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How do Black British communities culturally respond to mental distress: a qualitative reflexive thematic analysis

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ABSTRACT

Objectives To explore how Black British communities culturally recognise, cope with and manage mental distress and to consider the implications of these responses for equitable mental health prevention.

Design Qualitative study using semi-structured focus groups, analysed with inductive reflexive thematic analysis.

Setting Online focus groups were conducted across the UK.

Participants 36 adults aged 23–68 years, including Black British community members (n=11), mental health professionals (n=14) and practitioners from African and Caribbean third-sector organisations (n=11). 35 participants self-identified as Black British African and/or Caribbean.

Results Five interconnected themes were identified: (1) mental resilience, characterised by emotional suppression, concealment of distress and coping in solitude; (2) faith in distress, including the utilisation of church communities and prayer; (3) escapism through substances; (4) physical and creative release and (5) peer support.

Conclusions Black British communities draw on a range of culturally accessible coping strategies that can both sustain well-being and shape pathways to care. Preventive mental health models should recognise and work alongside these existing responses to support more equitable, culturally responsive early intervention beyond statutory services.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Black British communities face higher rates of serious mental illness (eg, psychosis), lower engagement with statutory services and are under represented in preventative care.

⇒ Explanatory research has focused mainly on barriers to accessing care and has overlooked cultural differences in how mental distress is responded to within Black communities.

WHAT THIS STUDY ADDS

⇒ Through qualitative focus groups with community stakeholders, five overarching themes captured the cultural responses to distress in Black communities.

⇒ Participants described these responses as culturally embedded and often protective, yet they can delay help-seeking or exacerbate distress when used exclusively or long-term.

⇒ Alternative and positive coping styles were also noted as emerging among the younger generation.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Clinical services should better acknowledge and incorporate the existing ways Black communities in the UK respond to mental distress, to create greater equity in the delivery of care and in emerging preventive mental health services.

INTRODUCTION

In 2023, mental health services in England received a record 5 million referrals, marking a 33% increase since 2019 and an 11% rise from the previous year.[1] To reduce the burden on service demand, policymakers have highlighted a renewed focus on early intervention and preventive mental health.[2] To advance the development of early and preventive mental health strategies, services must go beyond the existing boundaries of the clinic and engage with determinants of mental ill health and their psychological impacts in the general population.[3] This is particularly important for specific ethnic minority groups, particularly those of African and Caribbean descent, who, despite experiencing disproportionately higher rates of serious mental illness[4] are less likely to seek early mental health support and more likely to access care through more negative and coercive pathways.[5–7]

Cultural coping theory argues that the cognitive and behavioural strategies an individual uses to interpret, manage and respond to mental distress are not universal but rather develop in specific cultural contexts.[8] This perspective is rarely taken into account in existing research on mental health service utilisation within the Black British community, which primarily focuses on barriers to service access and help-seeking patterns.[9] There is a wealth of theoretical discussion and empirical work on how historical, systemic

and traditional factors shape the mental health needs and response of people from the Caribbean[10 11] and sub-Saharan Africa.[12 13] In the UK, Jongsma argues that excessive psychosis rates in these communities are best explained by the accumulation of social adversity and exclusion, which produces predisposing psychological and biological states.[14] We also know that these populations draw on traditional and spiritual healing practices, combined with religious structures, to facilitate positive well-being.[15]

Little is known about how these processes intergenerationally transcend within the Black population in the UK, and if other cultural coping processes exist that might shape early engagement with psychiatric care. Identifying the culturally normative ways all groups recognise, cope with and manage early mental distress is essential for aligning new preventive strategies and bridging the gap between mental health needs and early support-seeking. This understanding is particularly important for Black British communities, who are underrepresented in existing preventive mental health services in the UK.[2]

This study adopts an early mental health responses perspective, informed by cultural coping theory. 'Cultural coping' refers to the non-professional and acquired strategies that individuals adopt to identify, understand and manage psychological distress under the influence of community norms, values and historical experiences.[16] 'Mental distress' is used to describe a transdiagnostic construct of emotional and mental suffering arising from sustained stressors; reflecting interacting social, psychological and biological processes, including perceived inability to cope and associated functional harm.[17–19]

Research objectives

Aim

To explore how Black British communities culturally recognise, cope with and manage mental distress, with particular attention to responses that are found in non-clinical community populations.

Objectives

This study sought to:

1. Identify and characterise the cultural coping strategies/responses (attitudes, beliefs and the overt and covert behaviours) through which Black British communities respond to mental distress.
2. Examine how these strategies are valued and emphasised within Black British communities.
3. Consider the implications of these strategies for equitable mental health provision and preventive mental health interventions.

METHOD

This study adopted a qualitative constructionist methodology[20] in which participants' accounts and perspectives were seen to reflect culturally and socially situated understandings rather than objective facts. A reflexive thematic analysis (RTA) approach was selected to facilitate interpretive engagement with participants' meaning-making, with the researcher's reflexivity used to critically examine how positionality influenced data interpretation.

Sample and recruitment

Three stakeholder groups were invited to participate in nine online focus groups (three per group). These groups included: (1) mental health professionals with experience of working with Black British communities; (2) practitioners from African and Caribbean third-sector organisations and (3) Black British individuals from the general population.

Participants were recruited between May and November 2024 via online social media adverts and through direct invitations to specialty third-sector organisations offering mental health support to Black British communities.

The focus groups were conducted between June and November 2024 via commercially available videoconferencing software. Group discussions were preceded by an icebreaker exercise, where participants collectively reflected on a case scenario and discussed common experiences and culture within the Black British community. Semistructured questions were used to elicit the participants' personal or professional experiences and perspectives on cultural responses to mental distress. Focus groups were kept homogeneous by stakeholder assignment. Sessions were recorded, transcribed verbatim and anonymised (see online supplemental material for icebreaker exercise and semistructured discussion guide).

Sample size sufficiency was considered against Malterud *et al*'s[21] five dimensions. These dimensions supported the judgement that a sample of 30–40 participants across nine focus groups provided sufficient information to address the study aim.

Data analysis

Braun and Clarke's six-phase RTA process was used to analyse the data,[22] with NVivo software used to manage coding and theme development. The lead author led each of the six analytic phases—familiarisation (active listening to recordings before transcription, followed by repeated digital and printed reading of each transcript), initial coding (both semantic and latent), the generation and review of candidate themes, theme definition and naming and report production. The first and second authors met regularly throughout to discuss initial codes, candidate themes, theme structure and theme naming, with theme development unfolding through a shared iterative process. The third author subsequently reviewed the developed themes and provided either agreement or a critical challenge, prompting further refinement. Where divergent interpretations arose between researchers, these were treated not as discrepancies but as opportunities for reflexive dialogue, returning to the data to deepen the analysis.

Patient, public involvement and engagement

Informal meetings were held with representatives from Black British third-sector organisations to gather feedback on the research aims and objectives, study design and the recruitment strategy. Patients and the public were not directly involved in formulating the research questions, in designing the focus group schedule or in the analysis or interpretation of the data. Several prospective participants were consulted on whether the proposed focus group length and structure were acceptable. Before writing up the study, research findings were shared with third-sector practitioners and caring professionals at a community knowledge exchange event, where the themes, study limitations and proposed future directions were presented, and feedback obtained.

Reflexivity

The lead author is a British-born Black Nigerian man, and this cultural proximity to participants substantively shaped both data collection and interpretation. Following the RTA tradition, the lead author's subjectivity was treated as a resource for analytic insight rather than a bias to be neutralised.[23] Cultural proximity supported rapport-building during focus groups and afforded interpretive sensitivity to culturally embedded meanings—for example, recognising the implicit weight of phrases relating to 'strength' or 'privacy' within Black British family contexts. At the same time, this closeness carried an emotional burden, particularly when participants spoke of distress through lenses of racism, oppression and marginalisation, and required active discipline to ensure that personal interpretation did not eclipse participants' accounts.

Several reflexive practices supported this work. A reflective diary was maintained throughout the project to document emotions, evolving thoughts and analytic decisions, and to separate the lead author's personal responses from participants' meaning-making. Peer supervision with colleagues from a range of ethnic backgrounds prompted broader thinking about codes and themes and challenged assumptions that might otherwise have been culturally taken for granted. Individual supervision with the third author, a Black British Caribbean man, deepened both the conceptual interpretation of the data and the framing of subjectivity as a methodological resource.

Given the sensitive nature of the project, participants were informed in advance that discussing mental health experiences might be emotionally distressing. They were advised that they did not have to answer any questions they felt uncomfortable with and could take a break or withdraw from the discussion at any time without providing an explanation if they became overwhelmed. A pre-agreed risk management protocol was also in place, allowing confidentiality to be broken and supervisory advice to be sought if concerns about risk to self or others emerged.

Each focus group concluded with a verbal debrief that acknowledged the sensitive nature of the discussion, provided an opportunity for personal reflection, and signposted participants to relevant sources of support.

(Detailed inclusion/exclusion criteria, focus group schedule and step-by-step analytic procedure, sample size justification are provided in online supplemental materials 1).

Table 1 Participant demographics

Characteristic	Group	n (%) or range
Total participants		36
Age (years)	All participants	23–68 (M=35)
Ethnicity	Black British Caribbean	11 (31)
	Black British African	23 (64)
	Mixed African/ Caribbean	1 (3)
	Asian British	1 (3)
Stakeholder group	Community members	11 (31)
	Caring professionals	14 (39)
	Third sector practitioners	11 (31)
Years of experience	Professionals	2–20 (M=7)
	Third sector	1–30 (M=6)

FINDINGS

36 adults (aged 23–68) participated in 9 focus groups, each lasting 82–95 min. 11 community members, 14 caring professionals and 11 staff or volunteers from third-sector organisations. 35 participants self-identified as Black British Caribbean and/or African; 1 professional participant identified as Asian British (table 1). Five overarching themes generated from the RTA captured how participants described or experienced the cultural response to mental distress in Black British communities (table 2).

Table 2 Themes and subthemes

Theme	Subthemes
Mental resilience	Suppression of emotions; concealment of distress; coping in solitude
Faith in distress	Church relationships; prayer as a coping mechanism
Escapism through substances–cannabis and alcohol	
Physical and creative release	Healing through physical activity; creativity as coping
Peer support	Healing in sisterhood; strength in brotherhood

Mental resilience

Participants described cultural beliefs and community expectations that being strong and self-reliant in the face of mental distress was functional. Being mentally resilient was seen to be shaped by material pressures, intergenerational expectations and the importance of preserving status and respect within family and community. This theme further comprised three subthemes: suppression of emotions, concealment of distress and coping in solitude.

Suppression of emotions

The active minimisation of emotional expression was described in all focus groups and was seen as a socialised process, with sadness or anxiety viewed as a weakness that could interfere with daily responsibilities, work demands, family provision and material survival:

> I ain't got time [to be distressed], I've got to make money, the bills have got to be paid… I've got kids to be looking after, I can't be sitting there crying. (Caring professional)

Suppression was therefore framed not only as a cultural ideal but as a pragmatic survival strategy, in which material needs were prioritised over emotional ones. Several participants situated these expectations within an intergenerational context, describing how parents who had migrated and endured significant hardship dismissed younger generations' distress:

> The main thing I get from parents is like, why has my son got mental health issues? He doesn't even know the struggle I've come from. I moved to this country, I worked my ass off, they don't know about stress. (Third-sector worker)

Caring professionals additionally noted that these strategies, while functional in the short term, could be experienced as counterproductive over time because the underlying issues driving the distress remained unaddressed.

Concealment of distress

Actively concealing distress was described and was seen as a means of protecting status and respect and of avoiding gossip, shame or judgement:

> There's a huge emphasis on privacy… there is a sense of shame in regard to, oh, I don't want so and so to know that I need help. (Caring professional)

For some participants, particularly young men, the threat associated with disclosure was sharpened by gendered expectations:

> If you felt like really low on yourself, you're not going to go and put it in the group chat… he'll just be like oh, bro, you're soft. (Community member)

Disclosure could therefore feel actively unsafe, risking not only embarrassment but loss of peer and community standing. Professionals and third-sector workers more often described observing this concealment from the outside, noting how it could delay or prevent engagement with formal support.

Coping in solitude

Many participants described dealing with problems on their own or withdrawing socially until the distress subsided. While this fostered a sense of independence and resilience, it could also delay help-seeking and, in some accounts, deepen distress over time:

> We suffer in silence because you don't want to burden anyone else. (Community member)

> My Black male friends or cousins are less likely to speak up and more likely to internalise things a lot more by looking to other ways of helping them to [independently] manage what's going on. (Caring professional)

Across the three subthemes, mental resilience operated as a layered cultural response, protective under conditions of material precarity, but capable of exacerbating distress when sustained over time.

Faith in distress

Religious communities were described as central to how mental distress was understood and managed across all stakeholder groups. Faith functioned both as an active practice and as a relational resource and was often described as a first port of call before or instead of formal mental health services. This theme comprised two subthemes: church relationships and prayer as a coping mechanism.

Church relationships

For many, the Christian church was the primary place they turned for comfort and advice, offering both spiritual care and a tangible sense of community and family:

> I think we kind of go to church more than we go to like mental health services… We find a sort of solace in church where we feel encouraged by a community… a lot of social support from people in the church. (Third-sector worker)

The church was often described as a trusted alternative to statutory services, with one caring professional noting, "They say that there is more of a connected sense of community. I trust this community and they might know a few things, so I'd rather go there than speak to someone in the NHS (National Health Service)."

Community members described church relationships in positive terms as a viable, culturally familiar route to support. Caring professionals and third-sector practitioners, while acknowledging this protective function, were more cautious, particularly around the risks posed by extreme or high-control religious groups for vulnerable individuals:

> You know that community [name of an extreme religious group in London, England] takes them in, validates them, gives them tools, ideas and strength but there is no return back, they get sucked in… This community is now my family… then when they hit crisis you see this further isolation. (Caring professional)

Prayer as a coping mechanism

Prayer was widely described as both a culturally expected and personally meaningful response to distress, practised individually and collectively. It was framed both as an active practice and as a means of receiving care from others ('being prayed for'), with both serving to demonstrate the strength participants drew from their faith:

> Pray about it… You need to pray about all of these things and of course, ensure that God's helping you in this situation. (Community member)

Across all stakeholder groups, prayer was generally framed more positively than church relationships, with greater alignment in its perceived value. However, divergent voices within the community member group complicated this picture, critiquing passive reliance on prayer and arguing for personal agency alongside faith:

> I'm thinking. Guys… why don't we come as a community to try and solve these problems instead of us, just going constantly to church to pray every day praying, praying, God fix this!… God has to meet you halfway. (Community member)

> People might refuse medical help because they believe in prayer and that God will sort it… God helps those who help themselves, you're not doing anything to take action. (Community member)

Faith, therefore, operated as both a sustaining and constraining cultural response, a source of community, identity and protection, but one whose protective function depended in part on whether faith was held alongside, rather than instead of, personal agency and broader sources of support.

Escapism through substances: cannabis and alcohol

The use of cannabis and alcohol was described as a socially accepted means of numbing emotional distress, offering temporary relief from negative thinking, aiding sleep and was, for many, deeply normalised as part of family and community life. Cannabis was widely described as a tool for managing emotional and psychological distress, particularly among men:

> It [cannabis] increases all the dopamine and happiness in your body, even if it is just for a temporary period, even just for 2 hours, they believe that it just takes your mind off all the thinking. (Third-sector worker)

> A lot of my male cousins actually, they like to smoke because it helps them sleep, especially if they have had a lot of trauma… in my view, it's just a plaster, but in their view, it's really helping them. (Caring professional)

The concerns about the function of substance use as a coping mechanism differed across stakeholder groups. Caring professionals and third-sector workers tended to hold both negative and positive perspectives in tension, acknowledging the relief participants reported while expressing concern about dependence, particularly among younger users:

> People that I work with who are 13, 14, 15, very young and they become like dependent on it… they say you know, it relaxes me, it calms me down, helps me sleep… So they see the positive impact of it, but when they do not have it they are dysregulated and struggle to function. (Third-sector worker)

Cannabis use was also described as intergenerationally normalised, with caring professionals noting that older generations sometimes minimised concerns about its harms, 'the older generation are still holding onto the narrative that weed is not harmful, although it is.'

Importantly, not all participants accepted the framing that cannabis use was widespread or culturally inherent in Black British communities. One third-sector worker explicitly pushed back against this stereotype:

> Oh do you guys [Black people] smoke? Because I thought you all did. That assumption we all do it because you've seen it on the TV, in music videos, we're not all Bob Marley. (Third-sector worker)

Alcohol was similarly framed as a culturally normalised coping resource, sometimes described as 'everyday therapy'. Several community members reflected on how this normalisation was passed down across generations:

> Both of my parents were going through depression, but they still had to raise us… my dad was an alcoholic, he would drink a whole bottle of brown alcohol in one sitting… We would also indulge in it as we didn't know it was a coping mechanism. (Community member)

Counter-narratives were also present, with one community member offering a first-person account of recognising and stepping back from substance use as a coping strategy:

> I was one of those guys that would numb myself by going out… caught in that constant cycle, having to retake 2 years of university because I was constantly going out drinking with people until I realised that my mental health was declining even more. (Community member)

Substance use was therefore seen as a culturally normalised but contested coping resource, providing genuine, if temporary, relief, while also intersecting with the more solitary forms of coping described in theme 1, and carrying particular risks for younger users and for those whose use was sustained beyond its initial protective function.

Physical and creative release

Participants spoke of a growing trend towards more adaptive, active forms of coping, particularly visible among younger generations. In contrast to the more passive or concealing strategies, physical activity and creative expression were framed as ways to actively engage with and process distress, often without needing to articulate it explicitly. This theme comprised two subthemes: healing through physical activity and personal creativity as a coping mechanism.

Healing through physical activity

Across all three stakeholder groups, exercise, running, gym training, calisthenics and walking were described as an increasingly visible coping strategy, particularly among younger Black men:

> In [UK city], there's the younger Congolese generation, like the guys my brother's age. Those guys meet up every weekend, and they do like 5K runs. They do calisthenics. So they're just meeting up, working out with each other and really talking about things. (Community member)

Physical activity accommodated both solitary self-regulation ("just going there… going by myself") and communal connection, a way of "really talking about things" without the formality of explicit emotional disclosure. Third-sector practitioners actively organised these spaces:

> We do an annual silent walk and a lot of the people that come on it will say, this is the only place I can be silent in nature while walking and not be interpreted negatively in any way, I can feel safe to be silent, I don't have to put on a show or act, I don't have to smile, I can be okay. (Third-sector worker)

In contrast to the expectation to suppress distress and appear strong, these spaces did not require them to conceal how they were really feeling. Caring professionals additionally noted gendered patterns, with male partners using physical activity as preparation that enabled later reflection.

Personal creativity as a coping mechanism

Music, poetry, singing, rapping and online creative expression were highlighted as therapeutic outlets, particularly for young Black men whose access to direct emotional disclosure was constrained by gendered cultural expectations:

> A lot of young Black boys are into music, rapping, singing, and poetry. It's a real outlet for young people… they can be seen and heard and validated, and it can feel less vulnerable because they're not saying, this is how I feel… they're still able to get things off their chest, but in a way that feels comfortable to them and less intimidating. (Third-sector worker)

> Just even expressing yourself online helps, even if that's through music or your art… nowadays [Black] people are finding different creative ways to cope with the mental side. (Community member)

Creativity, therefore, offered indirect, symbolic emotional expression, therapeutic without being therapy, and was seen as bypassing the suppression and concealment dynamics described earlier.

Unlike substances and faith, framings of physical and creative release were largely consensual across stakeholder groups, with no participants expressing strong reservations. Together, these practices were positioned as actively chosen, generative cultural responses to mental distress, particularly among younger generations, offering culturally accessible ways to process emotion alongside, or in place of, more traditional or concealing forms of coping.

Peer support

Peer networks were described as essential sources of emotional and practical support, with patterns of interaction differing along gendered lines and reportedly shifting over time. Across both subthemes, peer support emerged as a culturally safe means of being held through distress without the formality or vulnerability of formal therapy, and as a partial antidote to the coping in solitude described in theme 1. This theme comprised two subthemes: healing in sisterhood and strength in brotherhood.

Healing in sisterhood

Women's peer networks were described as direct, verbal and proactive in noticing distress:

> I think women friendships, they talk more about the nitty gritty stuff you know, they're more of a ride and die for their sisters [friends]… they'll check up on their friends and do welfare checks and they will do prayer groups. (Community member)

Sisterhood was characterised not only by openness in conversation but by an active vigilance; women were described as "able to recognise [distress] earlier and be there early on for whatever their friends are going through". This early-recognition function contrasts directly with the suppression and concealment described under Mental Resilience, where distress could go unspoken until crisis. Sisterhood also overlapped with the faith-based responses described in theme 2, with prayer groups serving as both a religious and a peer-support practice.

Strength in brotherhood

Men's peer networks were described as operating along a spectrum from indirect, activity-based companionship to more direct emotional disclosure, with a clear sense of cultural shift over time:

> They will say, oh, bro, let's play on the PS4 or PS5… let's go play football, let's do this, but not actually saying I'm going through [mental distress]. But actually doing those things is really helping them because they're going through a difficult time. (Caring professional)

Brotherhood, in this indirect form, often did the work of support without requiring direct emotional disclosure, overlapping in practice with the communal physical activity described in theme 4. However, several participants described an increasing willingness among Black men to engage in more direct emotional conversation with peers:

> Where we're at now, in this stage of our lives, we're able to talk freely with each other, like I can call some of my friends and be like bro, I'm not having a good day and we can talk about it with no judgement. (Caring professional)

> In recent years, I'm noticing that as a Black man, my friendship groups are becoming more expressive about mental health difficulties. (Community member)

This cultural shift, while not universal, was described as a meaningful counter to the gendered concealment described under Mental Resilience, particularly the fear of being seen as 'soft' within peer networks. Like physical and creative release, peer support was framed largely positively across stakeholder groups, with no participants expressing significant reservations. Together, these accounts position peer support as a culturally embedded, increasingly visible response to mental distress, operating both alongside and beyond statutory services and offering a flexible space where support can be given through words, through activity or through quiet presence.

DISCUSSION

This study explored how Black British communities respond to and cope with mental distress and identified a set of adaptive and maladaptive responses (mental resilience, the role of faith, escapism through substances, physical and creative release and peer support) centred on internalised mental defences, personal coping strategies and community resources.

The theme of mental resilience is supported by prior research showing that Black British individuals often feel pressure to conceal distress to maintain strength and respectability,[24–26] a pattern also reflected in the wider international literature.[27] Our findings extend this work by linking mental resilience to perceived socioeconomic disadvantage, positioning it as an adaptive survival strategy that enables prioritisation of essential material needs. This direct pairing of coping responses with material deprivation is consistent with the theory of the hierarchy of human needs, in which basic material needs precede psychological ones.[28] It also helps connect existing research on socioeconomic disadvantage and poor mental health with reduced early help-seeking.

However, our study also highlights the costs of prolonged mental suppression. While initially protective, sustained concealment of distress can increase psychological burden and social isolation. This aligns with evidence that emotional suppression predicts lower social support, reduced closeness and poorer social satisfaction.[29] Structural and socioeconomic disadvantage may partly explain disproportionate mental ill health in the Black British community,[14 30] with mental suppression potentially mediating this relationship by intensifying social disconnection and limiting access to supportive resources.

The role of religious institutions and practices in supporting mental well-being in Black British communities is well documented, with faith communities often providing belonging, meaning and emotional support that buffer against distress.[31] Prayer was described as a culturally resonant coping strategy; however, some participants cautioned that overreliance on prayer may delay formal help-seeking and reinforce solitary coping. This concern reflects literature on spiritual bypass, which describes the use of spiritual beliefs to avoid engaging with psychological distress.[32–34] Although this framework was not explicitly referenced by participants, its underlying logic may also be relevant within UK Black communities.

Psychological and spiritual well-being are widely recognised as overlapping domains,[35] yet statutory mental healthcare remains largely shaped by Western philosophical traditions, with limited consideration of Black African and Caribbean spiritual frameworks.[36] While some non-Western practices (eg, mindfulness)[37 38] have been incorporated into mainstream care, comparable engagement with Black forms of spirituality remains underdeveloped.[39] Our findings suggest that uncritical or superficial incorporation of religion into preventative strategies is ill-advised, and that further work is needed to understand how spirituality can be integrated in ways that are culturally grounded, psychologically supportive and non-harmful for Black communities.

Participants also described a generational shift toward more adaptive coping strategies, including engagement in physical activity and creative expression. Creative outlets—particularly music and poetry—were framed as safe and culturally affirming spaces for emotional release. These practices align with narrative identity theory,[40] and broader literature demonstrating the therapeutic value of arts-based practices in emotional processing and well-being.[41 42] Peer support was strongly valued. Women more frequently described open dialogue, mutual emotional disclosure and participation in prayer or faith-based groups, whereas men tended to engage through shared activities. Notably, some men reported increased openness within these relational spaces, suggesting that activity-based peer contexts may offer greater safety for personal disclosure. These indirect and non-pathologising routes to processing distress are widely recognised as effective.[43 44] Group-based activities also foster informal social connections, which are known to promote closeness and belonging and to mitigate loneliness and social disconnection.[45] Taken together, these activities and social systems underscore the value of considering occupational, social interventions as viable early preventative approaches within Black communities.

Substance use was largely described as a culturally familiar and, at times, acceptable coping strategy. While some participants framed substance use as a form of self-medication, this was viewed more critically within our professionals' focus groups, which mirrors debates within the academic literature.[46] Regardless of its perceived function, our findings suggest that preventative models must engage with substance use in a culturally sensitive and nuanced manner, acknowledging both potential harms and culturally grounded meanings. This could include targeted public health campaigns, raising awareness about its use and potential harms.[46] Failure to do so may perpetuate a disconnect between new prevention

models and Black communities, contributing to disengagement and reduced help-seeking.[47 48]

Strengths, limitations and future directions

This study captured a broad range of perspectives on how Black British communities respond to mental distress, offering an account of culturally embedded coping strategies that have been largely absent from dominant discussions focused on help-seeking and service use. By including both community members and professionals, and by adopting an exploratory qualitative design, we were able to map a wider ecology of responses operating outside formal care systems and to move beyond narrow or deficit-based interpretations of mental health behaviour.

Nevertheless, several limitations should be acknowledged. First, the use of the umbrella term 'Black British' risks obscuring important cultural, historical and sociopolitical differences between African and Caribbean heritage communities. Second, the online focus group format may have limited spontaneity and depth of interaction compared with face-to-face methods. While the inclusion of professionals enriched contextual understanding, it may also have diluted accounts grounded solely in lived experience.

Although coping strategies were analysed as discrete themes, participants often described them as interrelated and enacted in combination—a complexity that warrants further investigation.

Importantly, the study was not designed to unpack the structural and historical conditions under which these coping strategies emerged. While experiences of discrimination, generational adversity and identity were discussed, it remains unclear whether the responses identified should be understood as culturally inherent practices or as adaptive responses to enduring structural inequalities. This distinction is crucial for prevention, as the same strategy may function simultaneously as resistance to marginalisation and as a constraint on help-seeking within inequitable systems of care. Future research should therefore examine the historical, structural and cultural contexts that shape these responses, including intergenerational processes related to migration and acculturation, and use comparative methods across ethnic groups to clarify which strategies are specific to Black British communities.

Directions for equitable prevention

Primary prevention is a strategy that targets populations and subpopulations whose risk of developing a condition is significantly higher than average.[49] Kirkbride *et al*[3] argue that such approaches should be prioritised in mental health prevention, with a particular emphasis on addressing the social inequities that contribute to the onset of mental disorder. Our findings highlight a clear relationship between material and psychological needs in Black communities, mirroring existing theories.[14] Equitable prevention models should be sensitive to this association by considering how to address both these needs in novel developments.

We also argue that preventative solutions could be codeveloped with Black-led churches and community organisations. In the USA, there are established examples of faith-based organisations providing mental health support to African American communities—by addressing both material and psychological needs within a religious framework.[50] Such approaches could be adapted in the UK as part of an integrated prevention strategy. This could also include the development of enhanced peer-to-peer support programmes and the creation of culturally safe spaces. Justification for this approach is supported by theoretical lenses such as cultural security[51] and community capacity building.[52] Together, these frameworks highlight the importance of supporting Black communities in the UK to safeguard, preserve and further develop cultural traditions, practices and forms of knowledge that are protective and advantageous for mental well-being.

CONCLUSIONS

Although further research is required, it is evident that Black British communities respond to mental distress through culturally rooted practices that may protect well-being but can also delay formal help-seeking and, in some contexts, intensify distress. By shifting attention beyond service use to these embedded coping strategies, our findings extend existing research and help explain the persistence of mental health inequalities. Recognising cultural practices not as barriers but as resources, we argue that preventative mental health approaches must address both material and psychological needs and be codeveloped with community, voluntary and faith-based organisations to deliver more equitable, acceptable and effective care.

Contributors OA conceived and designed the study, led participant recruitment and conducted all focus groups, transcribed and coded the data, led the formal analysis and drafted the original manuscript, including the present revision. LB contributed substantially to study design and methodology, supported recruitment, provided supervision and reflexive dialogue throughout data collection and analysis, and contributed to refinement of the analysis and to the critical revision of the original manuscript. SLG contributed to the conceptualisation and development of the research question and provided critical feedback and refinements on the subsequent manuscript drafts. Microsoft Copilot, a large-language-model-based AI system, was used in the final stages of manuscript preparation. The technology was used to proofread the text and identify unclear phrasing. It was not used to generate scientific content, analyse data or interpret results. All AI-generated suggestions were reviewed, edited or rejected by the authors, who take full responsibility for the final manuscript. OA and LB act as joint guarantors and accept full responsibility for the work, had access to the data and controlled the decision to publish.

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consent and were informed of their right to withdraw. Verbal consent was obtained from all participants at the start of each focus group.

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