Diversity in Health and Care 2011;8:81–92

Research paper

Ethnicity, gender and mental health

Mark Robinson
Research Fellow, Centre for Men's Health, Faculty of Health and Social Sciences, Leeds Metropolitan University, Leeds, UK

Frank Keating
Senior Lecturer in Health and Social Care, Royal Holloway, University of London, London, UK

Steve Robertson
Reader in Men's Health, Centre for Men's Health, Faculty of Health and Social Sciences, Leeds Metropolitan University, Leeds, UK

What is known on this subject

- A disproportionate number of BME men, compared with white men, come into contact with mental health services via adversarial or crisis-related routes.
- Common concerns include the high rates of schizophrenia and psychotic disorders, and low levels of confiding/emotional support for BME men with mental health problems.
- The reluctance of BME men to engage with services at an early stage has been viewed in terms of mistrust of services, reinforced by racialised experiences of services that lack cultural competence, as well as gender attitudes to health, and stigmatisation of mental ill health in society.

What this paper adds

- It explores the social underpinnings of the views of BME men about their well-being. This highlights the influence of gender and culture on social, relational and normative aspects.
- It examines BME men's experiences of poor mental health, identifying how the influence of social expectations about gender, combined with racialisation and other social factors, could contribute to a negative cycle of disempowerment and stalled recovery.
- It makes evidence-based recommendations for creating environments of trust and breaking the cycle, with regard to services engaging with the formative influences of masculinities and ethnicities, and with men's understandings of and wishes for well-being, and with a focus on men's self-defined expectations and lifestyle preferences.

ABSTRACT

This paper reports on primary research that focused on men from specific black and minority ethnic (BME) groups. The project aimed to provide a better understanding of the men's beliefs about mental health and their experiences of mental health services. The paper presents key findings and issues in interpreting the experiences of BME groups. It considers the complexities of men's gendered identities and the interplay of these with 'race', ethnicity and cultural influences.

Twelve focus groups, each consisting of men from specific BME groups, were convened in various locations in London and the West Midlands. The ethnic groups were as follows: two African-Caribbean groups, two African groups, two Indian groups, two Pakistani groups, two Bangladeshi groups and two Chinese groups. The findings include BME men's narratives of well-being, which highlight the importance of relational and normative aspects and the influences of gender and ethnicity on aspirations, identity and values. Factors contributing to mental illness relate to gendered and racialised social expectations, economic factors, generational and gender issues, and experiences of services. The paper concludes that a complex mix of gendered and racialised experiences, including social stigma, the coercive power of institutions, and men's own perceptions of services, and vice versa, can contribute to cycles of disengagement and isolation for marginalised BME men with mental health problems. Specific recommendations are made for breaking out of the cycle. For research, it is suggested, the priority should now turn to identifying and assessing initiatives that address the issues, and in particular, identifying models of support towards recovery.

Keywords: gender, ethnicity, mental illness, recovery, stigma, well-being

Introduction

This paper reports findings from a recent research project which aimed to provide a better understanding of black and minority ethnic (BME) Men's beliefs and experiences with regard to mental health, and their experiences of mental health services. The 'Improving the Mental Health of BME Men' project was commissioned by the Men's Health Forum and funded by the Department of Health (the primary funder), the National Institute for Mental Health in England (NIMHE) and the Football Foundation. The project aimed to work with BME and mental health organisations to inform healthcare professionals about ways of engaging effectively with BME men, and to consider the future development of resources for this group. The project also aimed to increase awareness of mental health problems and services among BME men.

For the purposes of this paper, BME is an umbrella term that refers to men who describe themselves as belonging to a minority group in the UK, with a shared ethnicity and language and/or culture. This included African Caribbean, African, Indian, Bangladeshi, Pakistani and Chinese men, but could also include diverse white European groups, Irish, Travellers, mixed heritage men, and various groups of asylum seekers and refugees. The paper highlights BME men's views of their well-being and their narratives concerning histories of emotional distress and mental illness, and attributions of causality. In particular, the paper explores the place of gender within BME men's beliefs and experiences, and examines the implications of BME men's experiences of socially mediated disempowerment for potential approaches to supporting them to recovery.

Current evidence

People from BME communities are more likely to experience inequality and social exclusion, including racial discrimination, poor socio-economic status and unemployment, all of which are risk factors for poor mental health (Office of the Deputy Prime Minister, 2004; Joseph Rowntree Foundation, 2007; Gervais, 2008). The literature identifies issues specific to particular groups as well as shared concerns that affect all BME groups, such as high rates of schizophrenia and psychotic disorders (King *et al*, 1994; Bhugra *et al*, 1997; Lloyd *et al*, 2005; Kirkbride and Jones, 2008), and low levels of confiding/emotional support for BME men with mental health problems (Sproston and Nazroo, 2002). This article highlights these shared concerns and then explores their gendered dimensions.

The social construction of mental illness is a recurring theme in accounts of diverse understandings of mental illness among specific BME groups (Kleinman *et al*, 2006). In particular, a relationship has been identified between perceived racism and mental ill health (Karlsen *et al*, 2005), which is exacerbated by the social disadvantages experienced by BME men (Nazroo, 1997; Erens *et al*, 2001). The over-representation of BME men in prisons is also correlated with social exclusion (Nazroo, 1997), and raised levels of mental health problems within prison populations are a major concern (Fazel *et al*, 2005).

Compared with white men, BME men disproportionately come into contact with mental health services via adversarial or crisis-related routes (Sainsbury Centre for Mental Health, 2006). For example, rates of hospitalisation with mental health problems are higher among BME men in general, and admissions and lengths of stay are particularly high among black groups (Healthcare Commission, 2008). These findings have been interpreted as evidence of persistent institutional racism (McKenzie and Bhui, 2007). A reluctance of BME men to engage at an early stage with services (National Institute for Mental Health in England, 2004; Galloway and Gillam, 2006) has been viewed in terms of mistrust of services, reinforced by racialised experiences of services lacking in cultural competence, gender attitudes to health, and stigmatisation of mental ill health in society (Johnson and Verma, 1998, Bhui *et al*, 2001, Tidyman, 2004; Foolchand, 2006; Keating, 2007). This delay in help seeking contributes to low referral rates from GPs for further treatment (Begum, 2006).

Recommendations from research for improving service delivery and enhancing engagement include the development of culturally competent mainstream services and advocacy services, sounder financing of support services for recovery, training of staff, improved partnerships, and development of non-statutory provision (Seebohm *et al*, 2005).

Although policy recognition of the complex interplay between gender and ethnicity and its importance for mental health promotion has been forthcoming (National Institute for Mental Health in England, 2007), this interplay remains under-researched. However, changing gender roles and expectations are also important influences on BME men's mental health, affecting the gendered aspect of major risk factors associated with elevated levels of stress (Baker, 2000; Sproston and Nazroo, 2002). As the following section makes clear, understanding the intersecting forces relating to gender, ethnicity and mental health that contribute to BME men's well-being poses specific challenges.

Theoretical issues

Challenges arise when concepts such as *gender, ethnicity, 'race'* and *racism*, and *mental illness* are linked in order to analyse and understand men's experiences. Concerns about identity were crucial to the men's accounts. Gender theory conceptualises masculine identity in terms of social practice in everyday life, whereby identities are socially constructed through (inter)action (Connell, 1995), in the contexts of other overlapping layers of identity construction, such as class, and obviously 'race' (Frosh *et al*, 2002).

Two recent theories about gender highlight this complexity. The first is that of *gender as performance*. Since the 1970s, ethnomethodologists have explored how gender is achieved through action and interaction (Brickell, 2005). The concept of gender as repetitive acts that establish an apparently coherent and stable *core gender identity* was developed by Butler (1990). According to this view, gender is constituted through the reproduction of social scripts, and no stable gender identity exists prior to that.

Secondly, the construction of *multiple masculinities* (Ridge *et al*, 2011) refers to plural and hierarchically arranged masculinities (Connell, 1995). It has been suggested that the social construction of masculinities in the 'current Western gender order' consists of a hierarchical order composed of *hegemonic (*in other words, *dominant), subordinated, marginalised* and *complicit* masculinities (Connell, 1995, p. 77; Robertson, 2007; see Box 1). In this project, findings concerning BME men's struggles to sustain a healthy masculine identity position were interpreted within a view of masculinities as multiple and variegated, constructed anew in practice by each person in relation to positions made available within wider cultures, involving tensions and the 'pain of belonging or not belonging' (Frosh *et al*, 2002, p. 174).

Following Keating (2007) and Cooper *et al* (2005), we also viewed race and ethnicity as social constructions, with different individual and social meanings according to the context in which they are applied. Racialisation, namely the process of producing racial meanings, is one facet of the men's identities, and overlaps with other social divisions, such as age and gender (Keating, 2007). A further issue was the stigma surrounding mental illness (Goffman, 1963) and that arising from other factors such as institutional racism. When a person is labelled as having a mental illness, they take on an identity that is stigmatised (Fernando, 2006). It has to be noted that stigma theory bases universal claims on evidence and theory collected cross-culturally, rendering problematic any ethnic-specific analysis of stigma which operates within a concealed norm of white ethnicity (Falk, 2001).

Methodology

The project aimed to provide a better understanding of BME men's beliefs and experiences with regard to mental health, and their experiences of mental health services. The design consisted of a literature review of current evidence on mental health and services for BME men, and primary research involving focus groups consisting of men from specific BME groups.

Ethical approval for the research was granted by the Research Ethics Committee of Leeds Metropolitan University Faculty of Health.

Data collection and analysis

There were 12 focus groups, each consisting of men from specific BME groups. They were selected as a purposive sample through contacts known to the research team and the advisory group, and convened in various community locations in London and the West Midlands. The groups were stratified by age, with six groups consisting of men aged 18–25 years and six groups consisting of men aged 26–55 years (see Table 1). The sampling, interview topic schedule and questioning were informed by theoretical insights into the social construction of mental illness (Kleinman *et al*, 2006; see Box 2). The segmentation by age and

Box 1 Hierarchical order of social construction of masculinities

- Hegemonic masculinities refer to the cultural dynamics by which a (male) group claims and sustains a leading position in social life.
- Subordinated masculinities are subordinate to this leading position, where subordination involves cultural stigmatisation and material practices (e.g. economic discrimination). Subordination has historically been experienced by, for example, gay men.
- Marginalised masculinities are marginalised from full participation in society by material practice, although there may be no direct overt threat or attempt to exclude, as for example is the case for men with sensory disabilities.
- Complicit masculinities involve men benefiting from the general effect of hegemony without meeting the normative standards of hegemonic masculinity.

Table 1 Stratification of groups by age

BME group	Age range 18–25 years	Age range 26–55 years
African Caribbean	1	1
African	1	1
Indian	1	1
Pakistani	1	1
Bangladeshi	1	1
Chinese	1	1

Box 2 Outline of topic schedule

1 What were the men's views of mental health and well-being?
2 What were the men's understanding of mental ill health?
3 What were the men's views of the reasons for mental ill health?
4 What were the men's understanding of social issues relating to mental health and illness?
5 How did the men experience and cope with mental illness?
6 What experiences did the men have of seeking different forms of help?
7 What were the men's experiences and views of services and treatment?
8 What were the men's views of their information and resource needs?
9 What were the men's perceptions of information resources and outlets?
10 What strategies would the men suggest for promoting well-being and recovery?

ethnicity took account of theoretical insights into gender and ethnicity, and of changing experiences of masculinity, the particular challenges facing younger men (e.g. regarding substance misuse and mental health), racialisation and the stigma surrounding mental health across the life-course.

The focus groups were recorded and transcribed verbatim. Transcribed data from the 12 focus groups with BME men were entered into NVivo software, and thematic analysis was performed to address the main research aims, highlighting the main areas from the interview topic schedule. The analysis used a 'constant comparative method' (Glaser and Strauss, 1967), which was further informed by:

1 an initial analysis framework developed from previous evidence review and theory (see Box 3)
2 identifying new themes from discussion groups
3 synthesis of both of the above.

Ethics

Information sheets (translated where appropriate) were provided to all participants as part of the recruitment process. All of the participants who expressed interest were invited to participate. Written informed consent was obtained from all participants.

Findings

This section presents findings related to the following key themes: views of mental well-being, causal explanations of ill health, finding help, and practical resources for change.

Box 3 Initial analysis framework

- Familiarisation with transcribed data
- Development of a thematic framework of key issues in data and previous evidence
- Indexing and coding data using the framework
- Summarising and charting key themes from the coded data
- Mapping the connections between key themes to provide explanations (Pope *et al*, 2000)

Views of mental well-being

BME men's complex views of mental well-being reflected both individual differences and collaborative thinking, where men engage together in a meaning-making process. Three models that underpinned BME men's understanding of mental well-being emerged from the data. Their views often involved more than one of the following underlying models, which appeared to allow the men to adopt different, socially mediated positions from time to time during discussion. The ability to articulate different positions can involve different levels of reflexive awareness concerning identity, but if recognised within recovery practice in mental health it may be a key aspect of supporting men to find narratives of hope.

Models that highlight social underpinnings of mental well-being

Social relational and normative aspects were considered extremely important. Social norms, although presenting problems of unattainability for some men (e.g. because they cannot live up to ideals), have a major impact on well-being, in that men want to feel that they fit in. Here the intersection of gender and cultural norms is apparent:

> 'In our culture we are the men. We are providers. And there is a lot of pressure to provide for our families and weddings and deaths.'
>
> (Pakistani man, 26–55 years age group)

Mental health was also perceived as involving the ability to perform daily societal routines and activities. Watson (2000, p. 118) described this as the functional use of a 'normal everyday body' in order to fulfil specific (gendered) roles required in the social world. This has been seen as constituting men's most common mode of experiencing and 'caring' about their own bodies (Robertson, 2007, p. 68). However, the problem for men with mental health concerns is that this puts them in a state of dependence with external social structures and pressures which can prevent them from working in a rewarding way in the social world.

> 'What is normal though?'
>
> (Indian man, 26–55 years age group)

> 'Being able to work is normal.'
>
> (Bangladeshi man, 18–25 years age group)

> 'To live normal – we don't use the word normal any more, normal is a word that we don't really understand.'
>
> (Indian man, 26–55 years age group)

> 'Being normal, being able to do a normal job, having a family.'
>
> (Indian man, 26–55 years age group)

> 'They are fantasies aren't they? Because you can't get a job.'
>
> (Indian man, 26–55 years age group)

Being unable to fulfil normative social routines was also a threat to men's sense of being in control. There is an apparent gendered dimension to viewing mental well-being in terms of control of thought and action, since to be in control is an important aspect of *hegemonic masculinity* (Robertson, 2007).

Integration with their physical and social environment was also central to well-being for the BME men. The importance of friendship and family relationships was highlighted, while being accepted and embraced by significant others and being enabled to give affection were important to the well-being of those with a history of mental ill health. This social–relational emphasis indicates that, for marginalised older BME men in particular, well-being is not always associated with self-sufficiency (a hegemonic trait sometimes associated with white men), but rather with interdependence:

> 'Making friends, talking to people. Yes, it's very important as a person when your people love you and you can also give back their love. And that's well-being.'
>
> (African man, 26–55 years age group)

> 'When I am healthy, my brother and sister, they say come to us, come to us.'
>
> (Bangladeshi man, 26–55 years age group)

Models that highlight holistic aspects of mental well-being

Many BME men also highlighted the fact that holistic aspects are central to well-being. With regard to holistic emotional/expressive aspects, the emotional dimension was strongly related to self-esteem or self-acceptance, which had powerful emotional effects related to men's identity. For example, emotional resilience was important to well-being, and involved maintaining a personal balance. The importance of self-efficacy (that is, being in control of one's thoughts, decisions and actions), independence, awareness, goal orientation and motivation was highlighted. Self-efficacy, associated with the importance of identity to well-being, is also compatible with interdependence:

> 'It's being comfortable within yourself, and that is what wellness is to me.'
>
> (African Caribbean man, 26–55 years age group)

> 'For me, mental well-being is like you begin with yourself first; accept yourself.'
>
> (African man, 26–55 years age group)

> 'Happy or not is not a problem, the most important is whether you can accept yourself.'
>
> (Chinese man, 26–55 years age group)

The emphasis on cognitive and emotional balance and harmony with the social and physical environment perhaps resonates with a non-Western holistic view of human life as an indivisible whole in which mind, body, spirituality and other dimensions are ultimately interconnected, and a balance is sought between the elements (Fernando, 2009). In this sense, men's emotional state was viewed as being embodied in 'thinking, moving, feeling complexes which radiate through the body' (Boden and Williams, 2002, p. 497) and which connect with wider environments. This can be viewed as reflecting a historically and/or culturally embedded viewpoint that is compatible with a potentially self-directed and emergent lifestyle narrative of choice, rather than with hegemonic masculinities.

Models that highlight a spiritual dimension to well-being

Faith in more than mundane social norms was also important for some to provide space for reflection, and self-integration or coherence. There was also a suggestion that male role models who had struggled and thrived from similar ethnic backgrounds would have a significant role in assisting men towards well-being, as through their stories these men could become trusted holistically with a spiritual as well as physical connection.

This section shows that a number of different socially mediated positions were taken by BME men with regard to well-being. Some of these positions (e.g. about bodily activity and control) appear to be representative of a western, gendered social discourse irrespective of ethnicity, whereas others (e.g. holistic integration) appear to be representative of a more cross-cultural social discourse of non-western provenance. Positions about social norms and expectations for men as providers appeared to indicate a specific intersection of gendered and cultural influences.

Causal explanations of ill health

BME men's accounts of risk factors for mental illness included major social determinants such as social expectations, racialisation and socio-economic exclusion. Personal determinants such as biological inheritance and cognitive factors relating to self-efficacy were deemed important. In addition, highly significant mediating service factors with regard to treatment, care and recovery emerged. This section focuses on social expectations, highlighting gender-based issues, while also drawing attention to the intersection of multiple social influences relating to BME men's expectations of services, treatment and recovery. The literature on racialisation and the social stigma surrounding mental health is extensive. However, less has been written about the further impact of masculinity and expectations about male roles. The impact of these factors varies according to age, within cross-cutting social processes that were highlighted as contributing to a disempowering spiral for BME men with experience of mental illness.

A common thread uniting BME men's wide-ranging accounts of causes of mental ill health relates the stressful impact of unreasonable and/or unrealistic social expectations on individuals' identity and mental health. *Hegemonic masculinity* exerts immense pressures on men to attain ideals, racialisation creates undermining negative and positive stereotypes, and acculturation in communities may also challenge males with contradictory and sometimes unattainable customary and economic expectations. Contradictions in expectations were evident among men from diverse ethnic communities, across different age groups, thus overriding generational differences. These expectations are influenced by forces that include the following:

- how BME people are treated in society
- how people with mental health problems are treated
- the power of institutions to control and coerce people with mental health problems
- perceptions of BME people of mental health services, and vice versa (Keating, 2007).

To these must be added a fifth influence, namely how men are viewed and view themselves within society.

Young men

Young men who were well aligned themselves more closely with hegemonic norms, and were therefore less willing to admit weakness, than older men, many of whom had a history of mental illness. In some younger male peer groups, hegemonic masculine identities were sustained in the context of young men's perceptions of limited economic opportunity and racism. There seemed to be little room for articulating different positions, negotiating emotional vulnerability or coping with transitions. In the accounts of some men, with the apparent absence of alternative male role models, such as older mentors, little space remained for displays of male–male intimacy, or for disclosure of weakness. Hegemonic masculine identities were sustained by the peer culture in what seemed, to some extent, to be a defensive cultural move in the context of perceptions of lack of economic opportunity and systemic racism, but which offered little support for negotiating vulnerability or coping with transitions (e.g. from adolescence to adulthood, employment, family stress or bereavement):

'It's a survival of the fittest thing because the environment has certain standards and certain ways of living up to that. Everyone wants to get to a certain place.'

(African Caribbean man, 18–25 years age group)

There was a perception that, in this context, a young man seeking help for a mental health problem would be rejected as not masculine enough, at risk of stigmatisation by his peer group, his family, his wider community and a racialised society. Alongside gendered peer proscription on displays of vulnerability, there might also be gendered inhibitions within the family about showing emotions. The effect at worst was to generate lack of trust, together with denial and repression.

'You just hold it in until the point you can't take it no more, all right, and then someone will trigger you off and that's it.'

(African Caribbean man, 18–25 years age group)

'My Dad said last year "Stop being a girl. Stop crying." So I haven't cried. I just get on with it and I still get on with it.'

(African Caribbean man, 18–25 years age group)

'Keep it locked up – if you tell one guy and you think you can trust him, he'll probably go and tell another mate and he'll tell everyone.'

(Pakistani man, 18–25 years age group)

Older men

Older men experienced gendered pressures of expectation from their social environment to be providers, and managed experiences of racism and isolation. For at least some of these BME men, male social identities were marginalised by the stigma surrounding mental illness, race, and not sustaining hegemonic masculinity. This confirms previous research indicating a gender-related stigma with regard to mental health interventions, which was partly related to stressful feelings of being unable to cope with aspects of daily life (Robertson, 2007).

Many older men struggled to measure up to family expectations. For example, in families of South Asian heritage it was said that the oldest son should be strong and economically resilient to support the extended family:

'In the Bengali community and a lot of other communities, the eldest, huge responsibility, huge pressure, and the pressure was so much with me.'

(Bangladeshi man, 26–55 years age group)

For these older men, rifts could arise due to failure to sustain the expected masculine family provider role. Some older men, having experienced mental health problems, described emotional attrition, contrasting their experiences with those of younger people. They described the erosion of identity and promise, with their hopes being worn down by financial pressures, changes in the types of work that men must do, and family rifts. Older men of South Asian heritage had struggled to provide support to extended family members, often trans-continentally. Some men spoke from beyond broken marriages, isolated and burdened by family and community rejection. Their fathers' generation had perhaps been ill equipped to support them through mental illness. The intergenerational family differences were isolating in that the men felt unable to confide in anyone. They lacked family or peer support, or support services:

'He was very supportive the first 12 months, but then the barriers started to build up, arguments, and because the parents aren't of the same ideology and psychology as the children there are barriers, conflicts.'

(Indian man, 26–55 years age group)

'For men there have been no Asian male counsellors, no specific support scheme.'

(Indian man, 26–55 years age group)

'Part of being a man is keeping it locked in. You don't tell anybody.'

(Indian man, 26–55 years age group)

Men's views here consistently offered confirmation of the social and cultural construction of mental illness and care (Kleinman *et al*, 2006). Their narratives highlighted a complex web of intersecting social influences on expectations of BME men, which confirmed previous research findings. These were as follows.

- The racialisation of identity formation. Racialised identity formation starts early, and the widespread perception of racism causes stress, mistrust, diminished self-esteem and lowered likelihood of disclosure. Men's narratives of racialised identity development and discrimination in service and leisure encounters were often interwoven with those of community marginalisation and exclusion.

  'Say you're going to a social club, where there's a whole variety of people, white, black, all types, and there's someone come up to you saying "You're Bengali, get out of here, don't ever come back".'

  (Bangladeshi man, 18–25 years age group)

- Experiences of the mental health system and services. BME men's mistrust of service provision for men with mental health problems was far-reaching. Perceptions of racialised services reinforcing gendered patterns and the stigma surrounding mental health often led to fear, avoidance of help seeking, and further risks of isolation for vulnerable men.

'A lot of people don't actually get help. They either get arrested or they get sectioned. That's obviously where the condition has escalated.'

(African Caribbean man, 26–55 years age group)

- Socio-economic factors. Financial hardship is a major stressor underlying mental health problems. Older men were expected to perform traditional provider roles, and younger men faced a crisis of expectations relating to consumerism. BME men with mental health problems then faced further major challenges over unemployment, change in family status, and treatment costs.

'I was a businessman, in this company I lost when there was a recession. I lost my home, also my business.'

(Bangladeshi man, 26–55 years age group)

- Acculturation. BME men described gendered and racialised challenges involving family migration and cultural transition. Tensions that were experienced in terms of relationships, acculturation and social class mobility created stresses throughout the life course of British-born BME men.

'My parents were foreign to this country, and had foreign ways and attitudes and it fed down to me. As an English-born person I have to go into the mainstream with foreign attitudes and teaching, and the stress of going into the mainstream and trying to do everything normal that my other white kindred do, it didn't work. I was getting racism, negativity, pushed to one side and it brought a lot of stress.'

(African-Caribbean man, 26–55 years age group)

- Community and family. In some environments, ill health of a family member puts the family's reputation at risk, and stigma constitutes an economic threat. While BME men tended to describe stigma and taboo as attributes of communities' specific social models, the communities themselves were seen as changing and internally differentiated. Social stigma was seen as universal. Social stigma surrounding mental health in families and communities could reinforce 'masculine' reluctance to seek help.

'In every society there is stigma about mental illness.'

(Indian man, 26–55 years age group)

'Everybody judges you. You become dysfunctional so you can't operate in society like normal people would.'

(Indian man, 26–55 years age group)

- Biomedical and cognitive causes. BME men described an interaction of social, biological and cognitive causal factors relating to illness. Stories of mental ill health running in a family could contribute to stigmatising every member of that family. Causes of mental health problems were recognised as being psychologically complex and dynamic, influenced by childhood and adolescence, including (but not confined to) gendered and racial causes.

'It's a composition of hereditary and environmental factors.'

(Indian man, 26–55 years age group)

Figure 1 demonstrates how the influence of social expectations about gender could contribute to a negative cycle of stalled recovery. Younger men sought to sustain expectations around hegemonic masculinities, but in the context of other biopsychosocial risk factors shown above, they had little scope for adopting alternative positions to express emotional vulnerability or cope with transitions. Older men experienced gendered pressures arising from the expectations for them to be economic providers for family networks. If they could not achieve this and if alternative narratives were not available and they developed mental illness, they could be marginalised by social stigma and by the impact of service treatment regimes. For many older men, this translated into a cycle of stalled recovery and disempowerment (see Figure 1).

Finding help

The most important factor for BME men when looking for help was trust. These men often lacked hope-inspiring relationships of trust to enable disclosure of vulnerability, and to assist them towards recovery. The participants considered the following human resource factors to be important.

- Independent male advocates within a particular community could support men towards recovery and empowerment, provided that they received sufficient training.
- Informal mentors or life coaches with experience of mental illness and recovery, perhaps from specific BME communities, could have credibility with peers.

Advocacy has been demonstrated to have great potential for promoting engagement and greater choice for BME men (Newbigging *et al*, 2007). To engender trust, non-medicalised community-based approaches to mental health promotion are recommended (Friedl, 2002; Tidyman, 2004).

The following resources also need to be developed with due consideration for specific challenges with regard to trust.

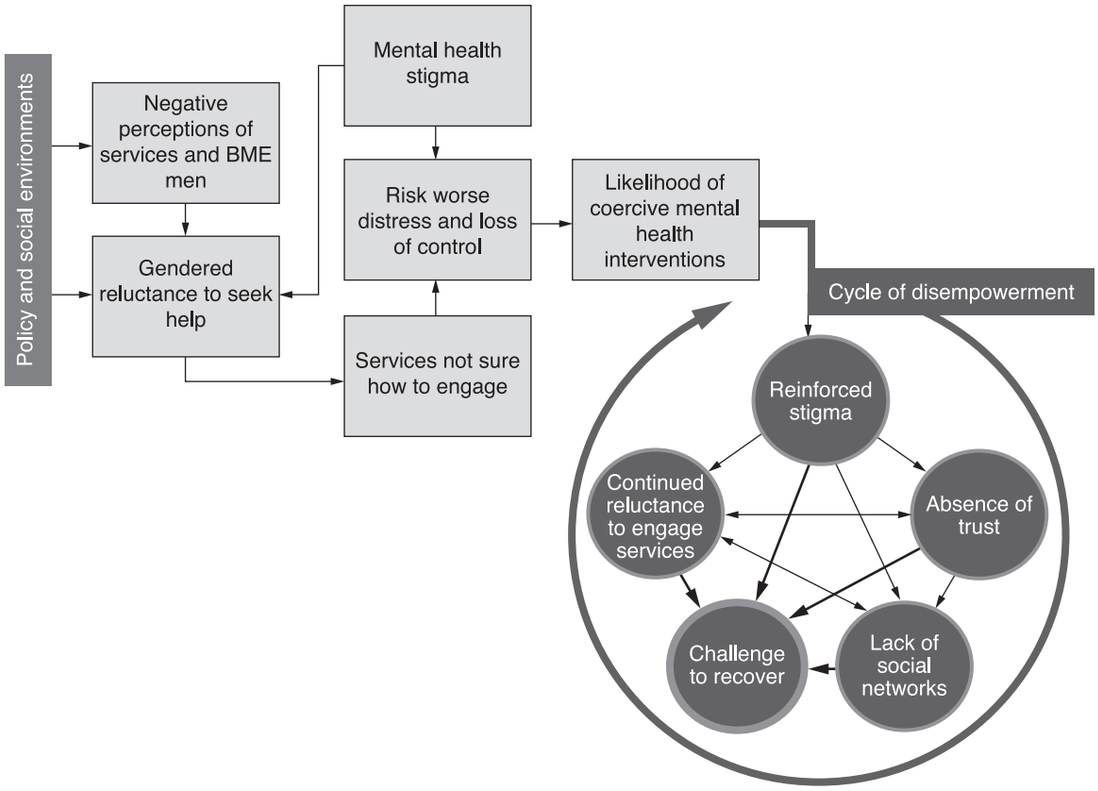

Figure 1 Cycle of disempowerment

- Peer support and friendships. Opportunities for trust building and social participation were sought by BME men with mental health problems. Participating in men's groups and meeting others with similar experiences was found to be therapeutic. Self-help groups, if protective of confidentiality, might offer great potential for support and overcoming isolation. Having a trusted friend was highly valued, but younger men felt that male friends might be judgemental.
- Family. Seeking help from family members could be problematic due to anxieties and stigma. In general, fathers were considered difficult to approach, whereas mothers were felt to be more approachable. This is an important consideration for health promotion messages.
- Services. To build trust, a drop-in-centre with staff who knew the community well was felt to be useful, and personal key workers who visited men could be valued.

Practical resources for change

BME men deployed a wide range of strategies and resources to enhance their well-being.

Exercise was associated with masculinity in different ways. For younger men, a masculine physique was strongly associated with self-confidence, whereas older men with a history of mental illness viewed exercise as one way of recovering within an embodied social practice that included carrying out routine activities, engaging in relationships, and taking an interest in the environment. Some medication regimes (e.g. treatments for reducing psychotic symptoms) unfortunately reduce the capacity for physical activity, despite the benefits in terms of improving mood, raising self-esteem and relieving stress. Therefore it is critically important to integrate medical treatment with a more holistic recovery programme.

Creative or expressive activities and meditative routines were perceived as having the potential to calm the mind, increase self-esteem, overcome stigma and construct positive ideals. These activities may also provide a sense of coherence and control over men's inner worlds.

The lack of information about mental health for BME men and boys was highlighted. A diversity of approaches should reflect the needs and preferences of BME men across generations. It was felt that the following types of information need to be included:

- information about recurrence prevention for young people and communities

- improved information about the causes, diagnosis, symptoms and management of mental illness
- a directory of services and support
- advice about confidentiality, procedures and pathways to care
- advice about recovery, finances, work, training and leisure.

Conclusions and recommendations

A complex mix of gendered, racialised, community and individual experiences provides the context for BME men's identities and experiences. The intersection of these factors poses a risk for some men's emotional resilience and well-being. The impact of social stigma surrounding mental health, the coercive power of institutions, and men's own perceptions of services, and vice versa, increase this complexity of risk, substantially affecting the vulnerable identities of BME men with mental health problems. Over a prolonged period this mix of factors can contribute to cycles of disengagement from services and isolation for marginalised BME men with mental health problems, and to difficulties in engaging in empowering and effective activities towards recovery. Across different generations, these complex social influences affect the expectations and identity of the BME men whose voices were heard in our study, pressurising them to conform to unrealistic or conflicting ideals in a stress-inducing way, or dampening and even defeating their expectations, making it increasingly difficult for them to integrate multiple aspects of self.

To create environments of trust and break the cycle of blocked recovery among many older BME men who have experienced prolonged periods of mental ill health, two specific recommendations are made.

1 In terms of well-being, engaging with BME men's understanding of and desire for their own health and well-being can enable practitioners to support these men more effectively. Instead of reinforcing narratives of illness, this approach helps to put BME men back in control.
2 In terms of pathways to recovery, practitioners are not always enabled by their organisational contexts to play an advocacy role or to win BME men's trust. Greater use of independent advocacy can help BME men to break the cycle.

To prevent young BME men both in the current context and in future generations from repeating the same disempowering cycle, it is essential to develop effective partnerships with community organisations and across sectors, and to create safe environments where young men can talk about their vulnerabilities. To ensure that early interventions do not follow the course frequently experienced by older men with long experience of mental health problems, in addition to the above recommendations, the following practice approaches are suggested.

- Male hegemony. It is vital to understand how masculine identity affects men's ability to talk openly about being vulnerable and to seek ways to communicate effectively.
- Complexity of experience. When working with BME men it is important to engage with their narratives in their complexity. This means engaging with specific formative experiences as BME men.
- Expectations. Practitioners should be aware of the detrimental effect of lowered or unrealistic expectations on BME men's well-being, and should help these men to explore and define their own expectations of life, and thereby support them in self-determination.
- Lifestyle. BME men's lifestyle preferences should be understood and respected, and practitioners should support these men in pursuing their chosen physical, expressive and social activities.
- Spirituality. A holistic approach is needed that includes understanding possible specific meanings of spirituality for individual BME men in relation to well-being and connection with their environment.

A priority for research should be to identify and implement models of support towards recovery, and to research their effectiveness, including a wider range of minority ethnic groups. It is suggested that the underpinning basis for effective interventions is likely to derive from a more socially oriented model consistent with the complex formative experiences of BME men that have been described in this paper, including the interface between masculinities, ethnicity and mental health.

ACKNOWLEDGEMENTS

The authors would like to thank the Men's Health Forum for commissioning and supporting this research. The research was funded by the UK Department of Health, the National Institute for Mental Health in England, and the Football Foundation.

REFERENCES

Baker S (2000) *Environmentally Friendly? Patients' views on conditions in psychiatric wards*. London: MIND.

Begum N (2006) *Doing It For Themselves: participation and black and minority ethnic service users*. Participation Report 14. Bristol: Policy Press.

Bhugra D, Leff J and Mallett R (1997) Incidence and outcome of schizophrenia in whites, African-Caribbeans and Asians in London. *Psychological Medicine* 27:791–8.

Bhui K, Chandran M and Sathyamoorthy G (2001) *Asian Men and Mental Health Assessment*. London: Confederation of Indian Organisations.

Boden S and Williams S (2002) Consumption and emotion. *Sociology* 36:493–512.

Brickell C (2005) Masculinities, performativity and subversion: a sociological reappraisal. *Men and Masculinities* 8:24–43.

Butler J (1990) *Gender Trouble*. New York: Routledge.

Connell R (1995) *Masculinities*. Cambridge: Polity Press.

Cooper L, Beach M, Robinson R *et al* (2005) Delving below the surface. Understanding how race and ethnicity influence relationships in healthcare. *Journal of General Internal Medicine* 21:21–7.

Erens B, Primatesta P and Prior G (eds) (2001) *Health Survey for England: the health of minority ethnic groups '99. Volume 1: findings*. London: The Stationery Office.

Falk G (2001) *Stigma: how we treat outsiders*. New York: Prometheus Books.

Fazel M, Wheeler J and Danesh J (2005) Prevalence of serious mental disorder in 7,000 refugees resettled in western countries: a systematic review. *Lancet* 365:1309–14.

Fernando S (2006) Stigma, racism and power. *Ethnic Network Journal* 1:24–8.

Fernando S (2009) Meanings and realities. In: Fernando S and Keating F (eds) *Mental Health in a Multi-Ethnic Society: a multidisciplinary handbook*. London: Routledge.

Foolchand N (2006) *The Mental Health of the African-Caribbean Community in Britain*. London: MIND.

Friedl L (2002) The mental health benefits of arts and creativity for African and Caribbean young men. *Journal of Health Promotion* 1:3.

Frosh S, Phoenix A and Pattman R (2002) *Young Masculinities*. London: Palgrave.

Galloway C and Gillam S (2006) *Mental Health of Chinese and Vietnamese People in Britain*. London: MIND.

Gervais M-C (2008) *The Drivers of Black and Asian People's Perceptions of Racial Discrimination by Public Services: a qualitative study*. London: Department for Communities and Local Government.

Glaser B and Strauss A (1967) *The Discovery of Grounded Theory*. Chicago: Aldine.

Goffman E (1963) *Stigma: notes on the management of a spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Healthcare Commission (2008) *Count Me In 2008: results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales*. London: Commission for Healthcare Audit and Inspection.

Johnson M and Verma C (1998) *It's Our Health Too: Asian men's health perspectives*. Southern Birmingham Community Health NHS Trust and NHS Executive Ethnic Health Unit. CRER Research Paper 26. Coventry: University of Warwick.

Joseph Rowntree Foundation (2007) *Poverty Rates among Ethnic Groups in Great Britain*. York: Joseph Rowntree Foundation.

Karlsen S, Nazroo J, McKenzie K *et al* (2005) Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine* 35: 1795–803.

Keating F (2007) *African and Caribbean Men and Mental Health. Better Health Briefing No. 5*. London: Race Equality Foundation.

King M, Coker E, Leavey G *et al* (1994) Incidence of psychotic illness in London: comparison of ethnic groups. *BMJ* 309:1115–19.

Kirkbride J and Jones P (2008) *The Mental Ill-Health of People Who Migrate, and Their Descendants: risk factors, associated disability and wider consequences*. London: Government Office for Science.

Kleinman A, Eisenburg L and Good B (2006) Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. *Journal of Lifelong Learning in Psychiatry* 4:140–49.

Lloyd T, Kennedy N, Fearon P *et al* (2005) The incidence of bipolar affective disorder in three UK cities: results from the AESOP study. *British Journal of Psychiatry* 186:126–31.

McKenzie K and Bhui K (2007) *Suicide Prevention for BME Groups in England: report from the BME Suicide Prevention Project*. London: Centre for Health Improvement and Minority Ethnic Services.

National Institute for Mental Health in England (2004) *Celebrating our Cultures: guidelines for mental health promotion with the black and minority communities*. London: Department of Health.

National Institute for Mental Health in England (2007) *Positive Steps: supporting race equality in mental health care*. London: Department of Health.

Nazroo J (1997) *Ethnicity and Mental Health: findings from a national community survey*. London: Policy Studies Institute.

Newbigging K, Mckeown M, Hunkins-Hutchison E *et al* (2007) *Mtetezi. Developing mental health advocacy with African and Caribbean men*. Adults' Services Knowledge Review 15. London: Social Care Institute for Excellence. www.scie.org.uk

Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion Report 126*. London: Office of the Deputy Prime Minister.

Ridge D, Emslie C and White A (2011) Understanding how men experience, express and cope with mental distress: where next? *Sociology of Health and Illness* 33:145–59.

Robertson S (2007) *Understanding Men and Health*. Buckingham: Open University Press.

Sainsbury Centre for Mental Health (2006) *The Costs of Race Inequality*. Policy Paper 6. London: Sainsbury Centre for Mental Health.

Seebohm P, Henderson P, Munn-Giddings C *et al* (2005) *Together We Will Change: community development, mental health and diversity*. London: Centre for Mental Health.

Sproston K and Nazroo J (eds) (2002) *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)*. London: The Stationery Office.

Tidyman M (2004) *Making it Diverse: mental health promotion and black and minority ethnic groups*. Radical Mentalities Briefing Paper 3. London: Mentality.

Watson J (2000) *Male Bodies: health, culture and identity*. Buckingham: Open University Press.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr Mark Robinson, Centre for Men's Health, Faculty of Health, Leeds Metropolitan University, Queen Square House, 80 Woodhouse Lane, Leeds LS2 8NU, UK. Tel: +44 (0)113 812 1982; email m.r.robinson@leedsmet.ac.uk

Received 1 December 2010
Accepted 7 March 2011