

Staying Strong: Exploring experiences of depression and anxiety in Black Caribbean women in the UK

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Abstract

The image of the Strong Black Woman (SBW) is a western cultural construct that depicts Black women as strong, self-reliant, independent, yet nurturing and self-sacrificing, putting others' needs before their own. Research in the US has indicated that this image negatively impacts on the emotional well-being of Black African heritage women by increasing depressive and stress symptoms, and acting as a barrier to help-seeking for emotional support (Beauboeuf-Lafontant, 2007, 2008; Watson & Hunter, 2015). The image of the SBW, and how it shapes the emotional wellbeing of Black women, has not been explored in the UK context. This is problematic, since very little is known more broadly about how this group of women experience and manage mental health problems. The current study began the process of addressing this omission by exploring Black Caribbean women's experiences of mental health issues. Using five focus groups with a total of 18 participants, the study explored how a sample of Black Caribbean women within the UK, experience and manage symptoms of depression and anxiety in relation to the SBW image. Thematic analysis of the focus groups data revealed that participants had an ambivalent relationship with the SBW ideal; they rejected it, describing it as mythical, whilst simultaneously embracing its strength component. The importance of 'being strong' consistently underpinned the participants' narratives. For many, strength and resilience were viewed as necessities to survive a society which they regarded as racist. However, despite the perceived functionality of 'strength', many illustrated how this strength impacted upon their ability to effectively cope with symptoms of anxiety and depression, leading them to deal with these symptoms in restrictive and sometimes unproductive ways, such as somatization. The findings from this study offer implications for understanding Black women's experiences of mental health problems. Furthermore, they also increase awareness of the SBW image for mental health professionals, and demonstrate the impact this image can have on Black women.

Introduction

Background and introduction to the study

It has been well established that exposure to multiple stressors such as poverty, social exclusion, and discrimination can increase an individual's susceptibility to mental health problems (Denny, Clark, Fleming & Wall, 2004; Fischer & Holz, 2007; Karban, 2011; Lehmillier, 2012; McLeod & Shanahan, 1993; Thomas, Witherspoon & Speight, 2008). The Black African Caribbean population living in the UK (hereafter referred to as Black) have a long history of experiencing these factors, including racism and socioeconomic inequalities (Fryer, 1984; Keating, Robertson, McCulloch & Francis, 2002; Williams & Williams-Morris 2000). It is therefore likely that members of Black communities are susceptible to experiencing mental health problems. Research in this area has tended to explore the Black UK population as a whole, not considering possible gender differences in the experience of mental health (Bhui, 2001; Sharpley, Hutchinson, Murray & McKenzie, 2001), or has mainly focused upon the mental health needs of Black men (Berthoud, 1999; Keating, 2009). Very little is therefore known about the mental health needs of Black women, which is troubling since it has been reported that these women are more susceptible to mental health problems due to their adverse life circumstances (Mohamed, 2000), and yet they are less likely to access health services for emotional and psychological support (Keating et al., 2002).

The small amount of UK research conducted on the mental health experiences of Black women has found that they are reluctant to seek help for psychological and emotional problems, and commonly manage such difficulties through trying to 'stay strong' (Edge & Rogers, 2005; Sisley, Hutton, Louise Goodbody, & Brown, 2011). This need to 'stay strong' has been linked to the 'Strong Black Woman' (SBW) image – a racial and gender construct that depicts Black women as inherently resilient and strong (Beauboeuf-Lafontant, 2007; Harris-Perry, 2011). The SBW has historically been associated with African-American women, although it appears to be common in several Western countries, having been documented in Canadian and UK literature (Edge & Rogers, 2005; Etowa, Beagan, Eghan & Bernard, 2017; Schreiber, Stern & Wilson, 1998, 2000). As discussed below, the SBW ideal has been increasingly of interest to researchers (Beauboeuf-Lafontant, 2003, 2007, 2009; Harrington,

Crowther & Shipherd, 2010; Harris-Perry, 2011; Jones & Shorter-Gooden, 2003; Kerrigan et al., 2007; Watson & Hunter, 2015), with a considerable amount of US research dedicated to examining this image. For example, several studies have highlighted the negative impact the SBW image has upon the health and emotional wellbeing of African-American women (Donovan & West, 2015; Harrington et al., 2010).

Despite the SBW image having international reach, much of the research in this area has been conducted in the US, with little exploration of other contexts. It is therefore possible that the SBW ideal has significant implications for how UK Black women experience mental health problems. To my knowledge, there is no research that explicitly examines the impact of the SBW within a UK context. This study therefore presents findings of a qualitative nature that explores how Black women negotiated their mental health problems in relation to the SBW image. In particular, it focuses upon the two most commonly experienced UK mental health problems – depression and anxiety (Evans, Macrorys, & Randall, 2015). This brief overview will be elaborated upon in the literature review section of the thesis (pp. 13-27), where the prevalence of mental health problems within UK Black communities is discussed, along with the implications of the SBW image on Black women. First, however, within this introduction section of the thesis, the SBW image will be introduced, since this is a central concept within the thesis. Following this, the relevance of this study in the field of counselling psychology will be discussed; my personal interests in the topic will then be explained; ending with an overview of the structure of the thesis.

The Strong Black Woman image

The SBW image, which has also been referred to as the 'superwoman' role (Reynolds-Dobbs & Thomas, 2008; Wallace, 1979; Woods-Giscombé, 2010), portrays Black women as 'she-warriors'; with an innate capacity to withstand adversity at all times despite external stressors (Beauboeuf-Lafontant, 2009). Characteristic behaviours typically associated with the SBW are to be self-sufficient, to confront all trials and tribulations independently and to remain strong and fiercely independent at all times and thus avoid appearing 'weak' (Abrams, Maxwell, Pope & Belgrave, 2014; Beauboeuf-Lafontant, 2005, 2007,

2009; Kerrigan et al., 2007). Furthermore, she must retain the ability to provide an unlimited source of support to her family and others around her, often at the expense of her own needs (Abram et al., 2014; Watson, 2013; Watson & Hunter, 2016; West, Donovan & Daniel, 2016).

Some may argue that all women, regardless of their ethnicity, race or cultural influences, are pressurised to exhibit strength in times of crisis. The distinctive factor that separates Black women from women of different ethnicities is rooted in socio-historical factors such as transatlantic slavery. It has been argued that the origins of the SBW dates back to North American Chattel Slavery (Abrams et al., 2014; hooks, 1981, Harris-Perry, 2011). During this time, African-American women were forced to endure – and subsequently survive – brutal and barbaric treatment from White slave owners. This created the perception amongst these owners that these women possessed a superior physical and psychological type of strength compared to White women. This perception, however, only served as a justification to continue such inhuman treatment of African American women for decades (Harris-Lacewell, 2001; hooks, 1981). Whilst the notion of strength stemmed from outside of the African American community, for women in this community, strength was also a requisite to personally survive daily life that was filled with violence and brutality (hooks, 1981). Furthermore, being strong and caring for others was necessary for community survival, since African-American women were responsible for looking after the vulnerable, such as young children and pregnant women (hook, 1981). It is important to note that whilst the SBW image has been documented to hold relevance for African American women, this image is historically familiar to UK African Caribbean women also, due to their shared heritage since both groups emerged from post slavery Black Atlantic communities (Bush, 1990; Gilroy, 1993).

Despite the abolishment of slavery in the eighteenth century (Bush, 1990), the SBW image has not been relegated to history; rather this ideal is transmitted globally via media, where Black women are often portrayed as SBW's. For instance, there are various song lyrics promoting Black female independence, determination and self-sufficiency. Alicia Keys, a Black US female singer-song writer, in the song *Superwoman* sang about being proud to be able to maintain strength in the face of adversity:

*Even when I'm a mess,
I still put on a vest,
With an S on my chest,
Oh yes,*

Furthermore, Destiny's Child, a US Black rhythm and blues group, comprised of Beyonce Knowles, Kelly Rowland and Michelle Williams, also sung about possessing the ability to maintain resilience and strength when experiencing life difficulties in their song *Survivor*:

*I'm a survivor,
I'm not gon' give up,
I'm not gon' stop,
I'm gon' work harder,
I'm a survivor,
I'm gonna make it,
I will survive,
Keep on survivin'.*

These song lyrics appear to reinforce the SBW ideal – they convey the message that Black women can exhibit resilience and strength when dealing with their responsibilities and life challenges. Moreover, it can be argued that these lyrics indirectly encourage Black women to suppress their emotional pain, and any signs of vulnerability, in favour of promoting independence and strength.

This ideal is also transmitted via Hollywood films and US television shows as Black women tend to be cast as feisty and strong characters, thereby perpetuating the idea that Black women possess a superhuman type of strength. For instance, the Black actress Kerry Washington plays the character Olivia Pope in the US TV drama series *Scandal* (Rhimes, 2016). Pope is portrayed as a powerful, highly-independent, determined woman who does not tolerate sad and distressing emotions. Likewise, the Black actress, Jennifer Hudson played a strong and emotionally resilient character in *Sex and the City* (King, Melfi, Parker & Star, 2008). In British television soap operas, British Black actresses are often

cast as gutsy, strong and independent characters, such as the Black actress Rachel Adedeji who joined *Hollyoaks* in 2016 to play Lisa Loveday (Redmond, 1995 – 2017). This character is depicted as strong-willed and 'with attitude'. Furthermore, in the British films *Adulthood* (Madani & Clarke, 2008) and *Anuvahood* (Taussig et al., 2011) the Black women characters were depicted as strongminded and feisty in comparison to the White women characters in the films. These are just a handful of examples, there are many more.

Online news articles and blogs are another way the SBW ideal is transmitted, with various UK articles calling attention to the damaging effects of the strength expectation on Black women (Cox, 2016; Frank, 2016; Sinclair, 2015). In an article for the online magazine called *Gal-dem*, Varaidzo (2016) explains that Black women feel unable to talk openly about mental illness because of the SBW expectation, so they suffer with mental health problems in silence. She advocates for creating safe spaces where Black women can discuss their mental health needs without feeling pressurised to embody the SBW ideal.

Importance and Relevance for the field of Counselling Psychology

To understand the significance and relevance of this research for the field of counselling psychology, it is important to begin by briefly examining the nature and values of this field.

Counselling psychology has a longstanding commitment to social justice (Goodman et al., 2004; Motulsky, Gere, Saleem, & Trantham, 2014). Some have argued that social justice has been central to the counselling psychology profession since its inception (Motulsky et al., 2014; Palmer & Parish, 2008). The concept of social justice, has been based on the idea that all members of society regardless of their ethnicity, culture, sexuality, religion, disability, age, or other distinctive characteristics are given fair treatment and an equal share of benefits, resources and opportunities (Chung & Bemak, 2012; Speight & Vera, 2004). The social justice approach within counselling psychology, therefore, highlights the need to recognise and challenge the oppression and control of marginalised individuals (Speight & Vera, 2004); it also highlights the need for counselling psychologists to work towards social justice (Goodman et al., 2004). According to Fouad, Gerstein and Toporek (2006), this can be achieved through activities such as working towards promoting therapists' multicultural

competences, as well as combating the systematic barriers that affect the mental health of marginalised people.

In the US, counselling psychology has had a well-established relationship with social justice movements and connected values (Cutts, 2013). However, the relationship with social justice is less explicitly developed within UK counselling psychology (Cutts, 2013); despite its main aims which are to encourage counselling psychologists to challenge the social marginalisation of individuals (British Psychological Society, 2005). Moller (2011) argued that counselling psychology in the UK has "an overly rigid and often over identification with phenomenology and humanistic values" (p.8), rather than a commitment to diversity and multiculturalism. Furthermore, it has been argued that counselling psychology, as a discipline, needs to place more focus upon the collective, the community and the social environment in order to resolve human suffering, rather than locating the cause of the problem within the individual (Goodman et al., 2004; Thatcher & Manktelow, 2007; Speight & Vera, 2004).

As discussed above, Black women are socially marginalised and experience social injustice (Carby, 1997; Weekes, 1997). Although the BPS (2005) aims to work against social injustice, there has been little literature focusing upon the social marginalisation of Black women in UK counselling psychology. This research, therefore, is an important addition to an overlooked area of study. It provides a platform for the voices of Black women to be heard by mental health professionals and thus this research will have the potential to help with the development of appropriate and inclusive mental health provisions for this socially marginalised group. Additionally, the act of 'giving voice' to Black women and listening to what they have to say in their own terms, rather than testing preconceived ideas or assumptions, coincides with the values of counselling psychology. Within counselling psychology, emphasis is placed upon individual subjective experiences, making meaning of these experiences in ways which can be understood by others (Strawbridge & Woolfe, 2003). I now discuss my personal interest in this topic.

Personal interest in the topic

My interest in this area was formed by my own personal experiences as a Black woman, who favoured showing signs of strength over distress. I would often slip into the SBW persona when faced with life difficulties; I would adopt

an 'I can handle it' attitude or silently repeat a 'you can do this' mantra to myself in attempt to smother out any feelings of distress. I knew that I was not the only Black woman who did this; I was aware of countless other Black women who engaged in these same behaviours. This led me to wonder about UK Black women's experiences of mental health problems and the impact that 'being strong' had on them.

During my counselling psychology training, subjects such as ethnicity and culture featured very little within the course material. Furthermore, my search amongst the counselling psychology literature identified relatively little on the experiences of Black women and mental health. It was for these reasons that I chose to explore Black women's experiences of mental health problems as a topic for my thesis. I outline my personal interest not only to identify my positioning with the topic, but to highlight how this might have shaped the present research and how I attempted to manage this throughout the research process. I elaborate on this subject in the reflexivity section of the thesis (see pages 41-45).

Overview of the structure of the thesis

This thesis is divided into five sections including this introductory section, followed by a literature review, where I review the relevant theoretical and research literature related to the research topic. I end this section stating my research aims and questions which have served as the focus of the study. Following this, I provide details of the methodological approach taken, outlining the epistemological positioning, methodology adopted and methods used at each stage of the study. In the fourth section, I outline my own experiences, assumptions and beliefs about the research topic, in attempts to engage in the necessary research process of reflexivity. Within the final section – results and discussion – I report the findings of the study in relation to the research questions posed, whilst also reflecting upon these findings in relation to prior literature. I also refer to the limitations of the study and recommendations for future research and clinical practice.

Literature review

An electronic literature search was conducted on selected databases, these included, but were not limited to: PsycINFO, PubMed and Sage journals. The search engines GOOGLE and GOOGLE Scholar were also used. Searches for articles deemed relevant were also carried out in the *Journal of Black Psychology* and *The Counselling Psychologist*. The following key words were used in searches: Black and Minority ethnics in psychology, Black women and mental health; African Caribbean's perceptions of counselling; African Caribbean and mental health; diversity and Counselling/Clinical Psychology; Strong Black women; Strong Black women and mental health problems; Black women and depression/anxiety; Black women and help seeking. Furthermore, relevant published books and internet articles were reviewed and evaluated for the significance to the topic of Black women's mental health problems. Given the paucity of UK literature available on Black women's experiences of mental health problems, the review will draw heavily upon US literature.

This literature review begins with discussions around the definition of depression and anxiety and the risk factors for these two mental health disorders. Within this section, literature detailing the prevalence of these risk factors within Black Communities will be explored. The review will then turn to an exploration of the prevalence of these two disorders within the Black population. The final sections critically engage with research on help seeking behaviours amongst Black women experiencing mental health disorders and the implications of the SBW ideal for the health and emotional wellbeing of Black women.

Depression and anxiety

Depression and anxiety are some of the most common mental health disorders in the UK. According to the Office of National Statistics, 1 in 5 adults in the UK experience anxiety or depression at any one time (Evans et al., 2015). Depression and anxiety disorders are both emotionally disabling (Martin-Merino, Ruigomez, Wallander, Johansson, & Garcia-Rodriguez, 2009; Paykel & Priest, 1992), with depression cited as the most common mental health problem contributing to the suicide rate in the UK (NICE, 2011). The fifth edition of the American Psychiatric Association (APA)'s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) states that depression causes irritability, depressed

mood, fatigue, decreased pleasure and feelings of worthlessness. Sleep disturbance, restlessness, excessive worry, and muscle tension are listed as common symptoms of anxiety (APA, 2013).

Causative factors of depression and anxiety

Due to the debilitating effects of depression and anxiety (Martin-Merino et al., 2009; Paykel & Priest, 1992) and the global prevalence of both conditions (Baxter, Vos, Scott, Ferrari & Whiteford, 2014; World Health Organisation, 2015), a large amount of research has been dedicated to identifying causative factors of these two disorders. Research into this area has highlighted the relationship between the biological factors and these disorders, centred on underlying biochemical abnormalities in the brain as a causative factor (Deacon, 2013; Leo & Lacasse, 2008). However, other research has identified the importance of the social environment – suggesting that negative interactions with the social environment can play a significant role in the development of mental health problems (Broman, Mavaddat, & Hsu, 2000; Fergusson, Horwood, & Lynskey, 1997; Mill, 2015; Moffitt, Caspi, & Rutter, 2006).

Black people in the UK have faced a long history of racism – a form of discrimination that derives from the belief that groups should be treated differently according to the colour of their skin (Glenn, 2009). There are several types of racism, including racial microaggressions, whereby a person of colour is subjected to brief and everyday acts that carry a subtle hint of prejudice (Sue et al., 2007). Research has found that these acts, despite their subtlety can adversely affect the emotional wellbeing of its victims (Donovan, Galban, Grace, Bennett, & Felicie, 2012). Institutional racism is another form, whereby social institutions such as governmental organisations, schools, and courts of law treat groups of people differently and negatively based on their race (Brennan, 2017). Institutional racism can greatly impact upon a person's social environment because it leads to social inequality such as poor housing, unemployment and poverty (Equality and Human Rights Commission, 2016).

Given the potential challenges Black people face within their social environment, this study will examine the impact of the social context as a causative factor of depression and anxiety instead of exploring the biological factors. This will be discussed in the following three sections: Economic deprivation, unemployment and racism.

Economic deprivation: This can be particularly corrosive and detrimental for an individual's mental health (Funk, Drew, & Knapp, 2012; Hanandita & Tampubolon, 2014; Mills, 2015), since poverty creates additional life stressor such as homelessness, financial worries and household debts (Mountney, 2012). UK research consistently identifies poverty rates for Black and Asian people as higher than those for White British people (hereafter referred to as White people). Kenway and Palmer (2007) explored the poverty rates amongst different ethnic groups and found that 30% of the UK Black population lived in poverty compared to 20% of the White population. High rates of poverty have also been found amongst Black women living in the UK (Nandi & Platt, 2010). Furthermore, recent figures from the Department for Work and Pensions (DWP) (2017) found similar rates of poverty amongst ethnic groups – indicating that Black households are at a great risk of being in poverty compared to other groups.

Since Black people are more likely to experience poverty and because poverty negatively affects mental health (Mountney, 2012); it is likely that Black people are more vulnerable to mental health problems. Research into this area identified a link between poverty and mental health problems for non-White ethnic groups (Funk et al., 2012; Hanandita & Tampubolon, 2014; Mills, 2015; Mountney, 2012). Additionally, research on Black women living in poverty identified financial strain as a significant contributing factor to their depression (Edge & Roger, 2005; Siefert, Finlayson, Williams, Delva & Ismail, 2007).

Unemployment: The unemployment rates for Black people living in the UK are much higher compared to other ethnic groups (Abbott, 2012; Ramesh, 2012). Recent UK figures have found considerably high unemployment rates amongst Black and Black Caribbean populations (13.8%) in comparison to the White population (4.9%) (Office for National Statistic [ONS], 2015). An enquiry during 2012 into unemployment and UK women of colour found that these women, and particularly Black women, were affected by unemployment (Runnymede Trust, 2013). One explanation for this is racial discrimination, since the Black women who responded to the enquiry reported experiencing racial discrimination. They felt they were asked specific interview questions that assumed they were single

mothers, had many children, and/or were lazy (Runnymede Trust, 2013). Such questions appear to be reflective of the racial stereotypes of Black women (Harris-Perry, 2011; Reynolds, 1997). The enquiry highlights that Black women are subjected to subtle forms of racial discrimination early in the recruitment process, which ultimately limits their chances of employment rendering them more likely to be unemployed.

It has been suggested that unemployment can seriously implicate the health and wellbeing of individuals, affecting their self-esteem and self-worth (Goldsmith, Veum, & Darity, 1997; Sheeran, Abrams, & Orbell, 1995). Furthermore, research in this area has found that unemployment can negatively affect mental health; with reports that mental health problems were higher amongst unemployed individuals compared to those who were employed (Fergusson, Horwood & Lynskey, 1997; McGee & Thompson, 2015).

Racism: This form of discrimination is theorised to adversely affect mental health by generating feelings of worthlessness, powerlessness and low self-esteem (Curtis & Lawson, 2000; Fernando, 2003). The association between racism and mental health problems has been widely documented. Research has identified that everyday racism can trigger the onset of depression and anxiety. This was highlighted in Ong, Fuller-Rowell and Burrow's (2009) study where they gathered the self-recorded daily diary entries of racist experiences (such as being ignored, denied services or overlooked) from 174 African American doctoral students. The authors found when participants endured racist episodes they reported higher levels of anxiety and depression. Research has also found that a racist act does not necessarily have to be committed for racism to scar an individual's mental health and emotional wellbeing, since the perceived threat of racism has been linked to common mental health problems (Chakraborty, McKenzie, Hajat, & Stansfeld, 2009; Kessler, Mickelson, & Williams, 1999; Williams, Neighbors, & Jackson, 2003).

A number of scholars writing over several decades have discussed the significant implications of racism on the psychological wellbeing of Black people (Fanon, 1986; Feagin, 2001; hooks, 1981). Furthermore, the associations between racism and mental health problems have been widely researched, especially amongst Black populations living in the UK (Chakraborty et al., 2009;

Karlsen & Nazroo, 2002) and amongst African American populations in the US (Williams & Williams-Morris, 2000). Alcock (1999) argued that Black people living in the UK have faced a long history of racism and early Black Caribbean migrants were subjected to overt forms of racism, such as hostility, harassment, abuse, and even violence. Bryan, Dadzie and Scafe (1985) explored the experiences of the early Black women migrants and described how they were subjected to racism in many areas of their lives. In relation to employment for example, they were either employed as low paid domestic labourers or they were denied employment opportunities due to the colour of their skin. In addition, they were often targets of violent physical and psychological abuse by members of the White population.

Even though Bryan et al.'s (1985) work was written more than 30 years ago, more recent literature suggests their findings still have relevance, with scholars theorising that Black people experience subtle, yet frequent accounts of racism on a daily basis, known as microaggressions (Constantine, Smith, Redington, & Owens, 2008; Sue et al., 2008). The term microaggression has been defined as '...everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group' (Sue et al., 2007, p. 273). Further US research in this area has found Black women in particular commonly reported experiencing subtle forms of racism on a daily basis such as feeling invisible and silenced within the workplace and other professional settings, and feeling expected by others to live up to racial and gender constructs, such as the SBW and the Angry Black woman (ABW) construct (Lewis, Mendenhall, Harwood, & Browne Hunt, 2012). Due to their subtle and frequent nature, microaggressions are often dismissed by individuals and thus often go unnoticed, undetected or unchallenged. Emerging research in this area, however, has established that these microaggressions can impact an individual's mental health leading to negative outcomes such as stress, feelings of anger, invisibility, and marginalization (Donovan et al., 2012; Sue et al., 2009).

The above research and literature has identified that Black people in general have greater exposures to multiple stressors, such as racism, employment difficulties, and financial deprivation. Since these stressors have been well recognised as causative factors in the development of mental health problems, it is likely that Black people have an increased vulnerability to

developing such problems. The next section explores the rates of mental health problems within the UK Black communities.

Prevalence of mental health problems within UK Black communities

Research has highlighted that UK socially marginalised groups generally have poorer health (Nazroo, 1997), and have greater barriers to accessing health care compared to the overall population (Aung, Rechel & Odermatt, 2010; Ngwena, 2013), with some groups faring much worse than others (Peate, 2012). The association between being a member of a socially marginalised ethnic group and the likelihood of developing a mental health problem has been well documented (Cooper et al., 2008; Fernando, 2003; Hutchinson, Morgan, & Murray, 2008).

Research has highlighted that depression in socially marginalised ethnic groups is 60% higher in comparison to the White population (Hailwell, Main & Richardson, 2007) and Nazroo (1997) found a higher prevalence of depression in Black participants compared with White participants. Similarly, Rehman and Owen's (2013) used a convenience sample of 740 people from socially marginalised ethnic groups to explore rates of depression and anxiety within these groups. They found that nearly half of all Black Caribbean's (43%) surveyed had been diagnosed with depression and over a quarter (26%) had been diagnosed with anxiety, thereby indicating that high rates of depression and anxiety exist (or are diagnosed) within this population.

Additionally, UK research identified Black people to be more likely to be diagnosed and treated for psychosis in comparison to White people (Keating, 2009; Pinto, Ashworth, & Jones, 2008). Black men are particularly over-represented at the severe end of mental health services (Keating et al., 2002), and they are reportedly three times more likely than the general UK population to be admitted to psychiatric units (Mind, 2013a). Studies in the 1990s that explored Black populations in Jamaica (Hickling & Rodgers-Johnson, 1995), Trinidad (Bhugra et al., 1996), and Barbados (Mahy, Mallett, Leff, & Bhugra, 1999) found lower rates of psychosis in comparison to Black African Caribbean populations living in the UK. This suggests that Black individuals of African-Caribbean heritage living in the UK experience certain social factors that are not shared by other Black populations living outside of the UK.

Institutional racism within British psychiatry could be a potential explanation for the high rates of psychosis within Black African-Caribbean populations. Macpherson highlighted the term as the “collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin” (Macpherson, 1999, para. 6.34). Although, it is important to consider that whilst it is plausible for Black people to have higher rates of mental health difficulties, due to social marginalisation they face; institutional racism within British psychiatry may also play a significant role in the elevated rates of psychosis in Black people, in the sense that Black people are more likely to be diagnosed. It has been suggested that Western psychiatrists’ practice within a Eurocentric diagnostic framework (Singh & Burns, 2006) and thus are more likely to misinterpret the behaviours and distress of Black people due to being unfamiliar with Caribbean beliefs (Littlewood & Lipsedge, 1981; Sashidharan, 1993), which could readily lead to problems in diagnosis. For example, Grier and Cobbs (1968), in their book *Black Rage*, used the term “healthy cultural paranoia” to describe a defensive strategy developed in response to living within a racist environment. In a hostile and racist society, Black people, for their own survival may maintain a degree of suspicion and mistrust of (White) others. However, this paranoid stance, can be misinterpreted by medical professionals who are insensitive to the racialized experiences of their Black patients, and thus pathologize such coping mechanisms.

A survey conducted by the National Centre of Social Research asked adults across England about their experiences of mental health and found that women were more likely to have been diagnosed with a common mental health disorder (CMD) compared to men. The findings also suggest that an increased social disadvantage and poverty is associated with a higher risk of CMD (Stansfeld, et al., 2014). Black women experience both racism and sexism, along with other social disadvantages (Collins, 2009; Harris-Perry, 2011; hooks, 1981; Nandi & Platt, 2010) and therefore are likely to be at a greater risk of experiencing some mental health problems than Black men and White women. It is for this reason that the prevalence of depression and anxiety within Black women will be explored in the following section.

Prevalence of depression and anxiety in Black women living in the UK

To understand the experiences of mental health problems amongst Black women, research has generally compared the prevalence rates of mental health problems between White and Black women. However, the results of this research have been inconsistent. Early studies in this area found lower rates of anxiety amongst Black women in comparison to White women, (Nazroo, 1997; Shaw, Creed, Tomenson, Riste & Cruickshank, 1999). However, other studies have reported higher rates of anxiety amongst Black women when compared to White women (McManus et al., 2009). The discrepancies in the findings may be due to Shaw et al. (1999) and McManus et al. (2009) neglecting to control for variables that are considered risk factors for anxiety, such as the socio-economic and marital status of respondents. It is well established that low socio-economic status and single parentage are two factors that render an individual vulnerable to anxiety (Baer, Kim, & Wilkenfeld, 2012; Mullins et al., 2010), thus controlling for these variables may have reduced these discrepancies.

Regarding research on depression within the Black female population, the longitudinal cohort study by Edge et al. (2004) identified that Black women were less likely to present with depressive symptoms to health professionals compared to White British women. However, when it came to Black women self-identifying their depression, Stansfeld et al. (2016) found the prevalence of depression to be higher in Black women compared to White women, indicating that there is a reluctance amongst Black women to report mental health problems to professionals. Interest, therefore, has been raised regarding the extent to which Black women (and Black people in general) seek professional help for their emotional distress; this will be explored and discussed in the next section.

Help seeking patterns within UK Black communities

Primary health care provides a pivotal role in the detection and management of mental health problems (Gask, Sibbald, & Creed, 1997). In the majority of cases, GPs are usually the first point of contact for people with mental health problems (Airey, Boreham, Erens, & Tobin, 2003). Yet research has identified that Black people usually encounter mental health services via the police and the criminal justice system (Banerjee, O'Neill-Byrne, Exworthy, & Parrott, 1995; Keating, 2009). This begs the question of the extent to which

Black people are likely to seek help for their mental health problems rather than find ways to cope (or not) without professional help.

Prevalence studies have found mixed results with regard to rates of help seeking behaviours for mental health problems amongst UK Black and White populations. Some research has shown that socially marginalised ethnic groups were just as likely to seek help for mental health problems from Primary Health Care services compared to White British people (Maginn et al., 2004; Shaw et al., 1999). In contrast, more recent studies found Black people were less likely to seek help (Cooper et al., 2010). Cooper et al. (2013) reported that Black African Caribbean people are less likely to consult their GP about their mental health problems and are less likely to take antidepressants in comparison to their White counterparts.

The reason for the inconsistencies between findings could be due to the studies adopting a 'gender-blind' approach – they provided no information on the gender ratio of participants – that fails to take account of the differences between women and men. The studies also neglected to analyse the help-seeking patterns of men and women separately. It is well established that the help seeking patterns of women and men vary greatly; the figures from the 2014 Adult Psychiatric Morbidity Survey demonstrated that women were more likely to be treated for common mental health disorders compared to men (Mental Health Foundation, 2016). Controlling for this variable may have reduced the inconsistencies within findings.

Within the help-seeking literature focused on social marginalised groups, several reoccurring barriers to accessing mental health support have been identified; such as stigma, mistrust of mental health services and using alternative sources of support (Adkison-Bradley et al., 2009; Edge et al., 2004; Sisley et al., 2013). Each barrier will now be discussed in turn.

Barriers to help-seeking: Stigma

Mental illness within Black communities is highly stigmatised (Keynejad, 2009). In Black women, it is often viewed as a weakness due to the previously mentioned socio-cultural narratives emphasising the strength of Black women. In several US studies, many Black women participants held the perception that the average Black woman was inherently strong, thus they believed this strength protected them from mental health issues. This consequently led these women

to believe that mental health problems were a sign of weakness and failure (Beauboeuf-Lafontant, 2007, 2008; Watson & Hunter, 2016). Research has highlighted that the stigma of weakness is a significant factor that creates a barrier to seeking help, particularly amongst Black women (Beauboeuf-Lafontant, 2007; Corrigan, 2004; Schreiber et al., 1998, 2000). In Schreiber et al. (2000) study on Black West-Indian Canadian women, the participants reported that they would resort to masking over feelings of distress for fear of being stigmatised by others due to their depression. Similarly, UK research exploring Black women's experiences of depression highlighted that the women feared that others would perceive them as unable to cope or weak. As a result, the women were often found to repress their symptoms of depression in an attempt to appear strong and in control, and thus were less likely to seek help for their depression (Edge, 2008).

Barriers to help-seeking: Mistrust of mental health services

Racism, racial stereotyping and cultural ignorance has been found to be widespread among mental health service professionals (Keating et al., 2002; Keating, 2009; Keating & Robertson, 2004), with Black service users often reporting negative interactions with these professionals (Gould, 2012; Keating et al., 2002). Studies have also highlighted that the forms of treatment that Black people receive for mental health problems differ from that offered to their White counterparts (Kane, 2014; Keating, 2009). For example, Black people are more likely to be medicated for mental health problems rather than offered talking therapies (Keating et al., 2002). Furthermore, they are more likely to be detained under the Mental Health Act (Care Quality Commission, 2011) and once in psychiatric services, they are more likely to receive restrictive forms of treatment, such as higher doses of medication, and they are more likely to be physically restrained (Keating et al., 2002). In some cases, the use of physical restraint has resulted in death. David Bennett, for example, was a patient in a medium secure unit in Norwich, after an altercation involving another patient and staff, he was excessively restrained by four members of staff for 25 minutes, which ultimately led to his death (Department of Health, 2005; Mind, 2013). An inquiry found institutional racism was an underlying factor in his death (Independent inquiry into the death of David Bennett, 2003). Such incidences

and factors have appeared to generate a deep-rooted mistrust of professional mental health services within Black communities. Black people have expressed a reluctance to use mental health services for fear of mistreatment, perceiving them as racist (Cooper et al., 2012), untrustworthy (Keating et al., 2002), unhelpful (Keating & Robertson, 2004) and culturally inappropriate (Cooper et al., 2012). UK studies exploring Black women's experiences of mental health problems reported similar findings, with a reluctance to seek help, resulting from a fear of being over-medicated and mistreated within mental health services (Edge & Rogers, 2005).

Barriers to help-seeking: Use of alternative sources of support

Due to the stigma associated with mental health problems, Black women have preferred to use private coping strategies as a way of managing their difficulties (Cinnirella & Loewenthal, 1999; Edge, 2008; Sisley et al., 2011). Current research has highlighted that they often adopt a self-help method to manage their mental health problems. For instance, Edge (2008), in a UK qualitative study of depression, found that Black women would attempt to search for ways to help themselves before they sought professional help. Sisley et al. (2011) found that Black women attempted to self-manage their emotional distress using a wide range of negative and positive coping strategies, including self-harm, alcohol, and spirituality.

Black women often lean towards spirituality as a preferred coping mechanism (Adkison-Bradley et al., 2009; Edge, 2008; Edge & Rogers, 2004). For instance, Lawrence et al. (2006) found Black women considered conversing with God through prayer as an effective means of overcoming depression. Similarly, Sisley et al. (2011), in their qualitative study of emotional distress in Black women, found these women used their faith as a source of support. Community Churches have also been mentioned as a source of support by these women – with women considering attending Church for support and help for mental health problems. Even women who were not actively religious considered seeking help from the Church instead of accessing professional help (Edge, 2008; Edge & Rogers, 2004).

In summary, the above findings suggest that Black women experience several barriers to accessing professional support for mental health problems.

Self-management techniques such as 'covering up' distressing feelings are a barrier to seeking help, and these techniques have been linked to the SBW ideal (Beauboeuf-Lafontant, 2007). US and UK Black feminist scholars have critically discussed the SBW construct and the impact it can have upon Black women's social, economic and emotional well-being. In the next section, therefore, the implications of the SBW ideal for Black women will be discussed.

Implications of the Strong Black Woman image

As noted above, US Black feminist scholars have argued that the SBW image was created in response to the brutal and harsh treatment of Black women during slavery of African Americans (Collins, 2000; hooks, 1981; Wallace, 1979; White, 1999). To be strong and maintain one's strength during these times was essential for the survival of Black women and their community (White, 1999). Today, Black women living in the western world no longer have to contend with the brutality of slavery; however, they do have to contend with other adversities such as poverty, racism and sexism. Given the bleak reality that Black women face, it makes sense that many Black women participants in research studies adopt the SBW ideal into their self-identity (Abrams et al., 2014; Beauboeuf-Lafontant, 2009; Woods-Giscombé, 2010). On the surface, therefore, it appears to be advantageous to be a SBW, since strength and resilience can effectively cushion against the numerous stressors Black women face.

Several US studies have shown that Black women have positively viewed the SBW as a source of encouragement to overcome obstacles and as a form of protection against varied discriminations (Abrams et al., 2014; Watson & Hunter, 2016; Woods-Giscombé, 2010). During open-ended qualitative interviews, Black women within the US, of various ages (18-65 years) and educational backgrounds emphasized that the internalization of strength helped them overcome challenges in life, but also inhibited their emotional expressivity and discouraged them from seeking help from others (Watson & Hunter, 2016). The Watson and Hunter study, therefore, demonstrates that despite the perceived benefits of aspiring to the SBW ideal, embodying this ideal can impact negatively upon the emotional wellbeing of Black women. Scholars have indeed speculated about the negative impact the SBW image has on the health and wellbeing of Black women, and argued that Black women who highly identify

with this image may feel societal pressures to constantly maintain a strong exterior (hooks, 1981; Harris-Perry, 2011). Consequently, attempting to maintain this strong exterior – at all times – can hinder the expression of other emotions, such as fear or sadness, thereby leaving these emotions to mount up and inadvertently create stress (Beauboeuf-Lafontant, 2008; Watson, 2013; Woods-Giscombe, 2010).

This has been evidenced in several relevant US and UK qualitative studies exploring Black womanhood. Within these studies, many Black women reported that they felt a societal expectation to embody qualities of the SBW image, and thus would banish any behaviours that conflicted with this image such as the expression of emotional pain (Beauboeuf-Lafontant, 2008, 2009; Edge & Rogers, 2005). Beauboeuf-Lafontant (2007, 2009) conducted two studies where she interviewed Black women about their perceptions of strength in relation to depression. The majority of the participants viewed depression as an undesirable illness since they felt it conflicted with the SBW image. The participants would therefore regularly silence their distressing emotions – and not seek help – in order to create a façade of strength.

There is evidence that silencing these distressing emotions is not an effective strategy, since it does not relieve or soothe Black women but lead, instead, to an engagement with maladaptive coping strategies such as disordered eating (Harrington et al., 2010), excessive drinking (Beauboeuf-Lafontant, 2008; Sisley et al., 2011), and increased distress and rumination (Giscombé & Lobel, 2005; Mitchell & Herring, 1998).

The experiences of Black women living in the UK have generally received very little empirical interest, thus the UK research in this area has been limited. Despite this, the limited research has echoed the above findings from the US. In Sisley et al.'s (2011) study on UK Black women and emotional distress, the participants reported that they felt the need to fulfil the SBW expectation, leading them to mask over their emotional distress. Similar findings were produced in several other UK studies (Edge & MacKian, 2010; Edge & Rogers, 2005). The UK research, therefore, highlights the impact the SBW can have on UK Black women's management of their mental health difficulties. Although since the primary focus was on the mental health of these women, rather than the SBW image, there is little empirical data on this concept in the UK context and

how it impacts on Black women's experiences of managing mental health difficulties. Further UK research specifically focused upon this concept, therefore, needs to be conducted in order to fully understand something about the relationship between the SBW image and the mental health of UK Black women.

Overall, the above findings identify a critical link between living up to the SBW image and mental and physical health decline, indicating that attempting to embody the SBW can have a detrimental impact upon the emotional wellbeing of Black women. Although these articles clearly present some significant and interesting findings about the SBW ideal and mental health problems – with depression a particular focus in Beauboeuf-Lafontant's (2007, 2009) studies – so far, the literature has neglected to explore the impact of this ideal on anxiety. Since anxiety is a common mental health problem in the UK (Evans et al., 2015), with some studies suggesting that Black women in particular potentially falling victim to this mental health problem (McManus et al., 2009; Rehman & Owen, 2013), it is surprising how little empirical interest this area has received.

Two recent US quantitative studies have attempted to address this absence (Donovan & West, 2014; Watson & Hunter, 2015), with the former finding that Black women who reported moderate to high levels of the SBW endorsement were more likely to report depression and anxiety symptoms in comparison to Black women who reported low levels of the SBW endorsement (Donovan & West, 2014). The other study produced similar findings, with the endorsement of the SBW ideal being significantly associated with greater depression and anxiety (Watson & Hunter, 2015). Thus, both qualitative studies suggest that the SBW plays a significant role in mental health difficulties of Black women.

Although the two quantitative studies provide some new insight into the impact of this ideal on Black women's experiences of anxiety and depression, there is a need to further explore how it impacts on Black women's experiences and to hear from Black women in their own words about the SBW ideal.

Although quantitative methods can be beneficial when exploring relationships between phenomena, qualitative approaches are better suited to exploring the experiences, beliefs, and perceptions of a group of people (Creswell, 1998). For example: How do Black women understand their experiences of depression and anxiety? What does it feel like to experience anxiety in the context of a socio-

cultural assumption that Black women are, and should be strong? A qualitative approach is needed in order to fully answer these questions: this will lead to a better understanding of Black women's experiences of anxiety and depression in relation to the SBW image.

Furthermore, there has been little research on the experiences of Black women living in the UK, both generally, and within counselling psychology specifically. The UK based studies that have been conducted in this area (e.g. Edge & Roger, 2005; Sisley et al., 2011) have uncovered some interesting findings as discussed above, however they do not explore Black women's experiences of depression and anxiety in direct relation to this image. As noted above, much of the research in this area has been conducted in the US; caution, however, needs to be taken in terms of transferability of US research on African-American women to the experiences of UK Black women, as their experiences may differ due to societal, cultural and political differences (Loury, Modood, & Teles, 2005). It would therefore be beneficial to conduct a UK-based study of Black women to obtain a meaningful account of their specific experiences.

Study Rationale

Depression and anxiety are the most common mental health problems in the UK (Evans et al., 2015), and since it has been established that exposure to multiple stressors can increase an individual's susceptibility to these problems, it is likely that Black women, considering their exposure to numerous life challenges, have a higher risk of experiencing depression and anxiety than other groups such as White women. Within UK research, however, the views of Black women in regard to their mental health needs have been largely overlooked, with very little research focusing upon this area (Edge, 2006; Sisley et al., 2011). This is problematic since UK research has indicated that Black women are reluctant to seek help for mental health problems (Edge, 2006; Shaw et al., 1999; Sisley et al., 2011), and when such problems go untreated, it can cause serious and long lasting mental health consequences (Mind, 2013; NMIH, 2016; Ritter & Lampkin, 2010). A better understanding of Black women's experiences is needed to better equip mental health professionals to work effectively with Black women. This new-found knowledge will hopefully lead to better engagement and utilisation of mental health services.

US research has identified a relationship between the SBW ideal and the emotional wellbeing of Black women, and since this ideal has an international reach, it is possible that it has significant implications for how UK Black women experience mental health problems. To my knowledge, there is no research that explicitly examines the impact of the SBW within a British sample. To address this gap in the research literature, the current study – using a qualitative approach – explored UK Black women’s experiences and management of depression and anxiety symptoms, in direct relation to the SBW ideal. A qualitative approach was adopted since it has been well recognised for its ability to gain rich knowledge within under-researched areas (Mason, 1996; Smith & Bowers-Brown, 2010). Unlike the previous studies – as noted above – where semi-structured interviews have been the primary method adopted, this study utilised a socially mediated form of data collection, namely focus groups. This method is appropriate (as will be discussed further below) given that the emphasis of the proposed research is on exploring the experiences of members of a social group – Black women.

Research Aims and questions

The current study was designed to explore the SBW ideal as a possible context for how Black women living in the UK experience and manage symptoms of depression and anxiety. Considering the paucity of literature in this area, it was anticipated that the research findings begin the process of better understanding how Black women experience mental health problems, thus adding to, and expanding the limited literature in this area. It was also hoped that this new-found understanding could be clinically relevant to practitioners in two ways. Firstly, the findings can increase awareness of the SBW image amongst practitioners and thus better inform them of how to support Black women in therapy. Secondly, the results have the potential to aid the development of appropriate and culturally sensitive mental health interventions for Black women.

Research questions

The following research questions were addressed in this study:

1. How do Black women experience and manage symptoms of depression and anxiety?
2. To what extent does the SBW image shape and inform, and provide a context for, Black women's experiences and management of depressive and anxiety related symptoms?

Methodology

Design

The research adopted a qualitative methodology, using focus groups to gather data from Black Caribbean women living in the UK. All focus groups were conducted and analysed by the researcher: focus group data was transcribed by a professional external transcriber, and inductive thematic analysis (TA) (Braun & Clarke, 2006) was chosen as the method of analysis.

Theoretical standpoint

It has been argued that researchers using TA should outline their theoretical standpoint – including their ontological and epistemological positions – when conducting research (Braun & Clarke, 2006). Ontology encompasses perceptions of reality (Bhaskar, 1998), whereas epistemology is a philosophical grounding for how we come to know this reality; it is concerned with understanding what kinds of knowledge are trustworthy and valid (Maynard, 1994).

As a counselling psychologist in training, I believe that reality is unattainable in its purest form because it is highly influenced – or distorted – by social context, language, concepts, and social positioning (Danermark, Ekstrom, Jakobsen & Karlsson, 2002). The closest we can get to viewing reality is therefore through one's perception of it. Due to my ontological beliefs, this research adopted a critical realist position (Bhaskar, 1998). Critical realism adopts the determination to "gain a better understanding of what is 'really' going on in the world", whilst acknowledging that this reality cannot be fully accessible because the perception of reality is shaped by contextual factors (Willig, 2013, p.11).

Due to the social focus of the research, and reflecting the ontological position, the research is informed by a contextualist perspective (Braun & Clarke, 2013). Broadly mapping onto a critical realist ontology, contextualism is underpinned by the assumption that there is no single reality, but reality is constantly changing in relation to context and the position of the researcher (Braun & Clarke, 2013). The study's focus is placed upon the person-in-context, placing emphasis on understanding the person – as a thinking, feeling human being, with an identity, personality, unique history, and background – in relation

to the context in which they are situated in (Ushioda, 2009). Within the contextualist perspective, because the researcher is required to consider their own perspectives and assumptions when conducting this type of research (Braun & Clarke, 2013); I attempted to highlight and recognise my own assumptions and positionality in the reflexivity section (see pages 41-45).

Rationale for a qualitative methodology

Counselling psychology research employs both quantitative and qualitative methodologies, although in the UK context qualitative methodologies dominate. Qualitative research is open-ended and exploratory (Braun & Clarke, 2013), thus has a potential to generate new or unexpected knowledge into the area of counselling psychology. Counselling psychology places great emphasis on the client's subjective experiences, and seeks to understand their inner worlds and constructions of reality (Strawbridge & Woolfe, 2003). It aims "to engage with subjectivity and intersubjectivity, values and beliefs" as well as respecting "first person accounts as valid in their own terms" (British Psychological Society, 2005, pp.1-2). Similarly, qualitative research is concerned with understanding the meaning of individual experiences (Willig, 2008). It provides insights into how individuals make sense of their reality (Braun & Clarke, 2013; May, 2002; Willig, 2008), with Braun and Clarke (2013, p.8) claiming that this type of inquiry allows "access to individuals' subjective worldviews and meanings". Given the similarities between the underlying philosophy of (some forms of) qualitative research and the field of counselling psychology, qualitative research appears to be a suitable method for counselling psychology research.

Qualitative methodology was also chosen because of the complexity of the research topic. Previous US literature has illustrated the complicated relationship Black women have with the SBW stereotype (Etowa et al., 2017; Mitchell & Herring, 1998; Nelson, Cardemil & Adeoyeal, 2016; Walker-Barnes, 2014; Watson & Hunter, 2016). Qualitative approaches are effective at exploring such complexities (Willig, 2008) as they encourage detailed and in-depth consideration of complex and multifaceted human phenomena (Braun & Clarke, 2013; Morrow, 2007). Additionally, since there is little research in this area, a flexible, open-ended method of data collection was viewed as advantageous.

Rationale for a thematic analysis

Given that Interpretative Phenomenological Analysis (IPA) is a popular choice within counselling psychology (Steffen & Hanley, 2014) and because it shares many similar features with TA, it was carefully considered as a method of analysis. However, thematic analysis (TA) has been deemed to be a more appropriate method. Like TA can be, IPA is concerned with making sense and providing rich descriptions of people's experiences (Smith, Flowers, & Larkin, 2009). Furthermore, the analytical processes for these approaches are broadly similar, both are centred on the process of developing codes and themes through immersing oneself into the data (Braun & Clarke, 2006; Smith et al., 2009).

There are, however, some important differences between them: IPA is essentially phenomenological since it places emphasis on individuals' lived experience, and how they construct and make sense of that lived experience. With this approach focusing on making sense of individual's subjective reports, it has been criticised for failing to consider the ways in which the social context informs individual experiences (Braun & Clarke, 2013; Parker, 2005; Todorova, 2011). This limited engagement with the social is potentially problematic given the social focus of the proposed research (i.e. how the social construct of the SBW contextualises how Black women manage and negotiate experiences of distress). TA, however, is a method that seeks to ascertain recurring patterns or themes within the data across an entire dataset (Braun & Clarke, 2006). This allows scope to consider the broader phenomena across the data set, such as the impact of the wider sociocultural context on individual experience.

Grounded theory (GT) was also another approach considered. GT places emphasis on the social processes rather than individual experiences, and because this approach shares similar features with TA; it was also considered as a possible method of analysis. Despite the many different versions of GT (Charmaz, 2008), its main objective is to use "a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon" (Strauss & Corbin, 1998, p.24). Given the exploratory nature of this study, concerned with identifying experiential commonalities across participants rather than developing theories or hypothesis, TA was deemed to be a more suitable method.

Unlike IPA and GT, TA is not “wed to any pre-existing theoretical framework” but is flexible in approach and can be applied within a range of frameworks (Braun, & Clarke, 2006, p.9), including critical realism (Willing, 2008) – the chosen ontological approach for the research. TA was also employed in the current study because, rather than focusing on ideographic meaning, it was designed to focus on common themes, allowing the inclusion of social and cultural phenomena as well as individual experiences.

TA can be conducted in one of two ways; it can be driven by existing theory, which is known as theoretical or deductive thematic analysis, or it can be driven by the data (while acknowledging that the researcher’s interpretive frameworks and philosophical commitments will always shape their engagement with the data), which is known as inductive thematic analysis (Braun & Clarke, 2006). As previously mentioned, UK literature exploring the experiences of Black women and mental health is scarce, therefore a theoretical TA was deemed inappropriate as it uses a top down approach driven by pre-existing theory. Instead inductive TA was chosen, with themes being identified through the data, in attempt to maintain a focus on the participants’ experiences.

Rationale for focus groups

The focus of the proposed research is on how Black women – as a social group – negotiate their experiences of mental health problems in relation to socio-cultural images of Black women, such as the SBW ideal. Given this, it was appropriate to use a socially mediated form of data collection via focus groups. According to Wilkinson (1999), a focus group is a discussion that takes place among a group of selected people motivated to explore a particular subject. Due to the social nature of focus groups, they have been perceived by many as a more naturalistic way of data collection compared to other methods such as individual interviews, since focus groups discussions have the potential to mimic everyday conversations (Kamberelis & Dimitriadis, 2013; Krueger & Casey, 2014). Interviews solely rely upon researcher-participant interactions (Kvale & Brinkmann, 2004), thereby potentially creating narrow responses. Focus groups, however, provide participants with the space to take part in a series of social exchanges where they can explore a subject together (Hennink, 2014; Krueger, 1988); this encourages the rich and detailed co-construction of meaning

between participants that would not be accessible through individual interviews (Hennink, 2014).

Based on the assumption that individuals prefer to talk to others who share commonalities rather than talk solely to a researcher (Lederman, 1990), focus groups have been deemed particularly effective when conducting research involving marginalised social groups. This is because they facilitate individuals in talking about their views and experiences with the mutual support of other members, who may express similar feelings that may remain unexpressed in other environments (Culley, Hudson & Rapport, 2007; Kitzinger, 1994; Liamputtong, 2007; Peek & Fothergill, 2009; Pollack, 2003). Furthermore, they can shift the emphasis from individual to collective experiences, which can be beneficial in researching marginalised groups since social and political processes that influence these groups' experiences can be exposed (Wilkinson, 1998). Pollack (2003) identified focus groups with Black women to be a valuable source of understanding the experiences of women in prison. Through gathering Black women together, Pollack found that the Black women were not only able to talk about their experiences; it provided them with the space to articulate the impact of systemic racism, classism, and sexism in relation to their lawbreaking. Focus groups were, therefore, considered the most appropriate method for data collection for the proposed study due to the ability to produce a breadth of information on a specific subject, and the ability to expose social processes.

There are, of course, limitations to the focus group method. There is the concern that one person may dominate the group discussion, which may result in others withholding information (Fontana & Frey, 1994, cited in Peek & Fothergill, 2009), or participants relying on others in the group to carry on the discussion (Morgan, 1997). However, this issue is largely associated with the size of the focus group, as it has been argued that larger groups are difficult to manage and it can prove difficult for quieter participants to voice their opinions in larger groups (Peek & Fothergill, 2009). To alleviate this challenge, I conducted small focus groups consisting of 3 to 5 women of Black British African Caribbean heritage. The sample size was guided by Braun and Clarke's (2013) recommendations: it was small enough to be able to manage the focus group effectively, yet it was sufficient to capture rich discussion. An assistant – another Black woman – aided me in the running of the groups. Her role was to greet

participants, hand out and collect consent and demographic forms (see Appendices 8 and 9), and to take notes throughout the focus groups to aid the transcription process.

Recruitment

The aim was to recruit adult (aged 18 and older) women of Black African Caribbean heritage to part take in the focus groups. Researchers have often found it challenging to engage members of Black communities and other socially marginalised groups in research (Hoppit et al., 2012; Johnston & Sabin, 2010; Moore, 2006). This can be made harder when attempting to research members of populations who may conceal parts of their identity to avoid stigma (Benoit, Jansson, Millar & Phillips, 2005), such as concealing a mental health diagnosis to avoid stigmatisation. Therefore, to increase participant engagement, the study aimed to recruit participants who self-defined as having had experiences of depression and anxiety, rather than a formal diagnosis of depression or anxiety.

To successfully recruit Black female participants with experiences of depression and anxiety, snowball sampling was used as it is particularly effective in locating members of 'hard to reach' or 'hidden' populations such as Black women (Atkinson & Flint, 2001; Braun & Clarke, 2006; Faugier & Sargeant, 1997); additionally, social media was used as a platform to advertise the study. Participants for a total of five focus groups were sought. One focus group consisted of participants recruited through the UWE psychology participant pool. Research advertised on Facebook generated responses that formed two focus groups; the other two focus groups were recruited through snowball sampling from my personal and professional networks.

Participant information

The final sample consisted of 18 participants across the five focus groups who were familiar with, and self-identified as having had experience of depression and anxiety symptoms. None of the participants had a current medical diagnosis of depression or anxiety. The participants were aged between 19 and 57 and all identified as heterosexual. A summary of participant information is detailed below in Table 1.

Table 1: Participants' Demographic Data

Age range	19 – 25 (2) 26 – 34 (4) 36 – 44 (3) 45 – 49 (1) 50 – 54 (4) 54 – 57 (4)
Employment status	Student (3) Full-time employment (8) Part-time employment (4) Unemployed (1) Self-employed (2)
Social class	Middle class (5) Working class (9) No class category identified (4)
Children	No children (5) Children (13)
Sexuality	Heterosexual (18)
Country of birth*	Bermuda (1) England (13) Jamaica (4)

*all participants were UK residents at the time of the study

Procedure

The focus groups were conducted in a range of settings including a church hall, a university group study room, a participant's workplace, and a meeting room in my place of employment. All groups were audio recorded using a digital voice recorder and the length of recordings ranged from 1 hour, 18 minutes to 2 hours, 39 minutes. Initial contact was made with each participant via email before conducting the focus groups; this offered opportunity to clarify the time and location of the group, to outline the aims of the study, and for me to answer any questions the participants had about the study.

All focus groups started with an introduction. This consisted of welcoming the participants, group member introductions, setting ground rules (for instance,

respecting other opinions, one person speaking at a time, respecting others' anonymity) and outlining the focus groups aims, followed by answering any questions the participants had. Visual aids can be usefully employed in focus groups to prompt responses about the research topic (Hennink, 2014), however since all the participants were well accustomed to the SBW ideal, I believed that they would not need to be explicitly highlighted with audio-visual materials. I decided against using visual aids and therefore used an ice breaker question instead: "When I say Black women what words come to mind?" I felt that this was a simple, non-taxing question that was related to the research topic and slowly introduced the participants into the research questions. For a full list of the focus group questions please see Appendix 1.

After conducting the first group, the transcripts were reviewed with my research supervisor. My focus group moderating style was highlighted as being too rigid, which impacted upon the fluidity of the focus group conversation. It was agreed that further flexibility in applying the focus group questions would be beneficial to allow the conversations to flow more freely. To facilitate this, I learnt the focus group schedule from memory so that I could ask the questions in the moment, rather than sticking to a rigid focus group schedule; this worked to encourage a more in-depth and complex conversation.

Ethical considerations

Ethical approval for this study was granted from the University of the West of England, Health and Applied Sciences Faculty Research Ethics Committee (FREC). Before each focus group, participants were asked to read the participant information sheet (see Appendix 2), which detailed the nature of the research study, what participation involved, and the uses to which their data would be put. Informed consent was obtained from each participant before participation by means of signing a consent form (see Appendix 3). All participants were given the opportunity to ask questions about the research before and after the focus group and were made aware of their right to withdraw their participation from the study.

Due to the nature of the material being explored, participants were invited to disclose only as much personal information as they felt was comfortable prior each focus group. I was aware that reflecting upon personal mental health issues could potentially cause distress, thus time for a 'debrief' was planned for

at the end of the focus groups. Furthermore, participants were provided with information and contact details of local counselling and support services (see Appendix 2).

Careful consideration was given to preserve the confidentiality and security of data. Each participant's identity was known by the researcher, the research assistant, and the professional transcriber, with both latter signing a confidentiality agreement (see Appendix 4/5) to ensure confidentiality. Each focus group recording was transferred onto a USB memory device and was given to the professional transcriber for the purposes of transcription. Furthermore, all participant names were changed to pseudonyms and I removed any information that could identify the participants after transcription.

Data analysis

The focus groups were analysed using Braun and Clarke's (2006) model of TA, which included the following six phrases:

Phase one: Familiarising myself with the data. A professional transcriber was employed to transcribe all the focus group audio recordings. I therefore had to check all the transcripts to ensure that they were 'accurate' in accordance with what – and how – things were said. This involved listening to the recordings whilst reading the transcripts. I reformatted the transcripts using Braun and Clarke's (2013) transcription guidelines – actions such as laughter, coughing and pauses were identified in parentheses. After making sure that each focus group was 'accurate', I began immersing myself in the data, repeatedly reading transcripts multiple times whilst simultaneously jotting down my observations, thoughts, reflections and ideas in relation to the research question.

Phase two: Generating initial codes. This phase involved a process of systematically working through the entire dataset to create codes. Interesting features of the data were broken down into meaningful segments and coded using a word or short phrase. Coding can be done on two levels: semantic coding, which involves capturing the descriptive content; and latent coding, which focuses on capturing the implicit meanings within the data (Braun &

Clarke, 2013). I coded at both levels. Each focus group was coded separately using Microsoft Word (see Table in Appendix 6 for example of data coding).

Phase 3: Searching for themes. This phase involved sorting codes into potential themes across the dataset. Braun and Clarke (2006) proposed that a theme should capture a significant aspect of the data in relation to the research question. A considerable amount of thought and time was therefore given to the relationship between codes and between themes, making sure that the codes collated within each theme captured meaningful and relevant aspects of the data.

Phase 4: Reviewing themes. This stage involved reviewing the themes identified in phase 3 to make sure they 'fitted' within the research aims. During this phase, I repeatedly refined the themes, rejecting some and modifying others. I checked that individual themes were clear and distinct from one another, and related to the research question (Braun & Clarke, 2013). Furthermore, I checked the validity of the themes to ensure that they captured participants' narratives, through making sure the meaning of the individual codes was reflective of the themes. I created a thematic map (see figure 1) which provided a visual representation of the meanings and patterns in the data; this aided my understanding of the relationship between codes and themes. For instance, two overarching themes were developed and refined to help the reader understand the complex story of the data, with overarching theme 1 focusing upon the participants relationship with the SBW image, whilst overarching theme 2 focusing upon the consequences of this relationship.

Phase 5: Defining and naming themes. I constructed a narrative for each theme to help me clarify and define their essence. In some instances, direct quotations from the participants were used in the theme names, thus staying close to participant accounts.

Phase 6: Producing the report. This process involves telling the 'complicated story of your data' (Braun & Clark, 2006, p.23), thereby stressing the importance of capturing the narrative of the data and convincing the reader of

the validity of the analysis. This was achieved through using enough participant quotations to allow for the evaluation of the relationship between analysis and data. Additionally, these quotations were interwoven into the theme descriptions to aid the complex storytelling of the data to the reader (Braun & Clarke, 2012).

Reflexivity

Many qualitative researchers argue that researchers are active agents in the qualitative research process; that their values, interests, and perspectives actively shape the research and the knowledge it produces (Braun & Clarke, 2013; McLeod, 2001). For this reason, many have highlighted the importance of reflexivity in qualitative research. Reflexivity is the process whereby the researcher acknowledges the impact that their own experiences and assumptions (as well as the methods they chose, their disciplinary background and so on) can have on research outcome, and attempts to make this visible to the reader (Mortari, 2015; Ortlipp, 2008), while also acknowledging that such self-insight is always limited. I will now state my relationship with the research topic and my personal background.

Personal history: I am a 36-year-old Black woman. My two brothers and I were born in the UK to Black Caribbean working-class parents, my mum being Trinidadian and my dad, Jamaican. My parents got divorced early on in my childhood and we were raised by my mum as a lone parent. Consequently, as a child, I had very little contact with my dad. Growing up, the Black women I encountered consistently presented as capable and strong, despite living amongst adversity such as inadequate housing, poverty and racism. Yet I never once heard them complain or buckle under the pressures of life. Instead I heard them speak about 'holding your head up high', 'never giving up' and 'keeping strong'. Consequently, I grew up believing that being strong was an essential part of being a Black woman.

Strength, for me, felt entwined within my Black identity and my womanhood; the three could not be pulled apart. Strength, my gender, and my Blackness were fused together. This left me feeling that strength was an unavoidable feature of the Black woman. In accordance with this view, I grew up suppressing my 'unhappy' emotions in favour of strength. Instead of talking to others about my troubling thoughts or sad feelings I would suppress them, presenting as a strong woman who could handle any adversity. Years of suppression took its toll: the troubling thoughts developed into anxieties which I found difficult to contain, yet I was reluctant to seek help. Even though I was aware of support services, like counselling, I felt that I needed to 'be strong' and cope with my anxieties independently. By my late twenties, my anxiety was

crippling, which pushed me into the therapy room. Through talking to other Black women, I realised that I was not alone. I noticed that the SBW was an influential image within the lives of many Black women. Furthermore, several years later, as I started practicing as a counselling psychologist trainee, I noticed that I had very few Black women clients. This led me to become curious about the relationship between Black women, mental health and the SBW image – a curiosity that fuelled my desire to conduct this study.

Insider and outsider: I considered myself an insider researcher; an individual who conducts research with members of their own social group based on characteristics such as occupation, ethnicity, gender, and culture (Hayfield & Huxley, 2015; Loxley & Seery, 2008). Like myself, the research participants were of Black Caribbean origin, over the age of 18 and able-bodied. While only a few held university degrees – like myself – all but one participant was employed.

The advantages of being an insider have generated much discussion in the qualitative methodological literature, in particular in relation to the ability to access participants. It is assumed that an insider is situated in a position that allows easy access to participants (Greene, 2014; Hayfield & Huxley, 2015). Additionally, research on socially marginalised groups has shown that being an insider increases participation (Dwyer & Buckle, 2009); the participants may assume the researcher is 'one of them' so automatically grants a certain level of trust that would not be afforded to an outsider (Dwyer & Buckle, 2009). This trust may ease the development of rapport between the researcher and the participants, making the interaction much more 'natural' and open: this potentially results in the generation of richer data (Hayfield & Huxley, 2015; Talbot, 1999). Furthermore, insiders have pre-existing knowledge of the research topic; they are potentially more aware of complex issues and therefore, are more quipped to ask meaningful questions which may assist in the generation of rich data (Bridge, 2001).

At first glance, being a Black woman researching other Black women's experiences might be viewed as advantageous. I can, apparently, overcome the aforementioned challenges concerning access to research participants. Additionally, having lived as a Black woman in this society, I 'know' what it is like to be Black and female in the UK and I will have shared similar experiences

of discrimination, racism and inequality. However, despite the advantages of my familiarity with this research topic, it also brings potential pitfalls.

The limitations of being an insider researcher has been discussed, primarily that familiarity with a research topic can potentially produce disastrous results (Breen, 2007). Pitman (2002) wrote that this awareness can provide an "illusion of sameness" (p. 285), which can increase the risk of the researcher making assumptions based on their own experiences or prior knowledge. Likewise, DeLyser (2001) noted that greater familiarity can result in the researcher being less inquisitive, thus ask less questions compared to an outsider (Greene, 2014). This may result in the generation of narrow or limited research data. Greene (2014) explains that reflexivity is particularly important to the insider researcher since it maintains a certain degree of space between the researcher and the researched, leading to fewer assumptions and 'blind spots'.

Reflexive process: There are several methods that can be used when engaging in reflexive practice. The keeping of reflective journals is often beneficial as is discussing and sharing – if ethically appropriate – research data with research team members (Hayfield & Huxley, 2015; Ortlipp, 2008). Hayfield and Huxley (2015) suggest that having reflective conversations with others can provide an important perspective on the research topic that may help offset pre-existing knowledge or preconceptions. When carried out with peers positioned outside of the group in question, such conversations provide a particularly effective method of viewing the research from a different socio-cultural outlook (Ortlipp, 2008).

As an insider, I was highly aware that my own experiences of this topic could heavily cloud the ways in which I conducted the focus groups and viewed the data. I therefore used many reflective techniques including self-interviewing and "stream of consciousness writing" (Van Heugten, p. 207). I would regularly ask myself questions about the research topic and record my answers using an audio device. This helped me distinguish between my inner thoughts and beliefs from those of the participants. I also used reflective journaling and I would often speak to others, particularly my research supervisor and researcher friends about my experiences. These techniques were employed to help me 'see clearer', to separate the strands of what the participants' experienced from my

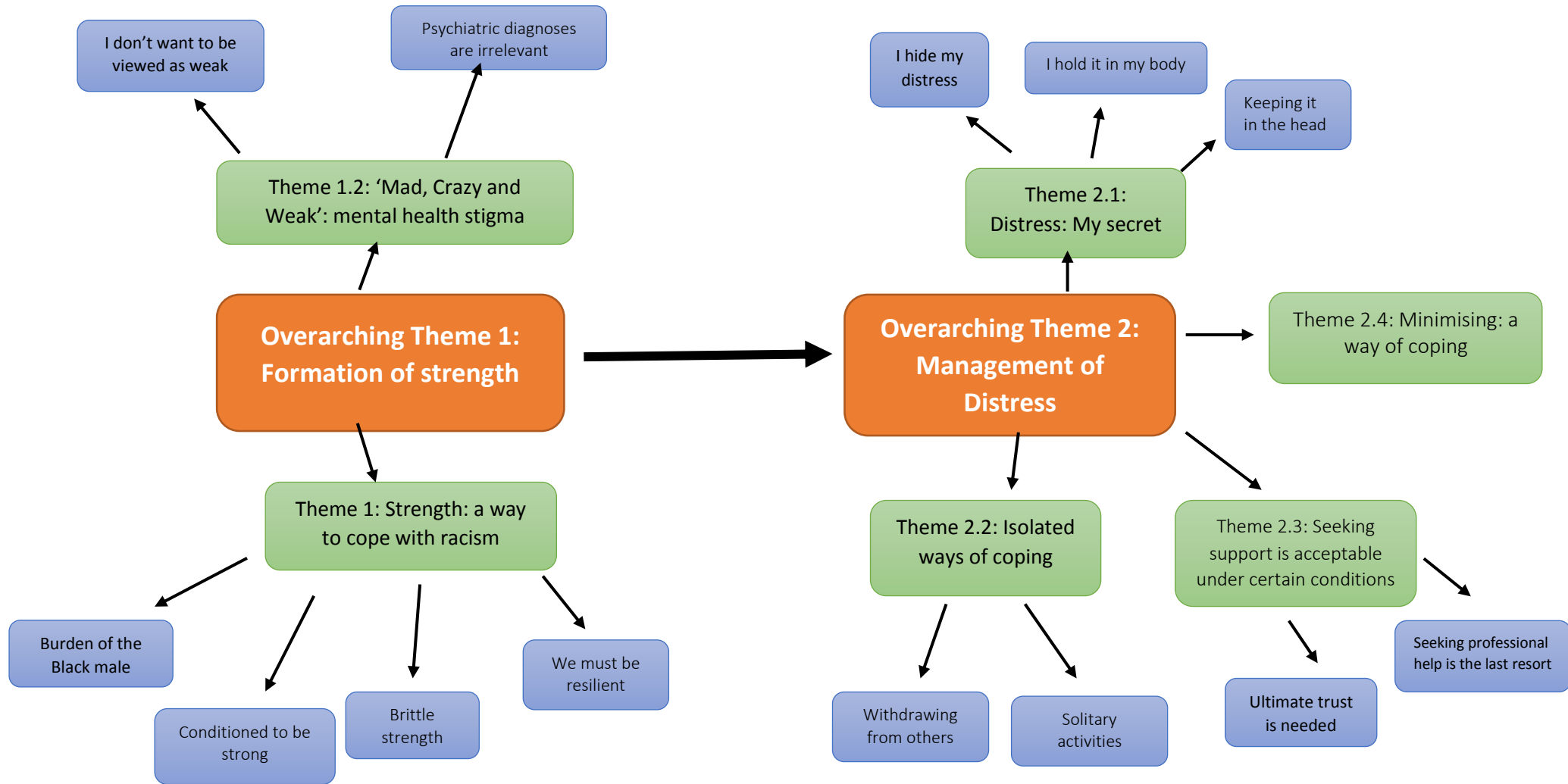
own experience, and then present an account of their experiences as best as possible with minimal filtering.

For instance, in focus group 1 and 2, the participants spoke about racism on several occasions. However, I only really 'heard' these comments when my research supervisor pointed them out to me when reading through the focus group transcripts. This was because personally, I have often viewed racism as normal (i.e. something that happens when you live in a White society) and thus I have always mentally swept these experiences away; trying to not absorb them; trying to not let them affect me in anyway. Consequently, I feel that this coping strategy affected the way I heard the participants' stories about racism. I was not able to 'hear' the participants' experiences and I therefore could not explore them. It was only through talking to my supervisor and reflective journaling about my own painful experiences of racism, I was then able to distinguish my own thoughts and opinions from that of the participants. This allowed me to hear the participants' racist accounts with clarity and thus explore them in a meaningful way.

Results and Discussion

This section presents the thematic categories generated during analysis of five focus group transcripts. The question guiding this enquiry was: How does the SBW image shape and inform, and provide a context for, Black women's experiences and management of depressive and anxiety related symptoms? Analysis of the dataset generated two overarching themes that capture how the participants made sense of the SBW image whilst experiencing and managing their distress. To orientate the reader, it can be noted that the overarching theme 'Formation of strength' focuses upon the influence of the participant's social context in relation to the development of their beliefs about the SBW ideal, whilst the overarching theme 'Management of distress' assesses the impact of these beliefs upon the participant's experiences and management of distress. I will discuss in turn each of the two themes and the associated sub-themes.

Figure 1: Overview of themes



Overarching theme 1: Formation of strength

This overarching theme focuses upon how the participants developed their ideas of strength and the SBW image. Participants described how they were expected, even from a young age, to possess characteristics of the SBW. Furthermore, the participants felt that their social context affirmed the need to be strong. They described experiencing social challenges such as racism, sexism, and lack of social support, and thus believed that 'staying strong' was a 'somewhat' effective and socially acceptable way to cope and overcome such challenges. Two themes constitute this overarching theme: *Strength: a way to cope with racism*; and *'Mad, Crazy and Weak': Mental health stigma*.

Theme 1: Strength: a way to cope with racism

The theme Strength: a way to cope with racism – with its four sub-themes: We must be resilient; Burden of the Black male; Conditioned to be strong and Brittle strength – focused upon the SBW image, how the participants viewed this image, and the impact they perceived it to have upon them. All the participants were intimately familiar with this image, having been affected by it in some way. The participants' descriptions of this ideal were similar to those of participants in previous studies, with the SBW being described as: not complaining; demonstrating emotional control; not asking for help; and remaining tenacious despite the circumstances (Etowa et al., 2017; Nelson et al., 2016; Watson & Hunter, 2016; West et al., 2016).

Many of the participants appeared to have an ambivalent relationship with the SBW ideal. For instance, typical SBW traits such as 'being strong', hiding distress and protecting others, consistently underpinned the participants narratives, yet they also adamantly rejected the reality of the SBW image, branding it a myth. One participant argued that it has been forced upon Black women "...by White people isn't it, it's not labels that we as Black women have placed on ourselves" (Naomi, FG4). Another participant also dismissed this ideal and framed it as a "...caricature of how other people see Black women..." (Sam, FG2). Many were highly critical of this image deeming it problematic and restrictive of the Black woman's identity. Instead they valued the strength component of this image; believing that the strength and resilience of Black women was a reality, which is rooted in the need to survive a racist society.

Therefore, with the study aiming to stay close to the participants accounts, the term 'strength' rather than the SBW ideal is often referenced. This will be discussed in the first of the three sub-themes below.

Sub-theme 1.1.1: We must be resilient

This sub-theme captures the participants' sense that they had no choice but to be strong, because of the intersecting impact of racism and sexism in their lives. As in previous studies on Black women and health related issues, the history of Black women played a significant role on how the participants saw themselves today (Edge & Rogers, 2005; Etowa et al., 2017; Harris-Perry, 2011; Woods-Giscombé, 2010). Many referenced the strength of their (distant) ancestors, Black women who were slaves, and argued that these women historically had to be strong to survive the cruel and brutal treatment they received during transatlantic slavery. They felt that contemporary Black women still required strength due to two distinct but intersecting forms of oppression – racism and sexism.

Racism appeared to contaminate much of the participants' lives, particularly in the workplace, receiving persistent and insensitive questioning and racial remarks by non-Black colleagues about their Blackness and culture. Serena (FG1) recounted her deputy manager questioning her Blackness due to the lightness of her skin tone:

Serena: ...my deputy manager and he was like [fast pace talking]
"You're not a Black woman, like Black Black"...

Lara: [in overlap] ((Gasp))

Anna: [in overlap] ((Gasp)) oh gosh

Serena: ...and I'm like "I'm still Black!" Yeah this is the type of thing
[questions I get asked] (.) Like I had to explain to him that you
can still have people that are Black and light skinned, like I had
to literally explain it to him...

I argue that the racist incidents described by participants were often implicit, ambiguous, and indirect racial insults synonymous with the concept of racial microaggressions (Sue et al., 2007, 2008) rather than more overt forms of

racism. Increasing research on microaggressions has shown that these commonplace, subtle forms of discrimination adversely affect the mental health of people of colour (Donovan et al., 2012; Nadal, 2011; Nadal et al., 2014). Furthermore, they are extremely difficult to challenge due to their subtle nature (Sue et al., 2007). This was reflected in the participants' comments, where some spoke about the difficulties in pinpointing racism in the workplace. They described racist incidents as intangible acts, which left them feeling psychologically wounded. One participant, Paula, noted that she was trying to "constantly [make] sense" of potentially racist encounters – often questioning whether she had been subjected to racism at all. Additionally, many participants frequently described being racially stereotyped in their predominately White work environments. They felt their confidence, passion and assertiveness was often misinterpreted as aggression, causing them to be branded as an 'Angry Black Woman'. Annette commented:

Annette: I think we come across as being aggressive and not assertive, I think we are assertive but we come across as being aggressive especially in a work place if you challenge anything it's-its you're aggressive you know-you're not assertive

Emily: I think that comes back to what you said as well, about how society [perceives us] ... when you make a stand in confidence [at work] then it's seen as a threat and they see us as aggressive.

To alleviate this racism some engaged in altering their behaviours, such as monitoring their speech and hiding parts of their cultural identity. Carly (FG2) explained how she would silence her opinions to escape being stereotyped:

"...[I] felt really conscious of not trying to be so (.) outspoken as well sometimes, because of this stereotype so almost sometimes trying to reign myself in, so that I didn't come across as being that angry ... I know you've got the strong Black woman but you've also got the angry woman

type, so I'd sort of like, not say as much because I didn't wanna (.) to play up to the stereotypes..."

Alterations in participant behaviour could be viewed as a strategic attempt to navigate through a racist society psychologically unharmed (or harmed as little as possible). Alternatively, it could be a consequence of internalised racism – the process of absorbing and accepting the negative, stereotypical or devaluing beliefs, held by the dominant groups in society (Alleyne, 2004). Such a process can often lead to feelings of inferiority or self-hatred, which can compel one to shed parts of one's identity to feel accepted (Pyke, 2010). Jones and Shorter-Gooden (2003) wrote how African American women actively modify parts of themselves to be accepted by (non-Black) others. They explained how these women would alter their outer appearance, modify their speech and conversational topics when mixing in environments populated by non-Black people.

Similar to the above, the participants described censoring their own behaviours to not 'stand out', and to become accepted within social environments predominantly populated by White people. In the quotation below, Lara (FG1) spoke about refraining from referring to her Black culture in conversations with her White work colleagues out of a fear of being viewed as different and thus inferior:

Lara: ... I feel like I have to restrict myself, I'm just like "Yeah, I eat bun and cheese' [Caribbean snack food] and even with music and like I am sat with my headphones on and she's [work colleague] like "What you listening to?", and I thought, 'I really can't tell you that!'

Group: ((interrupted loud laughter by all members of the group)).

Lara: so I feel like (.) it's just kind of like, (.) I've got this façade over me in terms of (.) who I really am ... when they say "What you doing on the weekend" it's like "well yeah I'm going to the raga dance" like I don't go to those kinds of places anymore (.) But I feel like they would look at me so differently ... like I'm in a different type of class...

Similarly, in the extract below, Anna had seemingly internalised one of the Western dominant representations of Black women as being irrational and aggressive (Harris-Perry, 2011). She therefore ensured that she behaved in a manner acceptable to her White counterparts. This involved not speaking her mind 'too much' when talking with other White women to avoid being viewed as the stereotypical ABW:

Anna: "...I am very conscious of that [being viewed negatively] you know especially in places like at work or in my son's school (.) I don't, you know, so you know I can articulate myself quite well so I tend to speak to people rather than just literally kind of be this stereotypical um, yeah, you know aggressive person, you know and sometimes I think that's how it can come across if you speak your mind too much you're kind of being put in this box really of being aggressive, I just yeah, I don't want to be her."

From the participants' narratives, it was clear that they were mindful of how others (non-Black people) viewed them – they seemed to experience a type of 'double consciousness' – a term coined by Du Bois (1994). This is the sensation of always looking at one's self through the eyes of others. Within a US context, Du Bois (1994) wrote about the brutal and racist treatment Black people received. As a result, he believed that to 'fit in' and situate themselves in a (White racist) society, Black people were forced to view themselves not only from their own unique perspective, but to also view themselves in terms of how they might be perceived by the outside (White racist) world.

Participants in managerial positions described experiencing frequent questioning of their authority and credibility in the workplace. They often felt

excluded from work projects and felt others disregarded their work contributions, as illustrated in the conversation below from focus group 4:

Paula: ...what is it that's stopping them doing that [answering her emails] but yet when it's a White colleague that occupies a lower level than myself, they suddenly understand that or when it's coming from your manager

Dawn: ...feels like it's not taking you seriously, as a Black person they're not taking you seriously

Naomi: absolutely

Paula: it's a form of racism

There appeared to be a sense of fatigue amongst the group as Paula shared her thoughts. Weariness, however, was not an option for these Black women, since they felt strength was needed to withstand these experiences.

The participants described how – in general – society held age-old racist ideas about Black woman. Even though they did not explicitly use the well-known phrase 'mules uh de world', as quoted in Zora Neale Hurston's (1937) classic US novel of a Black woman's journey to self-discovery, they felt that others viewed them in this way, as somehow sub-human. Mitchell and Herring (1998) used 'mules uh de world' to refer to US Black women, arguing that they receive the same treatment as work animals; they are not afforded the same rights as humans, such as respect or rest, and are expected to live in harsh and difficult environments. These sentiments were echoed in the participants' comments; they implied that as Black women they experienced a crude form of racism where they were viewed as subhuman, exempt from feeling pain, fatigue, or sadness like other humans. Tiana (FG5) explained:

"...I'd like to be human...people just treat us like machines, like, 'no you just keep going, yeah, your strong keep doing it', but at some point, I need a break, I need to be like 'okay no-not today'."

Littlewood and Lipsedge (1982) explained that the historic racist notion of Black people as primitive, unintellectual and “happy-go-lucky” is deeply embedded within the European consciousness. This notion promotes the idea that Black people are unable to experience emotions such as sadness, these being the prerogative of civilised, sensitive and intellectually aware individuals – namely White people. Furthermore, Harris (2014) notes that the SBW image “ultimately flattens Black women’s humanity, making it harder for others to see us as complex beings”. Paula (FG4), for instance, felt perplexed by her work colleague’s inability to notice times when she was emotionally struggling at work and felt that it led to them dehumanising her:

“...you have to be crying and laying down on the floor half dead before they [work colleagues] realise that blood flows through my veins, I bleed as well and I do get emotional but because I’m not coming in and crying about any old thing that’s (.). What-what is it that makes me strong when you see me? What do you see about me that you think I’m strong? What is it that makes me strong?”

Derogatory phrases such as “lowest of the low” (Lara, FG1), “bottom of the pile” (Anna, FG1), “second class citizen” or “uneducated” (Annette, FG3) were used to describe societies perceptions of Black women in the UK. One participant, Paula (FG4), referred to Black women as “...the N’s [Niggers] of mankind”. She argued that nothing significantly has changed since transatlantic slavery; they are merely contemporary versions of the Black woman slave because “so much more is expected from the Black [woman compared to people of other ethnicities]...”

Some participants articulated that Black men have it ‘easy’ in comparison and experience less discrimination compared to Black women, whereas Black women are exposed to both racism and sexism. Additionally, some argued that Black women are born into circumstances in which they are compelled to continually battle their way through high levels of sexism inside the home, and racism outside of it. Consistent with the US literature on patriarchy within Black communities (hooks, 1981; White, 2008), some participants spoke about the power imbalance between Black men and women. Despite the Black woman’s

pivotal role within the family, participants felt that they often held less power or authority compared to Black men. Lara (FG1) commented:

"...my granddad was a strong Black man, and my Nan – well she was a strong Black woman in terms of what she carried, but in terms of, like, Granddad [he] was the ruler ...".

With Black women holding a lower-level position in the family home, some participants felt that this led to maltreatment. Maltreatment of these women within the family home was described as a common occurrence, thus strength was viewed as a necessary tool to cope or 'get through' such adversity:

"...so there was that whole thing around um how we felt Black men treated Black women and you-there was a resilience you needed to have to kind of work around that kind of abuse situation..." (Sam, FG2).

Due to the frequent occurrence of racism and sexism, therefore, the participants felt it was necessary for Black women to remain strong to be able to 'power through' this oppression or maltreatment. Lara (FG1) described having to develop a tough exterior to help her cope with racist abuse. She summed up:

"...we're resilient because (.) we kind of have to be, so from a young age growing up...you kind of go through life but you have to keep batting these things off [racist experiences], so carrying on going through it, like, so by the time you get to my age or even before my age you-you do kind of get strong to people saying horrible things to you or you just get kind of tough...".

Furthermore, Sam (FG2) expressed her tiredness at having to constantly battle her way through sexism and racism:

"...when, you know, do you get a break? when do you get to be a woman or a person without having to have this fight or that fight so you're walking the streets you've got to be resilient, you're at home you've got

to be resilient...so I think that Black women in particular there's a level of resilience that we've learnt it's part of the (.) armour...".

'Donning the armour' is the Black woman's way of allaying vulnerability, of shielding oneself against oppressive attacks of racism or sexism. Many spoke about the difficulties that Black men created in their life and felt, at times, that they had to work harder because of these complications; this will be discussed in the next section.

Sub-theme 1.1.2: Burden of the Black male

This sub-theme captures the participants' negative perceptions of Black men. They described them as lacking in focus and direction in life, which is clearly demonstrated in Serena's description of her siblings below:

Serena: I would view me and [my sister] Corrine as quite strong (.)
[my sister] June she's just in a world of her own and as for um
(.) the guys [my brothers] I think definitely (.) they're a little
bit lost actually kind of um.

Lynn: ((laughs))

Lara: ((laughs))

Anna: That's generally the theme! We have a theme for our family as well...The girls definitely outweigh the boys in our family.

Many implied that Black men struggled through life and were unable to cope with adult responsibilities, such as securing employment and parenting children, this resulted in some participants feeling unable to rely on Black male family members for simple tasks, which consequently created more work for them:

Lara: ...if we want anything done we have to do it, we can't rely on them
[Black male siblings] I can't rely on any of the men in my family.

Anna: Me too, apart from my dad, you know, because he's from a
different generation but my brother's two years older than me and

he's the eldest of my siblings and just, yeah, you wouldn't rely on him (.) for anything.

Lynn: ...Yeah I think that's really true because one of my younger brothers, I'm almost like his human diary, I have to text him "so and so's birthday today don't forget to ring so and so" ((laughs)), you know, you know, ((laugh)) so yeah I think you're right.

Anna: I used to do that with my brother but that's a full-time job, I can't live your life and mine at the same time (.) So I just you know I tried to be a decent aunty to his children and I just got-actually he appals me because he'll just go off for like literally like two years, you know, (.) you'll never see or hear from him, my sister's just don't do that, like what is that? ...

The participants in focus group 4 echoed similar sentiments:

"no I don't I'm not very, I'm quite sort of negative about my Black men, you know, because I think they really haven't stood up to mark, you know, you know, when I think of my father and his generation and, you know, going back to what you say about, you know, as a man our parents, our fathers, you know, who went out there and they grafted in some awful situations to bring the money home to feed however many kids they had and stuff like that, you know, our Black men our generation they almost think well (.) it's to be expected that you as a woman you go out there and do your bit and [the Black man] sits at home and do fuck all or whatever" (Naomi, FG4)

In some ways, the views of the participants echoed those of the wider culture. The British media has a long history with negatively stereotyping Black men. In Reynold's 1997 article, she claimed that Black men (at the time), more so than any other cultural group, had been a popular focus for the tabloid media, which have often portrayed them as lazy, undisciplined, criminal and promiscuous. The same is arguably true of the way Black men are often depicted in contemporary mass media. The mentoring group REACH carried out a study in 2011 of media representation of young Black men and found that the mainstream news media painted a highly distorted picture of them. They were regularly linked to violent

crime, and particularly murders involving knives and/or gangs, whilst stories involving wider social issues, such as health, were not as frequently or prominently reported (Cushion, Moore & Jewell, 2017). Additionally, when Black men are portrayed in other ways within the news media, these depictions often centre on labelling Black men as lazy or underachieving, especially in the educational system (Harker, 2012; Holloway, 2016; Kelekelo, 2017). Kelekelo (2017) argues that being labelled in such negative ways provides the perfect breeding ground for these men to experience discrimination and racism from the wider society.

Consistent with the Equality and Human Rights Commission report in 2011, where it found that a large percentage of Black Caribbean households are headed by one parent – nearly always the mother (Platt, 2009), many participants confirmed that Black men were largely absent from family life. They spoke about the short supply of Black men in their lives – about absent romantic partners, fathers or brothers – who were either lost within the prison system, involved in criminal activity, or who were suffering from mental health issues. Racism and institutional racism is a large factor in the absenteeism of Black men within families (Fatherhood Institute, 2010). UK figures show that Black men are more likely to be jailed for committing a crime than White men (Hopkins, Uhrig & Colahan, 2016), and are more likely to be sectioned under the Mental Health Act (Lambeth, 2014), which could in part explain their absenteeism. Participants therefore felt compelled to be strong, since they had to assume the role of financial provider and caregiver to their family members and their children (if they had them). In the extract below, Paula (FG4) explained that due to the absence of Black men, Black women had to become self-sufficient and independent to provide for their families:

“...cus I think Black males they're in prison or they've given up..., [or] ...mental health (.) But we and lots of Black women are heading households and they have over the years learnt erm, they've become professional”.

Lara (FG1) similarly commented:

“...Yeah and as women growing up, you see your dad with multiple different women and you see your mum slogging away, you know, ...you see your mum as one woman struggling to make sure that you grew up, you know, you get nice things [and] your dad's doing nothing at all to support you”.

Lack of support from the Black men within the family, combined with the constant exposure to racism and sexism as demonstrated in the previous sub-themes, caused participants to feel that Black women had no choice but to be strong and to 'do it all'. With this knowledge and experience, the message of strength was passed down from one generation to the next; this will be explored in the next sub-theme.

Sub-theme 1.1.3: Conditioned to be strong

Strength was viewed as an unavoidable aspect of a Black woman's experience. The participants believed that Black women are socialised into being strong – a process that started in childhood. Paula (FG3) explained that she was taught the “language” of resilience from a young age; she described being regularly instructed to carry out adult tasks independently: “at eight years old I was looking after my younger siblings I recall changing their nappies; eight!” Others spoke about the expectations placed on Black children and claimed that they were expected to cope with difficult situations and experiences. Lucy (FG2) noted that there is a cultural expectation for Black children to 'absorb' painful feelings rather than express them compared to White children. From the participant's accounts, it appeared that growing up, pain and suffering was normalised amongst the lives of Black people, and thus children were taught to silence their emotions and 'get on with it' because coping with difficult events was perceived as a normative part of daily living. Lucy explained: “...you're just expected to take [abuse] – it hurts but it's what everybody goes through ...”. Walker-Barnes (2014), in her book *Too Heavy a Yoke*, writes that African American parents, predominantly mothers, will socialise their daughters into being strong and encourage the suppression of emotions as they are aware and also fearful of what lies ahead of them, such as racism, sexism and classism. Teaching their daughters to be strong is believed to be an effective way to help them manage and cope with these life adversities. This could be the reason why

little tolerance was given to the open expression of the participants' unhappy emotions as children in this study. Annette (FG3) recalled:

Annette: ...but remember, when we were growing up as well, we can't cry, 'what you crying for?', they [parents] can hit us and they are telling us not to cry so we have been brought up to be strong from day one really!

Emily: Hmmm [softly spoken]

¹?: Hmmm, yeah [softly spoken]

Note the use of the collective wording "when we were growing up", together with the other participants' validating utterances. This implies that the silencing of emotions amongst Black women during childhood is a common shared experience.

Research indicates that Black children are racially socialised by their parents to teach them about the realities of racism and prepare them to overcome these experiences (Thomas & King, 2007; White-Johnson, Ford, & Sellers, 2010). However, the participants identified a clear distinction between the socialisation process for girls and boys. They described how Black girls were often expected to 'be strong' and were subjected to regular messages about being assertive, protecting themselves, and caring for others: "...what I've always been taught to do is serve other people, be a help to other people..." (Sam, FG2). Whereas, the participants felt the boys were not subject to these messages. Anna (FG1) noted:

Anna: ... I think that my mum and her siblings put a lot of energy into the girls and making sure that we were kind of- 'we don't-people don't trample on you (.) and you don't accept that' ... and I think they did a lot of that with us but I think they assumed boys were actually okay but actually you've got to talk to them too. Do you get what I mean?

¹ Speaker unidentifiable

Lara: Yeah

Lynn: Yeah

US researchers have found that there is a difference between the way girls and boys are racially socialised; African American mothers' socialisation practices with their daughters include higher expectations, increased responsibilities, and additional demands compared to how they socialise their sons (Mandara, Varna, & Richman, 2010). In support, Thomas and King (2007) explored the concept of 'gendered racial socialization': the messages communicated to African American girls by their mothers about racism and sexism. They found that this process included messages about: strength; self-determination; assertiveness; self-pride; recognising equality and male-female relationships. This study found similar findings, therefore, adding a UK perspective into this area. Growing up, Sam (FG2) recalled her mother teaching her similar messages:

"Yeah because I was taught to deal with it [distress], I was taught to cope- by my mother so, you know, words like- you don't need your own man and that sort of thing and build your own career and don't depend on anybody and be strong and be independent-that was the big word, ²be independent rely on yourself, yeah that was the mantra when I was growing up".

Whilst much of the socialisation process occurred through messages about strength and independence, participants described a social learning aspect. Participants learnt how to be strong through observing the Black women around them, mainly their mothers who "...were strong [and who] had to get on with it..." (Emily FG3). Some participants clearly appreciated these childhood teachings about strength, indicating how helpful they were in the formation of their own identity. Sam noted that such teaching "...fed me, it made me who I am...", attributing her self-assurance to the childhood messages she received.

² Underlining is used to indicate emphasis on words spoken

Such messages help Black women acquire self-belief and confidence as demonstrated in the conversational dialogue in focus group 1:

Anna: ...looking at the males in my family I don't feel they are, they're not comfortable in their own skin. Whereas we are actually encouraged to be strong Black women. I don't think the same message was given to the boys. Do you know what I mean?

Lara: Yes absolutely

Lynn: Yeah, yeah

Whilst some participants expressed an appreciation for their childhood 'strength teachings', there were also some clear resentments towards these, as reflected in the extant literature (Abrams et al., 2014; Etowa et al., 2017; Woods-Giscombé, 2010). The expectation to be strong and to adopt an adult-like sense of strength as children left some feeling inadequate. They explained that when behaviours that did not conform to notions of strength were shown to others, they were teased or labelled as a "cry baby" (Lara, FG1), "too sensitive" (Anna, FG1) and 'self-indulgent' (Lucy, FG2) by family members. Lara recounted:

"I grew up with my mum's side of the family and (.) me expressing this [sadness], "Oh she's just a cry baby" (.) Well so you're taught to sweep your feelings and emotions under the carpet...".

Rather than appear weak, Lara (FG1) chose to hide her feelings from her family; and this behaviour continued into her adult life; "...sweep [ing] ... feelings and emotions under the carpet..." appeared to be a common behaviour amongst the participants. Many described times when they stifled sad emotions instead of expressing them. This ultimately created what they felt was an illusion of strength but not 'real' strength, which will be detailed in the next theme.

Sub-theme 1.1.4: Brittle Strength

Even though the participants described Black women as strong, they explained that there was a fragility to their strength. In common with the US literature in this area (hooks, 1981; Mitchell & Herring, 1998; Walker-Barnes, 2014; Williams, 2009), many described it as a superficial type of strength that created the illusion that 'all is okay' when in reality there is "...so much stuff bubbling under the surface" (Lara, FG1). Beneath the layers of strength potentially rests a multitude of distressing and unprocessed emotions such as sadness, pain, and hurt. Annette (FG3) noted the extent to which she has masked over her pain with strength: "...you've built up, you've built it up [resilience], and you're not going to let anyone see that you're breaking down inside." Additionally, Sam (FG2) commented that she rarely allows others to see her true feelings, which often leads others into believing that she is coping, when she is not. Sam referred to the 1957 published poem titled 'Not waving but drowning', by British poet Stevie Smith to further illustrate her experience:

"...you know, that thing of 'I'm not waving I'm drowning' that kind of thing everyone thinks you're okay because, you know, you cope and sometimes you don't cope..."

Black women's strength appeared to be underpinned by a weakness – a brittle type of strength that provided an outward appearance of strength while concealing a multitude of emotional wounds, scars and vulnerabilities. This form of strength allowed for an external image of coping and being in control, when in actuality, feelings of helplessness, hopelessness, fear and sadness existed. It was believed that this display of brittle strength perpetuated the maltreatment of Black women. Lara felt that men took advantage of her (mis)perceived strength, and thus were more likely to disrespect her because she would not complain or express her dissatisfaction. She explained:

"...I'm a woman and yes you hurt me and you frustrate me but you don't break me (.) they kind-I feel like I take on a lot more on my shoulders [disrespectful behaviour] because you don't think I'm going to crumble,

you know, I don't break down crying in front of you every-you know 'ahh you cheated on me, you didn't call me back!!'..."

Additionally, Carly recalled times when she tolerated unacceptable behaviour to maintain an appearance of strength:

"...I just think I wish I didn't have to feel that I needed to be so strong and I think it allowed me to put up with erm a lot more than I should have because of that (.) 'we are strong we're resilient', you know,..."

The participants' accounts illustrate that this brittle strength reflected a 'stoical acceptance of situations [they]... have been powerless to change' (hooks, 1981, p.83). hooks (1981) argued that this type of strength provides Black women with a false sense of power that keeps them entrapped within oppression. Thus, the 'strength' demonstrated by, and seen by, the participants was an indication of submission to oppressive circumstances rather than a sign of resistance or defiance. It enabled Black women to endure the pain and hurt associated with life difficulties and challenges, but it did not stretch to provide them with the resources to challenge these experiences. One participant suggested that there was a "twisted" (Sam, FG2) element to such strength, whereby being 'too strong' enabled Black women to become stuck in cycles of abuse. She noted:

"...she [her mum] has kinda got that battered woman syndrome-she's there-she's not going to go ... it almost taught me the wrong thing, she was almost too resilient, you know"

Sam believed that Black women were often "strong for the wrong reasons". This 'brittle' strength enabled them to tolerate unacceptable behaviour rather than change it. hooks (1981, p.6) wrote that there is a lot of confusion between the terms endurance and transformation amongst Black women, and argued that being 'strong in the face of oppression is not the same as overcoming it'. Mitchell and Herring (1998) explained that even though Black women understand the implication of adopting this type of strength, they still find it

difficult to talk about their emotional difficulties, due to the stigma surrounding mental health problems in Black communities, which will be explored in the next theme.

Theme 1.2: 'Mad, Crazy and weak': Mental Health Stigma

This theme, with its sub-themes '*I don't want to be viewed as weak*' and '*Psychiatric diagnosis are irrelevant*', describes the way in which mental health problems are regarded within Black communities and the impact this has on the participants. All participants were adamant in their views about seeking help for mental health problems, feeling that these are common human experiences; as such they must be treated like any other human health condition. As Sam explained: "...you go to the dentist for a toothache you get, you know; mind-ache, go see a therapist. What's the big deal?" However, as each focus group discussion unfolded it became apparent that seeking help for mental health problems was a "big deal", due to the negative beliefs held in wider Black culture about mental health problems.

Sub-theme 1.2.2: I don't want to be viewed as weak

Whether they were conscious of it or not, most of the participants appeared reluctant to seek help for their own emotional distress, with many providing contradictory accounts of their beliefs about strength. On the one hand, they felt that emotional expression was important and vital for healing; on the other, however, they felt that seeking help for these difficulties was a sign of weakness. Carly (FG2) commented:

"I found my strength in being weak because if you ask for help or to break down and be like 'no I just can't cope and I just can't, and that's it' ((laugh)) so I'm human that's what I found my strength in, just because I did take on so much for so long-that my strength was actually 'I need help and I am actually human-no that's not right and I'm not putting up with that' so I kinda found my strength in my weakness"

Like many of the participants, Carly indicated that even though she viewed emotional expression and seeking help as a strength, she could not let go of the

notion that crying and being in touch with her emotions equated to weakness. In the following extract from Focus Group 3, Annette spoke about her difficulties in expressing her sadness and explicitly equated the behaviour of crying to being weak. Furthermore, she alluded to the idea that behaviours such as crying and showing sadness robbed her of her 'strong' identity:

- Annette: Because I'm always like the strong aunty, nothing bothers me, and I would cuss at everybody who hurts my little family. Do you know what I mean? I'm that independent, strong one they can rely on. And I think crying and showing my emotions shows a weakness.
- Marva: But it's not
- Annette: I know that! ((laugh))
- Emily: It's recognising your vulnerability
- Interviewer: Can I ask, who sees it as a weakness?
- Annette: I see it as a weakness. It's me, it's totally me.

The participants' responses to Annette – on the surface – indicated that they believed crying and seeking help did not signify a weakness. Furthermore, this was also echoed by some participants in other focus groups, who spoke about seeking help as "strengthening" (Sam FG2). For example, Tiana (FG5) commented: "I'm very practical so if I know there's a resource out there that will help me I will go to that...". Although, as the focus group discussions unfolded these participants provided contradictory messages, Tiana noted that she would be "hesitant", to speak to another Black person if she was suffering from mental health problems, in fear of their negative judgement.

It was evident that the participants' opinions about mental illness stemmed from negative beliefs held in the wider culture about mental health problems (Dean & Phillips, 2015). Additionally, it has been well-documented that there is a strong cultural stigma against mental illness among African heritage communities (Keynejad, 2009; Memon et al., 2016; Rehman & Owen, 2013). For a long time, depression was seen, and to some extent still is seen, as a 'White person's illness' (Amankwaa, 2003; hooks, 1993) and viewed as a sign of weakness (Edge & Rogers, 2005; Jackson & Heatherington, 2006; Walker-Barnes, 2014; Watson & Hunter, 2016). Therefore, consistent with previous UK

studies on mental health issues within Black communities (Cinnirella & Loewenthal, 1999; Memon et al., 2016), the participants spoke about mental health stigma as a barrier to help-seeking in these communities. It was apparent that distress was often seen as a character flaw, or as a sign of a weak mind. And, since there is a cultural expectation for Black women to be strong, women who suffer from distress maybe especially prone to being labelled as weak (Walker-Barnes, 2014). For Tiana (FG5), to be labelled as weak, when reaching out for support felt frustrating. She talked about Black women not being able to attend openly to their mental health needs without being criticised in some way by members of the Black community:

Interviewer: ...could you say you need a break openly to other people (.) do you think?

Tiana: I think that you could but as soon as you say that, it will, like, change people's perceptions of you because, like, as soon as you say that, they're, like, automatically thinking you're weak

There was, therefore, a great amount of shame and embarrassment associated with mental health problems, which appeared to impact on the women disclosing these problems to others or seeking help. Carly told the group how she found it difficult to talk to others about her depression and was surprised at the level of openness her White friend – who was also suffering from depression at the time – displayed:

"...I don't know if it's a strong Black woman living in a Black community, but you don't kind of say that you're ill – like that your mental unwell... it's not so open and we don't seem to, you know-and [her friend] was just... so open to saying 'I'm seeing a psychiatrist I talk to someone and I take medication' and there's me not even wanting to say to my doctor 'I think I'm depressed...'. "

Carly demonstrated that she experienced shame from having depression, which then hindered her from seeking help and telling others about it. This shame

appeared to have been influenced by the cultural stigmas against mental illness within the Black community, which will be discussed in the next sub-theme.

Sub-themes 1.2.3: Psychiatric diagnoses are irrelevant

Some participants implied that family and friends within Black communities found it difficult to relate to psychiatric labels such as 'depression', and they would either catastrophize such labels or trivialise them. Some participants felt that members of Black communities would disregard the complex nature of depression and would simply view it as "you're feeling a bit low" or "feeling sad" (Tiana, FG5); this tendency to minimise depression has also been noted in relation to the wider society as a whole (Wood, Birtel, Alsawy, Pyle & Morrison, 2014). However, mental health problems were also viewed in an extreme way by the Black community, for instance when Lara told her aunty about her feeling depressed, her aunty automatically equated depression with feeling suicidal:

"...like I remember saying to my aunty once "I'm so depressed' and she like "You're not depressed, that means you want to kill yourself" (.) but I think you know (.) it is...it is...there's levels to depression I think and I was definitely on the scale..."

Beauboeuf-Lafontant (2007) explained – in relation to African American women – there is an intolerance to seeing them as having vulnerabilities, and thus when they do rarely express them, it is often unexpected and thus catastrophized by others in society. From the participants' accounts the same appears to be true of UK Black women.

Some participants felt that within the Black community, mental illness was not seen through the medical model perspective as a form of illness. It was, instead, viewed as abnormal and deviant behaviour, and thus terms such as 'mad' and 'crazy' were used to describe people who were suffering from mental illness (Mantovani, Pizzolati, & Edge, 2016). This is highlighted in the extract below where Carly (FG2) explained that the terms depression and madness were often fused together:

- Carly: And you have this type of 'ahh he's a mad man' type of thing so it's not like mental ill, it's like you need to be walking down the street (.) talking to yourself in shoddy clothes, that is mad, so for you to come in and say I am depressed (.) 'aah no you're not mad, don't be so stupid'. There's no distinction between the two.
- Sam: Yeah good point.
- Lucy: Hmm yeah.

The stigma attached to mental health problems appeared to be ingrained within the Black community, one participant spoke about being taught from a young age that "madness" was catching: "I can remember a rhyme that we were taught when we were young about not going near a mad boy (.) yeah, so the joke is, you know, keep away from the madness...it's catching" (Sam, FG2). Stigma concerns maybe particularly salient for Black women, who are already stigmatised because of their gender and race (Collins, 2009; Harris-Perry, 2011; Watson & Hunter, 2015). Research has found that when UK Black Caribbean women highlighted mental health stigma concerns, they showed a reluctance to seek help for mental health problems (Edge & Rogers, 2005). Findings from this study support this notion. For example, Sam (FG2) explained that her family members would not seek any therapeutic interventions despite experiencing distress out of fear of being seen as 'mad': "for example my sister, or my brother actually ... could do with it (therapy) but they're not going anywhere near it because that means you're a mad person!".

Mental health problems appeared to be so far removed from, and unacknowledged within, the Black community – "it's almost like Black people don't have mental health" (Tiana, FG5) – that when Black people experienced distress or were diagnosed with a mental health problem, this diagnosis was often overlooked and instead regarded as some kind of a spiritual phenomenon, such as being "possessed of the devil" (Sam, FG2) or "a demon" (Lucy, FG2). Research exploring barriers to help-seeking for mental health problems in Black African-descended communities, found that mental illness was viewed as having supernatural origins, such as evil spirits and devil possession (Jackson & Heatherington, 2006; Mantovani et al., 2016; Nsereko et al., 2011).

Due to the stigma surrounding mental health problems, some of the participants were reluctant to openly admit that they were experiencing any type of mental health problem, since they believed it left them vulnerable to stigma. They also felt that experiencing such problems reflected badly on the whole family; they explained that mental illness brought shame on their family: "Like your mum's done something wrong in bringing you up?" (Sam, FG2). Therefore, mental illness was often silenced for fear of potential repercussions to the family's reputation as well as personal social stigma.

In conclusion, this overarching theme has outlined the multiple ways in which the participants' social context shaped their ideas and beliefs about the SBW. The participants felt that they were encouraged from a young age to adopt SBW characteristics by family members and the wider Black community. Furthermore, they felt that strength was not an option, but rather a necessity to survive living in a racist, patriarchal society. The participants' views also suggest that Black communities attaches high levels of stigma to mental illness. These problems were thought to bring shame to the individuals, especially to Black women who were purposely raised to be emotionally strong, thus the participants felt pressured to live up to the SBW image. However, consistently presenting as strong leaves very little scope to be vulnerable, seek help, or to attend to one's emotional wellbeing. In the next section, the impact of the SBW image on how the participants cope with and manage emotional difficulties will be discussed.

Overarching theme 2: Management of distress

This overarching theme consists of four main themes that examine how the participants cope with, manage, and experience their distress. Throughout the focus groups, it became clear that the social challenges the participants faced, along with the range of cultural beliefs they perceived to be held within the Black community, has led them to manage their experiences of depression and anxiety in quite specific ways. For instance, concealing their distressing symptoms, using distraction techniques, and minimising the extent of their distress to others. There are four themes that constitute this overarching theme: *Distress: My secret; Isolated ways of coping; Seeking support is acceptable under conditions* and *Minimising: a way of coping*. I will now discuss in turn each of the four themes and the associated sub-themes.

Theme 2.1: Distress: My secret

This theme, with its two sub-themes: *I hide it from others* and *I hold it in my body* focuses on how the participants spoke about managing and coping with their distress in the presence of others. There appeared to be an element of secrecy surrounding distress, thus the participants described some distinctive ways of concealing their distress from family members and friends.

Sub-theme 2.1.1: I hide it from others

The participants either hid their own distress or knew of Black women who would regularly hide their distress. This secrecy appeared to be linked to the SBW image. Some talked about hiding their pain and sadness from family members because they were fearful of being viewed as weak. Marcia (FG5) stated:

"I probably wouldn't go to her [mum] because I just don't-I just don't want it to change her idea of me, again it's one of those things, if I come to her with a problem I mean yeah she's my mom and she wants to help me with stuff, but I feel like I just don't want her to think of me differently... like think of me as like erm 'she's like soft'..."

A few implied that hiding their distress was habitual; it was a long-standing management technique. Pat (FG3) reflected:

"...I think a lot of the time we just don't know how to (.) actually manage ourselves [our distress] in that way to be quite honest, because as I said we are very good at wearing a front, we are very very good".

Pat believed that Black women possessed an exceptional ability to hide their distress. Pat also alluded to the idea that consistently hiding distress impinged on Black women's ability to manage their distress in effective ways. Sam found it difficult to talk about her unhappy emotions due to habitually masking them, she reflected: "I feel when I'm in trouble or I'm vulnerable or I need help I can't say the words, I can't get them out, I can't do that very easily, I can help everybody else..." Sam described how she found it easier to help others rather than help herself.

Serving and protecting others is a key function of the SBW's role (Beauboeuf-Lafontant, 2007; Collins, 2009; Harris-Perry, 2013; hooks, 1981; Nelson et al., 2016; Romero, 2000; Walker-Barnes, 2014; Watson & Hunter, 2016). Walker-Barnes (2014) notes the SBW is a perpetual care-giver and spends most of her time caring for, and attending to the needs of others, whilst neglecting her own needs. Similarly, many of the participants spoke about hiding their distressing problems from family members to avoid exposing them to any pain or upset. Annette (FG3) explained that she refused to display distressing emotions in front of her son; this led her to question the impact this may have on his ability to manage his own distress in later life. Annette reflected:

"...we don't show that emotion to our children because I know that I never showed conflict to my son at all, so any how I had an issue with anything, my son wouldn't know about it (.) so I don't know if going out into the real world he could deal with conflict because it wasn't happening in our home (.) So I don't know if sometimes if we make it worst for our kids as well"

The participants did not limit their protective nature to just family members; it seemed that they also felt responsible for protecting others outside of their families too, and they also observed other Black women feeling the same. Paula (FG4) described being at the receiving end of a Black woman's protective nature. She explained that her close friend concealed the fact that she was dying from cancer for three years, until the last few days of her life. Paula painfully recounted:

"..she [friend] didn't tell me she was dying till f-that woman had me believe it for three years ((pause)) that she was just not very well and about five days before she died she called me and said 'I need to see you, I'm at the oncology' and I brought her a get well card signed from people in the building and she said 'Paula, thank you very much for that, but I'm not coming back (.) I'm not coming back and if I live until next week I'll be really happy' and I sat there and just ...why haven't you...[told me]."

Paula felt her friend had hidden her cancer diagnosis because she wanted to protect her. Dawn described a similar experience where she did not tell her family about her cancer diagnosis: "I told my manager cus I knew I had to have time off and Naomi [work colleague]...I didn't even tell my partner I didn't even tell my children...." Like many other participants, Dawn's (FG4) reluctance to tell her family was in part due to her desire to feel normal and maintain an appearance of strength, but she also indicated a desire to protect her family from experiencing distress. Dawn recalled telling her daughter she was having an operation for an abscess instead of an operation for her breast cancer:

"...my youngest daughter I told her a year later... because she thought I was going in for [an] abscess... she was ...fourteen, fifteen (.) She was about to do her GCSEs and I didn't want to tell her cus I didn't want it to, you know, so erm... after my operation... I think within a couple of days I was down at the shop cus I had to go out and do some shopping, I had to maintain even with my daughter, I was at home for about five months, I got up with her every morning, every morning I got up with her cus I didn't want her to think anything".

Emotional distress for this group was an intensively private experience, since their accounts clearly illustrated the great extent to which they were willing to conceal their own distress, to maintain an appearance of strength, and to protect others from experiencing any worry or upset. Jones and Shorter-Godden (2003) would suggest that these symptoms are classic expressions of the Sisterella Complex. They argued when in distress, Black women overwork themselves, conceal their needs, and shift their attention to fulfil the needs of others. However, concealing one's pain does not make it disappear, certainly not for the current group of women, rather it appeared to manifest within the body, creating negative psychological and physical complications. Beauboeuf-Lanfontant (2009) in her book 'Behind the Mask of the Strong Black woman' argued that consistently attempting to embody strength is costly to Black women's health, which has also been illustrated in previous US research (Abrams et al., 2014; Etowa et al., 2017; Harrington et al., 2010; Woods-Giscombé, 2010). For example, in one study, African American women who

endorsed the SBW image and thus hide their distress, were more likely to experience physical and psychological health issues, such as migraines, hair loss, panic attacks and weight gain (Woods-Giscombé, 2010). The impact of holding distress within the body will be discussed in the next theme.

Sub-theme 2.1.2: I hold it in my body

Due to the reluctance to talk about distress, some participants described carrying it around in their bodies, phrases such as “I bottle things up” (Lynn, FG1), “hanging onto it and keeping it to myself” (Paula, FG4), “holding everything in” (Carly, FG2), and “heavy on your shoulders” (Lara, FG1), were used when talking about their distress. Serena (FG1) felt her anxiety in her chest, she noted: “...it just sits there and sometimes it's there for days [points to chest] that anxiety”. Similarly, Lynn (FG1) commented:

Lynn: ...it's actually my chest more than anything, it can really (.) become quite tight real tight (.) if there's something that I'm really upset about (.) as well (.) It really effects my chest

Anna: It's like borderline anxiety isn't it?

Lynn: It is yeah exactly.

For many, the body appeared to be a container for their distress – a place where their distress was kept from prying eyes. This, however, resulted in detrimental consequences for the body, in the form of somatization, which is the process whereby emotional distress is transformed into physical symptoms (Lemma, 1996; Woolfolk & Allen, 2007). Bagayogo, Interain and Escobar (2013) claim that sociocultural factors, particularly mental health stigma, can influence the presentation and formation of distress; when there are high levels of cultural mental health stigma, higher rates of somatization can occur. This has been found to be true of Black women. For example, in Myer et al.'s (2002) US study, African-American women receiving outpatient treatment for depression reported more somatic symptoms than the White women participants. Equally, given that the participants in this study felt that it was culturally unacceptable or inappropriate to express upsetting emotions outwardly, these emotions appeared to build up within the body and manifest as somatic symptoms. Paula

(FG4) commented on the effects of holding upsetting emotions within the body, and recognised that the act of holding on to them was more harmful than the upsetting problem that produced them in the first place. This is noted in the conversational dialogue below:

- Dawn: Do you keep a lot of things to yourself?
- Paula: Yeah I do, yes I do and sometimes the fact that I know I'm hanging onto it and keeping it to myself and not discussing it openly (.) it actually makes me feel as though I'm going to be ill, yeah
- Interviewer: Ill?
- Paula: Because I'm worried about hanging onto that and it makes me think I'm gonna be [ill] so it's not the problem itself but I'm hangin' on to it and I'm thinking this is going to make me ill and stop thinking about it
- Naomi: Yeah isn't it, because you let it fester and fester

In the following two extracts, Lara (FG1) also reflected on the negative consequences of storing distress in her body:

"For me um (.) I internalise it a lot (.) um which I don't think is a good thing because it manifests in other ways so for me personally, it comes out in my body, so I will catch colds umm I will have aching bones and muscles and things like that, get headaches um but yeah and I-I yeah internalise it, so just try and get on with things".

"... I went to the- um- I had-I was being harassed by um a neighbour a couple of years ago and um I went to the doctor because I was having pain in my back (.) and they sent me to the physio person and he just touched me and he was like "That's stress!" and the woman's moved out and it doesn't feel the same."

Carly (FG2) recalled the devastating consequences of holding her depression within her body, but her laughter when mentioning losing her hair minimises the seriousness of what is being described:

“...just lots of going within and really just holding everything in and just carrying on and until yeah, I keep losing a bit more hair ((laugh)), yeah it comes out as physical manifestations because I will literally will just carry on”.

Both Lara and Carly’s comments illustrate the extent to which they have not only suppressed their distress, but they have also ignored their bodily symptoms of distress in attempt to “just carry on” (Carly, FG2) and maintain functionality. There was a very strong sense within the focus groups that the participants simply could not afford to stop and attend to their own needs. They either had too many people depending on them or they had no one they could depend on (see above Sub-theme 1.1.2: *Burden of the Black male*). Some participants were quite troubled by Black women’s ability to neglect their emotional needs and consciously chose to start talking about their distress to others, as highlighted in a later theme (see Theme 2.3: Seeking support is acceptable under conditions). However, they acknowledged the difficulty of this task, for example:

“...sometimes, yeah, I just have to get it out rather than keeping it in because I find for me keeping it in, just, yeah, makes me feel just too (.) dark for me, yeah, I don't like to internalise it to that degree so I'm trying to stop doing that” (Anna, FG1).

Lucy (FG2) explained that talking about her distress was also beneficial for her. She noted:

“I think when I get distressed and that I actually talk about it, and this is something that I think I've learnt so, I do the opposite of what a lot of [Black] women probably do, so I do talk, I do force, you know, force myself to be open about how I feel”.

This theme indicates that the participants found it difficult to express their unhappy and difficult emotions to others. Consequently, this led them to predominately manage their feelings in an isolated manner as discussed in the next theme.

Theme 2.2: Isolated ways of coping

This theme captures how the participants managed their feelings of anxiety and distress. With the cultural strength expectations placed upon Black women within the Black community, combined with the stigma surrounding mental health problems, participants felt that the journey to better mental health was a journey they had to take alone. The participants described some distinctive ways of coping and managing their distress, which will be discussed in the following three sub-themes: *Withdrawing from others*, *Keeping it in my head* and *Solitary activities*.

Sub-theme 2.2.1: Withdrawing from others

Social withdrawal is a typical sign of depression; sufferers can experience a strong urge to pull away from others when depressed (Johnstone, 2007; Rowe, 2003). Traditionally, social withdrawal is thought to be a negative symptom of depression (Rowe, 2003); however, some of the participants described social withdrawal as a functional way of coping with their distress, and thus viewed it as productive. Gut (1989) wrote about depression as being a source of protection, since it allows for healing to take place. Some participants felt compelled to 'hibernate' and spend time alone processing their distress, which is detailed below in the sub-theme: Keeping it in the head. Sam (FG2) felt that being alone was necessary to feel better:

"...if I get really unhappy I retreat um not massively it's not that I won't talk to people or anything but I suddenly sort of feel very erm self-like I need to do it for myself so I kind of retreat".

Sam continued to describe the importance of spending time alone when in distress:

"...but stillness is really important. And quiet I need peace and quiet, and so when I do the retreating thing it's you know (.) I will go outside and just sit and be and if someone even walks behind me it's like it's almost like you feel raw, and I just want to be in a little bubble, so my thing is to find the quietest space I can and just be in it, I don't want to talk to anybody I don't want the phone I don't want anything...".

Sam's use of the word "raw" indicates how vulnerable she feels when in distress, and thus her withdrawal from others was used as a source of protection from further exposure to upset. Similar patterns were described by other participants. Serena (FG1) and Anna (FG1) both described how they would perform a type of 'conversational withdrawal' (Schmale & Engel, 1975) from family members and friends if they felt that these people were causing or contributing to their distress.

Some participants went on to explain how they felt compelled to isolate themselves because they did not want to burden other people with their problems:

"Yeah just a lot of retreating definitely not speaking to people (.) and yeah just not wanting to bother people and not even thinking that they can help" (Carly, FG2).

Lynn (FG1) also found that she would isolate herself in fear of becoming irritable and frustrated with the people around her, and thus would isolate herself to protect others.

"For me I just keep away from people (.) I literally just keep myself locked in my house (.) quite literally because ((pause)) again it depends on the situation (.) um I don't know I think because sometimes I can't trust my own self because not even I know what's going to come out of my mouth ((laughs)) it might be best if I just (.) so I just tend to keep away from um people".

However, this management style did not serve her well, when questioned how this helped her she replied: "I wouldn't say it makes me feel better if anything, it makes me feel a bit depressed, you know, a little bit low". Thus, this technique only seemed to serve others, which further illustrates Black women's protective nature, as demonstrated in the theme: *I hide it from others*. As mentioned above, the process of withdrawing from others was often accompanied by a type of mental activity, such as overthinking. During this process, the participants allocated time to think or work through their distress, which will be further illustrated in the sub-theme below.

Sub-theme 2.2.2: Keeping it in the head

This sub-theme captures the participants' thought processes and experiences in relation to coping and managing their distress. Due to the reluctance to talk about their distress some resorted to 'keeping it in their head'. They would either ruminate, or try to mentally process it on their own. Despite both being thought processes, these were clearly two distinct ways of experiencing their distress. In line with previous research, the participants described how they would dwell on their distressing problems (Schreiber et al., 2000), they used words such as 'overthinking' or 'analysing everything' to describe this process of rumination. Lynn (FG1) described keeping distressing thoughts to herself and repeatedly thinking about them for several days:

"Yeah I really start to think back and I picture everything and, you know, all visually (.) the whole thing, the words that have been used, I analyse absolutely everything and I will analyse that (.) you know (.) depending on the severity of that issue (.) I might analyse that for maybe a week (.) even two weeks could be, you know, and if it's an issue where um (.) if it's a minor thing (.) where it's just (.) irritated me, say that might last two of three days..."

Lara felt that her distress triggered a cycle of negative thoughts, which then manifested into uncontrollable 'dark' thoughts:

"...I over analyse things I overthink things and then I start thinking of (.) dark things as well (..) you know like 'what if I wasn't here, and how

would they treat me then' and I hate that, and I can't stop it and I think that's because I internalise it so much, there are so many questions then that I'm questioning and answering myself".

For some, the cycle of negative thinking felt unproductive and harmful, consequently they learnt to talk about their distress to trusted people. Anna (FG1) explained:

'It's a struggle for me to keep it in really, like yeah, as the older I get I'm struggling with, kind of, keeping it [in] I have to let it out, look at it put it to bed because otherwise it just goes round and round in my head (.) stops me from sleeping and things...".

Unlike rumination, which appeared to be a symptom of distress, mental processing was described as a management technique. Some participants frequently used the word 'process' to describe how they managed their distress. For instance, Sam (FG2) noted, "I hoick myself up I kind of process it-think about what it is". Processing emotion, in psychodynamic terms, consists of using a variety of tools to heal and recover from trauma and distress (Cabaniss et al., 2016). The participants explained this activity as a solitary activity, where they felt a need to process their distress or the problems causing them distress by themselves before they told others. Dawn explained that she had to process her own cancer diagnosis before she told anyone else. This act of processing seems to be vital in helping the participants understand and come to terms with their upsetting feelings. However, again this act appeared to be a product of the SBW trait; it appeared to be protective of others. Since through mentally processing their distress, the participants could 'come to terms' with it, and thus were more likely to talk about it in a calm, less distressing way, to prevent causing alarm in others. Naomi (FG4) explained that she could only talk to trusted friends about her distress after she had processed it alone:

"...if it was something a bit more you know ((pause)) maybe serious or, you know, I probably wouldn't, I'd probably have to process that for myself and how I go through that, you know, agony and, you know,

processing what would you do and talking it through my head, you know, before I actually reach a conclusion of right ok, so I understand this a bit better, I know what's happening maybe then I might talk to Paula or Daw [close friends] about it".

The participants' accounts indicate that talking about their distress was a difficult task to do, and thus it was managed through a form of mental activities, such as rumination and mentally processing. However, these were not the only two ways of managing their distress, they described managing their distress via other non-cognitive ways, as illustrated in the next sub-theme.

Sub-theme 2.2.3: Solitary activities

Along with thinking about their distress, the participants described performing solitary activities to help cope with distress. Activities such as comfort eating, sleeping, and watching television were described as ways to distract themselves from experiencing upsetting feelings. Naomi (FG4) explained that watching television helped her "zone out"; she used this activity to help her relax. Whereas writing was used as a self-care activity, some of the participants would write to help them cope and manage distressing feelings and thoughts. They would secure some personal time away from others with just "me and my pen and pad" (Carly, FG2) to write down their inner thoughts and feelings. Lucy noted using writing to cope with distress, despite – at times – it being difficult due to the 'strength expectation':

"...I write a lot I write things down, erm, I try and be honest even when it's difficult to be honest but that's taken time to get there and it even feels a bit 'ahhh' when I'm doing it because again I was taught to suck it up get a grip, you know..."

The process of writing was used therapeutically to release and make sense of painful emotions. Sam (FG2) would often write in her diary during difficult periods in her life; she noted how beneficial this was for her:

"At the time it was really good my diary was my friend, yeah, it was like that's the one place I know, you know, yeah, it was very therapeutic

actually at the time because there was some hard stuff I was going through, so it really worked...".

Writing was clearly beneficial for some participants, and since it was done in private, it appeared more appealing. Lucy (FG2) noted:

"...when I was a kid I used to just write lots of lists because it would help me just to pour [out my emotions] and I just do it as a habit now so if something is on my mind I just write it down and think nobody's going to see it, I could screw it up and burn it if I need to..."

Some participants described using exercise to help ease distress and increase positive emotions. Marva (FG3) described the benefits she gained from exercising:

Marva: Exercise is the biggest hidden secret of a drug that exists, exercise has the ability to change your mind in ten minutes of a power walk you can literally change your mind, you can go to thinking that you're fat to thinking that you're slim within ten minutes of exercise I don't know how people don't exercise ((pause)) I have had days when I just feel overwhelmed and I go to the gym and I'm like 'Woo' what just happened? What just happened!"

Pat: I agree yes it does work

Dancing was also mentioned as a helpful way to cope with overwhelming difficult emotions. A few participants described how it helped them to manage their distress. Carly (FG2) used dancing to push away her feelings – "...moves the emotional energy just away...", whereas Emily (FG3) used it to help lift her mood: "...whatever I start dancing and praising [God] whatever and I feel much better". Again, this activity was performed in isolation, in a single room, such as a bedroom.

Music was described as an effective way to cope with distress by several participants across the different groups. For example, Tiana (FG5) commented:

"I like to just listen to music and walk around in circles in my room just doing stuff". Many other participants described taking 'themselves away' and having 'me time', where they would seek comfort and solace in music. Sam (FG2) noted: "...certain kinds of music (.) kinda soothes me, yeah, peace and quiet music...". Naomi (FG4) felt that music helped her to relax and unwind. She allocated a weekly slot for herself where she could listen to music alone:

"...my children know that-cus Mia [daughter] will come downstairs and she'll see, you know, the blank tv screen and the music going and it's, like, you know, does a U-turn and goes back upstairs [and] leaves me alone, it's my time"

For other participants, music was used as a vehicle to help them connect with, and release their sad emotions. Carly (FG2) explained:

"...yeah with music especially I didn't actually realise until you'd actually mentioned that it was a way of coping but definitely music and all different kinds. It could be that I need to cry so I want to hear some 'Mary' [Mary. J. Blige – R&B singer]..."

Faith and prayer was used to cope with sad and painful emotions. Participants in two out of the five focus groups described putting their "faith into God to deal with the [distressing] situation" (Annette, FG3); one participant (Paula) felt unable to confide in others and thus when in desperate need of support, she would turn to God despite claiming she was not religious. Paula (FG4) explained:

"...sometimes it really does feel it's that bad or I get so anxious about things that I think [the] only person who can help or tell me what to do is God and I get up the next day and I think right tomorrow I'm gonna start praying to God, and I manage to do it for two days..."

The participants in this study were not unique in turning to spirituality as a source of support during difficult times. This phenomenon has been previously

noted in other UK studies (Edge & Rogers, 2005; Lawrence et al., 2006; Wray & Bartholomews, 2006), where turning to God or the church has been deemed effective by Black women when coping with emotional distress (Lawrence et al., 2006; Wray & Bartholomews, 2006). However, Edge and Rogers (2005) argued that there are risks for Black women of consistently drawing upon spiritual sources of support – doing so may negatively impact their willingness to seek professional psychological help.

This theme described how the participants would separate off from the outside world in order to engage in solitary activities in an attempt to 'fix' themselves. Despite the claimed effectiveness of this approach, it did have its limits, which pushed the participants to seek help via other avenues – for example, talking to others as a source of support. However, seeking help from others only happened under certain conditions.

Theme 2.3: Seeking support is acceptable under conditions

This theme with its two sub-themes *Ultimate trust is needed* and *Seeking professional help is the last resort* focuses on the conditions under which the participants felt comfortable seeking support from others. The findings of this theme closely parallel those of Edge and Rogers (2005). Through interviewing 12 Black Caribbean women living in the UK about perinatal depression, these researchers uncovered the 'dirty laundry phenomenon' (Walker-Barnes, 2014, p.63), whereby their participants felt it inappropriate to discuss problems outside the home. This phenomenon has been well-documented in the literature (e.g. Amankwaa, 2003; Walker-Barnes, 2014; Williams, 2009), including this study where the participants felt conflicted by the Black cultural tradition of 'don't air your dirty laundry out in public', when attempting to seek support. Like many Black women of African heritage (Walker-Barnes, 2014; Williams, 2009), the participants were raised believing that emotional and relational problems should not be shared with others – "...we don't want no one to know our business..." (Annette, FG4) – particularly family problems. Carly (FG2) noted: "...you just don't go and speak about your problems, you're not meant to go and speak about what's going on in your house ((laugh))...". Naomi explained that she

would rarely speak about her family problems to other people, especially work colleagues:

- Naomi: I think it's cus we don't come in and share with them [work colleagues] ((pause)) our angst what's happening at home, what's happening with our children what's happening with our families, we don't share that we don't make it public knowledge so I think...
- Dawn: separate
- Naomi I wouldn't come in here and say to my two White counterparts oh I had an awful night last night with my son he was aggressive disrespectful I wouldn't
- Paula: I wouldn't either

There appeared to be a cultural mandate placed upon Black women – a mandate that provides them with clear guidelines on who to talk to and what to say – to not speak about family issues outside of the family home. However, interestingly, these issues were not spoken about inside the home either:

“...if you have a problem it stays in the family, it doesn't-does not go outside, so if you're gonna tell someone, talk to the family, but then often you don't feel like you can talk to the family anyway, so you end up keeping that inside...” (Tiana FG5).

Family members were expected to simply cope with problems alone. Some participants expressed that coping with their distress alone was burdensome and began to speak about and share their problems with others. However, this sharing of information was only performed under certain conditions, which will be illustrated in the following two sub-themes: *Ultimate trust is needed* and *Seeking professional help is the last resort*.

Sub-theme 2.3.1: Ultimate trust is needed

It was clear that 'ultimate trust' was needed when talking to others. Many participants explained how they found it hard to talk about their emotions and needed a trusting and safe environment to do so. Lara (FG1) mentioned a handful of people that she trusted enough to talk to. Anna (FG1) also needed trust and would only talk to "certain people" when in distress. Carly (FG2) felt having "trusted friends" were important for her when dealing with her own distress. She explained:

"...over the years I've developed much better female friendships so I do have the 1 or 2 good female friends now where we've made it a point now where we will go and talk to each other and just have a safe non-judgemental space, and we can say whatever, but that, like, something that was hard to come by and it took a lot of time".

Some felt comfortable talking about their unhappy emotions or distressing problems with trusted friends or relatives because they were secure in the idea that these conversations were confidential. Emily (FG3) explained the importance of talking about her problems and felt comforted by the notion of friendship confidentiality. She explained:

Emily: I must admit I do, I've got three people, three friends who I know I can talk to and I off load to them, I do! and I know it's not going to go anywhere else, you know, and it's really important because I think part of our downfall is that yes we're strong emotionally as well as erm mentally and having to carry stuff but it's like a pressure cooker if you don't allow it to come and allow the healing to take place, or whatever changes need to be made (.) it's going to explode somehow or somewhere isn't it, you know."

Annette: Yeah

In contrast to the 'ultimate trust is needed' rule, the participants found that despite not always knowing all the members in the focus group, they felt it

had been a good space for them to express their emotions. They enjoyed talking, listening and sharing their experiences with other Black women. Some explained how they seldom get the opportunity to talk about issues concerning Black women, therefore they found the group experience refreshing and insightful. Lara (FG1) felt she had benefited from hearing the experiences of other Black women:

Lara: ...to be quite honest it's kind of lifted my confidence a bit here today, hearing everyone else's experiences and kind of making me feel like I'm kinda on the right track I'm not so

Anna: Far removed?

Lara: Yeah yeah....

Like many other participants, Serena (FG1) expressed how much she had enjoyed the focus group and how she wanted to attend more groups:

Serena: ... I just want to do more things like this now (.) now that I've come to one especially more to do with like being Black um and being a Black woman and stuff like that

Anna: yeah

Marcia (FG5) summed up:

"It made me think a lot about, like, my every day experiences because like I don't really, I don't have conversations like this any other day... I just don't sit down with my friends and go 'let's talk about Black women stereotypes', it kinda makes you question it a little bit...the pressures that have been on you"

Some implied benefiting therapeutically from the focus group:

Tiana: I feel like a dam burst inside of me I was expressing everything

Group: ((General laughter))

Some participants likened the focus group to actual therapy: "for me this is the closest thing to counselling" (Paula FG4).

Sub-theme 2.3.2: Seeking professional help is the last resort

Some participants viewed therapy as a last resort since they felt they should ideally depend on themselves to resolve their problems. When discussing ways to cope with depression Serena (FG1) explained that she would support herself: 'I become my own best friend and just um talk to myself really...".

Another argued that Black women are expected to fix their own problems:

"...I feel like because historically there was no one else to go to (.) we've always had to fix our own problems and so even now whilst there is help it's kinda, like, well we've been doing it for generations, why do you need help now, like, the strong Black woman before you were able to fix their problems..." (Tiana, FG4).

Therefore, therapy was usually accessed when these participants were no longer capable of suppressing their distressing symptoms; or these symptoms were getting in the way of their ability to function normally. For instance, Serena (FG1) only sought help for her depression after repeatedly thinking in detail about committing suicide:

"...but I would just actually think (.) how would I do it [commit suicide], like, I wouldn't want my niece and my mum to find me, how would I do it, I wouldn't want them, some stranger to find me do you know what I mean..."

Lara (FG1) sought help for therapy when she felt unable to suppress her distressing emotions any longer, she explained: '...everything was just like- I just felt like I was in dark...'. Furthermore, it was her manager at work who

encouraged her to seek professional help. Sam (FG2) noted that at the time of accessing therapy she felt that she had no option to do so because of the poor state of her mental health:

“...so what put me into therapy was that I kind of had no choice it was either descend into mental illness or seek some help so I pushed it to the point where I was having kind of episodes of not really knowing who I am, what I was doing so I then took myself off [into therapy]...”.

Some felt it was acceptable to seek help when faced with major life tragedies. For instance, Sally felt therapy was acceptable (just about) if it was to help people cope with bereavement: “...I can understand that with things like ... death, I think we would need somebody that's trained and knows how to talk us through it...”. Despite Annette’s previous reluctance to show emotions to others, she talked about having had therapy after her dad passed away, she recalled:

“...when my dad died I thought I was alright-but I was messed up and I went to a counsellor and I cried when I went to the counsellor, it was the only time I could cry...”.

In line with previous literature in this area, the participants adopted a three-tier approach to help-seeking (Edge, 2013). Starting with self-help, next turning to trusted friends or family members and then, as a last resort, accessing professional help (Edge, 2013). Despite the participants’ attempts to seek help for their emotional distress, we can question the effectiveness of their requesting help, since the participant comments in the focus groups suggest that they had difficulty expressing the full extent of their distress to others. This will be discussed in the theme below.

Theme 2.4: Minimising: A way of coping

This theme captures the ways in which the participants would communicate their distress to others. When they did eventually talk about their distress, as discussed in the sub-theme *Ultimate trust is needed*, they would regularly minimise their feelings in the presence of others to protect them from

experiencing distress and/or to conform to the SBW image. Lara (FG1) spoke about regularly minimising her upsetting emotions to friends in fear that she would upset them:

Lara: I'm trying not to say things to people that might hurt their feelings and that's where I internalise it as well, so people have been so rude and so mean to me and because I don't want to say to them to hurt their feelings 'You're being mean to me that made me cry' because it might upset them

Lynn: Yeah

Anna: I do that

Some participants spoke about minimising their depression when talking to health professionals. They shared several instances where they would refuse support offered from health professionals or would dispute a depression diagnosis due to not wanting to be viewed as mentally unwell, or because they thought they could deal with it on their own. Pat (FG3) noted: "I was recommended a [counselling] service that was free erm, but obviously I didn't go because I thought I could deal with it myself". In the extract below, Lynn (FG1) explained that she minimised her depression because she did not like the thought of others seeing her as unwell:

"...the doctors had um a couple of years ago diagnosed me with depression and I actually told the doctor I didn't have depression ((laughs)) because I was that adamant that-that you know my pride was too strong I haven't got depression what you talking about?"

In another focus group, Carly (FG2) described a similar situation when she was first diagnosed with depression:

"...I was sat in her office-sat in the doctor's office crying and she was like 'Are you depressed?' and I was like (.) 'No!' You know, looking back years later I was like 'oh my god I was depressed...'"

It was evident that the process of minimising was also happening within the focus groups. There was a sense that the participants were downplaying their emotions. They appeared tentative about portraying the full extent of their distress and would use words that minimised their emotions such as: "a bit of a rant" (Serena, FG1); "*borderline* anxiety"; "*borderline* manic" (Anna, FG1) or would speak in ways that dismissed their distress such as: "...when I feel distressed or depressed or whatever you want to call [it].." (Sam, FG2). They would also laugh at themselves when talking about their distress. For example, in the theme *I hold it in my body*, Carly (FG2) laughed after describing how her depression was causing her to lose her hair. One participant clearly minimised her distressing experience as she relayed it to the group:

"I had (.) I don't-I wouldn't necessary call it a breakdown because in my mind (.) I feel like a breakdown is worse than what I experienced, but I don't know if that's just me being a strong Black woman just being like (.) but I was at a point where everything was just like-I just felt like I was in dark like everything, nothing was good I couldn't see anything being happy or, you know, the people I was around they weren't encouraging, you know, everything was just not working, everything was bad um (.) and it was a manager I spoke to and she was like "You need to go to the doctor" she said, like, 'Tomorrow I'll be ringing you, and you speak to your doctor'..." (Lara, FG1).

The way in which Lara introduced her distressing experience did not seem to reflect the actual experience. It was clear that this experience was very distressing for her, and her reluctance to label it as something serious – like a breakdown – indicates the extent to which she was minimising it. Lara's comment could be explained by the psychodynamic concept, defence mechanism, the process whereby the mind unconsciously uses certain mental stratagems to protect itself from unpleasant thoughts, feelings, and memories (Freud, 1992; Jacobs, 2017; Kline, 1993). The defence mechanism that was clearly present within the focus groups was minimisation, which involves lessening or deemphasising the severity of the distress (Kline, 1993; Gabbard, 2017). Thus Lara – unknowingly when retelling this experience – may have been

psychologically protecting herself, since this process protects her from fully connecting with its painful content (Freud, 1992; Jacobs, 2017)

Similarly, humour was used as a defence mechanism when describing racist experiences (Kline, 1993; Vaillant, 1992), since the participants' personal accounts of racism – when told to the group – were often interrupted by, or ended in, laughter. For instance:

"...you know my daughter is still trying to persuade people at school, you know, that I'm a Black child I was still born in England, you know, [she is] like seven (.) you know stuff like that you still have to say that stuff out loud like (.) 'No I was born here (.) in England ((laughter))" (Anna, FG1).

"[people at work] ask me these really silly questions that (.) they expect me to know because I'm Black, do you know what I mean....they just expect me to be (.) know every question as a Black woman really and speak for the whole Black race so yeah ((chuckle))" (Serena, FG1).

Even what appeared to be painful and overt forms of racism appeared to be minimised using laughter, as demonstrated in focus group 4:

Paula: I got it in the 70s it was nothing for somebody to drive along car full of White guys-spit make monkey noises...

Dawn: Yeah yeah yeah

Naomi: Yeah

Paula: And calling you chinky and sambo

Dawn: And want to know why the palms of your hand are White cus you're monkeys ((chuckle))

Paula: Sambo I didn't realise sambo was a derogatory word to Black people till I was about fifteen cus I was reading from a book in my nursery school

Group: ((laughter from all participants))

Paula: And kids are going sambo sambo sambo

Group: ((roaring laughter from all participants))

It was interesting to notice that as Paula recalled this memory, there appeared to be a disconnection between the narrative and her emotions. What would appear to be a painful memory was told with laughter and smiles, and was greeted by others in the group with laughter. There was a sense that this laughter was used to collectively minimise the painful content of these racist experiences.

Later in the focus group Paula goes on to explicitly explain how she would regularly minimise the impact of racist assaults from work colleagues because she did not want to upset them. In the conversational dialogue below, Paula describes how her colleagues respond when she confronts them about their racist attitudes, she stated:

Paula: It's kind of like shock and sometimes their response their upset yet again, makes me kind of pull back, cuz I think oh so and so's getting upset and they're going to be-so then you don't want to go on to describe everything else that's happened to you because you're sorry for them

Interviewer: So it gets reversed?

Paula: Yeah

Interviewer: And you end up feeling like you need to support them almost?

Paula: Yeah

As Paula spoke, there was a heaviness that permeated the room, indicating the extent to which she found these situations difficult and tiresome. The others nodded in agreement, thereby illustrating that they too are well accustomed to, or familiar with, these situations.

This theme clearly demonstrated that participants used minimisation in several ways, in the first instance the participants demonstrated that they minimised their distress in an attempt to protect others. Secondly, this strategy was used to appear strong and capable to others and to avoid being labelled with stigmatising mental health diagnoses, and thirdly it was unconsciously used to protect the participants from connecting with their own distressing feelings.

Minimisation, therefore appeared to be a multifunctional way to help participants cope with and manage their distress.

In conclusion, the notion that feelings should be hidden was related to culturally-based beliefs located within the UK Black community. This led participants to manage and cope with their depressive and anxiety symptoms in specific ways, as outlined in this overarching theme.

General Discussion

Summary of findings

The findings of this study demonstrate the complex ways in which Black women experience and manage their symptoms of depression and anxiety in relation to the socially constructed image of the SBW. Whilst this study echoed the findings of previous research on how Black women manage emotional distress in several ways – such as securing personal time to enjoy an activity, turning to God, and somatization (Edge & Rogers, 2005; Sisley, 2011; Woods-Giscombé, 2010). It also identified several new findings. For instance, the findings focused on processes of minimisation of traumatic experiences and withdrawing from others as a source of protection, the fact that ultimate trust is needed when confiding in others, and the emphasis on mentally processing distress in isolation from others provide new insights into how Black women managed their distress. Furthermore, the study expanded the existing understandings, providing additional information on how Black women experience and manage their distress. For instance, this study expanded upon findings by Myer et al. (2002) which found high rates of somatic symptoms within African-American women who had depression. The participants in this study also reported what could be regarded as high levels of somatic symptoms. However, this study also provides an understanding of why somatisation occurs within this group of women; namely that the participants felt that emotions such as sadness were deemed unacceptable (for Black women) in both Black communities and the wider society. Therefore, they were more likely to repress their emotions, which then provides a pathway for these emotions to manifest through the body.

Thematic analysis identified two overarching themes that highlight how understanding and managing depression and anxiety related symptoms was influenced by the SBW image and by a range of interwoven sociocultural factors. The current findings offer insight into the role of the SBW in the lives of Black Caribbean women living in the UK, with regards to how they experience mental health problems. Frequently the participants' narratives reflected commonalities between the reported experiences of African American women (Abram et al., 2014; Beauboeuf-Lafontant, 2007, 2008; Nelson et al., 2016; Watson & Hunter, 2016; West et al., 2016) and African Canadian women (Etowa et al., 2017;

Schreiber et al., 1998, 2000). Like their counterparts in the United States, the participants were compelled to adopt characteristics of the SBW, despite adamantly rejecting this ideal, describing it as an unattainable expectation placed on them by Western culture. They saw themselves, their foremothers and the other Black women around them in this ideal; believing that 'being strong' was the only way to survive a racist and patriarchal society, thus strength was perceived to be a functional component of their identity. It was therefore challenging for the participants to completely abandon 'strength', because doing so meant abandoning a part of themselves. Strength appears to be interwoven into the fabric of Black womanhood.

However, as Beauboeuf-Lafontant (2009, p.5) explained, the SBW 'cannot be strong and have needs of her own'. The participants' narratives echoed these sentiments, since they felt talking about their distress conflicted with the SBW ideal and thus would conceal their distress, in order to present themselves as strong and capable to others. The participants therefore would cope and manage their distressing emotions in specific and unique ways, such as somatization, listening to music, shutting themselves off from others. This new found understanding of how the participants cope and manage distress – within a UK context – has the potential to help with the development of appropriate and culturally sensitive mental health interventions for Black women.

Implications for practitioners and service development

It is important to point out that there is great diversity among Black women, according to age, generation, class and sexuality (to name a few dimensions of difference) and practitioners should pay more attention to their intersecting identities when working with such women. I do not intend to promote the idea that all Black women experience depression and anxiety in a monolithic way and thus should be supported using only specific interventions, but instead attempt to illustrate that some possible ways of working with Black women effectively given the intersections of various forms of difference and social marginalisation in their lives.

The analysis highlighted several implications for practitioners, and some possible avenues for therapeutic intervention. For example, given that the participants felt comfortable with expressing their vulnerable feelings within the study, interventions such as group therapy for Black women should be

considered as an alternative way of supporting these women with depression and anxiety (Jones, 2017; Jones & Warner, 2011; Neal-Barnett et al., 2011). Since mental health issues are rarely discussed in Black Caribbean communities, and because of the self-silencing effect of the SBW ideal, a group setting maybe more fitting in relation to other mental health interventions. Hearing other Black women discuss their struggles with depression and anxiety can help in many ways; it can highlight that they are not alone, normalise symptoms and alleviate mental health stigma. In turn, a group setting can provide a venue where understanding and healing can take place. Research into therapeutic group interventions with US Black women has shown that these are effective in reducing depressive and stress-related symptoms (Jones, 2017; Jones & Warner, 2011; Neal-Barnett et al., 2011).

The participants' experiences of the focus groups suggest that they benefited from having Black moderators (myself and the research assistant), who understood what it was like to be a Black woman. Many explained that they would have been reluctant to participate in the research with a White woman moderator, because of the 'social distance' between them (Ludu, 2016). They alluded to the fact that the social positioning of a White woman was very different from their own position, which may have resulted in her inability to comprehend their experiences. However, since ethnic matching for all Black women is highly unachievable due to the small number of Black therapists in the UK (Netto, 2001), non-Black counselling psychologists need to make themselves culturally competent, to help close this social gap.

Research indicates that cultural competence impacts upon therapeutic satisfaction for marginalised ethnic groups (Constantine, 2002; Gim, Atkinson, & Kim, 1991). Chang and Berk (2009) found that cultural incompetence behaviours suggesting a lack of cultural awareness and knowledge, was associated with treatment dissatisfaction for marginalised ethnic clients. Furthermore, Thompson, Worthington, and Atkinson (1994) found that African American women clients engaged in greater depth of self-disclosure and were more willing to attend therapy when their counsellor attended to their cultural context. Thus, counselling psychologists – when working with Black women clients – need to be aware of the social, political, and cultural context of these women clients and the unique difficulties they face in the UK. Greene (2000)

urged practitioners to pay attention to, and to help clients explore, how racism, sexism, and other types of oppression are present in their lives and the impact they have. Awareness of the SBW image would be beneficial, since this knowledge would enhance the practitioner's ability to understand their clients lived experiences, and it would provide the practitioner with the ability to integrate appropriate therapeutic interventions into the therapy. For example, in keeping with the SBW characteristics, the participants reported prioritizing caring for others rather than attending to their own needs and self-care. Skills that promote self-care can be taught, such as mindfulness based stress reduction or relaxation training (Watson & Hunter, 2016).

Additionally, through being culturally competent, practitioners are less likely to stumble into performing unintentional acts of racism, such as microaggressions (Burkard & Knox, 2004; Sue et al., 2007). The participants highlighted the considerable extent to which they experienced microaggressions and the negative effects it had upon their emotional wellbeing. Given that all individuals are socialised into a racist society (Carter, 1995), therapists are no exception and are just as prone to committing acts of racism as other members of society (Sue, 2005; Sue & Sue, 2008). Literature in this area has suggested that marginalised ethnic groups are susceptible to experiencing racial microaggressions in therapy (Burkard & Knox, 2004; Thompson & Jenal, 1994, Sue et al., 2007, 2008; Sue & Sue, 2008), especially when the therapist is not aware of their own racial 'bias' and prejudices or finds it difficult to talk about cultural issues, such as racism (Sue et al., 2007). McIntosh (2017) suggest that difficulties in talking about cultural issues can be solved through practitioners having honest conversations about culture and diversity within a range of contexts.

Research indicates that there are several racial microaggressions that are common in clinical work, including blaming the victim, racial colour-blindness and denying clients' experiences of labelling racism (Sue et al., 2007). Therapy is supposed to be a safe space for the client to explore painful and troubling experiences, racism being one of them, thus experiencing racism in the therapy room, can not only re-traumatise the client but can sabotage the therapeutic alliance (Bordin, 1979; Constantine, 2007, Owen et al., 2011) and perpetuate the very problems the client seeks to overcome. It is, therefore, important for

the practitioners to recognise, explore and reflect upon their own prejudices and assumptions (Huq & McIntosh, 2015), as this can increase self-awareness and prevent racial microaggressions from occurring in the therapy room (Mazzula & Nadal, 2015; Nadal, 2011; Ridley, 2005).

Many participants stressed the value of trust, indicating that trust was needed for them to open-up and accept support from others. Thus, the provision of a safe and trusting environment, is of course, needed for all therapeutic interventions, but in therapy with Black women its importance is heightened. 'Don't air your dirty laundry' was a shared value amongst the participants; they had been taught to silence their distress, upset and pain from a young age and breaking this silence was often associated with feelings of shame and weakness. It is, therefore, crucial that the therapeutic setting be safe and congruent. A clear outline of boundaries, confidentiality and an explanation of the therapeutic process may help to build trust and a therapeutic alliance, where the client feels safe enough to explore and express their emotions. Romero (2000) suggested that this safe expression of emotions can be achieved through exploring the SBW image and its self-silencing properties with Black women clients. Additionally, since the participants demonstrated the difficulties in directly articulating their distress, and they employed defence mechanisms such as minimisation, suppression and humour (Gabbard, 2017; Jacobs, 2017; Vaillant, 1992), it is important for practitioners to 'hear what is not being spoken' (Etowa et al., 2017, p.392) when working with this group. It is important for practitioners to be aware that Black women may underreport their distress, or attempt to portray themselves as 'keeping it all together'. Furthermore, given that Black women are potentially more likely to experience somatic symptoms of distress, as illustrated in the current study and in previous research (Myer et al., 2002; Woods-Giscombé, 2010), practitioners need to pay attention to any reported physical complaints as potential indicators of distress.

Limitations of the research

Although this research contributes to the existing literature regarding socially marginalised groups and mental health problems, like all research, it is not without its limitations, which will now be addressed. In the recruitment process, participants were invited to take part to discuss the influence the SBW has on their ability to cope with common mental health problems, thus giving

rise to the limitations of a volunteer sample (Gravetter & Forzano, 2009). For example, it is likely that the participants in the study had a certain type of relationship with the SBW, which enabled them to talk about their distress more openly compared to those who did not participate. Furthermore, the women in the study may have held different beliefs and coping styles from the women who did not participate.

The women in the study lived in two main cities located in the South West of England, both cities were relatively multicultural with established Black communities. It is possible, however, that the conceptualisation and reactions to the SBW image may differ amongst women in differing social and cultural contexts, such as women living in different geographical locations and with different religious backgrounds. For example, a Black woman living in a large Black Caribbean community in Lewisham, London might have different ideas about how an SBW would behave or look like compared to a woman living in Scotland in a predominately White community. Additionally, given that all the women in the current study identified as heterosexual, it is unclear whether the findings can be transferred to women from LGBTQ communities, such as lesbian or bisexual women. These women have to manage multiple marginalized identities – ethnicity, gender, and sexuality (Bowleg, Huang, Brooks, Black, & Burkholder, 2003) – which may impact upon their relationship with the SBW image and thus alter their experiences and management of distress. Further investigation could focus on whether the SBW image is similarly or differentially experienced by women from the LGBTQ communities.

Moreover, as discussed earlier (see 'reflexivity' section, pp. 41 - 44), the findings of this study were undoubtedly influenced by my own experiences and assumptions. Despite engaging in good reflexive practice and attempting to address the possible failings of my 'insider status'. It is nevertheless possible that my 'insiderness' influenced the way I conducted the focus groups, and how I heard and read the data which may have limited the findings. For instance, had I been an outsider, I may have asked more questions or probed a little deeper into the participants' responses. I however felt myself shying away from doing this. Platt (1981, p.82) clarified 'to ask for explanation is to define oneself as not a member of the community and disturb a personal relationship'. Perhaps my inhibition was due to not wanting to alienate myself from the group, and thus

lose the connection that was made through my insider status. Additionally, I was grateful that the participants were willing to talk about their emotions and vulnerabilities with me. Personally, I have always found this task extremely uncomfortable and thus at times – whilst conducting the first couple of focus groups – I fell into the illusion of sameness. I assumed that my discomfort was shared by all the participants, therefore, I became reluctant to ask in-depth questions in fear of making them feel uncomfortable (see Excerpts from Reflective Diary for a detailed account of this in Appendix 10).

As discussed previously, the study adopts a critical realist stance, meaning that the data is seen through the 'reality' of the researcher rather than assuming data directly reflects reality (Bhaskar, 1998; Minger, 2014). Therefore, within this epistemology stance, all researchers play a role in the research process and will have an impact on the research findings. Despite the limitations, the data presented in this study informs understanding of how these Black women experience and interpret the meaning of the SBW image. Furthermore, the data presented here provides a voice to a population that is often unheard, which helps fill the gap that exists in the current UK counselling psychology literature.

Directions for future research

The experiences of African American women in relation to mental health problems has been well documented (Amankwaa, 2003; Beauboeuf-Lafontant, 2007, 2008; Black & Woods-Giscombé, 2012; Etowa et al., 2017; Watson and Hunter, 2015; Woods-Giscombé, 2010), in comparison to the limited UK research exploring Black African Caribbean women's experiences (Edge & Rogers, 2005; Edge, 2007, 2013; Rabiee & Smith, 2014; Sisley et al., 2011; Wray & Bartholomew, 2006). The need for enhanced understanding in this area has been frequently outlined (e.g. Edge, 2013; Sisley et al., 2011). Findings from this current study partially fill this gap in the literature through highlighting the complex relationship Black women have with mental health problems. More research is needed to enhance understanding of the experiences of these women in relation to mental health problems, and hopefully address psychological help-seeking disparities. However, the current findings offer a rationale for adopting specific therapeutic interventions when working with Black women, such as group therapies and mindfulness-based interventions. This said, an examination of the use of these interventions with Black women would also be useful to

maximise the effectiveness and appropriateness of such interventions, along with further exploration into other therapeutic practices that may be suitable to meet the needs of this group. Even though the participants were fairly heterogenous in terms of age, socio-economic and employment status, it is possible that there may be unique experiences amongst women who hold multiple socially marginalised identities which are not captured in this study. Future studies that include women from LGBTQ communities, women who identify as disabled, and women who reside in highly populated White communities is needed to enhance understanding in this area.

Conclusion

This study has sought to understand how Black women, in their own words, manage and cope with self-identified mental health problems in relation to the SBW image. The findings suggest that the participants had an ambivalent relationship with this ideal. For example, atypical SBW traits such as 'being strong', hiding distress and protecting others, consistently underpinned the participants narratives, yet they adamantly rejected the notion of the SBW, declaring it as unrealistic and mystical. The participants did, however, explicitly embrace the notion of strength, claiming that 'being strong' was not a choice, but a requirement to survive a society that they regarded as racist and sexist. Consistently maintaining strength was found to have impacted upon their ability to effectively cope with self-identified symptoms of anxiety and depression, leading them to deal with these symptoms in restrictive and sometimes unproductive ways, such as hiding their distress from others, minimising distress, and somatisation. With this understanding of how the participants coped with and managed distress, the study has emphasised some possible productive avenues for therapeutic interventions and ways of working with Black women. For instance, the need for practitioners to 'hear what is not being spoken' (Etowa et al., 2017, p.392) whilst working with Black women, due to the self-silencing nature of the SBW image, and instead to seriously consider any physical symptoms when assessing the severity of distress. Therapeutic interventions that overlook the notion of strength and the potential impact it has on the lives of Black women are likely to be ineffective. Thus, the task, therefore, is for practitioners to educate themselves in this area to ensure they provide appropriate and effective mental health support to this group of women.

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