DENISHA MAKWANA BSc MSc

Black people's experiences of therapy

Section A: Black people's experiences of psychological therapy within the USA and UK: A thematic synthesis of qualitative studies

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A thesis submitted in partial fulfilment of the requirements of
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Acknowledgements

Thank you to all the Black men and women who trusted me with their stories. I hope that together we contribute to changing the systems. Thank you to all my supervisors; Dr Sue Holttum, Dr Isaac Akande, and Dr Matt Richardson, who were committed to the research, and all offered me support in different ways. Thank you to my friends and family who have been my cheerleaders throughout, and always offered their words of encouragement.

Summary of the Major Research Project

Section A is a systematic review of qualitative literature which explores Black people's experiences of therapy. The review extracted fifteen studies from the UK and USA. The studies were critically appraised and thematically synthesised. Six themes were discovered through synthesis which included; impact of racism and stereotypes, socio-cultural perceptions of mental health, therapeutic alliance, positive change within therapy, helpful and unhelpful structures of therapy and cultural adaptation. The findings are discussed in relation to how Black people experienced therapy in general, and what enhanced and hindered experiences of therapy, whilst reflecting on prior literature. Key clinical and research implications are explored in relation to improving therapy for Black people and highlights where the current gaps are.

Section B is an empirical study which explores psychological therapy experiences of Black people, who have been diagnosed with a psychosis-spectrum disorder. The study used narrative analysis as a methodological approach, and ideas from critical race theory as an interpretive framework. The stories of ten participants were analysed through thematic narrative analysis to derive six themes; experiences of oppression, accessibility, "Therapy is good"-helpful processes in therapy, safety and the therapeutic relationship, "It's not personal"- Disempowerment within therapy, resources outside of therapy. The themes are reflected on in comparison to prior literature and the key aims, which were to explore what Black people's experiences were of receiving therapy within an NHS community mental health team, and to explore how race, gender and mental health interact in people's experiences. Key implications of the research are provided regarding further research and clinical work. Overall, the study found that Black people with a psychosis-spectrum disorder found therapy helpful, however current systemic processes prevent Black people from feeling safe to disclose key aspects of their experiences in relation to their identity.

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SECTION A:

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Abstract

There are many health inequalities experienced by Black African-Caribbean communities within the United Kingdom (UK) and United States of America (USA). Individual, interpersonal and structural factors associated with these inequalities, may impact access to therapy, and the experience and outcomes of psychological therapy. Studies looking at Black people's experiences of therapy have been helpful in identifying helpful and unhelpful processes however, there have been no prior reviews collating these experiences. This review explores and synthesises data from qualitative studies focusing on Black people's experiences of different models of psychological therapy in the UK and USA. Fifteen studies met the inclusion criteria. A thematic synthesis was conducted, creating six overall themes; impact of racism and stereotypes, socio-cultural perceptions of mental health, therapeutic alliance, positive change within therapy, helpful and unhelpful structures of therapy and cultural adaptation. Generally, Black people who participated in the studies reported positive experiences of therapy, which was facilitated by a positive therapeutic alliance, acquiring specific skills, and appropriate cultural adaptation. Further research is required in examining Black people's experience of therapy within different settings within the UK, as most of the studies identified were based in the USA.

Keywords: Black, experiences, racism, psychological therapy, therapeutic alliance, cultural adaptation

Introduction

Definition of key terms

Black: This review used the term "Black" in reference to people whose ethnic origin is either African, Caribbean, or dual heritage. It has been viewed as a political and sociological term referencing a group of people, who have been most vulnerable to racism (McKenzie-Mavinga, 2009). It was acknowledged that Black people will not have universal experiences and that within their experiences there is heterogeneity.

Ethnicity: "Ethnicity" has been referred to the historical cultural patterns and collective identities shared by groups from specific regions of the world. In the UK, the term is used interchangeably with terms "race" and "culture" (Fernando, 2017).

Culture: Prior definitions have been criticised for illustrating culture as "static", "decontextualised", with little room for experiences of "transculturalism" and makes space for the use of stereotypes (Roy-Chowdhury, 2022). Instead, Roy-Chowdhury (2022) argued for a definition that considers the interactional and contextual nature of the phenomenon. "Culture does not only make available to the individual a behavioural repertoire, but presents particular orientations toward behaviour, which provide contexts for understanding beliefs, motivations and emotions."

Race and racism: Historically, the term "race" originated in Europe to describe and group "others" as inferior in relation to White people. Inferences were largely based on physical appearances, and it became a powerful way to assert underlying biological differences (Fernando, 2017). More recently, it has been recognised as a social-political concept (Fernando, 2017), although there is a lack of agreement regarding the construct within psychological research (Meyer & Zane, 2013). Chang & Berk (2009) recognised that the psychological significance of "race" is interpersonal, in that it impacts the way others behave, react, and perceive racialised people. This review recognised that the original

concept has been refuted and referred to "race" as a socially-constructed concept, examining its role within the experiences of Black people. There were multiple definitions of racism in the literature (Schmid, 1996). Fernando (2017) described racism as a way of thinking that positions those who are White as superior and justifies their privilege and power over those who are positioned as "racially inferior". This review positioned racism as embedded in the social, economic, political and institutional systems within the UK and USA.

Eurocentrism: This term has been used to describe the perception that European White values, traditions and behaviours are the norm, and therefore may be perceived as superior to values, traditions, beliefs, behaviours that are associated with difference (Awosan et al., 2011).

Mental health inequalities

Since COVID-19 and the resurgence of the Black Lives Matter movement, there has been greater attention on the inequalities that Black people have experienced predominantly in the USA and UK (Wood, 2020). However, these inequalities existed prior to these events (Howitt & Owusu-Bempah, 1994). In the UK, the dominant narrative to explain inequalities led to Black communities being labelled "hard to reach". This terminology has been criticised for positioning the problem within Black communities rather than recognising the problem as systemic (Kalathil, 2013). Additionally, racial stereotyping of Black people, in the context of mental health need, has led them to being stereotyped as "dangerous", "deficient" and "deviant" and met with more violent responses such as restraint, rather than being seen as suitable for accessing therapy (Briggs & McBeath, 2010; Keating, 2016).

The report "Advancing mental health inequalities strategy" (NHS England, 2020) highlighted that these inequalities exist at multiple levels. This includes inequality in access to services and treatment, inequality in experience of services and treatment, and inequality in outcomes of treatment. Black people are more likely to be detained under the Mental Health

Act yet are less likely to be offered talking therapy and medication (Das-Munshi et al., 2018; Nazroo et al., 2020; Schofield et al., 2016;). These health inequalities are also compounded by intersectional identities such as gender, disability, religion, sexual orientation, and deprivation.

Prior research has found that disparities in receiving mental health treatment can be linked to individual, interpersonal and structural factors (Planey et al., 2019). These include stigma and shame within Black communities about mental health and therapy, mistrust and fear of mental health services, a lack of knowledge about how to access therapy, eligibility issues, therapists' lack of cultural sensitivity and knowledge, language barriers, and the impact of stereotypes and racism (Arthur et al., 2010; Awosan et al., 2011; Bhui et al., 2018; Keating & Robertson, 2004; Motley & Banks, 2018; Thompson et al., 2004; Vereen, 2007). Similar barriers are also reported as being experienced by Black children and adolescents (Kapadia et al., 2021). Additionally, Black people may prefer to use alternative healing pathways and coping strategies such as visiting faith leaders and praying (Shippee et al., 2012; Ward & Heidrich, 2009). Ideas from Critical Race Theory have been utilised to argue that many of the barriers can be explained by recognising the systemic impact of racism, which has shaped systems, thinking and policy and positions racialised communities as inferior to White communities (Keating, 2016; Patel, 2022).

Experiences of therapy

Black people are less likely to seek therapy (Lawton et al., 2021) and when they do, there is evidence of early termination, as well as negative outcomes relative to White individuals (Awoson et al., 2011; Rathod et al., 2010). Stemming from research since the 1950s (Tien & Johnson, 1985), a frequent finding within the literature suggested that Black clients may feel more understood by Black therapists. Due to historical and contemporary experiences of oppression and discrimination, Black clients may employ a level of "cultural

mistrust" with a White therapist, influencing self-disclosure and safety within the therapeutic relationship (Awosan et al., 2011; Ridley, 1984, Whaley, 2001). Furthermore, participants have shown concern that White therapists, who have little cultural knowledge and sensitivity, may perceive them through the lens of negative stereotypes (Awosan et al., 2011; Tien & Johnson, 1985, Thompson et al., 2004; Ward, 2005). White therapists are less likely to explore race and racism with Black clients (Lawton et al., 2021), which may be influenced by ideas that psychotherapy models are "race-less" (Qureshi, 2007). Some therapists also feel incompetent in having these conversations (Rathod et al., 2010). Increased client self-disclosure, trust and strengthening of the therapeutic alliance have been reported when therapists address race within therapy (Knox et al., 2003). Although this is inconsistent within other studies where addressing racial issues did not impact ratings of therapy (Thompson & Alexander, 2006). Black clients' perception of their therapist's competence, knowledge, non-judgemental attitude, and ability to convey empathy have led to positive experiences of therapy, despite racial differences and a lack of focus on race (Chang & Berk, 2009; Qureshi, 2007; Ward, 2005). This finding is consistent with general literature, which illustrated that the therapeutic alliance is an important factor for enhancing the effectiveness of therapy (Holding et al., 2016; McPherson et al., 2020).

Cultural adaption has been suggested to include people's ethnic, cultural and religious interpretations of mental health within therapy (Awosan et al., 2011; Rathod et al., 2010). There are mixed findings as to whether cultural adaptations of therapy are effective. In some cases, they may dilute core components of therapeutic interventions, continue to reinforce an individualistic perspective, and are not more effective (Huey et al., 2014; Jones et al, 2018; Keating, 2016).

Given the current disparities in access, satisfaction, and outcomes of therapy, and the drive for therapy services to become "antiracist" (Williams et al., 2022), a review of how

Black people have experienced therapy is required. A review of studies of Black people's experiences of therapy within the last ten years may establish whether experiences of therapy have changed and may provide clarity around some of the mixed observations within older literature. Much of the prior research discussed has used quantitative methodology or reviewed studies that are randomised controlled trials (RCTs), used unqualified therapists, and used college students as the sample (Awosan et al., 2011). Subjective perspectives of therapy can shed light on how therapy is experienced, which is important given that client perspectives of the therapeutic relationship have been strongly correlated with outcomes of therapy (Meyer & Zane, 2013).

Rationale and Objective of Current Review

A better understanding of the experiences of Black people within therapy is necessary to further understand what processes either hinder or facilitate successful experiences of therapy. A search on PROSPERO did not identify any systematic reviews that focus specifically on Black people's experiences of therapy. Whilst there is merit in quantitative and mixed methodology in exploring experiences of therapy, qualitative studies are likely to provide richer data about processes and experiences in therapy.

This review aimed to answer the following questions;

1) What is the nature and characteristics of the qualitative studies that have looked at Black people's experiences of therapy and therapeutic interventions?
2) What does the evidence indicate about Black people's experiences of therapy?

Method

Eligibility criteria

The review attempted to identify studies which qualitatively captured Black people's experience of psychological therapy. The inclusion and exclusion criteria for identifying studies is outlined in Table 1. It was assumed that the number of peer reviewed journals identified would be limited. Therefore, a decision was made to include grey literature such as dissertations. Studies that featured participants who were either over eighteen or under eighteen were included given that the barriers are similar for all age groups.

This review included studies from 2013-2023, to correspond with policies and political movements related to improving inequalities for those from ethnic minority backgrounds, which are likely to have impacted therapy provision and research. In the UK, NHS policies advocating to improve mental health services for people from Black and Ethnic Minority backgrounds were first initiated in 2010, because of the Equality Act 2010. Equality objectives within the NHS have had to be revisited every 4 years, from 2014. In the USA, the Black Lives Matter movement was created in 2013, and in 2017 the APA updated it's 2002 guidelines on working multiculturally (APA, 2017). Additionally, the COVID-19 pandemic and murder of George Floyd led both the UK and USA revisiting inequalities experienced by Black communities. It therefore felt justified to look at studies which reflect this period. A decision was made to limit inclusion of studies to those based in the UK and USA since the impact of systemic oppression in accessing mental health services is similar.

Table 1

Inclusion and Exclusion Criteria

Category	Inclusion	Exclusion
Research Focus	Client experiences of psychotherapy or counselling or psychological interventions.	Experiences of psychotherapy or psychological intervention from perspective of therapist or observer. Interventions that do not focus on mental health/wellbeing. Experiences of mental health services.
Population	Identify as adults, children or adolescents. Identify as male, female, non-binary or other gender. Identify as belonging to a Black ethnic identity. This includes Black British, Black African, Black Caribbean, Black dual heritage, Black mixed heritage, African American.	Identify as a non-Black ethnic identity. Studies that aggregate Black ethnic identity experiences with other non-Black ethnic identity experiences.
Country	USA and UK.	Studies located outside of the USA and UK.
Setting	Any setting.	
Type of therapy/intervention	Individual therapy, group therapy, family therapy. Any therapeutic model.	App or computerised therapy.
Study Design	Qualitative studies	Quantitative studies and mixed-method studies.
Language	English.	Non-English.
Publication	Published studies, peer-reviewed journals, doctoral research.	Other forms of grey literature such as media articles and book chapters. Review articles.

Time frame	2013-2023	Studies published prior to 2013.

Search Strategy

After initial scoping searches, five databases were used to conduct the systematic search; PsycInfo, ASSIA, Medline, British Nursing Index and Web of Science. The British Library EThOS database was additionally used to search for eligible dissertations in the UK. PsycInfo and Web of Science were sufficient in identifying dissertations from the USA. The search terms alongside Boolean operators applied are outlined in Table 2. Additional filters were applied to only include studies published in English and between 2013 and 2023. Search terms and filters were applied for titles and abstracts of studies. Some key search terms were shaped by previous reviews, for example search terms for different types of therapy (McPherson et al., 2020; Planey et al., 2019). In addition to searching databases, the references of studies that met inclusion criteria were scanned for additional studies.

Table 2

Search Terms

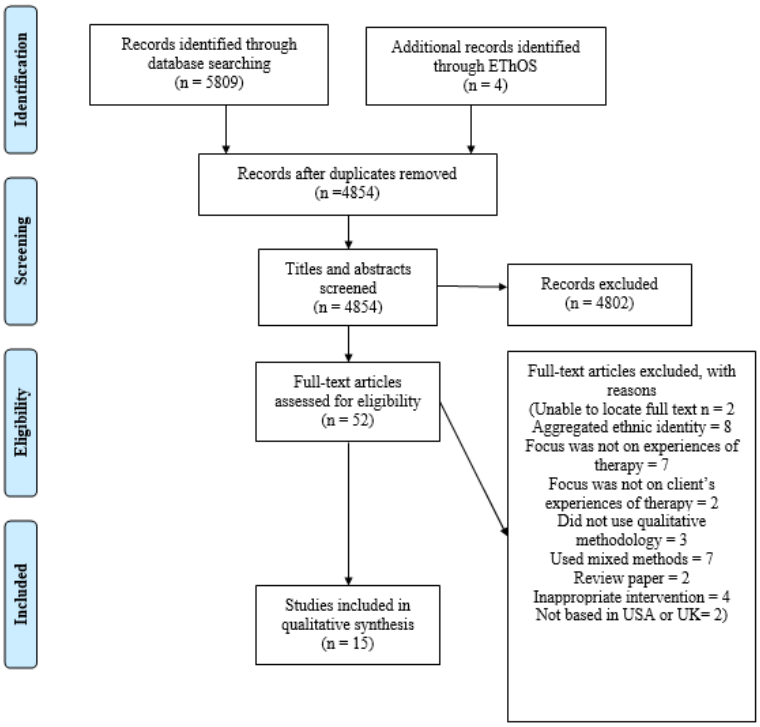
	AND	AND
Black OR	experience* OR	therap* OR
Black British* OR	narrative* OR	mental health intervention* OR
Black African* OR	perspective* OR	psychological intervention* OR
Black Caribbean* OR	belief* OR	psychotherap* OR
African American* OR	attitude* OR	CBT OR
American Caribbean* OR	interview* OR	cognitive behav#ral therapy OR
African-Caribbean* OR	opinion* OR	Interpersonal therapy OR
Afro-Caribbean* OR	view* OR	IPT OR
Black Mixed* OR	perception*OR	psychodynamic OR
Black Dual* OR		Mindfulness-based cognitive
Biracial*		therapy OR
		MBCT OR
		counselling* OR
		couples therap* OR
		family therap* OR
		psycho* treatment OR

Study Selection

The search was completed in September 2022 and identified 5813 studies. Once duplicates were removed, the titles and abstracts of the remaining studies were screened according to the inclusion and exclusion criteria outlined in Table 1. Fifty-two studies remained eligible after this process. The full text versions of these papers were screened to ensure they met the eligibility criteria. Once studies were further excluded, fifteen studies were identified as meeting the inclusion and exclusion criteria. The PRISMA diagram (see Figure 1) outlines the search process.

Figure 1

PRISMA Diagram



Data Extraction

A data extraction proforma was utilised to summarise the key characteristics of each study. Each study was extracted for the type of publication, sample characteristics, setting,

data collection method, analysis method and study objective. If specified, studies were extracted for information about the therapeutic approach, and gender and ethnic identity of the researcher and therapist. Table 3 outlines the data that were extracted for all fifteen studies.

Quality Assessment

The Critical Appraisal Skills Programme (CASP) was used to perform a quality assessment of the fifteen studies as it is an accepted approach for appraising qualitative research (Boland et al., 2017). Ten questions were provided as prompts to assess the appropriateness of aims, design and methodology. Researcher reflexivity, ethics and the clarity of findings were also assessed using the tool. The study by Ashley and Brown (2015) was deemed as low quality (see Appendix A), however was included in the review due to the lack of studies within the area.

Synthesis

Data from the fifteen studies were compared for the synthesis. Similarities and differences between the studies are described. All studies analysed their results using an analytical method which resulted in themes across participants. A thematic synthesis was conducted across the fifteen studies, as it has been deemed a useful approach for synthesising qualitative studies (Thomas & Harden, 2008).

The results section of each study was carefully read and data that were relevant to the experiences of therapy such as prior beliefs about the therapy/intervention, processes which enhanced or hindered therapy, and recommendations for improvement were synthesised. Data that were not directly related to participants' experiences of the therapy/intervention were excluded. For example, Ashley and Brown (2015) included a theme about participants' feelings about foster care. Quotes within the results section and

author summaries were included as data for coding. Following the methodology of Thomas & Harden (2008), a stepped approach was used for the thematic synthesis. Relevant data from the results section of each study were coded line by line. An inductive approach was used to code the data. The second stage was to organise the codes to create descriptive themes. Descriptive themes are themes that align closely to the data provided within the study. The third stage of the synthesis involved creating analytical themes. Analytical themes were created through the researcher's interpretation of the descriptive themes to create additional understanding of the data. A critical realism (Schiller, 2016) framework was utilised as an epistemological approach.

Table 3

Study Characteristics

Study (year), location	Type of publication	Sample	Data collection method	Analysis	Study objective	Therapy intervention/therapy model	Identity of the researcher	Identity of therapist	Main findings and themes
Ashley & Brown (2015) USA	Peer-reviewed journal article	N=9 Females who identified as African American In foster care Aged 10-18 years old. No sampling technique specified	Pre and Post in depth interviews	Derived themes but no analysis methodology was specified	To explore the effectiveness of the intervention using experiences of the sample	A culturally relevant, strengths-based intervention called Attachment tHAIRapy. The intervention provided hair care and mental health therapy sessions over four months. Group therapy	Not specified	Trained agency psychotherapy and a licensed hair practitioner	Theme 1: Feelings about foster care Participants shared that they kept their distance from foster parents, and felt closer to others in their social system (e.g. siblings, friends) Theme 2: Significant relationships The therapy intervention (therapy alongside youth having their hair done) had a positive impact on self-esteem and their relationship with others. Those who had their foster parents attend, found this helpful for strengthening their relationship. Theme 3: Feelings about therapy The pairing of haircare with therapy led to positive shifts in how participants felt about accessing and using therapy. Theme 4: Feelings about hair Most participants shared frustration about the nature and condition of their hair generally. The researchers made further interpretations about what the impact of this on the participants' self-esteem and internal psychological states. Theme 5: Racial identity development Participants were more interested in maintaining their natural hair after the intervention, however only felt this was possible with support and guidance. The researchers interpreted this as a way to increase healthy racial identity development.
Coombs et al. (2022)	Peer-reviewed journal article	N=15	Semi-structured interviews	Thematic analysis	To describe the	Ten free sessions of evidence-	A Black female cisgender	Clinicians included licensed	Theme 1: Receipt of services at a church-affiliated mental health clinic

USA	Identified as Black. 13 females, 2 males Aged 27-69 years old Accessing mental health clinic from the HOPE centre (First Corinthian Baptist Church)	experiences of Black Americans seeking and receiving care from the clinic and to understand perspectives on the Black Church's role in supporting mental health services	based psychotherapy such as cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT) accessed through a mental health clinic affiliated with a church Individual therapy	psychiatrist conducted the research interviews.	doctoral and master's-level social workers and supervised social work student interns. All of the clinicians identified as Black cisgender women	*Impact of religious affiliation and church promotion on care initiation* It was important to receive mental health services in a church-affiliated setting as spiritual beliefs could be integrated with therapy experience. It also positively challenged people's preconceptions of therapy which were based on ideas that church related activities such as praying was enough to support mental health. Promotion of the service from church staff was helpful. Mindfulness group sessions perceived as helpful. *The Hope centre environment* The setting was described as a "positive, peaceful, welcoming, and serene environment." *Accessibility of services* It was important services were free of charge. Some wanted the centre to provide longer term therapy. *Impact of services provided* Tools and skills learnt through the service were seen as helpful including meditating. The service was seen as particularly helpful in processing trauma. Theme 2: Perspectives on the role of the Black church in addressing mental health needs. Many participants thought it was important and effective to have church staff promote and advocate for mental health support and treatment. *Barriers related to church affiliated or church based mental health services* Hypothesised barriers included access to individuals who did not have Christian faith background. Participants thought the staff had certain knowledge and wisdom. Finding similar staff was described as making it difficult to expand the service wider.

									Religious conceptualizations of mental health as a barrier to treatment Christian conceptualisations of mental health were described as creating stigma and shame.
Dera (2021) UK	Dissertation	N=13 Males who identified as Black British Aged 24-33 years old Purposeful and snowball sampling Accessed six sessions of therapy	Semi-structured interviews, telephone and online	Thematic analysis	To explore young Black men's experiences of formal help-seeking for psychological distress	Therapy accessed from primary care, private and NHS Individual therapy	Black African female mental health professional	N/A	Theme 1: Navigating socio-cultural barriers *Therapy is for crazy people* Participants described the social stigma attached to therapy which was driven by societal and cultural portrayals of therapy and acted as a barrier to access. *What happens at home, stays at home* Participants spoke about gender and cultural socialisation which placed expectations on Black men that they should deal with difficulties themselves and keep problems private. *The strong Black man* Participants described complexities of Black masculinity. Participants described expectations that Black men were required to be strong and survive unsafe social conditions, however in many contexts their internal vulnerability and psychological wellbeing was often overlooked. Theme 2: It's a big step asking for help *Denial, fear and delay* Participants described individual barriers to accessing help, which included denial of a problem with mental health, lacking the language to articulate the problem, and using own coping strategies before accessing support. *Is there accessibility for me as a young Black man?* Factors that supported access to therapy included accessing therapy that was convenient (e.g. after work), recommendations through others, well-explained and straightforward procedures, access to material resources. Barriers to access included lack of awareness of how to access therapy through the NHS, lack of follow up, and procedural steps associated with

the NHS which were perceived as unfamiliar and uncomfortable.

Theme 3: Being taken on a journey

Feeling un(safe)

Participants described distrust of the process and therapist in the early stages of therapy. The uncertainty of what to expect next left participants feeling hypervigilant.

Assurance of a confidential space led to feeling safe. Gradually feeling safe led to participants to be open and relax.

Therapist disclosure also led to increased rapport, whilst perception that therapists were judging them led to termination.

Doing the work

Participants described a sense of agency in their own recovery through engaging in tasks and homework.

For some a solution-focused approach was preferred over more discursive approaches.

Choice and flexibility promoted a positive experience, whilst a lack of collaboration led to termination.

Will you understand the culture I'm coming from?

A third of participants described preferring to work with racially similar therapists as there was an expectation that they would better understand social and cultural contexts.

Concern for confidentiality, over-familiarity and geographical proximity were described as reasons for not preferring a therapist from a racially similar background. A racially similar background was also not always perceived as a prerequisite for developing rapport with the therapist.

Therapy was an achievement

Participants described the transformative elements of therapy including the long-term impact, and the desire to become advocates for therapy.

Theme 4: Build bridges of trust and collaboration

									Find out where we are Participants described strategies to increase access to therapy including increasing the visibility of NHS services, collaboration with Black communities, and culturally relevant and compassionate ways to engage Black men. *If they are talking about therapy, I don't see myself* Participants reflected on the lack of representation of Black men in the media, within services and in the community.
Jensen et al. (2021) UK	Peer-reviewed journal article	N= 22 "service users" with psychosis, N=12 family members Aged 18 years old and over Identified as Black British, African-Caribbean or Mixed African Caribbean Receiving care from NHS inpatient or	Interviews	Framework analysis	To explore participants' views of Culturally adapted Family Intervention (CaFI) on completion of therapy	A culturally adapted version of cognitive behavioural model of Family Intervention. Manualised, ten sessions Therapy accessed as a family	Trained researcher.	One therapist trained in cognitive behavioural therapy and a co-therapist with previous experience in working within mental health services but no training in psychological therapy	Theme 1: Perceived benefits *Personal benefits* Service users reported personal and interpersonal benefits such as adaptive coping mechanisms (e.g. doing breathing exercises when anxious). *Greater knowledge and understanding* The intervention was seen as informative and educational for better understanding their diagnosis and normalising symptoms. *Better communication with family and health professionals* Service users felt more comfortable sharing their feelings with family and about communicating their needs with healthcare professionals. Theme 2: Barriers and limitations *Barriers for attendance and commitment* Lack of motivation, tasks being too easy, and experiencing symptoms were identified as barriers to therapy. *Suggestions for improvement* Shorter sessions were mentioned by one participant and presence of a family member was mentioned by another participant. Theme 3: Delivery of the therapy *Perceptions of therapists and family support members* (proxy family members) Service users felt safe talking to therapists.

		communit y service		All had positive relationships with FSMs who described a gradual process to being open and honest. *Therapy components and practical considerations* Flexibility and choice about time and location were valued, alongside a clear weekly structure. Ten one-hour sessions were viewed as acceptable by most. *Cultural appropriateness* Most participants praised the advert which led them to decide to take part. The majority thought that the intervention met the needs of African-Caribbean people. However, some felt that it did not. Family members Themes: Theme 1: Perceived benefits *Increased knowledge and understanding* Family member's thought the intervention helped them understand the service user's diagnosis. *Improved relationships and communication with service users* Some reported fewer family conflicts, and many reported being better able to communicate feelings. *Improving coping strategies and problem-solving skills.* Some reported being better able to respond to service users' stress and difficult interpersonal dynamics. Some felt they already knew how to cope and therefore felt some of the sessions were less helpful. Theme 2: Perceptions of therapists *Characteristics of therapists* Therapists were perceived as competent, professional, supportive, knowledgeable, able to listen and tailored information.

									Collaboration and inclusion of family members was perceived well. Theme 3: Delivery of therapy *Location and time of day* There was a preference for therapy to be at home. Flexibility of time and location was perceived positively. *Number, length, and duration* Most agreed that one hour was enough time for each session, whilst some thought it could be longer. Half of the participants agreed that ten sessions was enough, whilst others suggested more. Theme 3: Accessibility of therapy content, supporting materials and cultural appropriateness *Therapy content* Content was mostly viewed positively. *Supporting materials* The booklet on understanding psychosis which was co-developed by service users and a research advisory group was seen as suitable. *Cultural appropriateness* Most family members thought the intervention met the needs of African-Caribbean people, but many could not identity what parts of the therapy had been adapted and thought it would be suitable for everyone. Some participants felt that incorporating culture creates further division and stigma.
Johnson (2020) USA	Dissertation	N=10 6 females, 4 males Identified as Black or African American	Semi-structured interviews, online	Transcendental phenomenological	To explore the experiences of African Americans who have	Couples therapy	African American male graduate student in a university Human Developmen	N/A	Theme 1: African Americans endorse couple therapy and experience it favorably *Couple therapy was a resource for treating relational issues* Couples therapy was perceived positively for addressing couple-related issues, including communication, trauma, impasses, infidelity, and financial incompatibilities.

	Aged 26-50. All had accessed couples therapy as a couple Criterion sampling	participated in couples therapy	t Family program.	*Couple therapy led to the enhancement of communication skills* Skills learnt in therapy supported communication within the couple, and for some with other family members too. *Focus on solutions* Some participants commented that solutions offered in therapy were the most helpful component. *Endorsement of mental health care treatment for individual issues while being treated in couples* Many participants shared that couples therapy supported them with improving self-care, pursing personal endeavours, and making personal changes. *The value of having a provider offering insight* Many valued the facilitation from the therapist and their competency to offer guidance. Theme 2: The therapeutic alliance has a central role in couple therapy with African Americans *Importance of safety and therapeutic alliance* A few participants felt that some communication or emotional issues were not managed well by the therapist, and this created mistrust. Some participants felt that some issues were not resolved and a debrief at the end of sessions would have felt helpful. *Disclosure and the therapeutic alliance* Some participants chose not to disclose some information due to the therapist's approach or the consequences of the disclosure- for example "no-secrets policy". Some participants found it difficult to disclose information and be vulnerable in front of their partners. *Hopefulness in the therapeutic alliance* Based on the alliance, participants described feeling more or less hopeful.

Some participants found reflective questioning from the therapist a helpful process.

I am feeling connected when acclimating to the process of couple therapy

Some participants spoke about their process of finding a suitable therapist and "shopping around".

Partner involvement

Some participants spoke about the challenge of therapy becoming heavily focused on their partner, which could impact the focus of the work on the relationship.

All women participants spoke about the positive experiences their partners had in therapy, especially noticing the shift in perception of accessing therapy.

Theme 3: Therapists addressing culturalism and racism in couple therapy

The couple therapist and participant's racial likeness

Racial likeness was perceived as an important factor for rapport building in the early stages. All female participants had shared that their partners had preferred a therapist of the same race. The preference for racial likeness was associated with a perception that the therapist will be more understanding of racial experiences.

Cultural sensitivity and cultural factors in the process of couple therapy

Participants felt it was important for therapists to understand the cultural experience of identifying as African American. Choice of words, use of humour, office decorations, use of interventions were all gauges for participants to assess cultural sensitivity of the therapist.

Only one couple discussed race with their therapist.

Racial stigma

									Some participants shared that there was still some stigma about Black people accessing therapy. There were mixed experiences about whether these prior reservations were shifted after accessing therapy.
Nixon (2021) USA	Dissertation	N=6 Females who identified as African American Received therapy from European American clinicians Aged 21-65 years old Time-location, criterion-based, and snowball sampling	Semi-structured interviews, online.	Qualitative transcendental phenomenological. Analysis was conducted using Moustakas' data analysis method and "Strong Black woman" schema as a conceptual framework	To explore how the endorsement of the SBW schema affects African American women's experiences and perceptions of the therapeutic alliance with European American clinicians	Individual therapy	Black American female	European American	Theme 1: Feelings of discomfort in therapy Participants described feeling uncomfortable during therapy due to perceptions that the therapist may not understand them due to demographic differences, and not knowing what to expect. Some participants described discomfort from perceived racism during the therapy process. Theme 2: Therapist's inability to relate to or understand the culture and life of African American women. Five of the six participants described experiences where their European American therapist were unable to relate to African American culture and lived experiences of being a Black woman. Theme 3: Poor connection and engagement with therapist Most participants described a difficult relationship with the therapist and felt they had little connection with the therapist. Factors that impacted this were perceived racism, and intent in accessing therapy (e.g. one participant had to access therapy as part of career progression). Theme 4: Lack of confidence in the therapist Discomfort within therapy and perceived lack of cultural understanding from the therapist led to most participants feeling a lack of confidence in the therapist. Theme 5: Double-sided notion of SBW schema Participants described the positive and negative aspects of the schema. Negatives included the view that due to therapists' lack of cultural understanding, strong Black women may be perceived as angry, aggressive and difficult. The positives included the strengths in the ability of

									African American women to take on and handle everything and identify as self-sufficient and independent. Theme 6: Personal strength and independence All participants identified as "strong Black women". They described this as not a choice or option, but an expectation placed on them and a necessity to survive. They described their strengths as being independence and able to handle adversity. Theme 7: SBW schema hinders the therapeutic alliance Participants described the stigma around accessing therapy, and a cultural perception that it is seen as weakness. The lack of understanding of this from therapists, racism, and a misperception of strong Black women led to participants terminating therapy and not developing a strong therapeutic alliance with their therapist.
Nurse (2020) UK	Dissertation	N=9 8 females, 1 male Aged 18-24 years old Accessed atleast six or more sessions of therapy Purposive sampling	Semi-structured interviews	Thematic analysis	To explore the understanding of young people from Black communities' experiences of CBT for depression	Cognitive behavioural therapy for depression accessed through Improving Access to Psychological Therapist (IAPT) within the NHS Individual therapy	Black Caribbean female psychologist	Not specified	Theme 1: The therapy experience Being heard Participants felt heard by the therapist, and this led them to be open. *Having tools* Participants expressed the helpfulness of the skills, strategies and solutions which supported them to manage their distress. Many spoke about their own agency in doing the work with support from the therapist. *Comparisons to counselling* Most participants found the solution-focussed approach of CBT helpful. Some commented on the importance of knowing the difference between the types of therapy. *The challenges and fears* Some participants did not feel the strategies offered to them provided a solution to their problem.

Participants spoke about withholding some information as there was a perception that the therapist would not understand cultural, social, and historical contexts of the participant and their Black experience.

Participants shared that factors such as race and finance were not discussed in therapy but could have been useful.

Theme 2: Navigating getting help

Additional struggles

Participants described racial inequalities they experienced in relation to being young Black adults.

Bottling up

Participants described "bottling up" emotions as they had observed family members and other Black people doing the same. Some participants discussed the importance of family members modelling accessing support and normalising distress, so that young people could better respond to their own distress.

Stigma and labels

Participants spoke about the stigma related to mental health, vulnerability, and accessing therapy held within Black communities.

Some discussed the Strong Black woman stereotype which led to difficulty in expressing feelings in case it was perceived as weak.

Conceptualising distress

Participants made sense of their distress by talking to friends and using the internet. Both these approaches were helpful for understanding their difficulties and provided information about help-seeking. Participants spoke about the helpfulness of seeing other Black people online talking about their experiences.

The role of mothers

									Most participants described their mothers playing an influential role in supporting and encouraging them to access help.
Pritchett-Johnson & Jones (2020) USA	Peer-reviewed journal article	N=8 5 females, 3 males Identified as African American Aged 19-24 years old	Semi-structured interviews, telephone	Thematic analysis	To explore the effectiveness and impact of the F4T program from the perspective of F4T participants	F4T is a community based therapeutic model for Black young people. The model includes group and individual therapy interventions using narrative, interpersonal, motivational interviewing and emotion-focused approaches Group therapy	First author conducted interviews, identified as African American female counselling psychologist. One of the researchers was also part of the F4T program.	Not specified.	Theme 1: Recruitment Word of mouth and role modelling as opposed to flyers and outreach events were perceived as helpful recruitment strategies. Theme 2: Programming Participants found the format of the intervention helpful. It was described as structured whilst allowing for flexibility and openness. Theme 3: Cultural essence Participants found the personality of the facilitators relatable, open, and friendly. The racial and cultural background of the facilitators, and racial and cultural awareness were mentioned as helpful components of the intervention. Theme 4: Impact Participants shared that the intervention impacted them individually in that they gained more self-confidence and awareness. Participants also described relational benefits including that they were more "mindful" to their reactions towards others and were better able to listen and communicate with others.
Qureshi (2018) USA	Dissertation	N=15 4 females, 11 males Identified as Black or African American Aged 15-16 years old	Face to face semi structured interviews	Transcendental phenomenological.	To explore the experiences of lower-income Black adolescents' in family therapy in an residenti	Family therapy received in an RTF	Pakistani, Muslim, heterosexual female	10 therapists. 7 female, 3 male 3 White, 2 Black/African American, 1 Hispanic, 1 other, 1 not specified	Theme 1: Views on receiving family therapy in RTF Most participants viewed accessing family therapy as a requirement to leaving the facility. Most participants viewed family therapy positively. Participants named ways it was helpful to them, e.g. helping them to express their feelings, open up, communicate, listen to others, deal with family relationships. Theme 2: Therapeutic alliance and relationship with RTF therapist Some participants compared their experience to prior experiences of family therapy. These prior experiences were perceived as unhelpful as

	Purposeful and criterion sampling	al treatment facility (RTF)	6 licensed	participants felt they were unheard, or the therapist did not seem to understand, listen, or appear to care. All participants perceived their relationship with the family therapist as positive, and that the process of building the relationship took time. The gradual process led to participants feeling comfortable be open and honest. The therapists' ability to validate, listen, understand, and provide solutions were all described as helpful for the therapeutic alliance. The race and gender of the therapist was important for three participants due to a perception that the similarity of gender and race would promote better understanding. Theme 3: Development & cognitive shifts in self Participants described positive shifts in their perception of family therapy. Participants described noticing how they had "changed" and "matured" after going to therapy. Theme 4: Treatment goals in family therapy in the RTF Participants described the purpose of family therapy as a way of improving family relationships including communication skills. Many noticed an improvement in communication, self-expression, empathy towards family members, emotional regulation, and their behaviour. Many described the involvement of family in therapy as a transformative process. Theme 5: Views on racial inequalities and injustice Most participants discussed racial inequalities between Black and White people, including the way Black people are treated in society. Some participants reflected on the experience of racial oppression within the juvenile justice

									system and society, which impacted the way decisions were made towards the participants. Theme 6: Experiences with trauma & loss Participants discussed that the experiences of re-traumatisation within the RTF impacted participant experiences and peer relationships, which could lead to further distress. Participants also described many losses as a result of staying in an RTF, including the loss of family and loss of freedom.
Shundi (2020) UK	Dissertation	N=6 Females, who identified as Black African first generation migrants in the UK Aged 32-54 years old Accessed at least four counselling sessions Purposive and snowball sampling	Face to face semi-structured interviews	Interpretative phenomenological analysis (IPA)	To explore Black African women's lived experiences of counselling therapy	Individual counselling therapy	Black African woman trainee counselling psychologist	N/A	Theme 1: Preconceptions, stigma, scepticism about the therapist and preferred ways of coping *Preconceptions* Preconceptions about Black women being expected to exhibit strength and handle life challenges impacted help seeking. Many of the women bottled up their problems and emotions and did not think they required professional help. *Stigma* Most participants associated counselling with mental health illness. Due to the stigma associated with mental health illness within Black communities participants were concerned about accessing therapy. *Scepticism about the therapist* Participants were worried they would be negatively judged by the therapist. They were concerned that the therapist would not understand them due to racial, cultural and religious differences. *Preferred ways of coping* Cultural beliefs and identification as a strong African women shaped what was an acceptable response to mental health difficulties. Participants coped with distress by keeping themselves busy, self-isolating, avoiding dealing with distress, and physical exercise. Some were able to share problems with friends and family members- usually mothers and sisters.

Many participants spoke about spirituality and faith.

Theme 2: The important characteristics within the counselling experience

Therapist characteristics

Participants preferred to work with a therapist they were comfortable with and could relate to.

Some participants took a neutral position in regard to whether the ethnicity and gender of the therapist was important, as long as the therapist had other characteristics such as the ability to listen, care, and understand.

Ways of working

Therapists' understanding and acknowledgement of participants' culture was perceived as important, however many participants felt their therapist lacked this understanding.

Many participants described being unaware of the treatment model used (e.g. CBT).

For some the language and questionnaires used by the therapist was perceived as a barrier.

The relationship

Participants described positive and negative perceptions of the relationship with their therapist.

Negative perceptions of the therapist were associated with a difficulty being open.

Participants' perceptions that the therapist was professional, able to listen, and understand were associated with positive perceptions of the relationship.

Theme 3: Post counselling reflections on the therapeutic process and changed perceptions

The pathway

The experience of the referral pathway impacted on the perception of therapy.

Many participants were referred by the GP.

Lack of information, lack of clarity, and inconsistency in information were associated with negative experiences.

									Long waiting times were experienced as a barrier, and for some negatively impacted on whether therapy would be accessed in the future. *The environment* Many participants were worried about being seen by people they know. *Changed perceptions* Many participants experienced a positive shift in the perceptions of therapy.
Socarras et al (2015) USA	Peer-reviewed journal article	N=6 Female mothers who identified as African American Aged 22-39 years old Purposeful sampling	Pre and post intervention interviews, face to face	Inductive approach using a constructivist theoretical perspective	To explore the experiences of African Americans' enrolled in an culturally centred parent enrichment program	Adapted brief intensive child-parent relationship therapy (CPRT)	Graduate students and a faculty member from a counsellor education program. One graduate student identified as Asian, the other identified as Latino and the faculty member identified as White	Two graduate students and a faculty member	Theme 1: Barriers to utilizing counselling or parenting services *Cultural discontinuities* Participants perceived that counselling services did not fit their own cultural values and lifestyles. Some perceived that those who conducted interventions did not represent them. *Family stressors* Participants wanted counsellors to better understand the stress that came with parenting. Theme 2: Perception of parenting and child's play *Close bonds to their children* Participants described close and strong bonds to their children. Negative behaviour from their children was recognised as part of their developmental level. *Focus on discipline* Many participants described wanting support with discipling their children, as it was seen as a stressful aspect of parenting. *Applied CPRT skills in daily lives* Participants described an increase in knowledge of CPRT techniques such as encouragement and limit setting. They were able to apply these techniques in their daily lives. Some parents reflected on how applying the techniques led to positive changes in how they responded to their children. *Gained a better understanding of child's play*

									Participants demonstrated a better understanding of the meaning of play after the intervention, including the different types of play. Theme 3: Perception of CPRT group process *Social support from the other group members* Interactions with other group members and facilitators were perceived as supportive. Some of these relationships with other parents continued outside of the intervention. *Culturally centered atmosphere* Participants perceived the language was adapted helpfully to match the language of participants. This led participants to feel involved, acknowledged and valued.
Toynes (2020) USA	Dissertation	N= 8 4 Black/African American males and 3 Black/African American Females, 1 White American female. Aged 20-70 years old Sampling approach not specified	Semi-structured interviews. Observations, field notes, demographic information was collected but not measured.	Interpretative phenomenological analysis (IPA)	To explore how married Black males experienced couples-group narrative therapy and the impact it had on their relationship and sobriety.	Couples-group narrative therapy with Black males who were recovering from addictions to controlled substances.	Not specified.	The researcher was the therapist.	Theme 1: Recognition of the problem The technique of externalising the problem, was perceived as helpful for differentiating between themselves and the problem. Participants were also able to reflect on other aspects of the problems such as fear and control and the ways these impacted their relationship. Participants found it helpful to listen to others' stories in the group to recognise their own difficulties. Theme 2: Feelings of comfort Participants spoke about the importance of support from other members of the group, which led to feeling more comfort and less alone. Theme 3: Increased support Participants reflected on the helpfulness of sharing their stories in a group space. Some reflected that it was helpful for their partner to hear other stories to recognise the pain and discomfort they may have caused in their own relationship.

Venner & Welfare (2019) USA	Peer-reviewed journal article	N=8 7 females, 1 male Identified as Black Caribbean Aged 40-59 Snowball sampling	Semi-structured interviews	Transcendental phenomenological approach	To explore the lived experience of Black Caribbean immigrants' experiences accessing mental health treatment in the USA	Individual therapy	First author identified as a female, first-generation Black Caribbean immigrant and mental health professional. Second author identified as a female, fourth generation American with ancestors from Western Europe and the Middle East and a mental health professional	5 White female therapists, 1 White male therapist, 4 Black female therapists (some participants had seen more than 1 therapist)	Theme 1: Black Caribbean immigrants are reluctant to seek mental health treatment Many of the participants reflected on the stigma and negative stereotypes associated with mental health treatment within Black Caribbean society. Accessing therapy was perceived as something that Black Caribbean people did not do, and if they did it should be kept private. Theme 2: Black Caribbean immigrants do not believe that their presenting issue was tied to their culture, and therefore do not want to bring culture into the therapy space. All but one participant did not associate their presenting difficulty with their Caribbean identity. For example, one participant shared that they had accessed therapy due to feeling depressed after a divorce and therefore it had no relation to their culture. Theme 3: The ability to discuss culture in the therapy session is sometimes important. Participants felt that the therapist should understand Caribbean values and language, and that culture and Caribbean identity should be discussed in therapy. However, some participants did not want to raise these in therapy, as they believed their White therapist may not understand. One participant described a positive experience when discussions about identity and immigration experiences were asked about. Theme 4: Sometimes receiving effective therapy requires changing counsellors Participants described changing therapists due to a perception that their therapist could not understand their experience and cultural needs. Some participants reflected that they would have had a better therapy experience if they had changed therapists.

									Theme 5: Some Black Caribbean immigrants believe that treatment effectiveness is related to therapist race, culture and/or gender Many participants preferred a therapist of a similar cultural and racial background. Half the participants felt that gender was important.
Woods-Giscombe & Gaylord (2014) USA	Peer-reviewed journal article	N=15 12 females, 3 males Identified as African American Aged 24-57 years old Current or prior experience of mindfulness meditation training Purposive sampling	Standardised open-ended interviews	Applied thematic analysis	To explore the cultural relevance of mindfulness meditation training	Mindfulness meditation practice	African American researcher and psychotherapist with experience in mindfulness meditation and research on mindfulness and health disparities and a European American researcher and director of a mindfulness meditation program with experience in mindfulness and research.	N/A	Are there experiences or practices similar to mindfulness meditation that are part of African American Culture? Prayer was perceived as a similar practice to meditation, in that it encouraged people to be present, and provided similar benefits such as mental clarity. Some participants likened mindfulness meditation to cultural communal rituals, and dancing. **How Does Mindfulness Meditation Fit in or Conflict With Your Spirituality or Religion?** Most participants did not believe there were any conflicts and thought that mindfulness meditation could enhance their religious practice. Some participants recognised the similarities between the messages behind hymns and biblical texts, and mindfulness meditation. **Would You Recommend Mindfulness Meditation Practice to Your African American Friends or Family?** All participants shared that they would recommend it to friends or family. **Why Would You Recommend Mindfulness Meditation Practice to Your African American Friends or Family?** Participants shared that mindfulness meditation was helpful for enhanced stress management, direct health improvement, and enhanced self-awareness.

What Would Prevent You From Recommending Mindfulness Meditation to Your African American Friends or Family?

Respecting a person's level of openness to new experiences, respecting religious ideology, and respecting personal preferences for self-expression and stress reduction were all provided as reasons which may influence why a participant might not recommend the practice.

What Changes or Modifications Would You Recommend for a Mindfulness Meditation Program for African Americans?

Emphasising the health benefits of mindfulness meditation

Participants felt it would be helpful to have discussions about the research on the benefits of meditation, particularly about the health benefits against health conditions that impact African American people.

Connecting mindfulness meditation practice to familiar religious or spiritual ideology.

Participants suggested that if mindfulness meditation was to be introduced to African Americans, it may be helpful to connect it with biblical texts and hymns which share similar messages. Another suggestion was for churches and community leaders to connect mindfulness meditation with existing cultural rituals. Some participants noted that emphasis should be placed on it being a practice for stress reduction rather than connecting it with religiosity so it could be widely accepted by African Americans who share diverse beliefs.

Connecting mindfulness meditation with familiar activities

Participants shared that the practice of mindfulness could be likened to other activities such as knitting, or shelling peas, and that it may

									be helpful to associate these forms of activities from cultural traditions with mindfulness. *Enhancing the ways that mindfulness meditation is taught to African American audiences.* Participants shared that African Americans may prefer an African American instructor. Some other suggestions included culturally appropriate music, creating a buddy system, reducing the time for participating in practices, and clarifying the difference between mindfulness and meditation.
Wu et al (2022) USA	Peer-reviewed journal article	N=3 Female Identified as a Black kin caregiver Aged 37-64 years old	Semi-structured interview	Inductive analysis	To evaluate the acceptability of a culturally adapted parenting programme for Black kin caregivers	Family Check up/Everyday Parenting Program is a brief, strengths-based intervention to enhance parenting practices in low-income families. It uses motivational interviewing techniques and supports caregivers' appraisal of strengths and challenges in their family. The program was facilitated as home visits and a family camp.	Not specified	Three Black facilitators, who had experience working with Black families and children were trained by the FCU/EDP Program.	**The most important things learned** Participants shared that "making effective requests" to their children was the most important strategy they learnt. **Acceptability and cultural adaptation** *Curriculum* All participants believed the curriculum was culturally related to their communities. Some participants reflected that whilst the programme seemed manualised, the examples that were provided were more relatable. Participants felt the language, curriculum and strategies were culturally relatable. **Hands-on activities** Participants felt that more activities would have been helpful so they could be practiced within the training. **Time management and self-care** Participants shared that they would have liked support on how to balance their time between different children and having time for themselves. **Research evidence** One participant shared that it would have been helpful to have a better understanding of the research behind the intervention. *Intervention process and format*

		Accessed as family, individual and group based	Participants shared that they appreciated that the facilitators were parents and came from a similar cultural background to themselves. Participants would have liked longer sessions, and to have more activities in the evening. Participants reflected that the location of the intervention- a campsite, was enjoyable, however some felt that it was inconvenient.

Results

Descriptive data about the fifteen studies is described, with a methodological critique evaluating the strengths and limitations of the studies. Following this, a thematic synthesis outlines the themes highlighted about the experiences of therapy across the studies.

Overview of studies

Twelve of the studies were from various locations within the USA and three were based in the UK. The settings in which the studies were conducted varied and included primary, secondary, and private care settings. The context of accessing therapy is different in the USA in comparison to the UK. In the USA, therapy is accessed privately, through insurance plans or Medicaid for those who are on lower incomes and do not have insurance. Therapy can also be accessed through community health centres, which may offer services based on income. In the UK, therapy is available either for free from the NHS, or through private practice for a fee. Some of the USA interventions described in the studies could be accessed for free as part of the research (Wu et al., 2022), through the church (Coombs et al., 2022) and through a youth community program (Pritchett-Johnson & Jones, 2020).

The studies explored therapy interventions that were delivered individually to families, groups, and couples, and there were a range of therapeutic modalities examined such as narrative therapy, CBT, mindfulness and motivational interviewing.

Six of the studies evaluated therapeutic interventions, which were described as cultural adaptations (Ashley & Brown, 2015; Coombs et al., 2022; Jensen et al., 2021; Pritchett-Johnson & Jones, 2020; Socarras et al., 2015; Wu et al., 2022).

Of the fifteen studies, eleven were published in 2020-2022. These studies were published amidst the context of COVID-19, the murder of George Floyd and the Black Lives Matter movement, all of which created noticeable shifts in attention to the inequalities that Black people experience.

Eight of the studies were in peer reviewed journal articles. It was considered important to recognise that seven out of the fifteen studies were dissertations. Due to dissertations having fewer restrictions in word count, more information was available regarding methodology and ethical consideration, and this was helpful for transparency and assessing the quality of the research. However, the scarcity of published articles within this area may additionally reflect a wider inequality of allocation of research funding.

A range of qualitative analysis methods were used amongst the studies including thematic analysis, inductive analysis, framework analysis, grounded theory, interpretative phenomenological analysis (IPA), transcendental phenomenology. Two of the dissertations used specific conceptual frameworks through which they analysed the data; "Strong Black Woman" schema (Nixon, 2021) and narrative therapy (Toynes, 2020).

Most of the researchers identified as Black and were from a range of disciplines; clinical psychology, social work, counselling psychology, family therapy. Four of the studies did not report information about the researcher(s). Many of the therapists that were discussed within the studies or delivered the interventions were from various ethnic backgrounds and had varying qualifications. However, eight of the studies did not report the characteristics of the therapists.

This review specifically focussed on studies prioritising the perspective of the client. All studies focused on clients' observation of themselves within therapy, their observations of the therapist and their observations of the relationship between themselves and the therapist. Studies which focused on specific interventions were more interested in clients' observations

of the content. All studies focused on treatment in its entirety, rather than observing an episode within therapy, or a session of therapy. All studies explored all sequential phases of therapy including the context, process, and impact.

Methodological critique

Research design

Each study presented a clear objective, including research questions, which the study aimed to answer. All studies used interviews to explore their objectives, and this was justified in the studies. Toynes (2020) also used observations and field notes to triangulate the data. One study (Ashley & Brown, 2015) was rated as poor quality as it did not have a clear study methodology, which meant it lacked details about sampling and data analysis.

Whilst interviews are viewed as the most common and useful approach in collecting qualitative data, there are some limitations (Al-Yateem, 2012). Given that many of the study objectives were to explore the lived experience of Black people, interviews may have been a helpful way of collecting this. However, data collected from interviews, particularly semi-structured interviews may have been subject to different types of bias depending on what questions were being asked and by whom they were being asked. This brings strengths and limitations, as researchers who identified as Black themselves may have been able to interpret data from a different lens to a researcher who was not Black. Additionally, some participants may have felt more comfortable sharing their experiences with a researcher who identified as Black.

Johnson (2020) mentioned within her limitations that as an African American and couples therapist, the questions that she asked in the interview were created to demonstrate "counter narratives". Only a few of the studies mentioned researcher bias in their limitations (Johnson, 2020; Nixon, 2021). The researchers were transparent about how their identity as

Black may have impacted the interpretation of the data. To counter researcher bias, many of the studies used the method of bracketing to raise awareness of potential ways that bias might be introduced to their data. The studies that were less transparent about researcher bias were those where the objective was to assess the acceptability of an intervention. For example, the study looking at the Future 4 Teens model (Pritchett-Johnson & Jones, 2020) may have been subject to researcher bias, as one of the researchers was also part of the team that delivered the intervention. However, this was not discussed within their limitations. For some studies, interviews were conducted retrospectively, and therefore may have been subject to recall bias.

Studies which used a conceptual framework such as "strong Black woman schema" were helpful in producing experiences of therapy through a particular lens, allowing for alternative perspectives. Researchers can reduce researcher bias, also known as "tacit theories", by using conceptual frameworks. This can lead to higher quality research and help guide the research process (MacFarlene & O'Reilly-de Brún, 2012). Within these studies researcher bias was also reduced by inviting participants to review the data.

The study by Johnson (2020) was impacted by COVID-19 and had to conduct online or telephone interviews. They discussed in their limitations how this would have excluded those who did not have access to the internet, and that the quality of the interviews may have been impacted.

Sample

Most of the studies used purposive sampling or snowball sampling approaches to recruit people. Given that the objective of these studies was to explore lived experiences of those that identified as Black, these sampling approaches were reasonable for achieving this. However, these sampling approaches may have been impacted by selection bias. Participants may have been more likely to have similar experiences, and those that may have had negative

experiences may have been less inclined to take part or been asked to take part. These approaches are often used for convenience rather than data saturation.

Sample sizes of the studies ranged from three participants to twenty-two participants. Many of the studies shared that small sample sizes meant that their research was limited, particularly as data saturation for theme development had not been met. Many of the studies recruited more females than males, except for those where the objective was to recruit males. This may have reflected the observation in prior research that fewer Black men than Black women access therapy (Hankerson et al., 2015).

Some studies discussed the difficulty in recruiting participants. Venner and Welfare (2019) stated that seventy-five percent of the participants they had approached to take part had declined. These people did not want their names associated with mental health treatment, believed the counselling they received was not associated with mental health treatment or were unavailable to participate. The study with a sample size of three (Wu et al., 2022) was impacted by COVID-19, and had to terminate recruitment due to safety reasons. Both examples reflect wider contextual issues that produced barriers to recruitment.

Thematic Synthesis

The thematic synthesis identified six themes with additional subthemes as illustrated in Table 4.

Table 4
Themes and subthemes identified across studies

Themes	Subthemes
Theme 1: Impact of racism and stereotypes	
Theme 2: Socio-cultural perceptions of mental health and therapy	
Theme 3: Therapeutic alliance	Developed with time Characteristics of the therapist Client-therapist match Addressing culture and race
Theme 4: Positive changes in therapy	Changes in relation to self Changes in relation to others Acquiring skills Changes in perception of therapy
Theme 5: Helpful and unhelpful structures of therapy	Models of therapy Accessibility Environment
Theme 6: Appreciation of cultural adaptation	

Impact of racism and stereotypes

The impact of racism and racist stereotypes reportedly impacted Black people prior to accessing therapy and during therapy. One study (Nixon, 2021) discussed the impact of direct experiences of racism on therapy. A participant (Nixon, 2011, p.61) shared that they had experienced racism by reception staff, and another shared a comment by the therapist that was received as being racist, which led to the participant to "shut down" and believed the therapist did not see "Black women as human beings". Both these experiences had impacted their participation in the therapy, relationship with the therapist and perception of therapy. It

also led to participants developing a "lack of confidence" in their therapists' abilities (Nixon, 2021, p.71).

Whilst the impact of direct racism on therapy was not discussed within other studies, the impact of the "Strong Black" archetype was discussed in five studies (Dera, 2021; Nixon, 2021; Nurse, 2020; Shundi, 2020; Venner & Welfare, 2019). Participants discussed how it led to beliefs that they would be perceived as "weak" if they were to access therapy (Dera, 2021, p.136) or that they could not cope with life's challenges (Shundi, 2020). Participants talked about this leading to "bottling up" feelings (Nurse, 2020, p.71; Shundi, 2020, p.64), and being afraid of talking about feelings (Venner & Welfare, 2019), leading to dealing with problems independently or within the family. Additionally, participants spoke about how this was perceived as "angry, aggressive, and difficult" by White people (Nixon, 2021, p.73). There was a reflection that the schema was "double-sided", in that some participants found that being a "Strong Black Woman" was positive as it reflected "being able to take on and handle everything", and the ability to be "self-sufficient and independent".

Black men from the Dera study (2021) reflected on how accepting that they needed help offered a route to liberating themselves from the stereotype of a "Strong Black Man", and therapy reinforced the idea that it was okay to be vulnerable.

Black men reflected that prior to therapy, they had never been offered it and were offered peer support instead (Toynes, 2020). Some were not aware of the options available and struggled with the language to describe their distress (Dera, 2021).

Young Black people reflected on the racial differences as to who got referred to the residential treatment facility where they had access to family therapy. The participant noticed that "…it's more African American in bad facilities like this. You don't get too many whites" (Qureshi, 2018, p.182). She further reflected that White adolescents were more likely to enter

on the basis of mental health problems, whilst Black adolescents were more likely to enter after getting "into a fight or she done stole something" (Qureshi, 2018, p. 182).

Socio-cultural perceptions of mental health and therapy

Six studies discussed stigma around mental health and accessing therapy, based on socio-cultural conceptualisations (Coombs et al., 2022; Dera, 2021; Johnson 2020; Nixon, 2021; Nurse, 2020; Venner & Welfare, 2019). Having mental health difficulties and accessing therapy was described by participants as associated with being "crazy" within African-Caribbean communities. Talking about feelings and problems outside of the family to a stranger was also seen as something that was not commonly done within these cultures (Dera, 2021; Johnson, 2020). Some felt that ideas from Christianity and the church also reinforced some of this stigma (Coombs et al., 2022). One participant shared that within the African American community a common method of healing was to, "Take it to God, pray on it, go to church, not go sit in front of a provider and share what's going on with you." (Coombs et al., 2022, p.79).

Additionally, some studies discussed alternative ways Black people coped with distress. These other strategies included prayer, self-reliance, seeking support from friends and family, pastoral support from places of worship, journaling, going for walks, and meditation. In some cases, therapy was sought when all other strategies had failed (Coombs et al., 2022; Dera, 2021; Shundi, 2020).

Therapeutic alliance

Developed with time

Participants shared that building a relationship with the therapist or facilitator "was a process that took time" (Qureshi, 2018, p,212), including taking time to be "open" and be "honest" (Jensen et al., 2021, p.278). Participants spoke about feeling unsafe, hypervigilant,

and vulnerable in front of a stranger, making it difficult to be open to begin with. For some, there was a gradual shift from this to feeling safe and contained (Dera, 2021). For others, there was a sense of uncertainty as to what to expect from therapy (Dera, 2021; Nixon, 2021).

Characteristics of the therapist

Within many of the studies, participants articulated the characteristics of the therapist that led to a positive therapeutic alliance. Positive experiences were related to feeling safe, heard, and acknowledged with therapists who were perceived as knowledgeable, competent, patient, understanding, validating, calm, and supportive (Dera, 2021; Jensen et al., 2021; Johnson, 2020; Nurse, 2020; Qureshi, 2018; Pritchett-Johnson & Jones, 2020; Socarras et al., 2015). Some participants spoke about the importance of therapist/facilitator disclosure in facilitating better connection and believing the therapist was better able to understand their own experiences (Dera. 2021; Wu et al., 2022). Participants' paid attention to the language, use of humour and office décor to assess whether they would relate to their therapist (Johnson, 2020).

Negative experiences were related to feeling not heard, feeling judged, not feeling understood, discomfort, feeling dismissed, and a lack of empathy and compassion from the therapist (Qureshi, 2018, Nixon, 2021; Shundi, 2020). One participant shared how the language used within questionnaires negatively impacted their experience (Shundi, 2020). Another reflected on how the therapist often left issues unaddressed which left the couple feeling exposed, which impacted the safety of the therapeutic alliance (Johnson, 2020). Not feeling understood by the therapist, experiences of racism within the therapeutic space, a fear of being judged by the therapist and initial mistrust of the therapist led to participants withholding information (Nurse 2020; Shundi, 2020).

Client-therapist match

Many participants felt they required a therapist with the same culture, gender and/or race as themselves. If an exact match was not found, therapist matches based on gender and race were preferred (Venner & Welfare, 2019). The study looking at Black women's experiences with American European therapists reported the most negative experiences (Nixon, 2021). Participants did not think their therapist would be able to relate to them based on racial, gender and socioeconomic differences. This led to feelings of discomfort, restricted disclosure, disengagement, poor therapeutic alliance and switching therapist. Across the studies there was a belief that White therapists would never be able to understand their experiences (Dera, 2021; Shundi, 2020; Venner & Welfare, 2019). Relating to the therapist on some level (age, experience (e.g., of being a parent, having a mental health problem), race, culture, and gender), was important for connection, safety and perceiving the therapist as understanding. Adolescents who participated in the F4T community therapy model associated relatability in terms of race, culture, and age of the facilitators with effectiveness of the model; "It wasn't like ya'll were 40-year-old White people here for case studies . . . I felt loved from everybody . . . it was like everything just clicked" (Pritchett-Johnson & Jones, 2020, p.234).

For some participants, choice in the therapist seemed to be valuable to support them in their goal for therapy. This sometimes meant choosing a therapist who represented difference, for example one participant wanted to work on her relationships with men and felt that a male therapist would be helpful in supporting this (Nixon, 2021).

A few participants felt that the race, culture, and gender of the therapist was not important. One participant who had a White female therapist, thought that what was most important was the therapists' ability to listen to her (Shundi, 2020). Safety, connection, and trust were valued as more salient features for some (Dera, 2021).

Addressing culture and race

Some participants thought it was necessary for the therapist to have knowledge of the participant's individual differences (Socarras et al., 2015; Venner & Welfare, 2019) and for therapists to have "done their homework" in relation to racial issues (Johnson, 2020, p.49). Some reflected on the importance of the therapist understanding social challenges such as finances, and other social stressors, which intersected with their race (Qureshi, 2018; Wu et al., 2022). Most of the participants across the studies reflected that culture, race and socio-cultural trauma were never brought up in therapy, even by those with therapists who identified as Black. Some participants felt that they had come to therapy to address a problem such as "depression" and did not feel that their Caribbean identity had anything to do with it (Venner & Welfare, 2019). Others felt that being a Black American male was "normal" and therefore it did not feel like something to discuss within therapy (Qureshi, 2018, p.258). These participants felt that feeling safe and being listened to was more important. Within the Venner and Welfare (2019) study a few participants' therapists acknowledged that race and culture needed to be discussed, however their White therapists decided they were not competent to do this and referred these participants elsewhere.

When culture and race was raised within therapy, participants reported a positive experience (Johnson. 2020). For example, one participant appreciated when her therapist specifically asked about her immigration journey (Venner & Welfare, 2019), whilst another participant commented on how the therapist was "not assumptive, but was openly willing to discuss their racial differences and how it helped facilitate a bond for both her and her partner." (Johnson, 2020, p.59).

Positive change within therapy

Changes in relation to self

Participants viewed therapy as "self-investment" (Dera, 2021, p.127). Many participants noticed changes in self-development, confidence, awareness, self-esteem, self-motivation, and self-expression (Ashley & Brown, 2015; Coombs et al., 2022; Pritchett-Johnson & Jones, 2020; Woods-Giscombe & Gaylord, 2014). One participant reflected that accessing therapy was supportive in making changes on herself, "There's a lot of work that goes into therapy. I did a lot of work on myself and a lot of reflection on myself, and I could've only got [this by] being pushed on a one-on-one basis by a therapist" (Coombs et al., 2022, p. 79). Some participants spoke about being better able to embrace vulnerability and shame (Dera, 2021) and to process trauma in a way where they could learn self-love (Coombs et al., 2022). One individual shared, "I just remember how to think beyond my feelings in that moment . . . I learned how to assess my thoughts and feelings and express that without it being too aggressive" (Pritchett-Johnson & Jones, 2020, p. 234).

Change in relation to others

Participants reflected on how therapy improved their communication and relationships with others including family, friends, and staff (Ashley & Brown, 2015; Jensen et al., 2021; Johnson, 2020; Pritchett-Johnson & Jones, 2020; Qureshi, 2018; Wu et al., 2022). This also included being able to empathise better with family members (Qureshi, 2018; Wu et al., 2022). Some of the couples within the Johnson (2020, p.55) study reflected on how techniques used by the therapist such as gauging communication at the beginning of the session and sharing a "feedback loop" were helpful for discussing conflict and communication in their relationship.

Acquiring skills

Participants felt that having solutions and learning skills was a valuable aspect of therapy. Participants valued having something to "walk away" with (Nurse, 2020, p.63), and skills learnt from therapy were associated with long-term development (Coombs et al., 2022; Dera, 2021). These were found useful when they were personalised and assisted people with specific goals (Qureshi, 2018). Modelling, examples, and role play of solutions were also seen as helpful (Johnson, 2020). One participant reflected how mindfulness practice was particularly helpful in managing stress; "African Americans in particular don't get a lot of skills about how to cope with stress, even though we're one of the groups that's under the most amount of stress. So I think it's particularly useful for African Americans and people of color in general" (Woods-Giscombe & Gaylord, 2014, p. 143).

Changes in perception of therapy

Perceptions of therapy seemed to change throughout the course of therapy, where there was initial scepticism, distrust, and a belief that therapy may not be helpful. Many participants shared that they would recommend therapy to others and particularly advocate therapy to those who come from Black communities (Coombs et al., 2022; Dera, 2021).

Helpful and unhelpful structures of therapy

Models of therapy

Those within group therapy settings discussed how they felt comfort, increased support of others within the group, and a chance to hear from others going through similar problems (Socarras et al., 2015; Toynes, 2020; Wu et al., 2022). Family therapy was perceived as helpful for some, but others perceived the attendance of family members as a barrier (Ashley & Brown, 2015; Jensen et al., 2021, Qureshi, 2018). Young people within

family therapy felt that they were “left out” of conversations and therefore felt unheard (Qureshi, 2018, p. 224). Narrative therapy within a group setting for couples, was helpful for couples to recognise the problem was external to the individual/couple (Toynes, 2020). For some the “rules” of therapy could be perceived as a barrier. For example, participants shared that within couples therapy they were not able to disclose information without their partner knowing and this was not received well by all participants (Johnson, 2020, p. 53). Participants within this study felt that a debrief towards the end of sessions would have been helpful. Across the models, participants commented on collaboration, choice and flexibility, within a clear structure which they perceived positively (Dera, 2021; Jensen et al., 2021; Nurse, 2020; Pritchett-Johnson & Jones, 2020).

Accessibility

Therapy received from the NHS was perceived as less accessible than therapy accessed from private therapy due to the lack of choice and flexibility, and negative perceptions of how Black men were treated within the NHS (Dera, 2021). Participants also reflected on the pathway of accessing therapy in the UK. Positive experiences of therapy were associated with positive experiences of the pathway to therapy (Shundi, 2020). Access to therapy, within a church setting was also perceived well as it was accessible, free and could help tackle some of the stigma associated with mental health (Coombs et al., 2022). Across the studies there was a theme that therapy was less accessible to Black men (Coombs et al., 2022; Dera, 2021; Johnson, 2020).

Environment

Therapy and therapeutic interventions were received in a range of locations; homes, therapist clinics, church, family camps, community locations, residential treatment facilities. It was difficult to conclude which locations were preferred, as there were pros and cons raised

for all. However, there seemed to be a disparity between services that were located within the community. Within the Coombs et al., (2022, p.79-80) study participants commented on the therapy space within the church as a "positive, peaceful, welcoming, and serene environment", and discussed the environment as a "safe space" where "You don't have to worry about outside forces…".

Appreciation of cultural adaptation

A few studies focused on Black people's experiences of cultural adaptation made to therapy. Within some of these studies, it was unclear what cultural adaptations were made. Participants within the Jensen et al., (2021, p.283) study were unable to recognise how the therapy was culturally adapted. Some of participants in this study felt that it was not necessary and caused further stigma, "We [are] normal people like everybody else. That's all, there's no...it pisses me off a bit when 'there's a cultural need'". However, participants felt that the visibility of Black people accessing therapy was important, for example the study had advertised the therapy with representations of Black people on their leaflet. Additionally, participants from the Coombs et al., (2022, p.79-80) study found it valuable to access services within the church by someone "you look up to, somebody that you can see yourself in, and somebody that is trusting" and for this person to validate and normalise that it was "okay" to have "weaknesses" and access help. Within the Ashley and Brown (2015) study, cultural adaptation was made where therapy was offered to foster children alongside a hairdresser who worked with Black hair. This cultural adaptation was received positively by the Black girls who received therapy. Some participants were able to identify similarities between mindfulness practice and African cultural practices and spiritual practices associated with the church (Coombs et al., 2022; Woods-Giscombe & Gaylord, 2014). Participants valued the integration of mental health services that were affiliated with the church (Coombs et al.,

2022). Within the Woods-Giscombe & Gaylord (2014) study, a suggestion was made to incorporate content from the Bible with mindfulness. Cultural adaptations made to the content and language of the intervention for Black kin caregivers was also perceived as appropriate for Black communities (Wu et al., 2022). Across studies, cultural adaptation which incorporated an aspect of Black culture (e.g. hair care, spirituality, community based), was helpful for improving accessibility to therapy and counteracting stigma of accessing therapy to support with mental health difficulties.

Discussion

Overview of findings

The objective of this review was to synthesise Black people's experiences of therapy and therapeutic interventions within the UK and USA. The review identified fifteen studies and extracted themes across the studies.

Across the studies, there was a consensus that therapy was perceived as a positive experience for Black people who participated in the studies. Positive experiences were linked to characteristics displayed by the therapist/facilitator, a space to be heard, and learning skills to enhance self-development and relationships with others. Therapist characteristics, such as understanding, empathetic, calm, professional, were found to facilitate positive experiences reflecting similarities with prior research looking at client's experiences of therapy (Holding et al, 2016; McPherson et al., 2020; Rogers, 1957). Additionally, gender, race, and/ethnicity matching were also perceived as supportive of positive experiences in therapy, reflecting prior research (Nwokoroku et al., 2022). Many suggested it supported in building a safe and trusting therapeutic alliance, where the client felt understood. However, not all participants perceived ethnic/racial matching to the therapist as necessary for a positive experience of therapy, which reflected similar findings as Sass et al., (2009). Interestingly, many

participants did not experience conversations within therapy, which focused on race, racial trauma, or culture. Talking about difference and similarity regarding racial identity may have brought discomfort and uncertainty (Long, 2022). Black people within therapy may have been responding with silence in relation to the denial or defensiveness of their therapist (McKenzie-Mavinga, 2016), or may have experienced cultural mistrust (Whaley, 1991).

Barriers to accessing therapy included racism, impact of stereotypes and socio-cultural perceptions of mental health which reinforced stigma of accessing therapy. The "Strong Black" schema seemed to be a large barrier to accessing therapy and influenced processes within therapy particular with White therapists. The need to be "strong" may have been a survival response to the racism that Black people experienced on an individual and systemic level and is likely to have been a strategy that has been passed down intergenerationally (Boyd-Franklin, 2013). Within therapy with White therapists this has been often misperceived as "angry", "aggressive", which has led to Black clients feeling unsafe, misunderstood and unheard (Ashley, 2014). In one study (Nixon, 2021), this led to disengagement and negative experiences of therapy. Additionally, stigma about mental health within Black communities has been found to be a common barrier in the literature in seeking therapy. Black people may have preferred to keep personal information to themselves or within the family. This may have been as a response to the injustice in the way systems (e.g. criminal justice, police, social services) react to Black people when personal information is shared (Boyd-Frankin, 2013). The findings from the review suggested that positive experiences of therapy were successful in shifting prior scepticism and mistrust about therapy, with many advocating for more Black people to access therapy.

Additional barriers included not being given the option to seek therapy, not knowing the pathways to access therapy and not knowing what to expect from therapy.

Cultural adaptations were mostly well received, reflecting prior research (Vahdaninia et al., 2020). Interestingly, those that were perceived well (Ashley & Brown, 2015; Coombs et al., 2022; Wu et al., 2022), were facilitated by Black therapists/facilitators, whereas in studies where it was perceived less well, suggestions were made for more Black therapists/facilitators (Jensen et al., 2021). This intervention was also based in the UK and lacked transparency as to what cultural adaptations were made. It may be helpful for definitions of "culture" to be revisited when adapting therapy in this way as there is a danger of being stereotyped, and that beliefs, behaviours and values that are cultural may be seen as dysfunctional and pathologised (Naeem et al., 2019). This may have explained, why some participants felt like cultural adaptations reinforce stigma.

Strengths and limitations

This review synthesised data from studies which only used qualitative methodology from the perspective of the Black clients. This provided rich and insightful data about Black people's experiences of therapy.

Given that there have been no systematic reviews focusing on Black people's experiences of therapy, it may have been helpful to review studies further back than 2013 to examine similarities and differences across time and historical contexts.

Studies were mostly based in the USA, therefore it may be less generalisable to locations where access to therapy is not set up in the same way.

Many of the studies had small sample sizes, and this reflected difficulties in recruitment and the impact of COVID-19. Whilst, small sample sizes can provide rich data, within the studies reviewed there was evidence that some of the themes did not reach data saturation. This may impact the validity of the themes within studies, but also the themes that were synthesised within this review. Additionally, as this review aimed to synthesise Black

people's experiences together, heterogeneity within experiences of adults and adolescents, and males and females may have been lost.

The inclusion of studies that used mixed-methods, may have provided additional insight. It may have been helpful to examine whether quantitative outcomes were similar or different to what was reflected in client experiences.

Implications for clinical practice

The review highlighted that Black people find therapy helpful for improving their relationship to themselves and others. Therefore, an effort should be taken within therapy providers to ensure that there is equality in accessing therapy for these communities. Race/gender/culture matching of therapist and client can improve the process of building a therapeutic alliance and the lack of this option may lead to disengagement. If this is unavailable, visibility of Black people accessing therapy may be beneficial. For example, providers may want to produce a leaflet or video representing Black people's experiences of therapy and what to expect from therapy.

Access to therapy within community spaces where people already feel safe, such as churches, could alleviate some of the stigma (Codjoe et al., 2021). It may be helpful to explore ways in which a Eurocentric perspective of mental health can become aligned with the cultural beliefs, values, and practices of Black communities. For example, the Attachment tHAIRapy (Ashley & Brown, 2015), was a good example of this where therapy was offered alongside hair treatment for foster children. Additionally, it may be helpful to acknowledge the role that racial trauma and cultural mistrust play in shaping the way Black communities respond to the concept of mental health and the systems which offer therapy.

The findings reinforced prior recommendations in the literature for therapists to be culturally sensitive and competent. Additionally, a step further than this would be to adopt an

"anti-racist" approach. This may involve becoming aware of language use, "doing the homework" to understand different cultural and spiritual practices, and having conversations about the social and racial issues that impact these communities (Mckenzie-Mavinga, 2016). Utilising supervision to reflect on clinicians' own blind spots, may prevent racism being enacted in therapy (Mckenzie-Mavinga, 2016).

Implications for future research

Further research exploring the experiences of therapy and therapeutic interventions is required, particularly within the UK. These studies may benefit from exploring barriers and facilitators of referral pathways and other systemic processes, which impact access to therapy. Additionally, more research is required on the experiences of Black people who terminate therapy early, those who have negative experiences and those who come from LGBTQ+ backgrounds as few of these experiences were captured within the studies reviewed. Research investigating cultural adaptation to therapy is also necessary, with a deeper examination of how therapy/interventions are culturally adapted, and whether they are experienced as better by clients. Research may benefit from collaboration of lived experienced researchers and service-users.

Conclusion

Exploring the experiences of clients receiving therapy is valuable in assessing the processes within therapy. The current review highlighted several factors that are associated with Black people's experiences of therapy. Generally, many Black people had positive experiences of therapy. Implications from the findings include better effort to encourage equality in access to therapy for Black communities, and encouragement for cultural competence and adaptation within therapy. The findings from the review reinforce prior research insights into how Black people experience therapy.

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SECTION B: EXPERIENCES OF PSYCHOLOGICAL THERAPY OF BLACK PEOPLE WITH A DIAGNOSIS OF PSYCHOSIS SPECTRUM DISORDER

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Abstract

A call for psychological services and therapist to become “antiracist” has led to increased attention on mental health inequalities faced by Black people, with further attention on how Black people experience therapy. There is a lack of research as to how Black people, with a diagnosis of psychosis experience therapy. Ten Black people with a diagnosis of psychosis, were interviewed about their stories of receiving therapy from a community mental health team within the NHS. A thematic narrative analysis highlighted six themes across participant narratives, these included; experiences of oppression, accessibility, “Therapy is good”-helpful processes in therapy, safety and the therapeutic relationship, “It’s not personal”-Disempowerment within therapy, resources outside of therapy. Overall, the findings suggested that Black participants with a psychosis-spectrum disorder had helpful experiences of psychological therapy. The therapeutic relationship, techniques, and a greater understanding of their conditions was highlighted as helpful processes. However, strategies that could be perceived as protective against racism, may hinder what is shared within therapy. Further research may be helpful to explore how systemic processes impact therapy experiences. The study also includes implications for how therapists can improve Black people’s experiences of therapy.

Keywords: Psychological therapy, self-disclosure, therapeutic relationship, critical race theory, racism

Introduction

The COVID-19 pandemic, the murder of George Floyd, and the resurgence of the Black Lives Matter movement highlighted the inequality experienced by Black communities as an impact of racism. As a result, therapy professions created recommendations to become "anti-racist" (Willams et al. 2022). Kendi (2019) defined anti-racism as striving for racial equity. He described the root of racial inequalities within structural policies that have been embedded in society. To address racial inequality Kendi argued that these policies require challenging. This is in opposition to expressing ideas of racial hierarchy and rooting racial inequalities in groups of people, which Kendi (2019) conceptualised as practicing racism.

Psychological therapy disciplines have been criticised for being "neutral" to issues socio-political issues such as race and racism (Ahsan, 2020; Wood, 2020). Kendi (2019, p. 9) described "race neutrality" as being the "most threatening racist movement". To be truly antiracist, it has been argued that psychology professions should recognise the impact of racism outside and within the therapy space, which "both bear traces of and function to reproduce racial power" (Salter & Adams, 2013, p. 782). Otherwise, there is a danger that racism is likely to continue to be enacted in therapy spaces (Lawton et al., 2021; McKenzie-Mavinga, 2016).

Critical Race Theory

It has been argued that traditional psychology theories, methodologies and epistemologies are not sufficient in examining the experiences and needs of those who have racialised identities (Crossing et al., 2022; Salter & Adams, 2013). Critical race theory (CRT) was originally developed as a critical framework by Black legal scholars in response to the inattention towards how racism operates within and across all systems (West, 1995). Its use has now expanded to academic research in several fields (e.g., psychology, social work,

education) with a focus on the lived experiences of marginalised communities (Crossing et al., 2022; Keating, 2016, Salter & Adams, 2013, Shelton & Lester, 2022, Solórzano & Yosso, 2002). CRT has attempted to explore the direct and indirect impact of race and racism (Graham et al., 2011) whilst positioning the experiences of marginalised communities as knowledge. Some of the core ideas of CRT include:

a) Racism is embedded in the ecological systems of society (e.g. social, health, economic, political systems), and is normalised and common (Ladson-Billings, 1998; Patel, 2022)

b) Racism is sustained by Whiteness. Through the violent and oppressive acts of colonialisation and slavery, racial hierarchical structures were set up in a way that normalised the domination of White people and the subjugation of indigenous people. The ideas and actions of White people became classified as superior and the human standard (Salter & Adams, 2013).

c) Intersectionality. Through the work of Crenshaw (1991), the CRT approach acknowledges how other identities (gender, sexuality, age, disability) interact with race and system of oppression.

Racism and psychosis

Since the 1970s, Black African and Caribbean people have been overrepresented in being diagnosed with psychosis in the UK (Fernando, 2017). Over the years many biological and social hypotheses for this overrepresentation have emerged and shaped how services intervene. These have included a link to cannabis use, genetic predisposition, socioeconomic deprivation, discrimination, and exposure to childhood abuse (Fernando, 2017; Nazroo et al., 2020; Pinto et al., 2008). In neglecting the social-political context, these bio-psycho-social conceptual models have failed to acknowledge the role of racism and situate the cause of

mental distress within Black people and their families (Fernando, 2017). Drawing on historical socio-political contexts Fernando (2017) and Metzl (2010) suggested that the pathologising of Black people, was an attempt to control and contain reactions and resistance to racism and oppression.

It has been argued that the colonial mindset impacts current systems, where human rights are violated through the normalisation of violence towards Black people (Kinouani, 2021). Keating and Robertson (2004) illustrated how the "big, Black and dangerous" stereotypes which have been derived from the colonial mindset, leads to mental health staff fearing Black patients, thus evoking responses of violence (such as increase in medication, restraint, and police involvement) and a "cycle of fear". This may explain why Black people with a diagnosis of psychosis are more likely to experience "more pronounced experiences of powerlessness" (Lawrence et al., 2021a). The fear of services and generally of White people, has been termed "cultural mistrust" (Awosan et al., 2011; Whaley, 2001). It has been described as a healthy coping strategy to protect against the threat of racism. However, it may be misdiagnosed as a symptom of psychosis, such as paranoia, delusions and hallucinations (Garretson, 1993). Similarly, McKenzie-Mavinga (2016) explains how "Black rage" a reaction to suppressing the pain of abuse created from the everyday, historical, and intergenerational racism (McKenzie-Mavinga, 2016), is likely to be pathologised or denied. There has been evidence that Black people may experience racial trauma associated with real and perceived experiences of racism (Comas-Diaz et al., 2019), which can be linked to chronic stress, increased inflammation, and further trauma (Kinouani, 2021). Recent studies have linked experiences of psychosis to childhood traumatic events and post-traumatic stress disorder (PTSD; Burger et al., 2022; Hardy, 2017). However, this definition of trauma does not describe the daily and chronic experiences of racial trauma. The Power Threat Meaning Framework (PTMP; Johnstone & Boyle, 2018) has been more effective in formulating

imbalances of power within systems such as racism and has conceptualised responses as a reaction to the threat created from imbalances of power. However, further work is needed to evaluate its acceptability in formulating experiences of racial trauma.

Fernando (2017) illustrated that via Whiteness racism has become embedded in knowledge including theories and models. This may explain how responses to racism become pathologised and how cultural beliefs may be viewed as dysfunctional (Naeem et al., 2019). Additionally, within mental health professions, Whiteness has been seen as the standard whereby the culture, values and beliefs of other groups is compared. An example of this has been seen in the NICE guidelines for psychosis (2014), which recommended addressing "cultural and ethnic differences in beliefs regarding biological, social and family influences on causes of abnormal mental states". This guideline positioned White beliefs as the standard, where cultural and ethnic differences in beliefs only exist in the "other".

Narratives of psychosis

Narrative approaches within mental health research have been helpful to recognise how people make sense of themselves and their distress. These approaches have identified how wider "dominant" narratives that sit within social and cultural contexts may shape individual narratives. CRT focuses on the "counter-stories" that are told by those who are marginalised, with an aim to challenge the "dominant" narrative. Research focusing on the narratives of psychosis, have identified that the Western medical model shapes the dominant narrative of psychosis and provides context in shaping individual personal narratives (Lawrence et al., 2021b). This dominant narrative can be experienced as stigmatising and oppressive (Colbert et al., 2013). It has been highlighted as upholding oppressive power relations, which are heightened for those from marginalised backgrounds (Crowe, 2006). Research adopting narrative approaches (Bonnet et al., 2018; Colbert et al., 2013; Lawrence et al., 2021b) have shared alternative individual and community narratives of

psychosis, which included narratives of hope, narratives of recovery and narratives of identity. The study by Lawrence et al., (2021b) categorised narratives of both White and Black Caribbean individuals who had been diagnosed with psychosis and their experience of mental health services. They identified three narratives; “losing self within the system”, “steadying self through the system”, and “finding strength beyond the system”. The latter was most experienced by Black participants in the study and illustrated that strength and recovery were supported by individual, interpersonal and intrapersonal factors, and challenged the dominant discourse of psychosis.

Experiences of psychological therapy

NICE guidelines have recommended that CBT is offered to everyone with a psychosis-spectrum diagnosis (NICE, 2014). CBT has generally been criticised for lacking cultural relevance and sensitivity, which has been linked with greater disengagement from therapy and negative outcomes (Holding et al., 2016; Lawton et al., 2021; Minsky-Kelly & Hornung, 2022; Rathod et al., 2010;). In addition, CBT has failed to connect client difficulties with the systemic historical and socio-political contexts that have harmed people (Ahsan, 2020; Rogers-Sirin, 2017 as cited in Minsky-Kelly & Hornung, 2022) and therapists who have used CBT have been found as less likely to discuss race and racism (Beck, 2019). An absence of exploring these concerns within professions may lead to a transference of denial within therapeutic relationships with clients (McKenzie-Mavinga, 2009).

Cooper et al., (2016) demonstrated that eliciting narratives from service users about their experience of therapy can be helpful for improving mental health services in the NHS. “Touch points” have been described as experiences within the story which may be particularly memorable or elicit an increase in emotional expression. The study identified five touch point categories across the six service user stories about their experience of therapy;

"Before therapy", "First appointment", "Relationships with staff", "The physical environment", "Length of therapy and endings", and "Progress made in therapy". There have been no qualitative studies which have focused on the lived experiences of Black people with a diagnosis of psychosis or "psychosis spectrum disorder" and their experience of therapy, with many looking at experiences of mental health services.

Fernando (2017) called for an exploration of access to therapy, what has been offered and how it has been offered. Given that racism may be operating within mental health services in the NHS, it is helpful to consider how this may impact Black people's experience of therapy, particularly if NHS services are committing to antiracism. Furthermore, there is a need to bring a counterpoint to the received frameworks of clinical psychology.

Rationale

Given the potential for psychological therapy to be a helpful space for Black people (Section A), where the impacts of racism can be explored, a better understanding of how therapy is experienced by Black people with a psychosis spectrum diagnosis (e.g. schizophrenia, bipolar disorder, schizoaffective disorder) is necessary. The use of theories from and influenced by CRT to interpret how racism indirectly and directly shapes Black people's experiences of therapy, can improve ways in which psychological therapies better meet the needs of Black service users. In addition, it can guard against missing potentially important aspects of participants' experience due to unintentional imposition of an insufficiently racism-aware framework. An exploration of male and female experiences may provide insight as to how race, gender, and mental health diagnoses impact experiences of therapy.

Aims of the research

The aim was to provide rich, in-depth insights into how Black participants, with a diagnosis of psychosis spectrum disorders, experience psychological therapy within NHS services.

The following questions were used to frame the inquiry:

1) What are Black participants' stories of encountering psychology services?
2) Within their stories, what are participants' experiences relating to intersections of mental health, race, and gender in psychological therapy?

Method

Design

A qualitative research design was used, guided by a narrative analysis approach and CRT theoretical approach. Both CRT and narrative analysis approaches were utilised as they prioritise lived experiences, illustrate how people make sense of their experiences, and situate experiences within a wider context (Riessman, 1993; Riessman, 2008; Shelton & Lester, 2022). This has been seen as vital for understanding experiences and implications of racism.

Thematic narrative analysis (Riessman, 2008) was used to analyse the content within the stories, rather than the structural, visual, and dialogic elements of the story often referred to as the "How" and "Why". This approach has been useful for keeping individual stories "intact" across participant stories (Lawrence et al., 2021a; Riessman, 2008). It therefore complemented a CRT approach which recognised the heterogeneity of stories within marginalised communities and aimed to resist generalisations (Crossing et al., 2022). CRT approaches promoted "identity-consciousness and reflexivity", which required the researcher to reflect on their positioning, identity and how this impacted the research (Crossing et al., 2022; p. 8). Ideas of intersectionality and the systemic embeddedness of racism was utilised

in thinking about the data, whilst identity-consciousness and reflexivity were processes used within the methodology and analysis.

Participants

Fifteen participants demonstrated interest in participation, however only eleven of these consented to participate. The four participants who did not consent, included three participants who the lead researcher was unable to contact, and one participant thought they were too unwell. One participant's data was excluded from analysis as they did not provide enough information within the interview. Inclusion criteria for participation included identifying as Black British, Black African, Black Caribbean, Black mixed heritage, and any other Black ethnic identity, receiving current care from the CMHT, offered psychological therapy, and been diagnosed with a psychosis spectrum disorder. Participants could participate if they had either refused to have therapy, terminated sessions, were currently accessing therapy, or had completed therapy. Participants were excluded if they were deemed as not having capacity to consent. The demographic data of participants is presented in Table 1. Participant ages ranged from 25-54 years. Seven participants were male, and three were female. English was not the first language for one participant; however, they preferred not to use an interpreter. All but one participant had been accessing psychological therapy via the CMHT. Four participants had completed therapy elsewhere either in another NHS team, in the same CMHT team or within a research trial and were not currently accessing therapy. Most participants could not remember the type of therapy they had been offered (e.g. CBT).

Table 1

Demographic data of participants

Pseudonym	Ethnicity*	Age	Gender	Employment status	Accessed therapy from CMHT?	How many sessions?	Offered therapy elsewhere?
Samuel	Black British African	46	Male	Unemployed	Yes, in therapy	14	No
Tanya	Black British and Black Caribbean	40	Female	Unable to work due to mental health condition	Yes, in therapy	Not sure	No
Leon	Mixed heritage- Black Caribbean and White European	34	Male	Unemployed	Yes, completed therapy	15	No
Joanne	Black African	26	Female	Unable to work due to mental health condition	Yes, in therapy	Not sure	Yes- completed therapy
Jacob	Black British	25	Male	Unemployed	Yes, in therapy	8	Yes- completed therapy
Adam	Black British	47	Male	Unemployed	Yes, completed therapy	Not sure	No
Dylan	Mixed heritage- White British and Black Caribbean	33	Male	Unable to work due to mental health condition	Yes, in therapy	2	No
Elijah	Mixed heritage- White British and Black Caribbean	54	Male	Unable to work due to mental health condition	Yes, completed therapy	Not sure	Yes- completed therapy
Marcus	Black British African	29	Male	Full time employment	No	Not sure	Yes- completed therapy

Ava	Black African	39	Female	Full time employment	Yes	Not sure	Yes-completed therapy

*Participants were asked to specify ethnicity in their own words, however for the purpose of anonymity these have been categorised into ethnic identity categories.

Procedure

Recruitment

Participants were recruited from four community mental health teams (CMHTs), from the same NHS Trust based in London, UK, using opportunity sampling. Clinicians within each team were presented the aims of the research and eligibility criteria in a presentation format by the author. The research was advertised to participants by clinicians within the team using a flyer (see Appendix D) and information sheet (see Appendix E). Once getting consent from the participant, psychologists within each team passed on the name and contact details of participants who were interested to the author. Participants were then contacted via telephone by the author, where they had the opportunity to hear more about the research, ask questions and could agree to participate. All participants were compensated for their participation in the study.

Demographic questionnaire

A demographic questionnaire (see Appendix F) was administered before the interviews, which assessed for eligibility to participate. Participants were telephoned and the questionnaire was administered and completed by the author on Microsoft Forms.

Interviews

Interviews lasted from 25 minutes to 73 minutes (average= 48 minutes) and took place either at the community mental health team's base or online on Microsoft Teams. All

interviews were recorded on Microsoft Teams. Interviews were conducted and transcribed by the author.

Interview schedule

The interview used a largely unstructured approach, in keeping with narrative research to elicit participants' stories. Participants were first asked to share their experience of having therapy in their own words, starting from the time they were referred for therapy. It has been suggested that prompt questions are helpful for use in narrative interviews with people with a diagnosis of psychosis (Bonnet et al., 2018). Therefore, questions were created to support participants with their narrative. Prompt questions derived for the interview schedule (see Appendix G) were adapted from the "touch points" identified within the study by Cooper et al. (2016). These were created from service user narratives of psychological therapy and included "Before therapy", "First appointments", "Relationships with staff", "Physical environment", "Length of therapy and endings" and "Progress made in therapy". Participants were not limited to discussing these within their narratives, however it appeared to help some participants to construct their narratives in relation to time points. Additional open- question prompts such as "Can you tell me more?" were used for more in-depth exploration. An "anti-racism project steering group" within the NHS Trust, which included Black clinicians, service users and carers, were consulted about the research. Changes based on their feedback were made to the interview schedule and information sheet including simplifying the language.

Ethical considerations

Ethical approval for the research was granted by an NHS research ethics committee (see Appendix H). Informed consent was obtained for all participants using a consent form (see Appendix I) which participants signed in person, or electronically.

All confidential data such as interview recordings, demographic questionnaire data, participant contact details were saved to the author's secure Microsoft OneDrive, which was password protected. Interview recordings were transcribed and all confidential data (e.g. names, locations) were removed to protect anonymity.

Consideration was given to the sensitive nature of what participants may disclose, and therefore the researcher used skills to relay compassion and empathy, as well as offering breaks from the interview. Participants were informed that if they were to share anything that was of concern regarding their safety, or others' safety then the researcher would have to inform their CMHT. Additionally, during debriefing, participants were able to discuss their experience of the interview. Information about a specialist service, which supported with racial trauma was offered if necessary. The author was also able to reflect on any emotional content and concerns with supervisors based in the NHS Trust, who were also experienced clinicians that worked with the CMHTs and a project consultant. All NHS values were relevant to the research and were considered when thinking about the ethics and carrying out the research.

Data Analysis

Thematic narrative analysis was used for analysing the narratives. Whilst there are no set guidelines in using thematic narrative analysis, the author incorporated methodology used by Lawrence and colleagues (2021a) and Riessman (2008). Transcripts were transcribed to "clean-up" the narratives, by removing utterances such as "umm" and repetition. Each participant's transcript was read and re-read. Transcripts were coded in segments using N-Vivo and codes were grouped into touch point categories (see Appendix N). Touch point categories were used to structure the narrative case summaries, which were summarised from each transcript (see Appendix M) and informed the master narrative. Case summaries were compared to identify patterns where narratives converged and differed (Riessman, 2008),

including their positioning towards psychosis, and elements of the narrative that reflected intersectionality and additional contexts of oppression (see Appendix P). Emerging themes from the coded transcripts and patterns identified within the narrative case summaries were organised together to develop themes (see Appendix O).

Positioning

Critical realism was used as an epistemology framework. It has taken the position that reality can be observed independent of our thoughts abouts it, and that reality may be observable without one's awareness of it existing (Haigh et al., 2019). However, observations are always subjective, meaning that knowledge is constructed rather than discovered. It has not been possible to fully apprehend the underlying realities because we have not been subjected to the social and physical lenses through which we have observed them. Theoretical concepts from CRT outlined by Salter & Adams (2013) and Crossing et al., (2022) were utilised to guide interpretation of the data.

Quality Assurance and Researcher Reflexivity

Riessman (2008) argued that there are no set guidelines in ensuring validity of narrative analysis. However, where possible, procedures were put in place to support the trustworthiness and validity of the research. Attention was paid to where narratives converged and diverged to support trustworthiness (Riessman, 2008). Case summaries were discussed with supervisors and were shared with participants for triangulation. Four participants responded to the request, and two of these requested small changes to their summaries.

A reflexive diary (Appendix J) was kept throughout the research to keep note of decision-making and reflections. Self-reflexivity was important and was recommended in both narrative and CRT approaches. Reflections by the author were written down after

interviews were conducted and during the analysis. These were shared with supervisors to challenge bias and work through dilemmas. Supervisors' knowledge and reflections were invited to develop the lead researcher's thinking in relation to the development of themes. The author identified as a British Indian female, was training as a clinical psychologist in the UK and had their own experiences of therapy with a White female therapist and a South Asian female therapist. The lead supervisor identified as White British with experience of significant mental health difficulties and of psychological therapies, and the trust-based supervisors identified as a Black British male and a White British male. Supervision and the reflexive diary were used to support with reflecting on the author's intersectional identities, values, and experiences and how these may impact the narratives, and the interpretation of the narratives. Within supervision an adapted version of a cultural genogram (Hardy & Laszloffy, 1995) supported reflection on the relationship between the intersectional identities of the researcher, the participants, and the research. An early assumption was identified based on the lead researcher's own experience of therapy that research participants may prefer their therapist to share similar identity characteristics. As a result of reflection on this, questions regarding this within the interviews were carefully worded to avoid eliciting a biased answer.

Results

The experiences of ten participants were summarised using thematic narrative analysis. Descriptive information was summarised to support with contextualising participant's narratives of therapy (see Table 2). Using thematic narrative analysis, overarching themes were identified across participant narratives. Patterns were identified within these, to identity commonalities and differences across and within the participant narratives. The themes and patterns are listed in Table 4. A master narrative was created across participants (see Table 3).

Table 2

Descriptive information about therapy sessions

Pseudonym	Number of times had therapy	Type of therapy experienced	Face to face/online/telephone*	Person who referred for therapy*	Race and gender of therapist*
Jacob	Twice	Individual	Online	Nurse	White female Previously had an Asian female therapist
Leon	Once	Individual	Face to face	Self	White, female
Marcus	Once	Individual	Face to face	Nurse	Black female Asian female
Joanne	Twice	Individual	Online	Care co-ordinator	White female
Adam	More than once	Individual	Face to face	Care co-ordinator	White female
Ava	Five	Individual and family therapy	Face to face and online	Multiple people	Asian male
Tanya	Three	Individual and group	Face to face and online	Occupational therapist	White female
Dylan	Once	Individual	Face to face	Self	White female
Samuel	Twice	Individual	Face to face	Care-coordinator	Asian male
Elijah	Once	Individual	Face to face	Psychiatrist	Black male

**This data was captured for the most recent experience of therapy*

Table 3

Master narrative across the ten participants

Beginning	Most participants began their stories by explaining the events which led to their mental health deteriorating. Participants described multiple, external events which included loss (e.g. of a relative, unemployment), racism, and isolation. Overworking, putting needs aside, acting as if everything was fine, talking to friends were described as ways of coping that were no longer working. The

combination was often described as leading to a “psychological breakdown”, which led to hospitalisation. Some of the male participants acknowledged the link between smoking cannabis and impact on the brain, in addition to other events. Some of the participants also shared their experiences with mental health services, which were often described as controlling, violent and forceful.

Participants described the process of accessing therapy. Most participants were referred for therapy by a member of the CMHT, however some participants had asked for therapy themselves, or had been encouraged by their family. Family members were described as supportive in accessing therapy.

Participants described waiting a few weeks for therapy. Some participants were left wondering whether they had been forgotten about or worried that they would not receive the help.

Prior beliefs about therapy were described. Participant beliefs and attitudes toward therapy were mixed, many presented positive and neutral attitudes. Some participants were sceptical as to whether it would help them and whether it was for people like them. Others were open to anything that would help them with their “condition”.

Middle

Participants retrospectively described their thoughts about the first therapy session. A few participants were open to the process, which was influenced by whether they had experienced therapy before. Participants felt more comfortable after meeting the therapist and finding out how the therapist would support them with their goals.

However, some participants described finding the first sessions difficult due to the amount of questioning. For some this felt like they were being interrogated, and it felt inappropriate. Again, this process was understood and experienced better, after having already experienced therapy.

Participants described processes within the therapy that were helpful, these included having a space to talk and express difficult emotions and practicing strategies and tools (e.g., experiments, breathing exercises) that supported them with their goals. A few participants valued the space for learning more about early signs and causes. Participants were more likely to disclose information with the therapist after learning they were “nice”, “friendly” and knowledgeable.

Participants described some limitations to sharing information with their therapist, which left some people preferring to seek therapy elsewhere. These limitations included information sharing with other members of the NHS, triggering of strong emotions, and worrying how therapists would interpret the information or experiences. The environment of where therapy took place was also mentioned as unhelpful, as for these participants it triggered memories of traumatic past experiences with mental health services.

End

Participants, who had completed therapy shared their experiences of ending therapy. Most participants were sad about the ending and were worried about whether they would get the same help again. Participants shared their recommendations for what therapists and services can do to support Black people in therapy. These included

ensuring that therapists spend time listening to Black people's experiences and explaining the benefits of therapy. Additionally, participants recommended that therapy is not forced on people, instead ensuring therapy works for the person's "timeline" rather than the service's "timeline". All participants shared that they would recommend therapy to other Black people.

Table 4

Main themes and patterns

Themes	**Patterns**
Experiences of oppression	Experiences of racism
	Disempowering experiences with mental health services
Accessibility	Accessed after hospital and via CMHT
	Not knowing how to access through a different pathway
	Accessing therapy is "normal"
	More open to accessing after experiencing therapy
	Family and friends supportive in accessing
	Therapy would have been helpful earlier
	Therapy accessed during different transitional periods
"Therapy is good"- helpful processes in therapy	"Good for getting things off your chest"
	Expressing emotions not expressed elsewhere
	Making sense of difficulties and prevention
	Overcoming problems using techniques
Safety and the therapeutic relationship	Therapist knows what they're talking about
	Therapist is not intimidating
	Therapist is nice, friendly, understanding and listens
"It's not that personal" -Disempowerment within therapy	Information sharing with the Trust
	Repeating of painful information
	Compartmentalising problems
	Race and gender of the therapist
	Not being able to voice disagreement
	Fear of judgement from therapists
	Fear of misinterpretation and blame

	Environment triggering past traumatic experiences
Resources outside of therapy	Family and friends Advocacy Spirituality Employment

Experiences of oppression

Prior to accessing therapy, participants described their mental health deteriorating because of an event or series of events in which they experienced oppression by people and systems. For some participants their attempts to cope and survive these events, led to further deterioration.

Ava, Dylan, and Jacob explicitly linked experiences of racism to "psychological breakdown". Jacob shared that he "…thought [he] was racially profiled in a way that caused [him] to have like a psychological breakdown". Dylan identified as mixed-heritage and grew up in a predominantly White area. He linked getting deep into thinking about "White empowerment" as triggering "crazy thoughts". He acknowledged the attribution of cannabis to changing his brain but rejected this hypothesis as the only cause for his mental health decline. Dylan discussed an experience within mental health services prior to moving to London, which led him to reflect that his "crazy" thoughts may have been based on the reality of his experiences of racism. Additionally, Dylan shared how he identified with Black American stereotypes as he did not know anyone he could relate to, however this created further difficulties.

> I think what I'm speaking to my psychologist about now is how racism has affected my mental health. Yeah, I smoked weed…and that did my brain up but I think the racism that I experienced where I grew up was part of it. It affected me on the outside

> so...I've had crazy thoughts, real crazy thoughts. Yeah cause you know the conspiracy of White empowerment and stuff like that basically. I got really deep with it. (Dylan)

Ava described how as a result of separation from her birth family, she was raised by a White middle-class family. However, difficulties began when her White family began expressing racism, and would not attend her birth father's funeral. She coped with the pain of these experiences by "overworking" and trying to act like she was "fine", until she experienced her first "breakdown" and was taken to hospital. Samuel did not explicitly state that he experienced racism, however he shared that discrimination he experienced at work, led him to losing his job. This then ended up in feeling depression and relapsing. Being isolated at home, further impacted his wellbeing.

Elijah, Dylan and Tanya described difficult and oppressive experiences with mental health services. Tanya was a carer for someone who also received care under the same mental health trust. She described feeling stressed by the way the Trust had treated her. Lack of support and putting her needs aside, led to further deterioration.

> "It's madness! I've had madness from the British people, from the Trust. They control. They locked me up twice now. One time, no record...there was a fall out between the police and me. And they put me in the hospital for nine weeks. I wasn't arrested, I wasn't charged with anything. I was kidnapped by the police and I was thrown...seventeen hours in handcuffs, and for five hours I wasn't allowed to use the toilet. This was in the hospital. And they wouldn't give me my phone… Sometimes it gets unbearable. That's one reason why I haven't really given up cannabis because it's the only thing that relaxes me from this hyper mad world." (Elijah)

Accessibility

Most participants accessed therapy for the first time via the CMHT, after being in the hospital for their mental health. Accessing therapy was viewed as a "normal" process to both Leon and Marcus. Having always been aware and having knowledge of therapy, Leon asked to be referred. Despite this, later in his journey when therapy ends unexpectedly, he is unsure how to access therapy except through the team knowing he will be on a long waiting list.

> "I just thought it was part of the process of just coming out of hospital. And what I thought it was just normal, it's the standard thing to do, it's the right thing to do." (Marcus)

> "I've always been a strong believer that with the illness…therapy is as good as medication in some circumstances. So back when I was in hospital, I had originally asked for therapy there instead of giving me too much medication. And then we discussed it when I was out and then I finally asked for it. That was about it. It's just something that I've always known about." (Leon)

Jacob and Samuel expressed a greater openness to their current therapy experiences due to having already accessed therapy before, and therefore was familiar with the process, in particular to the assessment process. The openness to therapy was a shift from their first thoughts about therapy, where they both questioned the accessibility of therapy.

> "I think 'cause I've done therapy before, I found it quite easy to open up to talk, discuss my problem and how to overcome it…My thoughts before was that therapy was for richer people. For people that could afford it, to improve their lives in a way to make them feel better. But now I feel therapy is for all people, and it can help you improve your life. If you're from a low economic background or from a high

economic background, it doesn't matter. Anyone can access therapy if they want to." (Jacob)

"It just felt erm confusing and like they were interrogating me… But now I've come to understand why they're asking me questions." (Samuel)

Additionally, therapy appeared more accessible to Samuel as his friends and family thought it would help. Similarly, Dylan's mother thought therapy would be helpful to him, and he referred himself for therapy. He also thought it would have been helpful for him to access it earlier in his life.

"But as time went on, I like changed my mind about whether I wanted to do it... And I just thought let me just try and give it another go. People on the team and family were telling me as well." (Samuel)

In contrast to most of the participants, who had only been offered therapy in hospital, although many were also younger, Ava had accessed therapy four times before. Therapy was accessed during different transitional periods of her life, including during university after a bereavement, after giving birth, and she was currently receiving couples therapy.

"Therapy is good" – helpful processes within therapy

Therapy was described as "good for getting things off your chest" by Samuel, Dylan, Jacob, and generally all participants shared that the act of talking was a helpful process, for expressing and exploring problems and strong emotions, which could not be shared elsewhere.

"Yeah, I like to talk when I talk with them, I feel like I want to bring my inside outside." (Adam)

> “I was able to let out things that was going round and round in my head that I couldn't really speak to people about. I found that for me talking helps me. Just having an outlet, because otherwise I let things build up and then it just comes out at the wrong time, when no one is expecting it, because I've bottled up how I've been feeling all the time.” (Tanya)

> “If you get angry with psychiatrists they automatically put you on more medication. But with the therapist, you can get, not necessarily angry but you can express. And they don't put medication on you. So it's better.” (Elijah)

> “So it was my first adult experience, where it was just like, “oh, let's talk about how you grew up. Let's talk about how that's affected you. Let's talk about these really traumatic times and how they still affect you”, because I think I'm good at, masking my feelings, walking around like I'm OK with a big smile on my face. Like, everything's fine, not being very confrontational as a person.” (Ava)

Participants also found therapy helpful for understanding and making sense of their problems or their “condition”, which led to collaborative problem solving, and aligned with their goals for therapy.

> “She put in place...she showed me with diagrams, different strategies on how to cope with my issues. She told me the lead up... She told me what was the cause of the issue.... it was very useful. And we worked on that problem together, and we managed to solve it.” (Leon)

> “Helped me understand the condition better and how in the future I could stop it from happening again. So that was my main aim of the sessions to stop it from occurring again in the future.” (Jacob)

> “They helped me with like how the mind works, cause, they were psychologists. Like what's my thinking process, like what was I doing at the time? Like before I had my

relapse or my first episode what did I notice? And just the early prevention side, if I didn't go to therapy, I wouldn't know the early prevention and what to look out for. It helps to be vigilant, and on your toes, because it could happen once, twice, you don't know how many times. Therapy helps you to notice the early warning signs, so that I can just take my time and retrieve myself, come back, and just relax, or to talk to somebody or something like that." (Marcus)

Tools and techniques such as breathing exercises, exposure experiments, and surveys were helpful in supporting the participants to overcome problems and meet their goals for therapy. Many reflected on the transformations they observed in themselves and celebrated their progress.

"You know he got me to fill in a diary of activities and my thought process. Basically trying to understand that the voice isn't there to harm you, it's there to protect you. That's what I was taught by the psychologist…to look at things in a positive way. I have to give myself a pat on the back because I think I've done really well to go to the sessions in the first place and to get through sixteen sessions" (Samuel).

"Yeah one of the things my therapist did is send me a video of mixed race people talking about their ethnicity." (Dylan)

"And now, all that anxiety, it's just been replaced with pure excitement. I'm happy about that. Yeah I took lots of techniques from it. If I was to feel a wave of anxiety or panic, they taught me breathing techniques that I could use. And we put together a survey with about four or five questions on it." (Leon)

Safety and the therapeutic relationship

Perceived characteristics of the therapist enabled participants to feel comfortable, and to open up to the therapist. Dylan, Tanya and Elijah, all of whom described oppressive

experiences of mental health services, described their therapist as “passive”, “not patronising” and “not intimidating” in relation to other mental health staff. Both Tanya and Elijah commented that this led to therapy feeling more “human”. Additionally, participants spoke about the therapist showing “concern” and consistency. Leon, Jacob, Marcus, Adam and Samuel, spoke about experiences where they perceived their therapists as knowledgeable and an “expert”, who held knowledge of the “condition” that friends and family may not have. Therapists who were perceived as being able to listen, “friendly”, “nice” and “understanding” led participants to feel comfortable to open up and trust the therapist.

> “I was hoping that she wouldn't be patronising. A lot of the experiences that I've had in mental health services have been very patronising. Yeah, it's just easy to talk to her... Just the fact that she's there, like there's someone there to listen, there's someone really to listen, even just have a chat.” (Dylan)
>
> “Just having someone to talk to, who didn't seem threatening. I’m quite small, so they weren't quite big and sort of loud- mouthed, which would intimidate me and make me get a bit defensive sort of thing. She seemed really nice and she spoke to me just like I was another human being, not like someone who just come out of hospital and, you know, needed to be talked down to. It's been a positive experience. And they would just always be on time.” (Tanya)
>
> “He was passive than aggressive. I wasn't against the therapist, I liked the therapist. He was concerned about me. I thought it was more human.” (Elijah)
>
> “When I feel them like friendly. They really care about what I'm talking about. Yeah I can share, I feel comfortable. Not just, "I'm coming in, I'm doing my one-hour job and I'm going. You can feel that. If I feel that, I don’t share.” (Adam)
>
> “There was two people I was going to see. They were really nice people. They’re there to actually listen, they’re psychologists. They’ll listen and they’ll be helping you

> out. Both ladies knew what they were talking about, both ladies came to help me, the time I needed them." (Marcus)
>
> "I could hear that she knew what she was talking about, so it just eased my mind, that it's actually worthwhile here. From the outset, she was very good." (Leon)

Most of the participants did not share a preference for the race and gender of the therapist. For Ava having a therapist that was not White, led her to perceive that he may understand her experiences of racial trauma, whilst for Tanya a female therapist was preferred over a male, as she found him "nice but too domineering".

> "They were the first therapist that I had that has not been White and middle not that he's not middle class but I mean like you know he had this Black Lives Matter lanyard around his neck. I just couldn't stop staring at, which just felt slightly more relatable to that particular side of trauma and an understanding of racism in a way that would be lost on other therapists, I felt like that was quite nice." (Ava)

"It's not that personal" – Disempowerment within therapy

Participants described factors that prohibited them sharing experiences with their therapists. Many participants did not want to share "private", "deep" and/or "painful" experiences with their therapists. A lack of choice and power in decision-making and processes impacted on the content of what is shared with the therapist, and how safe participants felt.

Some participants did not want these experiences shared with other members of the team and NHS and documented on the system. They felt therapy within the Trust was not kept "private". Leon and Jacob shared preferences for seeking therapy elsewhere because of this.

> “But if someone else offered me therapy I think it would be better than these lot. I suppose there's some problems, they are way too personal to work on in that type of therapy. Because they would share with my care coordinator, and I wouldn't want like my problems being shared with them. It's put on the system where everyone involved in your treatment can view it. So, I don't think that's very private at all.” (Leon)

> “Obviously the therapist is staff from the Trust and the therapist is going to go back to the Trust staff and tell Trust staff everything. I think there would be things that you wouldn't really talk about because it's very private to you and you wouldn't want all of the Trust knowing all your business. Because you are a person and not a number. I've been a bit more reserved.”. (Tanya)

Elijah described several factors that prevented him from sharing with the therapist and mental health service; which included the therapist having no power to solve his problem, worries that his information will be used against him, and a recognition that he can not show strong emotions due to prior experiences from mental health services.

> “The therapist has no power to do anything, they talk to you. They say "That's sad. That's difficult", and this and that. But there's no solution to the problem.
>
> I'm a bit worried about the information getting to the intelligence hands, you know? Something used against me. And it will be more trouble if I tried to use violence, so I have to be passive, about the things that are concerning me. I have to be passive about it, I can't be too heavy.” (Elijah)

> “Yeah, sometimes go deep in my privacy. That little bit, I worry about. Because it's hurting me. It's hard for me and every time when I see a new therapist. I always asked from beginning again. I like to deal with one and continue with him or her. I don't want to share with everyone. I don't like it.” (Adam)

Jacob chose not to disclose information to his White female therapist, because of worries that he may be blamed and judged, particularly in regard to experiences of racism.

> "You feel like maybe a female would judge you more than a male would cause of certain stuff that happened, or that you may have done in the past… With the White therapist... cause the racial event was caused by White people in a way, it would make me feel in some type of way like I'm judging like her race in a way or I don't know how to put it...like I'm putting the blame on her in a way rather than with a, Black person, they'll be more of a shared experience in a way. Rather than me putting the blame on one race, "Oh you did this to me" or something like that. I'd be more free express what happened." (Jacob)

Ava chose to share problems that she felt she had control over until she could trust the therapist.

> "I just thought it was so many problems and there was not enough time to go through all of them. I just focused on the ones I had complete control over, which was work and I didn't talk about family or motherhood, which were the real problems. I kind of compartmentalised the therapy. And it wasn't very helpful in the long term doing it that way. I just thought it would be easier to focus on what I could control rather than what I couldn't." (Ava)

A few participants were unable to voice when they disagreed with the therapist. Samuel wanted to discuss his experience of discrimination further in therapy but was led by the therapist's perception of not dwelling on it. Similarly, Leon had agreed to do an experiment with the therapist, who then changed their mind after speaking to their supervisor. Leon felt unable to share that he would have liked to have done it.

> "…not to dwell on it so much, because it was just having an negative impact on me. So he told me not to dwell on it too much… he knows what he's talking about, so I didn't want to dwell on it so much. So I just left it." (Samuel).

Marcus was unsure if he agreed with the therapist who suggested that his spiritual practices may have led to his brain going in "overdrive" and causing him to become unwell. It led him to question whether he had to stop his practice, as well as withhold sharing of some experiences with the therapist. The formality of the relationship and worries about how the therapists may perceive his experiences also impacted what he felt comfortable sharing.

> "I did take my faith into the therapy, to let them know this is what I was doing. When she said, you're thinking about it so much maybe your mind went on overdrive. I was like, "Hmm?" (laughs) I was a bit like, "Ooo that's a bit…" 'cause that wasn't related to what I believe…There were certain things I didn't mention, because I was trying to figure it out, "Why am I seeing this? Because that's not normal". Deeper things as well like…there's certain things I didn't mention to them because I was like I don't understand it. I could have shared, but personally, I didn't know them too well. So, I wouldn't share like personal stuff. I knew they were there to help me, but those other things... Would they understand? Like would they judge me? What would they think? Would they be able to help me in that manner? Because it was like a spiritual kind of thing… It was formal, it wasn't like "Ah yeah I'm going to see my friend and I'm going to tell my friend like everything". When you really know someone, you can actually tell them all your problems." (Marcus)

Tanya and Dylan also spoke about the environment of which therapy took place. The therapy environment reminded them of traumatic experiences with the Trust.

> “I just think because so much has happened within the Trust, so much has happened, I had a couple of sessions outside of the team base. I didn't feel so claustrophobic.” (Tanya)
>
> “And then the environment as well that you have these meetings in not great. I would like to have a coffee and have a chat or outside in the park or something. I've got a history there, I get my injections there. It's not a good place. It can bring up things from the past and frustration and anger. I don't really want to go back to that place. It's like when you experience bad food, like one bad mouthful, you don't really want to go back to that place.” (Dylan)

Resources outside of therapy

All participants had helpful experiences of therapy and would recommend it to others. Many of them also described other resources that supported their wellbeing or enhanced their experience of therapy. For example, Joanne and Leon mentioned how family and friends supported them with therapy tasks outside of therapy. Ava and Tanya shared how advocacy from friends and family was important within mental health services. Spirituality was mentioned by Dylan, Marcus, and Elijah as something that was important to them and supported them with their wellbeing. Employment was also discussed as helpful, and some participants expressed a desire to connect with other people or be part of a community based on similar interests, not just because they have mental health problems.

> “And the doctors would be saying things that weren't quite right. And then my mum would come down and she'd be like, no, I'm not having them, not accepting this. She really kind of like, fought for me, for what was being done and what was being agreed. And because she did that, it resulted in me, being more cared for because somebody was asking, somebody was paying attention.” (Ava)
>
> “Well, I follow a particular religion. So I chant a lot. So I would chant about...

anything that's on my mind, anything that's making me nervous, anxious, or giving me troubles in my head." (Dylan)

Discussion

This study used thematic narrative analysis to explore Black people's experiences of psychological therapy. The findings will be discussed in relation to the research questions, and previous literature including CRT. Overall, the findings suggested that Black participants with a psychosis-spectrum disorder had helpful experiences of psychological therapy, however strategies that are protective against racism, may hinder self-disclosure in therapy.

What are Black people's experiences of therapy?

Prior research indicates that the stigma about accessing therapy within Black communities is often a limitation to accessing therapy (Section A). The findings from this study suggested that prior beliefs about therapy were often positive or neutral about therapy, and the decision to access therapy was encouraged by Black participants' family and friends. This finding highlights that support from family and friends may enhance access and engagement in therapy. Additionally, limitations about accessing therapy were mostly described as not knowing how to access therapy and being offered therapy at a later stage, especially through the NHS.

Therapy was described helpful as it provided a space to talk, where emotions that were usually suppressed could be expressed. Many of the participants found the insight, knowledge and techniques offered by the therapist helpful in supporting them to "overcome" problems and learn about prevention. Therapists who were perceived as "nice", "friendly", "consistent", "open", and "understanding", contributed to participants' feeling more comfortable to disclose information about their mental health condition.

Prior studies (see Section A) have similarly reported that the solution-focused element of therapy is perceived as helpful to Black people. Additionally, a space to talk, and therapeutic relationship were described as themes across several papers that looked at the experiences of people with First Episode Psychosis.

The main limitation to therapy described by participants was that it did not feel "private" and confidential in that information was shared with the CMHT and care-coordinator. This finding is explored further in the following section.

How did intersections of mental health, race, gender directly and indirectly impact Black people's experiences of therapy?

The way in which participants made sense of their mental distress resembled similar narratives to the Black women in a study by Kalathil (2011), who attributed mental distress to oppressive and traumatic events within a social-cultural and family context.

For some participants, racism was evident as a chronic stressor. Many of the male participants discussed experiences of coercion, aggression, and oppression towards them by mental health services. These experiences are consistent with prior literature reflecting the circle of fear, and violence towards Black people in a health context (Lawrence et al., 2021a, Keating, & Robertson, 2004).

The impact of racism and particularly the strategies adopted to cope with the impact have been previously linked with mental distress, loss of self-esteem and feelings of powerlessness (Vines et al., 2006). There is some evidence that has suggested that whilst Black women experience feelings of sadness and anger as a result of racism, they are less likely to express this. Keval (2019) suggested that Black women are often invisible within mental health services and are expected to be passive. Within the current study, female participants shared that they were likely to "bottle up" and mask their feelings, put their needs

aside, and continue working. Therapy was perceived as a space for both Black women and men to express and make sense of these feelings and were experienced as more humane. However, experiences of racism and mental health services were rarely brought into the therapy space, which was a finding consistent across other studies focusing on Black people's experiences of therapy (Section A). Additionally, therapists may not prioritise these experiences because guidance on how to deliver therapy for people with psychosis does not include discussion of racial trauma.

Previously in the literature, it has been described that suspicion and vigilance towards White people is a healthy survival strategy that is necessary for Black people to adopt in the context of a racist society (Ridley, 1984). In order to keep safe, Black people may be less likely to share the inner workings of their mind, and may hide aspects of their self, due to fear of being stereotyped as "dangerous". This may explain why Black participants in the study found it difficult to share "personal" and "deep" problems with therapists and why Black men in the study were conscious about expressing their anger and appearing violent. There were mixed findings as to whether greater disclosure is achieved with therapists that represent similar characteristics.

The findings highlight that when resistance is experienced within therapy, for example a client disengages in therapy, or does not disclose information, a closer look is needed at resistance within the systems and therapist, and a closer examination at the operations of power. Additionally, the findings raise questions about whether mental distress is "psychosis" or whether it is a consequence of daily experiences of racism. Despite an imbalance of power at a micro and macro level, in some cases therapy was helpful as a space where Black participants could feel safe to form a therapeutic alliance, and where Black participants could feel a sense of empowerment in overcoming problems which were perceived as a consequence of their "condition".

Limitations

All the clinicians who referred participants for the study were CBT therapists or clinical psychologists, and many had referred their own clients. Since none of the participants had terminated therapy early or had an overall negative experience of therapy, the recruitment procedure may have created a bias towards those who had engaged and expressed a positive experience of therapy. Whilst inclusion criteria included people whose first language was not English; few were referred for the study. Additionally, the way participants perceived the lead researcher and aspects of their identity may have influenced what participants felt comfortable sharing. Some participants had been curious about the lead researcher's own ethnicity and were more open about conversation on race after the disclosure of this information. Additionally, the interview questions shaped the narratives to be told in a linear format and may have influenced what was shared. It is understood that the CRT framework offered by Crossing et al. (2022) is to be used as it best fits, and that not all elements can be used equally. It was difficult under the requirements of writing a dissertation for a formal qualification to reject traditions of psychological research and inquiry, which Crossing et al (2022, p.20) described as a mismatch with CRT. It has been recommended that researchers use first person narration, and "the writing and writing style should reflect the emotional nature of the work" (Graham et al., 2011, p.87), which felt difficult to do when producing an academic piece of work. Given the number of participants, it was also difficult to avoid some generalisations between participants, which CRT is set against doing.

Future Research

There is a need to further explore how Black people experience different types of therapy in different settings, given the dearth of research in this area. Studies may benefit from exploring the micro, meso and macro processes within therapy (Nazroo et al., 2020), using methodologies and theories which consider the operations of power. Mixed methods

may be beneficial for triangulating lived experience with therapy outcomes and engagement data. There is also a need to explore resistance within systems such as decision-making within mental health services that can be deemed as racist.

Clinical Implications

The study findings suggest that whilst therapy was helpful for most participants, multiple factors limited disclosure within the therapy. Greater transparency and collaboration in contracting what can be kept confidential in the therapy space, may be helpful. Assessing racial trauma including the ways in which people adapt to survive this, may support conversations to talk about racism. Without this exploration, there is a danger that using current Eurocentric models to formulate real experiences of racism may lead to the pathologising and labelling of experience as "delusions", or symptoms of psychosis. This can contribute to further internalised racism, low self-esteem and mental health difficulties (McKenzie-Mavinga, 2016, p. 142). Therapists should be aware of the strengths and resources outside of therapy that promote people's wellbeing such as spirituality and family. Further information about accessing therapy could be provided to clients upon discharge.

Conclusion

Therapy is a helpful opportunity for Black clients, with a diagnosis of psychosis, to understand and cope with their experience of psychosis. For some it was a helpful space to be heard, and to feel safe. Participants found techniques learnt in therapy helpful and continued with these outside of therapy. However, due to negative experiences with mental health services, there was evidence that cultural mistrust impacted self-disclosure within therapy, questioning the effectiveness.

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DENISHA MAKWANA BSc MSc

SECTION C: APPENDICES

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2023

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A

Quality check using CASP

	Is the research valid						What are the results?			Will the results help locally?
Study	Was there a clear statement about the aims of the research?	Is a Qual. method appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Ashley & Brown (2015) USA	Yes	Yes	Yes	Do not know	Do not know	No	No	No	Yes	Helpful for assessing acceptability of intervention
Coombs et al. (2022) USA	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Helpful for assessing acceptability and experiences of receiving therapy within a

										church setting
Dera (2021) UK	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring Black men's experiences of therapy in the UK
Jensen et al. (2021) UK	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Helpful for exploring the experience of Black people receiving a culturally adapted intervention in the UK
Johnson (2020) USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring African American's experiences of couple therapy
Nixon (2021) USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring the experiences of African

										American woman of European American therapists
Nurse (2020) UK	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring the experiences of young people and CBT in the UK
Pritchett-Johnson & Jones (2020) USA	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Helpful for exploring experiences of a community youth intervention
Qureshi (2018) USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring the experiences of adolescents receiving family therapy in a residential treatment facility

Shundi (2020) UK	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring therapy experiences of Black women in the UK
Socarras et al (2015) USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring experiences of a specific parenting
Toynes (2020) USA	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Helpful for exploring experiences about narrative group couples therapy
Venner & Welfare (2019) USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring therapy experiences of Black Caribbean people in the USA
Woods-Giscombe & Gaylord (2014)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Helpful for exploring experiences

USA										of mindfulness
Wu et al (2022) USA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Helpful for exploring experiences of a specific parenting intervention

Appendix B

Coding for Coombs et al. (2022) paper

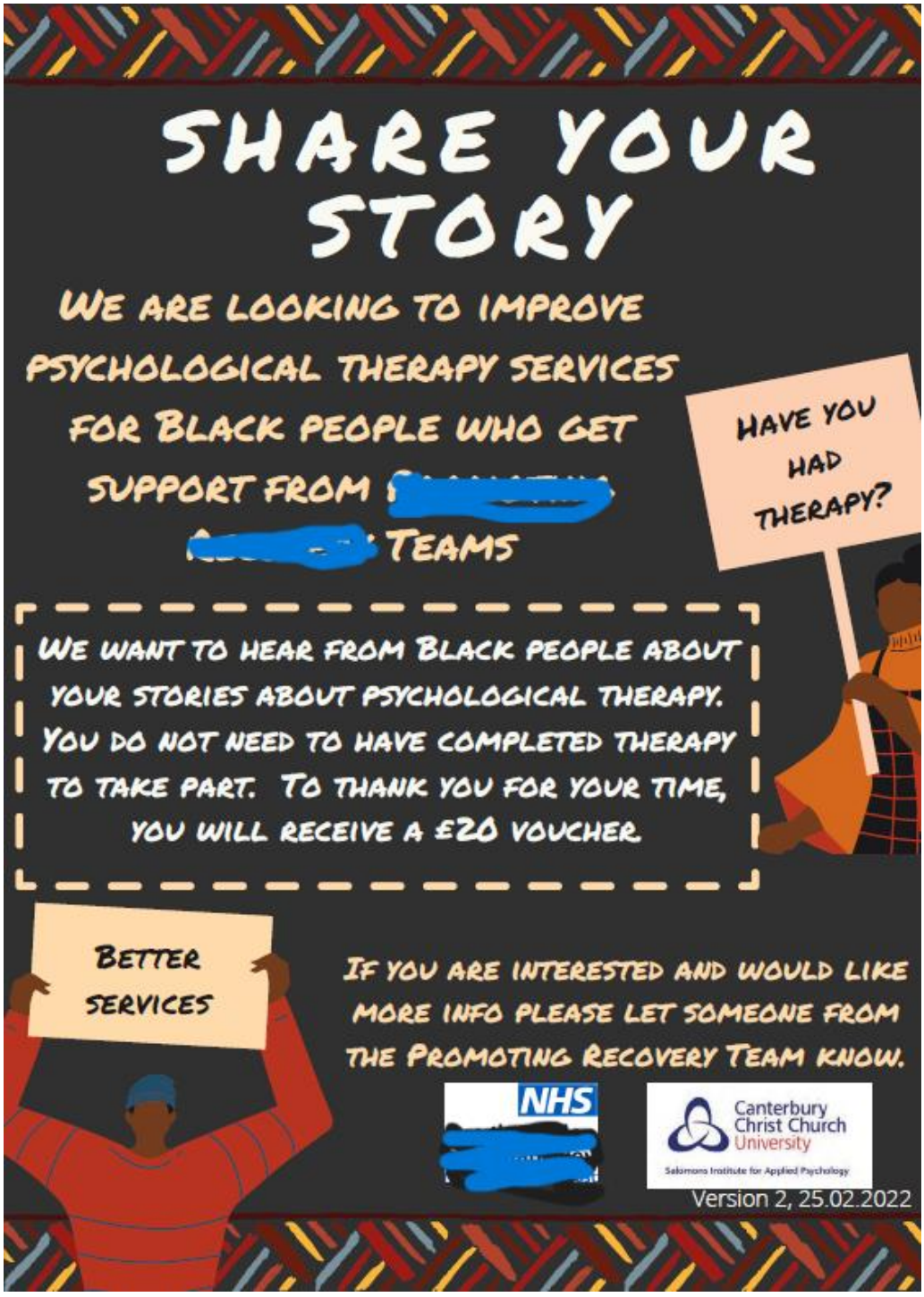
This has been removed from the electronic copy.

Appendix C

Theme development

Initial codes were grouped by paper and labelled by emerging themes on Mural software. Emerging themes were later renamed and defined.

Appendix D
Participant flyer



Appendix E
Participant information sheet

NHS TRUST LOGO REMOVED FOR ANONYMITY

Participant Information Sheet
Study Title: Black people's narratives of accessing psychology services

This research project has been approved by NHS and [Removed for anonymity] ethics boards.

This research project is being carried out by Denisha Makwana (Trainee Clinical Psychologist). The study is sponsored and funded by Canterbury Christ Church University.

It is supervised by:

- Dr Isaac Akande (Clinical Psychologist, [Removed for anonymity] NHS Trust)
- Dr Matthew Richardson (Consultant Clinical Psychologist, [Removed for anonymity])
- Dr Sue Holttum (Senior Lecturer, Salomons Institute for Applied Psychology, Canterbury Christ Church University)

Your care-coordinator or a clinician from the [Removed for anonymity] Team will have invited you to take part in this research project. You should only take part if you want to. Choosing to not take part will not disadvantage you in any way or effect your current or future care.

Before you decide whether you want to take part, it is important for you to read the information carefully and discuss it with others if you want.

Purpose of the research:
The Psychology Service in the [Removed for anonymity] is interested in creating an anti-racist psychology service. To do this, we want to invite 10-15 people, who identify as Black African, Black Caribbean, Black dual heritage, or any other Black background, to share their personal story about getting help from psychology services (e.g. getting therapy).

We are choosing to focus on Black people's experiences as previous research has shown that Black people are less likely to have psychological therapy.

This study will help psychologists better understand how Black people experience psychology services with the hope that we can improve services.

The research study is part of a Doctorate in Clinical Psychology and will be written up as part of the academic requirement. There is a possibility that the research findings will be shared more widely such as within conferences and research journals.

Please note that we are not offering psychological therapy as part of the research study, if you are interested in psychological therapy please let your care-coordinator or another clinician from the Promoting Recovery Team know.

What will happen if I take part?
We want to hear your experience of psychology services and getting therapy. We will ask you a few questions about your demographics (e.g. gender identity, age, ethnicity) and invite you to an interview with the researcher.

Your story will be recorded using a voice recorder. This is so that the researcher can remember your story.

You will have the choice to share your story over one session, with breaks or across two sessions. You will have up to two hours to share your story and this will be done using an online platform such as Microsoft Teams. If you do not have access to the internet, other options will be considered, such as doing the interview at [Removed for anonymity].

We will then look at your story and see what parts of your story may be important to share with people reading the research. We will look at your story to pick up some themes. This means we will be looking at the topics within your story and compare this to what the research says and what other people taking part in the study have said.

Lastly, if you would like to, you can read the parts of your story we have chosen to put in the final research report and share with us what you think.

What will happen with my story?

If you agree to take part in this research project, your story will be recorded. This recording will be kept safe on a password protected computer folder. The original recording will then be deleted. Your story will be written up, but any information that will identify you (e.g., names of people, locations) will be changed or taken out so that we keep your story anonymous.

We will re-write your story in a shorter form to publish in the research write-up and this may include direct quotes from your story.

Before any publishing, you will be invited to review the parts of your story we have looked at to see if you agree what we have picked up. But you don't have to do this part if you don't want to.

The research study will be written up as part of a doctoral research thesis and may be published in an academic journal. Parts of your story may be included in this and read by others.

How will we use information about you?
We will need to use information from you for this research project.

This information will include:

- Your name
- Your contact details
- Gender
- Age
- Ethnicity

This information will be used to do the research, but will not be published.

People who do not need to know who you are will not be able to see your name or other personal information. Your data will have a code number instead.

We will keep all information about you safe and secure.

We will write up the research in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- Or accessing Canterbury Christ Church University research privacy notice at https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx
- by emailing the main researcher Denisha
- by sending an email to dp.officer@canterbury.ac.uk (Data Protection Officer, for Canterbury Christ Church University)

How long will my information be kept?

Due to the university's policy, any personal information about you will be kept for 3 years and then deleted. All data, where your personal information has been removed (e.g. your story and themes), will be kept securely for 10 years. After this it will be deleted.

What are the benefits of taking part?

- You will get a £20 shopping voucher for sharing your story of using psychology services as part of the interview.
- If you decide that you want to review the parts of your story we have decided to share, you will be offered another £10 shopping voucher.
- Your story could help make psychology services better for Black people.

What if I don't want to continue?
If you decide later that you don't want to take part anymore, or you become too unwell to take part in the study, we will keep information we have got from you that you consented to. But you will not need to continue taking part in the research.

What might be difficult about taking part?
We recognise that telling your story may bring about pleasant feelings and unpleasant feelings. After the interview we will give you more details about where you can get more support. The researchers will try and help you if you get upset during the interview by suggesting some ways to relax.

If the P[redacted]ns are still helping you, we will ask you if it's okay to share things with them that we think they should know about keeping you safe. If anything comes up about your safety or someone else's safety being at risk then we will have to share information with the P[redacted].

What do I do if something goes wrong?
If something goes wrong or you are unhappy with any part of the research, please contact the research team by emailing BRIPS2022@gmail.com.

If you remain unhappy and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology –fergal.jones@canterbury.ac.uk

Who can I contact if I have questions?

If you have any questions or concerns about taking part in the research, please email the research team- BRIPS2022@gmail.com

STEPS IN TAKING PART

1. READING THE INFO SHEET AND SIGNING CONSENT FORM
2. TELLING AND RECORDING YOUR STORY
3. LOOKING AT YOUR STORY FOR THEMES
4. YOU WILL BE INVITED TO REVIEW THE THEMES
5. PARTS OF STORY GET PUBLISHED IN RESEARCH

Appendix F
Participant demographic form

Participant Demographic Form

Study Title: Exploring Black people's narratives of accessing psychology services

This form is to be completed by the researcher.

(Version 1, 25.02.22, IRAS ID: 307963)

* Required

1. Please input today's date *

2. What is the participant's name? *

3. What is the participant's date of birth? *

4. What is the participant's gender identity? *

- Female
- Male
- Non-binary
- Prefer not to say
- Other

5. What is the participant's ethnicity? *

6. What is the participant's employment status? *

- Student
- Part time employment
- Full time employment
- Unemployed
- Unable to work due to disability
- Retired

Psychological therapy

The next part of the questionnaire is to determine whether the participant has accessed psychological therapy.

7. Have they had psychological therapy from the [redacted] Team?
(If necessary explain that psychological therapy would have involved meeting with the team Psychologist to talk about personal problems and it may have involved thinking about other ways of coping) *

- Yes - on the waiting list
- Yes - currently accessing
- Yes - completed all sessions
- Yes - few sessions, then dropped out
- No

8. If yes, how many sessions of therapy have they had?

9. Has the participant been offered psychological therapy elsewhere? *

- ◯ Yes - on the waiting list
- ◯ Yes - currently accessing
- ◯ Yes - completed all sessions
- ◯ Yes - few sessions and dropped out
- ◯ No

10. If yes, how many sessions of therapy have they had?

11. What type of therapy did you have ? (e.g. CBT, Family therapy?)

Eligibility

If the participant does not identify as Black or Black mixed heritage or has never been offered psychological therapy they are not eligible for the study and therefore they will not be scheduled to have an interview.
If participant is not eligible let participant know that their data will not be used and they will not be able to take part further in the research.

If the participant is eligible, complete the next section.

Interview

Let participant know that they have 1 week to think about whether they would like to take part in the research. Make a note of the date and time agreed to call them to confirm whether they would like to take part below. Let them know during the next call you will agree an interview time and date.

12. Agreed date for call

13. Agreed time for call

Appendix G
Interview schedule

Study Title: Exploring Black people's narratives of accessing psychology services

Interview Schedule

1) Please tell me your story of when you first got psychological therapy from your [redacted] Team? (Allow for participant to tell story in their own words first)

2) If not brought up, ask follow up questions:
- When were you first told about the psychology service?
- What was it like being referred to get therapy? (How long did it take? What was it like being on a waiting list?)
- When did you realise you wanted therapy? (What was that like? Did you tell anyone? Was it your choice?)
- When was the first time you met with the psychology service?
- What was it like for you when you had your first session with the psychologist? (Do you remember what it was like going to the session? What were you feeling? What were your first impressions? Do you remember anything about the environment e.g. what it was like in the waiting room and sitting in the clinic room)
- Could you tell me more about your experience of therapy sessions? (What went well? What didn't go so well? How many sessions did you have?)
- Could you tell me more about the relationship with your psychologist? (Did you feel listened to? Did you feel like you could bring up any problems including things such as experiences of racism? Do you feel you were understood as a Black person?)
- If you ended therapy, what was your experience of that? (Did you get any support elsewhere?)
- What were the best and worst parts of your experience?
- Could you tell me about how much choice you had in your therapy? (What would you have liked to have more say on?
- Did you have a choice on the gender and race of your psychologist? (Did/would it make a difference?)
- Was your therapy face to face or online? What was your experience of that?

Version no. 1, 07/02/22, IRAS ID: 307963

Further follow up questions that may be used:

- Was there anything else happening at the time?
- What did your friends and/or family think?
- Do you think parts of your identity (e.g. your race, gender, sexual orientation, socio-economic status) impacted your experience?
- Can you tell me more about how they have impacted your experience?
- Would you have changed anything about your experience?

Appendix H
Ethical approval letter

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Appendix I
Consent form

Canterbury Christ Church University

NHS Trust Logo removed for anonymity

NHS Foundation Trust

Participant Identification Number:

CONSENT FORM

Title of Project: Black people's narratives of accessing psychology services

Name of Researcher: Denisha Makwana (Trainee Clinical Psychologist)

Thank you for reading the information sheet. If you're happy to take part in the project, please **read the statements below** and **tick the boxes** that apply to you.

1) I have read the information sheet and I have had the opportunity to ask the researcher any questions and have had these answered to my satisfaction.

Yes ☐ No ☐

2) I understand that my participation is my choice and that I am free to stop at any time without giving any reason, and without my health care being affected.

Yes ☐ No ☐

3) I understand that parts of the story, including direct quotes I share about using psychology services will be in the write up of the research and may get published in a research journal.

Yes ☐ No ☐

4) I understand that all personal information will not be shared with anyone outside of the research team and that my story will be stored securely on a computer. It will not be possible to identify me in any future publications.

Yes ☐ No ☐

5) I understand that in telling my story, I may experience unpleasant feelings, however support will be available to me.

Yes ☐ No ☐

Version no. 2, 18/04/2022, IRAS ID: 307963

6) I understand that if the researchers think that my safety or the safety of another person is at risk, this will be shared with the [Removed for anonymity] Team. This would be discussed with me first.

Yes ☐ No ☐

7) If I wish to remove my story from the research project, I understand that I can contact the researcher.

Yes ☐ No ☐

8) I consent (agree) for the interview to be recorded on a voice recorder.

Yes ☐ No ☐

9) I consent (agree) to take part in the research study.

Name of Participant	**Date**	**Signature**
Name of Researcher	**Date**	**Signature**

Appendix J
Extracts from Reflexivity Diary

This has been removed from the electronic copy.

Appendix K
Summary to HRA ethics panel and NHS Trust

This has been removed from the electronic copy.

Appendix L
End of study form

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Appendix M

Narrative case summaries

Marcus, male, 29 years old, Black British African.

Marcus accessed therapy from an early intervention team, which he accessed after the first time he experienced an "episode" and was hospitalised. The aim of the therapy was to explore the early signs to prevent "relapse".

Marcus thought that accessing therapy was a "normal" process after going to hospital. His friends and family were supportive of him accessing therapy and he was open to accessing it as he thought that psychologists, who have experience in seeing people with similar experiences, would be more understanding than family and friends who would have less insight and would not know how to advise.

Marcus was open to seeing how therapy could help. In his first session, he felt it went well, although may have had some worried that the therapists may judge him because he had been in hospital for his mental health.

Therapy consisted of learning and noticing the early signs of "relapse", which for Marcus included noticing when he was not eating, not drinking, and "overthinking". Marcus found this helpful as he was able to notice when he was becoming unwell and sought help from the psychologists. Marcus perceived the two therapists he had, as understanding and nice. He particularly found the Asian female therapist understanding when she supported him whilst he was experiencing "it". He recognised that the Black female therapist he had asked him "deeper" questions, but was unsure whether this had anything to do with him being Black.

Marcus mentioned several times that the Black psychologist had described his brain as going into "overdrive". Marcus was unsure at first whether he agreed with this, as he thought he had just been meditating and practising his faith. He wondered whether he needed to stop practicing his faith, but later realised that he would "need to stop putting stress on his brain" rather than stop practising his faith.

Marcus experiencing the end of therapy as "bitter-sweet". He was sad, as he was beginning to develop a more "personal" connection with the psychologists, and was beginning to open up. He was also concerned that he would not get the same support in the future. However, he realised that he was ready to end therapy.

Marcus had a helpful experience of therapy, as he felt understood by both therapists, and valued learning about the early "warning signs". He valued having someone to talk to and not being left alone after being hospitalised. Marcus felt it was difficult to share some of his "deeper" experiences, which he was unable to understand and therefore worried how the psychologists may interpret these experiences, and whether they would judge him.

Marcus would recommend therapy to others, and wanted people to know that it would help them feel more independent and they would not be left alone.

Leon, male, 34 years old, Black Caribbean and White European. Had completed therapy. First experience of therapy. Not sure of type of therapy.

Leon described therapy as something he has always found beneficial. He had asked for therapy from his community mental health team. In accessing therapy, Leon was sceptical whilst also being enthusiastic. He was unsure of how and if it would help, but was also open to seeing how and if it would help.

During the first session, Leon felt that the therapist had taken time to discuss how the therapy would support what he wanted. This led Leon to perceive the therapist as knowing what she was talking about, and this made him feel more comfortable.

Leon found it helpful when the therapist helped him understand the causes of the anxiety. He also described several tasks within and outside of therapy helpful such as meditation through an app and doing homework which helped him expose himself to experiences that made him feel anxious.

Leon did not feel that client-therapist match in terms of gender and race mattered, and did not feel that he needed therapy to speak about experiences such as racism. Leon felt that the White, female therapist had supported with the problem he had wanted support for. However, he shared that he would not disclose more "personal" problems with the therapist, and felt like this "type" of therapy was not suitable for those problems. He struggled with the idea that information shared in therapy would be passed on to other staff in the NHS such as his care coordinator and was confused as to how this was "private". If he was to access therapy he would want to access it elsewhere due to this.

Jacob, male, 25 years old, Black British.

Jacob had accessed therapy before, and had always accessed therapy after being hospitalised for his mental health. He had been referred by the nurse and was able to access therapy in a few weeks.

Jacob was open to the idea of therapy, and as had done it before he was aware of what to expect, which meant it took less time to open up in therapy.
Jacob described wanting to learn more about "the condition", learn about himself and learn about prevention within therapy, which he felt therapy did help him with.

Jacob accessed therapy on Teams. This was good because it was in the comfort of his own home, and the documents that were shared were helpful. However, Jacob preferred in person therapy, as he felt he would be able to share more without worrying that family may overhear.

Jacob shared how racial profiling led to the decline in his mental health. He only felt comfortable sharing these experiences with a therapist who was not White. Jacob was worried that if he disclosed to a White therapist they may accuse him of blaming them for the racism. He was able to disclose to an Asian therapist as he thought they may have a better understanding of the experience.

Jacob also shared that he could open up to his White female therapist because she was open and friendly. His prior experience of therapy led him to believe that for it to be helpful he would need to share the right amount of information and it would involve him directing the sessions. However, Jacob held back on some disclosures due to worries that the therapist may

judge him, and that his experiences may get back to the team. He shared that he would feel more comfortable disclosing certain experiences with a male therapist rather than a female therapist.

Jacob shared that if he was to get therapy again, he was not sure how he would be able to access it through the NHS. The only way he knew how to access therapy was by being hospitalised and he did not want to end up back in hospital. Jacob shared a preference for accessing therapy privately, as he could pick the therapist.

Samuel, male, 46 year old, Black British African
Prior to having therapy, Samuel had lost his job and was discriminated against. He was going to tribunal for it. The experience of losing his job and being discriminated against, triggered depression and "a relapse".

Samuel was unsure about whether he wanted help, and whether therapy would be helpful. However, he had therapy before, and thought it had been helpful to an extent, so thought he would give it another go. Talking to his family and staff from the team helped make his decision to go forward with therapy.
"I didn't know what to expect. I didn't know what to expect of the psychology sessions. Because I just thought it would be all about asking me questions. "

Samuel felt the therapist was good and that "he knows his job" but also led to Samuel not disclosing his needs if he thought it may go against psychologist's reasonings (e.g psychologist said not to dwell on past discrimination), although Samuel wanted space to talk about this more.

Samuel liked the way the psychologist "covered things". Samuel had wanted to work on three areas within therapy which included building up his confidence, motivation, and not letting his voices get to him. He felt that the psychologist addressed these. He found it helpful that the psychologist asked him about the activities he was doing, and got him to fill out a diary of weekly habit and thought processes. He also found it helpful that the psychologist had helped him realise that the voices were not always trying to be negative, but could also be seen as protective.

Samuel felt therapy was helpful and would not have changed anything about the psychologist or the therapy. Samuel did not think the race or gender of the psychologist mattered, and did not want to be seen as racist.

He felt that sometimes doing the suggestions from therapy was difficult because his "illness" made it hard. However, he expressed that he was proud he had completed 16 sessions of therapy.

Samuel would recommend therapy to others, he wanted psychologists to know that therapy should not be forced on people, but they should be given a choice and told about the benefits of therapy and what to expect.

Elijah, male, 54 years old, Black British Caribbean and White British. Elijah had been in contact with mental health services for over 25 years and he had only been offered therapy three or four years ago. He had been offered other support including occupational therapy which helped him with his spending, and also had support for stopping smoking.

Elijah found living in the UK very stressful. He shared that he struggled to talk to people about the problems he had because people did not understand him and would prefer to keep happy. He believed his problems were external including mistrust with the British intelligence.

Elijah spoke about some of the difficult experiences he has had with mental health services, which he described as “mad”, “dangerous” and “dishonest”. He shared that he had felt that the psychiatrist had put him in hospital because he had got angry. He had not wanted to share information with the psychiatrist but the psychiatrist had insisted on Elijah telling him. Elijah believed he had got “locked up” because of this. Elijah explains that he has to be passive about what concerns him because he it will “be more trouble” if he tried to use violence. Elijah also shared other experiences where he felt nurses were “aggressive” and dealt with problems by medicating him. He described feeling controlled by them, and a sense of “dissociation” from mental health services, due to these experiences. He also described his distress at being arrested by police which felt like a “kidnapping” and then being put in hospital without access to his phone.

Elijah described his first session of therapy has the psychologist not saying much and it being a “lot of questions. No answers.”. However, he felt comfortable as the psychologist was “passive” and not aggressive.

He accessed therapy once a week and experienced it as “good”. Therapy was face to face, although he had some sessions online which he did not like as he was concerned about where his information would go. Elijah shared that he felt he could express his anger with the therapist, unlike with psychiatrists who would “put more medication” on him. He found it helpful to hear from the psychologists reflections on how he was coping with his problems and how to cope with “a lot of heavy emotions”.

He found it helpful that at the end the therapist had written him a report highlighting the areas they were working on and how he could work on them.

Elijah spoke about how sometimes it got “unbearable” and described other ways he would cope. This included smoking cannabis which relaxed him from a “hyper, mad world”. He also felt that he had learnt a lot from reading books and spirituality. Elijah also enjoyed creating his own artwork.

Dylan, male, 33 years old, Black Caribbean and White British.
Dylan was currently in therapy and had two sessions of therapy. He had requested for therapy, after his mum suggested it would be a good idea for his future. He had not had therapy before, but reflected that it would have been good for him to have had it as "young lad".

His current therapist was White and female, and he was happy with the therapist. As the researcher I was unclear about his preferences, however from some elements of what Dylan

was saying, his preference towards having a White and female therapist, came from wanting to speak to more White people in London, and because of his relationship status. There was a sense that Dylan wanted to work something through regarding relationships, and that a female would help with this.

Dylan shared that "back in the day", reflecting on when he was younger, he would have preferred a Black therapist, as he experienced racism growing up in the North of England. However, Dylan talked about negative experiences of mental health services both in the North of England, and in South London, despite there being more Black staff in South London services. Dylan spoke about White clinicians in the North of England, threatening to force him to take injections, and was confused as he did not see himself as violent.

He talked about finding it difficult to communicate with Black African staff who had an accent, " I couldn't understand the African accent very well, but they took it like by offensively" and found the White therapist helpful because he could communicate without the "language barrier". Dylan spoke about Black clinicians trying to identify with him because they saw him as Black, and Dylan finding this difficult, as he doesn't just identify as being Black. “Especially in London, like I'm not London Black. I'm not London Black and I'm not I'm not White...”.

Dylan speaks about his journey as being dual heritage. There was a sense that Dylan was on a journey in embracing his White identity, and perhaps a White therapist could help with this. However, Dylan also shared that he would like a mixed race therapist, as he was "sick and tired of just getting Black points of view, or White points of view”. Although the therapist was White, Dylan had found therapy helpful because the therapist listened, and he was able to "vent". He has found it helpful to discuss with her his ideas about how racism had impacted his mental health. He believed that people should be supported to explore the root of their suffering earlier on and that attributing it to drugs or weed was not enough.

Dylan shared that he did not like the environment in which therapy took place, as it reminded him of when he used to get his injections. He shared that he would prefer to go to a park or for a coffee whilst having therapy.

Dylan found therapy helpful to be able to talk to someone, and perceived the therapist as nice, friendly and listening. However, he would have preferred to talk to a friend, but had been struggling with making friends in London.

Ava, female, 39 years old, Black African.
Ava speaks about how she ended up in MH services. She experienced a lot of stress and pressure, whilst studying and the loss of her father. She continued going as a way of coping until she had a “breakdown”. It was her sister and mother who identified that she needed support and took her to see her doctor. She ended up sectioned and on medication. She decided she needed therapy to better make sense of what was happening to her, as being in hospital was a confusing experience and she found medication "problematic".
Ava speaks about having "lots of issues" that needed understanding and feeling very "angry" and unpacking that in therapy. Ava speaks about her identity as Black and growing up with a White family in a White area, and how this came with "complications". Ava speaks about the multiple losses she experienced, from a young age up until she was sectioned.

Ava speaks about being sceptical about therapy offered from the community mental health team at first. She disliked the questionnaires that she was required to fill in, particularly the questions about ending her life. She thought these questions were extreme and inappropriate. Ava speaks about being able to get through the first session and the questionnaires, and recognising that she had a lot of "issues" that she has previously "buried".

Ava compares her experience of therapy with what it was like when she was a child. She shared that she was in and out of therapy as a child, but felt that a lot of the therapy was spent with her outside of the room, "making things". Ava spoke about how as an adult, she had more space to talk about what she had experienced.
Ava was first diagnosed over 10 years ago, and did not accept her diagnosis for about 5 years. During this time she was in and out of hospital and on medication. When she came to terms with the diagnosis she accepted support from psychologists. Ava shared that she had a period of time after this of "wellness" and was able to do "normal stuff" such as get married, get a career. She thought that her diagnosis had gone, and she would not need medication again. For Ava when she became pregnant, she began to overextend herself and engaged in therapy referred to her from the mother and baby unit.

Ava has had five therapists, she talks about her different experiences with three different therapists. Ava speaks about her female therapist from the maternity unit. She shared that she found it helpful for her to be female, because she found her sweet and nice. She said this was helpful because they were talking about nurture and motherhood. Ava then goes on to talk about a White European male therapist, who was not born in the UK. She shares that the therapy was "weird", but she speaks fondly of the therapist. She said that he did not understand her experiences as being British and Black, but was interested enough to find out about her experiences and understand. Ava speaks about how helpful she found it that he went "above and beyond" as he would visit her in hospital. Ava then speaks about her therapy from the community mental health team. She shares that the therapist is more "solution focused" and practical. But she liked this aspect. She also remembers seeing the “Black Lives Matter” lanyard around his neck and thinking that he may understand her trauma related to racism.

Ava speaks about the helpfulness of therapy and being a big advocate of it. She shares that she sees values in people working on themselves. However, she is less hopeful of how therapy can help with the generational and current systemic barriers that Black people experience which impacts their mental health. She thinks that the systems are not doing enough, and Black people require family and friends advocating and supporting them when they are struggling with their mental health.

Ava speaks about her own experiences with race, which are complex and traumatic. Ava speaks about the BLM as being traumatic for her and her Black friends, because there was heightened coverage of Black pain. It is unclear whether she has had a chance to unpick these and think about these in therapy.

Tanya, female, 40 years old, Black British Caribbean

Tanya had received therapy prior to receiving therapy from the community mental health team, which was also in the NHS. As COVID hit, she had accessed therapy from her current therapist via telephone and also joined a group. The therapy then ended, but she asked to be referred again due to difficult experiences in relation to family members being unwell. Tanya first got referred to the therapist via the occupational therapist, who she described as having a positive relationship with. Tanya was currently having therapy, this was face to face but was not in the team base. Tanya did not find her first experience of therapy helpful. Tanya had a male therapist during her first experience and found him to be intimidating. Tanya shared that she felt the male therapist was pushing to talk about experiences she was not ready to talk about. Tanya's recent therapist was female, which has been helpful as she did not feel intimidated by her. She valued being treated like an individual by the therapist, rather than "just a number".

Tanya was a carer to a family member who also received support from mental health services in the same NHS trust. Tanya shared that she had difficult experiences being a carer and having negative experiences with staff. This has made opening up to the therapist more complicated, as whilst therapy was confidential, Tanya worried that information would be passed on to other members of the team. She shared that this has made her more reserved in therapy, however she had been able to share and trust the therapist because they have a positive relationship.

Tanya shared that she valued the support she got during COVID, and the group therapy. Prior to her first experience of therapy, she did not really have any thoughts about therapy, as she had not had to think about it. She had friends that worked in the Trust, which helped her decide that it might be helpful for her. Tanya described her experience of having an "episode" as being frightening and was open to anything that would help her to not experience it again.

Tanya shared that she had not found having a White therapist a barrier, and talked about being able to disclose to the therapist. She shared that she was actually going to disclose a cultural experience with her therapist during the next session, and was hopeful that whilst the therapist may not have experienced the same thing, they would be open to listening and trying to understand. Tanya shared that she had negative experiences with staff who happened to be Black when a carer.

Tanya also felt that the Trust do not support and work with families as much as they claim to, and usually work with just the individual. Tanya felt like she could only access services as a carer or a service user, but there was a lack of consideration about service users who may also be carers. Tanya shared that she felt that psychological services should offer therapy at a timeline that suits the patient rather than suiting the service.

Joanne, female, 26 years old, British African.
Joanne had two experiences of therapy, both from the same team. Joanne was referred to therapy by her care coordinator. Joanne had her therapy online, which she preferred because she was quite nervous.

She hoped that therapy would help her with her anxiety and support with getting her out more. In talking about the therapy Joanne first accessed,
Joanne was anxious about having therapy, but she was able to go ahead with it.

Joanne found the techniques and tasks helpful in therapy such as the breathing exercise and a task that supported her to go out. Joanne found therapy helpful as she was able to work on her goal of managing her anxiety and getting out more.

Joanne did at times struggle with sharing information with the therapist, as she thought she would have a panic attack if she did. In thinking about what would have helped in that situation, Joanne shared that it would have been helpful for the therapist to help her with how to overcome the panic attacks in those situations.

Joanne's family were supportive of her going to therapy, and this helped her to go to therapy, they were also helpful with supporting Joanne with some of the tasks outside of therapy.

Adam, male, 47 years old, Black African.
Adam received therapy a few times, but was not able to recall how many times. It sounded like the focus of Adam's therapy was to think about his experiences of trauma, such as flashbacks.

Adam was referred to therapy by his care coordinator, however he did not know what therapy was, or what to expect from it. This was not explained to him until he got into the therapy room.

Adam described the first session as being asked a lot of questions about his past, all the way back to his childhood. Adam shared that at first he was a bit worried about sharing so much with the therapist, however after the third or fifth session he began to feel more comfortable. Adam described the therapist as being "nice" to him and friendly, which made him feel comfortable to share.

Adam shared that it was important to him that the therapist listened and showed they cared and were not just treating the therapy as something they do for an hour as a job. He said that at times, it got "too deep", in regard to talking about painful past experiences.

Adam said he found therapy "good" because it helped him with his thinking and feelings. He said that it was helpful to get everything that was "inside, outside". Adam was offered an interpreter during his therapy, he accepted this before, but did not want this for his latest experience of therapy. He said that it was the "same" either way.

Adam felt that it did not matter, what ethnic background the therapist came from, as he was used to working with different people. Adam said he was crying when his therapy ended, but he agreed that he no longer needed it. Adam found it painful to keep having to repeat his experiences each time to a new therapist. He shared that it would be preferrable if he could just have the same therapist each time.

Appendix N
Individual transcript

This has been removed from the electronic copy.

Appendix O

Theme development

Table demonstrates codes organised by each participant and touchpoint. Codes are highlight by the theme it was organised within.

Key

Experiences of oppression
Accessibility
Therapy is good- helpful processes
Safety and the therapeutic relationship
"It's not that personal" -Disempowerment within therapy
Resources outside of therapy

Participant	**Touchpoints**										
	Before therapy	Accessing therapy	Structure of therapy	First therapy session	Content of therapy	Progress made in therapy	Relationship with therapists	Environ-ment	Ending	Last thoughts	Miscella-neous
Marcus		Referral via CMHT after hospital. Belief that it was the "normal" thing he	Was able to access therapy a few times within same team including after relapse.	Was open to it, perceiving the therapists as listening and	Early prevention including noticing signs of becoming unwell.	Was able to notice early signs and seek help. Breathing technique and	Two therapists- Asian female, Black female. Described both as nice and understanding.		Described as "bitter-sweet". Sad to end therapy as concerned that he will not get	Would recommend therapy to others, as it was helpful to not go	

“had to do”. Friends and family were supportive of accessing therapy. Psychologists may be better able to understand based on their experience. Was open to therapy to see whether it would help.	Therapy received fortnightly, face to face.	understanding led to feeling safe to continue. Wondered whether he had some initial worries that the therapists may judge him due to his experience of mental health-stigma.	learning to plan and write things down described as helpful. Was not able to self-disclose personal, “deeper” experiences, due to worry about judgement, interpretation and lack of language and understanding to describe the experiences. Learnt that he would have to not put too much stress on his mind,	Length of time with them allowed to form trust and disclose more. Able to self-disclose some aspects of his identity such as faith which overlapped with his mental health experiences. Some disagreement with therapist about interpretation of this. Psychologists perceived as experts who have knowledge and experience that friends and family do not have.	same support and begun to develop a good relationship with therapist.	through further experiences alone, and to become independent and vigilant in noticing early signs.

					something he was still figuring out how to do.	Did not talk about racism.	
Leon	Always held a belief that therapy is beneficial. Requested it from CMHT. Waiting list experience as long which led to Leon feeling like they forgot about him.	Face to face and online. Online was helpful when Leon was struggling with his chronic physical health condition.	Started off as sceptical but open to seeing if it would help. Good from the outset. Therapist was "decipheri ng" and helping. They took the time to listen and speak to what Leon wanted help with. This was perceived as	Support with anxiety.	Rest of therapy perceived as helpful. Learnt about the causes and lead up of his anxiety and learnt tools- perceived as useful. Surveys and experiments mentioned as helpful. Learn to meditate and do mindfulness through an app which he	Had a good relationship with therapist, she listened and he felt at ease with her. Did not think race or gender of therapist made a difference.	Therapy terminated early due to therapist leaving. Wanted to be signposted to access more therapy.

therapist knowing what they were talking about.	continues to do. Held back from sharing more “personal” problems, which he felt did not fit with this “type” of therapy. Disagreed with information from therapy being shared with care-coordinator as this did not seem private. Would therefore prefer to access therapy from

						somewhere else. Did not feel like he needed to bring experiences of race or racism as did not fit with his goal for therapy. Friends were supportive with doing the homework tasks with him.					
Jacob	Attributed decline in mental health to being racially profiled but did not feel	Was referred for therapy by nurse after being in hospital, and was told it would help	Had therapy online, which was good as could access from home. Preferred face to face as he was	Knew what to expect due to already having had therapy, which led	How to recover from psychosis and prevention	Therapy helped with understanding the condition and learning ways to prevent it	Felt he may share more with a male therapist, who may have a different understanding to a female. A female	Feeling safe in the environment led to sharing more with	Felt happy for it to come to an end as had discussed everything he wanted to discuss with	"Therapy is good for getting things off your chest." Would recomme	Uncertainty as to how else therapy could be accessed as had only had access

this could be shared with a White therapist due to concerns they would not understand. Different reasons to decline in mental health each time, which linked to goal in therapy.

Prior to having therapy though it was for richer people. After having therapy with his psychosis. Had previously accessed therapy. Was open to accessing therapy after having had it before.

Few weeks wait for therapy.

Felt sometimes sessions were too long, but did not know how to tell therapist this.

worried his family may overhear.

him to feel more at ease and open up. Knew what he would need to share for it to be helpful to him. Laying the groundwork and getting to know each other. Knowing that information would be confidential led to more disclosure.

happening again. Documents shared were helpful to look back on.

Good to speak to people are trained.

therapist may judge these experiences. Felt there was not much difference between a Black therapist and a White therapist, although would not share his experiences with racism with a White therapist.

Therapist was open and friendly, led to feeling okay to share and not worry about being judged.

the therapist.

therapist. Had been offered group therapy, which he thought would be good to meet others.

nd it to others who have gone through similar experiences and would tell them to not judge the therapist too quickly or think they are plotting against you.

after hospitalisation. Consideration of accessing privately to avoid waiting lists and have a choice of therapist.

Samuel	realised it is for everyone. Decided to take up therapy because had a relapse and was feeling depressed. Losing a job that he was enjoying due to discrimination led to recent decline in mental health. Speaks about taking skunk when younger and how	Was referred by care coordinator. Was unsure at first as to whether they would help, but with time became more open to the idea. Talking to family and staff helped in making the decision. Family and friends were supportive of accessing therapy.	Face to face sessions, which were anxiety-provoking to begin with. Anxiety reduced by getting to know the psychologist.	First therapy was experience as "tough" due to all the questions. Did not know what to expect. Felt confusion and like an interrogation on when first accessed therapy at "peak of illness". Due to memory difficulties struggled to answer.	Asked for support in increasing motivation, confidence and to not allow voices to affect him as much.	Decided on three goals to work on which Samuel felt were covered in therapy, through learning tools and understanding the voices and his behaviour. Learnt to see things in a positive way and that the voice is not there to harm him. Good to get things off	Perceived psychologist as helpful as he was at good at his job and knowledgeable. Getting to know the psychologist better, eased anxiety. Did not mind about the race and/or gender of the therapist- "I'm not fussy". Therapist was not forceful, perception that it should not be forced on anyone, people to have a choice.	Was proud of attending 16 sessions and had 2 left.	Would recommend to other Black males and females, as it would help even if not now but in the future. Psychologists should take the time to listen, listen to their story, and understand them.

it took over him.

Had previously accessed therapy.

“It hurt” to be on a waiting list.

But after having accessed therapy Samuel understood the process better.

First few sessions were about how the “condition” was affecting Samuel.

his chest and talk.

Learning meditation, filling in a diary and writing notes was helpful.

Understood why to do the techniques offered but struggled to put them into place due to “condition”.

Wanted to speak more about the discrimination experienced at work, but perceived psychologis

Elijah	UK a stressful place to live. Has been accessing mental health services for 25 years but only received therapy 4 years ago. Occupational therapy which helped	Was open to therapy but a bit worried about where his information will go and who it will be shared with.	Therapy was once a week. Mostly face to face and a few times online. Did not like online as did not want his information getting into the wrong hands.	"A lot of questions …I was doing a lot of speaking"	t as telling him not to dwell on it. Samuel was unable to share that he wanted to talk about it more. "It was good". Feedback about progress and reflections from psychologist helpful.	Therapist perceived as "passive". Described liking the therapist, as illustrated concern for Elijah. Compared relationship as better than with psychiatrist, as could express anger. Felt therapist lacked power to manage his problem.	Described feeling unsafe in mental health services.	Received a report that summarised the work which he found helpful.	Spirituality, art, writing, reading and smoking weed as other ways of coping. Feeling lonely with lack of intellectual people to talk to. Reflection on the impact of

with spending, and support for smoking were accessed prior to therapy.	cuts on services and treatment.
Oppressive experiences with mental health services and police. Mental health services described as “mad” and “dangerous”.	
Mistrust of people, governme	

Dylan	nt and services. Links smoking weed to doing his "brain up" but perceives racism as root of the problem to decline in mental health.	Reluctant at first as did not think he had a problem, but his mother thought it would be helpful.	Discussing dual heritage identity and "everything on [his] mind regarding this. Therapist showed him a video of "mixed-race people talking about their ethnicity". Reflects that this would have been helpful when he was younger.	Preference for a White woman, as felt like he spoke to other Black family members and Black girlfriend. However, later reflects that he would find it helpful to speak to another mixed-race person and male therapist to get their perspective. Reflected that White people can sometimes lack understanding in relation to race due to ignorance.	Disliked environment in which therapy took place. Preferred to meet for a coffee or in a park. Environment brought up past experiences of having medication injections, which did not feel good.	Dylan's faith-including chanting and meditation were mentioned as also helping him, and a desire to share this with the therapist.

Speaks about his experience of racism when growing up, and due to dual heritage feeling like he did not belong.

First time accessing therapy and requested it.

Preference for face to face- enjoyed using the trains and coming in.

Felt good to get things off his chest.

White female therapist listened and was nice.

Preference to talk to a friend rather than a therapist, although struggling to make these friends in London. Did not just want to meet with other people who had mental health difficulties.

Oppressive and racist experience within mental health

	services - "scary" and a desire to see more Black staff.								
Ava	Ava attributes her first “mental breakdown” to stress caused from losses and experiences of racism.	Had accessed therapy on multiple occasions across her lifespan, including privately. Initially sister and mother recognised she needed help during first breakdown. Was currently accessing couples therapy from the community	Sceptical at first. Found the questions within questionnaires extreme and inappropriate.	Used therapy to process anger and discuss “complications” which arose from being adopted by a White family and growing up in a White area. Recognised she had “issues” that she had “buried”.	Therapy helpful for different reasons based on the time in her life she accessed it. Having the space to talk.	White European male – private therapist, therapy model was perceived as “weird” but spoke fondly of therapist and how he was the only person who saw her when she was not unwell. He went above and beyond. He did not understand her experiences of being a Black female. White female therapist-	Spoke about the importance of having advocacy when hospitalised in mental health wards.	An advocate of therapy, but felt that this was not the answer to the structural problems that Black people face. Was less hopeful about these problems being resolved. Spoke about the	Reflected on importance of her job in terms of recovery.

mental health. team

maternity ward. She was friendly and nurturing.

Male Asian therapist – CMHT- had a Black lives matter lanyard, which illustrated to her that he may understand those elements of her trauma.

Therapists brought something different which seemed to be what she needed during that time, and all created safety within the relationship despite their

pain that her and Black friends experiences during BLM and George Floyd's murder, unclear if discussed in therapy.

Tanya	Oppressive experiences within mental health services as a carer for a family member accessing services in same Trust, lack of trust in staff. Stress of this led to decline in mental health.	Referred by care-coordinator and occupational therapist within CMHT. Had accessed therapy before. Prior to her first experience of therapy, she did not really have any thoughts about therapy, as she had not had to think about it. She had friends that worked in the Trust,	Therapy currently received face to face but requested for it not to be in team base. During pandemic received via telephone.	Used therapy to talk about anxiety.	Therapist provided a different point of view. Therapy supported with doing activities she found difficult. Helpful to have someone to talk to who was non-threatening, as she had been coping by "bottling up".	gender and race. First therapy experience- White male who she found intimidating and pushed her to talk about experiences she was not ready to discuss. She decided to end therapy. This experience left her thinking she would prefer a female therapist. Current therapist- White female. Perceived as nice, non-threatening and treated her like an individual. Felt safe to explore cultural	Due to mixed experiences with the MH Trust, Tanya did not want sessions in the Team base. This led her to feel less anxious and claustrophobic.	Therapy should be offered on the person's timeline rather than the services timeline.

	which helped her decide that it might be helpful for her. Tanya described her experience of having an "episode" as being frightening and was open to anything that would help her to not experience it again.					experiences with therapist. Trusting relationship based on the therapist not judging and continuity.	
						Prior negative experiences with mental health staff including Black staff impacted negatively on self-disclosure within current therapy and ability to discuss these experiences.	
Joanne	Was told about therapy by care co-ordinator. Felt "anxiety" about	Therapy was on Teams, which she preferred	Perceived as good	Talked about wellness and anxiety	Perceived as good. Helped with feeling better. Mother was supportive in doing the	Had good experience of the therapists as they helped her with her goal to overcome aspects of her	Was initially worried she would forget everything, but found it helpful to

starting but went ahead as wanted to know if it would help. Was not on the waiting list for long, but being on one made her feel anxious she would not get to see a therapist.

tasks and sharing that it was good for her.

anxiety. Did not think characteristics of therapist matter (gender and race).

have cards and information about overcoming anxiety.

Found techniques helpful such as breathing exercises, listening to music, and exposure experiments.

Sometimes found it difficult to share as she thought she may have a panic attack. Would have liked the psychologist to suggest a plan on overcoming this.

Adam	Referred to therapy by his care-coordinator but he was unsure what it was, and what it was for.	Use of interpreter for some sessions. Preferred face to face as he liked to see the person in front of him	Remembers it as them asking a lot of questions, and he felt worried to share so much in the first session. Recalled them asking a history. Adam only felt comfortable sharing more deeper information after a few sessions, when he felt he could trust the therapist.	Discussion about what happened to him and flashbacks.	Perceived therapy as good. Good for sharing what happens internally externally. Helped to think better and make decisions more clearly.	When Adam perceived the therapist as nice, listening and that they really cared, he felt comfortable to share. However found it difficult when they dwelved too deep as this was painful, especially when having to repeat to different therapists. Adam did not think it mattered what gender or race the therapist was.	Adam was sad about the ending and cried. However he was comfortable that it was to end.

Appendix P

Additional theme and pattern development

Each narrative case summary was analysed using the questions in the headings to identify patterns within and across the narratives. Patterns were compared to ideas from CRT.

Participant	What was overall positioning towards therapy?	Intersections between mental health and race, gender?	Reference to additional contexts which impacted therapy
Marcus	Therapy helpful for prevention and access to experts. Took away tools and ability to seek help.	Race and gender kept outside of therapy. Some elements of faith brought to therapy.	Distrust of NHS led to distrust of psychologist/therapist. Therapy accessible and normalised by mental health services and family.
Leon	Therapy is beneficial. Different "types" of therapy outside of NHS may allow for deeper exploration. Took away tools from therapy.	Race and gender, and other elements of therapy kept outside of therapy.	Distrust of NHS led to distrust of psychologist/therapist. Therapy perceived as accessible and normalised.
Jacob	Therapy is good. Private therapy allows more choice. Changed perception positively of who can access therapy.	Experiences of racism contributed to mental health decline, but this experience felt only safe to share with a therapist that was not White.	Distrust of NHS led to distrust of psychologist/therapist. Therapy perceived as only accessible through hospital route (e.g. sectioned).
Samuel	Therapy was helpful, but "illness" makes it difficult to put into practice.	Experience of discrimination that contributed to mental health decline.	
Elijah	Therapy was helpful but continued feeling powerless.	Violent treatment from mental health services as a Black man. Anger towards staff because of oppressive	Distrust of NHS and other services impacted relationship with psychologist/therapist. Powerless within systems. Racism as a chronic stressor.

		treatment towards him (Black rage?).	
Dylan	Therapy was helping but would prefer to speak to a friend.	Violent treatment from mental health services as a Black man. Experiences of racism contributed to mental health decline.	Distrust of NHS led to distrust of psychologist/therapist. Racism as a chronic stressor.
Ava	Therapy was helpful across different life stages. Disconnect as to whether it can help with systemic racism.	Staying strong until "breakdown" as a form of coping – similarities with "Strong Black woman" trope. Feelings of anger – Black rage?, which only safe to process in therapy.	Painful impact of George Floyd's murder on Ava and friends. Racism as a chronic stressor.
Tanya	Therapy was helpful with the right therapist match.	Bottling up of emotions as a form of coping- similarities with "Strong Black woman" trope. Intersection of being a carer and service user. Imbalance of power between Black woman- White male therapist.	Distrust of NHS led to distrust of psychologist/therapist.
Joanne	Therapy helpful for anxiety. Anxiety made it hard to self-disclose.	Race and gender kept out of therapy.	
Adam	Therapy was good but trust in the therapist takes time.	Race and gender kept out of therapy.	Distrust of psychologist/therapist initially which impacted sharing of information.