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Item Type	Journal article
Authors	Tuffour, Isaac
Citation	Tuffour, I. (2023) 'They tried to evil me': an explanatory model for black Africans' mental health challenges. <i>Nursing Inquiry</i> , 31 (2), article number e12602. https://doi.org/10.1111/nin.12602
DOI	10.1111/nin.12602
Publisher	Wiley
Journal	<i>Nursing Inquiry</i>
Download date	2026-03-16 18:19:44
License	https://creativecommons.org/licenses/by/4.0/
Link to Item	http://hdl.handle.net/2436/625316

'They tried to evil me': An explanatory model for Black Africans' mental health challenges

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Abstract

This paper explores the explanatory models of mental challenges among Black Africans in England. It argues that understanding these models is critical for providing culturally appropriate care to this population. The study employed qualitative methodology, and interpretative phenomenological analysis (IPA). Twelve mental health service users who are living in England and self-identified as first or second-generation Black Africans were purposively selected. The data were gathered using face-to-face semistructured interviews. Data were manually analysed in accordance with IPA concepts of searching for common, unique and idiosyncratic themes across transcripts. The findings revealed three themes Black Africans associated to their explanatory model of mental health challenges: complexities of migration, African-centred worldview and negative life experiences. To help alleviate the Eurocentric nature of mental health practice in England, it is hoped that this explanatory model will become an integral part of mental health practice in England and around the world.

KEYWORDS

Black Africans, England, explanatory models, interpretative phenomenological analysis, mental health challenges, mental illness

1 | INTRODUCTION

This paper is informed by a bigger project (Tuffour, 2017b) that explored the experiences of Black African service users in England in relation to recovery from mental health challenges. The findings from the study revealed that Black African service users viewed recovery as a pragmatic and subjective construct distributed across a continuum of clinical, functional and spiritual dimensions, resilience, identity and their social and cultural backgrounds (Tuffour, 2017b; Tuffour et al., 2019). More importantly, one of the significant findings to emerge from this study is that the causes of mental health challenges may differ according to cultural backgrounds, and that

Black Africans in England have their own unique explanatory model of these challenges (Tuffour, 2017b).

It was Kleinman et al. (1978) who coined the phrase 'explanatory model' to describe the complicated, culturally controlled process of making sense of one's illness, understanding of the causes, symptoms and consequences of their illness, as well as their expectations for treatment and recovery. The explanatory models are therefore culturally driven ideas that people assign to catastrophe, suffering or illness. They are moulded and shaped by societal expectations of the sick role, individual illness and help-seeking behaviour (Dinos et al., 2017). Cultural influences, according to Kleinman (1980) and Mullahey-O'Byrne and West (2001), do not

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only define an explanatory model of illness, but they also influence people's expectations of health service provision, and the expectations between the practitioner and the individual seeking help (Mullavey-O'Byrne & West, 2001). Explanatory models are therefore cultural transactions of clinical reality (Bassett, 2011; Fitzgerald, 1992; Fitzgerald et al., 1997).

1.1 | A note on terminology

At the outset, it was acknowledged that the terms 'Black', 'Black African', and 'sub-Saharan Africa' are complex and contentious. These terms conceal the heterogeneity of African cultures and risk reinforcing racial stereotypes (Agyemang et al., 2005; Aspinall & Chinouya, 2008). However, because this study focusses on people who identify as belonging to the geographical region of sub-Saharan Africa, the terms 'Black African' or African are used interchangeably to refer to people and their descendants with African ancestral origins who have migrated from sub-Saharan Africa to England. Also, the terms 'mental illness' 'mental disorders', 'mental health problems' and 'mental health challenges' are used synonymously in the mental health literature and practice. For the purposes of this paper, 'mental health challenges' is used in preference to other terms because it aligns with the principles of lived experience and the recovery concept that puts emphasis on the individual's own beliefs and experiences (Sunkel & Sartor, 2022; Tuffour et al., 2019).

1.2 | The difficulties of being a migrant and/or refugee

Migration is a complex and multifaceted phenomenon that can have a significant impact on the lives of migrants. The challenges associated with migration can vary depending on the individual migrant's circumstances, but some common challenges include postmigration stressors such as marginalisation, social oppression and discrimination that could contribute to mental health challenges (Barbui et al., 2022; Byrow et al., 2020). Research has shown that refugees who experience trauma before fleeing their home countries are more likely to develop severe mental illnesses later in life (Bogic et al., 2012, 2015). Refugees who experience postmigration stressors, such as language barriers, discrimination and social isolation, are also at risk of developing mental health problems (Hajak et al., 2021).

There is a growing body of evidence that Black Africans in the United Kingdom are more likely to experience mental health challenges than other ethnic groups (NHS Digital, 2021). This is likely due to the hostile immigration environment they have been subjected to, which has been exacerbated by successive UK governments' selectively restrictive immigration policies (Bowling & Westenra, 2020; Webber, 2019). However, the explanatory models that Black Africans in England attribute to their mental health challenges are not well understood. This paper aims to provide an

explanatory model of mental health challenges among this population, as well as a conceptual framework for that model.

1.3 | Worldviews and cultural values of Black Africans

It is important to remember that there is no single African worldview or cultural belief system. Thus, the beliefs and cultural values described here are just some of the many ways that Africans understand the world, culture and their place in it. These beliefs and practices have been shaped by a variety of factors, including the natural environment, history, a strong emphasis on spirituality, proverbs, metaphors, morality, self-respect and respect for other people and all of nature (Mbiti, 1990; Morgan & Okyere-Manu, 2020). To begin with, the concept of a supreme being is widespread in Africa and is often associated with the creation of the universe and the ordering of the natural world. The supreme being is often seen as benevolent and just and may be worshipped through rituals and offerings. In some cultures, the supreme being is seen as a remote and impersonal force, while in others, it is seen as a more personal and approachable being (Morgan & Okyere-Manu, 2020; Turaki, 2006). Also, belief in ancestors is a widespread practice in Africa. Ancestors are often believed to be able to influence the lives of their living descendants, and they may be consulted for advice or guidance. In some cultures, ancestors are seen as intermediaries between the living and the spirit world, while in others, they are seen as more powerful beings who can directly influence the course of events (Morgan & Okyere-Manu, 2020).

Moreover, many African cultures believe in the existence of spirits, which can be benevolent or malevolent. Spirits can be invoked to bring good luck or harm to enemies. Magic and medicine also belong to the realm of spiritual forces, and can be used for a variety of purposes, such as healing, protection or harming others (evil spirits). The evil spirits and the spiritual world are more feared than anything else in life (Morgan & Okyere-Manu, 2020). Furthermore, Africans often believe that human beings are spiritual beings and that their physical bodies are only one aspect of their identity. This belief is reflected in the importance of rituals and ceremonies, which are seen as ways to connect with the spiritual realm (Gyekye, 1997).

A central tenet of many African worldviews is communalism, which sees the individual as not separate from the community or the natural world, but rather part of a larger whole (Mbiti, 1990). Thus, in many African cultures, the individual is seen as part of a larger collective of a family, clan or tribe. This collective identity is often very strong and can be seen in the way that people interact with each other, and with the world around them (Gyekye, 1997; Menkiti, 1984; Wiredu, 1996). In some cultures, the collective identity is seen to ensure the survival of the group, while in others, it is seen to promote individual fulfilment (Mbiti, 1990). The communal nature of most African cultures means that mental illness is not just an individual problem, but also a family, social and

community problem (Kleinman, 1980). It is important to understand if Africans in England subscribe to this thought.

1.4 | Different cultural understandings of mental health challenges

Understandings of mental health challenges vary widely across cultures. However, the Eurocentric perspective, which emphasises individual pathology and pays little attention to cultural and social values, has traditionally influenced these conceptualisations (Rogge, 2011; Vaka, 2016). The Eurocentric understanding of mental health challenges is based on the medical model, which is characterised using diagnostic criteria and treatment typically involving medication, therapy or a combination of both (American Psychiatric Association, 2013). However, in non-Western cultures, mental health challenges may be seen as a spiritual or supernatural problem, a social or environmental problem, or a combination of these, and there is often a focus on the role of the family and community in the treatment (World Health Organization, 2001). When biomedical definitions of mental health challenges are applied to people from different cultures, there is a potential for conflict. Vaka (2016) argues that the Western approach to mental health challenges may not consider cultural subtleties, which could lead to misdiagnosis and inappropriate treatment.

In relation to non-Western cultures' conceptualisations of mental health challenges, Pacific cultures often see it as a holistic ailment affecting the mind, body and spirit (Leckie & Hughes, 2017). However, there is variation in how mental health challenges are conceptualised across Pacific subcultures. For example, Samoans generally view it as an altered state of mind, behaviour and emotions (Leckie & Hughes, 2017), while Tongans generally conceptualise mental health challenges in three ways: Tongan constructions, biopsychosocial constructions and intersections between biopsychosocial and Tongan constructions (Vaka, 2016). Also, there is evidence that Tongan youth are inclined to emphasise on biopsychosocial perspectives (Vaka et al., 2022).

Similarly, the conceptualisation of mental health challenges among sub-Saharan Africans is complex and varied. In many cultures, it is understood as a supernatural or spiritual problem (Atilola, 2015; Labinjo et al., 2020; McCabe & Priebe, 2004; Patel, 1995), or as social or personal problems in other cultures (Kpanake, 2018). In recent years, biomedical understandings of mental health challenges are gaining ground in the region due to Western influences (Cooper, 2015). Despite this, little is known about the explanatory models Black Africans in England attribute to their mental health challenges.

2 | METHODOLOGY

The study employed qualitative methodology, and interpretative phenomenological analysis (IPA). IPA was chosen because it provides a flexible and diverse method to understand lived experience by

integrating the works of prominent phenomenological thinkers (Smith et al., 2009; Tuffour, 2017a). City University of London Research Senate Committee, and an NHS Local Research Ethics Committee both approved the study's ethics.

2.1 | Research participants

Twelve mental health service users who are living in England and self-identified as first or second-generation Black Africans were purposively selected for this study.

2.2 | Data collection

To ensure authenticity, service users from the City University of London's Service Users and Carers Group Advising Research (SUGAR) were actively involved in the research design and the drafting of the interview schedule (Simpson et al., 2014). However, some authors have warned that integrating lived experience into research can be emotionally burdensome for service users, as it can trigger difficult memories or emotions (Faulkner & Thompson, 2023). Also, experimental knowledge can disrupt the illusion of objectivity in mental health research (Faulkner, 2017). Despite these reservations, the involvement of service users in this study has shown that patient and public involvement is maturing and gaining traction (Faulkner & Chambers, 2021).

Throughout the study, the ethical guidance, and safeguarding principles of respecting the participants' dignity, rights, safety, right to withdraw and wellbeing (Health Research Authority, 2020) were followed. The research process was explained to participants, and their informed consent was obtained. They were also informed that participation was entirely voluntary and that they could withdraw at any time without giving a reason.

The data were gathered using face-to-face semistructured interviews that were facilitated by an interview schedule. Questions included the following: How did you first become unwell? For you, what are the factors that contributed to your illness? What is your understanding of mental illness? What does hearing voices mean to you? (Or the terms the participants use). The interviews, which lasted between 35 and 60 min, were recorded and verbatim transcribed. To safeguard their privacy, participants were assigned pseudonyms.

2.3 | Reflexivity

I brought multiple perspectives to the study, including those of an insider, an outsider and somewhere in between. As a Black African and first-generation immigrant, I shared insider identities with the participants. I understood their negative experiences and acculturation tensions. However, since I had never experienced mental health challenges myself, I also saw myself as an outsider trying to understand their experiences. Moreover, as a mental health nurse

and researcher, I was somewhere in between the insider and outsider roles. This allowed me to generate a synergetic and expanded understanding of the participants' perspectives, while also maintaining a critical distance (O'Boyle, 2017; Tuffour, 2018).

I acknowledge that the way I phrased certain questions may have inadvertently shaped how some participants responded. For example, the question 'What is your understanding of mental illness?' may have led to answers focussing on the medical model of mental health challenges, while the question 'What does hearing voices mean to you?' may have inadvertently led participants to provide certain answers. While I concur that leading questions can influence participants' answers and skew the research findings (Kazdin, 2017; Rubin, 2012). It is important to point out that I made every effort to ask open-ended questions in line with the IPA semistructured interview procedure (Smith et al., 2009). In addition, involving SUGAR (Simpson et al., 2014) in the drafting of the interview schedule and pilot-testing the questions ensured that the questions were clear, understandable and free of leading questions. Overall, I believe that my unique perspective as an insider/outsider allowed me to gain a deeper understanding of the participants' experiences and to generate rich and detailed data.

3 | DATA ANALYSIS

Data were manually analysed in accordance with IPA concepts of searching for common, unique and idiosyncratic themes across transcripts. This entailed pasting individual interview transcripts in the middle of a three-column table, then initial reading and rereading for data immersion, then initial identification of exploratory themes, then clustering of themes into emergent themes, then charting or mapping the connections between the emergent themes, then looking for patterns across cases and integrating them into an inclusive table of superordinate and subordinate themes (Smith et al., 2009). A reflective journal documenting my initial thoughts and comments proved valuable during data interpretation.

In the next sections, the three themes: complexities of migration, African-centred worldview and negative life experiences associated with the explanatory model that the participants assigned to their mental illnesses will be thoroughly presented.

3.1 | Complexities of migration

The participants came to England for a variety of reasons. Many reported arriving in England as refugees fleeing from political persecution, wars and traumatic events such as physical and psychological abuse. Their stories were laced with hope for a better life. Yet, participants described their problems in adjusting to life in England, which frequently provoked nostalgic feelings and longing for their home nations as the start of their mental illness. Narratives revealed subjective accounts of how migrating to England contributed to their mental health problems. One participant narrated how

his protracted migration problems led to his physical and mental health problems:

Things like my immigration status ... I was just depressed and was just taking it out on people ... Basically I would go and sign on I think every month. I used to go ... and sign on. I wasn't allowed to work or any of that stuff it was waiting for them to decide what to do whether they would approve for me to stay in this country or not, it was really depressing. I used to travel there; I didn't even work, which was frustrating. I didn't have money to travel, and I would have to depend on my mum. Yeah, and my condition was not really that good at that point ... and ended up getting lost but it wasn't a good experience getting lost and hearing voices and all that stuff you know. My physical condition was not well; I used to follow what I was thinking and end up somewhere else and doing inappropriate things ... I just gave up on myself you know, I just gave up, I had no hope of at all of things, the amount of the immigration thing went on for was quite a while and I couldn't really understand why they wouldn't give me a stay here and stuff like that, why they wouldn't consider me.

Here, the participant is describing his frustration with the protracted immigration problems which he sees as a major stress in his daily life. He therefore frames his experience in the context of painful feelings associated with the handling of his asylum and/or resident permit application. His story shows that he considers the protracted uncertainty over his migration status unpleasant, yet he is unable to change it. The constraint put on him causes significant feelings of loss of autonomy and opportunities, leading to his mental health problems. His life experiences may be marked by feelings of desperation and powerlessness. Disillusionment, rage and hostility are also present, and they are aimed against innocent people. The participant also talked about how the protracted immigration problems triggered suicidal thoughts:

One time I ended up at the river in those days when there was flooding. I felt like jumping in there. It was scary ... actually. I left the house to buy a kebab and ended up just following my mind and physically I felt my legs were just pulling me somewhere else and stuff like that and I ended up at the river until one of my mum's friends saw me and convinced me to go home ... It was a Saturday evening when I left and I came back Sunday evening so I did not sleep at all. I had been walking around the river back and forth...It was not a good experience.

Despite this, he cheerfully announces that he has been granted a conditional leave to remain in the country:

I actually got discretionary leave to remain in the country, which unfortunately ends at the end of this year, and I have to apply again. I couldn't go to college or work when my immigration status was messed up. But I managed to go to college last year, I can do things like work. I can work.

The positive impact of being granted conditional right to remain in England means that this person is optimistic, but his future remains uncertain because the discretionary leave to remain in the country is only temporary. On the other hand, one could argue that his optimism is short lived as his long-running immigration issues appear to have taken their toll on him and have significantly contributed to his mental illness. Similarly, one participant blamed her mental illness on her migration to England:

Sometimes you feel bad like you ask yourself why? Back at home, I did not have this problem, and when I came here all of a sudden something happened to me. I ask myself why, why God? Why, God this happened to me, it's a bit sad.

The excerpt above can be read in two ways. First, the participant appears to imply that she would not have suffered from mental illness if she had not moved to England. Second, it appears that she blames and questions God for her mental illness. Perhaps she feels singled out or punished by God for allowing such tragedy to occur to her, or she believes God has abandoned her. Her tale conveys a sense of retribution and/or desertion, prompting her to grow enraged with God. Her story suggests that spirituality is important in her life, yet her experiences are marked by wrath, blame, desertion and regret.

3.2 | African-centred worldview

The accounts of the participants gave unique insights into how Black Africans often linked mental illness to African-centred worldviews (Tuffour, 2020). This was evident when one participant said:

They tried to evil me. They fought me ... to kill me ... and then they were doing that on and on and on ... I became sick then ... I was admitted for a couple of months ... But when I got back home, they started on me again. They started evil me, they tried to kill me ... So my tummy started getting big ... as if I'm swelling.

The narrative suggests that the participant has linked her social and cultural background with her experiences and associated the origin of her mental illness with evil spirits. There is also a perception in her narrative that her experiences are something inflicted by her enemies or are malicious human acts. The unpleasant physical experience intensified for the participant, and she continues to think

that the perpetrators are abusing, raping and even trying to kill her through witchcraft:

I just say that maybe it's just abuse because they rape me through the witch ... through the evil ... they try to kill me, they try to rape me ... it's not physical rape but I do feel it ... I feel that something is going on ... I asked them 'why are you doing this to me?' they said that they wanted to kill me ... I said, 'why do you want to kill me?' they said 'nothing. We just want to kill you'.

Although in the 'Western' medical psychiatry, an explanation of delusional thinking is plausible, the participant's experiences appear to fit the common Black African cultural belief and perception that the world is filled with affliction and wickedness, and it is not surprising that she is attributing such critical events to witchcraft or evil spiritual powers (Atilola, 2015; Patel, 1995).

3.3 | Negative life experiences

This theme expresses the participants' beliefs that their difficulties and negative experiences contributed to their mental illness. Participants spoke about experiences suffused with low self-esteem, sadness, insecurity, rejection and abandonment, lack of life opportunities and trauma that they believed have contributed to their mental illnesses. One participant reflected on the frightening ordeal of witnessing armed robberies which triggered his mental illness:

Like I had two previous occasions where I had armed robbers come to our house and on both occasions, I was the only male in the house, so it was quite frightening ... Well, the first time it happened I didn't go outside for a good month or anything; I was nine at the time I think, when it first happened. My grandma got roughed up a little bit so that was a little bit distressing for me to see. And the second time ... that's the one that I kind of remember very vividly because I was asleep, and he came and my mum was upstairs and she was screaming there was just a whole load of things happening. I don't really want to go into it too deeply.

The participant's traumatic experience is permanently embedded in his memory. It is apparent from the above narrative that he was overcome with so much emotion that he did not want to talk about it anymore. These painful and traumatic and unpleasant experiences have had very real consequences for his mental health. Likewise, fear of abandonment was reflected in one participant's account:

When I'm not feeling better maybe he will try to leave me ... He will not cope with me ... because of this same illness, my partner left me ... If I have another partner

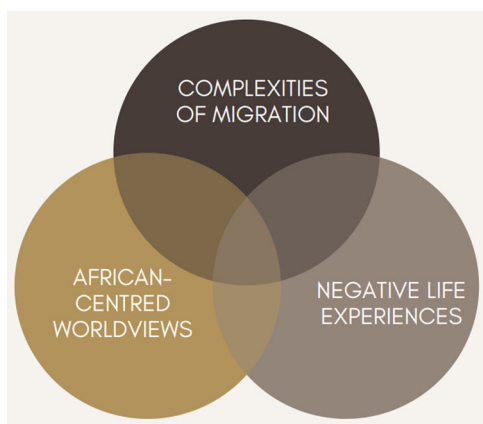


FIGURE 1 Conceptual framework of Black Africans' explanatory model of mental health challenges.

after that they will leave me because of that. I will not feel good.

Here, this participant appears to recount her heartache about her ex-partner leaving her because of her mental illness. In the extract above, the insecurity about a similar thing happening to her again seems very real. She is hinting that she may never have a partner in her life because of her mental illness.

3.4 | Explanatory model of mental health challenges for Black Africans

Participants in the study attributed their mental health challenges to the challenges of migration, African-centred worldviews, and negative life experiences. Figure 1 provides a conceptual framework that illustrates the three aspects of the participants' explanatory model of mental health challenges. It is hoped that this framework will become an integral part of mental health practice in England and beyond, as it would help to address the Eurocentric nature of mental health care. It is important to recognise that explanatory models are fluid constructs that can be influenced by a variety of factors, including the clinician's approach, the questions asked, the symptoms and severity of the illness and the patient's general psychosocial history. Furthermore, as the explanatory model may change several times throughout an illness, it is essential to revisit it at regular intervals (Dinos et al., 2017).

4 | DISCUSSION

This paper set out to determine the explanatory model of mental health challenges among Black Africans in England, as well as to provide a conceptual framework for that explanatory model. The following section contextualises the findings in relation to the existing literature. The findings, which were consistent with the

literature, demonstrated a robust relationship between migration and mental health challenges (Bogic et al., 2015; Bryant, 2023). As evidenced by the findings, many of the participants provided detailed narratives of their migration movements to England that corresponded to the three stages of migration described by Bhugra and Jones (2010): (i) premigration or deciding and planning the migration; (ii) actual migration and (iii) postmigration adaptation to the sociocultural lifestyle of the new society. The stress of adjusting to a new culture can contribute to mental health challenges in immigrants (Hajak et al., 2021).

Several participants in the study reported that traumatic events they experienced in their home countries contributed to their mental health problems. This is consistent with the research that has shown a correlation between trauma and severe mental health challenges in refugees (Bogic et al., 2012; Hajak et al., 2021; Kim et al., 2022). For example, Winter et al. (2016) explored the historical backdrop of Sierra Leone's civil war, presenting the accounts of survivors who were refugees who presented with mental health concerns and post-traumatic stress disorder (PTSD). Similarly, Nguyen et al. (2022) found that Syrian refugees who had endured torture had severe mental health challenges and complex PTSD.

Participants reported that negative life experiences they were exposed to when they came to England significantly contributed to their mental health challenges. Evidence suggests that major threats such as discrimination, economic problems, language barriers, loss of family and community support, poor access to social, educational and health services and uncertain asylum application procedures after arriving in a host country can contribute to mental health challenges (Jannesari et al., 2020; Sijbrandij, 2018). Moreover, findings indicate that many participants had unfavourable postmigration experiences such as restrictions, insufficient access to health, education, work and hostile reactions from the society, all of which affected their mental health and help-seeking behaviours. Several authors have found that mental health help-seeking amongst immigrants and refugees could be impacted by structural barriers (Barbui et al., 2022; Byrow et al., 2020).

The participants' narratives revealed that their African-derived cultures or worldviews and spirituality influenced their complicated conceptions of mental health challenges. This is consistent with the notion that people frequently use cultural circumstances and beliefs to explain their distress (Bracken & Thomas, 2005; Kleinman, 1988; Weiss, 1997). According to the findings, the majority of the participants initially believed that their mental health challenges were caused by an evil spirit, witchcraft, sorcery, magic or mystical powers. This is congruent with the findings that some sub-Saharan Africans are more likely to blame their mental illness on supernatural forces (Atilola, 2015; Labinjo et al., 2020; McCabe & Priebe, 2004; Patel, 1995). Also, several studies from sub-Saharan African countries, including Ventevogel et al. (2013) in Burundi, South Sudan and the Democratic Republic of Congo; Olugbile et al. (2007) in Nigeria; Abbo et al. (2008) in Uganda; Muga and Jenkins (2008) in Kenya and Mzimkulu and Simbayi (2006) in South Africa, support the participants' beliefs that their mental health challenges are caused by

mystical or supernatural powers, witchcraft, spirit possession and enraged ancestors.

4.1 | What the study adds to the existing evidence

The three specific domains: complexities of migration, African-centred worldviews, and negative life experiences that emerged as an explanatory model of mental health challenges among Black Africans add to our understanding of explanatory models of illness which are culturally driven and have an influence on help-seeking behaviours (Dinos et al., 2017; Kleinman, 1980).

4.2 | Implications for mental health nursing practice

As previously stated, explanatory models are culturally grounded concepts about a given illness (Bassett, 2011; Fitzgerald, 1992; Fitzgerald et al., 1997). The participants' explanatory models were fragmented and complex at the outset of mental health challenges, but these were easily dismissed after obtaining some understanding. This is consolidated by Dinos et al. (2017) who argue that explanatory models are not fixed or static, but complex, fluid and influenced by the individual's life experiences and circumstances. Understanding Black Africans' explanatory models of mental health challenges is therefore crucial for offering culturally appropriate care. The conceptual framework presented in this study should help mental health clinicians understand Black Africans' thoughts around mental health challenges as well as their cultural expectations about the challenges and their management. Practitioners should recognise that the Black African who believes that their mental health challenges are caused by witchcraft or spiritual imbalance may not be willing to take medication or seek help from the mainstream services. This paper argues that the worldviews of Black Africans should be valued, respected and integrated into mental health practice.

Moreover, it is crucial for mental health practitioners to recognise that different explanatory models can coexist but focussing on one model to the detriment of others may lead to less favourable outcomes. For example, focussing solely on the biomedical model of mental health challenges, may overlook the spiritual, social or cultural factors that may also be contributing to the patient's symptoms, and this may potentially prevent the individual from receiving the full range of treatment options available to them (Dinos et al., 2017).

Practitioners working with Black Africans experiencing mental health challenges should demonstrate a genuine interest in understanding their explanatory models by asking the eight questions suggested by Kleinman (1978, p. 256) to decode their understanding and expectations around their challenges: (1) What do you think has caused your problem? (2) Why do you think it started when it did? (3) What do you think your mental health challenges do to you? (4) How severe are your challenges/problems? Will it have a short or long course? (5) What kind of intervention do you think you should

receive? (6) What are the most important results you hope to achieve from this intervention? (7) What are the chief problems your challenges have caused for you? (8) What do you fear most about your challenges/problems? Involving people in the process of understanding and addressing their own challenges is more aligned with the service user involvement, principles of lived experience, and the recovery model than the medical model which can be limiting and disempowering because it does not always consider the individual's own beliefs and experiences (Sunkel & Sartor, 2022; Tuffour et al., 2019). However, the current study shows that individuals with serious mental health challenges who lack insight may have harmful beliefs that can hinder their recovery.

5 | CONCLUSION

The purpose of this study was to explore an explanatory model of mental health challenges among Black Africans in England, as well as a conceptual framework for that model. This research found that, in general, Black Africans identify three specific domains, which are partly influenced by their cultural and religious beliefs, as their explanatory model of mental health challenges: complexities of migration, African-centred worldviews and negative life experiences. Future research could investigate these three concepts separately to gain a better understanding of how they contribute to Black African mental health challenges.

ACKNOWLEDGEMENTS

The author is grateful to the participants who contributed their lived experiences to this study.

CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

DATA AVAILABILITY STATEMENT

Data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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How to cite this article: Tuffour, I. (2023). 'They tried to evil me': An explanatory model for Black Africans' mental health challenges. *Nursing Inquiry*, e12602. <https://doi.org/10.1111/nin.12602>