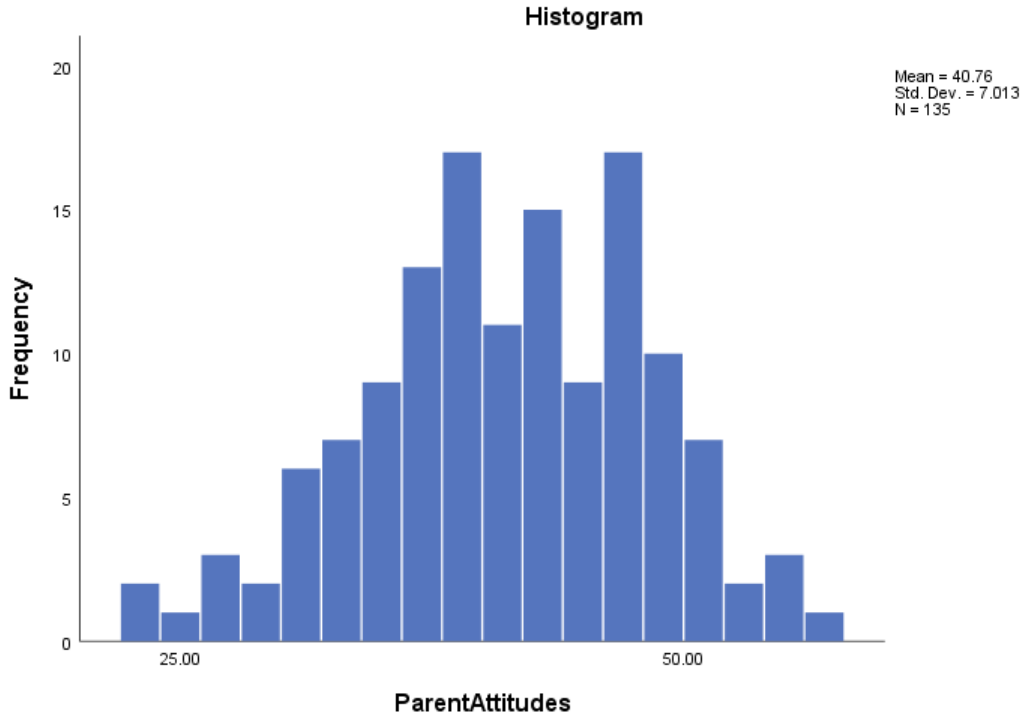
Or visit https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/ for various mental health helplines and websites.

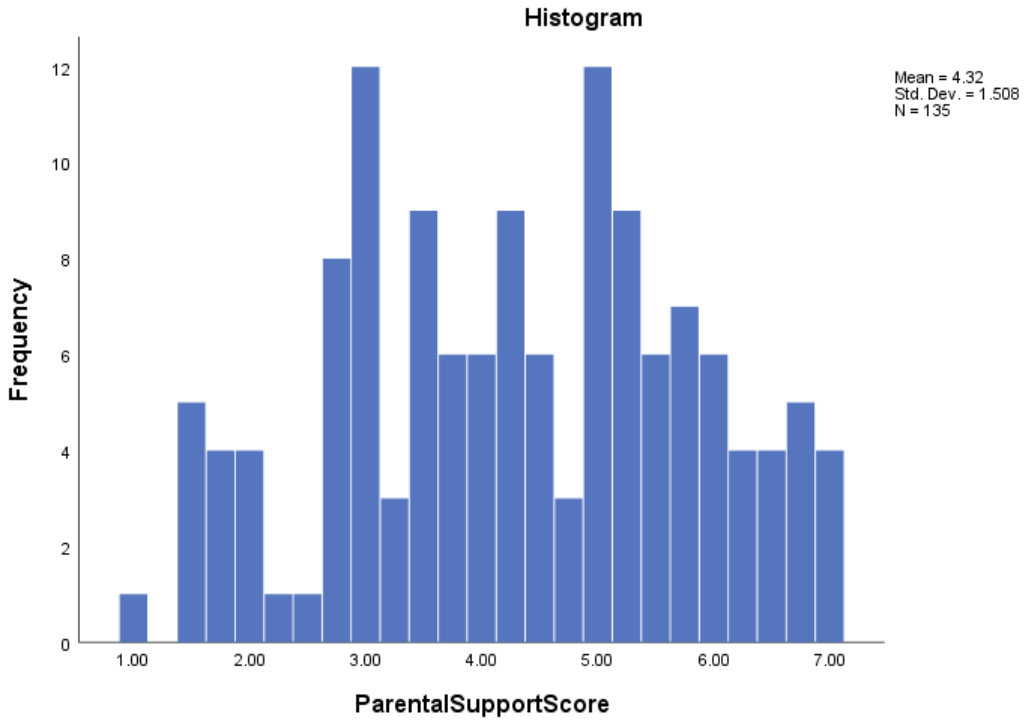
Thank you for your participation in this study! Please feel free to contact Olivia Kwakyewaa-Gyamfi (olivia.kwakyewaa-gyamfi@nottingham.ac.uk) or Dr Shihning Chou (shihning.chou@nottingham.ac.uk) if you have any further questions.

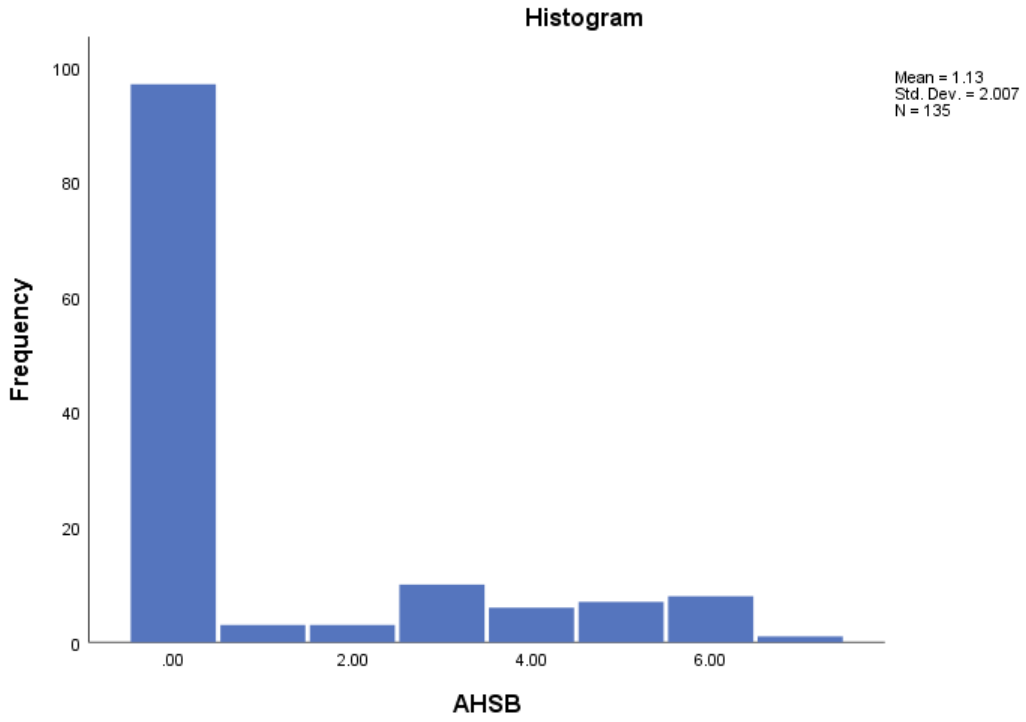
Appendix K: Histograms of variable distribution

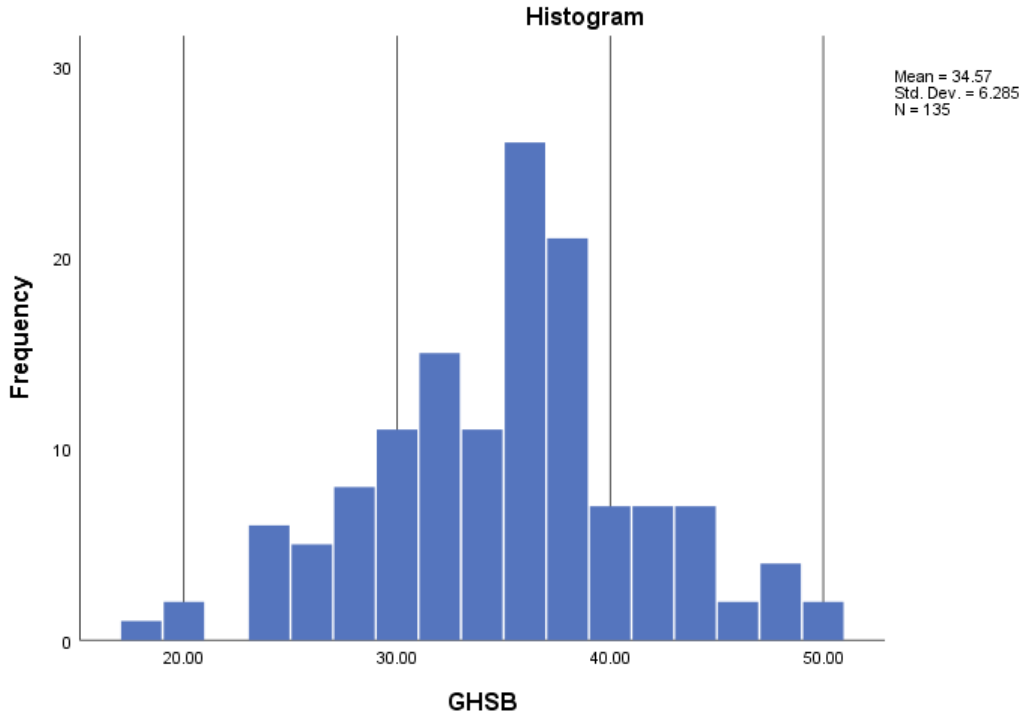




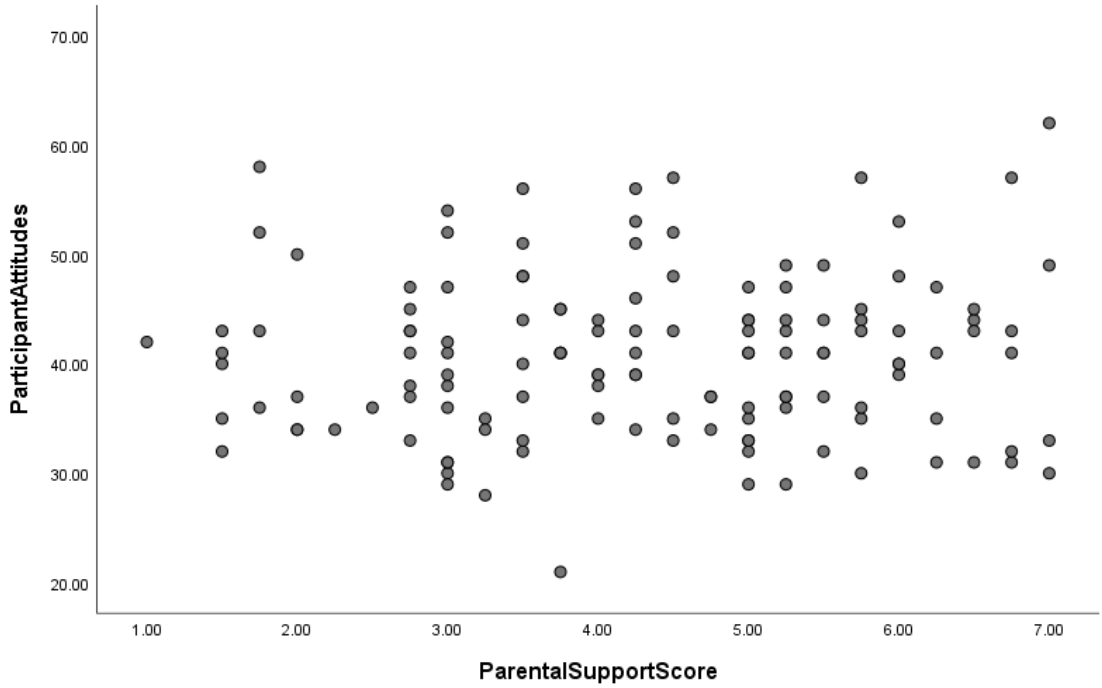

Histogram
Mean = 40.76
Std. Dev. = 7.013
N = 135
Frequency
20
15
10
5
0
25.00
50.00
ParentAttitudes


Histogram
Mean = 4.32
Std. Dev. = 1.508
N = 135
Frequency
12
10
8
6
4
2
0
1.00
2.00
3.00
4.00
5.00
6.00
7.00
ParentalSupportScore

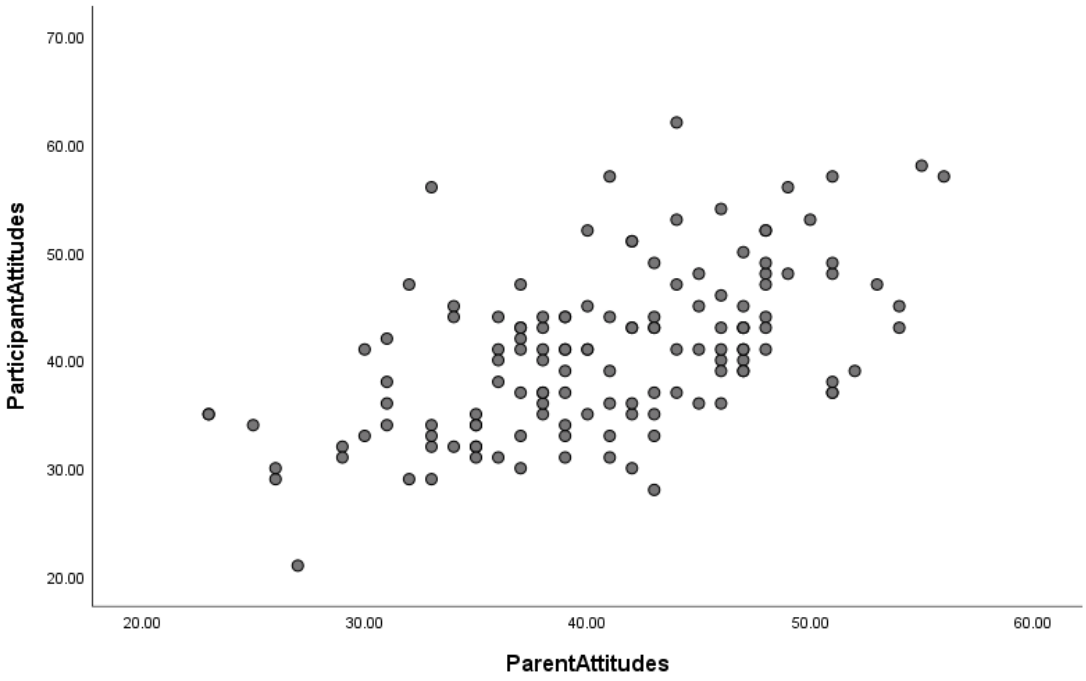

Histogram
Mean = 1.13
Std. Dev. = 2.007
N = 135
Frequency
100
80
60
40
20
0
.00
2.00
4.00
6.00
AHSB


Histogram
Mean = 34.57
Std. Dev. = 6.285
N = 135
Frequency
30
20
10
0
20.00
30.00
40.00
50.00
GHSB

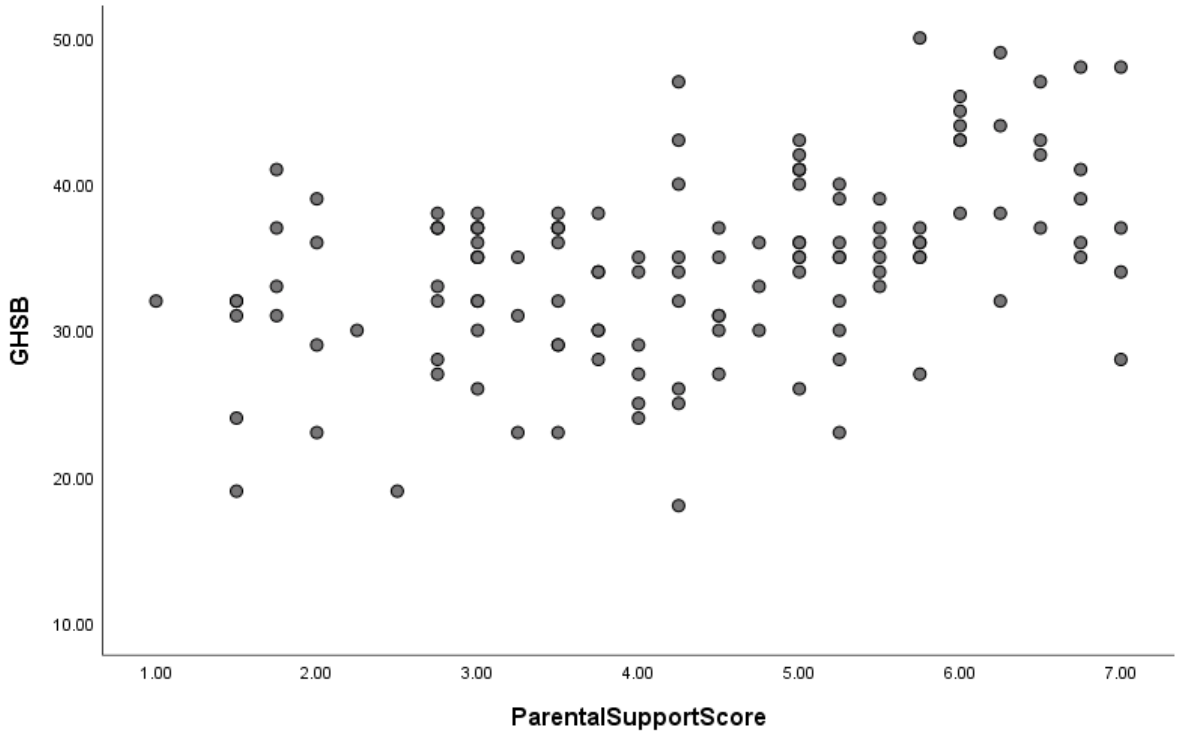
Appendix L: Scatterplots of variables



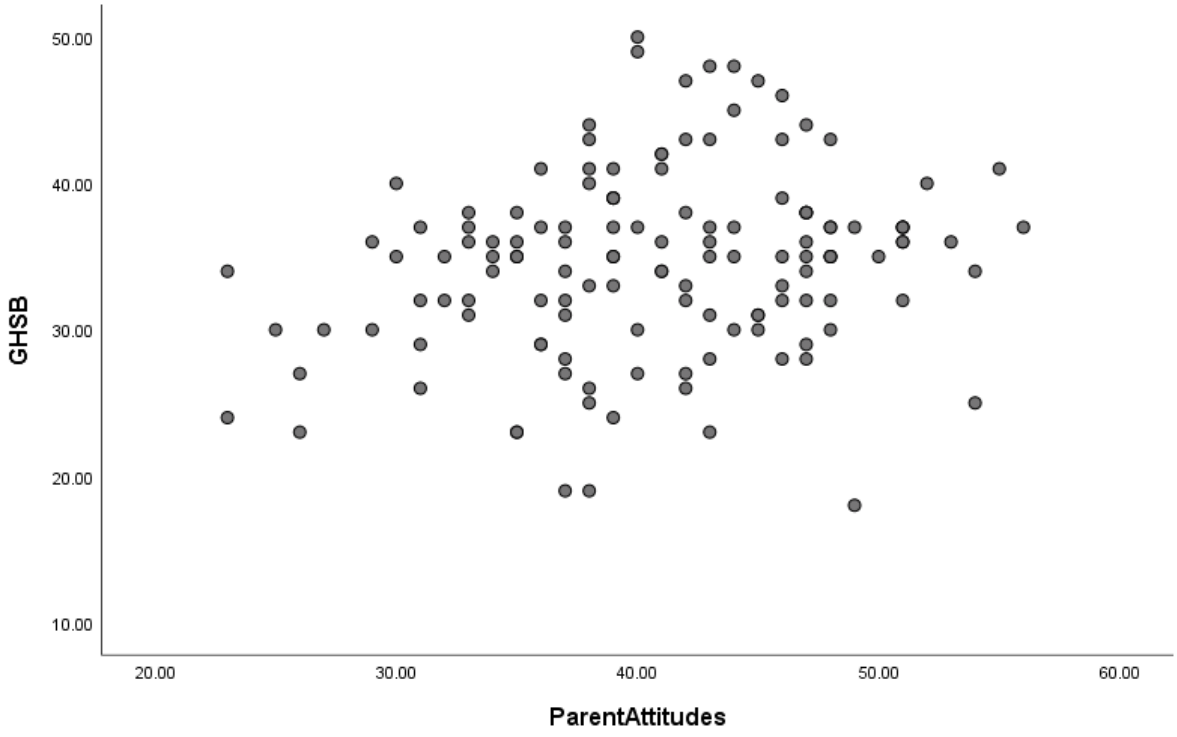
r = 0.05
p = .60



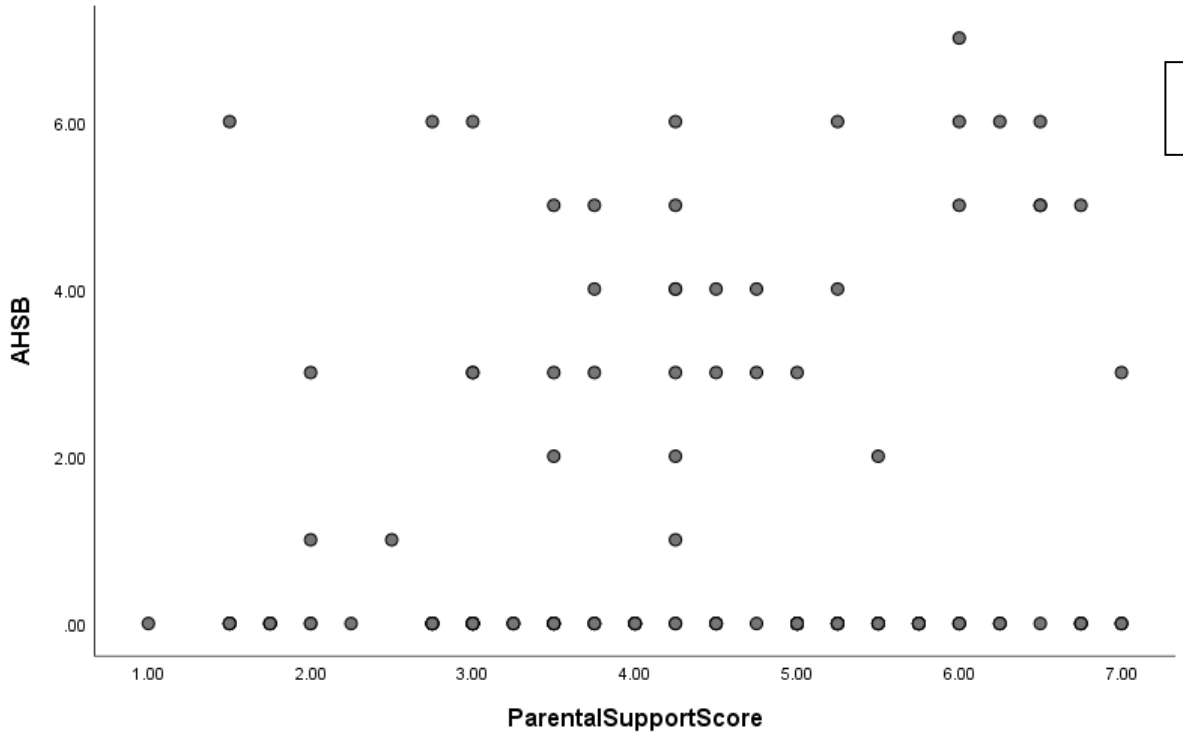
r = 0.54
p < .001

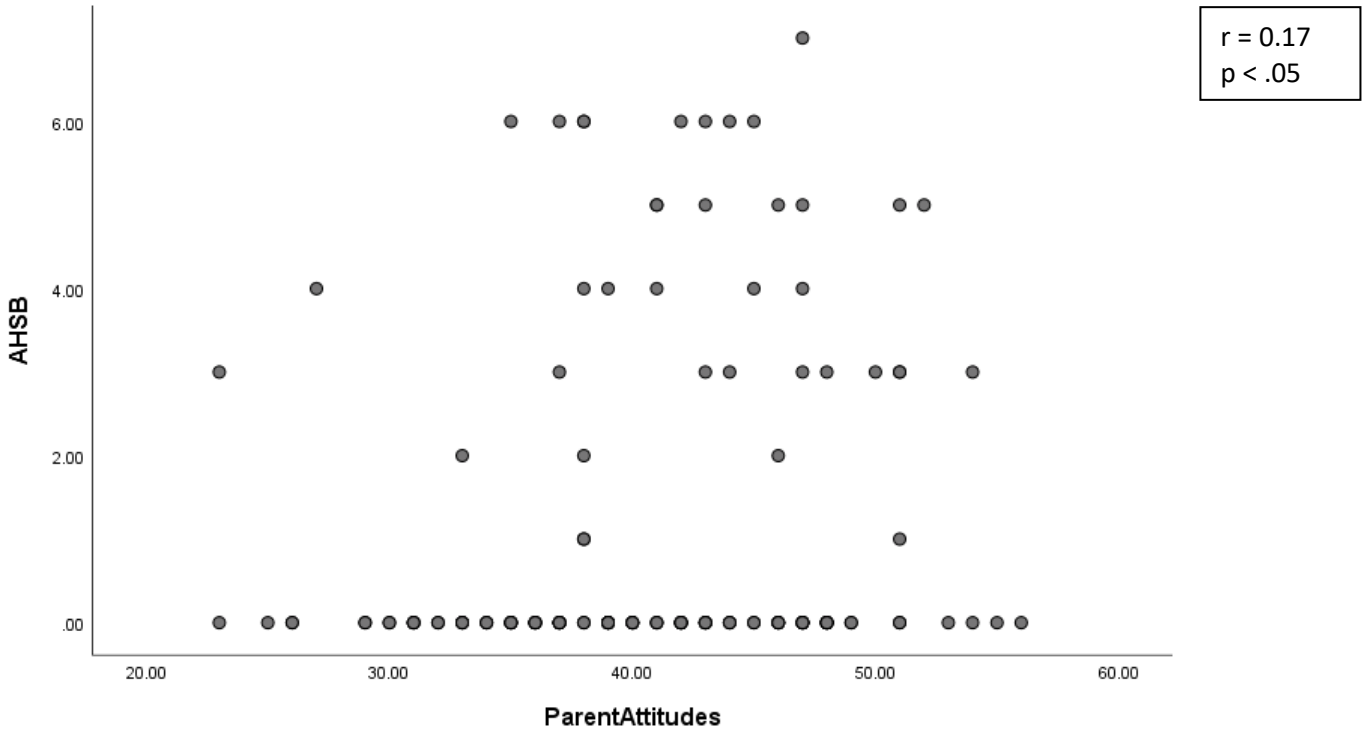


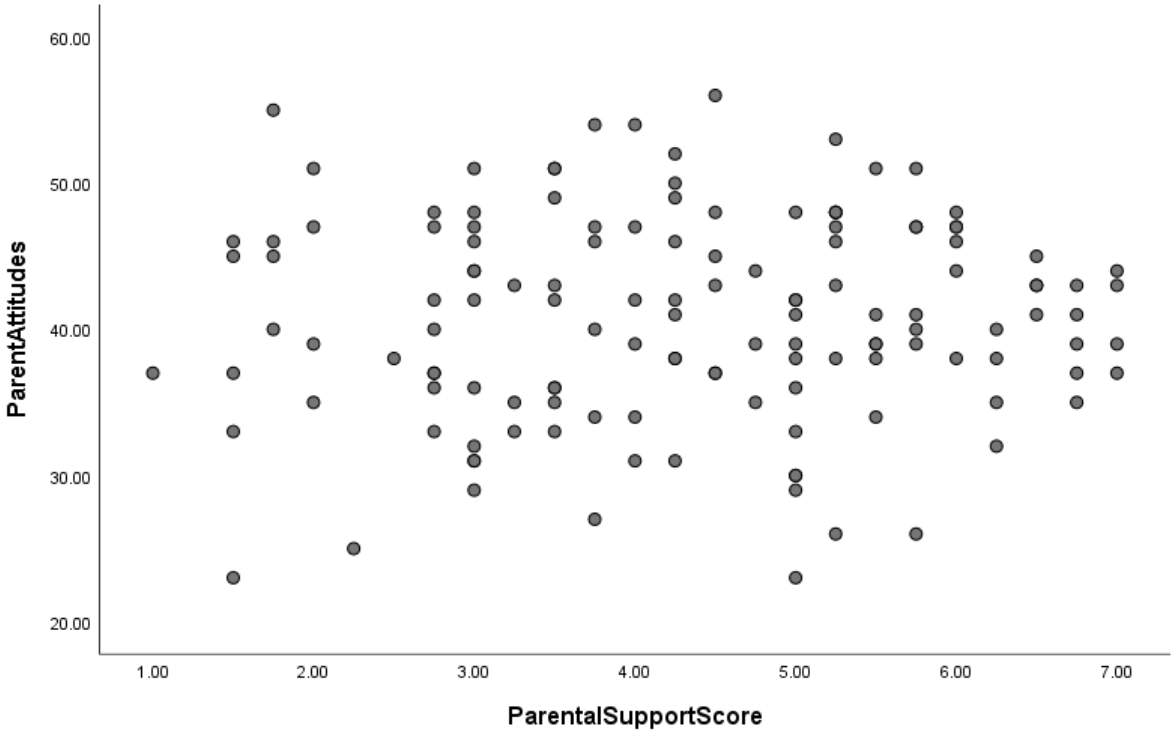
r = 0.43
p < .001



r = 0.21
p < .05


AHSB
6.00
4.00
2.00
.00
1.00
2.00
3.00
4.00
5.00
6.00
7.00
ParentalSupportScore
r = 0.07
p = .43


AHSB
6.00
4.00
2.00
.00
20.00
30.00
40.00
50.00
60.00
ParentAttitudes
r = 0.17
p < .05


60.00
50.00
40.00
30.00
20.00
ParentAttitudes
1.00
2.00
3.00
4.00
5.00
6.00
7.00
ParentalSupportScore

r = 0.03
p = .69

EXECUTIVE SUMMARY

This executive summary explains the background, aims, key findings and implications of the present study. The target audience of this summary are parents/guardians of young Black and Black Mixed ethnicity adults in the UK that are suffering with emotional wellbeing or mental health issues, as well as individuals working in organisations, charities or settings that provide support to these adults.

Background

Mental illness stigma is a concern for mental health advocates (Wahl, 1999). Stigma towards mentally ill individuals has been highlighted as an obstacle to recovery (Fink & Tasman, 1992) and a significant barrier to help-seeking and treatment in both black populations (Alvidrez, Snowden & Kaiser, 2008) and foreign populations (Li, Lee, Thammawijaya, Jiraphongsa & Rotheram-Borus, 2008). Low levels of perceived stigma have been positively associated with general attitudes towards seeking professional psychological help (Wrigley, Jackson, Judd & Komiti, 2005) and positive attitudes towards professional help-seeking was found to be a significant predictor of mental health help-seeking (Komiti, Judd & Jackson, 2006). This evidence suggests that stigma plays an important role in help-seeking behaviours and attitudes.

Parental support has been shown to be a protective factor against mental illness in transgender adolescents (Simons, Schrager, Clark, Belzer & Olson, 2013) and gay, lesbian and bisexual youth (Eisenberg & Resnick, 2006), with social support assisting help-seeking behaviours in foreign populations (Li et al., 2008). Evidence also suggests that parental support plays a significant role in reducing stigma of gay, lesbian and bisexual issues (Goldfried & Goldfried, 2001) and buffering the

negative outcomes of perceived discrimination in socio-economically disadvantaged Irish children (Bradshaw, Jay, McNamara, Stevenson & Muldoon, 2016). Although not mental health focused, this shows the effects of parental support in different contexts and in different populations.

Rationale

The topic of mental health in Black, Asian and minority ethnic groups is under-researched, even though BAME groups are at higher risk of developing mental ill health (Bhui & McKenzie, 2008). Black adults have the lowest treatment rate of any ethnic group (Lubian et al., 2016), are most likely to report a common mental disorder (Mental Health Statistics for England, 2018) and are most likely to be detained under the Mental Health Act (GOV.UK, 2019). Research also shows that mental health issues develop in childhood or young adulthood and three-quarters of all mental health issues are formed by the age of 24 (Mental Health Taskforce, 2016), yet the 16-24 age group are least likely to receive treatment for mental health issues. This evidence makes studying the factors that influence the help-seeking behaviours of young Black and Black Mixed adults important for this area of knowledge.

Research aims

The research aim was to explore if perceived parental support and parental attitudes towards mental health help-seeking is significantly related to help-seeking behaviours and attitudes in Black and Black Mixed ethnicity young people in the UK.

Data collection and analysis

Participants were recruited using social media platforms (Facebook, Twitter, Reddit). Data was collected using an online survey (JISC online surveys) that included a participant information sheet, consent form, screening survey, debrief form, and six questionnaires. The six questionnaires were:

- An adapted 18-item questionnaire of common mental health symptoms adapted from the Mayo Clinic website
- The family subscale of the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988)
- Two adapted versions of the Parental Attitude Towards Psychological Services Inventory (PATPSI) (Turner, 2011).
- General Help-Seeking Questionnaire (GHSQ) and Actual Help-Seeking Questionnaire (AHSQ) (Rickwood, Deane, Wilson & Ciarrochi, 2005)

Data was analysed using the statistical programme 'IBM SPSS'. Each variable was checked for normal distribution and then examined using either linear regression or Spearman's Rho correlation.

Key findings of research

Perceived parental support had a significant relationship with the likelihood of general help-seeking behaviour, suggesting that an increase in perceived parental support is related to an increase in likelihood of help-seeking behaviour in young Black and Black Mixed adults.

Parental attitudes towards mental health help-seeking has a significant relationship with all three of the outcome variables, suggesting that an increase in parents' negative attitudes towards help-seeking is related to an increase in

negative attitudes towards help-seeking and the likelihood of general help-seeking intentions in young Black and Black Mixed adults.

Implications of the findings

Greater efforts can be made within schools, communities and from mental health organisations to provide knowledge to black parents on the importance of supporting children with emotional wellbeing and mental health issues. This encourages more involvement in the help-seeking process and explains how negative attitudes towards mental health and help-seeking can impact their children's mental well-being and help-seeking abilities.

This finding can also encourage the development of family therapy groups that focus on those suffering with mental health issues within the Black community, offering a space for parents and children to discuss gain information on mental health and ways that they can support children/family members. By doing so, this can help to reduce reports of mental health symptoms and hospital admissions for Black British people, as well as increasing treatment rates in this ethnic group.

Recommendations

Future research in this area would benefit from the use of different research designs may produce further information that can aid understanding of the relationship between these variables, such as exploring the effects of perceived parental support and parental attitudes towards help-seeking over time in the Black population or exploring why Black individuals feel that parental support aids the likelihood of help-seeking, and why negative parental attitudes towards mental health and help-seeking may be related to their own attitudes and actions of help-seeking.

Perceived parental support and parental attitudes towards mental health help-seeking in relation to help-seeking behaviours and attitudes of Black and Black Mixed ethnicity young people in the UK

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Research Aims and Rationale

AIM

- To see if perceived parental support and parental attitudes towards mental health help-seeking are significantly related to help-seeking behaviours and attitudes in Black and Black Mixed ethnicity young people in the UK.

RATIONALE

- The topic of mental health in Black, Asian and minority ethnic groups is under-researched, even though BAME groups are at higher risk of developing ill mental health (Bhui & McKenzie, 2008).
- Research shows that perceived stigma/negative attitudes towards help-seeking is linked to mental health and help-seeking attitudes and behaviours (Li, Lee, Thammawijaya, Jiraphongsa and Rotheram-Borus, 2008; Wrigley, Jackson, Judd & Komiti, 2005) as well the effects of parental support in different contexts (Goldfried & Goldfried, 2001)
- Statistics indicate that Black British people are most likely to report a common mental disorder (Mental Health Statistics for England, 2018) and are most likely to be detained under the Mental Health Act (GOV.UK, 2019).
- Research has identified the 16-24 age group as least likely to receive treatment for mental health issues and younger adults as more likely to report more negative attitudes towards seeking mental health treatment than older adults (Gonzalez, Alegria & Prihoda, 2005)

Methods

The final sample used Black and Black Mixed British young people (*N*=135) who were born and raised in the UK to immigrant parent(s)/guardian(s) and are currently living in the UK. The age range was between 16 and 25 years.

Potential participants were invited to read the information sheet and give consent. After completion of the study, participants were presented with a debrief form, explaining the aims of the study. Data collection took place online using JISC online surveys and lasted for approximately seven days.

The measures used were:

- Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988)
- Two adapted versions of the Parental Attitude Towards Psychological Services Inventory (PATPSI) (Turner, 2011)
- General Help-Seeking Questionnaire (GHSQ) and Actual Help-Seeking Questionnaire (AHSQ) (Rickwood, Deane, Wilson & Ciarrochi, 2005)

This study was reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine & Health Sciences Research Ethics Committee (FMHS REC ref no: 216-1903).

Results

- No significant relationship was found between levels of perceived parental support and attitudes towards mental health help-seeking.
- No significant relationship was found between levels of perceived parental support and actions of help-seeking behaviour.
- Perceived parental support was found to have a high statistically significant relationship with the likelihood of general help-seeking behaviour.
- Parental attitudes towards mental health help-seeking was found to have a statistically significant relationship with all three of the outcome variables.

Implications of study and future research suggestions

- Greater efforts can be made within schools, communities and from mental health organisations to educate black parents on the importance of supporting children with emotional wellbeing and mental health issues. This can encourage black parents to be more involved in the help-seeking process, as well as shed light on how negative attitudes can impact their children's mental well-being and help-seeking abilities.
- The findings can also encourage the implementation of family therapy groups that focus on those suffering with mental health issues within the Black community, offering a safe space for parents and children to discuss their thoughts on mental health and gain information on how to support children/family members.
- The use of different research designs (such as longitudinal studies or thematic analyses) may produce further information that can aid understanding of the relationship between these variables

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REFLECTIVE REPORT

The idea of exploring help-seeking behaviours in the Black British population first came to me whilst watching a BBC Three documentary entitled 'Being Black, Going Crazy?'. This followed a black radio presenter who was sharing his experience with depression and exploring mental health within the Black British community. It was very eye-opening for me, as I was not aware of the extent of the racial disparities in mental health care before watching this programme. When it came time to fill out our initial research proposals, I was set on studying mental health within the Black community in some aspect.

My initial project title was 'The impact of 'African culture' on the likelihood of young Black British-African men seeking help for mental health issues'. I chose males as my target sample because I felt that there was a lack of research within the Black British-African community that focused solely on the mental health of men. I knew that I wanted to use a short, online survey for data collection, as it would allow for fast and easy obtainment of a large number of participants. I had done some reading around mental health in African and Black British cultures, focusing on how mental health was portrayed in African societies, the prevalence of mental health and the link between religion and mental health in Black communities. However, once I had my first supervisor meeting with Dr Shihning Chou (10/10/18) it became clear to me that trying to conceptualise 'African culture' as an independent variable would be difficult because culture is such a vague term that holds a different meaning to each individual. Shihning gave me a lot of information to reflect on for our next supervisor meeting. This included refining my research question, broadening my

target sample, exploring different theories that I could use in my work, what measures I could use, and how to conceptualise the variables that I wanted to study.

By our next meeting (01/11/18) I had decided to change my research question to 'Looking at parental support and attitudes towards mental health as predetermining factors for help-seeking behaviours in Black British men', with clear independent and dependant variables outlined. It was also at this stage that I started to outline and define concepts such as parenting, parental support, religion and mental health, as well as looking for measures for these variables and creating the questions for screening survey. As well as this, I started research into what type of statistical analysis I could use for my study. I decided on multiple linear regression, as I had found a study that was very similar to my proposed idea that had used this method of analysis.

On 15th November 2018, I sent Shihning my first draft of my research proposal with the working title 'Looking at parental support and attitudes to mental health as predetermining factors for views and actions of help-seeking behaviour in young Black British men'. Looking back on this draft, I feel as though there was a level of succinctness that was missing from my work – too many sections were drawn out, there was not enough conciseness in my explanations, and I was filling my sections with a lot of research that was not relevant to my research. I was and am happy with the original draft, as it provided the basis for the finished piece of work and provided me with a starting point to build on, as was Shihning.

I was sent back my first draft with comments from Shihning on 7th December 2018 and started revision for the full research proposal draft and ethics application deadline on 28th January 2019. It was also at this time that I decided to change my title to 'Parental support and parental attitudes to mental health in relation to views and actions of help-seeking behaviour in young Black British men'. However, due to sending my amended research proposal to Shihning late, I was unable to get my ethics application approved and has to miss the ethics committee review for February. In hindsight, this error on my part partly led to the limited time I had for collecting data. Had I sent off my application in time, I would have had extra weeks for data collection, potentially leading to a more representative sample for my study.

I met with Shihning twice (31/01/19, 21/02/19) and once again on 14th March 2019 after my ethics application was submitted. In this time, we discussed some revisions that needed to be made to my work – the biggest was changing my sample from young Black men to young Black people. This was suggested my Shihning due to the fact that women are more likely to fill out questionnaires that men. Her worry was that if I limited my sample to just males that I would not collect enough participants. I agreed with her and subsequently changed my research title to 'Looking at parental support and parental attitudes to mental health in relation to views and actions of help-seeking behaviour in young Black British people'.

Whilst waiting for my ethical approval, I continued to work on my dissertation and had a meeting with Shihning on 28th May to talk through my recruitment strategy for participants and plans for data analysis.

I finally received my ethical approval on 22nd May 2019. Because of the longer processing times for ethics applications, I only had seven days for data collection. I was confident that I would be able to collect enough participants within my timeframe as I was recruiting participants using social media platforms (Facebook, Twitter, Instagram, Reddit). Whilst the first day was quite slow and I only received several completed surveys, by the second day I had collected over 100 participants and by day three, I had collected my estimated number of participants. I was very shocked but excited and relieved that I had managed to collect enough participants within my limited timeframe.

I had another meeting with Shihning on 7th June, in which we discussed my plans for data analysis. She suggested that I first complete tests for normality and gender comparisons for my dataset, before conducting my multiple linear regression. When it came time for data analysis, I was very worried due to the fact that statistics is not a strong suit of mine. I went through my dataset, removed any that were incomplete and was left with 135 participants to conduct my analysis on. I computed new variables that I would use for my analysis and ran my tests before sending my output to Shihning as requested. Shihning did give me some feedback on the output that I sent to her, but I was still confused about whether I had conducted the analysis properly and how to interpret the output. However, I decided to continue on and write the draft of my dissertation, using Google and statistics videos from Youtube to help me interpret and write up my results. I think that this is the point where I should have asked for further help with my statistics, because I was really struggling.

I sent my first draft of my dissertation to Shihning on 27th June 2019. Shihning sent back her comments on 2nd July 2019 and as expected, said that I needed to redo my results section because it was not clear. I was expecting this feedback but was still discouraged by it. However, with her feedback she also suggested that I book an appointment with the School of Medicine stats advisor to go through my analysis and help me understand my output. She also offered me an extension on my final submission until 8th August 2019, which was approved by Dr Vince Egan. I went to the statistics clinic on 22nd July and had a meeting with Andrea Venn, one of the statistics advisors for the School of Medicine. She explained that I had conducted the wrong analysis, and that I should use linear regression as opposed to multiple linear regression. Together we went through my dataset, identified the variables that I needed to use and what analysis would be appropriate for my variables and research questions. The meeting went so well, and I am very thankful to Andrea for helping me understand how to conduct my data analysis and understand the output. Because of the meeting, I went home feeling so much more confident in writing a clear and concise results section.

Once I had the meeting and re-did my analysis, I was happy with the results and then able to write up my results and discussion sections. I sent my full dissertation draft to Shihning on 1st August 2019, and she sent back her final comments.

One of my main issues with the writing process is writing succinctly. I always seem to go into far too much detail, especially in regard to the evidence that I present in my work. This showed in my original research draft that was almost

3000 words. Thankfully, with every draft that I sent, Shihning was able to point out areas where I was not being concise enough and with time, I have learnt how to explain and critically evaluate research without writing a full paragraph. I think one of the most valuable skills that I have learned during this research process, and it is one that will aid me greatly in writing up future research. Another skill that I developed was my ability to focus my ideas. I think this was most obvious when you compare my original research title and plan to my final one. Again, with Shihning's guidance, I was able to refine my ideas and focus on specific concepts and variables to discuss in my introduction. Doing this made it easier to find measures for my data analysis.

I am very grateful to have had Shihning as my supervisor during this research process. She was supportive and thorough in her feedback of my drafts. Any questions that I had, she answered with detail. Any time I was confused or unsure on what to do with my dissertation, she provided me with a starting point to build on. As well as this, the university provided great resources (such as a stats advisor) that has made the research process less stressful.

Conducting this research has been a valuable experience for me. I have learnt how to define variables, refine my work, choose appropriate measures for my variables, critically evaluate work and provide support for and against the points presented. I would say that my biggest challenge was conducting my data analysis but getting support from the statistical advisor was very helpful for me. Completing this dissertation has improved my research skills in every way, and I feel much more confident in my ability to conceptualise, conduct and write up my own research independently. If I was to go through this again, I think the

main thing I could have done differently is to have a clear outline of what I wanted to study, using variables that are easy to define and easy to find psychometric measures for. A lot of my difficulty in completing this work came from trying to find definitions and concepts for the variables I wanted to use within my study's context. As well as this, I would make sure not to leave work until the last minute and work more efficiently.