Portfolio Volume 1: Major Research Project

A Thematic Analysis Exploring Young Black Men's Experiences of Accessing and Engaging in Psychological Therapy within Primary Care

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Glory be to God, his grace is sufficient for me.

I dedicate this thesis to my ancestors from the district of Makoni, Zimbabwe. I honour those of the Shumba totem, a lineage lauded for their tenacious spirit. Thank you for the gifts you have sowed in me. This journey would have been impossible without the village that weaved together like tapestry to raise me.

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"Chara chimwe hachitswanye inda" (One person cannot do all things alone)

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ABSTRACT

BACKGROUND: Despite the increase in initiatives to increase the accessibility of psychological therapy within the NHS, Young Black men's (YBM) experiences of psychological therapy are under researched. Young Black men are more likely to access mental health services (MHS) through police intervention(s) or the criminal justice system. This is compared to their White counterparts, who are more likely to access services through less punitive and disempowering routes.

METHODOLOGY: A critical realist research paradigm was used to qualitatively explore YBM's experiences of accessing and engaging in individual psychological therapy. This study incorporated semi-structured interviews with a purposive sample of 13 Black African and Caribbean men between the ages of 24 and 31.

FINDINGS: An inductive Thematic Analysis (TA) was used to interpret four themes: *"Navigating socio-cultural barriers;" "It's a big step asking for help;" "Being taken on a journey;"* and *"Building bridges of trust and collaboration.'* Participants situated their experiences of therapy within a social-cultural context that expects Black men to be strong, stigmatises mental health difficulties and discourages professional help-seeking. Problem acceptance, access to resources and perceived efficacy of therapy influenced decisions to seek therapy. Safety within the therapy room was negotiated and underpinned by disclosures of therapists' background, having a safe space for exploration and being empowered through collaboration. While some participants found it easier to relate to a Black therapist, it also raised concerns around confidentiality, suggesting the importance of offering choice. Assertive outreach, collaboration with local expertise and approaches that recognise Black men's unique socio-cultural identities were identified as best practice to increase access and engage YBM.

CONCLUSIONS & IMPLICATIONS: Young Black men should be given equitable access to psychological therapies. Policy makers and Clinicians should be aware that YBM have unique experiences with psychological therapies and should be knowledgeable and skillful in responding to these. Policy and clinical implications are discussed.

CHAPTER ONE: INTRODUCTION

Chapter Overview

In this chapter, I begin by positioning my research within a critical realist epistemological framework and refer to the terminology used in the thesis. I will highlight the state of MHS for Black people in the United Kingdom (UK), focusing on the Black male experience. I posit that examining the social milieu of Black men through the intersectional lens of masculinity norms, historical discourses and service engagement will be critical in understanding their psychological wellbeing and help-seeking experiences. The chapter concludes with a systematic literature review (SLR) on the help-seeking experiences of Black men, followed by the research questions and objectives of the current study looking at the YBM's experiences[1].

Position of the Researcher

Reflexive awareness in qualitative research is defined as the critical self-evaluation of the researchers' positionality. The process involves paying analytic attention to the impact of this position on the research process and outcome (Dowling, 2006). Acknowledging the researchers' experiences, values, beliefs, knowledge, and biases increases the credibility of the research and awareness of the researcher-researched relationship in the co-construction of knowledge (Cutcliffe, 2003; Finlay, 2002). I will be using the first-person perspective to represent my

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[1] Previous studies have defined YBM's as individuals aged between 18-35 (Myrie & Gannon, 2013; Time to Change, 2016).

reflections and personal judgments based on the available evidence (Webb, 1992). The third-person account will be used to centre the participants and the research.

Personal Relationship with the Research Project

Reflecting on my clinical portfolio over the last six years of working in mental health, I have only had one Black male service user allocated to me for therapy. During his first session, he was reticent about discussing his difficulties with me. He shared his mistrust of MHS due to several negative encounters with services. I desperately attempted to reassure him that he was safe in my care. I assumed that our shared racial identity would increase his trust in my ability to provide the care he needed. However, the naivety on my part and the verbal affirmation did very little to quell his valid concerns - he never returned. Heartbroken and disappointed, I ruminated on our conversation and mulled over all the possible avenues I could have taken to keep him in therapy. I reflected on my position within a system that had failed to provide the safety he needed at a time of significant vulnerability. This experience challenged me to investigate accessibility and service provision for Black men in primary care services. I was met with a lot of resistance from service leads on this path as my concerns were often dismissed as 'anecdotal' and unsubstantiated.

Though disheartening to hear, these encounters chimed a familiar hymn in my life: the chorus of epistemic invalidation and dismissal of lived experiences. Fuelled by anger and powered by a passion for pursuing the 'evidence,' I set sail on this current project. I wanted to invite YBM to share their multi-layered narratives of engaging and showing up to services, despite the odds being stacked unfairly against them. As a member of the Black community, a Trainee Clinical Psychologist and doctoral researcher, it is an ethical imperative to use my privileges to join in the

collective reform of mental health provision for Black men as a pressing social justice issue. My values around advocating for equitable access to services and prioritising the development of opportunities for change have been the bedrock of this project. I stand on the great shoulders of literary activists and writers who paved the way for this research to be an act of resistance and a tool for storying untold and marginalised narratives (hooks, 1989; White & Epston, 1990).

Epistemological Position

Epistemology is concerned with the nature of knowledge: its possibility, scope, and the processes by which it can be created, acquired and communicated (Scotland, 2012). In contrast, ontology is the study of 'being' which concerns itself with the structure of reality and what is possible to know about the world (Crotty, 2003).

I was attracted to a Critical Realist (CR) epistemology as its search for causation allows researchers to use retroduction[2] to examine the deeper structures of social events (Bhaskar, 2016) and the focus on suggesting practical policy recommendations to address social problems (Fletcher, 2017). There are divergent views on the underpinning of CR within the literature; many suggest it is a philosophy of science (e.g. Brown et al., 2003), while others maintain that CR is a

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[2] Retroduction refers to the application of an investigator's imagination to trace a causal mechanism (Pilgrim, 2019) Bhaskar's explains that a retroductive argument would ask: "what would if were real, bring about, produce or explain phenomena in question" (Bhaskar, 2016, p.3) This argument views retroduction as an imaginative and creative activity.

'meta-theoretical position' (Archer, 2016) rooted in post-positivism. Critical realism claims a realist ontology and a subjective epistemology; it agrees that there is a reality that is independent of us but simultaneously stipulates that knowledge of this reality is "always mediated through the filter of human experience and interpretation" (Fletcher, 2017, p. 183). Critical realism is premised on looking beyond the domain of the empirical or actual (experienced or unexperienced) events to the domain of the real where the causal structures or 'causative agents' cohere (Archer et al., 2013, p. 25). By examining the real, CR aims to provide an in-depth explanation of phenomena and accepts that empirical observations are fallible as our contextual frameworks and perceptions shape them (i.e., one's research hypothesis).

With the current project, CR provides a framework to explore the underpinnings of social phenomena concerning YBM. The task of making sense of YBM's social reality can only be made possible if we understand the broader historical, social, and cultural factors constituting the various interpretations that influence Black men's experiences within MHS (Pilgrim, 2019). The data collected from participants is not presented as the truth or 'direct' reality but my interpretation of YBM's reality, shaped by the various lenses that I bring (i.e., culture, history, politics, gender, age). This position is underpinned by the assumption that YBM's experiences can tell us about a 'reality' that is material and has 'real' embodied and subjective effects on their lives (Maxwell, 2012, p. 8). These assumptions will inform my thinking and the research methods that I adopt to explore the research objectives.

Language and Key terms

Language is delineated as a crucial social practice in understanding our objective and subjective realities and, thus, our relationship with the construction and maintenance of power (Fairclough, 1989). The key terms referred to in this thesis will be summarised below.

Race

The idea of 'race' originated from anthropologists and philosophers such as Buffon in the 18th century, who used geographical location and phenotypic traits like skin colour to place people into pseudo-scientific racial groupings (Montagu, 1942). Although 'race' has been proposed as a social-political construct and not a biological marker of difference (Smedley & Smedley, 2005), there is contention around the construct in psychological research (Helms et al., 2005). Within this thesis, the validity of the construct is refuted but is seen as salient in the lives of racialised communities (Comas-Diaz & Jacobsen, 1991).

Black or Black people

The term 'Black' has been used as a political and cultural construct for people of African and Caribbean descent (Gaine, 2005). Historically, being 'Black' referred to one's skin colour, grouping heterogeneous people into one category despite their social, political and cultural

differences (Davidson & Patel, 2009). Due to the term 'Black'[3] being both descriptive and political, it is used in a capitalised format in this thesis except when citing authors who use different terminologies.

Culture

Culture can be understood as a set of contextual and evolving values, beliefs, and norms (e.g., language) shared within a community (Fernando, 2010; Triandis, 2002). Within high-income countries, culture is naively viewed in relation to skin colour and some aspect of an individual group that is considered as 'different' from the dominant group (Bhugra & Bhui, 2018, p.458). This thesis views culture as a complex and dynamic universalistic construct within which individuals create culture and are produced by culture (Patel et al., 2000).

Black Asian and Minority Ethnic groups (BAME)

The term Black, Asian and Minority and Ethnic (BAME) is often used interchangeably with Black and Minority Ethnic (BME) in the UK. Both have attracted traction as social and political catch-all phrases to encompass people who do not identify as White. A recent commission on race and ethnic disparities called for public sector organisations to discontinue the 'BAME' acronym due to its controversy (The Sewell Report, 2021). In this thesis, Census-specific categories such as 'Black African' and 'Asian Indian' will be used. Where an umbrella term is

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[3] As the term 'Black' has now been defined, future references will not use quotation marks to denote the descriptive term.

needed, "ethnic minority communities/people" and "racialised communities/people will be used interchangeably unless when citing references from authors who use different terms.

Racism

Racism is a form of discrimination perpetuated by a system of oppression and domination based on the notion that one race is superior to the other (Bulhan, 1985). The socioecological model articulates the existence of racism at multiple strata, from the intra-personal level (e.g., internalised racism) to the institutional level (McLeroy et al., 1988). Institutional racism is defined as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping, which disadvantages people in ethnic minority groups." (Macpherson Report, 1999, para 6.34).

Psychological Disorder or Distress

Psychiatric diagnoses have been criticised for their lack of validity and reliability (Johnstone & Boyle, 2018). This thesis positions psychiatric diagnoses as a heuristic strategy for developing and evaluating safe clinical interventions and can have utility in helping people access the necessary care (Perkins et al., 2018). However, they should be held lightly as explicatory hypotheses rather than incorrigible facts. When diagnostic terms are used by other researchers, inverted commas will be used to highlight the controversy surrounding them. Terms referring to

psychiatric symptomatology or sequelae will be described as 'psychological distress' or 'mental health difficulties.'

Psychological Therapy

Psychological therapy, also known as 'talking therapy' is defined as "meeting with a therapist to talk about feelings and thoughts and how these affect behaviours and wellbeing" (Paterson et al., 2018, p. 5). Examples of psychological therapy satisfying this definition include modalities such as cognitive behavioural therapy (CBT), psychodynamic therapy, acceptance and commitment therapy, counselling, and supportive counselling (National Institute for Health and Care Excellence [NICE], 2014; National Health Service [NHS], 2018).

Mental Health Services/ Mental Health care

These terms will be used interchangeably to refer to the formal provision of healthcare, such as psychological therapy within statutory services (i.e., NHS), third-sector organisations or state-commissioned services that are privately run. Mental health services in the UK are situated within a stepped care system composed of primary, secondary and tertiary care, usually staffed with multi-disciplinary professionals (NICE, 2011).

Primary Care Services

Primary care services are the first point of contact for people experiencing mental health difficulties. They are embedded within General Practitioner (GP) practices, community

pharmacists, health visiting teams as well as Improving Access to Psychological Therapies (IAPT) services (Mind, 2016).

Intracategorical Intersectionality

As a concept, intersectionality is likened to a lattice netting; it examines how the intersecting systems of power such as race and class combine to create different modes of discrimination and privilege (Crenshaw, 1989; Collins, 1990). The purpose of the intracategorical intersectionality framework is to provide a lens that "focuses on the complexity of relationships among multiple social groups, within and across analytical categories" (McCall, 2005, p. 1786). The framework acknowledges that Black men are a heterogeneous group with 'shifting' and 'fluid' identities. An intersectional approach is critical to consider how race, class and gender combine in unique ways to shape the determinants of Black men's mental health.

Overview of Empirical and Theoretical Literature

This section begins by outlining the current socio-political context of Black people within statutory services. I will then consider theoretical frameworks and empirical evidence on Black men's mental health and wellbeing from the lens of masculinity, current and historical discourses of 'race' and racism. Finally, a discussion on the impact of the socio-political context on Black men's relationship with MHS and help-seeking experiences will be presented.

Black Men in the UK – a Social or Structural Crisis?

"People are quick to marginalise and criminalise young Black men but rarely

comprehend the vicious webs they are trapped within. Our souls are wounded. We need to heal

before this cycle of trauma rolls on to the next generation" (Dodzro, 2021, p. 72)

The social construction of the Black male identity in the UK has become synonymous with narratives of crime, violence, social failure, and anti-authoritarianism (Law, 2002). These narratives are situated within a socio-political and historical context marked by the Windrush era[4] followed by African migration in the 1960s, various race riots (e.g., Brixton Uprisings in 1981)[5] , and more recently, the impact of the Black Lives Matters (BLM) civil rights movement following the tragic murder of George Floyd in the United States of America (USA) in 2020. Attention has been paid to the treatment and experiences of Black men situated in the metaphorical 'Bermuda triangle,' (Griffiths, 2018, p. 12) which constitutes the education system (entry point), criminal justice, and MHS. Black men have been over-represented at the sharp end of all three sectors from time immemorial, which has increased the urgency for research and tangible policies to address these well-documented structural and societal inequalities.

Data released from the Race Disparity Audit (Cabinet Office, 2017) brought together evidence to highlight racial disparities across various sectors. The top findings demonstrated that

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[4] The Windrush Era marked the arrival of people emigrating from the Caribbean to Britain between 1948 and 1971 to re-construct the United Kingdom following the end of World War II.

[5] See Brenton (2012) - The 1981 Brixton riots, or 'Brixton uprising' was a confrontation between the Metropolitan Police and Black British youth in Brixton, South London, England, between 10 and 12 April 1981. The riots were fronted by mostly young black men protesting against police brutality, high unemployment rates and poor housing.

Black boys faced the highest school exclusion rates compared to their White counterparts, and Black men were nine times more likely to be stopped and searched by police. Nationally, Black Caribbean people reported low levels of confidence in the police (62% compared with 77%) though Black African's perceptions were in line with the general population (also see Lammy, 2017)[6]. In 2017/18, the detention rates under the Mental Health Act (MHA) were four times higher for people in the Black or Black British group than those in the White group (NHS Digital, 2018). These concerning statistics highlight the racial and social inequalities documented over decades, with little action to change the trajectory of these trends (Griffiths, 2018; Majors et al., 2020). Due to the limited scope of this project, the experiences of Black men in MHS will be explored in detail to form the basis of the research objective of exploring YBM's experiences of help-seeking and utilising MHS.

Help-seeking, Gender Socialisation and Masculinity Norms

Help-seeking is defined as the behaviour of actively seeking help from other people on different levels, such as asking for information, treatment, or advice in response to an identified problem or distressing experience (Rickwood et al., 2005). Two main forms of help-seeking have been delineated, formal and informal: formal help-seeking involves consultation, advice, or support from recognised professional health providers. Informal help-seeking is sought from social networks such as friends, family, and religious leaders as well as self-help methods (Rickwood &

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[6] The Lammy Review was a government commissioned independent review of the treatment of 'BAME' individuals in the criminal justice system. The review offered 35 recommendations for judicial, police and probationary services to improve the outcomes and experiences of 'BAME' individuals. Statistical interpretations are viewed with caution as they do not locate the causative agents and context in which they arise.

Thomas, 2012). Broom and Tovey (2009) argue that we need to look at help-seeking disparities critically and that the ability to be aware and respond to these difficulties should be situated within social and cultural norms.

Gender role socialisation theories hold that social environments, from individual families, peer relationships to overarching culture, teach men and women to display distinct sex-ascribed behaviours and attitudes (Addis & Mahalik, 2003). Men are socialised from an early age to endorse masculine norms (Pleck, 1995), with any perceived transgression of male gender scripts resulting in personal condemnation, adverse psychological consequences, and negative self-judgement (Addis & Cohane, 2005). Pleck (1995) conceptualised this as a 'gender role strain' whereby men overcompensate through hypermasculine behaviours. He proposed that masculinity is an ideological construct shaped by time, social and cultural context. Mansfield et al. (2003) argue that the 'traditional' view of masculinity contributes to men's psychological distress by being inconsistent, impossible to achieve and inherently hazardous to their wellbeing. Despite extensive research supporting the masculine role socialisation paradigm, it has been criticised for failing to account for the contexts in which help-seeking for psychological distress occurs. Furthermore, as the construct is often treated as stable and internal, accounting for within-person and across situations, variability becomes challenging to identify (Addis & Cohane, 2005).

The 'help negation' effect (Deane et al., 2001) has been extensively studied in help-seeking contexts (e.g., Carlton & Deane, 2000; Cauce et al., 2002; Deane et al., 2001; Wilson et al., 2005). It describes an inverse relationship between self-reported psychological distress and help-seeking intentions occurring in the context of refusal or avoidance of available help (Wilson & Deane, 2010). Studies have found that as men become increasingly distressed, they are less likely to seek

help from health professionals (Milner et al., 2019). Some authors argue that this is due to the intersection between poor health literacy (Nutbeam & Kickbusch, 1998) and male gender norms that endorse self-reliance and emotional control (Addis & Mahalik, 2003). These factors contribute to men presenting to services late (Addis & Mahalik, 2003; Branney & White, 2008; Yousaf et al., 2015). The reactance theory suggests that when people perceive that their autonomy or self-control has been threatened, they will take steps to restore it (Brehm, 1966). Supporting this, Bauer et al. (2020) found that Black men constructed self-reliance as an indicator of resilience and autonomy. Although participants in the study acknowledged the limitations of self-reliance as a long-term coping strategy, participants did not consider accessing MHS to gain longer-term coping techniques. This study highlights the importance of exploring the motivators and barriers that men experience around service utilisation.

Men and Service Utilisation

Research has shown alarming disparities in service utilisation between men and women for most mental and physical health problems (Addis & Mahalik, 2003). Statistics in the UK indicate that in comparison to women, men are less likely to visit their GP's for health complaints (Galdas et al., 2005; NHS Information Centre, 2011), less likely to access psychological therapies (Glover et al., 2010), and more likely to present to secondary care services under compulsion or community treatment orders (CTO) (NHS Information Centre, 2011). These trends and figures suggest that men may use fewer preventative strategies than women and are more likely to contact services in the acute stages of psychological distress. Other researchers postulate that men's propensity to minimise pain and suppress the expression of need may also be responsible for lower engagement rates in preventive health care visits (Courtenay, 2000; Williams, 2003).

A series of inductive qualitative methods and analyses have yielded data suggesting that men's reticence to seek help may be linked to internalised gender notions which in turn create feelings of shame, embarrassment, and fear of appearing weak (Chapple et al., 2004; Gascoigne & Whitear, 1999; Moynihan, 1987). Though these studies provide valuable insights into delayed help-seeking among men, they were conducted in physical health settings with White middle-class men, limiting their representativeness to different life experiences and help-seeking contexts. For example, Gilbert et al. (2016) argued that for Black men, the gender notions mentioned above were compounded by an additional cultural, racial, and social conflicts around being the economic provider for the family while also facing socioeconomic disadvantage. Furthermore, a study by Memon et al. (2016) found that people from ethnic minority backgrounds described their ability to deal with problems in ways aligned with their ideas of masculinity, e.g., pride and strength in being a provider; while at the same time, they perceived services as not being "available for men of colour who have mental health issues" (p.4).

Both studies suggest that Black men's definitions, experiences of masculinity and perceptions of MHS are qualitatively different and broader than that expressed by White men, which may help to explain the disparities in help-seeking and service utilisation between both groups. The focus on men's mental health and help-seeking behaviours should begin recognising that gender (e.g., masculinity) arises at the intersection of intertwined social constructions involving racial, historical, economic, political, linguistic, interpersonal, and psychological threads (Falmagne, 2000; McCall, 2005). Current and historical societal discourses on Black masculinity and racism will now be explored to theorise the structures that may influence Black men's help-seeking patterns and experiences of MHS.

"Big, Bad & Dangerous": The Role of Current and Historical Discourses and Stereotypes on Black Men's Mental Health

Historically, Black men have been portrayed as dangerous, deceptive, cunning, or hypersexual deviants requiring surveillance and controlling or as lazy, childlike buffoons in need of uplifting (Collins, 2004; hooks, 2004). In contrast, stereotypical tropes synonymise White skin with "respectability, civility, and trust" (Anderson, 2011, p. 3). The negative societal depictions and stereotypes of Black males have served as the basis for societal discourses and policy regimes that disproportionately disadvantage and truncate their life chances (Brooms & Perry, 2016). The insidious nature of these ideological depictions of Black men has real material consequences for their social reality and how they are perceived and treated in society, as set out in the Angiolini Report (2017):

'The stereotyping of young Black men as 'dangerous, violent and volatile' is a longstanding trope that is ingrained in the minds of many in our society. People with mental health needs also face the stereotype of the mentally ill as 'mad, bad and dangerous' (p. 88).

The social construction of the Black man as 'mad, Black, and dangerous' pervades the mental health and criminal justice system, resulting in the overdiagnosis of schizophrenia (Pinto et al., 2008) the over-criminalisation of Black men (Lammy, 2017) and the risk of receiving coercive treatments (Majors et al., 2020; Rogers & Pilgrim, 2014). An independent inquest into the death of David 'Rocky' Bennett, a young Black man who died in a psychiatric hospital following excessive restraint, stated that the erroneous diagnosis of 'drug-induced psychosis' had no apparent medical basis, subsequently leading to the wrong treatment being administered (The

Bennett Enquiry, 2003). Much of the racial stereotyping around the 'big, Black and dangerous' discourse has influenced how mental health professionals treat and interact with Black men, as evidenced by the high incidence of excessive restraint used disproportionately against people from ethnic minority backgrounds (Mind, 2013a).

Experimental studies have also illustrated the causal links between racial profiling, Black men's height, and perceptions of increased threat within White majority groups (Hester & Gray, 2018). Based on subjective 'threat' ratings of 16 photographs of tall inter-racial men, the study concluded that while height was advantageous for White men, for Black men, their height amplified already problematic perceptions of threat, which placed them at the greater vulnerability of harassment and even injury.

As the study above relied on simulation exercises and hypothetical scenarios, its ecological validity and generalisability is limited. However, there is increasing support for the notion that experiences of racism (such as racial profiling) and discrimination increase the risk of mental health difficulties within the Black community, although empirical research exploring these associations remains limited (Chakraborty & McKenzie, 2002). Franklin and Boyd-Franklin (2000) proposed the clinical model of 'invisibility syndrome', which conceptualises the link between microaggressive practices and poor psychological wellbeing in Black men. They argued that experiences of racism invisibilise and subjugate Black men's masculinity, increasing their risk of psychological and racial injury.

Other studies have argued that associations between racism and mental health difficulties require a nuanced analysis of culture, socioeconomic factors, and gender and how they negate or compound experiences of racial discrimination within specific ethnic groups (Karlsen et al., 2005).

In a recent UK study, a cross-sectional analysis conducted with a large sample of ethnic minorities showed that those who experienced perceived racial discrimination had poorer mental health, poorer cognitive functioning, lower life satisfaction and more significant psychological distress (Hackett et al., 2020). Though the sensitivity analyses did not show substantial differences between ethnic minority subgroups, the study highlighted the importance of developing policy and targeted interventions to tackle the structural macro forces that shape the experiences of minoritised communities.

Attempts to Address Racial Disparities in MHS

The care and treatment of Black people have been the subject of numerous policy initiatives at local and national levels. The Stuart Hall report (Ashe, 2021) found that 589 different recommendations have been made by thirteen previous race equity reports and commissions between 1981-2021, many of which have either been ignored or shelved (e.g., Cabinet Office, 2017a; Care Quality Commission, 2011; Department of Health, 2005; GOV.UK, 2018; The Sewell Report, 2021). I will focus on the 'Delivering Race Equality' report (Department of Health [DOH], 2005), which has been widely critiqued for its failure to provide remedial action towards addressing racial inequalities.

Delivering Race Equality Report

The DOH commissioned the Delivering Race Equality policy in 2005 following the death of David 'Rocky' Bennett. The systems-level policy aimed to address deeply entrenched race-related issues with the vision of increasing the provision of culturally sensitive approaches for

people with ethnic minority status. The action plan encouraged local MHS to engage minoritised communities through community-based initiatives and non-statutory service provision. The equity board pushed for the recognition and acknowledgement of the historical failures of statutory services in engaging Black service users (Bowl, 2007). However, the DOH abandoned the policy following the Race Disparities Audit (Cabinet Office, 2017), which demonstrated that little had changed for the plight of Black people.

Many have criticised the inertia among services, policymakers and successive governments to make the recommended changes as a by-product of institutional racism, which has witnessed the unnecessary death of Black people due to physical and coercive restraint within MHS (Mind, 2013a). The attribution of disproportionate deaths to the "collective failure of institutions and unwitting prejudice" (e.g., MacPherson Report, 1999, para 6.34) has been criticised for obscuring anti-Black injustices that are "manifested in each of society's major parts… the economy, education, religion, and the family" (Feagin, 2001, p. 6). This position has helped highlight specific, intentional, and deliberate practices that contribute to the perpetuation of institutional racism without accountability or quantifiable change. The accumulation of historical disadvantage, racism, and governmental inertia in addressing these perennial inequalities have directly filtered down to the experiences of ethnic minority communities, particularly Black men's experiences of MHS.

Black Men and Mental Health Services – Fear, Failure, or Both?

Black men are more likely to encounter MHS at crisis point and usually via the criminal justice system (Joint Commissioning Panel for Mental Health [JCPMH], 2016; Leese et al., 2006).

In a study exploring YBM's experiences of being detained under the MHA, participants reported the disconnect between the intervention provided at a time of high vulnerability and the punitive treatment they received. Their experiences with MHS were described as traumatic and coercive rather than supportive (Khan et al., 2016). Black men are overrepresented in psychiatric inpatient services and are three times more likely than White men to be admitted even when presenting with the same difficulties (Bhui & McKenzie, 2008). From an economic perspective, the lack of early intervention for Black men is costly for the taxpayer. It is estimated that early intervention could save the NHS millions of pounds through reduced acute hospital admissions, shorter lengths of hospital stay and less use of high-cost intensive interventions (National Collaborating Centre for Mental Health; [NCCM], 2016). Despite the ethical and economic argument for increasing the accessibility of primary care services for marginalised groups, the gaps in access to early interventions have been shown through the under-representation of Black men in primary care services (JCPMH, 2016). People from minoritised communities experiencing mental health problems are less likely to access psychological therapy (Glover et al., 2010; Mercer et al., 2019), and when they do, are less likely to have good outcomes (Dyer, 2019) and more likely to report negative experiences (Cabinet Office, 2017) compared to White service users.

The existence of cultural/language barriers (Mind, 2013b) and experiences of unsatisfactory statutory care (Memon et al., 2016) have been cited as potential causal explanations for the observed disparities in primary care services. Respondents of a qualitative survey on accessing psychological therapies reported a lack of trust in healthcare professionals responding to their difficulties in a culturally sensitive way (Mind, 2013b). The survey study did not delineate the experiences of diverse groups within the "BAME" category. To that end, small

scale studies exploring the experiences of African-Caribbean service users found that cultural matching[7] to address cultural barriers was not seen as a panacea but recognised as necessary for those requiring culturally specific support (Secker & Harding, 2002; Warfa et al., 2006). Others have pointed to the epistemic injustice[8] in labelling minoritised groups as "culturally backwards, psychologically illiterate, lacking in insight and emotionally unsophisticated" (Wood & Patel, 2017, p. 3). These marginalising narratives locate the blame for non-engagement on individuals rather than critically examining the systemic conditions that render services unavailable or difficult to access (Kovandžić et al., 2011; Memon et al., 2016).

The 'Breaking the Circles of Fear' formulation (Keating & Robertson, 2004, Figure 1) proposes that the negative perceptions that Black men have of services fuel their fear of MHS, resulting in presentation to services at a point of crisis. Due to the severity of their mental health status during a crisis, services often adopt coercive restraints and physical treatments to reduce the perceived threat or harm, reinforcing the narrative of Black men being dangerous. Adopting practices that are perceived as oppressive often results in limited trust, engagement, and delayed help-seeking behaviour (Duncan, 2003; Keating et al., 2002).

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[7] Cultural matching as a definition consists of instances in which a client and therapist who share the same racial background rather than the same ethnic background are matched in therapy (see Cabral & Smith, 2011).

[8] Originally coined by Fricker (2017), epistemic injustice is a systematic theory which identifies the process by which one's meanings and contributions are excluded and silenced through distortion and misrepresentation. In the context of this study, epistemic injustice is viewed as a colonial project of distorting the ontology of ethnic minorities by way of erasing the epistemic validity of their knowing systems.

Figure 1

'Circles of Fear' Formulation
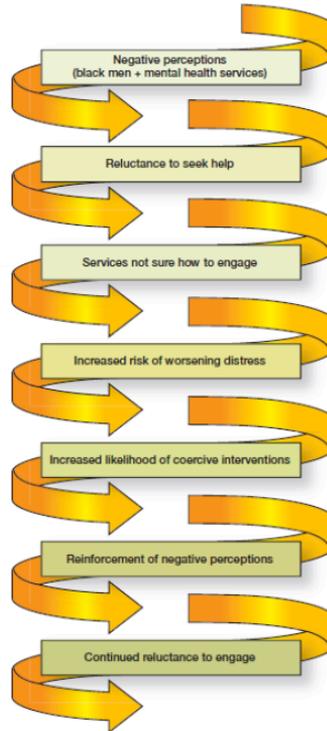
The 'Circles of Fear' formulation provides a conceptual framework for understanding the tensioned relationship between Black male service users and services. However, it is not without its limitations and omissions. The cycle fails to account for intragroup differences and mediating factors in service use. The experiences of Black men are often diverse, and their multiple intersecting identities underly their engagement with services. For example, differences in socioeconomic status (SES) between and within Black male groups may account for multiple layers of disenfranchisement, which are often understated due to the parochial focus on race-related disparities. Some studies have found that low income, lower levels of educational attainment and lower occupational status serve as barriers to service utilisation (e.g., Cadaret &

Speight, 2018; Lincoln et al., 2010). However, both studies were conducted in the USA; thus, extrapolation to a UK context may be problematic. The healthcare system in the USA is income/insurance-based; therefore, SES would be an important determinant for service utilisation. This does not necessarily imply that having free or state-provided care would increase the trust and accessibility of services in the UK when other institutional barriers exist (Memon et al., 2016). The premise of the argument here stands; patterns of help-seeking, including service (non) engagement, can become even more complex when the intersecting locations of Black men's identities and resources are taken into account (Cauce et al., 2002; McCall, 2005).

Conclusions from the Empirical and Theoretical literature

The literature presented highlights the challenges Black men face in statutory services from empirical evidence and various theoretical standpoints. Unfortunately, the nuance in Black men's experiences is often lost as research often homogenises a group that experience power in intersectional ways due to their various social and political identities. There is a shortage of literature focused on Black men in the UK, explicitly examining their beliefs, perceptions and engagement with formal and informal help-seeking. An idiographic approach to addressing this gap will elucidate the challenges, strategies and resources utilised by Black men to offset the psychological distress resultant from navigating racialised environments. A qualitative SLR was conducted to explore the available evidence on Black men's help-seeking experiences and to identify studies that illuminated if, how and why men delay or engage in help-seeking when they experience psychological distress.

Systematic Literature Review

Systematic literature reviews follow a high quality, comprehensive and rigorous process to draw robust conclusions from the existing evidence base on a particular topic (Siddaway et al., 2019). They also aim to highlight gaps in knowledge and provide recommendations for clinical practice and future research (Fink, 2005). In this next section, I shall present a literature review of the studies that address the following question: "What are Black men's experiences and views of mental health help-seeking?" The review question aims to present what is currently known, assess the quality of available literature on this topic and to address knowledge gaps.

Method

A scoping search on Black men's help-seeking experiences was conducted (including but not limited to Cochrane Library and the Centre for Reviews and Dissemination databases), revealing an absence of SLR's on the topic of investigation. The literature search followed a meta-synthesis approach, which integrates findings from multiple qualitative studies. It also provides an interpretative account of the available research to understand underlying phenomena and synthesise overarching narratives or constructs (Jensen & Allen, 1996; Sandelowski et al., 1997). The literature review included studies with qualitative data because of their focus on in-depth and diverse individual experiences of help-seeking in a way that structural surveys or quantitative methodologies may be restricted (Willig, 2008). The review also focused broadly on Black men of all age groups to keep the search as comprehensive as possible. Studies conducted in the last decade (2010-present) were included to capture contemporary studies in the context of the legislature and inclusive practices that have been mandated across MHS in the UK (Wilson, 2009). Although considerations were made to include countries with majority Black populations (i.e.,

Jamaica, South Africa), the structural differences in mental health provision, economic status and lived experiences of Black people within western and non-western countries would have presented difficulties in conducting a comparative synthesis of the findings. Western countries are defined as highly industrialised countries with cultural heritage from Europe (Ferris et al., 2017); studies outside of what is known as 'the West' were excluded. Studies written in a non-English language were excluded due to time constraints and a restricted research budget to commission the services of professional translators (Neimann Rasmussen & Montgomery, 2018). The inclusion and exclusion criteria can be seen in Table 1.

Table 1

Literature Search Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
- The study must contain a reference to mental health help-seeking experiences (formal or informal) - The study must include data from Black men - The study must consist of qualitative data. - The study must be written in or translated into English - The study must be in a peer-reviewed journal - The study must be empirically based (e.g., not a review of previous literature) - The study must have been published in the last 10 years	- The study focuses on participants under the age of 18 - The study looks at MHS for specific populations (e.g., service users with intellectual or physical disabilities). - The study is quantitative - The study focused on help-seeking in drug and alcohol services, physical health problems or other health problems, e.g., smoking cessation, HIV, diabetes - The study was published in a language other than English - The study was published over 10 years ago

Search Strategy

An electronic database search was conducted using Pub Med (27.10.2020); CINAHL (27.10.2020); PsyInfo (27.10.2020); and Social Care Institute for Excellence (06.11.2020). These databases were chosen to incorporate literature from various disciplines such as medicine, nursing, social work and applied social sciences. Alerts were created to enable consideration of relevant studies up to the point of analysis. Databases were searched using various terms associated with mental health help-seeking and people from a Black background (see Table 2). Subjective headings and thesaurus terms were checked to expand the search terms.

Further terms were identified through reading literature linked to the subject and gathering suggestions from my supervisors. In cases where subject headings were not available, free-text search terms were used. This helped to tailor the search strategy to each database. The search terms were truncated where appropriate to yield all relevant papers (e.g., help* = helping, helped). Boolean operators 'AND'/ 'OR' were combined within the search terms to yield as suitable papers.

Table 2

Search Terms Used in Systemic Literature Search

Search Terms			
Black	**Men**	**Mental health**	**Help-seeking**
Black AND	Men AND	"Psychological distress"	Help-seek* AND
African-Caribbean **OR**	Man OR	Anxiety OR	Help* OR
African-American **OR**	Male* OR	Depression OR	Support OR
"African***"** **OR**	Father* OR	Mental health OR	Therap* OR

"Caribbean*" **OR**	Dad* OR	"Emotional distress" OR	Counsel* OR
		Stress* OR	pastoral* OR
			spiritual* OR

The reference lists of the relevant studies located through the database were examined, identifying 3 further articles. Google Scholar was used to find citations of relevant papers sourced from reference lists. The combined studies were firstly screened based on the relevancy of the title. For the relevant studies, if the title was too vague, the abstract was reviewed. In just under 15 cases, obtaining the full text was necessary as the abstract did not provide enough information to decide on the suitability. Duplicate articles were then removed, and the remaining articles were examined using the inclusion and exclusion criteria.

The search identified 415 papers. The screening process identified 33 potential studies to be included in the review. Abstract and full-text search reviews led to further exclusions because the studies were not linked to Black men's help-seeking experiences, nor did they contain a large sample of Black men included in the analysis. A total of 9 studies were therefore included in the review. This process is outlined in Figure 2.

Figure 2

Systematic Literature Review Flow Chart
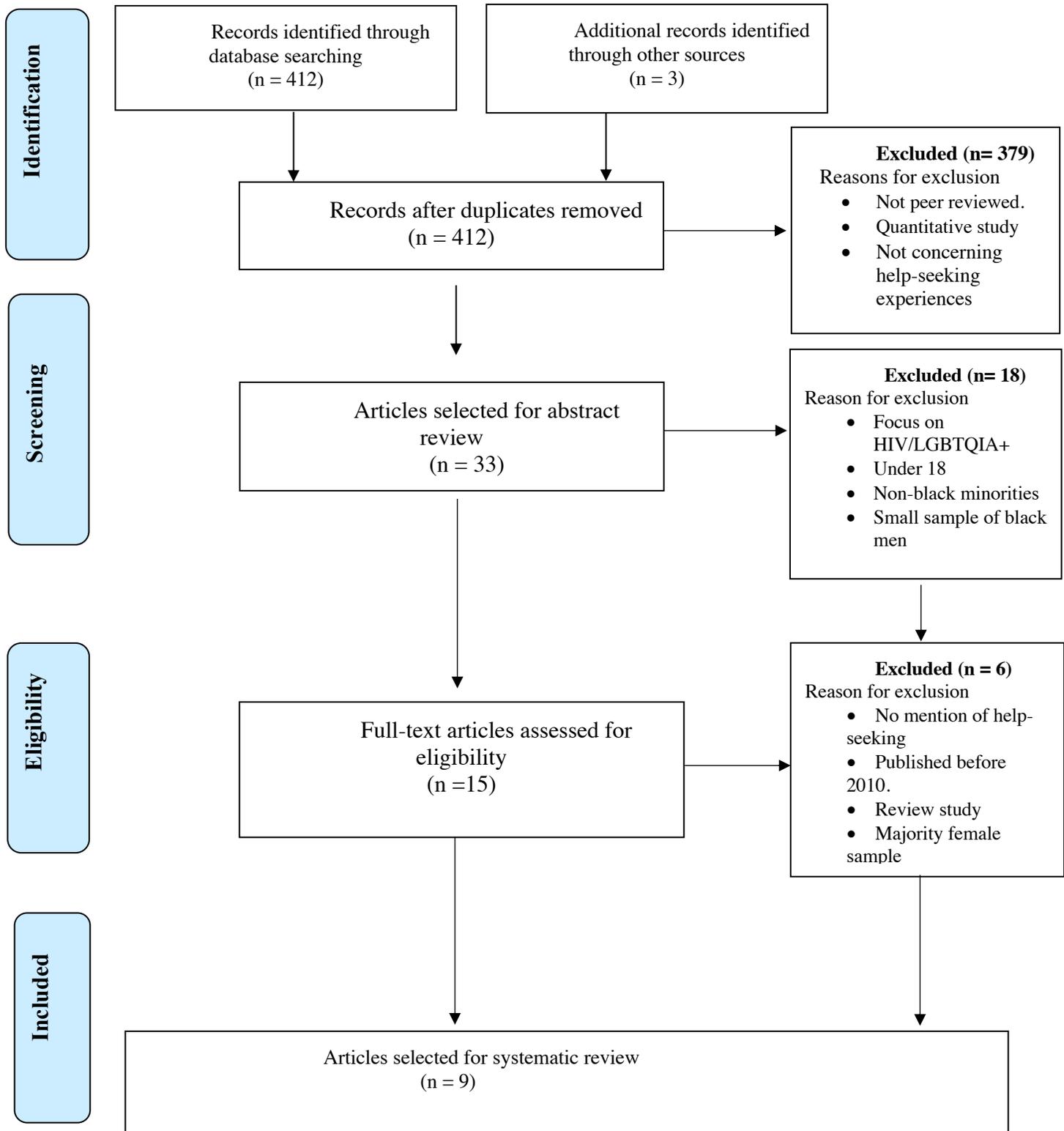
Results

The literature review identified nine suitable papers. The papers included were chosen due to their focus on help-seeking attitudes, beliefs, and experiences of Black males from different age groups. Of these papers, seven studies included a qualitative methodology and two utilised mixed-methodology designs. The latter included enough qualitative data to meet the criteria (Bauer et al., 2020; Rich et al., 2020). Most of the identified studies were based in the USA (n=6), with a minority based in the UK (n=3). All studies identified included a majority sample of Black men. Three papers looked directly at people's experiences of utilising MHS for psychological difficulties such as trauma and 'depression' (Lindsey & Marcell, 2012; Jacoby et al., 2020; Rich et al., 2020). Two papers explored Black men's narratives of 'depression' and their conceptions of help-seeking (Campbell & Allen, 2019; Myrie & Gannon, 2013). Two papers explored the role of stigma in help-seeking experiences (Mantovani et al., 2017; Ward & Beeson, 2013). Two papers focused on participants' views on MHS utilisation (Linney et al., 2020; Ward & Beeson, 2013). The former study focused on a homogenous sub-section of a UK Black community (Linney et al., 2020). During the search, relevant articles addressing help-seeking experiences within ethnic minority communities with small samples of Black men were preserved and discussed later in the thesis. A summary of the findings, including the strengths and limitations, can be found in Table 3.

Table 3

Summary of Studies Included in the Review

Title, Author, Country	Aim	Participants/Sample	Data collection	Data analysis	Summary of findings	Strengths and limitations
"Just fighting my way through": Four narratives on what it means to be Black, male, and depressed. Campbell & Allen (2019) USA	To explore the experiences of depression, help-seeking, and treatment in Black men.	Convenience sample (n=4) Age range: 39-54 years	Semi-structured individual interviews	Thematic Analysis (Braun & Clarke, 2006)	Participants reported the use of faith systems and informal support as sources of support. Narratives around stigma and being perceived as "weak" impacted help-seeking. Acknowledged impact of cultural beliefs/experiences on seeking treatment early.	+ In-depth, rich data from participants + Focus on men – adds to a limited evidence base - Small sample size, unsuitable for a TA methodology - Does not offer limitations, areas for future research or clinical implications of the study -Unclear on the procedures that were followed to increase credibility and reduce researcher bias
Sharing things with people that I do not even know': Help-seeking for psychological symptoms in injured	To describe how Black men perceive psychological symptoms after a trauma-related injury. To Identify	Random sample (n=32) AfAM men admitted to a trauma centre	Semi-structured individual interviews	Thematic and structural narrative analysis (Reismann, 2008).	Participants reported that the severity of their symptoms motivated them to seek help. Systemic barriers, fear of being misunderstood,	+ Large sample of Black men spanning a wide age range. +Mixed-qualitative methodology contextualised quantitative data. +Considered the intersection of race and gender in help-seeking

Black men in Philadelphia Jacoby et al. (2020) USA	factors that shape Black men's decision to seek help.	Age range: 18-67 (Mean age: 38.7)			and negative perceptions of health care services were perceived barriers. Participants also cited financial constraints and inadequate access to mental health care as help-seeking barriers. Some participants did not consider professional help and considered informal sources of support which were perceived as sufficient.	+Multiple analysts reduced the risk of bias + Clear clinical implications - Specificity of the "trauma" may not be applicable in cross-clinical settings - Broad definition of professional help' – participants had different definitions to researchers. This posed a threat to the construct validity under study
"Should I really be here?" Exploring the relationship between Black men's conceptions of wellbeing, subject positions and help-seeking behaviour Myrie & Gannon (2013)	To contribute to the current understanding of how Black men talk about their experiences and how this interacts with their conceptions of wellbeing and help-seeking behaviours.	Convenience and snowball sampling (n=9) Black African and Black Caribbean men Age range: 23-34 (Mean age: (26.7)	Semi-structured interviews conducted in a variety of settings	Foucauldian Discourse Analysis (Willig, 2008).	Four main themes were identified linked to the multi-modal oppression and discrimination of black men; the influence of hypermasculine construct in masking psychological vulnerability and the confluence of these factors results in delayed	+ Explored role of systemic factors on conceptions of wellbeing and help-seeking + Participants were able to comment on research analysis and certify the themes identified by the researcher + Offered clinical implications for service providers - Does not outline the data analysis process

					help-seeking from the community/ professionals.	- Participants recruited from one geographical location (predominantly London)
Pathways to help-seeking among Black male trauma survivors: Fuzzy set qualitative comparative analysis. USA Rich et al. (2020)	Explore how Post Traumatic Stress Disorder (PTSD) symptoms and depression act together with discrimination, stigma, and financial stressors to either hinder or facilitate psychological help-seeking in Black male trauma survivors.	Purposive sampling (n= 32) AfAm men Mean age = 38.70	Mixed methods QIDS scale (depression) and PCL-5 (PTSD) and Discrimination score (QIDS) Semi-structured interview guide for qualitative interviews	Fuzzy set Qualitative Comparative Analysis (fsQCA) Thematic and structural narrative analysis	The findings indicated that the presence of severe trauma symptoms in the absence of contextual factors such as discrimination and financial worry facilitated help-seeking. Inversely, structural factors in the absence of severe PTSD were a causal recipe for help-seeking. The barriers and facilitators to help-seeking pathways are complex and intersectional.	+Use of robust mixed methodology to explore complex interactions + Large sample + High validity; repeated interviews after 3-months + Used multiple subject reviewers to ensure interrater agreement - Only 10% of subjects selected from the whole sample were selected for qualitative interviews. Their experiences might not represent the wider sample. -The qualitative analysis procedure of arriving at the themes was unclear
Exploring the relationship between stigma and help-seeking for mental	Explore the factors involved in the social production and practice of	Purposive convenience sampling in faith-based communities	Semi-structured interviews with a topic guide	Thematic analysis	High levels of stigma in African-descended communities result in a preference for help-	+ Use of co-production with local programme organisers + Multi-researcher data checking increased inter-rater reliability

illness in African-descended faith communities in the UK. UK Mantovani et al. (2017)	stigma in African-descendant communities and how these impacts mental health help-seeking with formal healthcare services	(n= 26); 15 Black African Caribbean men, (n=11); Black African Caribbean women Age range- 24-75 Included faith leaders(FL), active members (AM) and regular attendees (RA)			seeking in church communities over formal services, but lack of understanding among faith leaders perpetuates interpersonal stigma. Family rejection, ostracisation from the community and internalised stigma also increased the risk of social isolation.	+Internal validity increased by familiarising culture of participants and owning position as White researchers -Participants were from African descended communities; their views might not represent British born participants -Limited representativeness as the researchers did not gather the perspectives of stigmatised individuals and people from secular communities
A crazy person is a crazy person. It doesn't differentiate": an exploration into Somali views of mental health and access to healthcare in an established UK Somali community	To investigate Somali views on accessing appropriate healthcare, improving access, and reducing barriers. Long term aim is to improve knowledge of mental health and access to services.	Convenience sampling in community centres (n=23); 12 male participants British Somalis Age range 20-60	Focus group interviews with key topics of discussion 5-6 single-sex groups	Thematic analysis	The findings highlighted the lack of knowledge and information as a barrier to help-seeking. Differences in the cultural conceptualisation of distress and community stigma affected the relationship with service use. Some participants held misconceptions	+ Participatory action research– use of local knowledge and expertise + Researcher reflexivity on their position as an 'outsider' and the impact on participants + Codes and themes were checked with Somali community researchers - Non-representative sample – a subsection of the Black African community in Bristol

UK Linney et al. (2020)					about mental health aetiology, which they associated with negative consequences, i.e., deportation. Participants also expressed concerns about confidentiality breaches which explained distrust in authorities. Recommendations include tailored interventions, Somali health care staff & community-based support.	- Power dynamics between participants in a focus group setting were not addressed -Researchers were non-Somali -language barriers may have impacted interpretations/credibility of findings
"We're Going Through a Lot of Struggles That People Don't Even Know About": The Need to Understand African American Males' Help-Seeking for Mental	To explore influences of help-seeking for emotional problems among Black men within a community-based sample. Secondarily, the	Purposive sampling in community-based organisations (n=27) Age range 15-26 Mean age 20.4	Focus groups composed of 5-8 participants	Inductive analysis method using established constructs from the theories of health care use (Crabtree & Miller, 1999)	The main themes were around; Taking care of oneself; personality characteristics such as self-assurance and ego/pride facilitated or hindered help-seeking. Participants also used introspective activities	+ Collated data from community-based samples rather than a clinical sample + Use of qualitative methods to generate consistent themes across all age groups + Independent investigators reviewed themes for reliability and credibility

Health on Multiple Levels Lindsey & Marcell (2012) USA	projects aimed to understand the factors the precursor to a crisis/psychological breakdown.		and substances to manage emotional problems. Interactions with potential sources of help were determined by the relationship quality/closeness, preservation of confidentiality and relatability with health care professionals. Participants reported moments of 'crisis' as critical drivers for seeking help.	+ Explored multi-influences on help-seeking individual, social and systemic influences of help-seeking -Ethical approval unclear - Analysis methodology is unclear - The management of ethical issues is not addressed - Researcher did not disclose personal relation to the subject matter and the influence of this on data analysis -Wide age range in participants, which could have potentially involved the mixing of minors with adults. Steps taken to safeguard younger participants and address power dynamics are unclear

We Are Our Own Counsellor": Resilience, Risk Behaviors, and Mental Health Service Utilization among Young African American Men Bauer et al. (2020) USA	To explore whether resilience, risk factors and utilisation of mental health services varied by the number of traumatic experiences	Purposive/Convenience sampling in community sites (n=55) Age range 18-30 with Mean age of 23.	Quantitative surveys on traumatic events, resilience, risk factors 6 semi-structured individual interviews 9 focus groups composed of 2-13 participants	Mixed methods Hierarchical linear regression Phenomenological approach	Participants contextualised 'resilience' preference to self-manage emotional difficulties over seeking help from formal mental health services. Their attitude towards help-seeking was linked to masculinity norms of self-reliance, success, and substance misuse. Spirituality and religiosity were seen as positive coping tools. Participants identified that these strategies had short-lived effects. Despite this, a small minority still expressed a desire to seek help from services even with this understanding.	+ Utilised qualitative measures to contextualise the construct of resilience from the YBM perspective. + Relatively large sample increasing representative power + Varied age range of participants + Utilised mixed methods to understand individual factors affecting resilience, i.e., trauma + Use of an independent research assistant for coding increased trustworthiness of findings - Data from the focus group is limited in depth and breadth -Researcher does not own positionality with the research -Recruitment was conducted in an urban area via a job readiness programme. The composition of participants involved might apply to those in employment or living in suburban areas.

African American Men's Beliefs About Mental Illness, Perceptions of Stigma, and Help-Seeking Barriers Ward & Beeson (2013) USA	To provide more insight into AfAm men's subjective perspectives about mental illness and help-seeking. The study also aims to explore the barriers AfAM experience in help-seeking.	Purposeful sampling (n= 17) Age range: 24-75 with Mean age of 54.	Semi-structured, individual, face-to-face interviews	Dimensional analysis- an alternative to grounded theory (Kools et al., 1996)	Participants endorsed a range of beliefs about mental health beliefs from a biopsychosocial perspective. Some participants believed mental health illness would result in imprisonment/sectioning, while others considered it a part of everyday life. Participants were optimistic about help-seeking and encouraged their friends to seek professional treatment. Participants preferred coping mechanisms that included community support from family and friends and spiritual support derived from religious beliefs and practices such as praying	+Qualitative methodology is well suited to an under-searched topic + Researchers owned their power with the subject matter + Interviewer was a Black male, and this was reported to increase trust between subjects + interviewer +Transparency around the coding process reduced researcher bias +Adds practical implications for clinical practice, i.e., cultural competence, outreach programs and future research - Use of the CSM model might have restricted the breadth of responses available to men - Most of the sample had previous mental health contact – this might explain their favourable attitudes towards help-seeking - Small sample size - Study did not give equal weight to help-seeking barriers as

	and taking concerns to God.	postulated in the research questions
	Limited knowledge was cited as a barrier to help-seeking.	
	Stigma was not found to be a barrier to help-seeking	
	Participants were keen to be involved in research to help improve their understanding and awareness.	

Abbreviations: AfAM: African American; CSM: Common Sense model.

Quality Assessment

Critical appraisal in qualitative research involves the systematic and careful examination of research studies for their trustworthiness, value and relevance in a given context (Burls, 2015). The use of appraisal criteria is vulnerable to subjective bias as qualitative researchers from different disciplines, and theoretical backgrounds may have other criteria for assessing the quality of a study (Sandelowski et al., 1997). The Critical Appraisal Programme Tool (CASP) qualitative tool checklist was used for this review (CASP, 2018). It is a comprehensive tool comprised of ten items assessing three broad categories: rigour, credibility, and relevance, which are viewed as cornerstones of trustworthy qualitative research (CASP, 2018). The CASP tool is considered a user-friendly option for novice researchers and is supported by an extensive evidence base within health-related research (Carroll & Booth, 2015; Noyes et al., 2018).

During the review process, I reflected on my positionality as a Black female researcher and the influence of my background and experiences on the process. Reflecting on my position helped maintain the transparency and credibility of the appraisal. Credibility in qualitative research is equivalent to internal validity in quantitative research within a positivist framework (Lincoln & Guba, 1985). Credibility checks can be conducted using a triangulation method of incorporating multiple qualitative analysts. To enhance the review's credibility and rigour and reduce the potential bias of having one reviewer, two doctoral colleagues reviewed 25% of the identified papers (n=3), which revealed a 95% concordance rate in ratings. The ratings on the quality of the papers were combined and tabulated, as shown in Table 4. The overall quality of the papers and a meta-synthesis of the main findings will be presented in the upcoming section.

Table 4

Critical Appraisal of included research

Criteria Yes= criteria met No=criteria not met Cannot tell	1)Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Campbell & Allen (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Highlights the importance of understanding informal help-seeking channels used by Black men

Jacoby et al. (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Considers symptom severity as a mediator of the help-seeking process. It also suggests the importance of seeing Black men as a heterogeneous sample.
Myrie & Gannon (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Offers practical implications for primary care practitioners to avoid diagnosis-based language with Black men and acknowledge sources of oppression and discrimination.
Rich et al. (2020)	Yes	Cannot tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Provided insight into the combination of practical and structural barriers to help-seeking and suggests policy level changes to address this.
Mantovani et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	A valuable contribution to the evidence base around mental perceptions and help-seeking behaviours in faith-based communities.

Linney et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Provides an in-depth understanding of a culturally homogenous group that is under-researched.
Lindsey & Marcell (2012)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Demonstrates the multi-level (individual, social, systemic) factors in help-seeking and offers recommendations for future research.
Bauer et al. (2020)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Adds resilience as a potential moderating factor YBM's relationship to the understanding of help-seeking.
Ward & Beeson (2013)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Provides new insights into Black men's willingness to seek help which has not been explored in previous research.

Quality Evaluation of the Literature

The studies included in the literature review attained a moderate-high quality rating. Most studies had specific methodological strengths, which increased their credibility, trustworthiness, and rigour. All studies had clear aims, which helped to assess the appropriateness of methodological choices. Purposive sampling within community-based settings was the most popular approach, which fitted the recruitment of homogeneous participants. However, this might have limited the representativeness of the findings as the experiences of help-seeking may represent the perspective of participants who may not have direct knowledge or contact with formal MHS. While most studies had older Black men, three studies included data from YBM; this was a particular strength as research on help-seeking experiences within this age group tends to be sparse.

The methodological choices made by researchers were appropriate to the research objectives in most of the studies. Campbell & Allen (2019) reported a small sample size of n=4 and utilised TA. Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003) may have enabled a more in-depth analysis of subjective experiences than that afforded by TA which is better suited for larger samples (Braun & Clarke, 2006). Studies that used unfamiliar methodologies (Myrie & Gannon, 2013) would have benefitted from having outlines of the processes followed to arrive at the findings. The unclear analytical procedures in the studies utilising mixed methods approaches (Bauer et al., 2020; Rich et al., 2020), also presented difficulties in scrutinising the trustworthiness of the findings, primarily due to the small representation of qualitative data. However, both studies provided useful insights on formal help-seeking given the overrepresentation of qualitative data from community-based samples.

Some studies helpfully acknowledged their 'outsider' status as researchers and thus employed members of the participants' community to support data collection to enhance rapport and participant trust (Linney et al., 2020; Ward & Besson, 2013). This helped clarify the various roles taken by members of the research team, including the process and steps followed to increase the internal validity of the data collection. Mantovani et al. (2017) specifically commented on their position as White researchers with Black African communities and used co-researching practices to increase familiarity with their participants' context. This was the strongest aspect of their research. Contrastingly, the overall quality was compromised in two papers (Lindsey & Marcell, 2012; Myrie & Gannon, 2013) which did not disclose transparency checks to reduce the risk of bias. However, in studies where independent reviewers were not used (Linney et al., 2020; Myrie & Gannon, 2013), member checking[9] strengthened the validity of the findings, although researcher reflexivity on the ethical considerations of the process was unclear.

Most studies sufficiently addressed ethical considerations such as preserving anonymity and confidentiality of participants' data. Lindsey and Marcell (2012) did not provide evidence of the steps to safeguard younger participants grouped into mixed-age focus groups. However, the study gained consent from the participants and received ethical approval, which mitigated these concerns. In most studies included in the review, the ethical considerations did not extend to areas

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[9] Member checking provides an opportunity for participants to approve particular aspects of the interpretation of the data they provided (Creswell & Miller, 2000) Researchers in both studies used this method to validate the congruence between the data analysis and participants' experiences.

such as safeguarding, de-briefing, and sharing research findings. These approaches would have been important, particularly in studies with vulnerable groups (Jacoby et al., 2020; Lindsey & Marcell, 2012; Rich et al., 2020).

All studies provided clear statements of findings that helpfully linked with the research objectives. Some studies included clinical populations and provided critiques around constructions of help-seeking; they emphasised the importance of clarifying definitions of help-seeking (Jacoby et al., 2020; Rich et al., 2020). To conclude, all studies demonstrated the importance of interpreting findings in their context rather than generalising conclusions about Black men's help-seeking behaviours. The next section will provide a meta-synthesis of the findings, holding in mind the nuances and heterogeneity in the narratives shared by participants.

Synthesis of Main Findings from Literature Review

Thematic analysis was used to synthesise the findings following the guidelines by Braun and Clarke (2006). After reading the included studies to gain an understanding of the data, specific findings about Black men and their mental health help-seeking experiences were reviewed. First-order data represented quotes from the participants; second-order constructs included my interpretations of the extracted data. The data was then synthesised into codes that were clustered into three major themes: i) *the role of socio-cultural norms and beliefs in help-seeking*; ii) *experiences of informal support and iii) barriers to help-seeking*. Six sub-themes were also identified. The themes were then reviewed, refined and checked against the findings of each study to assess their relevance to the review question. The themes and sub-themes are represented in Table 5.

Table 5

Table of Themes from the Meta-Synthesis

Major theme	Sub-themes
Theme 1: The role of Socio-Cultural Norms in Help-Seeking	1. Keeping things inside: secrecy and shame 2. Hyper-masculinity
Theme 2: Experiences of Informal support	1. Spiritual and pastoral support 2. Social support
Theme 3: Barriers to Help-Seeking	1. Social stigma 2. Mistrust of professional services

Theme 1: The Role of Socio-Cultural Norms on Help-seeking

In seven out of nine studies, secrecy and shame were identified as a sub-theme under the umbrella of beliefs about help-seeking (Bauer et al., 2020; Campbell & Allen 2019; Jacoby et al., 2020; Linney et al., 2020; Mantovani et al., (2017); Myrie & Gannon 2013; Ward & Beeson, 2013). In four out of the nine studies, hypermasculinity was constructed as a second sub-theme that interacted with shame and secrecy (Campbell & Allen, 2019; Jacoby et al., 2020; Lindsey & Marcell, 2012; Myrie & Gannon, 2013).

Sub-theme 1: Keeping Things Inside: Secrecy and Shame

Secrecy and shame were identified as dominant themes within the literature, with seven studies highlighting the role of cultural beliefs in hindering help-seeking within the Black community (Bauer et al., 2020; Campbell & Allen, 2019; Jacoby et al., 2020; Linney et al., 2020; Mantovani et al., 2017; Myrie & Gannon, 2013; Ward & Besson, 2013). The cultural notion of

'keeping things in' was described as a preference towards keeping private and family affairs within the community, including any difficulties or distress:

> *"You don't go outside, to someone else to sort of talk about your problems, not airing your dirty washing, so there's this constant built in thing of like 'well, that's not what we do"* (Myrie & Gannon, 2013, p.17).

Here, references were made to the socialisation processes within Black cultures where Black men are dissuaded from opening to people outside of their family and social community. In some studies, participants described mental health as a "taboo" subject often attached to secrecy. The shame manifested in the the ostracisation of people who share their difficulties (Mantovani et al., 2017). The fact that mental health difficulties were kept a secret in these communities was implicated in delayed help-seeking. In some unfortunate cases, the denial of the problem was driven by the idea of mental strength, (i.e., resilience) was the only tool needed to overcome adversity:

> *"we are strong", and when you are strong, you can get over anything. And, like I say, make you not want to get help, think you are all right. And I mean they would think you are all right. And they would just think you're weak if you tell them something like that."* (Campbell & Allen, 2019, p. 609).

This suggested that people experiencing difficulties were perceived to lack the strength that community members expected. For some participants, these narratives were constructed through the lens of masculinity.

Sub-theme 2: Hypermasculinity

Several Black men in the studies drew upon various constructions of masculinity to talk about how their male identity interacted with their wellbeing and help-seeking behaviour. In Myrie and Gannon (2013), hypermasculinity[10]was characterised as stemming from the ideology of *machismo* which is defined "*as a rejection of characteristics such as showing fear, being distressed or displaying signs of emotionality*' (Mosher & Tomkins, 1988, p. 69). Within this sub-theme, participants named the socialisation process that men are trained to uphold:

"You don't go to people to talk to people about your problems, for a female yes. But it's not a manly thing for a man to do it. It's not seen as a manly thing to do in this generation. It's not how he raised me. It's like a sign of weakness" (Jacoby et al., 2020 p. 10).

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[10] Hypermasculinity is not clearly defined and delineated within literature but is seen to represent the macho ideology that honours "superior, masculine" affects and humiliates the displayer of "interior, feminine" affects. Macho scripts exaggerate masculine gender role behaviour to serve hostile dominant interpersonal goals motivated by affects of excitement, gender disgust and contempt. (Mosher & Tomkins, 1988, p.64).

The theme of mental health distress as a 'sign of weakness' was prominent in most of the studies and appeared to be linked to broader cultural expectations of showing resilience and fortitude (Campbell & Allen, 2019; Jacoby et al., 2020; Mantovani et al., 2017; Myrie & Gannon, 2013). The above quote in Jacoby et al. (2020)'s study alludes to the implicit rules dictated to men as part of their upbringing. This was also identified in Myrie and Gannon (2013)'s study, where the socialisation process was constructed in military terms, e.g., *"trained to be a soldier"* and *"acting tough",* which were seen as necessary characteristics to survive oppression and discrimination (Myrie & Gannon, 2013, p. 17). The study suggested that discourses of acting tough and being 'soldier-like' were connected to experiences of systemic oppression. Bauer et al. (2020) suggested that Black males may be prepared to show resilience in the face of inevitable and expected adversity to preserve their sense of autonomy. In other studies, some participants recognised that disclosures and expressions of vulnerability were often misattributed as anger:

"I *can't stand the label of being an 'angry Black man', but I don't think I want to deal with um, 'angry, crazy Black man' you know"* (Campbell & Allen, 2019 p.600)*.

A few studies commented on the conflict that men experienced between their perceptions of masculinity and the decision to seek help (Jacoby et al., 2020; Lindsey & Marcell, 2012; Myrie & Gannon, 2013). The conflict also manifested as a pressure to 'perform' wellness: "*You smile on the outside and cry on the inside* (Campbell & Allen, 2019, p.600)" to avoid being judged negatively by fellow peers. Within participants' accounts, several references to mental health were made, including being a sign of *"total insanity"* (Mantovani et al., 2017, p.4) and

associations with violence and danger (Campbell & Allen, 2019; Lindsey & Marcell, 2012; Mantovani et al., 2017; Myrie & Gannon, 2013). This highlighted the limited access to knowledge and awareness of mental health within the Black community. Consequently, the combination of mental health misconceptions and perceived threats to masculinity may underpin participants' concerns about being perceived as weak or a burden to others in the pursuit of informal support.

Theme 2: Informal Help-Seeking Experiences

The availability and quality of social support influenced participants' relationship with help-seeking. Participants in numerous studies indicated the importance of community and informal support as valuable resources to mediate mistrust of professional services.

Sub-theme 1: Social Support

Immediate family members and friends were identified as key sources of support in four out of the nine studies (Campbell & Allen, 2019; Jacoby et al., 2020; Lindsey & Marcell, 2012; Myrie & Gannon, 2013). Significant others were seen as a critical social factor in motivating Black men to seek care and participate in health-related activities. Existing social networks and a preference to *"deal with things in the family"* (Myrie & Gannon, 2013, p.17) were also described as preferred channels of support due to notions of belonging and familiarity. These factors were perceived as precursors for establishing supportive networks (Linney et al., 2020; Myrie & Gannon, 2013). In Mantovani et al. (2017), people outside the community were perceived as incompetent as *"they do not understand their culture, values or their norms"* (p.7). Services were also viewed as untrustworthy due to practices that were perceived as oppressive. However, the preference for support from family and friends was not always seen as the first choice for some

participants; one participant reported being fearful of judgement and *"being seen as different"* (Campbell & Allen, 2019, p. 607). The type of problem and the ability of the source of support to help were reported as critical mediating factors in help-seeking intentions from one's social network. One participant described trust issues and discomfort in sharing personal or emotional-laden information with people within his social network:

> *"To be honest, I ain't telling my homeboys my problems because they ain't gonna be there to help me. I am sure of that… They might be your homeboys one minute, [but] the next minute they will turn around and out your business out on the street"* (Lindsey & Marcell, 2012, p.358).

This quote illustrates that while relational closeness may be viewed as necessary, it may not always garner trust due to concerns about confidentiality. Some participants expressed a preference for seeking help outside of the social support network as they would receive professional and unbiased support for their difficulties (Campbell & Allen, 2019; Lindsey & Marcell, 2012). In all four studies, it was evident that social support was far-ranging, from immediate family to community organisations such as the church.

Sub-theme 2: Spirituality and Pastoral Support

Religion and spirituality were commonly cited as important pillars of psychological support during periods of distress and hardship in addition to personal coping strategies, such as *"asking God to take away the anger"* (Jacoby et al., 2020, p. 11) *or "going to Jesus first"* (Lindsey

& Marcell, 2012, p.357). Participants stated that their local churches and faith communities provided a sense of belonging and supported them in a way that aligned with their cultural and religious values. Often, church leaders were seen as the first port of call:

"My deacon in church, he comes the second Sunday of every month to give communion. I can call him anytime for a prayer. He's a man of God. He knows the power of prayer" *(Jacoby et al., 2020 p. 11).*

The accessibility of church leaders and trusted community members were cited in two other papers (Linney et al., 2020; Myrie & Gannon, 2013). In both papers, participants described the closeness and belonging involved in negotiating help-seeking. On the other hand, some respondents were critical of spirituality-based mental health approaches as they believed these practices impeded help-seeking from MHS:

"If somebody comes into the church with a mental health issue, they [pastors] are most likely to pray for this person and annoy the person without asking them to try things, rather than asking the person to seek professional help" (Mantovani et al., 2017, p.7).

A participant in a study by Campbell and Allen (2019) shared this view. They expressed that spiritual approaches were best complemented by other methods such as professional support, as prayer alone was insufficient to support their difficulties. This links with the findings of Mantovani et al. (2017), where faith leaders recognised that they were not equipped to assess the

presenting problems of church members and felt limited in their ability to respond in ways that facilitated formal help-seeking:

"*In many cases, we are not equipped to distinguish the spiritual need and what is a mental health need*" (Mantovani et al., 2017, p. 8).

This sub-theme illustrated the symbolic centrality and multifunctionality of the pastoral support for mental health, but it also highlights the limitations of these support channels. The findings also demonstrate how the lack of mental health expertise within faith leaders necessitated individuals' engagement with formal MHS.

Theme 3: Barriers to Help-Seeking

The final theme of the meta-synthesis explored participants' accounts on the barriers to help-seeking. Participants identified a range of obstacles that prevented early outreach to MHS. Two sub-themes were described: mistrust of professional services and social stigma.

Sub-theme 1: Mistrust of Professional Services

One of the central themes in six out of the nine studies was the mistrust in professional services, which was described as a primary barrier to help-seeking (Campbell & Allen, 2019; Jacoby et al., 2020; Lindsey & Marcell, 2012; Linney et al., 2020; Mantovani et al., 2017; Myrie & Gannon, 2013). Participants in these studies spoke about their fear of misdiagnosis and confidentiality concerns. In Jacoby et al. (2020), participants were fearful of being negatively

judged by mental health professionals. Participants reported that these negative perceptions had consequences on their interactions with professionals:

"Honestly, I can't handle counsellors cause I'm not just gonna go ahead and tell a stranger everything about me. It might take me about (thinks and mumbles) 20 sessions for them to… get into my head… I'm not going to go in there and tell you "Oh, I'm feeling down about this [is] wrong [with me]. Counsellors will get your parents locked up" (Lindsey & Marcell, 2012, p. 358).

Previous negative experiences with healthcare professionals seemed to inform participants' decision to disclose difficulties to receive the appropriate support. In Myrie and Gannon (2013), systemic factors such as oppression and discrimination contributed to the deep mistrust of professionals. The role of structural racism added to the stigma around mental health help-seeking validated participants' fear of being sectioned if they presented to services (Jacoby et al., 2020; Mantovani et al., 2017). Some participants shared their negative experiences of being sectioned with a mental illness, which affirmed their beliefs about the unsafe and discriminatory practices within MHS (Jacoby et al., 2020; Mantovani et al., 2017). This seemed to connect to the mistrust and perceived ineffectiveness of professional help: *"they don't have compassion for people… it's just poor service." (Jacoby et al., 2020, p. 9).* Interestingly, this was not reflected in all accounts; participants who experienced trauma-related difficulties and severe 'depression' expressed a willingness to engage with services despite the perceived barriers (Campbell & Allen, 2019; Jacoby et al., 2020). In Rich et al. (2020), the cost of therapy and lack of health insurance were

reported as barriers to help-seeking over mistrust of professionals. The willingness to engage may have been determined by the severity of their distress which warranted professional input. This demonstrates that even within a homogenous group, factors such as distress severity and socio-cultural factors combine in ways that create pathways to help-seeking or pathways to not seeking help (Linney et al., 2020; Rich et al., 2020). The individual differences reflected within clinical and non-clinical samples may suggest that perceptions and experiences of help-seeking may be moderated by personal factors and societal factors such as social stigma, which are dynamic within and between individuals.

Sub-theme 2: Social Stigma

The interrelationship between social and internalised stigma was explored in six studies (Campbell & Allen, 2019; Jacoby et al., 2020; Lindsey & Marcell, 2012; Linney et al., 2020; Mantovani et al., 2017; Myrie & Gannon, 2013). The impact of social stigma on individuals with mental health difficulties and their communities was deconstructed here:

> *"You are rejected by your own community, by your own environment. They will say you are not useful anymore. Stigma affects [individuals] in terms of denying things"* (Mantovani et al., 2017, p.5).

This extract illustrates the impact of community stigma on the individual in making sense of their experiences and the social consequences of ostracisation and isolation. For some participants, seeking help within their immediate context and professionals came with

intersectional layers of stigmatising positions: being Black, mentally unwell and male, all of which restricted their receptiveness to sharing their difficulties (Campbell & Allen, 2019; Myrie & Gannon, 2013).

The role of internalised stigma and fear of attracting negative labels may help explain participants' tendency to resort to personal coping strategies as a means of conforming to the cultural expectation to "*get on with things" (*Myrie & Gannon, 2013, p.18) but also to offset the adverse effects of social stigma. The interaction between internalised and social stigma was linked to a multitude of social and personal consequences: loss of aspirations (Mantovani et al., 2017), failure to achieve desired levels of success (Bauer et al., 2020) and being ostracised from the community (Linney et al., 2020).

> "*It breaks down communities in terms of communication. It develops – people are isolated. It's almost self-perpetuating; a self-perpetuating snowball. The more it goes on, the less we talk, the less we talk, the more it goes on" (*Mantovani et al., 2017, p. 7).

Similarly, in Bauer et al.'s (2020) study, the personal consequences of social stigma included: habituation to adversity, problem minimisation and concealment of emotions. Interestingly, the older participants in Lindsey and Marcell (2012) did not endorse stigma as a barrier to discussing mental health problems within their networks. This appeared to be mediated by their proximity to people experiencing similar difficulties and their maturity and life experiences. Expressions of indifference to stigma were captured in one account:

"Well, I've been around a lot of people that are mentally ill but I never thought anything

about it. You know, like symptoms and what they had to do and things like that. Yeah, I just

take it as it comes, it's nothing new" (Ward & Besson, 2013, p. 376).

Correspondingly, some participants did not regard stigma as a barrier to help-seeking but the lack of resources and relatable examples of members within the community who had sought professional help (Jacoby et al., 2020). The divergence in views highlighted the role of stigma, particularly the role of generational differences (Campbell & Allen, 2019; Linney et al., 2020), personality characteristics (Bauer et al., 2020), and resources and awareness (Jacoby et al., 2020; Rich et al., 2020) in the help-seeking dynamic. Taken together, the findings in this sub-theme demonstrate that while stigma is a significant barrier, not all individuals are affected by it. However, for those affected, it can have severe implications for their psychological wellbeing. Mantovani et al. (2017) identified the limitations in their study by not eliciting direct responses from those at the receiving end of the stigma. These findings together provide important clinical implications to reduce barriers to help-seeking.

Clinical Implications

The review highlighted some implications for clinical practice and service delivery to understand better the psychological wellbeing and help-seeking experiences of Black men. For example, in Myrie and Gannon (2013), recommendations are made for services to consider moving away from the medical model as a frame of reference for individuals who are 'doubly' stigmatised and attribute their distress to experiences of oppression and discrimination. From an engagement

point of view, some studies highlighted the importance of building trust and confidentiality with Black men by providing safe, culturally sensitive, and relatable approaches. Some studies have highlighted the role of faith leaders and trusted social network members as potential bridges to repairing the pervasive mistrust in professional services. Lastly, the studies demonstrated that a 'one-size fits all' approach cannot effectively meet the needs of Black men as their perceptions and experiences of help-seeking are diverse. To conclude, any attempts to reduce help-seeking barriers may benefit from adopting an intersectional approach.

Evaluation and Conclusions of the Systematic Literature Review

As demonstrated by the previous section, this SLR is believed to be the first of its kind exploring Black men's experiences of mental health help-seeking. A particular strength of all the evaluated studies was the examination of personal, interpersonal, and systemic levels that coalesce in the help-seeking experience. More meaningfully, the studies highlighted the dangers of viewing Black men through a monolithic lens; their views and experiences are heterogeneous. However, the findings must be interpreted with caution as some sample sizes were small and specific to localised populations. Most participants were recruited from non-clinical samples, thus calling to question the representativeness and applicability of the findings to clinical populations. It is worth considering how future studies can expand our understanding of how the key themes of this meta-synthesis would also be reflected in the experiences of people who access formal services.

Several studies were conducted in the USA, which further evidences the lack of research on help-seeking behaviours and experiences of Black men in the UK within the last decade. As mentioned in the earlier parts of the literature search, there are recognised nuances in the British

and American experience, which means that extrapolation from the USA context to the UK can be overlook the unique experiences of Black men (Myrie & Gannon, 2013).

Gaps in the Literature

Several gaps in the literature were identified in this literature review. Many papers explored perceptions of help-seeking, systemic barriers and minimally, the direct experiences of formal help-seeking for psychological difficulties. Many studies examined the barriers to help-seeking, but very few provided qualitative data on receiving formalised support within MHS. The studies that explored help-seeking within a clinical context were based on participants presenting to services under emergency care or in the secondary stages of their mental health difficulties. Many studies were conducted on older Black men with smaller numbers from YBM, who are often over-represented on the acute end of the mental health system (Keating, 2007). The absence of research of YBM's experiences within primary care, particularly psychological therapy presents an unique opportunity for this project to close the gap by exploring formal help-seeking within these contexts.

The Rationale for the Current Research Project

The current project aims to explore the experiences of YBM's experiences of formal help-seeking through the medium of psychological therapy. A further objective is to gather direct evidence of YBM's experiences of the therapy, potential issues and opportunities to inform good practice. Furthering our understanding of YBM accessing and engaging in therapy in primary care settings may curtail the current trend of accessing to mental health support through compulsory and punitive routes. Lastly, the secondary aim is to provide clinical implications for policymakers,

service providers and Clinical Psychologists (CPs) to improve the accessibility, support, and engagement of YBM in empowering and humane routes to psychological care.

Aims of the Research and Research Questions

This research aimed to examine YBM's experiences of psychological therapy through the following question:

What are young Black men's experiences of formal help-seeking for psychological distress?

Three further sub-questions were explored:

1) *What are the mediating factors that influence YBM's relationship with formal help-seeking?*

2) *What are YBM's experiences of accessing psychological therapy?*

3) *What are YBM's experiences of engaging in psychological therapy?*

CHAPTER 2: METHOD

Chapter Overview

This chapter outlines the method used to investigate the research questions. The research design is discussed, including the justification for TA and the epistemological choices. Information regarding the recruitment process, participant sample and data collection process will be presented. Professional and service user consultation (SUC) is reported in the context of developing the project. This chapter also reflects on and addresses ethical issues. The concluding section outlines the data analysis process and a quality appraisal of the current study.

Design

Qualitative Methodology

Qualitative research methods explore the quality and texture of people's subjective experiences rather than the cause-and-effect relationship (Willig, 2008). Researchers using a qualitative methodology focus on the meanings people attribute to events; they acknowledge that the process of interpreting these events is actively co-constructed with the participants (Taylor & Ussher, 2001). Qualitative research offers a unique and theoretically robust framework where subjective experiences can be studied in a way that is difficult to contextualise using quantitative research methodologies (Denzin & Lincoln, 1994).

The Rationale for a Qualitative Design

An in-depth review of the literature and extensive searches revealed a dearth of research looking into YBM's qualitative experiences of formal help-seeking. This knowledge gap provided a unique opportunity to explore the experiences of a marginalised and under-represented population within the mental health research arena. A critical realist framework was congruent with the research objective of gaining a better understanding of Black men's experiences while acknowledging my limitations in having direct access to their reality. I knew that to interpret the reality presented in the data, meeting participants face to face (albeit virtually) would provide an intimate opportunity to directly capture their subjective 'feel' of accessing and engaging with services. I was cognisant of the restrictions of using quantitative research as voices tend to be reduced to numerical data, which would limit the ability to make sense of individual experiences and structural forces that influence YBM's help-seeking experiences. The notion of 'giving voice,' commonly cited as a strength of empirical research, presented an ethical and methodological tension. Regardless of my intentions as a researcher, hierarchies of power and privilege are re-inscribed when the presumption of 'giving voice' to someone else is made. Black men have strong and audible voices but often denied acess to opportunities/platforms to be heard.

The central feature of CR is to provide an interpretation of reality through various lenses (Fletcher, 2017), which separates CR from 'naïve realism' where the researcher believes they 'give voice' to their participants (Braun & Clarke, 2006). I addressed the potential power differential inherent in the claim to 'give voice' by re-framing the project's unique opportunity to *amplify* YBM's voices and potentially challenge dominant cultural narratives held about YBM using appropriate qualitative methodologies to interpret their reality.

Consideration of Alternative Methodologies

I considered IPA and narrative analysis (NA) as potential methods for exploring the research question due to their interest in understanding in-depth, subjective experiences. An IPA approach is theoretically bound; it usually requires a smaller sample (6-8 participants) to explore how individuals make sense of their personal and social reality (Smith & Osborn, 2003). This methodology was unsuitable for the study's objectives due to IPA's strong interpretative nature and idiographic focus on the individual characteristics of participants. Due to the limited literature on YBM's experiences of psychological therapy, it seemed more appropriate to gain a larger sample and focus on searching for patterns across participants' narratives.

Narrative Analysis was also considered as it explores stories that people tell and how they tell them to help organise and make sense of their lives (Riessman, 2008). There is also a focus on the personal stories that are privileged over others (Wells, 2011). While acknowledging the importance of Black men's narratives, the primary aim of the research was to collate shared patterns of meaning on a particular experience rather than *'extended accounts of experience'*(Riessman, 2008; p.7). Of the qualitative methodologies considered, TA appeared to be fitting to address the research questions.

Thematic Analysis

I selected TA (e.g., Braun & Clarke, 2006) for the following reasons: theoretical flexibility, transparency, and suitability to large data sets. TA is a method of recognising and analysing patterns of meaning in a qualitative data set (Braun & Clarke, 2006). Thematic analysis is rooted in the older tradition of content analysis, which has been described to form the basis of qualitative

research in humanities (Smith, 2000). Braun and Clarke (2006) argue that TA should be considered a stand-alone analytic method due to its ability to identify, organise, describe, and report patterns of meaning across a data set. Thematic analysis illustrates these patterns in detail with interpretations used to make sense of diverse subjects (Boyatzis, 1998). Furthermore, TA's focus on understanding *'repeated patterns of meaning'* across a data set (Braun & Clarke, 2006. p.16) aligned with the study's objective of finding shared meanings in Black men's experiences of psychological therapy through *"careful reading and re-reading of the data"* (Rice & Ezzy, 1999, p. 25).

Through its theoretical freedom, TA rejects methodological boxes as typically found with other qualitative methods. This level of flexibility allows researchers to tailor the approach to the needs of their study (Braun & Clarke, 2006; Willig, 2013). Moreover, TA aligns with a CR paradigm. It can go beyond observable material to more implicit thematic themes acknowledging the power structures and relations that impact the meanings co-created by the researcher and participants (Braun & Clarke, 2006; Kiger & Varpio, 2020).

Thematic analysis takes two forms: an inductive 'bottom-up approach" where the themes are drawn from the raw data (e.g., Crabtree & Miller, 1999) and a theoretical or deductive "top-down" approach which is drawn from pre-existing theories and literature (e.g., Boyatzis, 1998). As the current project explored a novel area of research, I adopted an inductive 'bottom-up' approach to allow creative and fluid interpretation of the data and theme construction with minimal pre-conceptions. Engaging in existing literature may have hindered the process of making fluid interpretations of the data. However, due to my position as a Black researcher and clinician with influential relationships with Black men, it is impossible to divorce from my personal, theoretical,

and epistemological commitments,which undoubtedly influenced my relationship with the research process. Furthermore, engaging in previous literature enhanced the analysis by increasing sensitivity to more subtle features of the data (Tuckett, 2005). Engaging in bracketing interviews (Creswell & Miller, 2000) and reflective diaries were useful transparency tools to surface the influence of my interconnected identities and subjectivities on the analysis process.

In the analysis stages, themes are identified at two levels: a semantic (explicit) and latent (interpretative) level (Boyatzis, 1998). The semantic level remains at the descriptive level; the themes are identified based on participants' accounts without going beyond the *"explicit or surface meanings of the data"* (Braun & Clarke, 2006, p.84). On the contrary, the latent level seeks to theorise the significance of the patterns in content to examine underlying assumptions, broader meanings, and ideologies (Braun & Clarke, 2006; Patton, 1990). In this project, the analytic process progressed from the *descriptive* (semantic level) to the *interpretative* (latent level). This approach aligned with the CR 'contextualist' stance to theorise the social-cultural and historical contexts that govern the narratives shared (Willig, 1999). These considerations require a reflexive stance to be adopted while considering the strengths and weaknesses of TA.

Strengths and Weaknesses of Thematic Analysis

Thematic analysis is one of the most systematic and transparent forms of data analysis (Harper & Thompson, 2012). The transparency in the analysis process enables other researchers to rigorously interrogate steps undertaken by the primary researcher (Kiger & Varpio, 2020). A huge component of maintaining this transparency is owning the theoretical assumptions informing the use of TA by consistently enacting these through the analytic process and reporting of the

findings (Braun & Clarke, 2019). Through its theoretical freedom, TA does not require detailed theoretical and expert knowledge of other qualitative approaches. It offers an accessible and user-friendly form of analysis, particularly for early career researchers (Braun & Clarke, 2006).

Despite gaining popularity over the years, TA lacks clarity around conducting a rigorous analysis, which has been described as disconcerting for novice researchers (Nowell et al., 2017). This presents considerable challenges around consistency and coherence as the flexibility afforded by the method leaves it open to interpretation among qualitative researchers. However, Braun & Clarke (2006) have responded to this criticism by producing detailed guidelines on the six phases of analysis which have been disseminated and multiply cited within psychology. Additionally, Holloway and Todres (2003) argue that consistency concerns can be remedied by being explicit about the epistemological position underpinning the study claims.

Another disadvantage of TA compared to other methodologies such as NA and IPA is that it does not make any claims about the use of language in participants' accounts. The language that participants use to describe their experiences plays a significant part in constructing meanings and their attributions (Willig, 2008). On the contrary, CR challenges the use of discourse as the primary unit of analysis and argues that there is a material dimension to our lives that is partially non-discursive (Sims-Schouten et al., 2007). Critical realism as a framework is methodologically aligned with TA as the flexibility works well to unravel the surface of 'reality' and the underlying ideologies that inform the semantic content of the data (Braun & Clarke, 2008). The weaknesses of TA can be avoided by applying existing quality criteria that examine the rigour, trustworthiness, and credibility of the findings (Lincoln & Guba, 1985).

Data collection

Semi-Structured Interviews

In qualitative research, semi-structured interviews are the most widely used data collection method due to their compatibility with several forms of data analysis (DiCicco-Bloom & Crabtree, 2006; Willig, 2008). The interview as a research method is a purposeful data generating activity, characterised by *"understanding the lived experience of other people and the meaning they make of that experience'* (Seidman, 2006, p.9). A key benefit of semi-structured interviews is the practical ease of conducting them compared to other methods such as participant observation and diary-keeping, which require negotiation of access and commitment from participants. Potter and Hepburn (2005) challenge the validity and authenticity between the researcher and interviewee, resulting in data being taken at 'face-value'. However, it becomes less of a problem if the interviewee's words are not accepted as a direct reflection of their thoughts and feelings but as an interpretation of their reality. Lastly, semi-structured interviews were selected to allow for improvisation (Lewis-Beck et al., 2012) and space to follow topical trajectories as the conversation unfolded (Magaldi & Berler, 2020). Details of the interview schedule, including service user involvement, will be presented in the next section.

Devising the Interview Schedule

The interview schedule was developed to cover various themes about the therapy experience from initiating the process, progressing through sessions, and reflecting on the endings. The interview schedule was designed to be open and flexible to allow participants to raise any concerns or topics that resonated with their experiences (Whiting, 2008; Willig, 2008). I followed

the five-phase guide developed by Kallio et al. (2016) in response to the lack of a uniform, international protocol for designing a semi-structured interview. The full details on the steps followed are outlined in Appendix A. The final interview schedule can be found in Appendix B.

1. ***Phase One:*** *Identifying the prerequisites for using semi-structured interviews*

2. ***Phase Two:*** *Retrieving and using previous knowledge*

3. ***Phase Three:*** *Formulating and preliminary semi-structured interview guide*

4. ***Phase Four:*** *Piloting the interview guide*

5. ***Phase Five:*** *Presenting the semi-structured guide*

The formulation and piloting stages were conducted with professional consultants and SUC' s as outlined in the next section.

Professional and Service User Consultation

Professional Consultation

A professional consultation session was undertaken in February 2020 with a Principal Clinical Psychologist working in an NHS service for ethnic minority communities. The consultation involved discussing the project's aims, designing the interview schedule, and maximising recruitment outside of statutory services. The consultant also provided some useful contextual information about various initiatives geared at tackling inequalities in accessing primary care psychological therapies. Lastly, the professional consultant advised me to widen my research lens to include attitudes to help-seeking (via online questionnaires) and explore sources of informal support such as church leaders and community groups. In the later stages of the project, a Black male CBT therapist working within primary care played an instrumental role in validation checks, analysis and disseminating the findings.

Service User Consultation

The importance and benefits of involving service users/clients and carers in the research process have been stated by the DoH (DoH, 1999, 2000). In a recent SLR exploring the impact of service user involvement in research, Minogue et al. (2002) concluded that the benefits for service users were multi-fold, principally: gaining new knowledge, improving the sense of wellbeing and increasing self-esteem and confidence. Service user involvement was an integral part of designing, recruiting, analysing, and disseminating the project to ensure YBM's voices were centered throughout the research process, as stakeholders offering expertise by experience.

Piloting the Interview Schedule

Three male SUC's (2 Black African, 1 White Irish) were involved in the design and piloting of the interview schedules. The first stage involved connecting with one SUC who shared his experiences of using psychological therapy. He provided valuable insights into his previous involvement with commissioners and service providers in designing and delivering primary care services. The SUC emphasised the importance of maximising the sample size for credibility purposes and renumerating participants for their time considering their emotional labour and the historical mistrust in research engagement (e.g., Scharf et al., 2010). Both suggestions were incorporated into the project proposal and approved by the research team. All SUC's were compensated for their time and involvement in the consultation process.

The next stage involved designing the interview schedule. A draft copy of the interview schedule was sent to two SUCs via email for initial reactions and feedback. Further meetings were set up on Zoom to discuss each section of the interview. The consultants commented on the interview length and made suggestions to collapse the questions into themes to help streamline the interview. The final stage of the design process involved a virtual pilot interview with the third SUC. The feedback from the pilot interview was positive, although suggestions were made to incorporate more follow-up questions to elicit in-depth answers from the participants.

Participation Criteria

To ensure homogeneity in the sample of participants, inclusion and exclusion criteria was set out as shown in Table 6. Participants who self-identified as Black African and Caribbean men aged the ages of 18-35 were included. Being a resident in the UK was stipulated as a prerequisite

to account for potential extraneous factors in the experiences of psychological therapy outside the UK healthcare system. Participants were required to have completed at least six talking therapy sessions in line with good practice guidelines (NCCM, 2019). The minimum quantity of sessions and requirement to be out of therapy were also stipulated to allow participants to share and reflect on the breadth and depth of their therapy experiences. Participants who received therapy in secondary care services were excluded as this would signify severe and complex mental health difficulties. The research aimed to explore experiences of accessing and receiving therapeutic support in the primary stages of psychological distress. Lastly, the time since receiving therapy was restricted to the last three years to increase the credibility and relevancy of the findings to a more contemporary context and to optimise memory recall (Tulving & Thomson, 1973).

Table 6

Participant Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion criteria
- Between the ages of 18-35 - Self-identifies as African, or African-Caribbean or Mixed Heritage (White and Black African/Caribbean). - Based in the UK - Received six or more sessions of individual talking therapy sessions in primary care - NHS,	- Under 18 - Received therapy outside of the UK - Received therapy in a secondary care service - Currently experiencing severe mental health difficulties - Currently in therapy - The participant is personally known to the researcher

private providers and third parties
(i.e., charity sector)

- Received therapy in the last three
years

Recruitment

Purposive sampling was used to recruit eligible participants. This technique is used in qualitative research for *the identification and selection of information-rich cases"* (Palinkas et al., 2015, p. 2). The recruitment process took place between June 2020 – December 2020. Posters seeking research participants were advertised on Facebook, LinkedIn, and Twitter using accounts explicitly created for the research project. Research posters were also sent to local grassroots organisations known to work with YBM (see Appendix C). A snowball approach was also employed to recruit further participants. Participants were asked to share the study details with their peers who shared the same characteristics and were interested in taking part in the research (Berg, 2014; Patton, 1990). Twenty people expressed an interest in the project. Thirteen participants were eligible for the study following the screening process outlined in Figure 3.

Figure 3

Participant Flowchart

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┌─────────────────────────────────────────────┐
│         Expressed an interest (n=20)          │
└─────────────────────────────────────────────┘
              │
              │              ┌──────────────────────────────┐
              │─────────────▶│ • Did not meet inclusion     │
              │              │   criteria (n=4)             │
              │              │ • Did not respond to follow  │
              │              │   up emails (n=3)            │
              │              └──────────────────────────────┘
              ▼
┌─────────────────────────────────────────────┐
│ Confirmed eligibility criteria and            │
│ participated in study (n=13)                  │
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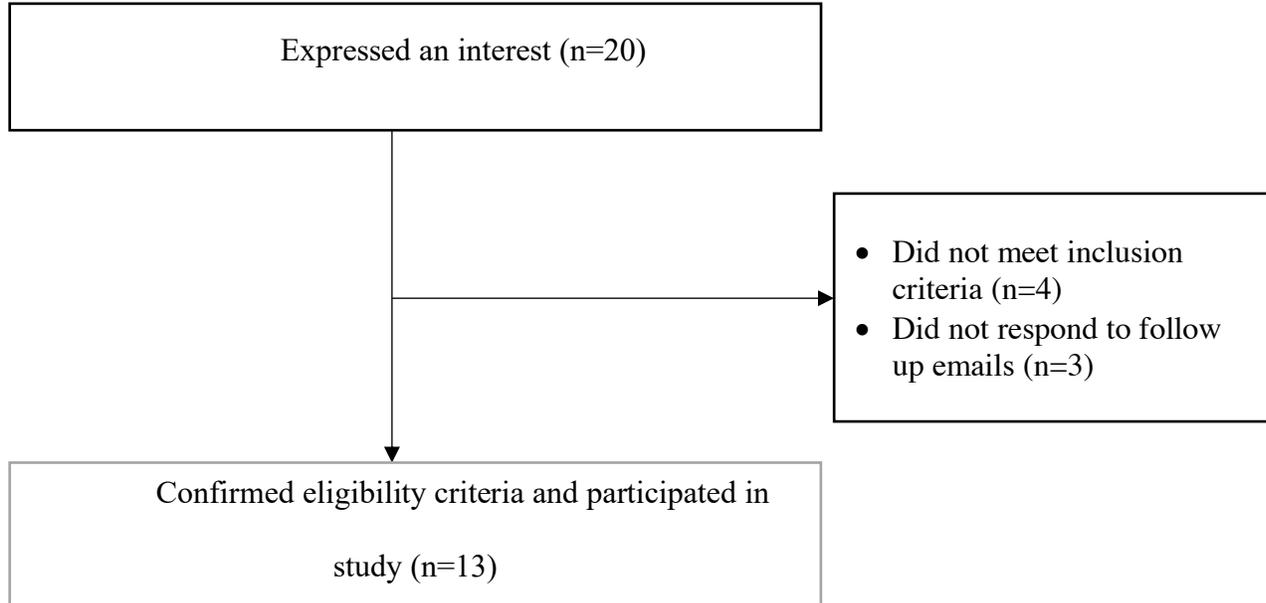
Participant Demographics

The sample consisted of 13 males between the ages of 24-33 years old. The mean age was 29 (SD = 2.87). All participants self-identified as Black British (n=10 Black African; n=2 Black Caribbean; n=1 Black Other). Participants self-selected their pseudonyms to preserve confidentiality and anonymity. The demographic and therapy details of each participant are summarised in Table 7. All participants were based in the South East of England and were all employed in professional occupations. All bar one participant was educated to undergraduate level, and four held a Masters' degree. Most participants identified as Christian, two were non-affiliated, and one was Muslim.

Table 7

Demographic Characteristics of Study Participants

Participant pseudonym & Ethnicity	Country of Birth	Type of service (NHS/Private/Third party)	Therapy modality	Type of referral	Time taken to access services
Victor Black African	Nigeria	NHS & Self-funded	Person-centred therapy & CBT	Self-referral	4 weeks
Nathan Black African	Nigeria	Private via workplace	CBT	Workplace wellbeing coach	6 weeks
Anthony Black African	England	Private – self-funded	Integrative Counselling	Self-referral	7 years
King Black Caribbean	Togo	Third-party-charity sector	Bereavement counselling	GP referral	1 year
Maxwell Black African	Zimbabwe	Private – self-funded	CBT	Self-referral	3 months
Edem Black African	United Kingdom	Third-party-charity sector	Psychodynamic therapy	GP referral	5months
Romeo Black African	Nigeria	Private	Integrative Psychotherapy	Self-referral	1 year
Ken Black Other	United Kingdom	Private	CBT	Self-referral	5 years
Dr Stone Black African	France	Private – medical insurance	Unknown	GP referral	3-4 years
Tom Black African	United Kingdom	NHS	Counselling	GP referral	4-5 years
Edison Black Caribbean	United Kingdom	NHS	CBT	Christianity	n/a
Spiela Black African	United Kingdom	Private via health insurance	Unknown	Health insurance check	2-3 years
Kojo Black African	United Kingdom	NHS & Self-funded	CBT	GP referral	3 years

Ethical Considerations

The University of Hertfordshire Health and Science Engineering and Technology department granted ethical approval for this project; Protocol number: LMS/PGT/UH/04147 (Appendix D). An amendment to change the interviewing method from face to face to a virtual platform was submitted and granted. The amendment also included a request to use third-party transcription services (Appendix E). The Code of Human Research Ethics (British Psychological Society, 2014) was used to ensure the project adhered to the ethical guidelines.

Informed Consent

All participants were provided with the information sheet upon expressing their interest in the project (Appendix F). The information sheet outlined the project aims, the commitment required to participate, the risks benefits, and how their data would be stored. Participants were invited to ask any questions about the information sheet before being sent the consent form to participate. Consent forms (Appendix G) were sent electronically: participants retained one copy, and the researcher stored the other securely. At the beginning of the interview, the consent form was re-visited, and further verbal consent was sought to audio-record the interview.

Confidentiality/Anonymity

Data was collected and managed according to the Data Protection Act (Parliament of the United Kingdom, 2018). The information retrieved from the demographic questionnaire (Appendix H) was pseudo-anonymised, downloaded and stored onto an encrypted hard drive. Transcripts containing identifying information were pseudoanonymised. Additional security was

implemented by allocating a unique code to each transcript to ensure that only the researcher could identify the participants. Participants were informed about the parameters of confidentiality as outlined in the consent form (Appendix G). They were informed that their data would be kept confidential unless in the event of safety concerns. The data safeguarding steps were outlined in the information sheet.

Right to Withdraw

Participants were reassured that withdrawing from the project would not negatively affect their involvement or participation in future projects. Participants were informed about their right to withdraw their data at any time up to a month after participating. The time to withdraw was stipulated because transcribed data could not be removed from the analysis once their data was included in codes and themes. The deadline to withdraw demographic details and other identifying information was September 2021.

Risk of Physical and Psychological harm

It was anticipated that some of the topics raised in the interview could potentially cause psychological distress for participants. Participants were being asked sensitive and potentially traumatising questions regarding their experiences of psychological therapy. I was also conscious that the interviews were conducted during the height of the BLM civil rights movement following the murder of George Floyd. Aware of the social-political context and the potential emotional impact, extra caution was taken to safeguard participants from distress. Participants were informed about their right to skip questions or stop the interview if they did not feel comfortable.

Due to the limited verbal and social cues in a video interview, I took conscious steps to pause frequently and allow participants to process and respond to the questions. Space was given for participants to share their reflections and experiences of the interview and to ensure they could share any concerns and receive support, if necessary, before terminating the interview. The final part of the interview involved debriefing (Appendix I) and sharing mental health support information, including specific mental health charities supporting the Black community (Appendix J).

Procedure

The research procedure is outlined in Figure 5. Participants were sent the information sheet and an eligibility questionnaire via email. Participants who met the inclusion criteria were sent a study invitation. Due to the restrictions of the COVID-19, all interviews were conducted online or over the telephone for health and safety purposes. In the invitation emails, participants were sent a consent form and a link to a calendar booking system to choose their preferred date and medium of contact. Participants who opted for a Zoom call received an encrypted auto-generated link for the interview. Those who opted for a telephone call were asked to provide their contact details. A link to the demographic questionnaire (Appendix H) was also embedded in the email; once completed, all data was downloaded and saved on an encrypted hard drive for General Data Protection Regulation purposes.

On the day of the interview, participants were asked for verbal consent to record at the beginning of the interview. To safeguard participants' wellbeing, they were reassured with the confidentiality statement and informed that they did not have to answer all the questions if they felt uncomfortable. They were also informed about their rights to take a break and withdraw from

the interview at any point. The interview schedule was used to guide the conversation with a degree of flexibility in response to the material raised by the participants. The interviews were conducted virtually, lasting between 30-60 minutes. Concerns about conducting remote interviews, i.e., lack of social and visual cues (Carr & Worth, 2001), were acknowledged and mitigated by allowing additional time for the interview and providing many opportunities to check-in. In line with the findings of a recent literature review (Archibald et al., 2019), many participants found the Zoom interface accessible, flexible, and familiar as they had transitioned to this mode of working due to the global pandemic.

At the end of the interviews, participants were given a debrief sheet, mental health support information and offered a £10 Amazon voucher as remuneration. Audio files were transcribed to text; three interviews were transcribed by the primary researcher, and the rest by a professional transcription under a non-disclosure agreement (Appendix K). All transcripts were listened to and manually checked for accuracy. Once transcribed, all audio files were deleted from my personal computer and hard drive. Transcripts were imported into NVivo 12 (QSR International Ltd, 2018) and analysed using TA.

Figure 4 *Procedure Flowchart*

Participants sent information sheet and eligibility screening questionnaire

Participants booked a video/telephone interview slot on a calendar booking system. Participant completes a demographic questionnaire and consent form.

Participant invited to interview. Location, date, time were confirmed via email.

Consent form received and re-visited. Interview takes place via telephone/Zoom using interview schedule (audio recorded).

Debrief sheet, support information and Amazon voucher were issued. Participants are given an opportunity to ask questions.

Demographic information and audio recordings were pseudoanonymised. Demographic forms, consent forms, audio recordings were stored on an encrypted hard drive

Audio recordings transcribed to text by author and professional transcription service who signed a non-disclosure agreement

Transcripts were checked for accuracy, amended and imported to NVivo 12

Data analysed using Thematic Analysis

Data Analysis

Braun and Clarke (2006) outline six phases of completing a TA, which can be applied flexibly to fit the research question and data. An inductive thematic analysis was followed in the TA as outlined in the methodology section. The phases that were observed to make sense of the transcribed data are outlined in Table 8. The quality assessment of the TA was checked against a 15-point checklist (see Appendix L).

Table 8

Six Phases of Thematic Analysis (Braun & Clarke, 2006)

Phases of Thematic Analysis	Analysis Steps
Stage 1: Familiarisation with the data	The audio recordings were reviewed, and the transcripts were read repeatedly. This process was enhanced by marking ideas for coding and recording initial reflections to identify ideas or patterns for potential codes or themes.
Stage 2: Generating initial codes	Initial codes were inductively generated from the transcripts using NVivo 12 (Appendix M). Co-occurring codes were automatically stored on the software and used in subsequent data sets. An iterative and non-linear process was followed to maintain a dynamic and active process. Reflective notes containing interesting observations were kept. Initial codes were sent to an external reviewer for validation (Appendix N).

Stage 3: Searching for themes	Codes were grouped (Appendix O), exported onto an excel spreadsheet, printed out and manually organised into broad themes (Appendix P). The process was experimental and recursive, with some themes being discarded or merged, and others were kept and represented as sub-themes. The 'candidate themes' and 'sub-themes' across the data set themes visually represented to prepare for the refine and review process.
Stage 4: Reviewing and refining themes	Themes were refined to represent a coherent narrative within the dataset (Appendix Q). The 'candidate themes' were first reviewed with the supervisory team and latterly checked with five participants via member checking (Creswell & Miller, 2000). Participants' valuable feedback helped to refine and re-name some of the themes/sub-themes. Each theme was scrutinised and checked for coherence to ensure that it captured the essence of the participants' narratives and the data corpus.
Stage 5: Defining and finalising themes	The overarching themes were refined into specific and concise themes/sub-themes represented in a preliminary thematic map (Appendix R). A 15-point quality checklist (Braun & Clarke, 2006; Appendix L) was used to ensure that the extracts had a rich and coherent analytic narrative capturing the data's overall narrative. The thematic map was further refined to ensure the specificity and preciseness of the themes. The final thematic map is represented in the Chapter 3.

Stage 6: Writing the report	The report synthesised the narrative accounts under the main themes supported by extracts to demonstrate their prevalence within the data set, including deviations and commonalities.

Quality, Validity and Self-reflexivity

In this next section, the quality appraisal of the project and my positioning within the project will be presented.

Assessing the Quality of the Current Research Project

Notions of reliability, validity, and replicability universally applied to evaluate quantitative research are not fitting for a qualitative research paradigm as they are rooted in a positivist paradigm (Smith, 2003). For this reason, the CASP (2018) criterium used in the SLR were used to evaluate the quality of the current study, as illustrated in Table 9.

Table 9

Assessment of the Quality of the Current Research using (CASP 2018) Criteria

Criteria for Quality (Y= Yes N= No? = Cannot tell)	Criteria	Evidence for meeting the CASP criteria
1. Is there a clear statement of the aims of the research?	Y	The objective of this project was to explore YBM's experiences of accessing and engaging psychological therapy in primary care settings. The Aims of the research and research questions were clearly stated in Chapter 1.
2. Is a qualitative methodology appropriate?	Y	A qualitative methodology was deemed appropriate for gathering the experiences of YBM using open-ended and explorative questions. The methodology also enabled a flexible stance to be adopted by responding and adapting to the data gathered and informing the data collection process. This iterative approach allowed for rich, in-depth and nuanced accounts to be collected.
3. Was the research design appropriate to address the aims of the research?	Y	The SLR findings indicated the lack of research on the qualitative experiences of YBM accessing and engaging in psychological therapy. A qualitative methodology was deemed appropriate to address the research objective as a gap was identified in the literature. Additionally, TA was selected due to its atheoretical, flexible and transparent stance. The use of SUC's and pilot interviews also confirmed the importance of adopting a qualitative research design for the topic under investigation.

4. Was the recruitment strategy appropriate to the aims of the research?	Y	The project utilised a hybrid approach of purposive and snowball sampling to maximise the recruitment of participants. A snowball approach was used as referrals from trusted sources may help generate interest and uptake research participation (Berg, 2014).
5. Was the data collected in a way that addressed the research issue?	Y	Participants were offered an opportunity to be interviewed via a video interface or telephone to allow for in-depth, open-ended questions to be asked using a semi-structured interview. This data collection format gave participants space to freely express their experiences and respond to the questions posed with flexibility. The data collection process is outlined in detail in the early parts of this chapter.
6. Has the relationship between the researcher and participants been adequately considered?		Given my 'insider-outsider' positionality as a researcher, it was essential to situate myself transparently and use different methods to surface my personal biases and subjective influences. These aims were achieved by positioning self in the introduction chapter, regular supervision, consultations with service users, inter-rater coding, a research diary (Appendix T), reflective notes/observations, and member checking sessions.
7. Have ethical issues been taken into consideration?	Y	Ethical issues are reflected on and addressed throughout, although specifically in the Ethics section of this chapter. A thorough risk assessment considering situational, environmental, and psychological risks to participants was conducted and approved by the Ethics Committee. Ethical amendments were made to respond to the situational changes in the project.

8. Was the data analysis sufficiently rigorous?	Y	A rigorous and in-depth analysis process was followed in the analysis section, which outlined the recursive steps observed to reach the final themes. The analysis involved extracting quotes representing the theme and subsequent sub-themes while also presenting extracts that deviated from the dominant story. I facilitated a member checking session with participants to check that the findings were consistent, and representative of the accounts shared in the interviews.
9. Is there a clear statement of findings?	Y	The discussion chapter begins with a summary of the research findings concerning the primary and secondary research questions.
10. How valuable is this research?	Y	This study is the first of its kind, looking specifically at YBM's experiences of accessing and engaging with psychological therapy in primary care. The findings contribute to the literature by providing an account that deviates from the dominant narrative of Black men being 'hard to reach' and challenging to engage. The research humanises Black men and provides the multiple facets that influence their relationship to help. Overall, the study offers important implications for CPs, mental health practitioners, service providers, and commissioners to re-orient and re-model mental health services to fit the unique psychological needs and respond to the challenges faced by YBM.

Self-Reflexivity

One of the essential elements of reflexivity is examining our social identity and how it interacts with the population under study (Day, 2012; Jacobson & Mustafa, 2019). As a young Black African woman and a mental health professional, I bring many personal biases to this project. I considered my position as an 'Insider-Outsider' (Dwyer & Buckle, 2009) researcher and the impact on how I approached, interacted with, and interpreted the findings. I reflected on the 'insider' privilege of 'race' and age proximity to foster trust and openness with the participants (Serrant-Green, 2012). On the contrary, I considered the potential bias to pursue subjects or topics of personal interest as an 'outsider' academic researcher and clinician. To aid the process of being transparent about aspects of my identity and the values and opinions that influenced the project, I completed two tiers of the "Social Identities Map" (Jacobson & Mustafa, 2019), as seen in Appendix S, reflecting the subjectivities I brought to the research. I have included excerpts from my reflective diary from various stages of the research process, including the analysis and interpretation of the results (Appendix T). Supervision from the research team helped consider my position within the construction of the research, from inception to the write-up phases. Space was given to reflect on the assumptions and prejudices that I brought to the study and for the research team to be transparent about their positions concerning the population under investigation.

CHAPTER 3: FINDINGS

Chapter Overview

In this chapter, the findings from the TA will be presented. Four themes and eleven sub-themes were constructed from the data as shown in the thematic map (Figure 5) and table of themes (Table 10). The themes will be elaborated on using verbatim extracts from anonymised interview transcripts.

Figure 5

Thematic Map of Themes and Sub-themes
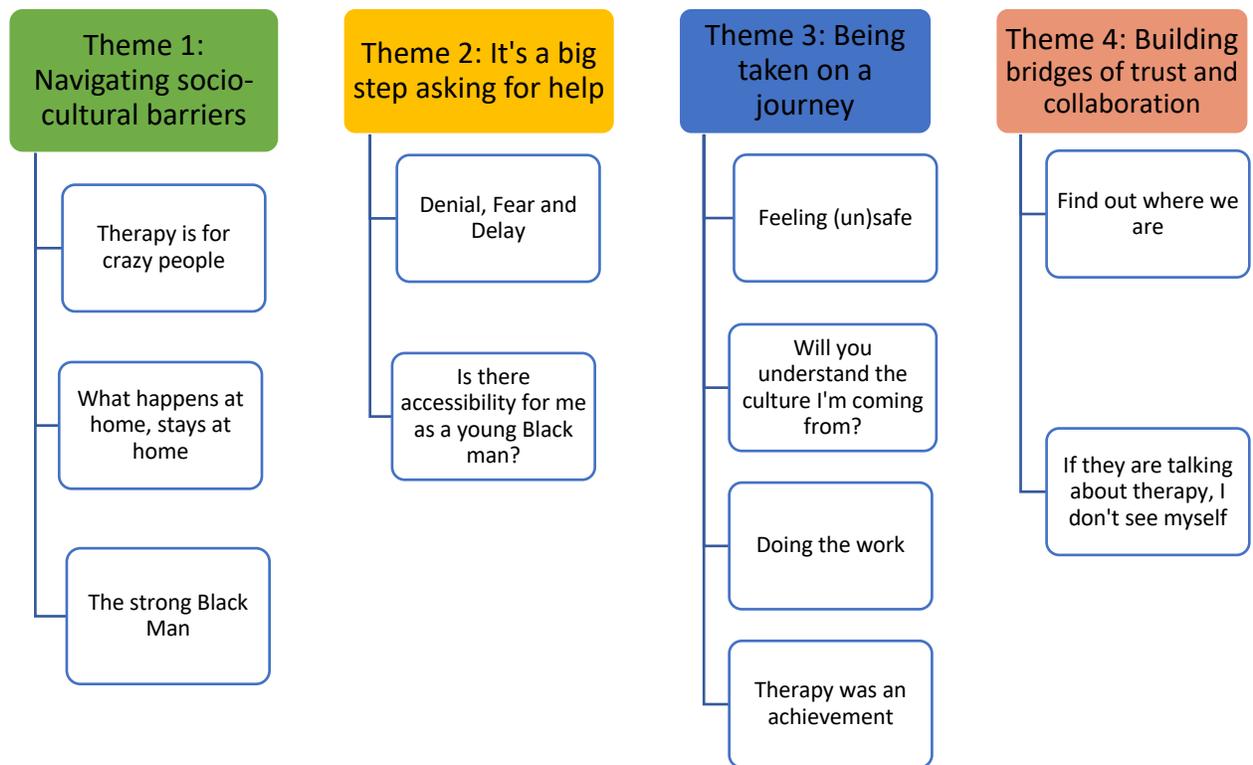
Table 10

Table of Themes from the Current Study

Theme	Sub-themes
Theme 1: Navigating socio-cultural barriers	1. *Therapy is for crazy people* 2. *What happens at home, stays at home* 3. *The strong Black man*
Theme 2: It's a big step asking for help	1. *Denial, fear, and delay in help-seeking* 2. *Is there accessibility for me as a young Black man?*
Theme 3: Being taken on a journey	1. *Feeling (un) safe* 2. *Will you understand the culture I'm coming from?* 3. *Doing the work* 4. *Therapy was an achievement*
Theme 4: Build bridges of trust and collaboration	1. *Find out where we are* 2. *If they are talking about therapy, I don't see myself*

Note on symbols:
(…) indicates words that have been omitted from the quote
(-) signifies pauses in speech
[ ] indicates words that have been added to improve clarity

Theme 1: Navigating Socio-Cultural Barriers

This theme explored the social and cultural barriers that influenced participants' understanding of psychological distress, relationship to seeking help and relationship with the therapist. "*Therapy is for crazy people*" explores the societal stigma attached to therapy. "*What happens at home, stays at home*" describes the socialisation and cultural scripts that discourage seeking external help. "*The strong Black man*" captures the intersecting and conflicting subject positions of being a Black man seeking and engaging in therapy while contending with masculinity and societal norms that promote self-reliance.

Sub-theme 1: Therapy is for Crazy People

Within this sub-theme, several participants described the social stigma that surrounds accessing therapy and the prevalence of negative narratives which act as a barrier to engagement:

Naithan: Things that could get in the way is the stigma first of all, yeah. Touching on that, I just think it's still viewed in probably a negative light. As much as we may talk about it

now, I don't think it really, it's emphasised just the importance of it or what it's for. (…) I know a lot of guys (…) they'll see mental health or therapy as a means of like when you've literally gone crazy kind of thing. (…) I think it's how it's portrayed within the black community to an extent.

Here, Naithan alludes to the lack of education and awareness around therapy, perpetuating the disquiet and stigma around it. Another participant shared this perspective and described how societal stigma towards therapy contributed to a three-year delay in seeking help:

Interviewer: You said you waited years, 4 years did you say sorry? What do you think kind of delayed that process?

Dr Stone: You want me to be honest, negative perception of therapy? (…) I thought that therapy was reserved to people who had serious, let's say, mental health issues, maybe going through some form of depression. So I would say almost, I felt like I was above therapy. Or I could self-help myself.

Victor described masculinity norms interacted with self-stigma around seeking therapy. He also alluded to the consequences of these social discourses, which can be confusing and conflicting:

I guess there is stigma as well like there are discourses on what it is to be a man or, for example, being emotional or like sensitive. So, there could be some self-stigma as well that I'm I so bad that I need therapy?

Several participants offered explanations for this prevalent stigma which included unfamiliarity with the therapy process, preference for self-reliance and the promotion of spirituality and prayer for resolving psychological distress. Spiela described the cultural scripts around those deemed eligible for therapy, namely White people. For him, asking for help carried negative connotations of being unwell, which he described to linked to limited knowledge about therapy.

Spiela: We've always been taught that therapy is a taboo, and it's something for White people. It's not for us, we are fine. (…) I feel (...) that ignorance of not knowing what therapy is and what it can do (…) you associate with it if there's something wrong with you.

One participant made an interesting point about the role of the media in perpetuating warped perceptions of therapy which fuelled stigmatising attitudes to therapy. The absence of role models or examples to draw from within Tom's local context contributed to the mystery and apprehension around seeking therapy:

Tom: The way people have to see it is that therapists are only ever seen realistically on TV (...) no one ever has any other version of what therapy is. (…) [Growing up], I didn't know anyone who went to therapy. None of my family, even in my church, no one went to therapy. (…) So that apprehension of what you see [is] that if you have therapy, you're crazy or there's something wrong with you.

The presence of role models and examples to draw from was an important conduit for de-stigmatising therapy for Naithan, who described his experience of engaging in dialogue with a friend:

Naithan: I [think] like our friendship actually grew from that conversation. I think it just lifted up this lid of not awkwardness but this lid of I guess shame when it comes to talking about therapy amongst men.

In sum, this sub-theme captures two layers of stigma: individual and societal stigma, which exists in the context of societal and cultural portrayals of therapy. Participants highlight the role of these discourses on their openness to engage with therapy and pointed to the factors that perpetuate stigma with the Black male community.

Sub-theme 2: What Happens at Home, Stays at Home

This sub-theme captured different socialisation scripts which surrounded participants' upbringing and shaped their relationship with emotionality and vulnerability. Kofi described his social environment growing up, which included the rules around privacy and the importance of keeping family matters within the home:

Kofi: So, I've had that upbringing that you don't share or you're very private. What happens at home, stays at home.

He shared the emotional consequences of these cultural scripts on his appraisal of distress and ability to ask for help:

Kofi: We Africans or Black people we don't share. So then that made it [asking for help] more apprehensive. Like I understood more. So, maybe that's the reason why I'm going through all this pain because of the way I am, but when you're in that state, you can't really self-reflect and see how you as a person, are you at.

In agreement with the expectations of an African household, Victor elaborated on the emotional and psychological consequences of showing signs of femininity. He reflected on the pressure to have an inherent awareness of coping as a man despite being ill-equipped with

emotional and practical coping tools. His reflections acknowledged the significant role that family and socio-cultural experiences could have on acceptable male gender expressions:

> *Victor: So my dad, any time I ask questions I would be denigrated, I'll be criticised, I'll be shouted at, I'll be threatened. And, you know, I would be blamed for not knowing. And it felt odd because you have, um, you haven't taught me how to do that. How do you expect me to know that then, you know, he says, then you see that I'm soft? The male kind of figures in my life when I often asked questions they would kind of echo the same thing that I'm too emotional for a guy.*

Participants also reflected on the emotional conflict around feeling unequipped to solve their difficulties and asking for external help, which was also condemned and negatively perceived by their parental figures. Kofi used combat descriptors to capture the conflict and emotional cost around his parents, failing to understand the need to take his problems outside of the family home:

> *Kofi: I think that the battle was trying to fix it yourself at that point. Because obviously in the back of the mind, they're like, if, for example, you have to go tell your parents, oh I'm going therapy. They'd be like what are you going to therapy for? Are you going mad? They expect you to fix yourself. If I was going for years and years of trying to be my own personal soldier trying to fix something, and it got to a point where I just couldn't do it anymore*

Accessing the construct of what is accepted as '*man enough*' disposition was challenging for two participants. They described their conflicting relationship with emotions due to the absence of father figures in the home constructively modelling vulnerability. Four participants shared the impact of an absent father on their relationships with their emotions. Ken reflected on how this void in his life had been repressed. His quote reflected his grief in missing opportunities to connect with the intimacy he needed growing up:

Ken: (…) A lot of us have grown up without men around, and we've kind of lost that ability to have intimate conversations about love and, you know, things with other men because of the lack of parental malehood if you like. And so that's kind of changed that - I didn't even realize this, but it has had a profound effect on all of us, you know, because we've kind of buried that sense of being able to open up.

Some participants described the experience of having male therapists with similar lived experiences as an opportunity to bridge this absent father gap and constructively connect emotionally with their shared identity and experiences. This level of connectedness also helped to foster proximity and attunement with the therapist other:

Anthony: (…) He was very much in tune with my upbringing being African, my experiences and being coming from like a broken home for example. But he said he didn't know much

about his African background because his father wasn't around, and so he understood the detachment of your parents and how it will affect your upbringing and your lifestyle and your mindset as well.

In summary, this sub-theme captures the gender and cultural socialisation which places expectations on Black men to keep problems private and rely on themselves. The expectations and social rules surrounding them and the lack of available male role models to support them in navigating their vulnerabilities influenced their perceptions of acceptable behaviours and responses.

Sub-theme 3: The Strong Black Man

Within this sub-theme, participants provided various accounts capturing the nuances and complexities of Black masculinity. They described the masculinity norms they subscribed to, and the implicit social contracts set up for Black men. Victor reflected on his dual position as a Black Nigerian man and the expectations that came with these identities:

Victor: I can't speak for all Black men, but I can speak for Nigerian men. Yeah, like boys or males are you know, brought up to be strong and to deal with the difficulties head-on and to be powerful. And emotions are not really dealt with across the culture. It is not accepted, it's something that you're just expected to just deal with.

Participants discussed the expectations placed on Black men to survive in social conditions that are environmentally and psychologically unsafe. Showing signs of weakness was synonymised with making oneself vulnerable to violence:

Spiela: I grew up in South London, Grove Park. It was do or die in my environment, you know, weakness will get you killed. And I've always had that kind of mentality throughout my life. I was just taught to not show weakness, don't do it, no matter how you feel, put on a face.

Others referred to experiences of being profiled and racially discriminated against, implying that the narrative around masking vulnerability did not exist in isolation:

Anthony: [Being] born and raised in London, (…) just the normal societal experiences of being a black person in your office or being, you know feeling anxious going to places because you're the only person, only black person there or being picked on because, you know, you're a black person in the shop.

Several participants also described the paradox of being hyper-visible because of their racialised identity but overlooked in their psychological health and wellness. Spiela captured the isolation that results from being strong on the exterior while feeling vulnerable on the inside:

Spiela: That's the issue with us Black boys, we feel like we're alone in that and if we are going through something, we think we are the only going through this and no one will understand because growing up, weren't asked, how do we feel? Are you OK? How are you doing? You expect to just get on with it from young black males.

Two participants expressed the consequences of this pressure to '*get on with it*' regarding their emotional wellbeing, primarily the pressure to be '*strong*' and be '*the provider*'. This served as a constant reminder of the multiplicity of their identities, as a man first and then a Black man:

Victor: I have been ingrained with that thing that you know that you should man up and you're not just black but you're a man and you're African and we are strong, get on with it. So yeah, I had to slap myself in the mirror a couple of times and just get on with it.

Anthony: And, you know, a lot of men are feeling intimidated by it and feeling a lot of pressure to be the man in the house, or be the man in a society that their egos won't be damaged too much or be not. (…). They will just do whatever they can to make sure that they can provide or be there (…)

On the other hand, others also expressed their revolt against these stereotypes and expectations by engaging in therapy. For participants like King, owning his vulnerabilities and

engaging in therapy was perceived as an act of dismantling the societal and cultural expectations placed on him as a Black man and re-defining what it meant to be strong:

> *Interviewer: How did you make or what sense did you make of your experiences as a young black man in therapy? I guess, what do you think that says about you as a person?*
>
> *King: I think it shows people that we do not need to conform to society's depictions of us as Black men. We do not need to conform to our culture's depictions of ourselves as Black men. At the end of the day, I'm a young Black man, and I've always been headstrong. I've always been one that's not afraid to be the Black sheep, I've always been one that's not afraid to take the leap.*

Similarly, for Romeo, admitting the need for help was perceived as a strength. He described defying the 'strong Black man' trope and prioritised his needs and motivation to get better over social/cultural validation. Denouncing the "strong Black man" construct here is seen as an act of accepting one's vulnerability and re-framing what it means to be a recipient of external help:

> *I don't think I was necessarily looking for anyone's approval. I didn't really care about the status quo of strong Black men or whatever. I was just like, I'm anxious, and I'm tired, so I need to get help.*

This theme captures the facets of Black masculinity, which place inordinate pressure on how they navigate society and the various experiences that put them at risk of emotional and psychological distress. The narratives also highlighted the challenges Black men contend with before arriving at the point of asking for help and their attempts to re-define the strong Black man trope.

Theme 2: It's a Big Step Asking for Help

This theme explores the factors that influenced participants' decision to approach or avoid healthcare services. '*Denial, Fear and Delay*' explores the process of accepting the presence of a problem, navigating fear, and initiating support. "*Is there accessibility for me as a young Black man*" captures the practical, social, and institutional determinants which were perceived as enablers or barriers to accessing therapy.

Sub-theme 1: Denial, Fear and Delay

Within this sub-theme, participants explored personal barriers to seeking therapy after noticing a gradual change in their mental health. Problem denial was reported as the most common barrier:

> *King: The only thing that stopped me would have been my own mind telling myself that*
>
> *I'm okay. Hence, I left it for so [a year] and a half coming up two years. I left it for so*

long before I actually sought out therapy because I kept telling myself there's nothing

wrong.

King described the decision-making process involved in identifying and accepting his difficulties. Problem denial was echoed by other participants who utilised self-prescribed, self-reliance strategies as the first line for solving their problems. These approaches were also linked to a sense of hopelessness and helplessness:

Ken: Well, you just do you live life normally. You wouldn't, and there isn't anything else you could do because (...) there's nothing you can do(...) you don't know of any other option, basically.

The tendency to '*get on with it*' was linked to limited awareness of other ways to resolve difficulties. Some participants described their resourcefulness in finding solutions before contemplating formal help-seeking:

Edem: The onus was not always relying on others, even though, yeah, I do need external help. But what can I do other than just wait and wallow? I was journaling, walks, meditation.

Many participants reflected on their sense of agency in actively seeking out strategies to self-manage. However, for some, this self-reliance came at the cost of noticing the early warning signs of worsening wellbeing. Kofi stated that the ineffectiveness of previously successful self-help strategies was the catalyst for seeking help:

I thought in my mind I was coping with it or dealing with it the best way possible because I've been dealing with it for over probably 10, 15 years. That (...) mentality has been able to [get me] past every situation. But how come now it wasn't working? (...) I had sleepless nights, my health was really bad and there was no way I could cope with it.

Other participants recognised these strategies were short-lived and were often employed to avoid or suppress emotional difficulties as Kofi stated: *"temporarily, it gave me good release."* The recognition of the transient nature of self-care strategies and their limitations manoeuvred participants to a place of admitting there was a problem. However, for some participants like Ken, this was at a point of crisis. Ken reflected on accepting the need for help as the beginning of a liberating path:

It's a big step asking for help, you know, and I know it sounds like cliché, but it really is (...) When you (....) make that decision to say, okay, but I need help, I can't do this by

myself, I cannot carry on, I can't live like this anymore, that in itself is an act of freedom

if you like. You know that kind of sets you free already, you're on the right path then.

Once the decision to seek help was made, being the recipient of professional support was described as a daunting and overwhelming process. Many expressed challenges in identifying and articulating their difficulties which resulted in multiple visits to the GP:

Kofi: I remember as I went to the GP three times and the first time I went there, I wanted to, you know, [say] this is what I'm going through. I came up with a story because I felt like it was embarrassing asking for help (...) So, it took me a lot of courage, going in every time, three times and the third time I'm just like, I can't sleep.

Tom: It was(...) I guess it was a little bit awkward because you were having to talk about more feelings rather than (...), your stomach is hurting or something like that (...) you're having to articulate and express emotions.

A common theme present in the exchange between the GP and participants was the focus on the somatic symptoms, which some participants perceived to be a more accessible and less stigmatising route to discussing their psychological distress. Giving language to unexpressed emotions also seemed to stem from the fear of accepting the existence of a more severe problem, as described by Tom:

I felt vulnerable. So, it felt like I was very exposed, I guess. Yeah, like, there was to a degree there was this cover that had come off. I think it was just me and whatever it is I'm supposed to be facing, so it's not necessarily the person who I was talking to (....) I probably shied away from talking about it because I [didn't want to] necessarily (....) acknowledge (...) I almost didn't want to come to terms with the fact that it might be not just, oh, I'm just feeling low or I'm just sad today, but it might actually be something clinical.

Conversely, participants like Anthony found it beneficial to have external validation of his problems being consistent with a clinical problem. This provided him with the language to name his difficulties. He shared that this opened a channel for self-acceptance and for him to begin engaging with professional help.

Anthony: [When] I started feeling unwell, so to speak [this] was back in 2012 when I didn't know the words of depression or anxiety (...) And so he [Doctor] was able to sort of give me the labels that I needed to sort of [confirm] my experiences.

To conclude, many participants highlighted the personal determinants influencing their willingness to avoid or approach services. The decision-making process involved many stages characterised by denial and fear of the consequences of accepting help. For many participants,

admitting the need for help was the most significant and courageous step, though accepting this reality also challenged their social and self-perception.

Sub-theme 2: Is There Accessibility for me as a Young Black Man?

Participants discussed the importance of convenience, consistency, and accessibility in alleviating the apprehension involved in accessing help. Some expressed relief when the therapy sessions aligned with their existing commitments and schedules. In that sense, therapy was not perceived as a disruption but as a convenient resource:

Anthony: I was able to attend on a weekly basis after work (...) I was very much open to the experience really. So, it wasn't like I was fearful of what I was going to encounter.

Consistency and predictability were also helpful considerations that presumably contained the initial apprehension. One participant weighed up the investment required in accessing therapy against the potential gains. The geographical distance required to access support invited fears around the usefulness of accessing help:

Edem: I feared that it would be a waste of time because I had to travel two hours to the next town for this, sometimes nearly three hours depending on traffic and it was always early morning and I don't drive so it was public transport.

Some participants expressed their challenges of navigating through vast information alone. The availability of social support, recommendations through therapy advocates helped to normalise their worries about the therapeutic process. Naithan acknowledged that the opportunity to access therapy through his employment alleviated the accessibility barriers that he anticipated. The combination of having the opportunity and the confidence to access the support opened a new channel of accessing the help he needed.

Naithan: I found it fairly easy because [of] the mental health champions, I guess at work the information is kind of all over the place. I think that's something I'm grateful for my workplace addressing…. As soon as I got in contact with one of the guys on there, he just got back to me and we were able to easily arrange a time to be off at work just to sit down, have a coffee, and for us to have a conversation really.

Contrastingly, Ken shared his frustration at a lack of follow up from a service provider, which reduced his confidence in the support available to him:

I don't think there was any accessibility for me as a young Black man (…) I think in my office there was like a leaflet. I remember once I said, you know, I'd call the people, they do like counselling, you get like three sessions. I called them and they never even called me back (…)

Ken also reported that he was not aware of other options available under the NHS "*I didn't know that it was possible to get therapy via the NHS.*" This was echoed by other participants who were unaware of the role of GPs in providing mental health support. The lack of awareness around statutory services was a dominant theme that influenced a quarter of participants decision to access private therapy. Other participants attributed their decision to access help from a private provider reduced confidence in receiving compassionate and relevant care from the NHS. Spiela drew from his research to decide on the best possible care:

> *Spiela: There's nothing wrong with the NHS. I'm not a big fan of it. However, reading all the cases, I'm a Black man, reading up all the cases and all the NHS treatments towards Black people, I decided to not take that risk.*

Though it was unclear what risks Spiela had associated with the NHS, Victor compared his experiences of private and NHS therapy. He perceived the former as more flexible and responsive to his care needs:

> *Victor: I felt that would be better. From my experience with IAPT is everything was protocol; some services and I didn't think that I'd get the best care that I needed. And there will be quite parsimonious with their treatment approach.*

Additionally, access to material resources was an important influencing factor; a few participants acknowledged their financial privilege in opting for the care they perceived as optimal or in line with their needs and preferences.

Kofi: I switched from NHS to private because that, to me, I felt private would care more... So that if you're paying for that time you make sure that everything around you is okay, because they want you to be good, but with NHS you just follow the steps.

The procedural steps and bureaucracy involved with accessing NHS support were commonly cited as barriers to accessing help, especially when this was measured against the courage, vulnerability and discomfort involved in asking for formal help. The presence of formalities such as form filling was experienced as unfamiliar, uncomfortable, and perceived as additional steps to overcome:

Maxwell: perhaps it will be difficult for me because there are always a lot of forms that you have to fill out at the beginning. And obviously, it's for a good reason, but just that always makes me feel uncomfortable because it just; I've always struggled to speak to people in the first place. When you put forms or contracts or anything in front of me, it just feels a bit too formal to me and it feels like I don't feel as comfortable and it takes me longer to get into the process.

The fear and discomfort around accessing help were attenuated by having easy, straightforward, and well-explained procedures. Having needs and preferences met, and procedures that centered comfort and choice were highlighted as helpful:

Spiela: They were very, very supportive it [was] very simple, very easy to go and find help and very helpful in finding me and connecting me to the right kind of therapist based on my area, region, location and how many sessions I want to start with. [It was] quite straightforward to be honest.

In summary, this sub-theme encapsulates the factors and considerations involved in accessing help, which entailed many steps. The process interacted with their perceptions of the available options, access to resources, receiving support to initiate the process. Whilst experiences of accessing help were diverse, flexible procedures and being given a choice on their care facilitated access to services.

Theme 3: Being Taken on a Journey

This theme captures participants' therapeutic 'journey' exploring the dynamics of being in an intimate space with a therapist and the difficulties that brought them to therapy. '*Feeling (un)safe'* represents the discomfort and apprehension experienced in the initial stages of therapy and the factors that produced safety. *'Will you understand my culture and where I'm coming from?'*

captures participants experiences of navigating issues of sameness and difference in social identities with the therapist. *'Doing the work'* reflects the experiences that empowered participants to take ownership of their recovery as well as the factors that hindered engagement. '*Therapy was an achievement'* captures participants' experiences of endings and harnessing the positive gains from therapy.

Sub-theme 1: Feeling (Un)safe

Participants described the hypervigilance and distrust they experienced in the early stages of therapy. They referred to being minimalistic in their initial disclosures by way of negotiating comfort and safety with the therapist. Kofi reported an internal conflict between his expectations of therapy and what ensued in the dynamic with his therapist:

Obviously from therapy… watching movies and stuff, I know it was a lot of sharing. That's the first thing. I know that a lot of you [who?] have to share and also something I wasn't built for, and in an hour you have to share so much. I remember the first session, it was like yes, no, yes, no, because I wasn't budging in, especially when I'm a six-foot-six guy as you know, and someone small is trying to get information from me. I'm not going to show a sign of weakness. I just didn't want to relax or anything. And because I didn't know what I was in for, I went into a defensive mode because I didn't know what was going to happen next.

This quote illustrated the influence of media depictions on Kofi's relationship with the vulnerability involved in sharing his difficulties with the therapist. In this case, the 'defence mode' was adopted to contain uncertainty and the unknown consequence of the therapist mining information from him. Maxwell also found the lack of disclosure/transparency from the therapist deviated from his expectations to have a deeply personal and meaningful connection:

I think, especially if someone you don't really know on a personal level and you're sitting there expressing how you feel, what you feel and you don't know anything about this person sitting in front of for me. Apart from their age, their agenda and their race can be quite difficult because almost you can feel that there's hardly really any common ground there, apart from you just being a human being.

The disconnect with the therapist's intentions/agenda left some participants concerned about the consequences of being vulnerable and disclosing their concerns:

King: The fear of what will it mean if I am allowing myself to be vulnerable? What will it mean if I open up and then it's thrown in my face? What would it mean if I trust you and then, you know, it comes back to haunt me?

Another participant described being emotionally 'detached' from the process as a strategy for managing the uncertainty. Being guarded and *'accessing experiences intellectually'* appeared

to contain the fear of being vulnerable in front of a stranger, which came at the cost of being inauthentic with the therapist:

Edem: I [noticed] retrospectively that it was as if I was analysing myself with the therapist in that detached sense, because I couldn't access a lot emotionally. So, I ended up accessing all the experiences intellectually, which I don't think really helped in the long term… she'd offer a point and then I'd offer a point. So, it ended up being like a discussion and a debate and not really like the therapy I expected which was to be a bit more emotionally connected.

The lack of clear guidelines or reference points in the preliminary stages of therapy appeared to increase the hypervigilance in the therapeutic space:

Kofi: You're always on edge because you don't know what's going to happen next because it was the first time in it. You don't know how to act.

Though the initial stages were fraught with anxiety, suspicion, and hypervigilance, many participants spoke about their gradual maturation in therapy. Dr Stone highlighted the transition from trepidation at the beginning of therapy to feeling safe and contained. He stated that this was made possible by assurances of confidentiality and having a safe space to process his experiences.

This may suggest that feeling safe was a pre-requisite for some participants to settle into the process and engage in the learning process:

Dr Stone: I feel like it's because you're in a room and it's this safe space and it's just dialogue between two people and it kind of doesn't leave that room. That confidentiality doesn't leave that room. (…) Obviously you conversate with people every day. But that experience is like nothing else because this is you opening up yourself and going back years back to process and learn things about yourself that you didn't think about.

Kofi added to this as he shared that the process of building trust and openness was gradual, and feeling safe was a necessary condition to enable transparent conversations with the therapist:

At the beginning…I wasn't budging down to let her get as much information as she needed, but by the second session, it was getting relaxed. And then by the third, the conversation was flowing. I realised at that point that I could share more with her.

Safety was associated with feeling relaxed within two accounts, starting with permitting themselves to relax and suspending their pre-conceptions of therapy. Safety also represented the absence of their daily worries/struggles in the therapy room. This was achieved through the freedom to express their lived experiences without fear of negative judgement:

King: During my journey of experiencing [therapy], one of the most powerful things that [I could] do is talk. And it doesn't matter what you're talking about, just talk and allow yourself to go on that journey. [You] Don't judge yourself. [You] don't worry about being judged.

Similarly, Spiela found it liberating to have a space to let his *'guard down'* and make mistakes in a way that was not afforded to him outside of the therapy room due to the standards set for him as a Black man in his professional contexts:

Spiela: So [as a] Black male, you always have this feeling. You just worry... you always have to be perfect, absolutely perfect every single day. And of course, that's a mental toll on someone. So going into therapy, I thought to myself, do I have to be perfect? And I thought - No. Therapy was the time where I let my guard down and make mistakes.

However, this experience was shared by all. Victor described a negative experience of being judged which departed from his expectations of the therapist:

I thought she was quite judgmental and she made a lot of assumptions. And she seemed quite cold. That she was just there. And yeah, it's so the tone of it was just rude and I felt

that she was looking down at me. And maybe that was my assumption but I guess yeah, I was really disappointed with it… We were just talking and there was nothing I was gaining at all so I terminated it.

The impact of the power dynamic was described in Victor's interactions with the therapist, which left him feeling undermined. The therapist's attitude was a deterrent to establishing safety, consequently resulting in the premature termination of the process. In four accounts, knowing more about the therapist helped to collapse the power dynamic, fostering trust and connection. Spiela's quote discussed reciprocity in his dialogue with the therapist. This helped to the enhance rapport:

Spiela: I became more open to ask more her more personal questions like (…) you're a mixed-race woman, like I'm a black male, I'm from the ends and I'm from hood and where are you from. And she started talking about herself so (…) she was just telling me how she kind of been about it. And it was really cool, just me able to break down that dynamic and become very open [.]. She started to seem a little bit as a friend just to kind of unload on and that really helped with the rapport. I kind of built that comfortably in the relationship together because she wasn't just a face or just an entity I had to go and respond to. She was giving me a stimuli back. (…) So, I started to react too so we were bouncing back and forth off each other.

Overall, this sub-theme illustrates the challenges participants experienced in navigating through the initial stages of the therapy. Moving from a place of trepidation to relational safety was enabled by assurances of confidentiality, being aware of the therapist's intentions/position, and being given the space and time to relax into the process. The process of building trust was described as gradual and co-created rather than a given.

Sub-theme 2: Doing the Work

Participants spoke about the power of feeling in control and being actively engaged in the therapy process. By having choice in the process, they felt empowered to make changes and take ownership of their recovery:

King: You're the one actually doing the work and they just know the means by which to extract that from you without making you feel pressured, without making you feel judged.

"*Doing the work*" was described in numerous ways. Ken explained the proactiveness required in therapy using tasks, homework and activities:

You know, do what they ask you, do the homework, put in the time, put in the effort, take time. They give you a book, read it, you know, and you will get more out of it.

There were varied experiences of engaging in 'homework' tasks. Some participants found it helpful in encouraging engagement and learning tools and strategies that felt aligned with their specific needs. This process was perceived as an act of self-investment:

Kofi: The NHS [therapy], it was very good because it made me give time, but obviously, with that homework, you give yourself time to work but like with that one it was more like a fix like you're trying to fix something. So you're actually working on it, you're working on yourself.

A third of participants preferred solution-focused approaches as they were appraised as beneficial over explorative and discursive approaches.

Anthony: A lot of men are solution-based thinkers, you know, I bring you a problem, you have to bring, give me back a solution that will counter and complete my problem. [Coming back] to me with words or inspirational phrases or direction is not going to give me the solution I need on my mental health, my finances, my relationships, my physical issues or whatever it could be.

It is important to note that some participants appreciated space for in-depth exploration. The use of homework was perceived as a barrier to establishing a connection at best and mechanical at worst. The common verbs/adjectives used by participants included "*mechanical,*"

"protocol-driven," "systematic," "structured," all of which encapsulated the negative elements of receiving a manualised approached. Kofi compared the differences between manualised and exploratory approaches:

> *Kofi: So for example with the NHS one, it was more to the book because I think the person I was with was, I don't know if she was a year in practice or so (...) She was basically by the book, but she would make everything a systematic approach. But then with the [private], it was more relaxed and you know, when you go home, you can do it if you want to. If not, you can come back and we can start again and fix up something else that comes up during that week.*

The importance of choice and flexibility in the therapy room, which many experienced, is highlighted as empowering and instrumental in encouraging collaboration and autonomy. Other participants also emphasised this:

> *Dr Stone: You're not going to be forced to speak about things that you don't want to feel uncomfortable. You don't have to talk about and it moves at your own pace. Nobody's going to force you to go quicker than you need to, and you don't, you're not going to feel (..) embarrassed or (...) you're a bad person*

When the collaboration was absent from the process, it had a negative impact on participants like Edison, which unfortunately resulted in premature termination of therapy:

I think when those sessions were going on; I didn't feel like I was getting any benefit. (....) I feel like if she'd maybe checked-in a bit more to see if I was understanding what we were talking about, then I couldn't really pass buffers like I kind of knew what was going on. I think I disengaged in that intervention quite early on.

Contrastingly, where there was a choice in the process of endings, two participants expressed this as a positive experience, although there was an acknowledgement that endings required continued learning to be one's own therapist:

Romeo: [Just] because you've because you finished your bout of therapy, whether it's four or five sessions doesn't mean you won't necessarily need to see a therapist again (...) I thought was like, cool, I've had four or five sessions, that's it finished finito, I'm all done now, but realizing that the mind is more delicate than that (...) you could be okay after it, but it doesn't mean that you won't need to put things into place to ensure that you stay upright.

To summarise, this theme demonstrated the common factors that helped participants feel involved and empowered in the process of therapy. Some approaches were perceived as more

helpful than others. Choice, proactivity, and flexibility were seen as key ingredients in the process of engagement and collaboration.

Sub-theme 3: Will You Understand the Culture I'm Coming From?

Participants expressed different views on their experiences of working with therapists with similar or different social identities. The most prominent one was race. A third of participants discussed their preference of working with racially similar therapists to overcome cultural barriers. Maxwell shared the importance of the therapist understanding his social and cultural context:

> *Maxwell: I think if we [have] the same ethnicity and the same culture, I believe that it would; it will be easier for me to connect with them because you don't have to kind of dance around the whole cultural differences thing (…) Obviously, pain is pain and suffering is suffering, but almost at the same time, Will you understand the culture I'm coming from? Do you understand how I am, why I necessarily think the way I think?*

This sentiment was echoed by other participants who preferred a racially similar therapist as this reduced the burden of explaining their reality. They perceived this to be essential for establishing an emotional connection with the therapist:

Edison: Having someone such as himself who is very familiar with this culture and these attitudes, I think took away a lot of the explaining I needed to do, it was almost an instant sense of, I understand what you're talking about, you, haven't got to explain it any further, I understand that kind of thing.

Other participants stated that White therapists would not understand their lived experiences as Black men and this would impede their ability to connect on a personal level as best captured here:

Spiela: I couldn't necessarily talk to a White[therapist] because I don't think they'd ever understand the pains of a six foot seven black male, born and raised in London going from the hood into a privileged the society so not knowing his place in my life and not knowing if he fits in. And know you know, a lot of my frustrations and fears stemmed from my interactions with White people, so I thought just it would be an absolutely pointless honest conversation to have.

However, expectations of racial sameness yielding a better connection were not always met. Despite participants initially stating a preference for a Black therapist, Victor reflected on his disillusionment at the mismatch between his expectations of a warm and nurturing Black therapist. He reflected on the therapist being a removed and detached "outsider:"

Victor: She was acting in a really, uh, yeah, white way as in that, this is me and that I am

superior, and you are not. Um, and nothing irritates me more than black people who are

basically, um, "Oreos". They call them that, who basically shed away their blackness and

they just hold to that view of being impartial, be cold and making them numerous

assumptions.

This linked with an interesting observation across several accounts where racial sameness

was seen as a disadvantage. Several participants stated a preference for working with a racially

different therapist due to confidentiality concerns, over-familiarity, and geographical proximity.

Kofi offered a nuanced perspective on the issue of confidentiality breaches within the

community as he perceived relations with other Black people in a familial capacity:

I think also because the person was Caucasian, so I was not having to open up to another

African or black person made it feel easier. (…) I'm not saying that a black woman or a

black man in a profession is not capable of doing anything, but to me, it's how I would

interact with them because automatically when we see them, I'll put them in a family, in a

friend zone, so again, I'll go, no, I can't share with you.

Racial similarity was not always perceived as the prerequisite for establishing a rapport. Many participants reflected on the therapist's qualities and identity factors such as faith and age over their racial similarity as important t determinants for establishing a connection. Some were non-selective about the ethnicity of the therapist:

Tom: You'll find that some very credible therapists aren't necessarily Black or hold a Black background. The thing is, if I had walked in and I saw a therapist and she was Black, it wouldn't bother me, I don't care. I more care about whether you can do the job, I couldn't care less about what colour or ethnicity you are.

Overall, having space to discuss social identities regardless of the perceived similarities and differences was seen as instrumental in establishing a connection, enhancing self-understanding and personalising therapy:

Edem: I think that's quite important especially for young black men to access those parts of ourselves that have to do with black identity as well as the many other identities we carry.

King: It allowed me to get to know myself a lot more. It allowed me to truly grasp who I am, what I believe in, what I think.

Dr Stone, however, preferred to focus less on his racialised identity due to the fear of having his individuality erased. He recognised the intragroup diversity within those racialised as Black:

Dr Stone: (…) I don't want to be like stereotyped (…) you don't want to fit into a stereotype. You feel like the therapist is asking questions about you. Me as a person. Yes, I am Black. I'm also myself. I'm different to other black people. So I think that was positive in the sense that, you know, I felt like it was about myself.

Romeo's poignant quote encapsulated the therapist's role in remaining curious, open and culturally sensitive, regardless of perceived similarity or difference.

If my therapist hadn't sought to understand that cultural dynamic and why it would affect me, we wouldn't have been able to get into things. I think it's a humility to be culturally aware and actually understand more the background of certain things.

To summarise, this theme captures the heterogeneity within participants' perceptions of racial and social identity as (non) essential ingredients in the therapeutic relationship. This seemed to be premised on establishing a sense of safety, connection, and trust with the therapist.

Sub-theme 4: Therapy was an Achievement

All participants reflected on their experiences of completing therapy and acknowledging the multi-fold benefits on their personal, social, and relational wellbeing. One of the most transformative aspects was embracing vulnerability and learning to overcome shame:

Romeo: I think it reinforced idea that it's alright to be vulnerable. It's alright to be honest and there is no shame in it and that's actually how you get help and you grow. So I think that's one thing, one thing that really reinforced in me.

For Naithan and Anthony, completing therapy despite their initial apprehensions was seen as an achievement that transcended the 'self' and benefited their ecosystems:

Naithan: [Therapy] felt like an achievement for me and it was something I was grateful for. And I remember saying strongly about it, yeah I was like this is something I know my future self is going to thank me for, you know.

Anthony: Things are getting better financially, career-wise, relationship-wise, family-wise, personal and mental wise as well, so that I can go through all of that and still make it out, you know, the sky's the limit, really.

In connection with this quote, others recognised the personal gains from therapy which included increased self-awareness, confidence and connecting with their sense of resilience:

King: It allowed me to realise that King, you're not as weak as you was telling yourself you are. You're not as low, you're not as unable, and you do not need to be scared. You do not need to be fearful of what's to come. What's to come is always going to happen regardless, just stay strong, and talk on your concerns, talk on your troubles, talk on your worries.

Others recognised that harnessing the positive gains of therapy and recovery was a non-linear process and required continual engagement:

Edem: I learned that I would like to go back to therapy because I had a lot of things I didn't access that I would like to. So I learnt and with myself, I still had a lot of work to do. Anthony: I can't afford to stop now because you know, it will only get easier and get better because I understand myself a lot more, understand people a lot more, I understand my experiences a lot more and things.

Though endings were appraised as challenging, Naithan spoke about the long-term impact of the strategies and tools learnt in therapy which he felt able to draw from in the face of racism and discrimination:

I've not had to seek out CBT in the middle of the pandemic or in the middle of you know, the things going on with racism. And I guess that's because consciously I guess I feel more equipped to handle it.

The most prominent therapeutic gain cited in five participants' accounts was the transformed perception of therapy and willingness to become advocates for therapy:

Naithan: I constantly talk about seeking therapy, and then I talk about some of the experiences I had there and the reasons why. Because I really want to use that platform to encourage other people, guys especially, to at some point maybe go through CBT. Anthony: I really think more people should get therapy. I've not really seen a lot of people, I know, speak about it. And so that's when I started pushing more people to get it and they'll share their experiences and writing blogs and stuff.

Both quotes illustrate the systemic impact of individual therapy, particularly around advocacy and wider promotion within social and familial networks. Participants reflected on their

motivations for doing so, particularly around increasing the acceptability of therapy within their spheres of influence and community at large:

> *Kofi: Even among friends…. if anyone needs to talk about anything or help with anything, just let me know. I think the more we help or we open up about [therapy] within our community, the easier it is for people to open up and break the ice.*

To summarise, this sub-theme captures the multi-fold benefits of therapy extending beyond the individual level. Participants highlighted the continual process of learning that takes places beyond therapy and the long-term benefits that are harnessed through practice and advocacy.

Theme 4: Build Bridges of Trust And Collaboration

The final theme captured perspectives on improving access and engagement in therapy for YBM. "*Find out where we are'* explored proactive outreach to communities to provide education, raise awareness and de-stigmatise therapy. "*If they are talking about therapy, I don't see myself"* captured perspectives on the lack of representation of YBM in therapy and ethnic diversity in the media and healthcare services.

Sub-theme 1: Find Out Where We Are

Most participants reflected on the expectations placed on Black men to reach out to services without the acknowledgement of the multitude of barriers and stigma that surrounds accessing therapy. Of note was the recognition of building bridges of trust as an essential part of garnering engagement:

Edem: I guess the approach is a bit more active and hands-on then waiting for people to come to you. I don't know if outreach is the right word but I think in order to get into talking to young Black men, it really takes building trust even before the therapy sessions.

Other participants' accounts helped contextualise the historical mistrust that contributes to the lack of acceptability of therapy within the Black community. Dr Stone emphasised the importance of education and awareness through reaching out:

Dr Stone: There's probably a good reason as to why maybe they're scared, maybe they don't trust in doctors and stuff like that. And they do trust, you know, doctors for their health, but their mental health. Again, it's a negative stigma. Um, so I think again, it's just really just that education and you're showing that will have a positive impact on you.

Anthony's account highlighted the proactiveness required on the part of service providers and the importance of increasing the visibility of NHS services and offering diverse pathways to engaging in people in psychological therapy:

I think it's a thing of where the providers should just be able to do what they can whether you know, group initiatives or one-on-one, or private or NHS, or going to the local councils or different boroughs to look for people to help them doing stands in troop supermarkets, doing, you know, leaflets indoors, you know, people are scared to look for help. (…) it's really touching the hand of people and saying, look, we're here to help you if you need it.

Several participants shared innovative ideas linked to the powerful analogy of *'touching the hand of people,'* and recognised the need to diversify and re-evaluate the 'traditional' models of reaching out and offering pluralistic forms of support. Three participants reflected on the under-utilised expertise, knowledge and influence existing in the community. Naithan reflected on the power of collaborating with influential voices in the public eye to encourage engagement:

Naithan: I think services; I guess maybe reaching out to people because young Black men would listen, I guess they'll listen to people who they're influenced by you know. So I don't know if it's reaching out to Black influencers who, like I'm not just saying stereotypically like, artists or musicians or like actors and stuff. Like if you can reach out to these guys to

I don't know if it's through an advert or promotion or just in dialogue to actual interviews because that could be through an interview just with the actual celebrity or someone to talk about their experiences of CBT to your mental health and therapy. I think that would definitely encourage a lot of Black men to seek it as well.

Many participants shared this perspective, challenged the standard provision of services, and suggested culturally relevant and compassionate ways of engaging Black men. Collaboration and joint working were seen as a direct means of accessing large audiences of Black men. Spiela also recognised the process as being proactive rather than passive. He named the importance of shifting the weight of this responsibility to service providers:

Spiela: So, they need to assert themselves in these smaller communities and build better networking with the target audience that they want to connect with. So, it's on them to make the effort to go there. (...) Find out where [YBM] are.

Some participants also recognised the challenges in 'reaching out', which are often stifled by systemic and structural underfunding and, at worst, driven by mechanical policies:

Anthony: It's tough because I know it starts from their head in terms of the government and it comes down, you know, the government needs to fund the mental health field a lot more.

So people can go into, people can get resources and help more people, not just black men,

but all people.

Victor: Services cannot be mechanistic and be so policy-driven anymore. They need to be

human; they need to actually care.

To summarise, this sub-theme captured participants' views and suggestions around increasing accessibility for Black men, which they felt required a practical and 'on the ground' approach involving collaboration and consultations with the expertise existing in the community.

Sub-theme 2: If They Are Talking About Therapy, I Don't See Myself

Most participants stated that services are often created in their likeness and image within this sub-theme, which some perceived to be exclusionary. One participant reflected on the single-sided narratives on 'acceptable candidates' for therapy in the media, which excluded Black men:

King: So, when I walk down the streets or whatever, I see a lot of adverts and they could

be about anything, and if they are talking about therapy, I don't see the image of myself. I

don't see the image of myself. Now me being me, I overlook that and I'll still go out and

seek it but someone else being someone else, they may look at that and be like, why am I

going to seek therapy? I don't see me.

Some participants reflected on the racial homogeneity within therapy services and providers, which crystallised the idea of therapy being the preserve of White people:

King: I'm not saying there's only white people in therapy, but what I'm saying is in that, there was no black person that I saw, like even in the pamphlets. And I just saw white people in them when I was going through them, white people, you know? So for me, it's a case of where's our representation? Where are we in the working field?

This quote indicates the importance of representation in therapists and those posed as suitable candidates for therapy in the media or service paraphernalia. This may encourage Black men to consider engaging with services. Several participants also stated that the lack of role models within their communities and therapy providers contributed to the isolation they felt in the process of engaging in therapy. They highlighted the importance of offering choice through the provision of multi-cultural and diverse therapists, particularly Black male therapists:

Maxwell: For me, it felt lacking, I didn't really see [me]; a lot of the [companies] or organisations I have gone to, I haven't really seen a lot of black men in them. This year I've found out obviously with the networks dedicated to black and the BAME organisations. But growing up (…) it was mainly women, I didn't really see a lot of men, black men.

King named the incongruence between the observed disparities, the needs of minority communities and their underrepresentation in psychological therapy. He attributed these disparities to institutional racism:

The whole Black Lives Matter is rampant right now and institutionalised racism comes in many different forms, systemic racism, same thing. (…) Because it makes little sense for me to talk about [mental health] in the UK or wherever and not include the minorities when the minorities are the ones that are suffering from this most. So then why is it that regarding counselling or therapy, we're not the representation when we are the ones that are suffering most?

To summarise, a clear narrative shared by most participants was that representation needs to occur at all levels from the media, service providers, all the way to the local context. However, it is also important to note that representation alone was not seen as enough to make services more inclusive:

Romeo: I think you have to be culturally aware of how (…) things can play up. I mean, cause I'm not too sure if there is any awareness but you know, for a lot of African people or, you know, like we come from different tribes.

Maxwell: I think, when you're speaking to someone, you have to understand that person's

culture, understand everything that person's experience in the world up to this point.

Some acknowledged the importance of therapists adopting practices rooted in curiousity, seeing the person and their context first and acknowledging the societal challenges that Black men contend with, regardless of the therapist's ethnicity.

CHAPTER 4: DISCUSSION

Chapter Overview

This chapter summarises the key findings of the project concerning the research aims and objectives. The results will be situated within a theoretical context and linked to existing literature. I will also discuss the strengths and limitations, implications, and suggestions for future research and conclude with my reflections on the project.

Revisiting the Research Questions

The research explored YBM's experiences of deciding to access and engage in individual psychological therapy. The main research question was: 'What are young Black men's experiences of formal help-seeking for psychological distress?' Three subsidiary questions were explored:

1. What are the mediating factors that influence YBM's relationship with formal help-seeking?

2. What are YBM's experiences of accessing psychological therapy?

3. What are YBM's experiences of engaging in psychological therapy?

Summary of Findings

Participants situated their experiences of deciding to access and engage in psychological therapy within a social-cultural context that encourages Black men to be strong, stigmatises mental health difficulties and sets cultural scripts that discourage seeking help outside the family. The decision to seek help was influenced by firstly admitting the need for help, having access to

resources and the ease of accessing services. In the therapy room, assurances of confidentiality, awareness of the therapists' intentions , having a safe space to explore, and empowerment through choice helped participants to traverse from a place hypervigilance to feeling safe. Therapist preferences were diverse. While some found it easier to relate to a Black therapist, others raised concerns around confidentiality. Assertive outreach, engaging with local expertise and culturally-humble approaches that recognise Black men's unique socio-cultural identities were recommended as best practice to engage YBM in psychological therapy.

The themes and sub-themes from the project will now be presented and situated within existing theory and literature.

What are the Mediating Factors that Influence Young Black Men's Relationship with Formal Help-Seeking?

The results of the current study corresponded with the studies in the SLR underscoring the role of a societal stigma in help-seeking (Mantovani et al., 2017); male socialisation scripts promoting restrictive emotionality (Addis & Mahalik, 2003; Linney et al., 2020; Myrie & Gannon, 2013); and cultural expectations to keep private matters within the family context (Bauer et al., 2020; Campbell & Allen, 2019; Jacoby et al., 2020; Myrie & Gannon, 2013).

It is beyond the scope of the to discuss each sub-theme under this research question in turn. Instead, the 'strong Black man' sub-theme will be discussed in detail due to its prominence within

participants' narratives and contributions to the knowledge gap. It also provided a critical lens and theoretical framework for conceptualising YBM's unique experiences of formal help-seeking.

De-Constructing "The Strong Black Man."

Edge and Rogers (2005) first researched the concept of the 'Strong-Black-Woman" (SBW; p.19) as a framework for understanding the structural pressures that Black women face in constantly negotiating their position in society and withstanding adversity at the detriment of their emotional wellbeing. The co-location of race as a unifying factor for people racialised as Black, regardless of gender, may suggest the need to be strong as a survival strategy in a racist society (Majors & Billson, 1993). From this perspective, there appears to be a link between the SBW concept and the help-seeking experiences shared by participants.

Participants reflected on the duality of the Black male identity, which constituted of navigating through socio-cultural scripts of keeping problems inside the family home *("what happens at home, stays at home"*) and upholding the gender norms endorsing emotional control independence self-reliance ("the strong Black man" [SBM]). These conflicting narratives gave rise to the men in this study appearing tough and invulnerable in the face of distress, which resulted in delayed access to formal help. Participants talked about their experiences of navigating society as hyper-visible beings (in terms of skin colour) and experiencing invisibility within the realm of their mental health and wellbeing. In the context of being racially profiled and experiencing discrimination, participants spoke in detail about the pressure to be perfect, in control and

emotionally robust. They narrated the existential threats that came with showing signs of weakness and fragility. Endorsing gender prescriptions of appearing strong and self-reliant were privileged by many at the cost of acknowledging their pain and, at worse, responding to their distress at a point of crisis. For some, this also manifested in questioning their eligibility for psychological help as they did not feel their problems were severe enough to warrant external help.

Franklin and Boyd-Franklin's (2000) '*invisibility syndrome'* offers a conceptual base describing the emotional impact of racism. The phenomenon describes the experiences of repeated racial microaggressions that cause individuals to internalise feelings of worthlessness. Individuals may struggle to affirm their feelings, beliefs, and talents due to a lack of acknowledgement by wider society. The formation of Black men's conception of masculinity can also be viewed within this gender-role strain paradigm (Pleck, 1995) unified under the theme of racism. The gender role strain theory outlines the norms and expectations placed on men to self-manage and display masculine behaviours. Participants in the present study often reported difficulties in recognising and admitting the need for help due to the fear of being perceived as weak, which would, in turn, threaten their masculine identity (Courtenay, 2000; Williams, 2003). In the SLR, these characteristics represented conceptions of 'hypermasculinity' (Mosher & Tomkins, 1988) engendered by rejecting and expressing distress. Other theorists argue that some men experience 'hypermasculinity' in disparate ways to the White male society due to their dual race and class subjugation (Cheng, 1999; Harris, 2000).

Theories of masculinity and men's health have been criticised for focusing on the hazardous influence of the male sex role and presenting deficit-based models implying that gender represents a singular male personality (Courtenay, 2000). This stereotypic notion obscures the various forms of masculinity that men can and do demonstrate (Connell, 2005). A congruent observation in line with this critique was evident in some participants' accounts which disavowed the SBM construct. Some participants identified the implicit harm inherent within the SBM construct and located it as the site of their distress (Franklin & Boyd-Franklin, 2000; Mansfield et al., 2003). The stereotype that Black men are 'big and dangerous' (i.e., strong and threatening) has been used to justify the use of excessive force (Keating, 2020; Majors et al., 2020; Rogers & Pilgrim, 2014) and higher prescriptions of physical treatments over psychological therapy (Keating, 2016). As such, the SBM construct is pernicious as it strips Black men of their vulnerability to psychological suffering, denies them access to humane treatment and reifies the notion of them being 'psychologically illiterate' (Wood & Patel, 2017).

With this epistemic backdrop, it is no surprise that some participants reclaimed the SBM construct as a sign of strength rather than an epitome of psychological invulnerability. For some participants, the decision to seek therapy was constructed as a sign of strength, while others perceived it as an act of resistance against stereotypes about Black men. These minority accounts demonstrated that men are not always passive victims of gender-prescribed notions but are active agents in constructing and de-constructing their preferred version of masculinity (Courtenay, 2000; White & Epston, 1990). This agentic position illustrates the part individuals play in exerting power

and producing the desired effects in their lives. However, this does not change the fact that the psychological impact of dominant discourses of Black masculinity should also be acknnnowledged challenged at a societal and institutional level, especially within MHS (Courtenay,1998). The next research question explored how these societal constructs influenced YBM's experiences of deciding to access and engage in psychological therapy.

What are Young Black Men's Experiences of Accessing Psychological Therapy?

Personal, Social and Institutional factors

The findings within this sub-theme highlighted the institutional and environmental determinants that influenced participants' decision to seek help from formal services. Within the accounts, factors such as geographical location, availability of resources (material and social), and institutional procedures were perceived as threats or opportunities in deciding on therapy uptake.

The adapted 'Health Beliefs model' (Henshaw & Freedman-Doan, 2009) offers a multi-level theoretical framework incorporating the psychological, social, and demographic factors that influence an individual's decision to access MHS. In the present study, mechanical procedures such as bureaucratic form filling and poor communication from service providers presented additional obstacles. Inversely, ease of access (straightforward procedures), convenient timings of sessions and accessible locations increased the motivation to access psychological therapy. Poor communication and interactions between service users and health care providers play an

instrumental role in encouraging or deterring future health-seeking behaviours (Farberman, 1997; Dowrick et al., 2009).

Other health behaviour models such as the Capability, Opportunity, Motivation and Behaviour (Michie, van Stralen & West, 2011) offer helpful explanations of the processes engendered in help-seeking processes, motivation, and adherence to mental health interventions. Michie et al. (2014) proposed that the motivation required to engage in health behaviour is modulated by social, practical, and interpersonal factors. In the present study, the availability of social resources such as access to advocates for therapy, workplace support and recommendations from others were perceived as extrinsic motivators for participants who questioned the benefits of accessing therapy. This corresponds with the health belief model, which postulates that cues to action such as social support could serve as important triggers for service utilisation (Henshaw et al., 2009). The findings also suggested that social support in the form of advocates was only effective to an extent, with one's beliefs about the ability to engage in therapy (self-efficacy) being viewed as more critical. For example, once referred to therapy, participants had to take proactive steps to engage with the recommended service. Doing so required the confidence and skills to initiate the process. The social learning theory considers the link between self-efficacy and the confidence that one can change the process of therapy (Bandura, 1977) as prerequisites for engaging in health behaviour. While self-efficacy theories provide a good model for predicting the motivation for seeking therapy (Rosenstock et al., 1988), in this study, other contextual factors

such as perceived efficacy of therapy and access to financial/economic means were additional components that interacted with the decision to access services.

The findings from this sub-theme suggested that access to therapy for YBM may be easier when paid for and may come with greater autonomy over care, both of which conflict with the NHS founding principles (NHS Constitution for England, 2021). A concerning finding was that despite some participants being aware of free access to NHS therapies, they resigned themselves to paying for therapy privately due to a lack of trust in the NHS's ability to provide care that aligned with their needs and preferences. This finding was consistent with previous studies that cited the perceived ineffectiveness of NHS services as a help-seeking barrier for ethnic minority communities (e.g., Kovandžić et al., 2011; Memon et al., 2016; Mind, 2013). Having the financial means to access private therapy was associated with increased choice, flexibility, and autonomy, which some participants found empowering. There have been suggestions that when people have agency over their treatment and care, this is more likely to lead to positive outcomes and personal empowerment (Morgan et al., 2017). While a minority of participants shared positive experiences within the NHS, there may be a failure in meeting YBM's diverse needs within the NHS, encouraging them to look elsewhere. The research shows that more needs to be done to ensure the provision gap is closed and that accessible and responsive care is not only received by those who can afford it and that the NHS does not become synonymous with sub-standard care.

What are Young Black Men's Experiences of Engaging in Psychological Therapy?

Being Taken on A Journey

For many participants, the process of 'being taken on a journey' in therapy corresponded with the findings of Hussain et al. (2020), who explored men's experiences of psychological therapy in forensic settings. Similar to their findings, participants described shifting from a guarded position, characterised by the protective elements of the 'guarded self', to a more receptive position of being the 'vulnerable, exposed self' (p. 417) as therapy progressed. Kimmel (1986) attributed the intrinsic fear in exposing vulnerability in therapy to shame-sensitivity associated with "not measuring up as real men" (p.4), which leads to self-silencing and minimisation of distress. However, in the stories shared by participants, shame was not explicitly stated as the organising principle for their guarded posture in therapy; they located their fear in the unfamiliarity and uncertainty of the process as first-time recipients of therapy.

Evidence suggests that a client's interpersonal expectations of therapy influence the process and outcome of therapy (Burgoon, 1993; Westra et al., 2010). Deane (1992) explored pre-treatment expectations of clients entering psychotherapy and found that many participants expected the therapist to dominate the session and perceived their role as compliant with the therapists' directives. In the present study, the compliance aspects manifested in them negotiating the therapeutic space by disclosing minimal information and intellectualising the process. Psychological defence mechanisms (DM) such as intellectualising are functional and unconscious psychological strategies that have the aim of protecting the self (e.g., from intolerable or acceptable

feelings like anxiety, shame, or anger) and preserving relationships (Juni, 1997). The DMs served the function of attenuating feelings of uncertainty around the parameters of therapy. The findings suggest the importance of acknowledging the overwhelming discomfort and uncertainty involved in asking for professional help. The simple process of clarifying and naming the assumptions underpinning the therapy process may help disconfirm pre-conceived notions while also setting clear expectations. This may heighten safety and empowerment in therapy (Frank & Frank, 1993) and begin the process of co-creating a brave therapeutic space where both parties have ownership of the experience. The key elements that facilitated feelings of safeness in participants' therapeutic journey were therapist disclosure, interpersonal relatability, and collaborative engagement which will now be discussed.

Therapist Disclosure

Therapist disclosure, also known as the "use of self" (Sleater & Scheiner, 2019, p. 119), is defined as a statement that reveals something personal about the therapist (Hill & Knox, 2002). The role of therapist disclosure as a conduit for strengthening the therapeutic relationship is the basis of humanistic psychotherapies (Jourard, 1971; Rogers, 1961). The 'common factors' model argues that the therapeutic relationship between the client and therapist (i.e., 'the working alliance') is the chief contributor to therapeutic change and has been consistently correlated with positive treatment outcomes (Rosenzweig, 1936; Horvath & Symonds, 1991; Martin et al., 2000; Sparks et al., 2008).

Some participants distrusted the therapist's intentions and worried about the consequences of disclosing their difficulties due to perceiving the therapist as neutral and distant. The role of cultural mistrust in therapy has been conceptualised as an expression of 'healthy cultural paranoia," which Ridley (1986) viewed as a reaction to interracial encounters in MHS and the fear Black people have of being erroneous diagnosed or pathologised. Critics have re-framed this nomenclature as functional apprehension to dissociate it from expressions of psychopathology (Ashby, 1986; Whaley, 2001).

Within the findings, several participants reported that awareness of the therapist's background and intentions reduced nervousness and mistrust, which helped establish an emotional bond. Within the literature, therapist disclosure is often conceptualised in the context of its influence on the client-therapist relationship; however, there is contention around its effects on enhancing or interfering with the therapeutic alliance (Audet & Everall, 2010). Although concerns have been raised around ethics (Peterson, 2002) and potential for boundary transgressions (Zur, 2007), disclosure literature has shown that the use of appropriate therapist disclosures can contribute to perceptions of the therapist as human, empathic, warm, and possessing positive regard (e.g. Hill & Knox, 2001; Knox et al., 1997; Norcross, 2002). Some literature states that immediate disclosures, which have a relational focus and serve a specific function (i.e. validation and empathy statements), are more appropriate than non-immediate disclosures relating to the therapist's circumstances, personal beliefs, and values (Audet & Everall, 2010; Knox & Hill,

2003). However, the research in this area has been primarily analogue in design, using simulations rather than in naturalistic settings.

The findings of this project contribute to disclosure literature by offering qualitative evidence from a naturalistic setting. Participants perceived non-immediate disclosures as meaningful, particularly concerning the therapist's upbringing, ethnic background, and cultural values. This was constructed from the lens of identifying common ground with the therapist which in turn encourage them to disclose aspects of their identity. Participants may perceive therapists as authority figures which may heighten their suspicion and hypervigilance given the negative interactions Black men often experience with institutions (Keating & Robertson, 2004).

These findings suggest that for some Black men, adapting therapy by providing disclosures that extend beyond the 'here-and now' may foster a perception of the therapist not exerting superiority within the relationship. Feminist therapists endorse the judicious use of therapist disclosure as a means to equalise power between the client and therapist (Mahalik et al., 2000; Tabol & Walker, 2008), mainly when working with men (Brooks, 2010; Danforth & Wester, 2014; Liu, 2005). As MHS often operate within unequal socio-historical contexts (Fernando & Keating, 2008), therapists working transculturally may need to self-disclose aspects of their identity to build bridges of trust and model transparency (Goldstein, 1994; Jenkins, 1990; Sue & Sue, 1999). As the participants in this study primarily engaged with ethnic majority therapists, this further explains therapists' role in making their intentions visible and fostering trust through disclosure. This recommendation would also extend to therapists working within their own cultural/racial group.

The findings from this study suggested that cultural similarity alone was not a prerequisite for establishing an emotional bond with the therapist suggesting the importance of holding an intersectional perspective.

Cultural Matching in Therapy

Much of the theory on cultural matching originates from social psychology theory, such as affinity bias which suggests that people tend to identify with individuals they perceive to be similar (Festinger, 1954). Furthermore, there is a historical assumption that cultural matching contributes to positive therapeutic change (e.g., Fabrikant, 1974). In relation to discussing issues of racialised identity and lived experiences, some participants described the instant emotional connection that they established with a racially similar therapist, which was perceived to reduce the emotional labour involved in explaining their reality as mirrored in racialised environments. Studies have also found that Black therapists reported having a better understanding of Black clients and their context, which created easier and faster therapeutic connections (e.g. Cabral & Smith, 2011; Goode-Cross et al., 2016).

However, the hypothesis that therapeutic alliance is strengthened under conditions of racial similarity has not been widely supported within the literature and the current study due to a legion of debates surrounding what constitutes a suitable 'match' (Cabral & Smith, 2011; Sue, 1988). Even with shared racial/cultural backgrounds, interpersonal differences between therapist and client such as geography, gender, socioeconomic status, and religion remain. This was evident in the present study, where some participants reported their disillusionment in being matched with

Black female therapists due to gender differences. Other participants expressed a preference for a faith-based match due to the centrality of religion and spirituality in their identity and experiences. The disadvantages of cultural matching also included concerns about potential breaches in confidentiality based on proximity, assumptions about community membership and overfamiliarity. These concerns have been articulated in research as examples of intra-ethnic transference, which result in fear of being negatively judged by an in-group member (Comas-Díaz & Jacobsen, 1991). Taken together, these divergences in experience indicate that the presumption of interpersonal similarity alone may be flawed, particularly when the client and therapist have incongruous life experiences and values. Furthermore, making assumptions of Black men's therapist preferences based on their race alone erases other intersecting identities that are less visible. The assumption that Black men are best matched with Black therapists may not encourage ethnic majority therapists to develop their awareness of the social-cultural factors affecting Black men and their impact on the dynamics within the therapy room (Sue, Arredondo & McDavis, 1992; Sue, 1988).

The research findings contribute to the field by suggesting that although cultural matching had an initial appeal for some participants, common factors such as the quality of respect and the connection superseded identity characteristics. The findings highlight that individual experiences with cultural matching must be acknowledged and validated through offering choice (Steinfeldt, Clay & Priester, 2020; S. Sue, 1988). Proximal factors such as cultural humility (Mosher et al.,

2017) from the therapist and promoting collaborative engagement were both described as important therapeutic components that helped facilitate strong working alliances.

Collaborative Engagement: Doing the Work

A fundamental part of the change process within therapy is the engagement in the 'tasks of therapy', which often involve goal setting, skills practice, and in-between session tasks (Bordin, 1979, 1994). Within the findings, participants described their experiences of being actively involved in the process of their care, collaborating with the therapist, and taking ownership of their recovery. Research studies have shown that proactive, solution-focused engagement methods bode well with young male service users who may struggle to engage in deeply personal psychotherapeutic work involving articulating emotions (e.g., Ellis et al., 2013; Ogrodniczuk, 2006; Rickwood et al., 2005).

There were mixed perceptions of what constituted successful therapy and 'doing the work' within the therapy room. For some participants, engaging in dialogue and connecting with past experiences was experienced as helpful. Many participants appreciated the proactive use of homework tasks premised on solution-driven approaches and reflected on the utility of being equipped with coping strategies. These strategies were appraised as an opportunity to regain control and feel empowered to take ownership of their difficulties, a process often described as 'becoming your own therapist' within the CBT literature (Fenn & Byrne, 2013, p. 580). This finding corroborates a recent study by Seidler et al. (2018) with young men who reported that

focusing on 'doing' rather than 'talking' produced feelings of strength and empowerment, which bridged the self-management of 'depression'. Together with the research findings, there is evidence that the use of masculine-sensitive and task-focused psychotherapeutic strategies may result in positive outcomes for men (Cochran & Rabinowitz, 2003). However, cautious interpretation of this finding is necessary as most participants received CBT approaches which may overshadow the experiences of those who preferred explorative psychotherapies.

Most participants within the present study received multi-modal and integrative therapeutic approaches, with the CBT approach described as proactive and action orientated. Other participants stated that the model did not align with their needs, particularly in the absence of collaborative practice. In the literature, the collaboration between the therapist and client is an active ingredient in therapy (Wright, 2006). The imbalance in power and the presence of prescriptive and one-directional approaches in CBT may explain the engagement challenges faced by some participants. In a recent study exploring YBM's definitions of mental health recovery, participants reported 'authentic' rather than professionally driven scripts were experienced as meaningful in (re) gaining their sense of agency (Keating et al., 2019). This suggests that YBM may benefit from flexible approaches that encourage autonomy and empowerment through choice and flexibility.

Lastly, participants reflected on the therapeutic gains made in therapy. The reports of positive gains align with studies that report positive outcomes for men (i.e., understanding of difficulties, sense of empowerment and better coping repertoire) following successful completion

of therapy (Hussain et al., 2020; Seidler et al., 2018). Many participants reported positive therapy experiences, which stimulated their interest in becoming advocates, thus demonstrating the psychological shift possible for participants despite commencing therapy fraught with mistrust and apprehension. Their investment in the process and inside experience provide useful implications for services to utilise peer support streams to empower and engage other YBM in taking up psychological therapy (Bellamy et al., 2017; Noorani, 2013).

Implications and Recommendations

The project was conducted in the context of a myriad of government-commissioned reports listing countless recommendations to address the racial disparities within MHS within the UK (e.g., Cabinet Office, 2017a; Care Quality Commission, 2011; DOH, 2005; GOV.UK, 2018; The Sewell Report, 2021). A notable criticism of such policies is the omission of recommendations related to service user experiences (Ashe, 2021). Consequently, the mental health field currently lacks an overarching consensus, or even a clear summary, of best practices and critical issues to consider when working with Black men in therapeutic settings. The participants in this project shared local and policy level invitations as captured in the fourth theme: *building bridges of trust and collaboration*. The key recommendations will now be outlined and translated into actionable implications in a topographical framework, beginning with the legislation and policy invitations.

Legislation and Policy Invitations

Some participants identified the need for additional funding for statutory services, which has been eroded over the years due to austerity policies (Cummins, 2018; Layard, 2012). This study highlighted that increasing funding into primary care therapies and prevention programmes will result in significant cost-saving exercise in lieu of the current expenditure on hospitalisation and CTO's that Black men are disproportionately subjected to (Centre for Mental Health, 2006; NCCM, 2016). Offering timely access to appropriate evidence-based psychological therapies for Black men could help to reduce these costs significantly.

The current provision model privileges direct funding into the NHS services, resulting in the centralisation of resources within clinical commissioning groups. While there is a lot of commendable work within the NHS, the participants invited policymakers to consider the diversification and devolution of funding into community projects and organisations that have historically provided services for YBM. Policymakers should seek to ensure that YBM are heavily involved in the commissioning of a wide range of talking therapy providers, including those from the voluntary and community sector, and level the playing field to enable them to compete for psychological therapy contracts with traditional providers.

For example, policy makers would benefit from engaging in reverse mentoring[11] schemes with grassroots organisations such as https://blackthrive.org and https://breakingmad.org which have exemplified the importance of the collaborative, co-produced and culturally sensitive provision of psychological support, particularly during the COVID-19 pandemic. While the single point of access model remains the main referral route into psychological therapy, indirect and non-medicalised routes of accessing NHS may need to be developed. This is important as some YBM may not necessarily locate their distress as a medical problem but rather a product of social causes (oppression); thus, other pathways may be more acceptable (Myrie & Gannon, 2013). For example, setting up workplace health partnerships with employers might increase uptake of NHS therapy as this route of access was seen as favourable and non-stigmatising by some participants.

A further recommendation made by participants was to increase the representation of the current workforce within NHS services, including intersections of faith, class, and gender. Over the last year, the Clinical Psychology profession has witnessed a welcome increase in funding to diversify and decolonise the psychology field (Health Education England, 2020). The increased

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[11] (See Murphy 2012) Reverse mentoring is an innovative and cost-effective professional development tool that capitalises on building bridges and sharing expertise between individuals, organisations or groups.

availability of funding to further these efforts will be fundamental in bringing innovation, diverse thought, and informed choice for service users to access therapists and services that reflect the local population. However, the findings also demonstrate that increasing ethnic diversity alone is not enough. Government efforts to increase diversity should be matched with funding for training, multi-cultural competency development (Falender et al., 2014) and clear auditing structures to monitor the workforce's ability to provide inclusive and ethical care for ethnic minorities.

Clinical Invitations

"Find out where we are"

The current provision model within psychology services places the onus on communities that have been historically underserved to initiate support; however, evident in the existing literature are the structural barriers for marginalised communities (Memon et al., 2016; Morgan et al., 2005). Black men are hyper-visible in cultural and social locations, which they have associated with safety, belonging and inclusion. An example of this is the "Virtual Barber Chair" (Now Croydon, 2021), a collective space providing check-in sessions for Black men to connect and share their experiences. In this study, participants proposed engagement models that shift the weight of responsibility to services by "reaching out rather than the traditional mantra of outreach" (Keating, 2020, p. 1). To address psychological fears around accessing therapy, Yang and Jackson (1998) suggest assertive community outreach with community 'gatekeepers' such as pastors, youth workers and community leaders who already have trusting relationships with hesitant service

users. Building bridges of trust would also entail acknowledging organisations or individuals that are actively engaged with YBM and offering opportunities for them to be partners or consultants in the promotion, design, delivery and evaluation of services (Joint VCSE Review, 2019).

Co-production, Collaboration, and Innovation

Co-production with YBM at all stages of the decision-making process provides opportunities to honour their lived expertise within this community, rebalance hierarchies and inequalities in power (Arnstein, 1969; Noorani, 2013). At the service provision level, the use of pre-therapy engagement groups to clarify the role of the therapist and expectations of therapy may help demystify and de-stigmatise therapy for YBM. Setting up peer support streams (Bellamy et al., 2017) with former service users to share their therapy experiences with prospective service users may be a way forward. Especially for individuals who have not previously sought therapy, setting realistic expectations for therapy from the service perspective may be an essential first step in orienting YBM to make informed decisions about accessing therapy. With the rise of social media marketing and usage among young people, utilising social media platforms to disseminate targeted mental health information will help increase the digital visibility of NHS services. There is an emerging evidence base supporting the effectiveness of social media in facilitating social connections, overcoming obstacles such as stigma and promoting early help-seeking (Freeman et al., 2015; Highton-Williamson et al., 2015; Latha et al., 2020; Naslund et al., 2016). Clinicians could harness the popularity of virtual platforms that have sustained many during the pandemic by

providing information evenings and psychoeducation sessions on accessing therapy to circumvent geographical restrictions and resource issues.

Striving for Cultural Humility and Gender Sensitivity

The findings of this study showed that striving for cultural matching is not a panacea for addressing inequality gaps and providing culturally sensitive approaches (Secker & Harding, 2002; Warfa et al., 2006). The invitation from participants is for clinicians to uphold a therapeutic stance grounded in humility and criticality. Rathod et al. (2010) found that White therapists would often avoid issues around culture for fear of saying the wrong thing or being politically incorrect. In this study, participants welcomed discussions about their culture and named the humility required to be curious about YBM's social context. Mosher et al. (2017) stated that cultural humility is engendered through clinicians increasing their self-awareness, interrogating current practices, and identifying institutional procedures that marginalise minoritised communities.

It is valuable for therapists to suspend assumptions on how 'universal' masculinity ideologies apply to YBM. Open-ended questions exploring the role of constructs such as the "SBM" within the therapy may be a helpful way of validating the conflicting narratives surrounding Black men who decide to seek therapy. Within trauma-informed thinking, appreciating intersectionality (Shimmin et al., 2017) involves acknowledging the intersecting and myriad ways in which people experience oppression and domination. Assessment tools such as the Cultural Formulation Interview (American Psychological Society [APA], 2013) may be a valuable

springboard to initiate meaningful conversations about the intersectional and fluid identities that YBM possess. Unique to this study is the suggestion that the judicious use of therapist disclosure may increase Black men's receptivity to conversations about culture/identity and also functions to equalise the power imbalances in the therapeutic dyad (Mahalik et al., 2000).

Lastly, CPs should acknowledge the gender disparities in services, particularly privileged therapeutic engagement models and clinical recommendations based on evidence from female populations (Good et al., 2005; Mahalik et al., 2012). Mahalik and colleagues (2012) developed a taxonomy of male-friendly adjustments for boys and men (e.g., use of male-congruent communication styles, interrogating harmful gender/cultural scripts and use of self-disclosure). To date, no commensurate professional practice guidelines have been developed by the BPS targeted at working with men in Clinical Psychology. This is a clear gap that should be addressed to incorporate gender-sensitive adaptations into current practice and training. With the aim of starting to develop a knowledge base about effective practices based on participants' responses, clinical invitations for CPs and mental health practitioners that can be embedded into assessment, formulation, intervention, and outcome measurement are illustrated in Figure 6 and operationalised in Table 11.

Figure 6

Clinical Implications and Values

Safety

Collaboration & mutuality

Empowerment, voice and choice

Awareness of cultural, historical and gender issues

Appreciation of intersectionality

Trustworthiness and transparency
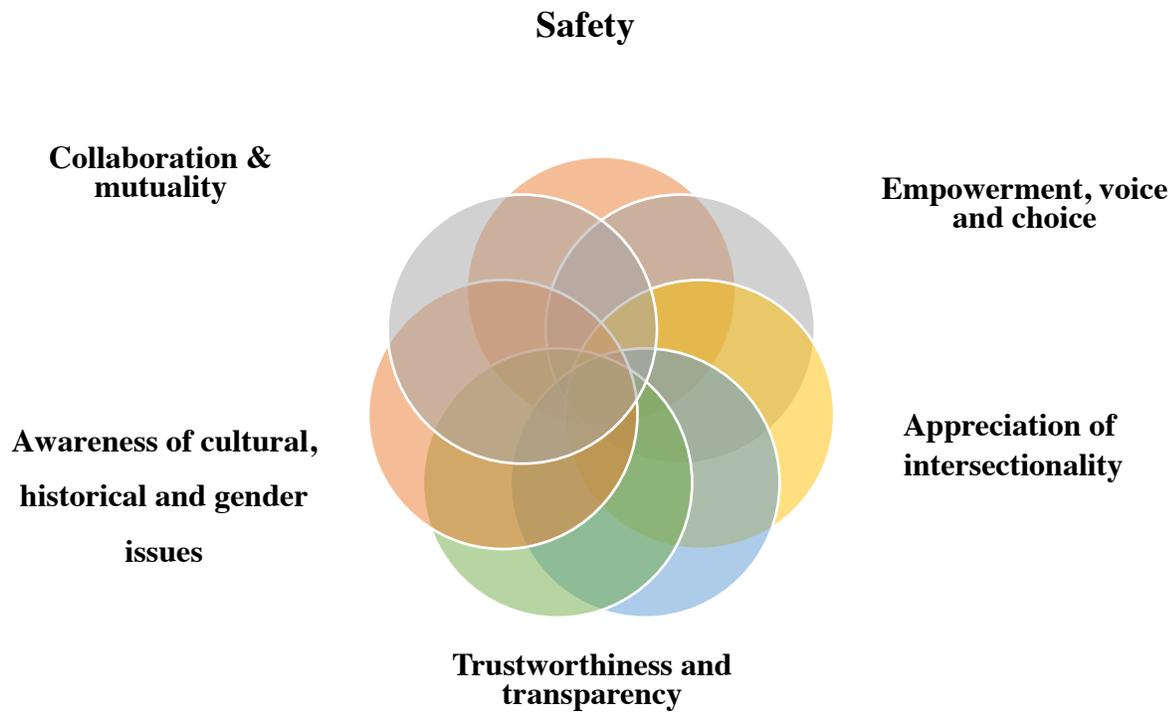
Note: Key principles of engaging Black men in therapy adopted from trauma-informed approaches (adapted from Bloom, 2006; Elliott et al., 2005).

Table 11

Summary of Clinical Implications

Clinical and service level considerations for increasing access and engagement of YBM	Invitations for Clinical Psychologists and Practitioners
Safety	Practitioners should ensure that therapy does not replicate experiences of discrimination outside of the therapeutic relationship for Black men.
	A safe therapeutic space can be created by setting clear expectations, dispelling preconceived notions, and reflecting on what it means for YBM to be in therapy. It is also important to consider differences in levels of expectations that are likely to exist between service users and manage them accordingly.
	"What do we need to consider in this space that would make you feel welcome in this space?"
Empowerment, voice and choice	Clinicians must remain unassuming in what is considered a suitable therapist match for Black men. Black men are willing to engage in therapy if they are given autonomy over the process. Empowering YBM in the room involves making micro-changes such as giving them control over what is disclosed, frequency of sessions, therapist type, and pace of sessions.
Appreciation of intersectionality	Clinicians should seek to understand the fluidity and diversity that exists with the YBM group. Services should respond to the heterogeneity in this population by understanding the context and conditions of YBM's lives. Extended formulation practice should seek to incorporate community, cultural, historical traumas such as racism, poverty, migration, colonialism, disability, homophobia, and intersections. (Sweeney et al., 2006).

Collaboration and Mutuality	Clinicians should honour the expertise, knowledge, and skills within the Black community and seek to collaborate with trusted parties/organisations to build bridges of trust and mutuality. Services should seek to involve YBM in the design, delivery, implementation of services as co-producers and equal stakeholders. This will help to address top-down power structures within services (Sweeney et al., 2016).
Awareness of cultural, historical and gender issues	CPs should be skilled at providing culturally and gender-appropriate assessments and interventions. The Cultural Formulation Interview (APA, 2013) invites opportunities to explore YBM's intersectional identities. Asking specific questions about identity and not making assumptions about the social axes that are most influential in how YBM position themselves may be helpful. *"As a trust, we aim to be inclusive. Is there any aspect of your identity that would be useful for me to know? This can be used to enhance the way we work together?"* (Accidental Activist, 2021).
Trustworthiness and transparency	Safe and skilful use of non-immediate self-disclosure in the initial stages of therapy indicates differences in culture and social status between the client and clinician. This requires transparency around their frames of reference, culture and owning knowledge gaps to establish trustworthiness. Clinicians should be supported in supervision and training to use self-disclosure with minority groups judiciously.

Critical Evaluation of the Study

This study is believed to be the first of its kind, adding empirical value to the limited understanding of the processes and experiences that constitute Black men's decision to access and engage with psychological therapy. More importantly, the project problematises the stereotypical

assumptions of men being 'hard to engage" concerning individual talking therapies. The study also increases our understanding of the factors that help and hinder positive therapeutic engagement for YBM, providing clear clinical implications and guidelines. However, some specific strengths and limitations are essential to keep in mind when interpreting the findings.

Study Sample

The study had a sample of thirteen YBM, who self-identified as Black and most were from a Black African, Nigerian background. This limits the transferability of findings to other Black subgroups, Black African-Caribbean, who have qualitative differences in their colonial and migration history and continue to be overrepresented in institutional care (Bhui, 2001; Karlsen et al., 2005; Morgan et al., 2005). Furthermore, as most participants occupied middle-class professions, their access to capital and resources may have afforded them access to private therapy due to their professional privilege(s). Their lived experiences might not represent Black men who occupy the lower levels of the socioeconomic ladder and may have less choice in accessing support that aligns with their needs. Studies have highlighted a correlation between low SES and MHS utilisation (e.g., Cadaret & Speight, 2018; Lincoln et al., 2010), suggesting that barriers to service utilisation may be more than race race-based and should take into account social-economic barriers.

Researcher Reflexivity

Being an 'insider-outsider' researcher added multi-fold benefits to this project. I came to this project with knowledge of the community under investigation. As a Black woman, my racialised experiences, proximity to the research topic and interpretations of the findings were inextricable. During the interviews, I noticed that participants responded openly to sensitive questions, offered rich reflections, and appeared relaxed in my presence, evidenced by the use cultural idioms and a shared vernacular. Greenwood et al. (2014) found that minority participants scaled down their responses to sensitive questions when in interviews with the ethnic majority group due to the fear of being mischaracterised or 'othered'. However, this insider position was also a limitation of the study. I was hesitant to ask follow up questions in response to participants' assumptions about my knowledge of cultural experiences/aphorisms. This could have impacted my ability to explore the meaning behind participants' statements. However, I was conscious about centering participants' narratives and creating a space for stories to live and breathe without imposing my interpretations (White & Epston, 1990).

DeLyser (2001) noted that greater familiarity with research subjects could compromise objectivity, increasing the risk of the researcher making assumptions based on prior knowledge and experience. Black researchers have argued that allegations of subjective bias have not been levelled at White researchers working with majority White populations (Serrant-Green, 2012). Operating within a critical realist framework provided a safeguard from the claim of objectivity. Instead, I remained transparent about the subjectivity of my interpretations. The study utilised peer

debriefing to share findings and elements of the research with a diverse group of supervisors, consultants, and doctoral colleagues to remain critical of the interpretations I made (Lincoln & Guba, 1985). The main strength of this process was the use of member checking. Five participants in the study were invited back to comment on the research analysis constructively and they validated commonality between the findings and their experiences. This research participation model set a precedent for active involvement of ethical practice in future research.

Recruitment Criteria

Due to the limited research into YBM's therapy experiences, the present study recruited YBM who had accessed therapy within and outside the NHS to circumvent access to participants. Widening the recruitments criteria highlighted the important institutional factors that influenced Black men's decision to opt for NHS or non-statutory services. As shown in Table 7 in the Methods chapter, at least half of the sample accessed private therapy. The views and experiences of the participants in this study may not be applicable in understanding care within the NHS, where more significant constraints exist. In addition, the study may also overlook good practices taking place within the statutory services due to the limited representation of participants from NHS clinical settings.

However, considering the lack of research into YBM experience of therapy overall, the research met the primary aim of understanding their experiences. The current study offered valuable insights and set the basis for future research to explore the factors that may help further our understanding of YBM's therapy experiences within statutory services.

Invitations for Future Research

The current study explored YBM's therapy experiences within the last three years, offering a cross-sectional account of accessing and engaging with psychological therapies. Many participants spoke about the multiple benefits that transcended their short-term therapy. As this field is often replete with the problem story of YBM, future research could thicken narratives around the therapeutic benefits from a longitudinal perspective. Research exploring YBM maintaining their resilience and harnessing the benefits of therapy, especially while navigating the environmental and social stressors associated with their racialised identities, will be crucial in widening access to positive and empowering narratives. This research could also be conducted using participatory action research (Baum, MacDougall, & Smith, 2006), providing a channel for YBM to take ownership of their stories and actively contribute to research that concerns their reality. Participatory action research is premised on equalising power in knowledge production and enabling YBM to voice what works for them. On this basis, co-researching YBM can be respected as survivors of social/institutional injustice and 'experts-by-experience' who offer ecological validity to the evidence base (Faulkner & Thomas, 2011; Noorani, 2013).

The current study also invites future researchers to explore the efficacy and utility of judicial therapist disclosure, especially when working with minoritised communities. Such research with therapists as participants would be essential in reviewing what is currently taught or discouraged around therapist disclosure within Clinical Psychology training programmes. Building a sound theoretical and empirical knowledge base on the utility of

therapist disclosure or, by extension, the "use-of-the-self" (Sleater & Scheiner, 2019) will provide clear implications for safe, skilled, and effective use of it as a therapeutic tool to optimise therapeutic working alliances.

Conclusion

This study explored the experiences of YBM accessing and engaging in psychological therapy within primary care settings. Given that this research area is dominated by narratives of YBM being 'hard to reach,' overrepresented in secondary care settings and not 'suited to talking therapies,' this study offered a counter-narrative from those at the heart of this conversation. The findings demonstrate that far from being reluctant to engage, YBM can and will engage in psychological therapy under dignified and safe conditions. The findings invite clinicians and services to be responsive to YBM's unique cultural context, offer choice, flexibility, and autonomy in the therapy room as a political and clinical tool for equalising the power differentials that YBM experience in society. There is no doubt that years of the systemic injustice faced by Black men will take years to reverse. However, there is an ethical imperative for CPs, policymakers, and service providers to use their collective power to dismantle existing barriers and work towards co-creating a system of provision that dutifully serves and humanises Black men. There is an invitation here for service providers and commissioners to critically engage in discourse on the current state of MHS provision, which continues to underserve YBM and is at grave odds with the tenets of the NHS constitution. The provision of equitable care for YBM is an urgent ethical and human rights issue that requires the implementation of actionable and measurable change.

Final Reflections

Through writing this project, the young man who inspired the birth of this project was my imagined accountability partner. I started the process with a myriad of unanswered questions, and as I have reached the finish line, I am left with unresolved feelings of anger, despair and sadness at the grave disparities that still exist in the care of Black men in MHS. I quoted papers from two decades ago chiming the same rhythmical pattern: inclusion, awareness, change, collaboration – all of which have historically fallen on deaf ears. The recommendations then are no different to what this project discovered. At various stages of this process, I felt completely disempowered in doing justice to stories I heard. At times, writing the research story felt like a desperate plea to legitimise and amplify YBM's narratives as a valid source of 'evidence.' At times, I felt the weight of responsibility to shift systems that are hopelessly stuck in a cycle of inertia and buried under masses of dust attracting White papers. The precious stories and the trust afforded to me by the participants in this study restored my hope. I was reminded about the transformative power of research in shaping how we think and feel about under-researched topics/groups. I have become intentional in creating safety through choice, acknowledging the privilege of accessing the lives of those who consult with me and honouring the small acts of political resistance inherent in the stories I hear. The stories I heard have also reminded me that Clinical Psychology cannot be apolitical in the face of inequity. This project calls for collective action towards dismantling unjust structures and the restoration of radical humanity in mental health provision for YBM through the work of our heads, hands, and hearts.

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Appendices

Appendix A: Devising the Interview Schedule

The section below outlines the 5-stages that were followed to devise the interview schedule according to Kallio et al's (2016) guidelines.

1. Identifying the pre-requisites for using semi-structured interviews

After surveying available methods to investigate the research question, semi-structured interviews were selected as the most appropriate method due to their flexible structure, ability to focus on sensitive topics (Willig, 2008) and glean diverse perceptions on the subject of study (Cridland et al., 2015)

2. Retrieving and using previous knowledge

A systematic literature review was conducted and critically appraised to retrieve previous knowledge on the topic. Within the literature, topics such as shame, stigma and masculinity were identified as key factors that influenced Black men's relationship with help-seeking. The interview schedules of previous studies exploring therapy experiences were reviewed (Hussain et al., 2020; Yasmin-Qureshi & Ledwith, 2020). I also consulted with three SUC's who provided valuable insights on their experiences of navigating psychological therapy services, including areas they reported to be important to their process. I also attended a research symposium on Black men and mental health, chaired by leading experts in the field such as Suman Fernando. The conference themes included: inclusivity, historical institutional racism and barriers to research participation within the Black community.

3. Formulating and preliminary semi-structured interview guide

The structure of the interview schedule was divided into four sub-themes: Help-seeking, the therapy experience, therapeutic relationship and reflections on the journey. The order of the questions was kept very loose to accommodate the dynamic and non-linearity of participants' responses and reflections. To that end, multiple opportunities were created to change the order of the questions without interrupting the interview flow (Dearnley, 2005). The consultation process involved the research team and one SUC to ensure that questions were well-formulated; questions that were perceived as leading, single-faceted or misworded were revised or eliminated (Cridland et al., 2015).

4. Piloting the interview guide

The piloting of the interview was a crucial stage in refining, reviewing and finalising the interview schedule. The first stage involved internal testing with my primary supervisor (Barriball & While 1994; Chenail, 2011). There were opportunities to consider potential bias or misleading questions; for example, as a Black British female researcher, I was keen to explore the role of the therapist's ethnic identity in the therapy process, which was based on my personal experiences. The wording of questions revealed potential interviewer bias and inappropriate leading questions (Chenail, 2011). The field testing involved simulating an interview situation with a SUC (Barriball & While 1994; Chenail, 2011). This was an opportunity to reflect on and test out the wording, intelligibility and appropriateness of the questions and identify areas that required adjustment in line with the research aims. Initially, there was confusion about whether

the interview schedule required participants to reflect on one or multiple episodes of therapy. I also noticed that the interview followed a very rigid structure with limited opportunities to elicit the participants' in-depth and varied perceptions and experiences. A decision was made to re-formulate the interview by incorporating pre-designed and spontaneous follow up questions to create space for participants to expand on their answers (Whiting, 2008) and improve coverage of the interview guide (Kallio et al., 2016). We also decided to build in warm-up questions in response to feedback from the SUC about the uncomfortable transition from the introduction section to delving into sensitive questions about their experiences (DiCicco-Bloom & Crabtree, 2006)

5. Presenting the semi-structured guide

The final interview guide (Appendix B) was presented in a logical, coherent and semi-structured manner. The items included were in line with the research aims and detailed enough to allow replicability for future use (Krauss et al., 2009).

Appendix B: Interview Schedule

Interview Schedule

Project title: Young Black Men's Experiences of Psychological Therapy

Introduction

Thank you for meeting with me today. As you know, I am doing some research on young Black men's experiences of talking therapy. This interview will last about 40 minutes to an hour; as it not intended to be a therapy session, it is less about the specific problems that led you to seek therapy but more about your journey and reflections. I want to own my context as a young black woman. I have no idea what it is like to be a young black man living in the UK. I will be exploring your experiences from a curious position and aware there might be some questions that don't feel comfortable for you. I just want to reassure you that you do not have to answer all my questions if you find them uncomfortable or upsetting. Please let me know if you don't understand my questions. I might not have worded them properly. To make sure I get a good sense of what you tell me, I might ask you to expand on things. Please remember you can request to stop the interview or take a break at any point.

Because I don't want to miss anything important, I would like to record the session. Is that okay with you? **Press record** It will only be listened to by the research team and will be destroyed afterwards. All your details will be kept confidential and anonymous.

Interview Questions

1. Please can you briefly describe the difficulties that you were experiencing that led you to seek therapy?

2. What were some of the first things (in terms of symptoms) that you noticed?

3. Were there any things that you did to cope with these symptoms?

4. What was your experience of seeking support from others such as friends and family?

5. From the first time, you noticed things were not well, how long did it take you to start seeking support from services?

6. What was your experience of seeking help from services?

   Prompts: Hopes, fears, barriers, facilitators

7. Do you have any thoughts of what might get in the way of black males accessing talking therapies?

8. What were your experiences of opening and talking through the things that brought you into therapy?

   a. Prompt(s): Was this experienced as useful? What worked? What didn't?

9. What did you make of your experiences as a Black man in the UK being in therapy?

10. Prompts: What do you think it says about you as a person?

11. Were there any other factors about the therapist that influenced your ability to connect to the therapist?

    Prompts: Ethnicity, age, cultural background

12. Were any aspects of your identity, for example, being a young black male, ever brought up in therapy?

    Prompts: What sort of things were explored? What was that like?

13. What did you learn (if anything) about yourself in the process of being in therapy?

14. What have you learnt from this process that you could share with services seeking to engage young black men with therapy?

Is there anything else you think is important for me to know as a researcher /ask to understand the experiences of black men accessing therapy?

Any last comments or reflections?

Thank you for taking your time to discuss your experiences with me.

Support information:

Debrief sheet:

Compensation:

Dissemination of results

Chosen Pseudonym:

Appendix C: Recruitment Poster

Are you a young (18-35) black man?

Have you ever been to therapy?

Would you be interested in sharing your experiences?

WE WANT TO HEAR YOUR VOICE!

Doctorate in Clinical Psychology Research Project

We are interested in hearing **your experience** of **talking therapy** in the NHS or the private sector. Research looking at the experiences of young black men accessing help for psychological distress is very limited. Your contribution will help us understand what is currently working, not working and what services need to do to support the psychological wellbeing of young black men.

Participation in this research will involve a **60-minute conversation** online or over the phone. In acknowledgement of your time and your kind dedication to the research, you will receive an Amazon voucher.

Please contact Noreen Dera (Principal Investigator) on **nd18aay@herts.ac.uk** to express your interest.

We look forward to hearing your experiences.

University of Hertfordshire **UH** Ethics Committee

This study has received ethical approval from the University of Hertfordshire Ethics Committee. Protocol number: **LMS/PGT/UH/04147**

Appendix D: Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Miss Noreen Dera
CC	Dr Lizette Nolte
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.
DATE	05/05/2020

Protocol number: **LMS/PGT/UH/04147**

Title of study: A Thematic Analysis of Young Black Men's experiences of accessing early help (formal support) for psychological distress.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

<u>**Permissions**</u>: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

<u>**External communications**</u>: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

<u>**Invasive procedures**</u>: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

<u>**Submission**</u>: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 05/05/2020

To: 30/09/2021

Please note:

Appendix E: Ethical Approval with Amendment to EC2 Form

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Noreen Dera
CC	Dr Lizette Nolte
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE	12/01/2021

Protocol number: **aLMS/PGT/UH/04147(1)**

Title of study: A Thematic Analysis of Young Black Men's experiences of accessing early help (formal support) for psychological distress

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Modification: Detailed in EC2.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 12/01/2021

To: 30/09/2021

Appendix F: Participant Information Sheet

Participant Information Sheet

Invitation

You are being invited to participate in a research study. Before you agree, it is important that you understand what your participation will involve. Please take time to read the following information carefully.

Who am I?
My name is Noreen Dera. I am a Clinical Psychology doctoral student in the School of Psychology and Sports Sciences at the University of Hertfordshire. Alongside my supervisor's Dr Lizette Nolte and Dr Roberta Babb, we are interested in finding out what it is like for young black men to access and engage in talking therapies for psychological difficulties.

What is the study about?

The NHS is the biggest provider of FREE psychological therapies for adults in the UK. Over the years, there has been a drive to improve the accessibility of services regardless of one's age, race, gender and ethnicity. However, national data suggests that young Black men are less likely to access talking therapies in the early stages of psychological distress and are more likely to be overrepresented in inpatient mental health hospitals.

This study will involve an hour-long interview to understand your experiences of accessing talking therapies for psychological distress as a young Black man. The findings may help to improve access to psychological therapy by investigating what is working and what also stops people. This will mean in the future, services can be more aware of how to meet the unique psychological needs of young Black men living in the UK.

Do I have to take part?

Participation in this study is completely voluntary. If you decide to take part, you can leave at any time during the process without giving a reason.

What are the risks of taking part?

For most people, talking about painful experiences from the past can bring strong emotions which can be very distressing. You don't have to answer any questions that you are not comfortable answering. If you find any elements of the discussion distressing or uncomfortable, you are welcome to ask for a break from the researcher. You can also ask to withdraw from the study at any point.

What are the benefits of taking part?

As a small gesture for your time and engagement with the interview, you will be rewarded with a £10 Amazon voucher for taking part. You will also be given a resource pack containing mental health support services.

Additionally, some people find it helpful to discuss their experiences in-depth with a researcher which may help to reflect on their journey of accessing psychological help. The indirect benefits of the study include helping services such as the NHS to better understand the needs of young Black males and things that make it more difficult or easier to access talking therapies.

What will happen if I feel distressed?

Due to the subject's sensitive nature, the discussions and questions asked during the interview may trigger strong emotional responses. To safeguard your wellbeing, you are welcome to take a break or stop the interview if you feel distressed at any point. You will be supported at various points of the interview if any distress is observed. If any risk concerns are disclosed, the researcher has a duty of care to inform relevant professionals/agencies and the Principal Supervisor of the project to ensure that these concerns are responded to appropriately and sensitively. You will also be given some information about support services you can access for additional help.

How will my taking part in this study be kept confidential?

All your details, consent forms and audio recordings from the interview will be stored electronically on an encrypted, password-protected hard drive which the researcher will keep. You will be assigned a pseudonym to keep your identity anonymous and confidential. Only the researcher will have access to your confidential information. You are free to withdraw your data at any time after the interview up until a specified date when the write-up and preparation for the submission process are underway. The deadline to withdraw your data will be February 2021.

Will my data be used in further studies?

Your data will only be used for the purpose of this study.

Who has reviewed this study?

This study has been reviewed by the school of Life and Medical Sciences (LMS), School of Psychology and Sports Sciences department.

<u>Who can I contact if I have any questions?</u>

If you would like further information or would like to discuss any details personally, please get in touch with me by email: nd18aay@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and considering taking part in this study.

Appendix G: Consent Form

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')
FORM EC3

I, the undersigned [please give your name here, in BLOCK CAPITALS]

……
…

of [please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]

…..………………………………………………………………………………………………………
…
hereby freely agree to take part in the study entitled:

A Thematic Analysis of Young Black Men's experiences of accessing and engaging in early help (formal support) for psychological distress

UH Protocol number: **LMS/PGT/UH/04147**

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed. I have been informed that a third party organisation will transcribe some of the recordings but full anonymity and confidentiality will be preserved.

4 I have been given information about the risks of my suffering harm or adverse effects. I have been told about the aftercare and support that will be offered to me in the event of this happening, and I have been

assured that all such aftercare or support would be provided at no cost to myself. In signing this consent form, I accept that medical attention might be sought for me, should circumstances require this.

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

7 I have been told that I may at some time in the future be contacted again in connection with this or another study.

Signature of participant…………………………………..Date…………………………

Signature of (principal) investigator……………………… Derah ………………………………

Date…………………………

Name of (principal) investigator [in BLOCK CAPITALS please]

NOREEN DERA

Appendix H: Demographic Questionnaire

Demographic Questionnaire

To help preserve anonymity and separate potentially sensitive/identifying information from your interview, please complete the following demographic questions to help me understand your current context.

* Required

1. Email address *

    _____

2. How old are you? *

    _____

3. How would you describe your ethnicity? *

    Mark only one oval.

    ( ) Black African

    ( ) Black Caribbean

    ( ) Black Other

    ( ) Mixed - White and Black African

    ( ) Mixed - White and Black Caribbean

    ( ) Mixed - Black African and Asian

    ( ) Mixed - Black Caribbean and Asian

    ( ) Mixed - Arab/ Middle Eastern and Black African

    ( ) Mixed - Arab/ Middle Eastern and Black Caribbean

    ( ) Mixed - Other

4. Which country were you born in? *

    _____

5.   If you were not born here, how long have you lived in the UK? *

     _____

6.   Which city do you live in? (city, region) *

     _____

7.   What is your highest educational qualification? *

     Mark only one oval.

     ( ) Phd or Doctorate

     ( ) Masters degree

     ( ) Undergraduate degree

     ( ) A levels

     ( ) GCSEs

     ( ) I have no qualifications

8.   What is your current occupation? *

     _____

9.   Do you consider yourself to be: *

     Mark only one oval.

     ( ) Heterosexual

     ( ) Gay/Lesbian

     ( ) Bisexual

     ( ) Other

     ( ) Other: _____

10.   What is your marital status? *

Mark only one oval.

◯ Single

◯ Married

◯ Civil Partnership

◯ Seperated

◯ Widowed

11.   Do you belong to any religious/faith group? *

Mark only one oval.

◯ Christianity

◯ Islam

◯ Hinduism

◯ Buddhism

◯ Sikhism

◯ Jewish

◯ Other

◯ Not affiliated

12.   Do you have any disabilities? *

Mark only one oval.

◯ Yes

◯ No

◯ Prefer not to say

Thank you for completing the questionnaire.
Your responses have be securely recorded.

Appendix I: Debrief Sheet

Dear (participant)

Thank you for taking part in this research. It is hoped that the findings of this research will help to provide an insight into the experiences of young black men who access talking therapy for psychological distress. This will potentially have implications for mental health services in delivering equitable, responsive and appropriate services for young black men, who are unfortunately under-represented in mental health services. When services are better informed about the experiences of the people who access services, this can help commissioners, service providers, and therapists consider ways of adapting services to be better suited to service users. Unfortunately, there is very little known about young black men's experiences, which often means many people can go unsupported until they reach a crisis point.

Your input today will be valuable in contributing to what we already know and providing new insights into what services can do to improve services for young black men in the future. Additionally, it hoped that by disseminating the findings of this study widely, it might also encourage other young black men to be aware of the lived experiences of others and the services available to them.

We understand that some of the discussions we've had today may trigger distressing feelings and thoughts. If you are feeling distressed and require further support, please let me know before you leave. We have also prepared an information pack for you to take with you containing some resources of support services available to you.

What will happen next?

The findings from this research will be analysed over the next few months to collate the themes from the various responses of those who have taken part. Once the results have been written up and submitted, there will be an opportunity to attend a feedback session to hear about the researcher's findings. If you cannot attend in person, a summary sheet will be sent to you via email with your consent. It is hoped that the results will be published for public dissemination and presented at various conferences and services. You have the right to withdraw your data until September 2021.

Thank you so much for taking part. I really appreciate your time. If you have any questions or queries, please do not hesitate to contact me at nd18aay@herts.ac.uk

Appendix J: Support Information

Support services for
your mental health

Alcoholic Anonymous
Call: 0800 9177 650 (24hrs)
www.alcoholics-anonymous.co.uk

Campaign Against Miserable Living (CALM)
for men of all ages
Call: 0800 58 58 58
www.thecalmzone.net

Dementia/Alzheimers Society
Call: 0300 222 11 22 (various times)
www.alzheimers.org.uk

Domestic Violence Helpline
Call: 0808 2000 247 (24 hours a day)
helpline@refuge.org.uk
www.refuge.org.uk

FRANK (Drug and Alcohol Advice)
Call: 0300 123 6600 (24 hours a day)
www.talktofrank.com

LGBT+ (Lesbian, Gay, Bisexual,
Transgender
Call: : 0300 330 0630 (10am-10pm)
www.switchboard.lgbt
chris@switchboard.lgbt

Rape Crisis (support for women and girls)
Call: 0808 802 9999 (various times)
www.rapecrisis.org.uk

SANEline (emotional support for yourself
and loved ones)
Call: 00300 304 7000 (6pm to 11pm)
www.sane.org.uk

Silverline (Support for older people)
Call: 0800 4 70 80 90 (24 hours)
www.thesilverline.org.uk

Victim Support
Call: : 08 08 16 89 111 (various times)
www.victimsupport.org.uk

National Association for People
Abused in Childhood (NAPAC)
Call: 0808 801 0331(10am-6pm/9pm)
www.napac.org.uk

The Black, African and Asian Therapy
Network
Find a BAME therapist in your area
www.baatn.org.uk

If you need urgent help

Go to your nearest hospital with an Accident and Emergency (A&E) and ask to speak to the mental health liaison nurse.
They can help you 24 hours a day.

If you need less urgent help

Don't suffer in silence! Get help. You could:

Contact your GP for an emergency appointment, or call the NHS non-emergency number: 111

Contact the Samaritans
Call for free: 116 123 (24 hours a day) Text:07725 90 90 90
email: jo@samaritans.org

Contact another organisations in this leaflet

Appendix K: Non-disclosure Agreement with Transcription Service

University of Hertfordshire

Doctorate in Clinical Psychology

University of Hertfordshire

<u>Transcription confidentiality/ non-disclosure agreement</u>

This non-disclosure agreement is in reference to the following parties:

Noreen Dera, Trainee Clinical Psychologist

And

Sonia Wilson

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient agrees to stop transcription immediately if they recognise any parties mentioned on the audio recording, and to return the recording to the discloser.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Name: Noreen Dera   **Signed:**   **Date: 6.06.2020**
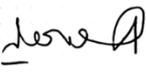
Name: Sonia Wilson   **Signed:**   **Date June 6, 2020**
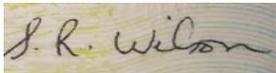
Appendix L: 15-Point Quality TA Checklist

A 15-Point Checklist of Criteria for Good Thematic Analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Appendix M: Transcripts with Initial Codes generated on NVivo

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Interviewer: Can you tell me a little bit about what influenced your decision to go private?

Respondent: One, I did not know much about the NHS in terms of what they offered. Another thing is that I wanted someone, even though I wanted a professional therapist, I still wanted someone who was Christian if possible, just because my faith is really important to me. Even though I didn't want typical counselling, I wanted them to have an awareness of my faith and belief in certain things because it was going to impact for me the kind of things I wanted to speak about. So that's why I went private. I found a therapist on the website for the Association of Christian Counsellors certified by the association of Christian counsellors.

Interviewer: Was the therapy mainly in person or both?

Respondent: It was mainly in person

Interviewer: Would you be okay to tell me, in a brief way what sort of difficulties that led you to seek therapy?

Respondent: I'd say I was experiencing quite a lot of anxiety and overthinking. One of things that they called it was relationship OCD. I've found that in my relationship, I was feeling extremely anxious at times and I was overthinking everything and I was almost looking for more, for reasons why it wouldn't work, then why it would work. So, I was very self-pessimistic in a sense of self-deprecating so because I didn't want to lose something precious to me, it would be good to face it, head on and speak to someone about it. Yeah.

Interviewer: And what were some of the first things that you noticed that things weren't very well for you? So in terms of symptoms, were there any signs?

Respondent: I would say the anxiety. So definitely just being generally anxious, going back and forth in my mind. So one day really excited about the future one day, dreading it, and almost my mind was almost like a ping pong ball. Like it was up and down how would enjoy the relationship. So, there were times I'll be really excited and, you know, happy and joyful. There'll be times when I would withdraw because I was so anxious and scared and yeah. And

Coding Density

perceptions of therapy are shaped by the media
faith central to identity and experiences
learning to observe experiences objectively
increasing visibility of NHS services
ethnicity did not impact choice of therapist
practical considerations around therapy access
choice and flexibility with private
therapist having a christian background
wanting a christian therapist
affordability
de-mystifying therapy
neutrality of therapist helped
generational differences in uptake of therapy
encouragement from friends
being vulnerable with therapist without fear of judgement

fleeting emotions
relationship anxiety

11072020Tom

done better or that could have been done better. Maybe I might have that opinion after now that things are different something or that I might feel a bit different, but actually because of what I was going through at the time and how I was at the time, I thought that's exactly what I needed. I wouldn't have changed a thing if I'm being honest.

Interviewer And kind of just thinking about your experience, how did you make sense of your experience of being in therapy as I guess as a young black man or as a man? How did you make sense of of that whole experience?

Respondent I mean, after, like, the second or third one, I just came to that conclusion that this was something that I didn't want to run away from, the fact that I thought and and that's why I say that with therapy, you've got to do at least two or three because the first one, usually you're probably going to say 'what is the point of this?'. But that's that's kind of the point. And that's where you want to be at, you want to be talking. And so I asked her about that as well. Oh, I get it. I guess I didn't need to be apprehensive, I didn't need to be worried or scared or whatever.

Interviewer Mm hmm.

Respondent Yeah, so that was so that was just that was just it was the mindset that needed to be changed and was going to change over time anyway. And to me, it was almost like it was going to change over time anyway. It was almost like finally admitting to myself that there was nothing to worry about in regards to that. Yeah, it was important for that perspective anyway.

Interviewer And just looking at the, you mentioned a little bit about your therapist much earlier when we were talking about you, you kind of experience of opening, about opening up about the things that brought you to therapy. And can you tell me a bit more about your therapist in terms of what did you find most helpful about them and you in supporting you in making sense of your experiences?

Respondent Yeah, I think our approach to me as an individual but also the things I was going through was really good. It was neutral, which I think was very helpful. It wasn't. It wasn't judgemental or you're the problem. It was nothing like that. It was like, OK, I'm listening. You don't have to say anything. Again, it was coming from a place of, it was

Coding Density

talking about emotions was overwhelming

therapist linking past and current experiences

Barriers to sharing problems with others

therapist was non-judgemental

better self-understanding

getting on with it

denying the existence of a problem

outsider therapist is unbiased

outsider therapist learning about cultural background

clear guidance and awareness of what therapy entails

creating space for open dialogue

therapy came at the right time

learning practical strategies to cope

accessing at a critical point

talking about childhood trauma was helpful

early intervention prevents problems later

noticing change in attitude overtime

learning to lean into discomfort

therapist qualities trump racial similarity

therapy requires persistence

Code   Annotations   Edit

...talking about the things that brought you to therapy? So thinking about kind of what was experiences useful? What worked? What didn't? Just that whole process, if you could give me some insight into what that was like for you?

Respondent: Sure. Yeah, as I mentioned before about the kind of the wait period before being actually seen and still doing what I could In the meantime, by the time it got to the talking therapy, there was already a detachment to the strong emotions attached to the depressive episode. So when I was in therapy, I kind of only notice retrospectively that it was as if I was analyzing myself with the therapist in that detached sense, because I couldn't access a lot emotionally. So I ended up accessing all the experiences intellectually, which I don't think really helped in the long term, but it was more like yeah, hmm, "he does do that". I was like "oh, yeah, no, I do that". Hmm, interesting. And then she'd offer a point and then I'd offer a point. So it ended up being like a discussion and a debate and not really like the therapy I expected which was to be a bit more emotionally connected.

So that experience of detachment has stayed with me throughout the process. I mean, I uncovered a lot about myself in that process regardless, but it wasn't what I was expecting. To be a bit more specific about the experience. We did cover a lot of themes, a lot of topics. I'm using them like themes. We talked about a little bit about my childhood, the pressures at home and then the main thing itself, what happened? My relationship and what caused the main kind of crumbling down into that depressive period. My therapist was a white woman, middle class about; I want to say early 40s. And I'm signifying that because I also realized how that drove the conversation into be a bit more intellectual. I wasn't misunderstood, but a lot of my experiences I felt I can talk about, like growing up in Togo or just a lot of experiences rooted in I guess I want to say black experience that I couldn't really access and because I couldn't really access them again, I ended up intellectualizing them to make it relevant to the space.

Interviewer: Hmm. What was that like for you not being able to access some of that in the therapy space?

Respondent: It was frustrating. Not in the space itself but outside when I left. I kind of wanted to talk about that but I don't know why I didn't, I don't know why I couldn't. But I also realized what we were doing was still helpful. Sometimes I guess, objectively dissecting my experience and trying to uncover ways I could better deal with things in the future. So yeah, there was a little bit of frustration. But in the space itself, I kind of sat with what I felt comfortable with, opening up about and what I didn't. And you know, that's okay. I found my peace with that. Yeah, the things I could talk about I did.

Interviewer: Hmm.

Coding Density

associated therapist dynamic with work dynamic around white people

black identity and the intersections were not explored

racial similarity helps with connection

difference between reality and expectations of therapy

engaged in therapy on an intellectual level

creating a comfortable environment

therapy requires readiness to engage

learnt accept personal qualities and characteristics

was realistic about what to expect in therapy

found it difficult to access childhood experiences

intellectualising the conversation with therapist

accessed support through a charity

codeswitching in the therapy space

using creativity to make sense of experiences

fear of being misunderstood

masculinity norms

therapy environment helped him to connect

community outreach

opening up is difficult

18062020Maxwell

up to you, I'm expecting something from you, I'm expecting you to help me with my problems or for you to help me find a solution to my problems. So it was hard for me because when I didn't receive that at times, I felt frustrated for opening up because it didn't make me feel better. So it was a struggle, like I said, it took me quite a long time to get comfortable because some of the thoughts that you speak about in your sessions, you don't share with anybody. So when you share something that you've never shared with anybody, and then in your mind, you might start thinking, okay, what are they thinking about me? What's she saying? What is he thinking? So you might start to kind of drawback a bit, you don't see the response that you were looking for or that solution you're looking for. So it kind of, I don't know it's like you take 2 steps forward and then take 4 steps back constant process.

Interviewer: What do you think that might be about what might be kind of, what are your thoughts about what might get in the way of opening up about those things?

Respondent: Just feeling vulnerable, I think vulnerability is one of the hardest things that any human can do really. I think, especially if someone you don't really know on a personal level and you're sitting there expressing how you feel, what you feel and you don't know anything about this person sitting in front of or for me. Apart from their age, their agenda and their race can be quite difficult because almost you can feel that there's hardly really any common ground there, apart from you just being a human being. It's like sometimes when you speak to you, you might speak to somebody or your family members or your friend, and they might share something a difficult time they've gone through. And you'd be like, okay, I've been through that as well, and then you have like a common ground where you can build something off and it starts to feel good. But when you're speaking to a therapist, what they're going to say is good and it's helpful, but that first point where you have to open up, you feel like you're just a piece of cattle on a show almost. You know you feel like oh my God man, they don't know anything about me, but I don't know anything about them and yes it's difficult at times.

Interviewer: And are there any aspects of therapy that you found helpful, anything that you think worked well?

Respondent: Yes, I think just the general structure, what works well to a certain extent that

Coding Density

power dynamics with therapist

space to relax or calm down before the session

expectations to be fixed by therapy

commitment to process over goals

proximity in age helps relatability

Barriers to sharing problems with others

difderence between reality and expectations of therapy

black men accessing help in crisis

superficial discussion about race

took a long time to open up

similar background reduces burden to explain things

lack of common ground with therapist

race discussions being tokenistic

relability with therapist

lack of role models or examples of people in therapy within social circles

friends don't always understand

maternal connection with female therapist

considering black men's vulnerability

being emotionally detached from the therapist

.082020LSpiela

here? She started asking me questions, just getting to know myself. So I initially started off as very formal, just getting all my information. I was kind of like, ah, if it's one of these formal things, I'm not really with it. You know, there's no care there. If there's no care there, you don't want to know about me. Like, I was just I was ready just to be like yeah, one-word answers. Waste my time. I was just thinking I'm going to curse off xxxx after this.

But I so once the formalities kind of went out the way she started just generally asking questions about myself, just kind of my upbringing. People like to talk about themselves, you know, even if they only put you in a certain environment, people like to talk to tell you about themselves, it's just kind of predictable about my upbringing, which kind of triggered a lot of kind of thoughts previously based on the questions she asking. And as the conversation went on, we got to know each other, she shared a bit, kind of you know, she shared a about herself as well and her upbringing. So I kind of built that comfortably in the relationship together because she wasn't just a face or just an entity I had to go and respond to. She was giving me a stimuli back. Right. So I started to react to so we were bouncing back and forth of each other. So that was really helpful to build that rapport. Think she did a very good job on building the rapport first. And of course, as that continued to go on, I become more open to ask more her more personal questions like, you know, you're a mixed-race woman, like I'm a black male, I'm from the ends and I'm from hood and where are you from. And she started talking about herself so, you know, really is

Coding Density

impact of race and class in upbringing
having similar upbringing with therapist
preference for black therapist
similar background reduces burden to explain things
go to where people are at
easy to access private
therapist need educating themselves on the black male experience
permission to let guard down in therapy
asking therapist about race
motivation to engage in therapy transcends the self
understanding the self in context
assumptions of white therapist
Working with a white therapist
first impressions of therapy
informal dialogue in sessions helped
seeking aspects of therapist to relate to
person centred questions helped to ease up the process
acclimatising to therapy process over time
factors that determine suitability of therapist
speaking to trusted friends
GP recommended therapy

Code
Annotations
Edit

Appendix N: Intercoder Review of Codes

Noreen's Codes	Review with suggestions
Part 1	
Mistrust In NHS	Agree
Seeking best possible care	Agree
Planned Endings	Structured therapy
Being stereotyped as a black male	Agree
Imposter Syndrome regarding achievements	Agree / Self-Doubt? / precarious identity position?
Anxiety	Agree
Wisdom is needed to progress in society	Battling against expectations within society
Impact of race and class in upbringing	Striving amidst race and contextual challenges
	High expectations from self
Pressure to excel and meet standards at work	
	Fighting against expectations as a blessing and a curse
Emotional consequence of having pressure as a Black man	
	Agree
Overthinking	
	Agree
Impact on emotional and physical health	
	Agree
Difficulty switching off	
	Agree / Noticing impact
Social Withdrawal	
	Noticing impact

Self-focus not present with others	Noticing impact
Sexual performance affected	Self-Help
Self-Help through reading	Self Help
Body focused techniques	Consulting
Consulting with friends from medical backgrounds	
Gym to keep mind clear	Self Help
Talking helps	Support from loved ones
Speaking to trusted friends	Support from trusted friends
Speaking to friends depends on the problem	Relatability from other men / Gender differences in support
Easier to talk to men about problems	Gender differences in support
Increase in responsibilities triggered problems	Difficulties increased with age and responsibility
GP recommended Therapy	Recommendation
Motivation to engage in therapy transcends the self	Agree
Ease of access	Agree
Hope to learn new tools	Hopes for therapy
Having realistic expectations to therapy	Realistic expectations
Fear of being vulnerable	Agree
Weakness will get you killed	Risks associated with showing weakness
	Agree

Men put on a façade	Don't show weakness
Opening up a sign of weakness	Therapy as liberating
Being vulnerable with therapist without fear of judgment	Agree
Socialisation of men	Agree
Masculinity norms	Barriers to access NHS
Easy to access private	Recommendation Barriers to accessing therapy
Family recommended therapy Cost can be hinderance	Agree
Lack of awareness	Mistrust in services
Mistrust in services for MH	Agree
Therapy is for white people	Mistrust in talking to strangers
Insecurity about sharing business with strangers	Agree
	Discomfort with formality
First impressions on therapy	Person centred approach
Formality at the beginning was off-putting	
Person centred questions helped to ease up the process	Addressing race
	Therapist disclosure
Asking therapist about race	
Self-disclosure from the therapist helped engagement	Therapist disclosure / power dynamic
	Feeling alone in struggle / socialised to not address emotions
Therapist disclosure broke down power dynamic	

That's the issue with us black boys, we feel like we're alone in that and if we are going through something, we think we are the only going through this and no one will understand because growing up, weren't asked, how do we feel? Are you OK? How do you doing?	Investment from therapist
And having that and that kind of shook me, you just have someone like you really do you really want to know about me and what I'm doing? And it's crazy. I know I'm paying you for it but it's still kind of a nice thing. And yeah, it was just really cool to experience learn and from her about herself and it made it easier for me to share things about things about myself, which kind of helped me to see sense about the way I am feeling about things like that was really good.	Being challenged in therapy / fear of breaking down
There was whatabouts, she was really good at asking me what about kind of questions, really challenging what literally whatever words I threw out. She would challenge every single word. So why would you use all or there then? That's a plural. She'd give me those kinds of questions and it just makes you think I was sort of making delve into it to break it down.	

## Appendix O: NVivo Codes Grouped together

- substance use
- therapist qualities
- therapy came at the right...
- understanding and aware...
- white therapist won't und...
- being actively engaged wi...
- choice and flexiibility with...
- difderence between realit...
- ease of access
- encouragement from frie...
- fear of being judged by ot...
- has become an advocate...
- keeping things private
- lack of awareness
- opening up is sign of wea...
- perceptions of therapy ar...
- readiness to engage
- relationship problems

Navigation View ...derstanding and s...

- social withdrawal
- stigma around therapy exi...
- therapist being patient
- therapy as for crazy people
- awareness of black men's...
- being proactive in finding...
- having an outsider helps...
- noticing change in self
- self-reliance
- use of prayer and spritual...
- better self-understanding
- community outreach
- problem worsening
- talking helps
- masculinity norms

Files\\06062020Victor
2 references coded, 1.03% coverage

Reference 1: 0.56% coverage

No, it was quite an isolating experience, I guess. I've been called, like, emotional in the past and I've been called sensitive. So I guess that kind of scarred me for life so I kind of dealt with my problems by myself.

Reference 2: 0.47% coverage

So the conclusion that I made is that I am meant to be my own therapist and reading psychological self-help books and apply it to my problems. Because I'm the only one that can really

Files\\18062020Edem
3 references coded, 1.48% coverage

Reference 1: 0.57% coverage

he onus was not always relying on others, even though, yeah, I do need external help. But what can I do other than just wait and wallow? I was journaling, walks, meditation. And mostly that stuff. I think I said...

Reference 2: 0.32% coverage

I mean, like me in the first place, the reason why it took me so long to get there was because I thought I could do it myself.

Reference 3: 0.59% coverage

I did think at one point the reason why it took me so long to get there was because yeah, I can do it myself. That male ego, "I can handle it. No, it's fine, I'll be fine". And that took a lot of unpacking of gains into therapy.

Files\\18122020Kofi
2 references coded, 0.73% coverage

Reference 1: 0.29% coverage

If I was going for years and years of trying to be my own personal soldier trying to fix

Appendix P: Stage 3 Analysis – Searching for Themes

Appendix Q: Stage 4 Analysis – Reviewing and Refining Themes
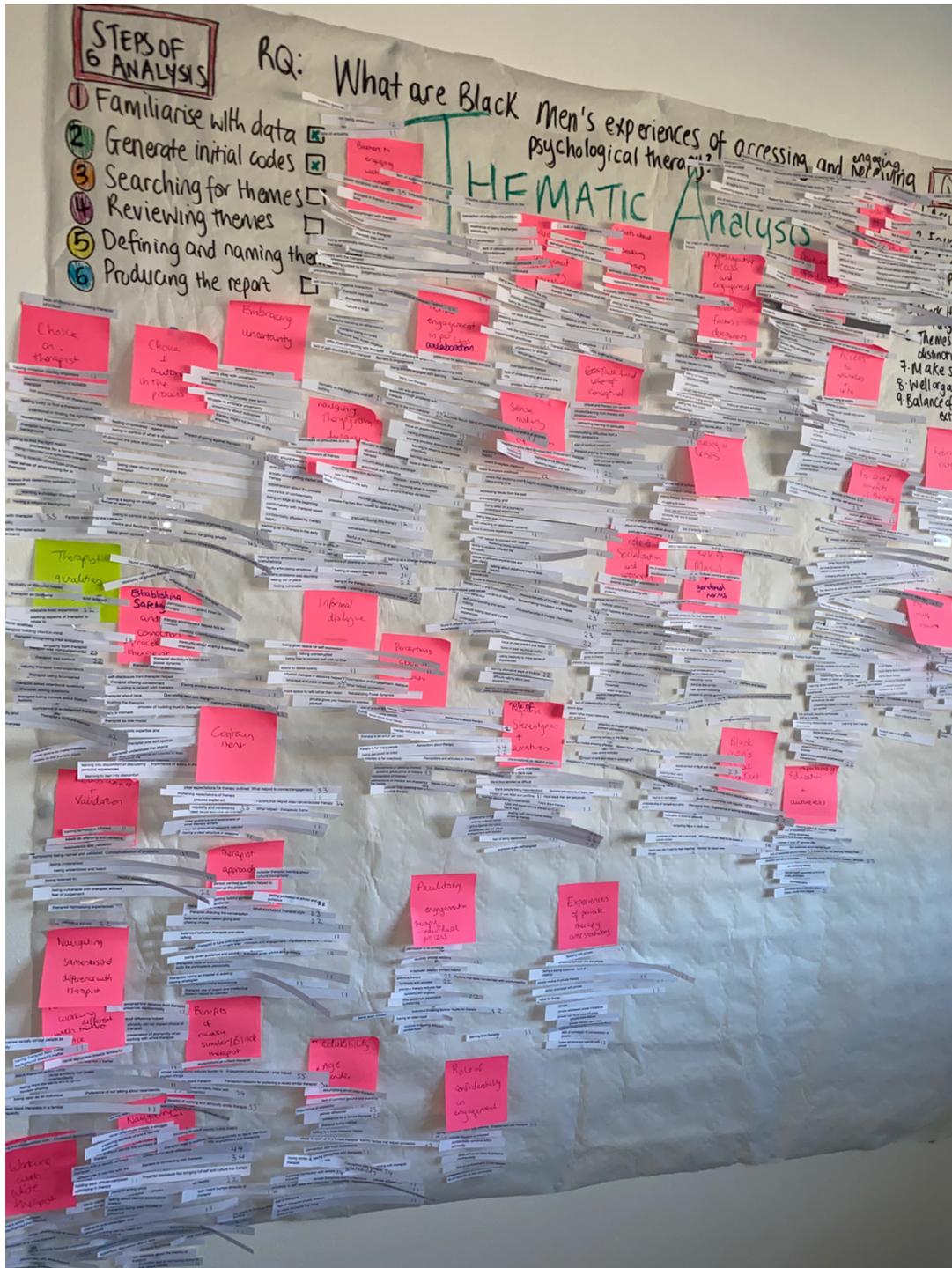
Appendix R: Preliminary Thematic Map
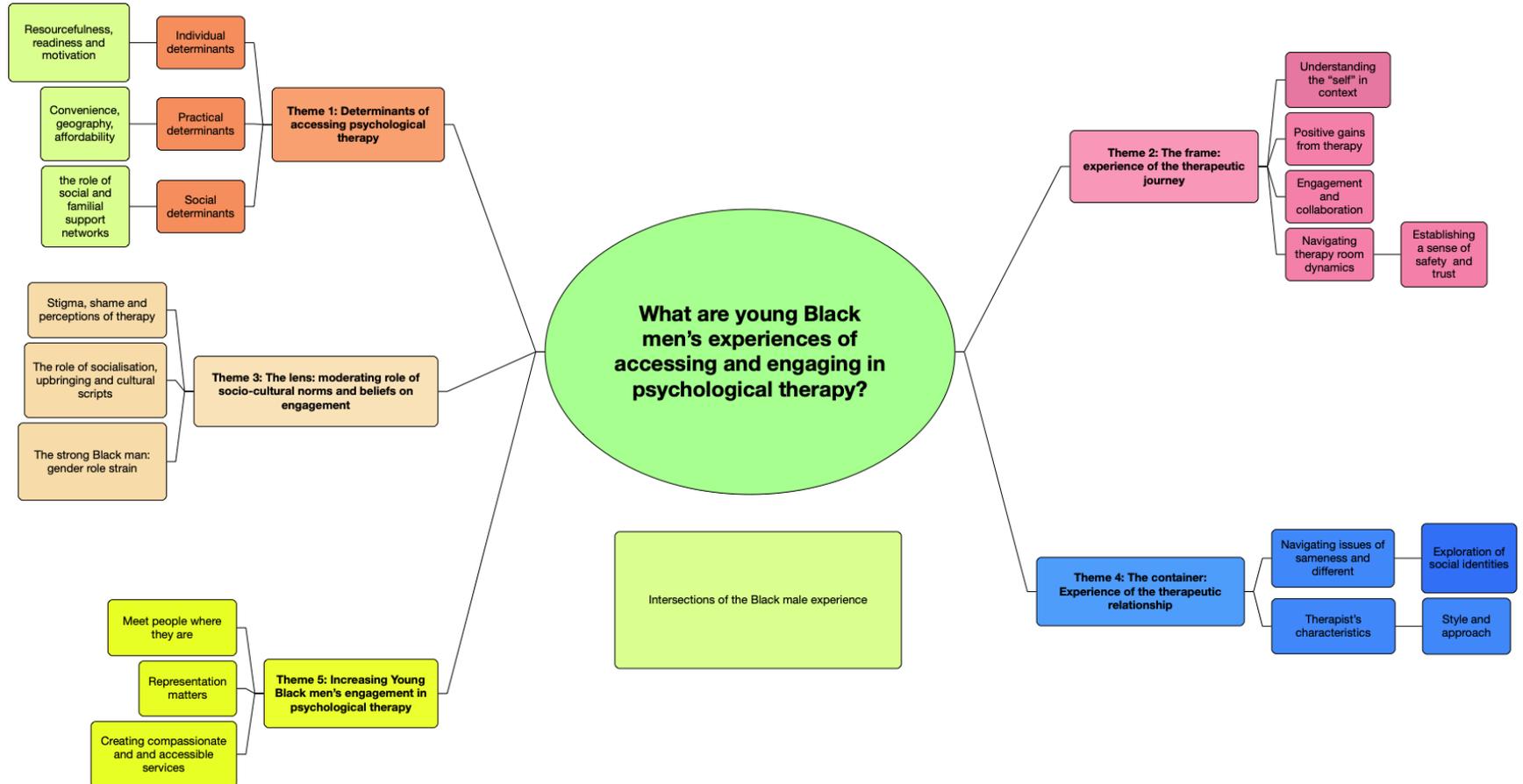
Appendix S: Social Positionality Map
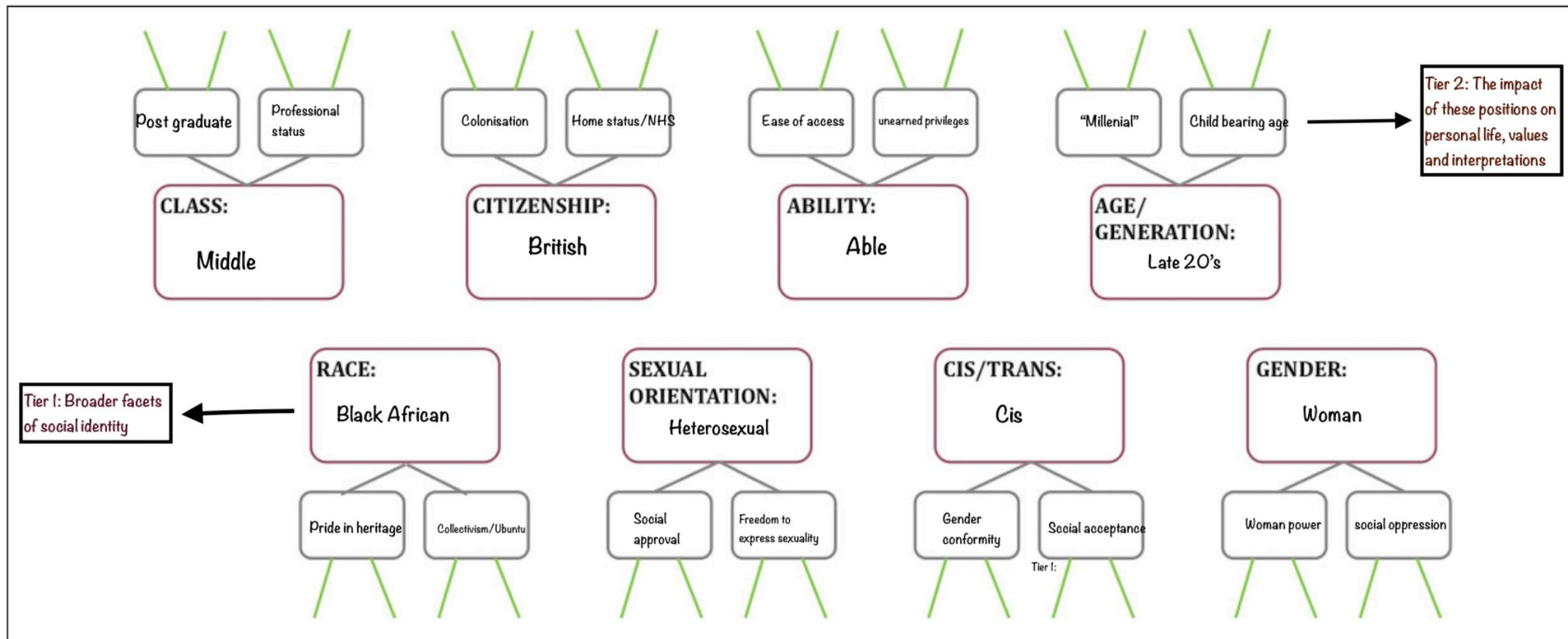
Appendix T: Excerpts from Reflective Diary

21.05.2020

Service user consultant meeting. We discussed the interview schedule and explored areas that I had omitted I.e., disability? I wondered what it meant to not attend to this – whether this was an oversight or a social axe that I do not routinely attend to in my practice.

We also discussed his experiences of therapy and what areas he felt were left unexplored by his therapist for example the role of his identity as White Irish man from a lower-class background and his willingness to do so but had no opportunity to explore this. The SU consultant encouraged me to incorporate this within my interview and explore YBMs process of talking about their intersecting identities in therapy. What does it mean to have a white SU – does that change the process or areas considered? Not really as he seemed cognisant of the struggles and systemic barriers faced by YBM which really helped our conversation to focus on the phrasing, placement of questions, ordering, etc which all provided valuable insights into how a SU might experience my interview schedule.

25.06.2020

Meeting with 6th participant. Interview went well but at times I found myself being drawn away from the interview script to find out more about the interviewees experiencing namely because he was speaking in third person. I wondered if this was a way of still being in denial that he had difficulties and accepted help – so to help lessen the discomfort, taking a de-centred position helped to make the conversation less about him but more about the general context.

A lot of comments like: "you know what it's like as a black person" "you know what it's like with our culture" assumption of homogeneity and perhaps feeling connected to me as a black researcher and feeling comfortable to make these statements and perhaps not having to explain further. I wonder if I could have had an opportunity to ask further to ensure I was not making assumptions about his position but also felt reluctant to ask for clarification for fear that this would replicate the experiences BP often have with non-black people which involve

17.01.2021 READING AND RE-READING TRANSCRIPTS

Reading my transcripts and one quote keeps ringing in my head. It goes, "I wish I knew therapy was for everybody" this had me thinking about who has been constructed to be fitting for therapy and how the media crystallises these narratives. There is a hidden inclusion and exclusion criteria which we see embedded in services too. Who gets to referred to Psychology v physical treatments dependent on the referring clinician's construction of who fits? Unchecked bias promulgates discriminatory practice.

13.02. 2021

Analysis notes

Over the last 2 weeks, I have been fully immersed in the preliminary stages of the data analysis, searching for initial codes in the data. The process of familiarisation, reading and re-reading the data has given me intimate contact with the participants' responses, felt-sense, utterances, and latent/manifest meanings of what the participants shared me. I was struck by the depth of their insights, especially their capacity to embody openness and transparency in sharing their experiences which also mirrored their process of therapy. I was so drawn to their narrative and noticed that my response to their disclosure was often met with mms and direct questions which I employed to maintain a degree of distance as a researcher due to my proximity to the subject matter. I have been conscious of my own biases as a researcher for example, whether I was making assumptions about the meaning that the participants were conveying based on my own lived experiences as a Black woman. I was also conscious of the influence of my knowledge in the subject area tainting the process of inductive coding. When I noticed my coding was moving towards a theory driven rather than data driven approach, I paused and took notes and recorded a memo observing my emotional reaction to the content. I also made sure that I had a post it notes on the corner of my laptop screen displaying the research question to anchor my process and to ensure I was maintaining an inductive approach. I also wondered if I was coding beyond what the data was conveying, for example eliciting latent codes. I was also surprised by some of the findings: for example, the discussions around race, the barriers and challenges black men face in even making the first step to speaking up and the role of cultural and masculinity norms I.e., what is expected being a constant force that men have to resist to place their wellbeing first. I was in awe of therapy being described as art and an act of self-care; these two descriptions really struck me viscerally and vividly described therapy beyond the physical realm moving more into a spiritual abstraction. This has really illustrated that one cannot fully divorce themselves from the subject; I have a whole context that influences my sense-making and being transparent about my process only helps to enrich the process and increase the credibility of the research.

9.03.2021 REFLECTIONS ON MEMBER CHECKING – PARTICIPANT FEEDBACK

In the second focus group, the discussions really challenge some of the themes that I had constructed by adding nuance to the 'strong black man' (SBM) trope. While others felt they did not identify with It, one participant felt that the intention behind SBM is to emphasise resilience an armour that he needs to put on to survive the harms of the world. He felt that the SBM has been wrongly communicated and he did not perceive it as a harmful stereotype. This reflection left me with a plethora of thoughts around how I present the theme around masculinity and appreciated this valuable feedback which wouldn't've been possible without the contributions from the participants. The participants agreed with the themes and felt that they truly represented their experiences, the 'engagement cycle' Many were in awe of the time and meticulousness that had been put into the project. I was left feeling mostly relieved that there was true concordance in my sense-making and the men's stories but also deeply touched by the validation they gave. While it has been a long, challenging, arduous and time-consuming process, getting the participant's rubberstamp on the findings is exactly what I needed and prioritised above everything. Now it is time to get writing!