Exploring Black British African and Caribbean Peoples' Experiences of Mental Health Challenges and Help-Seeking

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A thesis submitted in partial fulfilment of the requirements for the award of Doctor of Clinical Psychology

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Declaration

This thesis has been submitted for the award of Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted to any other institution, or for the purpose of obtaining any other qualifications.

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Lay Summary

Literature Review: Black British African and Caribbean people in the United Kingdom (UK) are suggested to be at higher risk of experiencing mental health difficulties due factors such as racism and poverty. However, Black British individuals can face challenges when trying to access mental health support. To understand these challenges better, a qualitative evidence synthesis was completed to review the existing literature that explores not only what Black British individuals believe mental health to be, but also, what their perceived needs and hopes are in relation to that view. Eleven studies were found from three electronic databases. During the synthesis, four themes emerged. Some participants rejected mental health challenges due to stigma and the perceived pressure to be "strong". Black British participants preferred to rely more on themselves and voluntary community groups rather than formal mental health services. Participants shared a need for services to better acknowledge what is meaningful to them, such as religion and experiences of discrimination. This indicates that more work needs to be done in formal services for Black British people to trust, feel understood within, and ultimately utilise this support. The review offers recommendations that can help make mental health services more accessible and culturally appropriate for people within Black British communities.

Empirical Report: Research findings show higher rates of self-harm among Black British African and Caribbean people in England, compared to other ethnic groups. However, Black British people are less likely to access formal mental health services, like their GP, to get help due to fears of racism and concerns of not being understood. For these reasons, research findings suggest that some people from these communities prefer community-based support. To understand this better, six Black British people with experience of self-harm and had either accessed community-based organisations or never sought any help were interviewed. The interviews were analysed and three themes were generated. Participants wanted people to understand that there are any ways and reasons to self-harm. Barriers to getting help included: their belief that they must be 'strong' and not

vulnerable, a mistrust in practitioners' ability to help, lack of awareness of services, time and finances, stigma and practitioners from the same ethnicity and culture as them. Facilitators to accessing community-based services included: Visible and simple services that are flexible and do not place additional pressures on the service user, staff and representation from the same Black British culture, being able to meet people that also self-harm and have mental health challenges, and services that acknowledge their identity and empower them. Recommendations are offered to improve accessibility, cultural competence, and meaningful support within community-based organisations.

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Firstly, I must express my gratitude to the six people who took their time to share their truth with me. You deserve to be heard and supported, and I hope this research is a step towards bringing more awareness and understanding. I hope I was able to honour your narratives, for I too have learned so much from you. I am also grateful to the individual who provided their time and expertise to help me develop the study materials.

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Table of Contents

Section One: Literature Review

Understanding Perceptions of Mental Health Care Needs and Access to Care among Black British African and Caribbean Adults in the United Kingdom

Abstract

Objective

Research highlights disparities within Black British African and Caribbean communities in relation to mental health outcomes, treatment, and access to appropriate services. The review aimed to synthesise extant literature on the beliefs of mental challenges, care needs and help-seeking desires among adult Black British communities in the United Kingdom (UK).

Method

A systematic search strategy of PsycINFO, Medline, Scopus and citation searches produced 11 studies that met inclusion criteria and examined Black British perceptions of mental health needs and desires for care.

Results

All eligible studies were qualitative, peer-reviewed empirical studies, appraised and analysed using thematic synthesis. Four superordinate themes emerged; ‘sense-making’, ‘social survival’, ‘pathways to care’ and ‘cultural care needs'.

Conclusions

This review centred Black British narratives and revealed cultural norms that dictate reduced disclosure of mental challenges. Black British individuals preferred to rely on themselves and voluntary community groups. Participants felt misunderstood and expressed desires for formal services to better acknowledge and incorporate their diverse worldviews. Recommendations are made to improve cultural humility and responsiveness within mental health services.

Practitioner points:

- Black British individuals may reject or minimise mental health challenges according to clinical frameworks, due to factors such as community stigma and internalised discourses of strength. Practitioners need to be responsive to this, taking care not to reinforce these stereotypes.
- Black British individuals prefer self-reliance or informal community support. Practitioners should consider how to better integrate these community resources into care pathways.
- Black British individuals perceive statutory mental health services as culturally insensitive and unable to adequately address their unique needs, worldviews, and preferences. Improving cultural competence is imperative.
- Talking therapies should utilise Black British expertise and include them as equal collaborators in co-designing culturally informed care and adaptive therapy approaches.

Keywords: Black British African and Caribbean, mental health perceptions, desire for care, evidence synthesis, thematic synthesis

Introduction

It is widely recognised that people of the Global Majority[1] are at increased risk of experiencing mental health challenges[2] due to disproportionate exposure to socio-economic stressors, such as racism and poverty (Kirkbride et al., 2024; Mangalore & Knapp, 2011; Mindell et al., 2014). Among these marginalised groups, profound disparities have been documented within Black British African and Caribbean [3] peoples' experiences of mental health treatment (Edge, 2008; Halvorsrud et al., 2019; Qassem et al., 2014)

Specifically, research illustrates how, when compared to their white counterparts, Black British people are over-represented in crisis pathways and inpatient units (Bansal et al., 2022; Care Quality Commission, 2024), more likely to receive a diagnosis of severe mental illness (Halvorsrud et al., 2019), and are three-to-five times more likely to be detained under the Mental Health Act (Department of Health & Social Care, 2021; National Health Service [NHS] Digital, 2024). Further, Black British males face even higher risk of being subject to compulsory powers under the Act (Barnett et al., 2019; Department of Health and Social Care, 2018).

At the same time, Black British people are less likely to present at primary care services, such as their GP, for concerns of mental wellbeing (Morgan at al., 2005) or receive talking therapies

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[1] The term 'Global Majority' refers to all people of African, Caribbean, East Asian, West Asian, or Southern Asian descent, and people of dual heritage who have been racialised as 'ethnic minorities'. The term encourages those so-called, who collectively make up around 80% of the global population, to consider themselves as belonging to the global majority (Campbell-Stephens, 2020). The term 'minority' is used when referencing existing literature to accurately reflect the language and framing used in that source.

[2] Terms like 'mental disorders' and 'mental illnesses' are used interchangeably in the literature are considered to reflect Eurocentric medical perspectives of psychological distress (Probst, 2015), often relating to anxiety and depressive disorders. The author uses 'mental health challenges' to acknowledge the diversity of lived realities and to honour the wide range of cultural meanings and beliefs people attribute to their psychological experiences.

[3] 'Black British' refers to the multi-ethnic group of citizens of either African or Caribbean descent. The author acknowledges that individuals within this group hold diverse life experiences.

(Harwood et al., 2021; Morris et al., 2020; NHS Digital; 2020). This co-occurrence of over-represented engagement in involuntary services, alongside under-utilisation of more ‘upstream’ primary care services generates questions on how accessible mental health systems are for Black British communities navigating mental health challenges.

Black British populations have been labelled as “hard to reach” (Davies et al., 2020; Sims, 2020). This language has been considered to perpetuate harmful stereotypes and legitimise existing hierarchies through deflecting attention away from barriers and inequalities that people of the Global Majority face (Darko, 2022).

In response to this, NHS England developed the first anti-racism framework (PCRF; NHS England, 2023) to guide improvement efforts. The framework is designed to assist mental health trusts and providers to enhance care experiences of racially and ethnically diverse populations. However, access is argued to be best considered as a dynamic relationship between the service, *and* the characteristics of the individual in which the service is designed to support (Penchansky & Thomas, 1981). However, the Individual characteristics of service users and their ability to engage with care are reported far less frequently in literature (Cu et al., 2021).

Levesque et al., (2013) offers a conceptual framework (see Appendix A) and uses transition points to indicate where barriers to access could occur at both the service and individual level. While it is not specific to Global Majority groups, the framework helpfully depicts how realised, delayed, or disregarded service utilisation can depend on perception of needs and cares for desire at the individual or population level.

Its relevance lies in the supposition that the ability to perceive ones need for care depends on health literacy, beliefs of sickness, and expectations towards services. The perception of mental health challenge, needs and desires for care, then, shapes the intention to seek, reach and obtain appropriate care (Levesque et al., 2013).

Within this, there are remarkably consistent findings on how experienced and anticipated stigma hinder decisions around disclosing distress (Arday, 2021; Dockery et al., 2015; Shefer et al., 2012). Continually, fear of discrimination (Keating & Robertson, 2002; Rabiee & Smith, 2014) and mistrust in services (Devonport et al., 2022) have also been found to inform the types of support sought within Black British communities. Kalathil et al., (2011) adds that informal support systems[4], such as church and family systems, were often the primary source of disclosure within Black British communities. This aligns with Edge's (2008) findings that more indigenous spiritual support networks acted as important option for managing mental health challenges.

Memon et al., (2016) conducted a qualitative study into minority ethnic barriers to accessing mental health services in England. They recognised an inability and unwillingness across minority groups to recognise and accept mental health diagnoses. Where symptoms were identified, statutory care was perceived as being unable to culturally adapt the standardised therapeutic interventions not originally designed for people of the Global Majority. In Alam et al's., (2024) recent systematic review, Global Majority groups experienced stigma around mental health challenges from their own communities as well as wider society. Participants also felt misunderstood and pathologised by culturally naive practitioners.

While these insights are valuable, both studies (Alam et al., 2024; Memon et al., 2016) capture experiences more broadly across Global Majority groups. This is reflected in Alam et al's., (2024) recommendation for future research to focus on the needs of specific racially-minoritised people. Further, Alam et al's., (2024) review included a restricted search strategy not borne from theory.

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[4] Informal settings in the community such as family or religious systems, relationship-based programmes, and third sector charities or groups

The experiences of Black British people have been reported once access has been established (Memon et al., 2016; Rabiee & Smith, 2014). However, the present review acknowledges that many people experiencing mental health challenges do not get to that point. Thus, highlighting a need to understand care preferences within the richly diverse Black British community.

The current review, therefore, both compliments and expands on existing literature and becomes the first to specifically contextualise Black British constructions of mental health. The review is timely, in keeping with mental health initiatives across the UK to build upon the existing intrinsic cultural resources within Global Majority communities (Health and Social Care, 2023; NHS Education for Scotland, 2023; NHS England, 2019). The review also surfaces as an opportunity improve accessibility and cultural humility within mental health services for the communities at disproportionate risk of developing poorer mental health outcomes (Kirkbride et al., 2024; Mangalore & Knapp, 2011; Mindell et al., 2014).

Considering qualitative findings in isolation can lead to the generation of narrow perspectives that constrain the development of richer or integrated narratives (Carroll, 2017). Therefore, a qualitative evidence synthesis (QES) was employed to systematically gather and evaluate phenomena that emerges across studies (Flemming et al., 2019). To address the paucity of literature on Black British experiences, the present review aims to conduct a QES to understand perceptions of mental health needs and desires for care among Black British adults experiencing mental health challenges in the UK.

Method

The protocol for this review was registered in advance on the PROSPERO International prospective register of systematic reviews (reference: CRD42024529020). This review used qualitative studies to answer the research question: what are the perceptions of mental health needs and desires for care amongst Black British African and Caribbean adults experiencing mental health difficulties?

Search Strategy

Three electronic databases, namely, PsycINFO, MEDLINE and Scopus, were searched using a search strategy informed by a SPIDER tool (Appendix B; Cooke et al., 2012) and Levesque et al's., (2013) conceptual framework. The search syntaxes (Table 1) incorporated synonyms, related concepts, and alternative spellings to achieve comprehensive retrieval.

Table 1

Search Syntaxes

Construct	Search Term
Black British African and Caribbean Population	“Black British” OR “Back and ethnic minorit*” OR “black African*” OR “British-Caribbean” OR “British-African” OR “Back Caribbean” OR “Mixed“ OR “Black African-Caribbean“ OR “black Afro-Caribbean” OR “African Caribbean” OR “African*”OR “Caribbean” OR “Carribbean” OR “Black” OR “BAME” OR “BME” OR “ethnic* minorit*” OR “ethnic* diverse” OR “Afro-Caribbean” OR “West Indian” OR “global Majority” OR “people of colour”
Perceptions of mental health and needs	“health literacy” OR “health belief*” OR “health need*” OR “expectations” OR “mental health belief” OR “mental health perception*” OR “mental health literacy” OR “knowledge of mental health” OR “perceptions of mental health” OR “mental health attitudes” OR “stigma” OR “barriers to care” OR “cultural belief*”OR “Mental health” OR “Psychological health” OR “mental illhealth”
Care Desires	“service access” OR “Healthcare access” OR “healthcare” “service utilis*” OR “service acceptance” OR “service utilisation” OR “help seeking” OR “accessing support” OR “cultural appropriateness” OR “health exclusion” OR “care disparit*” OR “decision making” OR “service engagement” OR “autonomy” OR “getting help” OR “appropriate*” OR “accept*” OR “care desire” OR “desire for care” OR “decision making”
Research Design	“qualitative” OR “interview” OR “focus group” OR “thematic analys*” OR “grounded theory” OR “Interpretative” “phenomenological analys*” OR “discourse analys*”OR “Semi stuctured” OR “in depth”

Note: Boolean operators refined the systematic database search. Individual construct terms were combined with 'OR' to account for variations, followed by 'AND' to refine the search.

Study Selection

The studies identified from the database search were imported onto an Excel spreadsheet for management and duplicates were then removed. The titles and abstracts of the remaining studies were reviewed against the inclusion and exclusion criteria (see Table 2). Full-text reviews were conducted for the remaining studies. Forward and backward citation searches, or reference mining, of eligible studies and a Google scholar search uncovered two additional relevant papers (Arday, 2021; Robinson et al., 2011).

As per the protocol, studies including mixed ethnic groups (Cinnirella & Loewenthal; 1999; Robinson et al., 2011) and professional groups (Arday; 2021; Keating & Robertson, 2004; Mclean et al., (2003) were included when Black British perspectives could be extracted.

To promote reliability and rigor, a secondary reviewer[5] independently screened five studies. No disagreement emerged between the reviewers.

Table 2

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
1. Primary empirical studies looking at perceptions of mental health needs and desires for care 2. Published in a peer-reviewed Journal	1. Adults from other ethnic groups or who identified as being from different ethnic backgrounds (e.g., Asian, Pakistani, Chinese, White, European)
3. Qualitative studies written in English and includes direct quotations. Mixed-methods studies included if qualitative data can be extracted	2. Child or adolescent populations
4. Exclusively UK-based studies to control for international differences in healthcare provision	3. Only professionals' and/or carers' experiences of services. Papers which review different groups' experiences can be included if meaningful data from the service users' experiences can be extracted.
5. Black British African, Caribbean, or mixed black adult participants aged 18+. Studies which included participants from other Global Majority groups included if data from Black British African, Caribbean, or mixed black populations could be extracted	4. Quantitative design studies, case studies, surveys, organisation reports, theses, and dissertations
6. Cultural adaptation studies that explicitly accounted for participants' culture, ethnicity, or race 7. No date restrictions applied	5. Studies that deviated from the subject by not relating to perceptions of mental health needs and desires for care

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[5] A same-year peer on the Doctorate of Clinical Psychology with qualitative research experience.

Data Extraction

Data was extracted and relevant details from each study were complied. This included author and publication information, aims, sample and characteristics, data analysis method, findings and critique (see Table 3).

Positionality and Reflexivity

A process of self-evaluation is crucial within qualitative research for identifying biases that could influence data extraction, interpretation, and analysis processes (Shaw, 2010; Shufutinsky, 2020).

It is important to acknowledge the researcher's position as a third-generation, mixed Black and White Caribbean woman raised in British culture and of brown appearance. The proximity to the review topic means that preconceptions likely exist due to personal experiences that require acute awareness and conscious bracketing. In addition, the researcher has an extensive education in psychology, with experience of working in mental health services. This background means that, despite employing an inductive approach, interpretation and analysis may also be influenced by learnt theory and clinical knowledge.

To mitigate these factors, the researcher resolved to remain reflexive by keeping a reflective diary throughout (see Appendix C for excerpts). This allowed for ongoing self-reflection and strived for transparent and flexible interpretation (Darawsheh, 2014). Regular research supervision[6] also gave external perspectives and acted as a space to discuss emerging insights and complex emotional responses.

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[6] Research supervisor identifies as a White male.

Quality Assessment

The quality of eligible studies was appraised using the Critical Appraisal Skills Programme (CASP; 2018) qualitative appraisal tool (See Appendix D). The researcher created an Excel spreadsheet to systematically assess the ten CASP criteria to each eligible study. A scoring rubric was developed to rate studies based on the CASP items, awarding one point for each met criteria and 0 if unclear or unmet. This resulted in a quality score ranging from 0-10 which translated into low (<3), medium (4-6) or high (>7) quality ratings. All CASP criterion were weighed equally.

Three of the 11 papers (25%) were selected at random by the secondary reviewer[7] who independently screened the full texts. Scores were compared through inter-rater reliability analysis which resulted in disagreement for one study. This was resolved through discussion.

All studies, regardless of quality, were included as Thomas and Harden (2008) suggests that restricting a review to only the most robust studies risks excluding novel findings that could meaningfully contribute to understanding. CASP appraisal results are detailed in Appendix E.

Thematic Synthesis

Data was analysed using thematic synthesis in accordance with Thomas & Harden’s (2008) guidance. To begin, the results of the of the 11 eligible studies were extracted and entered verbatim into the computer software NVivo 14 for Mac to allow for the volume of data. Line-by-line coding from 169 eligible quotes generated initial codes. The codes were grouped based on shared properties to create eight ‘descriptive’ themes and four subsequent ‘analytic’ themes. Theme development is illustrated in Appendix F.

Moreover, as studies are at risk of losing their original contextual nuances and methodological richness when merged with other studies (Thomas & Harden, 2008), a table of

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[7] A peer with qualitative research experience in the same year as the researcher on the Doctorate of Clinical Psychology

characteristics is offered to address this concern, provide context, and help preserve meaningful depth (Table 3).

Results

Summary of Included Papers

This review method was informed by Cherry et al's., (2024) guidance for students and is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

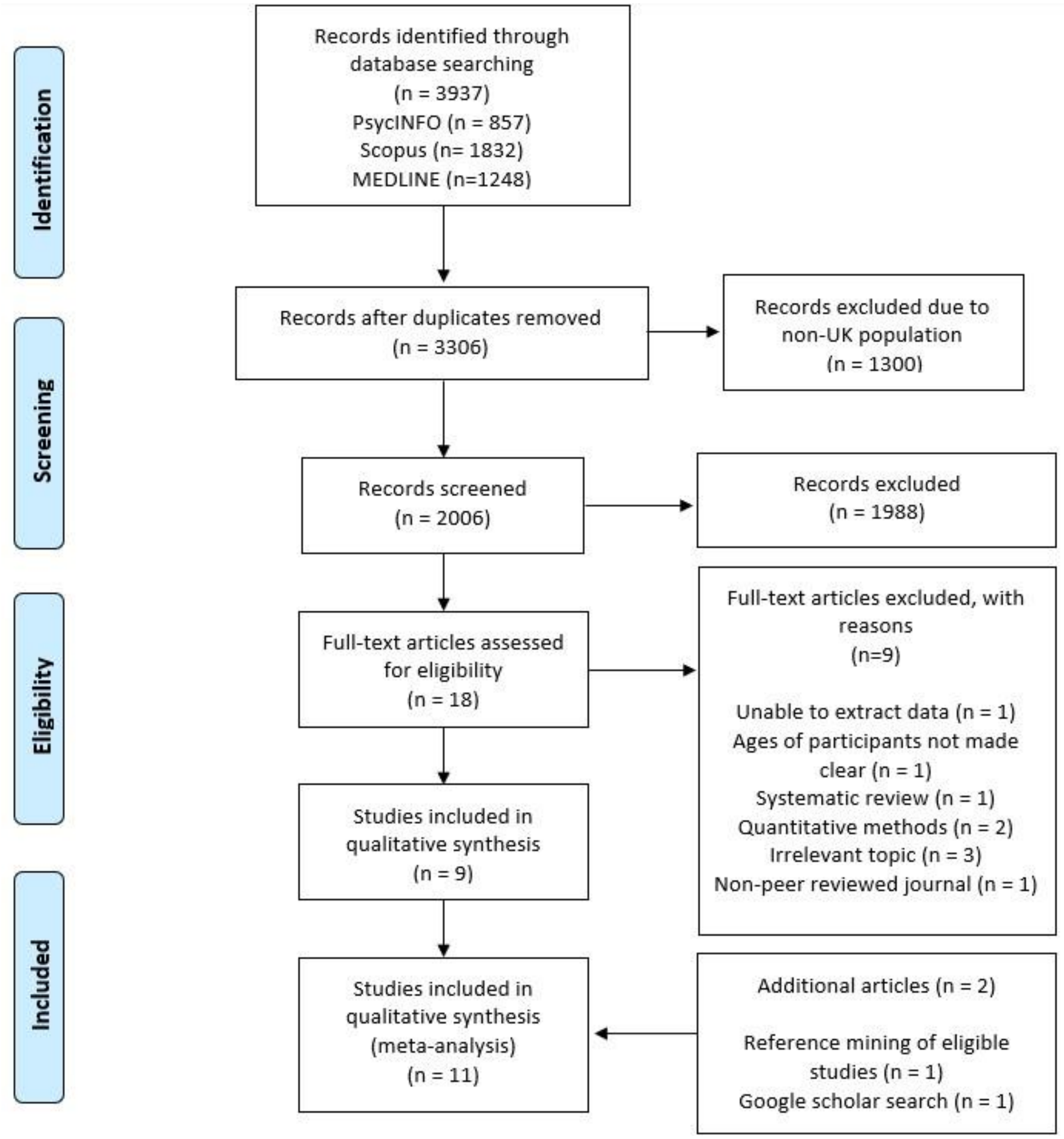
As depicted in the PRISMA diagram (figure 1; Moher et al., 2009) the database searches initially returned 3937 papers. Following de-duplication, 3306 papers were eligible for screening. Of these, 1300 papers were excluded due to having a non-UK population focus. The 2006 titles and abstracts were screened again with 1988 excluded. 18 studies proceeded to full-text review, of which nine were excluded due to an inability to extract data, unclear participant characteristics, irrelevant topics not capturing perceptions of mental challenges or desires for care, and non-peer reviewed publications. Nine articles met full inclusion for qualitative synthesis. Reference mining and targeted searching in Google Scholar identified two additional eligible studies, resulting in 11 eligible studies altogether.

All studies were of an interpretivist epistemic position and carried out between 1999 and 2023. Of the included studies, seven captured Black British experiences exclusively, and four captured Black British experiences among other ethnic groups. Four studies captured Black British experiences among carers, professionals, faith leaders, higher education students.

Participants were recruited from the general population, third-sector voluntary groups, universities, and primary mental health services. Ages ranged from 18 to 79. Other intersecting influences, such as ability and socioeconomic status, were rarely captured and so were not reported in this review.

Figure 1

PRISMA Diagram



Quality Assessment Results

All studies scored a five or more out of ten, and 91% of studies were indicated to be of ‘high quality’. The average score was eight. The studies were clear about their aims and appropriately employed qualitative methodology to illuminate participant experience. All but two studies clearly defined the recruitment strategy and all but one clearly detailed data collection methods. Only four papers explored the relationship between the researcher and the research, and three studies failed to address ethical procedures taken. Eight of the studies clearly demonstrated rigorous data analysis, and all but one study gave a clear statement of findings. Finally, all studies were deemed to offer value, in accordance with the contribution made to knowledge and understanding (see Appendix E for overview and justification).

Table 3

Table of Extracted Data Characteristics

Study	Aims	Sample and Characteristics	Data Collection	Data Analysis Method	Findings	Critique & Trustworthiness	CASP Rating (Out of 10)	Quality Rating
Allam & Binnie (2023)	To explore how black ethnic groups experience mental distress and find meaning according to cultural heritage	4 participants. 3 female 1 male. Aged 20-40 from local support groups, social media and a London University campus. Black African, Caribbean and Mixed	Individual semi-structured interviews, one virtual.	IPA Audio recorded and transcribed verbatim (Smith 1996)	Stigma surrounding mental health impacted acceptance of their experience and disclosure outside of the family. Mental health admission perceived as embarrassing. A need to raise awareness of mental health was established.	No mention of any credibility checks during data analysis however the author positions themselves within the research and acknowledges preconceptions.	10	High
Arday (2021)	To centre racialised experiences of Black people through the lens of mental health in education	40 participants aged 26-58 recruited from 14 UK universities and professional services. *14 Black British (8 academic staff, 6 professional staff)	40 semi-structured open-ended questionnaires semi-structured interviews, 2 unstructured focus groups	Thematic Analysis and NVivo Audio recorded and transcribed verbatim	A need to address people's ability to perceive and seek/desire mental healthcare services. Training healthcare professionals to understand intersecting discrimination and the impact of racism	Positionality established and secondary researchers enlisted to reduce bias given the researcher’s experience in cross-cultural working.	10	High

Bailey & Tribe (2020)	To explore help-seeking views and strategies utilised in relation to depression among older Black Caribbean people in the UK.	8 participants, 4 male, 4 female. Aged 65-79 UK Black Caribbean. Snowballing Recruitment from lunch clubs and day centres	Individual semi-structured interviews	IPA Audio recorded and transcribed in line with Smith et al., (2009) protocols	Men feel that seeking help for depression is not considered manly / experience shame. Cultural beliefs and attitudes impact help-seeking. A reluctance to admit or discuss as associated with demonic influences or spiritual weaknesses. A mistrust or suspicion towards healthcare professionals lead to self-reliance	No discussion section -findings not discussed within the context of relevant literature. Questionnaire informed by pilot interview. No considerations of the researchers own position, to account for bias.	7	High
Cinnirella & Loewenthal (1999)	To map group differences in beliefs about mental illness and explore how religious beliefs/ practices impact beliefs of treatment	52 participants 7 Black, African & Afro-Caribbean Christian females Convenience and snowball techniques. Initial contacts through acquaintances	Individual semi-structured interviews Audio recorded and transcribed / translated	Thematic Analysis using grounded theory	Fear of being misunderstood by outgroup health professionals. Religion did have an impact on their choice of strategies for dealing with depression. Existing fear of community stigma associated with mental illness and seeking help.	Reflexivity positionality not explored. Ethical procedures are not stated. Data collection method appropriate for theme generation. Limitations thoroughly explored	7	High
Keating & Robertson (2004)	To identify service and community impediments	*48 participants African Caribbean Service users (n = 29)	*8 Focus Groups (Krueger, 1994).	A computer-assisted programme (WinMAX)	Being labelled mentally ill invoked fears about the future. Stigma attached to mental illness,	Reflexivity/ positionality not explored. Some speculative/assum	8	High

	to change and recommend solutions.	Carers (n = 19) recruited from “groups and settings”	Audio recorded and transcribed verbatim	for text analysis (Kuckartz 1998) then Miles & Huberman (1984) thematic categories from codes	delaying help-seeking. Presentations to services in serious states of crisis. More community-based services needed but these need adequate resources to reduce the need for statutory services.	ptive statements made based on stereotypes not arising directly from the data. Agreement of codes between 3 coders was 82%.		
Manatovani et al., (2016)	To explore the social production and practice of stigma among African-descended communities and the impact on help-seeking	26 participants African Caribbean (n = 14) and African (n = 12). Aged 24-75 years Recruited from different faith-based organisations	26 Individual semi-structured interviews. Audio recorded. Transcribed	Thematic Analysis	Community-level stigma and diverse conceptualisations of mental illness hindered help-seeking behaviour. Mental illness associated with danger. Silenced delayed engagement with mental health services. Internalised stigma meant a desire to maintain an idealised social identity	Reflexivity/ positionality not explored. Internal validity increased through credibility checks (Lincoln & Guba, 1985).	9	High
Mclean et al., (2003)	To detail perspectives of mental health and health services,	30 participants. Purposive sample African-Caribbean non-	Semi-structured interviews and 2 focus groups.	Unclear "grid coding method"	Social exclusion and racist mistreatment both at the cultural and institutional levels, plays a significant role in shaping community members'	Reflexivity/ positionality not explored. Ethical procedures not stated. Unclear data analysis	5	Moderate

	through which inequalities are experienced.	professional and professional From voluntary groups	Audio recorded and transcribed		perceptions of mental health services.	method. Data collection appropriate for theme generation.		
Robinson et al., (2011)	To provide a better understanding of black men’s beliefs and experiences with mental health, and experience of mental health services.	Purposive sample (n = not stated) * Black African & Afro-Caribbean participants aged between 18-25/ 26-55 Recruited from known contacts	12 focus groups. *2 focus groups stratified by age consisting of.	Thematic Analysis and NVivo qualitative data analysis software	Unique mental health perspectives due to intersectional experiences. Social stigma and coercive power of institutions affects BME men's willingness to access services. Developing trust and partnerships with community organisations	Reflexivity/ positionality not explored. The analysis used a ‘constant comparative method’ (Glaser and Strauss, 1967). Number of participants not stated.	7	High
Sancho & Larkin (2020)	To understand the helpful and unhelpful critical incidents Afro-Caribbean undergraduates in accessing mental health services through 'wish lists'.	17 participants aged 18-25 year Female (n = 10), males (n = 7). Participants lived in the UK for a minimum of five years recruited from a university campus	5 focus groups (3-4 participants per group)	Thematic analysis within Critical Incident Technique (CIT) framework. Audio recorded and transcribed	Structural changes were identified as the most desired. 15 barriers, eleven facilitators, and 5 wish-list items. Mental health literacy, social networks, cultural sensitivity, and concerns surrounding services were identified as key factors underlying many categories.	CIT is justified and deemed appropriate given the underpinning theory and aims of the study. credibility checks resulted in a 98 % agreement between the independent judge and researcher.	9	High
Sisley et al., (2011)	To explore African	7 participants. Purposive sample	7 individual semi-	IPA and Nvivo qualitative	Five themes capture sociocultural norms and	Reflexivity established.	10	High

	Caribbean women’s viwes and experiences of distress and help-seeking and access to mental health services	African Caribbean. 2 in 30's, 4 in 40's, 1 in 50's. Recruited from self-referral community wellbeing workshops	structured interviews Audio recorded and transcribed	data analysis software	expectations influenced beliefs about MH and coping. Feelings should be hidden. The wider UK population stigmatises depression. Statutory and voluntary sector services perceived as hidden	Internal reliability and validity checks completed. Respondent validation from participant giving feedback on findings.		
Tuffour (2023)	To provide an explanatory model of mental health challenges among Black Africans in England as well as a conceptual framework for that model	12 participants purposive sample First or second-generation Black Africans in England Recruitment service not clear	face-to-face Individual semi-structured interviews Audio recorded and transcribed verbatim	IPA	African-centred worldviews and cultural beliefs influenced understanding of mental ill-health. Attribution to supernatural causes show preferences for culturally specific explanations and. Need for culturally sensitive and inclusive practices to recognise/respect cultural diversity.	Positionality established and a reflective journal documenting initial thoughts and comments proved valuable. Very little participant demographic information provided which would have added more context.	10	High

* Extracted data

Thematic Synthesis

The analysis identified four group experiential themes and associated subthemes. Combined, they capture the prevalent experiences described across the data (Table 4). Some overlap between themes can be observed. Additional quotes can be found in Appendix G.

Table 4

Themes and Subthemes

Themes	Subthemes
Sense-making	Mental illness coherence
	Cultural divergence
Social Survival	Stigma and Internalisation
	Family intricacies
	Other responses
Pathways to Care	Self-sufficiency
	Formal systems
	Alternative support networks
Cultural Care Needs	Inclusivity
	Cultural humility

Sense Making

This superordinate theme captures the complex interplay between individual sense-making and socio-cultural meaning-making of psychological distress.

Mental Illness Coherence. Participants highlighted challenges in identifying signs of psychological distress and articulated gaps in understanding of what mental illness looks like (Allam & Binnie, 2023; Arday, 2021; sancho, Bailey & Tribe, 2020; Mclean et al., 2003).

> *"We have a lot of work to do in terms of understanding mental illness to be a real thing…'" (Arday, 2021, p.93).*

In some instances, mental health challenges were positioned to exist exclusively within other ethnic groups (Allam & Binnie, 2023; Sancho & Larkin, 2020).

> *"[…] a white person's disease (.) […] that's something that white people have to deal with, that's their experience it's not ours." (Allam & Binnie, 2023, p.5).*

Intergenerational differences were also highlighted, with older Black British generations considered less able to recognise mental health difficulties (Allam & Binnie, 2023; Arday, 2021; Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Robinson et al., 2011; Sancho & Larkin, 2020; Sisley et al., 2011).

> *"My mum never really understood why people get depressed…I don't know if she even knows exactly what mental health is" (Allam & Binnie, 202, p.6).*

Cultural Divergence. Participants revealed how African-derived worldviews, religious and spiritual identities can influence the construction of mental challenges. Some people attributed causes of mental illness to malevolent supernatural forces or moral failings as opposed to bio-psycho-social explanations (Bailey & Tribe, 2020; Mantovani et al., 2016; Sancho & Larkin, 2020; Tuffour, 2023).

> *Mental illness, as somebody who comes from Africa, we think it's a curse. We think you're possessed by the devil, but it's a mental health problem. We don't know that (Mantovani et al., 2016, p.376).*

> *"It's like oh it's all in your head or you must be possessed [...] pray it away" (Sancho & Larkin, 2020, p.71)*.

There was also strong sentiment that having a mental illness was synonymous with "insanity" or "madness" and carried strong negative connotations associated with dangerous, violent or out-of-control behaviour (Cinnirella & Loewenthal, 1999; Mantovani et al., 2016; Mclean et al., 2003; Sisley et al., 2011).

> *"Those of us from Black background and some of us who were brought up outside of this country, our perception of mental illness is somebody's totally derailed and is walking in the street probably naked. It's somebody who is just a psychiatric inefficient. That's our understanding of mental illness, and so if anybody tells you that you have a mental health issue you are ready to fight them for saying that. I mean... because we relate mental health to insanity, a total level of insanity" Mantovani et al., 2016, p.376).*

These embedded ideologies and explanations of mental health challenges, therefore, limited coherence, acceptance and empathy extended to its very existence (Allam & Binnie, 2023, Bailey & Tribe, 2020, Cinnirella & Loewenthal, 1999, Mantovani et al., 2016, Tuffour, 2023).

Social Survival

Within this theme, social survival strategies employed by participants within the context of marginalisation are explored. Participants revealed a lack of perceived permission from the community to be mentally unwell and detailed conscious efforts to avoid labels that could undermine vital relationships and compound disadvantage.

Stigma and Internalisation**.** Stigmatic attitudes resurfaced and presented as a barrier to distress recognition and disclosure. (Allam & Binnie, 2023; Arday, 2021; Bailey & Tribe, 2020; Cinnirella & Loewenthal, 199). It became rapidly apparent that community stigma of mental ill-health resulted in feeling rejected, ostracised, and isolated from their own social support networks **(**Keating & Robertson, 2004; Mantovani et al., 2016; Mclean et al., 2003; Robinson et al., 2011; Sancho & Larkin, 2020; Sisley et al., 2011).

> *"You are rejected by your own community, by your own environment. They will say that you're not useful any more. Stigma affects [people] individually in terms of denying things. I mean as a victim, there's feelings of being kind of being hurt, being ostracised, being isolated and there's also the case of not seeking appropriate help, not engaging with the services available to actually deal with something properly. The biggest damage is the person's attitude to themselves, in terms of what they're going through and also how that influences what they do to try and deal with their situation" (Mantovani et al., 2016 p.377).*

Consequentially, a strong tenet of reluctance to disclose difficulties due to fear of being labelled as 'weak', 'loopy' or a 'failure' was observed (Allam & Binnie, 2023; Mantovani et al., 2016; Robinson et al., 2011; Sisley et al., 2011).

Interestingly, Black British participants identified the risk of discrimination being higher for them, as they described how judgement of having a mental health difficulty contended with other intersecting layers of identity (Arday, 2021; Robinson et al., 2011; Sancho & Larkin, 2020; Sisley et al., 2011).

> *“Consistently fighting that against a feeling of not only judgment for my condition but my race… it’s exhausting and I am convinced it makes my disorder worse” (Arday, 2021, p.93).*

For Black British men specifically, additional racial characterisations were experienced because of dominant and hypermasculine discourses surrounding them (Arday, 2021; Sancho & Larkin, 2020).

> *“Usually if the black male has mental issues you just think he’s aggressive, he’s abusive, that’s his nature, that’s not anything to do with his mind or anything […] that stereotypical like oh this aggressive male” (Sancho & Larkin, 2020, p.71).*

Black British participants relayed that community stigma translated into prejudices, portraying those with mental health challenges as personal failures, as opposed to having a common health issue deserving compassion (Allam & Binnie, 2023; Arday, 2021; Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Keating & Robertson, 2004; Mantovani et al., 2016; Mclean et al., 2003; Robinson et al., 2011; Sancho & Larkin, 2020; Sisley et al., 2011).

Family Intricacies. Participant insights revealed how multifaceted stigma operates at an individual level, and through networks of care (Arday, 2021; Cinnirella & Loewenthal, 1999; Mantovani et al., 2016; Robinson et al., 2011; Sisley et al., 2011). For example, participants expressed the risk of their family's reputation being severely damaged through gossip, resulting in damaged marriage prospects and being avoided (Allam & Binnie, 2023; Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Robinson et al., 2011).

> *"The one thing Black people hate is for anybody to and out that there is any form of mental illness in their families. . .it's the old taboo subject—somebody's mentally ill in your family, as a Black family you just don't go shouting about it. . .what they try to do is shut that person away and deal with it by themselves as opposed to going through all the networks and being exposed" (Cinnirella & Loewenthal, 1999, p.519)*.

In some instances, participants described how the family unit privately offered support, while upholding 'acceptable' public appearances of wellness (Arday, 2021; Bailey & Tribe, 2020 Sisley et al., 2011).

> *"The family unit may know what's going on but to the outside world…we're absolutely fine" (Sisley et al., 2011, p.398)*

Evident was the duality between private recognition and public denial required to avoid further marginalisation in highly stigmatising environments (Allam & Binnie, 2023; Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Robinson et al., 2011). Conversely, understanding and empathy were also viewed to be limited within the family system and this felt isolating for some participants (Arday, 2021; Robinson et al., 2011).

Other Responses. Participants expressed a reluctance to accept the presence or severity of the problem. Mental illness was viewed as a "hard thing to accept" (Arday, 2021, p.90) and was linked with processes of denial across most of the studies (Allam & Binnie, 2023; Arday, 2021; Bailey & Tribe, 2020; Keating & Robertson, 2004; Mantovani et al., 2016; Mclean et al., 2003; Robinson et al., 2011; Sancho & Larkin, 2020; Sisley et al., 2011).

> *“We kind of try and bury it, it’s not happened to us. It’s a sense of denial that this has not happened, so, we deny it. We’re not open with it and we don’t want to talk about it” (Mantovani et al., 2016 p.378).*

> *“I don’t think I have this issue, or I don’t think I’m that serious enough to even go and ask for- need a service to help me or consult me through this” (Sancho & Larkin, 2020, p.67).*

A cultural hesitance to overtly "confess" to psychological challenges surfaced among participant experiences, with less familiarity in discussing internal experiences openly. For some people, self-dismissal and emotional suppression acted as a defence mechanism understood by them as an adaptive response to protect themselves against existing stigma within their community (Arday, 2021; Mclean et al., 2003; Robinson et al., 2011; Sisley et al., 2011).

> *“I find the Europeans they handle mental illness differently to us … they are very easy to tell you they depressed … I cannot remember actually hearing any or many from our culture that will actually be confessing they are depressed” (Bailey & Tribe, 2020, p.116).*

> *“They are also in denial of accepting that ‘my child is having mental health issues’. Instead of them addressing it, they would rather look at it from a different point of view” (Mantovani et al., 2016, p.377).*

Pathways to Care

This theme focuses on the various pathways to care that were described by participants in managing mental health difficulties, in keeping with the perception of mental health needs.

Self-Sufficiency. Participants expressed a preference of self-sufficiency over professional help when facing mental health challenges (Allam & Binnie, 2023; Bailey & Tribe, 2020; Robinson et al., 2011; Sisley et al., 2011).

> *"I never thought of going for help anywhere. I just thought, 'girl, get on with it'" (Bailey & Tribe, 2020, p.117).*

Explanations of self-reliance were grounded in historical enslavement and spoke to a cultural legacy that promotes a discourse of strength in the face of adversity. This was a prized cultural value within Black British narratives (Arday, 2021; Bailey & Tribe, 2020; Mantovani et al., 2016; Robinson et al., 2011; Sancho & Larkin, 2020; Sisley et al., 2011).

> *"Because generations before have dealt with racism and what is expected is a continuous show of strength, anything else, or any other emotion is perceived as weakness" (Arday, 2021, p.90).*

Formal Systems. Seeking formal help from statutory services was synonymous with further stigmatic processes, oppressive labels and diagnoses which greatly discouraged participants from accessing them (Keating & Robertson, 2004; Mantovani et al., 2016; Mclean et al., 2003; Robinson et al., 2011; Sancho & Larkin, 2020).

> *"Coming to mental health services was like the last straw … You come to services dis-empowered already, they strip you of your dignity … You become the dregs of society" (Keating & Robertson, 2004, p.442).*

Participants also expected to be misdiagnosed, given medication and not helped in the form of being listened to (Mclean et al., 2003; Robinson et al., 2011*;* Sancho & Larkin, 2020). There was a prominent fear of formal services disempowering them.

> *"I don't know, I really don't know how he would help me. They normally just give you tablets and tell you to go away anyway don't they?... to me that's no answer, I think you need someone to listen, you know?" (Cinnirella & Loewenthal, 1999, p.512).*

Generational distrust of healthcare professionals also prevented participants from wanting to access formal services (Allam & Binnie, 2023; Arday, 2021; Sancho & Larkin, 2020).

> *"If you've got family who are like Rastas especially with my family […] believing that they don't have- like yeah black people's especially interest at heart or even the people in general […] even if you yourself don't believe that maybe these big organisations are like out to get you […] if the family and the people you are going to for support are kind of a bit not trusting of the mental health service then the last thing you would do is go and trust them" (Sancho & Larkin, 2020, p.71).*

Participants were generally pessimistic about the chances of being understood with standardised procedures due to their inability to fully address ethnic, religious or socio-economic needs (Sisley et al., 2011; Tuffour, 2023).

> *“There is a one-glove fits all approach that does not acknowledge the type of psychological trauma inflicted by racism and the types of approaches that are required to make sense of those experiences and move forward, as they can be hugely debilitating and destabilising. This can be further exacerbated when engaging with a healthcare professional that has no understanding of these types of plights” Arday, 2021, p.92).*

Statutory care was therefore considered the “last option” once all alternative avenues had been exhausted (Sancho & Larkin, 2020; Tuffour, 2023).

Alternative Support Networks. Following concerns and fears of formal help-seeking, participants described their attempts to identify alternative sources of support to get help without engaging in mainstream services (Bailey & Tribe, 2020; Mantovani et al., 2016; Mclean et al., 2003; Sancho & Larkin, 2020).

In keeping with the influence of religion, faith and spirituality, some participants sought spiritual counsel and attended community or faith groups to improve mental health (Bailey & Tribe, 2020; Mantovani et al., 2016; Mclean et al., 2003; Robinson et al., 2011; Sancho & Larkin, 2020; Tuffour, 2023). Participants believed in prayer and its privacy, and this acted as a form of self-administered therapy and protection from community stigma.

> *“It’s almost as if you’ve given the problem to God and you no longer have to deal with it” (Cinnirella & Loewenthal, 1999, p.516).*

Interestingly, the same concern for confidentiality, combined with a need ‘to talk things through’ acted as stronger motivator for participants to attend the GP, despite previously stated concerns of formal services (Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Sisley et al., 2011).

> *“There tends to be a taboo about mental illness in Black families to start with so they wouldn’t be seeking help from friends, they would probably want to go to their GP and for the rule of confidentiality to apply all the way around (Cinnirella & Loewenthal, 1999, p.519).*

Participants often shared how they felt that more informal and local resources, such as third sector organisations felt more accessible but were not visible in in the community (Keating & Robertson, 2004; Mclean et al., 2003; Robinson et al., 2011; Sisley et al., 2011).

Cultural Care Needs

This theme encapsulates the interaction between culture and care needs. Participants expressed their needs and wishes for their mental health difficulties.

Inclusivity**.** There was a prominent readiness for accepting anti-stigmatic messages within Black British communities (Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999), however a lack of perceived representation in services hindered this process (Allam & Binnie, 2023; Arday, 2021; Mclean et al., 2003; Sancho & Larkin, 2020).

> *“We’ve seen like the influx of erm posters regarding mental health and depression and anxiety. And I think if they [...] tried to use more Afro-Caribbean men, women, dark skin men women and start to [...] use people that actually [...] look like us [...] in their sort of media representation [...] then they can maybe see it as this issue isn’t just a Caucasian thing” (Sancho & Larkin, 2020, p.24).*

Participants expressed a need to be able to safely engage in normalising and empowering discussion with professionals and be given the opportunity to expand their understanding of mental illness, be supported with ownership and tackle stigma (Allam & Binnie, 2023; Arday, 2021; Mclean et al., 2003; Robinson et al., 2011; Sancho & Larkin, 2020).

> *"Having a space to safely disclose these experiences was vital to my self-preservation and sense of not feeling ashamed" (Arday, 2021, p.92).*

> *"… [We need] some kind of campaign and communication mechanism to upgrade the thinking and the perceptions around mental illnesses and mental wellness is crucially important…" (Mclean et al., 2003, p.665)*

Integrating existing community-based services were also considered desirable and situated within the opinion that collaboration between statutory, voluntary and community groups could strengthen local networks of care (Bailey & Tribe, 2020; Mantovani et al., 2016; Mclean et al., 2003; Sisley et al., 2011). The pursuit for support amongst participants, however, were obstructed by socio-economic barriers and limited knowledge of what support services were available (Mclean et al., 2003; Sisley p.398).

> *"But access to those is dependent on money. You know, you can't access alternative therapies unless you've got the finances, and then you've got to remember that the sort of economic circumstances of a lot of African-Caribbean communities is disadvantaged. So, knowledge of the alternatives might be there, but access to them isn't" (Mclean et al., 2003, p.667).*

***Cultural Humility*.** There was a perception that mainstream services are not adequately equipped to understand issues affecting Black British groups, such as racism (Arday, 2021; Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Keating & Robertson, 2004). Participants reflected a need for greater cultural sensitivity among providers and desired for the layers of cultural realities to be acknowledged beyond race (Bailey & Tribe, 2020; Cinnirella & Loewenthal, 1999; Mantovani et al., 2016; Mclean et al., 2003).

> *"There's a reluctance to recognise that the African-Caribbean community has culture, is a community of culture rather than a community of race, and there's a reluctance to see that cultural community as being potentially supportive, of holding within at the seams" (Mclean et al., 2003, p.664).*

Such observations on the failure of mainstream services to recognise the cultural uniqueness of the Black British community revealed a demand for alternative therapies that recognise different knowledge systems as valid (Arday, 2021; Cinnirella & Loewenthal, 1999; Robinson et al., 2011; Sisley et al., 2011).

> *"There is a one-glove fits all approach that does not acknowledge the type of psychological trauma inflicted by racism and the types of approaches that are required to make sense of those experiences and move forward, as they can be hugely debilitating and destabilising" (Arday, 2021, p.92).*

Participants also noted poor diversification of healthcare professionals. Here, ethnic matching to the clinician was the dominant preference. The importance of which was evident as participants spoke of needing to feel understood and connected with those involved in their care. (Allam & Binnie, 2023; Arday, 2021; Bailey & Tribe, 2020; Cinnirella &; Loewenthal, 1999; Mclean et al., 2003; Sancho & Larkin, 2020).

> *"A woman who is not of colour is not going to understand what I need […] I need to find somebody who will understand where I'm coming from" (Allam & Binnie, 2023, p.5).*

Finally, participants also voiced a desire for increased advocacy as a direct response to misrepresentation within the healthcare systems, and as a solution to their fear of being misunderstood within formal services (Bailey & Tribe, 2020; Mclean et al., 2003; Robinson et al., 2011)

> *"I think the way the care system set up in England and Wales; within that, you should be able to find an advocate who can represent you because a lot of what's going on, we are misrepresented. I have very strong views of that; A lot of things are going on in our lives as black people in this country, we are misrepresented …" (Bailey & Tribe, 2020, p.117)*

Discussion

This review aimed to understand access to care in relation to perceptions of mental health needs among Black British adults in the UK. Thematic synthesis identified four themes: 'sense making', 'social survival', 'pathways to care', and 'cultural care needs'.

Cultural Conceptualisations

The participants provided important insights into the diverse cultural conceptualisations of mental health among Black British communities. Conceptual gaps were observed, whereby some participants noted limited awareness and understanding of what constitutes as mental illness according to clinical perspectives. This echoes previous literature for people of the Global Majority generally (Conneely et al., 2023; Linton et al., 2022).

While clinical frameworks may dominate clinical spaces, mental health challenges were understood and explained using alternative explanatory models rooted in spirituality, religion, and morality. This held ongoing meaning for Black British participants which is important to consider and echoes recent survey results showing 84% of Black British respondents to self-describe as being spiritual or religious (Lewsey, 2023). This may impact mental illness being considered a common health issue (Bhui et al., 2008). Furthermore, desires to access statutory services may be further hindered as it places the responsibility of having to explain alternative conceptualisations of mental challenges on the Black British individual (Kalathil et al., 2011).

Intergenerational differences were also observed. Older community members were suggested to dissociate from mental health problems (Dare et al., 2022) due to being socialised to prioritise self-reliance, strength and silence around vulnerability (Mills & Edwards, 2002). The supposition here being that younger Black British individuals may be navigating differences between their own understandings and those of older family members.

Identity and Resilience

Stigma and its consequences emerged as manifesting both through overt community attitudes and internalised prejudice. Specifically, the review highlighted how Black British history of enslavement, fostered a cultural legacy that promotes inner strength and self-reliance when facing challenges. The finding replicates broader literature (Mclean et al., 2003; Rabiee & Smith, 2013).

With ‘mental illness’ and help seeking being strongly associated with vulnerability and weakness across Global Majority groups (Burr & Chapman, 2004; Edge & Rogers, 2005; Fish & Fakoussa, 2018), comes a lack of perceived permission to identify with being mentally unwell (Kalathil et al., 2011). In this review, participants disclosed a tendency to “get on with it”, to which Abrams et al., (2014) suggests risks reinforcing stereotypes of being a “strong black woman/man” and normalises non-disclosure and self-management.

It has been suggested that living with constant threats to one's identity and reputation requires protective actions to withstand marginalisation (Edge & Rogers, 2005; Faulkner, 2014). It makes sense, then, that Black British participants described having to shield themselves and their families from stigma through discretion. Specifically, employing strategies of denial, silence and emotional suppression can act as means of self-preservation but can also hinder service engagement (Chtereva et al., 2017).

Emotional suppression has been linked with prolonged suffering and worse outcomes when needs escalate and are untreated (Barnett et al., 2019). Therefore, a paradoxical nature to self-reliance emerged with it being both a strategy to manage intersecting oppression (Donovan & West, 2014), and a strategy that could increase the risk of depression and reduces self-care (Romero, 2000). This may explain why Black British people are significantly more likely to be compulsorily admitted to hospital (Barnett et al., 2019).

For Black British men in this review, stereotypes around masculinity and aggression further compounded stigma experiences at the intersections of gender and race. Dominant discourses of hyper-masculinity can breed a reluctance to discuss or disclose mental health challenges (Burkett, 2017) and are important for services to consider (Seidler et al., 2016).

Equitable Partnerships

People within the Black British community positioned accessing care as a shared responsibility between the individual, the community, and the service. However, statutory services were frequently perceived as disempowering and untrustworthy. This conforms to previous findings that mental health services are unable to adequately support people from Global Majority groups (Durà-Vilà et al., 2011; Meechan et al., 2021; Olaniyan & Hayes, 2022).

To address this, Black British participants suggested cultural safety could be achieved through confidentiality, increased representation, and acknowledgement of social determinants of mental health challenges, such as racism. Interestingly, despite how experiences of marginalisation, microaggressions and racist discrimination contribute to psychological distress amongst marginalised groups (Kirkbride et al., 2024), they remain peripheral in therapy (Dos Santos & Dallos, 2011; Erskine, 2002). It is no surprise, then, that Black British participants clearly desired empowerment through conversation, advocacy, allyship and support to engage in anti-stigma and anti-discrimination conversations. Such experiences call for anti-oppressive and empowering frameworks, particularly for communities facing extensive ethnic and racial oppression (Bansal et al's., 2022).

Centring the expertise and lived experiences of Black British communities emerged as a fundamental priority among participants who desired equitable mental healthcare support. Incorporating Black British perspectives into Eurocentric mental health systems and creating space for Black British community members was inferred. Bhui et al., (2015) highlights a need for services to better connect with Global Majority frameworks for understanding distress. Complimenting this, Rathod et al., (2019) provides a strong argument for culturally tailoring psychotherapies to validate worldviews and improve outcomes for racially and ethnically diverse populations.

Family dynamics emerged as complex. This, combined with participants desire for practices to use whole-person and whole-system approaches, invites opinions on holistic methods of care. For example, Afuape et al's., (2022) invites the systemic community to support Global Majority families in transitioning them from silence and survival to flourishment and empowerment. Where accepted, the appreciation and collaboration of differing expertise may support anti-stigma discussions.

Alternative methods of accessing help and healing also emerged. The third sector was identified as a source of holistic and non-stigmatising support which may support Brown et al's., (2014) quantitative results demonstrating higher utilisation rates of informal services for mental-health difficulties amongst Black British participants. This is supported by a Bansal et al's., (2022) recent review who found community-based supports were perceived as more culturally attuned and able to provide the spiritual and emotional nourishment that is highly valued within Black British cultures. However, these services were hidden or inaccessible due to financial barriers and lack of awareness around available support.

The review suggests a need for stronger collaboration and partnerships between statutory services and existing community assets to ensure Black British people have access to appropriate mental health resources. Enclosed in this finding is that Black British people are being systematically excluded (Darko, 2023), which sits within momentum to dissolve the idea that Global Majority groups are simply ‘hard to reach’ (Anderson, 2020; Darko, 2021; Ekong et al., 2022).

Critique of Studies

Of the 11 eligible studies included for review, nine of them recruited from towns or cities within England. Two studies hint at recruitment across the UK more broadly (Arday, 2021; Bailey & Tribe, 2020), however, the studies lacked clarity regarding the geographical scope from which perspectives were gathered. This limits regional representation.

Further to this, where participants in studies did understand their challenges as depression and anxiety, little information was provided on the experienced severity. Therefore, the review was unable to infer how these factors may influence motivation, health literacy or desires for care. This likely acted a missed opportunity to gain further insight into Black British needs and perceptions regarding over-representation in involuntary services (Bansal et al., 2022).

A strength is observed, however, in how all the studies demonstrated clear statement of research aims and objectives, allowing for understanding of the purpose and focus of the work. Appropriate qualitative methodologies like interviews and thematic analysis were rigorously applied to address the research questions.

Concerningly, several studies lacked transparency around the ethical procedures followed. Given the nature of the sensitive topics explored, and the finding that Black British individuals can be reluctant to discuss mental health challenges, important questions are raised around how potentially vulnerable participants were protected.

Strengths and limitations

To begin, MeSH[8] terms were not included in the search strategy and considered a limitation of the review. This would have increased search specificity and enhanced reproducibility (Soto, 2020). Using both free-text and MeSH terms would have afforded search rigor and reduced the risk of overlooking potential eligible studies.

The author acknowledges the limitation of not including grey literature in the systematic review, in that it may introduce bias by only representing published studies (Paez, 2017). A further potential limitation can be found within only including papers published in English. Research has shown that studies with positive findings are more likely to be published in English-language journals, whereas publications containing negative or differing results may be published in local journals (Heres et al. 2004). However, as the main purpose of this review was to understand experiences of those navigating British healthcare systems specifically, the focus was placed on research conducted within the UK.

Despite having no date restrictions to the search, literature was only found from the last 24 years, with the earliest eligible review published in 1999 (Cinnirella & Loewenthal; 1999). This might reflect changes in digital databases indexing practices over time. Nevertheless, a 24-year timespan could be considered as relatively recent or less-recent

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[8] Medical Subject Headings (MeSH) terms are standardised keywords used for indexing and categorising articles on databases.

depending on the lens. The researcher made a conscious effort to interpret the applicability and relevance of all studies according to current clinical practice and contexts, as Patsopoulos & Loannidis (2009) advise.

Another strength of this review can be found in the targeted recruitment strategies most studies used to address the lack of access to formal services. To elaborate, most studies recruited from informal voluntary groups which produced valuable insights on the perspectives of Black British individuals on statutory services when they had not already been accessed.

Maintaining a reflexive diary throughout the review process facilitated ongoing introspection and documentation of potential influences arising from the researcher's position. However, Given the inherently interpretive nature of qualitative synthesis, it is possible that certain elements of participant perspectives resonated more strongly with the researcher. Despite conscientious reflexivity, this may be reflected in the analysis.

Future Research

The experiences of Black British populations in Scotland, Wales and Northern Ireland may differ based on demographic factors, regional policies/services, and cultural dynamics unique to each region. Therefore, research capturing Black British experiences across the nation is need.

This review also indicated that intersecting experiences of identity, such as age and gender, was important within mental health needs and care desires. This deserves further exploration.

Finally, the review highlighted the need for statutory mental health services to be more accessible and culturally appropriate for Black British communities. Future research could focus on the evaluation or development of culturally adapted evidence-based practices that can effectively and meaningfully support Black British individuals.

Implications for Clinical Practice

The key clinical implications arising from participants' health perceptions and desires for care among Black British communities include:

Cultural humility in practice. Clinicians can help address social and internalised stigma by normalising discussions about mental health in a way that respects cultural and spiritual beliefs (Williams et al., 2023). The review findings suggest a need for culturally sensitive assessments and formulations. With consent, inviting meaningful involvement from the individuals support system or community into therapy may also be beneficial (Afuape et al's., 2022).

It is also crucial for clinicians to engage in ongoing self-reflection about their own racial, cultural, and social identities and how these influence their practice (Gopal et al., 2021). Regular supervision can help increase awareness of gaps in knowledge (Curtis et al., 2019).

Services should aim to recruit more Black British staff at all levels, from peer support roles to leadership/management positions (Olaniyan & Hayes, 2022). This could help address feelings of being misunderstood or "othered" and increase advocacy and allyship. It is also crucial that clinicians work to normalise help-seeking within Black British communities through visible representation (Sancho & Larkin, 2020).

Providing culturally informed care. Dedicated and ongoing training should aim to develop understanding of the intersecting influences that shape Black British conceptions of mental health (Bignall et al., 2019). Training could help practitioners avoid making assumptions, recognise stigma surrounding diagnoses, and adapt customary approaches that have been found alienating. Improving cultural humility, safety, and competency should be enhanced by learning about indigenous concepts of distress, health seeking behaviours, influences of faith, family and community (Kovandžić et al., 2011).

Community partnerships. Developing respectful partnerships between services and community organisations could help address mistrust (Campbell et al., 2004) by allowing culturally anchored support and psychoeducation to be provided in familiar settings (Rabiee & Smith, 2013). This may also encourage earlier help-seeking for Black British individuals (Kovandžić et al., 2011). However, responding to accessibility barriers involves continuous evaluation of practical barriers, such as transport and fee structures (Memon et al., 2016).

***Strength and resilience*.** While acknowledging structural inequities, the clinician should recognise the remarkable resilience demonstrated by Black British and other Global Majority groups in navigating adversities like racism (Williams et al., 2023).

Practitioners should work with individuals to strengthen protective resources and address some of the unfavoured consequences of dominant discourses of strength (Romero, 2000). Adaptive cognitive reframing may be helpful for some Black British individuals, which is a technique that sensitively targets the internalisation of racism (Graham et al., 2013). For example, it could be used to explore narratives that link help-seeking with weakness. However, when reframing help-seeking as a strength, it is imperative that the emotions and behaviours borne from discrimination are explicitly acknowledged and validated (Williams et al., 2023). Failure to do so risks perpetuating harm (Sathar, 2022).

Finally, given the findings of this review indicating that Black British participants felt services were not able to adequately support them, services should implement feedback, anti-racism policies and frameworks with meaningful accountability. The PCREF (NHS England, 2023) promotes cultural safety and offers suggestions at the service level, such as gathering routine feedback from Global Majority clients and carers.

Based on the findings of this review, a list of potential questions clinicians can ask themselves when working with people from Black British communities are offered in Appendix H.

Conclusion

The present review aimed to explore perceptions of mental health needs and desires for care among Black British African and Caribbean adults in the UK. Participants revealed limited mental health coherence between to dominant Eurocentric medical explanations. This divergence influenced recognition, acceptance, and subsequent help-seeking decisions within Black British communities. Mental health challenges were positioned as a problem to be managed independently and privately. These were considered adaptive responses to intersecting layers of perceived disadvantage and community stigma, maintained by discourses of historic resilience and strength. Where help was desired, informal systems were preferred, in keeping with participant views that statutory mental health services are culturally ill-equipped to provide relevant, meaningful, and sensitive support. This highlighted another desire for improved cultural competence whereby Black British individuals and advocates are involved in the development of equitable and responsive mental healthcare. Improved collaboration between statutory, voluntary and community services was desired, for services to able to offer, or at least signpost to support that acknowledges their perspectives, preferences, and abilities. This review addresses gaps in the existing literature by providing a comprehensive understanding of how mental health is constructed, responded to, and reflected within the Black British community.

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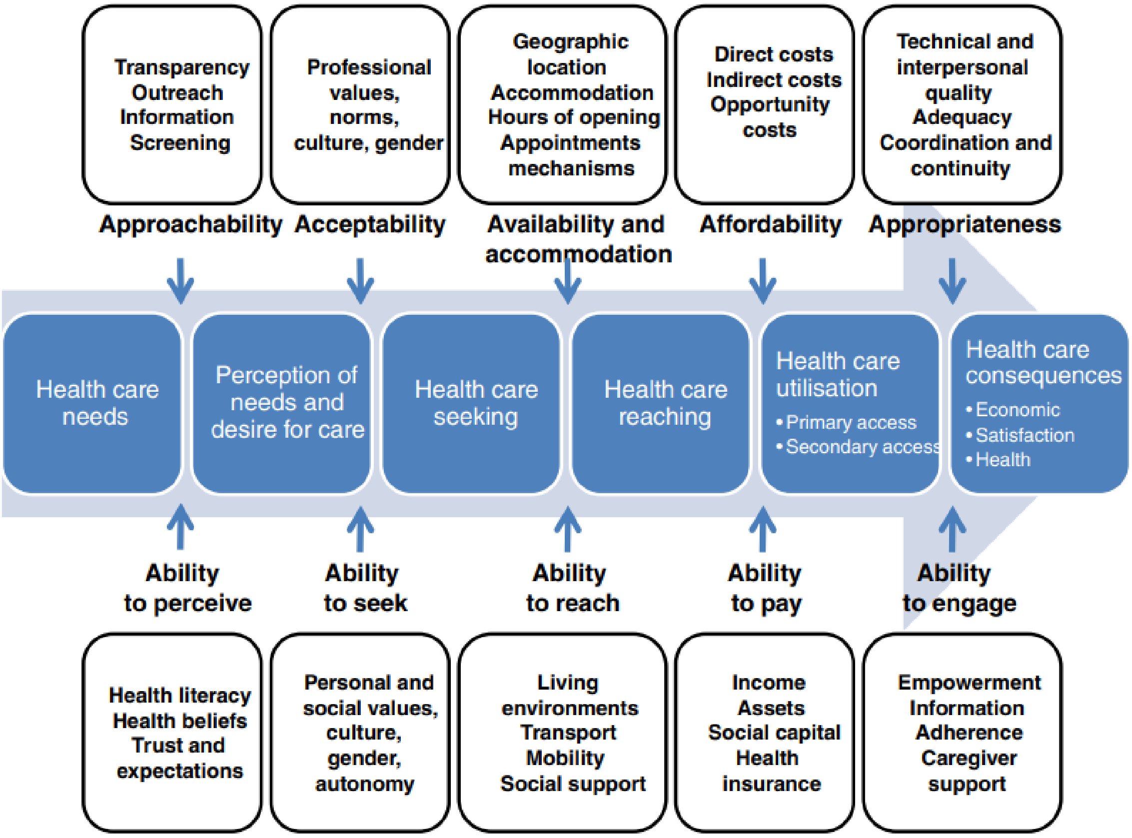
Appendix A

Levesque et al., (2013) Conceptual Framework of Access to Healthcare



Appendix B

Spider Tool for Qualitative Evidence Synthesis (Cooke et al., 2012)

SPIDER Tool		
S	Sample	Black British African, Black British Caribbean, or Black mixed adults aged 18+
PI	Phenomenon of Interest	Constructions of mental health, perception of needs, and desires for care
D	Design	Qualitative data: Interviews, focus groups
E	Evaluation	Opinions, thoughts, feelings, attitudes, perceptions, ideas, views
R	Research Type	Inductive “bottom up” qualitative studies: Thematic Analysis, Interpretive Phenomenological Analysis, Critical Incident Theory, Grounded theory, Discourse analysis

Appendix C

Reflective Journal Excerpts

- I feel tension. Why? I think the part about how the clinician is positioned was interesting. I am particularly drawn to this because I too recognise the inherent power that comes with being a clinician, and yet, how this is negotiated through other features of my identity. As a Brown trainee, I'm aware of my belonging to an often stigmatised and under-represented racial group, however, do I not work in these services that people from my community are working so hard to avoid?

- I am not a very religious person and I need to hold this in mind as it's coming up a lot in the papers. I can't help but wonder how must it feel for these people to feel like the only way they can talk about this problem is through silent prayer?

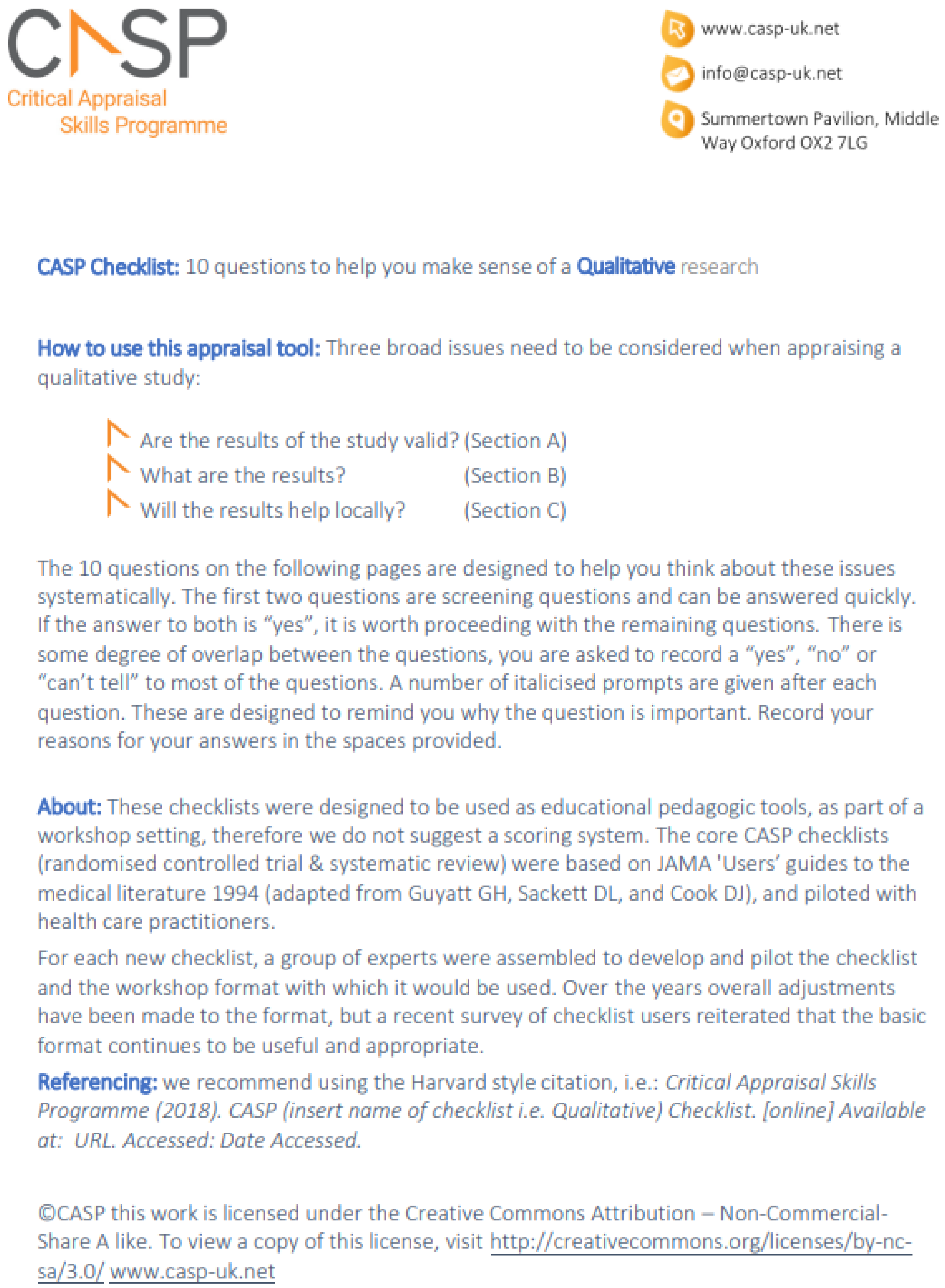
- This one was a particularly tough read and hits a bit too close to home. I already know I'm going to have to re-read it a few times. I have witnessed *and* experienced this first hand. How do I sit with this discomfort and what does it mean for the way I report this? – one for supervision.

- I think it will be helpful to ask Vyv what he thinks the participant meant when they said, "we don't want to be associated with weakness...so, if one is 'weak' then there's something wrong with you, and if there's something wrong with you then somehow you are less than". I'm noticing some assumptions based on my own experiences with this mentality. This to me feels like there's not a lot of room to be weak in this society. When I think about this it forms a picture about the participant not meeting desired standards set – or valued - by others, but particularly white people. But then this could also relate to a standard set in the community? Or by themselves?

- I'm struck by how in recent literature the same sentiments about distrust in services and racist practice is still as relevant as it was in the older papers. I am also reminded of how services can be diverse and still not inclusive. A powerful sentiment that drives my commitment to being an anti-racist practitioner and advocate. However, I must continually examine my own biases and blind spots. I fully appreciate the diversity across black Afro-Caribbean communities. As the participants said, I must listen, validate and normalise their experience as an individual. One size does not fit all. I should do more research into culturally adaptive models and make myself more aware of local community organisations.

Appendix D

Critical Appraisal Skills Programme (CASP) Tool (CASP; 2018)



CASP
Critical Appraisal
Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle
Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can’t Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix E

CASP Results

Author (year)	Clear statement of aims	Qualitative methodology	Research design	Recruitment strategy	Data Collection	Relationship between researcher and data	Ethics	Rigorous data analysis	Clear statement of findings	How valuable is the research?	Quality Rating
Allam & Binnie (2023)	yes	yes	yes	yes	yes	yes	yes	yes	yes	The research adds understanding on the influence of cultural heritage and family contexts on stigmatic attitudes, distress recognition and disclosure within the black community. It identifies the need for future research on inter-generational attitudes and culture-specific conceptualisations of mental health, while emphasizing the importance of	High

									culturally sensitive approaches in mental health services.	
Arday (2021)	Yes	yes	yes	yes	yes	yes	yes	yes	The research addresses the inequities and racism experienced by professionals and academic staff in higher education. The study also highlights the need for targeted psychological interventions to better support ethnic minorities in conceptualising and dealing with their racialised experiences, raising awareness of mental health issues, reducing stigma, and developing cultural sensitivity within mental health services.	High
Bailey & Tribe (2020)	yes	yes	yes	yes	yes	no	no	yes	no	The research addresses a significant gap in the literature and acknowledges that help-seeking	High

										patterns among people of Black Caribbean origin are not well-known, particularly in relation to mental health issues. The research highlights the influence of migration, racism, and discrimination on the mental health of Black Caribbean older adults.	
Cinnirella & Loewenthal (1999)	yes	yes	yes	yes	yes	no	no	unclear	yes	The research provides useful insights into the lay beliefs about mental illness held by groups. Identifying how the influence of social expectations about gender, combined with racialisation and social factors could contribute to a negative cycle of disempowerment and stalled recovery. Evidence-based recommendations are made,	High

										including creating environments of trust and breaking the cycle, with regard to services engaging with the formative influences of masculinities and ethnicities.	
Keating & Robertson (2004)	Yes	yes	yes	yes	yes	no	yes	unclear	yes	The research identifies several areas where further investigation is necessary. It highlights the need to explore ways to improve the relationship between black communities and MH services. The research contributes to understanding the barriers and dynamics in this specific context.	High
Manatovani et al., (2016)	yes	yes	yes	yes	yes	no	yes	yes	yes	The researchers highlight the role of stigma as a barrier to accessing mental health care and addresses the relationship between stigma, help-	High

									seeking, and diversity within African-descended communities in the UK. populations. The intersections of stigma, faith, and mental illness are examined providing insights into experiences and preferences of individuals. The findings are discussed in relation to current practice and the need for culturally sensitive services. New areas where research is necessary offered, such as exploring the perspectives of stigmatised individuals and individuals outside of faith-based organisations.	
Mclean et al., (2003)	Yes	yes	Unclear	Unclear	yes	no	no	no	yes	The researchers contribute to existing knowledge by confirming observations in the literature	Moderate

										regarding social exclusion and its impact on African-Caribbean community members' perceptions of mental health services. The research does not explicitly mention new areas for research, it suggests the need for further investigation into the experiences of social exclusion. The researchers acknowledge the importance of addressing local perceptions of services.	
Robinson et al., (2011)	yes	yes	yes	Unclear	unclear	no	Yes	yes	yes	The research explores the social underpinnings of the views of BME men about their well-being. This highlights the influence of gender and culture on social, relational and normative aspects.	High

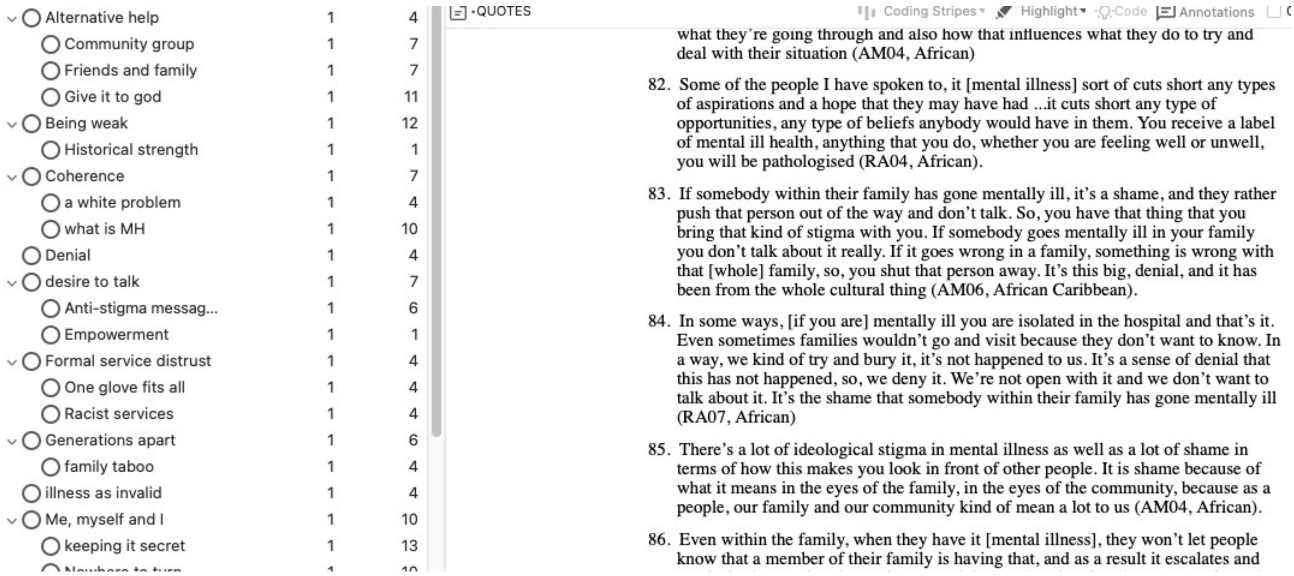
Sancho & Larkin (2020)	yes	yes	yes	yes	yes	no	yes	yes	yes	The research findings provide a new perspective on barriers reported in previous literature. Structural changes to services were most desired.	High
Sisley et al., (2011)	yes	yes	yes	yes	yes	yes	yes	yes	yes	The research makes valuable contributions to existing knowledge and understanding and highlights cultural contexts and specific experiences of African Caribbean women regarding mental health. It explores how societal expectations, gender roles, and cultural beliefs influence their conceptualisations of distress and coping strategies. The research identifies barriers and facilitators to help-seeking and the need for mental health services that	High

										are culturally sensitive, accessible, and provide a range of options	
Tuffour (2023)	yes	yes	yes	yes	yes	yes	yes	yes	yes	The research sheds light on the complexities of migration, African-centred worldviews, and negative life experiences as factors influencing mental health challenges. The findings of this research align with existing literature, and strengthens the validity and reliability of the study's conclusions. The identification of culturally driven explanatory models and their impact on help-seeking behaviours adds to knowledge of how cultural factors influence mental health perceptions and treatment-seeking preferences.	High

Note. Scoring strategy: ‘No’ = 0; ‘can’t tell’ = 0; ‘yes’ = 1. Quality range: <3 poor quality; 4-6, moderate quality, >7, high quality

Appendix F

Theme Development



Alternative help	1	4
Community group	1	7
Friends and family	1	7
Give it to god	1	11
Being weak	1	12
Historical strength	1	1
Coherence	1	7
a white problem	1	4
what is MH	1	10
Denial	1	4
desire to talk	1	7
Anti-stigma messag...	1	6
Empowerment	1	1
Formal service distrust	1	4
One glove fits all	1	4
Racist services	1	4
Generations apart	1	6
family taboo	1	4
illness as invalid	1	4
Me, myself and I	1	10
keeping it secret	1	13
Nowhere to turn	1	10

what they're going through and also how that influences what they do to try and deal with their situation (AM04, African)

82. Some of the people I have spoken to, it [mental illness] sort of cuts short any types of aspirations and a hope that they may have had ...it cuts short any type of opportunities, any type of beliefs anybody would have in them. You receive a label of mental ill health, anything that you do, whether you are feeling well or unwell, you will be pathologised (RA04, African).

83. If somebody within their family has gone mentally ill, it's a shame, and they rather push that person out of the way and don't talk. So, you have that thing that you bring that kind of stigma with you. If somebody goes mentally ill in your family you don't talk about it really. If it goes wrong in a family, something is wrong with that [whole] family, so, you shut that person away. It's this big, denial, and it has been from the whole cultural thing (AM06, African Caribbean).

84. In some ways, [if you are] mentally ill you are isolated in the hospital and that's it. Even sometimes families wouldn't go and visit because they don't want to know. In a way, we kind of try and bury it, it's not happened to us. It's a sense of denial that this has not happened, so, we deny it. We're not open with it and we don't want to talk about it. It's the shame that somebody within their family has gone mentally ill (RA07, African)

85. There's a lot of ideological stigma in mental illness as well as a lot of shame in terms of how this makes you look in front of other people. It is shame because of what it means in the eyes of the family, in the eyes of the community, because as a people, our family and our community kind of mean a lot to us (AM04, African).

86. Even within the family, when they have it [mental illness], they won't let people know that a member of their family is having that, and as a result it escalates and

Appendix G

Additional Extracts from Studies

Sense-making

Mental illness coherence

"African-Caribbeans are not recognising the more low-level symptoms of stress and anxiety as mental ill-health in themselves… Some people don't believe that you could be stressed and don't believe that as a mental illness" (Mclean et al., 2003, p.665).

"The older generation wouldn't even contemplate going to see a counsellor" (Sisley et al., 2011, p.398).

"I think a lot of people don't realise that they need help … some of them think oh pull yourself together… they don't know maybe I've been down for the last 2 months and probably need to go and get help" (Bailey & Tribe, 2020, p.115).

Cultural divergence

"*Probably because I'm black they think I'm mad" (Mclean et al., 2003 p.664).*

"let us bind and get rid of that spirit (laughs) … you know no Christian has any right with being depressed so you make such a big thing about it … cause I remember having friends who was

		depressed but they wouldn't tell … as this other person approached she said … shh" (Bailey & Tribe, 2020, p.116). *"I just say that maybe it's just abuse because they rape me through the witch … through the evil … they try to kill me, they try to rape me … it's not physical rape but I do feel it … I feel that something is going on … I asked them 'why are you doing this to me?' they said that they wanted to kill me … I said, 'why do you want to kill me?' they said 'nothing. We just want to kill you'." Tuffour, 2023, p.379)*
Social Survival	***Stigma and Internalisation***	
		"It's a survival of the fittest thing because the environment has certain standards and certain ways of living up to that. Everyone wants to get to a certain place" (Robinson et al., 2011, p.87). *"The moment you are diagnosed with something […] it puts you into a box and it gives you a label and sometimes you're almost characterised by that label and that's not something that a lot of Afro-Caribbeans would want to have or personally I would not want to have that" (Sancho & Larkin, 2020, p.7).* *"Your needs as a Black male regarding mental health can never be separated from the negative, hyper-masculinity chamber society puts us (Black men) in… how are you supposed to be vulnerable within that toxic context and present symptoms of mental illness*

> *when you are framed in that way…? It's a vicious cycle…" (Arday, 2021, p.9)*

> *"The fact that mental illness in these communities is kept 'as a secret and people will not even go to the doctor" (Mantovani et al., 2016, p378)*

> *'It's a survival of the fittest thing because the environment has certain standards and certain ways of living up to that. Everyone wants to get to a certain place (Robinson et al., 2011, p.87)*

Family intricacies

> *I have to be very guarded and quite protective […] that's a conversation I can't have with my family. Arday, 2021, p.7)*

> *There tends to be a taboo about mental illness in Black families to start with so they wouldn't be seeking help from friends, they would probably want to go to their GP and for the rule of confidentiality to apply all the way around. The one thing Black people hate is for anybody to and out that there is any form of mental illness in their families. . .it's the old taboo subject—somebody's mentally ill in your family, as a Black family you just don't go shouting about it. . .what they try to do is shut that person away and deal with it by themselves as opposed to going*

through all the networks and being exposed (Mantovani et al., 2016, p.379)

I remember when I went to see someone and his family was around him and I was speaking with him and the family was saying: ‘Could you please help him because we don’t have this in our family? He needs to pull himself together. He needs to sort himself out. (Mantovani et al., 2016, p.379).

Other responses

“I was in denial, erm, […] it’s one thing about looking at yourself and thinking, actually I need to seek help” (Allam & Binnie, 2023. P.5)

“[...] that sense of stubbornness towards okay well what’s the point of me going to the university mental health service when you know I don’t think I have this issue, or I don’t think I’m that serious enough to even go and ask for- need a service to help me or consult me through this” Sancho & Larkin, 2020, p.67).

Pathways to Care **Self-sufficiency**

“My Dad said last year ‘‘Stop being a girl. Stop crying.’’ So I haven’t cried. I just get on with it and I still get on with it.’ (Robinson et al., 2011, p.87).

> *Get on with things…and if you don't you're…failing as a woman or a mother or a wife (Sisley et al., 2011, p.398).*

> *But for me, I never thought of going for help anywhere. I just thought, 'girl, get on with it (Bailey & Tribe, 2020, p.117).*

Formal systems

> *"You receive a label of mental ill health, anything that you do, whether you are feeling well or unwell, you will be pathologised" (Mantovani et al., 2016, p.377)*

> *"A lot of people don't actually get help. They either get arrested or they get sectioned. That's obviously where the condition has escalated." (Robinson et al., 2011, p.88).*

> *"Coming to mental health services was like the last straw … You come to services dis-empowered already, they strip you of your dignity … You become the dregs of society …" (Keating & Robertson, 2004, p.442)*

Alternative support networks

> *"You have to decide and set aside … shame or embarrassment first of all to go and seek help" (Bailey & Tribe, 2020, p.116).*

'If it was not for a weekly group we have at my institution which has become a community and a… hub of sorts for BME staff… I think I might have had a breakdown of sorts" (Arday, 2021, p.91)

Cultural Care Needs ***Inclusivity***

"…We should break down that barrier of being shy to talk about it [...] so maybe just more events where people just speak about it [...] so making it more normal and erm breaking down the stigma really" (Sancho & Larkin, 2020, p.76)

"I had to search for hidden services because health professionals failed to provide information about a local black Caribbean and African service"' (Sisley et al., 2011, p.398).

know what's really killing us? We're economically shagged. You can't go nowhere, you can't get nowhere. That's what it is. All these things will just keep escalating. It can't change. We cannot get no better, and that's what's happening. Any area where you see there is high levels of unemployment, you're going to find high levels of mental health problems. It's because these people are suffering major frustration. They can't go nowhere, they can't see nothing. They can't see the wood for the trees because there is no way for themto get out of their situation (Mclean et al., 2003 p.665).

Cultural humility

> *“Talking on a one-to-one with people as a Black person I find it very difficult because I can’t really, they can’t relate to some of the things that are going on in my head, and I can see that they can’t and that frustrates me. If I was sitting and talking to a Black person every now and then I’d break into a little piece of patois and I know she can understand me.” (Cinnirella &; Loewenthal, 1999, p.513).*

> *the actual staff that manage these services and so on have to be culturally aware and not have their hangups. A lot of them come in with their baggage and they’re not leaving it at the door. They practise it every day. They see—if there’s a mental health patient who is big, a big black man, six foot two, somehow, they are afraid of him more than a six foot, seven foot, white man (Mclean et al., 2003 p.664).*

Appendix H

Questions for Practitioners

- How can I gain a deeper understanding of the cultural values, beliefs, and experiences of the individual/community? Is there someone I can consult?
- What biases or assumptions do I hold about Black African and Caribbean and mixed heritage people?
- Are traditional or faith-based healing practices meaningful for this person? How can I respectfully involve trusted community supports or incorporate cultural practices into treatment?
- What barriers has this person had to overcome to attend the service? (Historical trauma, family narratives of mental health, poverty, community stigma, etc)? How can I address these sensitively?
- Have I considered how attributes like gender, age, spirituality, sexuality, ability, and other intersecting identities shape their concept of mental health and needs?
- What steps have I taken to make services accessible in terms of location, operating hours, language/translation and cultural sensitivity?
- How do mainstream diagnostic tools and theories need adapting to appropriately assess cultural presentations of distress?
- Am I aware of and established rapport with community organisations to stay informed? Can I make appropriate referrals to known community groups when needed?
- How will I continuously evaluate whether my approach is meeting this person culturally and work to eliminate disparities in care?

Section Two: Research Report

A Qualitative Study Exploring Black British African and Caribbean Experiences of Self-Harm and Accessing Support within Third-Sector Organisations in England.

Abstract

Objectives

It is important to understand the underrepresented experiences of self-harm and accessing support among Black British African and Caribbean individuals. This study aimed to Black British individuals' thoughts, feelings, and experiences of self-harm, and to understand their lived experience of seeking, or not seeking, community-based support.

Design and Method

Purposive sampling was utilised to identify Black British people that self-harm and have either accessed community-based services or never sought support. Six people took part in semi-structured interviews. Interpretative Phenomenological Analysis was used to analyse the data.

Results

Three group experiential themes emerged from the data: 'complexities of self-harm', 'navigating expectations' and 'promoting equity'. Self-harm manifested in diverse ways and was something participants had a complex relationship with. Participants concealed self-harm to protect against stigma and to uphold valued cultural norms of strength and success. Community-based services were a preferred means of support but noted unaddressed hardships and a need for more culturally sensitive support.

Conclusion

Findings highlight the need for community-based services to develop equity-focused resources to achieve more culturally responsive care. Key findings, limitations and implications are discussed in relation to existing theory and suggestions for future research are made.

Practitioner Points

- Practitioners should be aware that self-harm extends beyond current stereotypical understandings. A broader view of self-harm must be taken to ensure individuals receive appropriate support.
- Services should consider, and sensitively address, the social, cultural and economic contexts in which self-harm is occurring for Black British service users to address potential barriers to care.
- Practitioners must build trust with Black British service users and appreciate that influences of fear of being misunderstood and judged in services.
- Services should seek to reduce stigma and improve access through community outreach programmes that build relationships with other organisations attended by those in need, such as faith-based organisations.

Keywords: Black British African and Caribbean, self-harm, third sector, interpretative phenomenological analysis, qualitative.

Introduction

Self-harm is a widespread public health concern (Mughal et al., 2023) defined by the National Institute for Health and Care Excellence (NICE) as “intentional self-poisoning or injury, irrespective of the apparent purpose” (NICE, 2022, p. 6). While over 73,000 people received emergency care in England for intentional self-harm in 2023 alone (Office for Health Improvement and Disparities, 2024) extant literature suggests that many incidents of self-harm are under-reported, and undetected (Geulayov et al., 2018; McManus et al., 2019).

Self-harming behaviours according to race[9] and ethnicity have been infrequently explored. That said, robust research has shown disproportionately elevated rates of self-harm among Black British African and Caribbean women compared to their counterparts from other ethnic and racial backgrounds (Al-Sharifi et al’s., 2015; Cooper et al., 2010). These findings may, in part, be attributed to the lived experiences of racism and marginalisation (Chakraborty et al., 2009), as well as the compounding effects of socioeconomic inequalities, such as poverty (Bamford et al., 2020; Mangalore & Knapp, 2011). Importantly, these disparities in self-harming behaviours align with the well-documented high prevalence of mental health challenges, including depression, within Black British populations (Bignall et al., 2019; Halvorsrud et al., 2019).

Yet, despite the disproportionately higher rates of self-harm and mental health challenges, Black British individuals remain underrepresented in primary care services and talking therapies

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[9] The author recognises that concepts of ‘race’ and ‘ethnicity’ are social constructs (Wijekoon & Peter, 2022). However, acknowledging how they shape lived experience is crucial for this study when considering the diversity within Black British communities. In keeping with the Journal Article of Reporting Standards for Race, Ethnicity and Culture ([JARS-REC] American Psychological Association, 2023a), these concepts are employed, yet defined, to avoid amalgamation and reflect intragroup differences. Thus, ‘Race’ refers to groupings based on physical characteristics, such as skin colour. ‘Ethnicity’ refers to a shared cultural identity through factors such as heritage, language, and beliefs (American Psychological Association, 2023).

(Morris et al., 2020). Hence, questions arise in relation to Black British individual experiences of help-seeking.

Some deterrents of accessing support have been identified in the literature and include fears of encountering racism and a perceived lack of cultural understanding within mainstream service providers (Keating & Robertson, 2002). In response to deterrents of accessing formal health support, many Black British individuals have expressed a preference for community-based support networks (Sisley et al., 2011), more formally known as the third sector[10].

Community-based organisations show promise in acting as a more trusted and culturally appropriate support alternative (Baskin et al., 2021). Consequently, attention is shifting to the role of community-based support and its ability to provide effective care for self-harm (Hulin et al., 2024). Studies indicate that community-based organisations have successfully addressed social isolation (Calò et al., 2021), and improved depression (Afuwape et al., 2010) for people within the Global Majority[11]. However, there are still knowledge gaps in understanding barriers to accessing community-based organisations, or what resources are needed to support Black British individuals that self-harm.

Self-harm appears to hold intricate and personal meanings that vary for those who engage in it (Lloyd-Richardson et al., 2007; Scoliers et al., 2008; Simopoulou & Chandler, 2020). It is no surprise, then, that exploration into the subjective experience of self-harm has uncovered complex psychological functions (Edmondson, 2013; Sutton, 2007).

One commonly reported function of self-harm is affect regulation (Kuehn et al., 2022; McKenzie & Gross, 2014). To elaborate, this is where self-harm serves to manage negative emotional

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[10] The ‘third sector’ is an umbrella term used to refer to value-driven, non-governmental and non-profit groups that work at the community-level to serve societal needs. Examples include charities, volunteer groups and social enterprises (National Audit Office, 2023). For this review, the term ‘community-based support’ is employed throughout to illustrate the level in which these organisations exist.

[11] The term ‘People of the Global Majority’ reflects how “minority” populations constitute the majority of the world’s population.

and cognitive intrapersonal experiences (O'Shea et al., 2019). From this perspective, self-harm can act as a means to cope with emotions, such as sadness or anger, that feel intolerably overwhelming for the individual (Tofthagen et al., 2021).

Psychoanalytic theories also offer insightful perspectives on the communicative functions of self-harm. One view, as presented by Favazza (1998), is that scars can express distress that is are challenging to articulate. This theoretical perspective closely relates to the supposition that self-inflicted pain can validate, and demonstrate, private psychological suffering through making the invisible, visible (Warm et al., 2003). Additionally, Edmondson et al's., (2016) systematic review revealed that participants' experiences of self-harm were positive and pleasurable, further demonstrating its complexity.

Another theoretical context relevant to why some Black British individuals may choose to not access mental health support is the concept of 'discourse of strength' (Beauboeuf-Lafontant, 2008). This idea sheds light on how culturally reinforced expectations of self-efficacy and resilience may discourage vulnerability. Such discourses are suggested to be rooted in the historical oppression of slavery, whereby Black African and Caribbean people were forced to develop survival mechanisms to withstand hardships beyond what is considered "normal" (Watson-Singleton, 2017). Over generations, cultural expectations of strength in the face of adversity may have become internalised in concepts prevalent today, such as the "strong black woman" (Parks & Hayman, 2024). Lending empirical support, Edge's (2007) study revealed how psychological wellbeing was maintained by Black Caribbean women navigating perinatal depression though a strong internal locus of control.

Research exploring self-harm within Global Majority communities more broadly primarily captures experiences within child and adolescent populations (Burgess et al., 2022; Farooq et al., 2021; Rehman et al., 2020). Furthermore, access is traditionally examined from the point of entrance to formal services (Memon et al., 2016; Rabiee & Smith, 2014). However, access has been conceptualised as a process beginning long before the point of entry (Levesque et al., 2013). There is extremely limited literature capturing the voices of adults who self-harm and have never sought formal or informal support. The present study, therefore, recognises a need to understand these experiences to gain a more holistic understanding of the barriers and facilitators to help-seeking.

Research Aims:

Evidently, greater insight is required into how Black British individuals, who engage in self-harm access and utilise community-based support services. While extant literature has provided quantified rates of the prevalence of self-harm in Black British communities (Cooper et al.., 2010), qualitative research is needed to explore the lived experience in these communities. This is crucial for developing responsive, equitable and culturally competent services that can appropriately address mental health needs and self-harming behaviours.

The study aims to address the gaps in the literature by exploring Black British individual's thoughts, feelings and experiences of self-harm, and to understand their lived experience of seeking, or not seeking, community-based support. To the best of the author's knowledge, this is the first study that aims to capture the voices of Black British individuals and their experiences of self-harm.

Research questions:

The aims of this study have resulted in three main research questions:

- How is self-harm experienced by individuals within the Black British ethnic group?
- How are ideas of self-harm constructed and viewed by individuals within the Black British ethnic group?
- What are the barriers and facilitators for accessing community-based support for self-harm within the Black British communities?

Method

Epistemological Framework

The author sits within the perspective that conditions and attitudes exist independent of an individual's understanding, while maintaining that knowledge and interpretation of these conditions are subjective and negotiated through social interaction (Gray, 2018). Compatible with this view is the epistemological position of critical realism (Bentall, 1999). Within the assumption that knowledge is local and context-dependent, critical realism reflects a phenomenological approach seeking to understand the lived experiences (Madill et al., 2000), and has the capacity to translate into person-centred approaches within clinical psychology (Hauser, 2023). It is therefore the chosen framework for this study.

Design

This study is grounded in the perspective that individuals ascribe unique and personal meanings to their lived experiences. One methodology concerned with generating an in-depth understanding of a person's lived experience, as well as the meaning they attach to it, is Interpretative Phenomenological Analysis (IPA).

Philosophically, IPA is situated between understanding subjective human experience, or phenomenology (Husserl, 1927) and the interpretation of text, otherwise known as hermeneutics (Heidegger, 1962). Within this, the researcher generates insights that exceed explicit declarations made by the participant. This process is referred to as 'double hermeneutics' (Smith & Osborn, 2003). To elaborate, IPA expects the interpretive process to occur at two levels. At the participant level, the participant makes sense of, and interprets their experiences within the research process. Meanwhile and thereafter, the researcher attempts to make sense of participant truths which acts as another level of interpretation. Thus, the researcher co-constructs meanings through empathetic and reflective enquiry, demonstrating the dynamic and interactive nature of IPA (Smith at al., 2009).

It should be noted that IPA does not aim to make broad generalisations. However, with caution, researchers seek to examine commonalities or differences within participants' narratives to identify patterns in how meaning is constructed (Smith at al., 2009).

Defending the application of IPA to the present study, then, lies within IPA's strong emphasis on individual experience. This allows for a deep exploration how discourses influence, and are influenced by, intrapersonal and inter-group dynamics. Its capacity to empower marginalised voices (Orbe, 2000) places IPA as an appropriate option for answering the research questions.

It could be argued that other qualitative methods, such as grounded theory (Glaser & Strauss, 1967) or thematic analysis (Braun & Clarke, 2006) could have been appropriate for interpreting the data, however, the author is less interested in what phenomena "looks like" and more interested in what it "feels like" for the participants. IPA was preferred because of its unique grounding in phenomenology and hermeneutic theory, which lends sensitivity to meaning-construction and the preservation of personal interpretations (Smith at al., 2009).

Reflexivity

Within IPA's theoretical stance that meaning is co-constructed between the researcher and participant, the researcher is situated as an active agent in the interpretation and construction of knowledge (Smith et al., 2009). It is important, therefore, for the researcher to engage in a process of reflexivity to understand how their worldviews, biases and assumptions may influence their interpretation of the data (Yip, 2023). This neutralising process allows for participant meaning to emerge authentically, as opposed to being viewed through a predetermined lens (Olmos-Vega et al., 2023).

For transparency, the researcher is a mixed Black Caribbean and White woman raised within British norms. She has an intimate familiarity with these topics of navigating marginalisation, and lack of familiarity in accessing mental health services for mental health challenges or self-harm.

Olmos-Vega et al., (2023) states the importance of going beyond descriptions one’s background. Therefore, a reflexive manuscript (see Appendix A) detailing personal, methodological and contextual reflexivity captures the researcher’s decisions and perspectives throughout the research (Olmos-Vega et al., 2023). It was used to heighten the researcher’s awareness of sense of self, and to navigate the experience of being an insider culturally, but an outsider professionally. Emerging thoughts and emotional responses to the data were contained within research supervision, transcript notes (Appendix B) and a reflective diary to support continuous reflection (Appendix C for excerpts).

Patient and Public Involvement

Patient and Public Involvement (PPI) strives to ensure that research is ethical and meaningful by actively incorporating the expertise of the public and patients most impacted by the study’s focus (British Psychological Society, 2018). Consequently, the relevancy and applicability of the studies using PPI are strengthened (NICE, 2013).

The aim to was to ensure the study was sensitive and socially impactful. To achieve this, the researcher consulted a PPI contributor on the study methodology and resources. The PPI contributor identified as a Black mixed African and Caribbean female who experienced self-harm. Together, all resources were reviewed at the design stage and a pilot interview was completed. From this, invaluable constructive feedback was received on the interview schedule, information sheet and consent form. For example, it was highlighted that wording on interview schedule could be changed from “black community” to “Afro-Caribbean community". Amendments were then made. The recommendations, amendments and compliments can be found in Appendix D.

Ethics

Ethical approval was obtained from the University of Sheffield Research Ethics Committee (Reference Number 053155; see Appendix E) and abided by the University's Research Ethics Policy

(The University of Sheffield, 2019). Due to the nature of this study, it did not require NHS ethical approval.

Recruitment and Participants

IPA advocates using a reasonably homogeneous and smaller sample to allow for highly detailed analysis (Smith et al., 2009). Homogeneity, in this context, does not imply that all participants have identical experiences, rather, it refers to the shared experiences related to the research topic (Smith et al., 2009). The study employed a purposive sampling strategy based on the theoretical grounds that Black British people are more likely utilise community-based services than statutory services (Keating & Robertson, 2004; Mclean et al., 2003). Specifically for this study, Black British individuals with relevant experiences and perspectives of self-harm and community-based service use were recruited according to the inclusion criteria (Table 1).

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Adults aged 18+	Individuals who identified as being from different ethnic backgrounds (e.g., Asian, Pakistani, Chinese, White, European)
Individuals who identify as Black British African and/or Caribbean or Mixed Black African and/or Caribbean	Individuals whose behaviour is not regarded as deliberate self-harm. E.g., repetitive head banging with individuals with learning disabilities
Self-Identifies as having lived experience of self-harm defined by NICE (2011). E.g., any act of self-poisoning or self-injury…. irrespective of motivation. This was stated on the advert.	Individuals unable to provide informed consent
Has accessed third-sector organisations or has never accessed any mental health support	Individuals who were unable to read or speak English

The researcher sent E-mails to third sector organisations across England. These services included self-harm charities, Global Majority community groups and mental health social enterprises (see Appendix F for networking sheet). An overview of the study, recruitment advert (See Appendix G) and information sheet (Appendix H) were attached. Most helpfully, some organisations included the advert in their newsletters.

Because the researcher was also interested in capturing the experiences of those who have not accessed support before, the advert was also shared on social media platforms, such as Linkedin and Facebook groups for people who self-harm.

Over the course of four months, 11 people responded to the advert. Of which, one met the exclusion criteria of being under 18 years old, and four did not respond at the stage of interview arrangement. In line with ethical conduct, participants did not have to give a reason for disinvolvement, and no reasons were given. No-one known to the researcher was directly invited to participate. A summary of participant demographic and contextual information of is presented in Table 3.

Overall, six participants considered appropriate for the research aims took part in the study; a number recommended for doctoral IPA studies (Smith and Eatough, 2007; Smith et al., 2009).

Data Collection

Participants responded to the researcher’s email address provided on the advert. Once contact was established, the researcher responded with thanks, the information sheet, and hyperlink to the Qualtrics online consent and demographic form (see Appendix I). Virtual interviews were arranged for all participants using Google Meet.

The interview schedule (see Appendix J) was informed by guidance (McIntosh & Morse, 2015), existing topics in the literature. The questions allowed for free speech through open, probing and follow-up questions.

Semi-structured interviews balance consistency across interviews, and flexibility within them (Mashuri et al., 2022). The decision to employ this method lies in its ability to generate detailed and nuanced findings while supporting comparability.

Interviews were anonymised and transcribed verbatim by a single transcriber within the University's transcription service. In one instance, the transcriber struggled to understand participants' accent and so the researcher completed transcription. All transcriptions were checked by the researcher against the audio recordings. The interviews lasted between 39 and 64 minutes (mean = 51.5 minutes).

The welfare for participants was protected through a protocol for managing distress addressed in the ethical approval process (Appendix K). Following the interview, a verbal debrief was offered and the debrief form was sent (Appendix L). Participants fed back that the study felt "respectful" and as though the researcher was "listening, not just interviewing".

Quality

The author assessed the quality of the study against the JARS-REC theoretically informed recommendations for scientific manuscripts (American Psychological Association, 2023a). The considerations are reported below in Table 2 for transparency.

Table 2

Quality Control

Guideline	Application and Relevance to Study
Title and Research Context	The author thoughtfully considered using the wording “Black British” in the title composition, understanding that it can inadvertently reinforce viewing White populations as "normative" research samples. As “race” and “ethnicity” are directly relevant to what is being studied, their inclusion in the title was considered appropriate. The researcher controlled for this by acknowledging this here, and using careful, conscious wording throughout.
Positionality and Reflexivity	The researcher discloses her position and provides a positionality statement and reflexive manuscript. In it, potential sources of implicit and explicit bias are considered.
Situating the Sample	The aim was to recruit a small and reasonably homogenous sample. The research represents the views of participants as opposed to all Black British people. Participants lived in various parts of England. Race and ethnicity are clearly defined ensure that the researcher has not operationalised them as constructs or reinforced interchangeable use.
Oversight	The researcher resolved to remain transparent by stating who had input into the research. The researcher’s supervisor[1] co-analysed one transcript and engaged in discussions about final themes and interpretations.
Grounding and Cultural Validity	The study embraced perspectives from a PPI contributor but acknowledges that true collaboration was not achieved in the study design (see limitations). Verbatim excerpts from participant interviews are presented to demonstrate emerging themes. The data is analysed and interpreted through a cultural lens by drawing on emic perspectives and focusing on cultural themes rather than imposing external frameworks.
Interpretation and Impact	The researcher recognises that this study is occurring in a particular sociocultural and historical context. Using IPA, the researcher considered if the findings are meaningful, recognisable and respects how the participants represented their shared realities and identities. The researcher resolved to ‘do no harm’ by considering if the findings could be misinterpreted or misused.

[1] A White Clinical Psychologist with extensive research experience who identifies as male

Analysis

Data analysis followed Smith at al's., (2022) guidance for conducting IPA. The researcher listened to one interview at a time, first without the transcript and again with to ensure familiarity with not just what the participant said, but how they said it. The transcript was inputted into the qualitative data analysis computer software NVivo 14 for Mac. NVivo was employed to facilitate the organisation and maintenance of the data. Here, the researcher made line-by-line exploratory comments of the participant's experience (see Appendix M for output).

One criticism of IPA studies is how they can get 'stuck' at the first-order level of analysis in only summarising participant sense making (Larkin et al., 2006). Therefore, to support the development of the researcher's interpretations, the researcher used the 'annotation' feature in NVivo to anchor reflections in the transcripts (Appendix B) and transition into the researcher's sense-making.

The comments from each transcript were merged according to patterns of meaning to construct experiential statements which were grouped into personal experiential themes (Appendix N). This process was repeated for the remaining five interviews. Then, the experiential themes were printed on to coloured paper, with each colour representing a different participant. The themes were then organised visually within cautious cross-case analysis (Appendix O). From this, group experiential themes were refined.

Results

A total of three group experiential themes emerged from the data analysis (Table 4). An interpretive account of each theme is introduced and summarised. Individual voices are presented through verbatim quotes (for additional extracts, see Appendix P). Importantly, these themes, while chosen due to participant value and significance, do not encapsulate the full diversity of Black British experiences of self-harm and help-seeking. Aspects of experience overlap themes. See Table 5 for participants' contributions according to each theme.

The researcher considered the relationship between the themes and presents them in a way that mirrors some of the participant's journey to support.

Table 3

Participant Demographic Information

Participant	**Gender**	**Age**	**Birthplace**	**Years lived in UK**	**Ethnicity**	**Support accessed**	**Self-harm category (NICE, 2011)**
1	Gender non-conforming	18-25	England	Since birth	Black African	Third sector	Cutting Self-poisoning Suicide attempts Starving
2	Male	26-35	Africa	>15	Black African	Third sector	Self-poisoning Suicide attempt
3	Female	26-35	England	Since birth	Mixed Black African or/and Caribbean	None	Cutting
4	Female	18-25	England	Since birth	Black Caribbean	Third sector	Cutting
5	Female	18-25	England	Since birth	Mixed Black African or/and Caribbean	Third sector	Cutting
6	Male	26-35	Europe	>15	Black African	None	Self-poisoning Excessive exercise Vomiting

Table 4

Themes and Contribution to Themes by Participant

Group Experiential Theme	**Subthemes**	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**
Complexities of Self-Harm	More than a Stereotype	✓	✓	✓	✓	✓	✓
	Refuge from Overwhelm	✓	✓	✓		✓	✓
	"It's a love-hate relationship"	✓	✓	✓	✓	✓	✓
Navigating Expectations	Feeling Othered	✓		✓	✓	✓	
	Protecting and Concealing	✓	✓	✓	✓	✓	✓
	Keeping it Moving	✓	✓	✓		✓	✓
Promoting Equity	Unaddressed Hardships	✓		✓	✓	✓	✓
	Preference - "We're not a Monolith"	✓	✓	✓	✓	✓	✓
	Helpful Systems	✓	✓		✓	✓	✓

Complexities of Self-Harm

Within this theme, the multifaceted nature and presentation of self-harm is captured. It explores diverse manifestations and motivations as shared by participants. Participants had a complex relationship with self-harm, as it provided both relief and further distress.

More than a Stereotype

All participants spoke to their use of a broad range of behaviours that knowingly caused emotional or physical damage to themselves. It was highlighted that self-harm is "not always the stereotypical ways that we think of" (P6) and can manifest through overt acts that go unrecognised or unacknowledged by society and services.

> *"I think people think of self-harm as the stereotypical maybe cutting with, you know, a razor but actually, you know, it can look like starving or using different instruments or, things that are really detrimental to your health, so all those things can be self-harm, but I don't think they're always seen as that" (P3)*

For most participants, these diverse forms of self-harm were co-occurring and included intentional cutting, starvation, excessive exercise, vomiting and self-poisoning. Suicide attempts were positioned as the ultimate self-injurious act.

> *"…I just wouldn't eat … I wasn't taking care of myself, and it would bring me physical pain being in the state where I wasn't giving my body nutrients and I would just be in intense pain because I would get these stomach cramps" (P1)*

Refuge from Overwhelm

Conveyed across all participants, was that self-ham was self-soothing when faced with life stressors, overwhelm and depression. It was perceived as a "side effect of the really fast paced society that we live in" (P3).

> *"I felt like I had to do it because it gave me some kind of, it was like a sense of release from every, all the emotions and the thoughts that I was keeping in, so it actually became that release but something that I felt that I had to do" (P3)*

For most, the act provided participants with a sense of release, and was considered satisfying though its ability to numb and distract participants from emotional distress.

> *"I remember just feeling this like deep sense of dread and doing it kind of just distracted the thoughts, it made me focus in on something that took me away from that … I think it just gave me a break away from that feeling honestly" (P1)*

A sense of accomplishment was experienced by participants when self-harm was used to respond to triggers of emotional distress. This left some participants feeling empowered when self-harming.

> *"…there being a feeling of satisfaction because it felt like I was actually doing something about these feelings… it came with that sense of accomplishment cause I could see the result after it" (P4)*

"It's a love-hate relationship".

Self-harm was something participants had "a love-hate relationship with" (P4) and this relationship was paradoxical and ever-changing in nature. While self-harm was employed to manage distress, perspectives revealed how satisfaction was temporary and thwarted by its inability to fully resolve inner conflict, deeming it a "short-term solution to a long-term problem" (P3).

> *"If you're not addressing the issue and just putting a plaster on whatever the issue, a broken leg right, what's the plaster gonna do?" (P6)*

Within these insights, participants identified unhelpful consequences of self-harm that invited further frustration and barriers, such as regret and having to hide parts of their body from friends and loved ones. Thus, further complicating the relationship they had to themselves and experiencing it as "a vicious cycle" (P1)

> *"like it was fine at the start and then after I would be like really upset about it and then it would regret it" (P5)*

In this way, self-harm was viewed by participants as an unhealthy way to manage distress, claiming "It's in the name, its harm, it's not doing any good" (P4). While this was recognised, the experience of self-harm, however, was described as addictive.

> *"…It was the best way for me to get addicted to this. I try to get emotional things away or try to, to stop overthinking regarding to this incident, so I tried to involve myself into all this and tried to hurt myself more and more (P2)*

One participant described how her relationship with self-harm intensified. Here, self-harm satisfaction was only achieved when the act matched the expectation of pain.

> *"I wasn't able to cut deep enough. With it being more painful it felt like what I was doing was actually working and when it wasn't it annoyed me cos I had this expectation that it would bleed a lot more and when it wouldn't, I would start like putting salt into my wounds just so I could see them more" (P1)*

Navigating Expectations

This theme explores participants' constructions of self-harm in the context of sociocultural norms and expectations. Participants noticed self-harm occurring in response to marginalisation and described a process of concealing their struggles manage the opinions of others and uphold traditions that prioritised strength and resilience.

Feeling Othered

From a young age, experiences of racism and marginalisation played an integral role in participants identify formation. This emerged as a trigger for self-harm for four participants. Their visible racial differences felt socially 'othered' within predominantly White environments. A lack of perceived belonging fostered internalisations of themselves as "different" (P4), which was experienced as socially isolating and generated fears of social exclusion.

> *"Being different I'd always assume would make people not want to be around me and that would mean I would be alone" (P1)*

Feeling ‘othered’ was compounded by societal preferences for White beauty standards and further exacerbated marginalisation for some. Three participants described a pressure to conform to these standards, which negatively impacted self-perceptions.

> *“I was the only person in my year who was Black so I wanted to kind of fit in and simulate being a certain size, shape, hair type, you know, that was something when I was growing up that was really quite influential” (P3)*

Participants recalled how they began to punish themselves in response to their lack of proximity to Whiteness. Here, physical attributes, such as skin colour and hair type, were regarded as flaws deserving of harm. One participant resorted to starving themselves “to correct my Black qualities” (P.5). For another, perceived worthlessness acted as a founding reason for cutting themselves.

> *“I wasn’t White British so I didn’t have straight hair, you know, for me the self-harm was almost erm, almost like a punishment for not being those things” (P4)*

Protecting and Concealing

Within the family context, Black British community, and wider society, participants unanimously described a lack of accurate understanding of mental challenges or self-harm. Here, participants detailed a difficulty in navigating the views and attitudes of others.

> *“There is still a lot of stigma which does prevent people from reaching out, whether its to friends or to family or professional support or, you know, hiding their scars, making excuses to how they maybe got the particular cut” (P3)*

A deep reluctance to discuss their experiences with others was observed within participants’ narratives. One of the reasons participants felt they had to “protect against other people’s opinions” (P.5) was because society’s view that mental health means you are “crazy” (P6).

Participants also spoke of generational differences in attitudes toward mental health difficulties, finding that older family members tended to have more stigmatising views. The stigmatic environment created an inability for participants to be wholly transparent about their struggles to their parents.

> *"I think like mental health like the awareness is very new and recent and having like an old-fashioned African mum, there is certain things that you don't really speak about to them and mental health and self-harm is one on the top list" (P5)*

In examples where participants did try to disclose aspects of their distress to their wider support systems, some responses were considered unhelpful, leaving them feeling even more isolated, "shut down" (P6) or "judged" (P3)

> *"When I was in pain, erm I think a lot of thought comes in and people try to neglect me. I try to come close to certain individuals to try to explain to them but because they think I'm a failed individual they try to neglect me, they try to neglect my attention, they try to, to avoid me." (P2*)

Participants went to great lengths to conceal their self-harm reality. One participant transitioned across different methods of self-harm produce an illusion of control that doubled as strategy to reduce the likeliness of acts being discovered by others.

> *"I make myself puke, you know, I do it to hurt myself, I realised that this was just not healthy for me, but then I transitioned to something else. I just replaced one way with another so I could tell myself, you know, "well I stopped doing that type". Its a delusion, as well probably to, to make, sure no one could catch on" (P6).*

Keeping it Moving

Traditions, norms and expectations played a significant role in participant’s decision not to seek support. The concept of self-harm clashed with valued family traditions and definitions of success within their community.

> *“Most African parents will push you towards that goal, go to school, have a good career, that’s the only way you’re gonna be successful. It’s like a cultural thing, you know, be a Doctor, Lawyer, Engineer. Self-harm doesn’t really fit in with that” (P5)*

Participants described how vulnerability was perceived as a weakness. There was a large sense of pressure to “keep it moving” (P3) the face of adversity. One participant explained that this was born from generations and generations being socialised to be strong and “*pick myself up by the bootstraps*” (P1) and this was embodied by them (P6).

> *“You are raised that you’re strong enough to handle anything…so when life throws you lemons, like cool, lets make some lemonade, okay well these lemons are sour, cool, well how else can I see this situation in a positive way. I’m never a victim and if I’m never a victim, then why do I need help from somebody else?” (P6)*

Expected gendered responsibilities and roles imposed additional pressures yet described to be important and valued within Black British communities. A dedication to fulfilling them, served both a contributing factor to life stressors, and a barrier to seeking help.

> *“In my society and my tradition, I’m going to be regarded as a failed individual with depression, so maybe everyone may be looking at me as erm, I failed my duty as a man” (P2)*

Promoting Equity

This theme examines participants’ experiences and preferences at the intersections of ethnicity, help-seeking and meaningful community-based support. While support preferences varied due to individual experiences, all highlighted the need for organisations to acknowledge their diversity and better consider access barriers.

Unaddressed Hardships

A shared commonality within participants' accounts, was that even the best-intentioned community support was only as "good as how many of us can get to it" (P4). Most participants noted how organisations were not visible.

> *"I don't think I've ever seen anything about self-harm groups or help, maybe pregnancy support or you know, get your vaccinations or things like that, I didn't necessarily see things that were like 'okay this is a space where you can come and erm you can talk'" (P3)*

Participants believed that visible organisations needed to better consider the systemic barriers to access faced by marginalised groups. As one participant poignantly noted, the very act of identifying and seeking help for self-harm stems from a position of privilege.

> *"Identifying self-harm and mental health as issues comes from a space of privilege, in the sense of being able to slow your life down. People in minority groups that are not from the East erm don't have always the luxury of slowing down. We are just about managing to put food on the table" (P6)*

Here, participants described compounding hardships, such as financial instability, which were ill-considered within support. Participants wanted services to first consider if people had the resources to do what was recommended for things like 'self-care'.

> *"A solution-based focus hasn't been that helpful for me because I can't always use those solutions, and when I can't use a solution there is a chance I will just fall back on to self-harm." (P1)*

There was also a need among participants for professionals to acknowledge how difficult it may be for the person to be at that session.

> *"Acknowledging the strength it takes to reach out to services to begin with. That person probably feels completely alone in that situation, they probably don't know anyone else who is doing this, who looks like them, and when it comes to services, a lot of the time the people that they are going to be interacting with don't look like them. It feels really foreign to you, takes a lot of power" (P1)*

Preference - "We're not a Monolith"

All participants highlighted that ethnicity, mental health and self-harm are deeply intertwined, and yet, are treated as three separate things, with ethnicity specifically being most unrecognised in support. This acted as a barrier to accessing what they considered meaningful support.

> *"[My] identity plays a big role in influencing my mental health, but she [support leader] was White British and, I don't (SIGH), I tried to express this to her but it was almost dismissed, like my identity wasn't really being recognised" (P2)*

For half of the participants, the lack of institutional representation was a problem due to perceptions that 'outsider' clinicians would not be able to fully understand their traditions and experiences of navigating discrimination. It was perceived, therefore, that a Black British therapist or leader would reduce the need to explain the intricacies of their identity and be less likely to pass judgement.

> *"I remember when my mum cut my afro-type kinky hair…that was such a catastrophic event and led to my first suicide attempt. If a professional already understands why that's such a big deal because they are also black and they understand just how much importance hair is put on to black women within the black community, that would've been comforting to me and I wouldn't have to worry about filling them in on every single detail…. I wouldn't feel so stupid saying I wanted to die because mum cut my hair off" (P1)*

On the contrary, two participants preferred a clinician from outside of the Black British community. They described how it felt easier to talk to someone who is less likely to share the same values as someone from within the Black British community.

> *"If he has the same mindset with others in the tradition, I think he would have little sentiment for me, because he may have tried to believe them or tried to think otherwise about my thoughts" (P2)*

However, while preferences varied, the shared sentiment among participants lied in their need for services to acknowledge, and not judge, their rich diversity and individual experiences.

> *"we're not a monolith, so there will be varied experiences, varied understanding, depending on where we grew up, who we were raised by, how old we are, so not to just assume I have a particular stereotype and work in accordance with that" (P3)*

Helpful Systems

Positive experiences of community-based services were shared by participants. Participants shared in the sentiment of enjoying being exposed to other Black British people also experiencing mental health difficulties: "I could finally speak about what was going on in my mind" (P5).

> *"I also did like a group as well, seeing other people as well and seeing their experience was so helpful" (P2)*

The flexibility of an organisation was prioritised, as it was important that in times of distress, no extra pressure or expectation was placed on participants. Voluntary services allowing them to "come and go when I want or need" (P2), as opposed to the expectation of complete participation was appreciated by participants.

> *"The charities or support groups I've contacted, it was rather simple, I kind a just turned up to the support group sessions. It was great, but when it came to something like counselling*

> *where I would talk about self-harm, I would have to go through quite a bit of paperwork" (P1)*

Participants considered the best organisations to be the spaces where meaningful discussion helped them make sense of their individual experiences of mental distress and self-harm in relation to their identity. One participant recommends working with discourses of strength to enhance utilisation.

> *"Some cultures people need help, other cultures wanna help themselves, if you wanna help me, help me to find a way to help myself….Help them open up to where they feel like they're helping themselves, as opposed to like they're getting help….Cause if they feel like they are getting help, boom, it will be "I'm good, I can take care of myself" (LAUGH) (P6).*

Discussion

This study aimed to aimed to explore Black British individual's thoughts, feelings and experiences of self-harm, and to understand their lived experience of seeking, or not seeking, community-based support. Three themes emerged from participants. Namely, 'complexities of self-harm', 'navigating expectations' and 'promoting equity'.

Complexities of Self-Harm

Participants described the use of multiple, co-occurring, yet less conventionally understood, forms of self-harm. This reflects a current understanding of self-harm, whereby individuals may experiment with different methods at once (Edmondson, 2013). Lending empirical support, Kapur et al., (2013) found that over 60% of participants switched to a different form of self-harm after cutting. The inference drawn from this, is that a limited understanding of the different methods of self-harm may hinder the exploration of a person's self-harm experience.

Self-harm was perceived as an important, albeit potentially dangerous, regulatory mechanism in times of distress for participants. Specifically, self-harm served as a means of managing overwhelming emotions and distressing thoughts. This is consistent with numerous studies confirming affect regulation as a primary function of self-harm (Kuehn et al., 2022; McKenzie & Gross, 2014). Additionally, participants provided valuable insights into their competing cognitions toward self-harm. On one hand, self-harm was experienced as empowering and providing of a sense of accomplishment. On the other, it failed to fully resolve the presenting difficulty, and for some, caused further distress.

This paradoxical relationship subscribes to the 'benefits and barriers' model proposed by Hooley & Franklin (2017). Within the model, self-harm is explained to fulfil important psychological functions, such as distraction from, and demonstration of, distress. Meanwhile, further interpersonal and intrapersonal consequences are created from engaging in the act, such as scarring and shame that can lead to isolation and damage self-esteem.

Relatedly, in Gray et al's., (2023) more recent exploration of this phenomenon, the experience of ambivalence towards self-harm was associated with higher levels of psychological distress when compared to those who solely wanted to avoid the behaviour. Its relevance lies in illustrating how ambivalence itself may function as a risk factor for poorer mental health and the potential perpetuation of self-harm over time. In line with these perspectives, the addictive nature of self-harm, as described by participants, appears crucial for understanding perpetuation, supporting how self-harm can transition from a transient coping strategy to an entrenched habit (Worley, 2020).

Navigating Expectations

Participants' early encounters with racism and social "othering" fostered struggles with identity development and sense of belonging from a young age. This aligns with research demonstrating racism's detrimental long-term effects on mental health (Nazroo et al., 2019; Wallace et al., 2016)

Interestingly, self-harm was employed as a form of punishment for lacking White attributes and as a method to “correct” Black British racial features. This is a novel finding that offers important insights into the intersections of race and self-harm. It confirms Stänicke’s (2021) proposition that self-directed pain can be experienced as deserved and represent a frustration of being restricted in life. Secondly, it supposes that services may benefit from exploring how internalised racial biases may influence self-harm experiences.

The punishing component of self-harm has been identified in previous literature (Klonsky, 2007). Some researchers use early Freudian formulations of guilt and self-directed aggression to understand contemporary perspectives (Goldblatt, 2010; Parfitt, 2006). Specifically, Freud’s concept of ‘moral masochism’ (Freud, 1924) suggests perceived short-comings and guilt can manifest through self-directed suffering. This may echo the role of self-punishment for perceived deficiencies.

Also surfacing was how persistent stigma and intergenerational differences toward self-harm acted as barriers to seeking help and disclosure for participants. The construction of help-seeking attitudes has been found to be underpinned by culture (Bhugra and Gupta 2011; Bhui 2013), and the meanings which they assign to them (Fernando, 2014). Exposure to opinions within Black British communities that connect mental health challenges to being a ‘failure’ may increase tendencies to conceal difficulties and decide against seeking help (Kovandžić et al. 2011).

Expectations of strength also deterred participants from disclosing difficulty and this is well documented in extant literature (Rabiee & Smith, 2013; Romero, 2000). The supposition here, is that strength was regarded as an important, yet sometimes problematic, performance that placed a hard-to-achieve expectation on participants and perpetuated the idea that one must cope alone. Nelson et al., (2016) offers support and suggests concepts of strength may be making it more difficult for individuals to recognise and accept mental health challenges (Nelson et al., 2016).

Promoting Equity

Participants appreciated the informality afforded by community-based support services when compared to statutory services and called for more “come-and-go” services. During times of distress, engaging with support on their own terms was appreciated. Recent research has found that a lack of flexibility in community-based services can act as barrier to service utilisation (Hulin et al., 2024). For marginalised groups, having autonomy and choice in one’s own care is important for self-determination and empowerment (Rwebugisa, 2020). Of course, this was only possible when participants were aware of these services. For some, there was a lack of visibility and awareness of these organisations. Concerningly, Vickers (2000) suggests that the invisibility of support can perpetuate stigma by implying that certain issues should not be discussed.

Perceived cultural naivety and the desire to be understood within one’s cultural context meant that some participants preferred to be ethnically matched to their clinician. This mirrors previous literature of participant preference among Global Majority service users (Cabral & Smith, 2011) and acted as facilitator for service access (Tabassum et al., 2000). When ethnicity is shared, services were perceived as more approachable (Li et al., 1999), better supported with language barriers (McClay et al., 2013) and reduced the stigma related to getting help through representation (Singla et al., 2014). This illustrates the importance of establishing trust within the therapeutic relationship (Kelly & Strupp, 1992).

An important development was found in how some participants preferred not to be ethnically matched to a clinician. Here, participants described feeling more comfortable with perspectives held from outside of the Black British community. This preference could demonstrate Green et al’s., (2019) point that fears of community stigma can breed distrust and be generalised to healthcare systems. It serves as a powerful illustration of the need for staff to recognise and respect service-user culture and to facilitate discussions of challenges that may be particularly stigmatised within their own community.

Finally, some participants felt that recognising one's mental health challenges required privilege they did not have due to financial and time pressures. This corroborates with Brown et al's., (2021) supposition that living at the intersections of oppression, daily realities of poverty, racism, and other stressors leave little capacity to prioritise mental wellness. Kovandžić et al's., (2011) concurred while anti-stigmatic movements and increased information of services can facilitate access, a critical obstacle to equitable access lies in the availability of services that are culturally attuned and experienced as appropriate by underserved groups. Without broader efforts to dismantle systemic inequities at their roots, even the most well-meaning programs will struggle to reach those most in need.

Strengths, Limitations and Future Directions

The study addresses literature gaps on the intersections of self-harm and race/ethnicity, and offers perspectives not previously found in the literature. Importantly, this study provided participants an opportunity to express their truth. The researcher was thanked for providing a space for their voice to be heard, and one stated the research topic itself felt "like an ally".

Given that cultural mistrust can affect participation (American Psychological Association, 2023b) the researcher's overt 'membership' to being Black British, may have facilitated a greater sense of safety for participants in voicing their experiences. This likely generated an openness within the interviews, as opposed to consciously filtering responses to avoid feeling uncomfortable or offensive. That said, the researcher acknowledges how this could be mitigated due to the researchers position of being a mental health professional. Conversely, keeping true to the findings of this study, some participants might have withheld information through fear of being judged by another Black British individual.

A limitation of the study is that it did not distinguish between the different types of community-based services from which the participants sought help in the analysis. The participants received support from various community-based organisations however these services may not have specialised in self-harm issues or culturally specific support for Black British communities. This limits the depth of the findings. Future research should distinguish between tailored and general services to better understand how well these services align with population needs and influence perceptions and engagement.

To ensure the research aligns with the needs, preferences, and priorities of those directly affected by the research topic (Jennings et al., 2018) the study invited a PPI contributor. However, engaging a PPI collaborator after the protocol and tools had already been designed does not constitute as true co-design and partnership in the research process. The researcher may have denied the study an opportunity to gain an even richer cultural understanding had it practiced higher levels of collaboration. Future research should practice the truest forms of collaboration when designing research to maximise impact and empowerment.

This study does not fully consider intersectional influences of self-harm or help-seeking. This represents an opportunity for future research to explore how factors such as gender, sexuality and ability status intersects with racial and ethnic identities to shape self-harm experiences and pathways to care. Additionally, the researcher recognises that while ‘Black British’ attempts to acknowledge African and Caribbean heritages within this population, it still risks ignoring intra-ethnic cultural differences. This conceals the heterogeneity of many communities holding diverse experiences, identities, migration histories and values.

Implications

Participants’ experiences were uniquely situated within a specific context, and does not represent the population, or even other Black British people who self-harm. However, the researcher acknowledges that facilitating meaningful change requires understanding common patterns of meaning to inform key implications (Tracy, 2010).

Support services should recognise the diverse manifestations of self-harm beyond cutting oneself. Without acknowledging different the forms and their personal relevance, practitioners risk engaging in a narrow exploration of service-user experience and important avenues for therapeutic change may be missed (Hetrick et al., 2020; Kothgassner et al., 2020). Furthermore, as illustrated in this study, service users can be aware of the conflict between simultaneously wanting to, and not wanting to harm themselves. These conflicts are likely crucial to understanding why the behaviour may intensify and reoccur (Gill et al., 2023). Space and time should be protected for service users to discuss their experiences of self-harm as well as their mental health challenges. Framing self-harm as merely a symptom and not addressing it may reinforce beliefs that it should not be discussed.

Systemic exclusion has been proposed to be perpetuated by a lack of culturally relevant psychological therapy available for people of the Global Majority (The British Psychological Society [BPS], 2017). Guidelines expect psychologists especially, to be committed and sensitive to multi-cultural experiences (BPS, 2017). Race, ethnicity and culture should be considered in the assessment, integrated at the formulation stage, and inform culturally adaptive interventions in order to support Black British service users to navigate societal influences and improve long-term outcomes (NICE, 2022).

To do this, practitioners must first reflect on whether common therapeutic approaches, which are predominantly shaped by Eurocentric norms, adequately address the diverse worldviews, preferences, and experiences of Black British service users. Practitioners should ensure that wellbeing is defined by the service and consider if models are fully attentive to cultural and systemic influences (Stubbe, 2020). Services may benefit from exploring if the alternative coping strategies recommended for regulating emotions and safety plans are realistic and achievable given their unique lived experiences of navigating intersecting challenges (NICE, 2022). Providers should consider this within the context of the social, economic, and time-related barriers (Fonagy & Luyten, 2021).

The specific cultural and historical contexts shaping Black British people's experience of self-harm also warrants dedicated enquiry. Given that Black British identity is constructed within a postcolonial legacy of slavery and societal racism (Mariska et al., 2019), practitioners should be aware, alert and attentive to the forms of discrimination and environmental oppression that service users may experience both within and outside of therapy spaces (NICE, 2022). Due to stigma and discourses of strength, service users may avoid even the most relevant topics (Akoury et al., 2019). Therefore, practitioners should be inquisitive and initiate these conversations sensitively.

Therapeutic tools that support the resistance of shame and reframe vulnerability as strength should be considered (Graham et al., 2013). Community-based services may benefit from working within the discourse of strength. Here, approaches that focus on the individuals' inherent resources and capacities could been found to beneficial for engagement (Romero, 2000). Community-based organisations may then be better equipped to foster a greater sense of ownership over the recovery process to enhance service utilisation (Ryan et al., 2010).

Recent guidance on community mental health services promotes person-centred and rights-based approaches. Here, services are urged to consider identity, the relationship one has to their community and broader aspirations to move away from one-size-fits-all approaches (World Health Organization, 2021).

The findings of this study do not completely concur with previous findings that ethnic matching was preferred. Some participants preferred not to work with Black British practitioners through the fear of them being, metaphorically, 'too close' and share in the stigmatic views from within one's own culture. Other participants preferred to be ethnically matched with their practitioner though fears that people from other cultures may be 'too far away' to understand self-harm in relation to their identity. This preference variability underscores why cultural competence is vital for practitioners, regardless of their race or ethnicity. No single approach will suit all individuals, and service-users must feel empowered to receive care on their own terms (NICE, 2022).

Practitioners should practice cultural humility by acknowledging the limitations of their own experiences and actively work to understand unique worldview without judgment (Stubbe, 2020). This demonstrates a need for ongoing reflexivity and training for both lay and professional workers within community organisations.

One way to improve awareness of services may be through proactive outreach strategies tailored to Black British populations (Hanif, 2023). This may include conducting intentional relationship-building within cultural communities and organisations (Kalathil et al., (2011).

Conclusion

This study provided important insights into the construction and experience of self-harm and help-seeking among Black British individuals. Internalised racism played a role in the onset of self-harm which served as a punishment, refuge from distress and an empowering experience for some participants. It also invited further hardship and feelings of shame and guilt. Participants' construction of self-harm occurred in the context of societal norms and traditional values within their communities. Here, recognising and seeking help for mental health challenges was regarded as a privilege some did not have. This experience was further compounded by stigma and expectations of strength which discouraged vulnerability and help-seeking. Community-based services were valued supports when they were visible. However, participants called for greater acknowledgement of their intersecting identities and experiences of self-harm. Services should promote culturally attuned self-harm management strategies that consider individuals' fears of being misunderstood and socioeconomic realities.

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Appendix A

Reflexive Manuscript

Personal Reflexivity

I, the researcher, am a mixed-race woman in her late twenties. I am visibly brown, with type 3B curly hair, and other visible features that most people would attribute to being “Black”. All my life I have been told I am ‘half’ of a race, an ethnicity, a culture, as opposed to ‘double’. One “half” of my family is from Barbados, and the other from England. For most of my life I have tried to make sense of where I ‘fit’ among my family, friendship groups, education systems, clinical settings, and just the world in general. Such “confessions” are important because they are relevant to how I connected with the participants, research process, and the subsequent decisions I made around analysis and write-up.

To begin, two things are of vital importance to share: 1) Some of my experiences of existing in this world were articulated by participants, which makes this thesis personal. 2) I believe this thesis is not only a piece of academic work, but a platform to advocate and spread awareness of a topic so hidden, that some people do not even believe Black British people to self-harm. I wanted to do the participants justice and honour their realities. My proximity to the research topic meant that I often had to ask myself “who is this for?” and use supervision throughout the research process.

Power sharing with my White, male, and qualified supervisor also impacted how this research was conducted and presented. I personally benefitted from many open and safe discussions about race/ethnicity and research. He was curious and inquisitive about my position and expertise. At times, I relied on my supervisors’ research expertise and guidance. The external lese he provided meant that I was appropriately challenged and directed. Knowledge sharing strengthened interpretive rigour and encouraged me to more clearly articulate how my positionality informed the findings. Acknowledging each other’s expertise accounted for power differentials between myself and my supervisor which supported interpretation.

Power sharing in the interviews was also interesting. Power was negotiated in many ways between the participants and me. For example:

- Participants were there to share their expertise, and yet I was the one asking the questions.
- I am also a Black British individual, but simply by being a mental-health clinician I felt like I was also part of the problem, or the system, that participants spoke so negatively about.
- I am also a Black British individual but only know about my experience as a Black British individual – not anyone else’s.
- I have no personal experience of self-harm or accessing services, and yet I am intensely trained to empathetically connect and formulate such experiences.

- In relation to colourism, I have “light-skinned” privilege, whereby my proximity to whiteness is closer, which may have been a consideration from participants in the interviews and influenced disclosures.

So how did these things influence the data? Self-awareness of these points alone, documented in my reflexive journal, enhanced the research quality. It kept me attentive to who was speaking, what I was saying and where I influenced conversations within the interview. The interviews were extremely rich, and I think that had a lot to do with a level of perceived safety, on both parts, within the interviews. Ultimately, I believe my position as a mixed-race researcher equipped me with insights, named here, that strengthened this work.

Methodological Reflexivity

Some participant’s experiences relating to race, ethnicity and culture felt very ‘close’. whereas other participant experiences of self-harm or community-service use were not. I think the rigorous – and not so easy - process of IPA and reflexivity logs really helped to keep the work true to what the participants were saying, as opposed to what I expected to see.

So how did I decide what the themes were ‘good to go’? or decide what to include, or not include, in the write up? Mainly, this was informed by ‘weighing’ of how much something showed up within participant narratives and within cross-case analyses. For example, only one participant mentioned religion, and briefly (which I expected to see more of given the findings of the literature review), and so this was not captured in the write up. I completely trust that if someone else looked at the personal experiential themes, then similar group experiential themes would emerge. My previous research experiences gave me confidence to demonstrate how my conclusions linked directly to participant experiences.

I fully accept that my use of quotes was intentional. With so many to choose from, I selected the ones that I believed to be powerful, eye-opening, and true to the point being made. In prioritising evocative quotes, I recognise that this is likely borne from personal investment in advocacy work to address inequalities within the Black British community. However, as previously stated, the use of supervision and reflexive practice upheld accountability, rather than projecting my own narrative. This was imperative, as, with any research, there is a risk that power held by the researcher could be exploited.

Contextual Reflexivity

Here, I discuss how I came to know the context of this research, how I sought to achieve a deeper appreciation of its nuances and considered the legitimacy of findings.

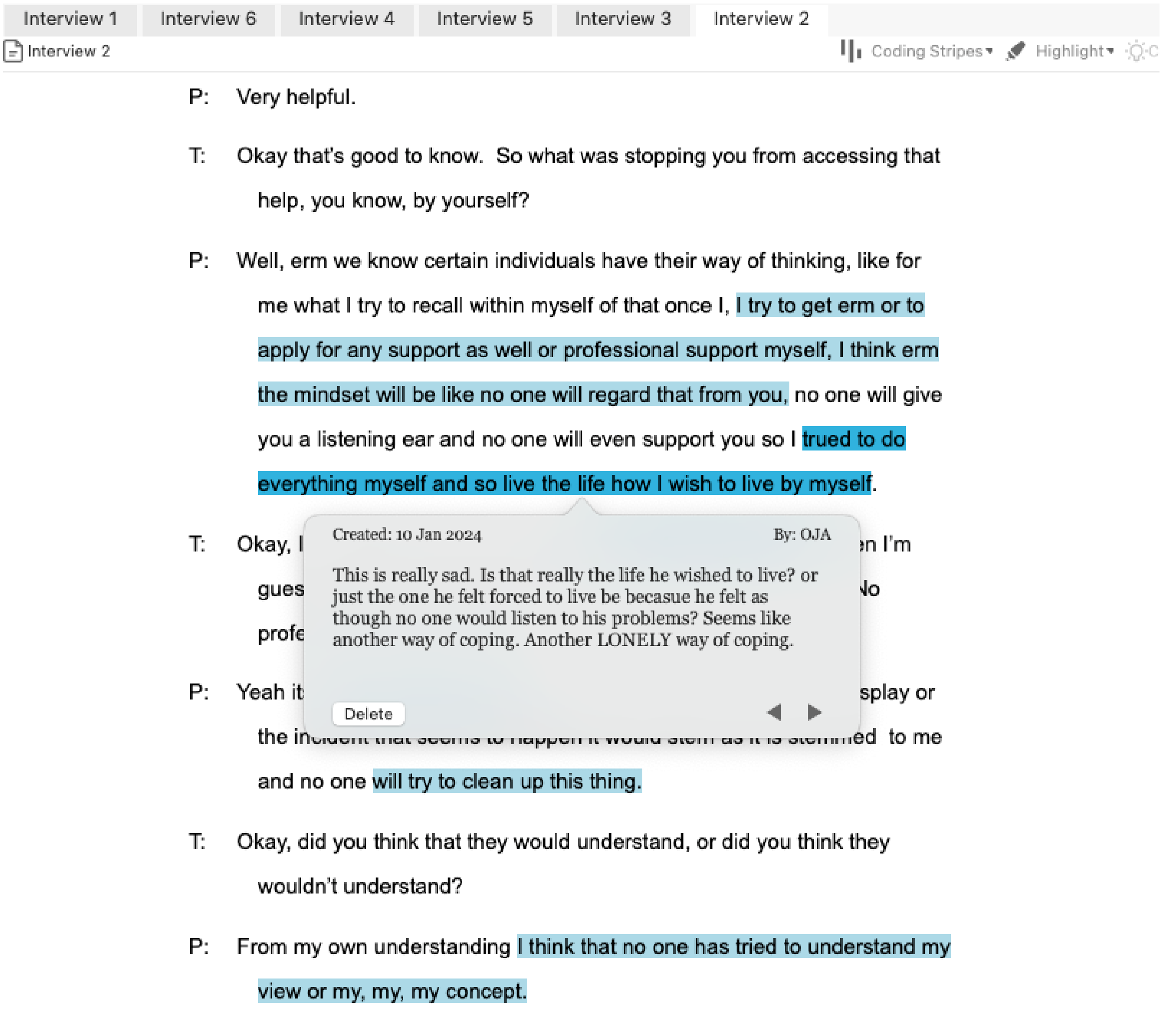
Before commencing the research, I was asked why I designed a research study to explore self-harm and help-seeking among Black British populations. Why not another ethnic group? Why self-harm? I answered: I remember, years ago, reading an article titled “black girls don’t self-harm” and immediately noticing that I have never known of any of my African or Caribbean friends or family to self-harm, but have White friends and family that do. I found myself asking why, over my 8 years of psychology experience, working with people with various mental health conditions, have I never worked with a Black British person that self-harms? Or have I? maybe I just didn't know? Why wouldn't I ask? This required me to check my own biases and assumptions. Consequently, I have held a professional interest in the experiences of mental health for people of the Global Majority and this informed my decision to research the present topics.

This exact interest, however, may have impacted the research in some ways. For example, I cannot separate myself from the theories I have learned across my academic and clinical career. I can only name them and be aware of them. This means that my interpretation of participants' narratives was likely shaped, on some level, by my training and clinical practice.

Finally, I wrote this thesis in a time where, politically, momentum and attention to the Black Lives Matter movement has slowed. The movement highlighted many inequalities and acts of injustice, it informed policy and amplified the voices of many Black British people worldwide. I hoped to maintain the ethos of the movement, by providing a platform for Black British people to be heard within the research world.

Appendix B

Example of Transcript Reflection



P: Very helpful.

T: Okay that's good to know. So what was stopping you from accessing that help, you know, by yourself?

P: Well, erm we know certain individuals have their way of thinking, like for me what I try to recall within myself of that once I, I try to get erm or to apply for any support as well or professional support myself, I think erm the mindset will be like no one will regard that from you, no one will give you a listening ear and no one will even support you so I trued to do everything myself and so live the life how I wish to live by myself.

T: Okay, I … n I'm gues … No profe

Created: 10 Jan 2024 By: OJA

This is really sad. Is that really the life he wished to live? or just the one he felt forced to live be becasue he felt as though no one would listen to his problems? Seems like another way of coping. Another LONELY way of coping.

P: Yeah it … splay or the incident that seems to happen it would stem as it is stemmed to me and no one will try to clean up this thing.

T: Okay, did you think that they would understand, or did you think they wouldn't understand?

P: From my own understanding I think that no one has tried to understand my view or my, my, my concept.

Appendix C

Reflexive Diary Excerpts

"…very thought proving. I didn't realise how much of an upsetting process this would be."

"IPA IS HARD!! I'm feeling de-skilled and it's stressing me out. Why is there so much paper involved?! I need a system".

"I was worried that I would struggle to "switch off" the therapist in me in that last interview, there was risk that it would become a therapy session with me addressing the participants needs rather than interpreting their experience. However, I think this very awareness helped me "lean in" to subjectivity and make a considerable effort to make sense of the participant, who was also at the same time making sense of their experiences – the interview schedule helped as well, of course!"

"What is the participant really saying here? Did I assume they meant that their family doesn't listen, or that they wouldn't understand? My immediate assumption is that she doesn't think she would be heard (?) but that is soley based in a guess based on how she said it – and maybe cause of my own experiences too?"

"I am struck by how much of an emotional experience the research has been, from start to finish. I completely underestimated how impactive it would be to listen to people talk so openly about how they harmed their bodies. At times I have found it hard to detach from the experiences of participants. I suppose on one hand this may be a good thing, in that it is likely an indication of how I truly immersed myself into the data. I am certainly noticing more of a need to check my position to this research".

Notes on implications for my own practice.

- I need to do better at acknowledging the role of race and ethnicity when working with people from the Global Majority. I should actively engage in these conversations; ask more what this means to them, how it impacts their life, and our therapeutic relationship.
- I have been learned the importance of being aware of the many ways a person can engage in self-harm. I, too, would've been less attuned to methods outside of cutting.
- I am going to make myself more aware of local community-based services. I have realised through this research that through a lack of awareness, I could not, myself, signpost a service user to such a service.
- Just being a Black British clinician in a service may make a difference in helping a service user feel represented and understood. Stigma within the Black British community, however, may deter them from wanting to work with me. They might fear that I hold stigmatic views.

Either way, it is my responsibility to build trust, and understand their experience and expertise.

- I need to ask myself how culturally appropriate an intervention is for a service-user. But before that, I need to be asking them about the barriers they had to face to even get to the session and adjust where possible. I will also be encouraging my colleagues to do the same.

Appendix D

Amendments made Following PPI Contribution

Consent Form

- Consent form formatting changed to a bigger font

- Inserted easily accessible "tick box" response

- Consent form now includes brief instructions of what the participant should do following completion. Email address was inserted as it is on the other documents

Interview schedule / Pilot

- Remember that people may be anxious about taking their experience, prompt yourself to introduce yourself and ask them about them before “diving in”

- Wording on schedule changed from 'black community' to “Afro-Caribbean community"

- On the interview schedule, it was felt some questions were too similar and would elicit similar answers. Removed one question asking the same thing, but differently

- Included a question that will highlight the participants experience specifically with the clinician to capture what may happen when there are differences/similarities in race and ethnicity

Debrief Sheet

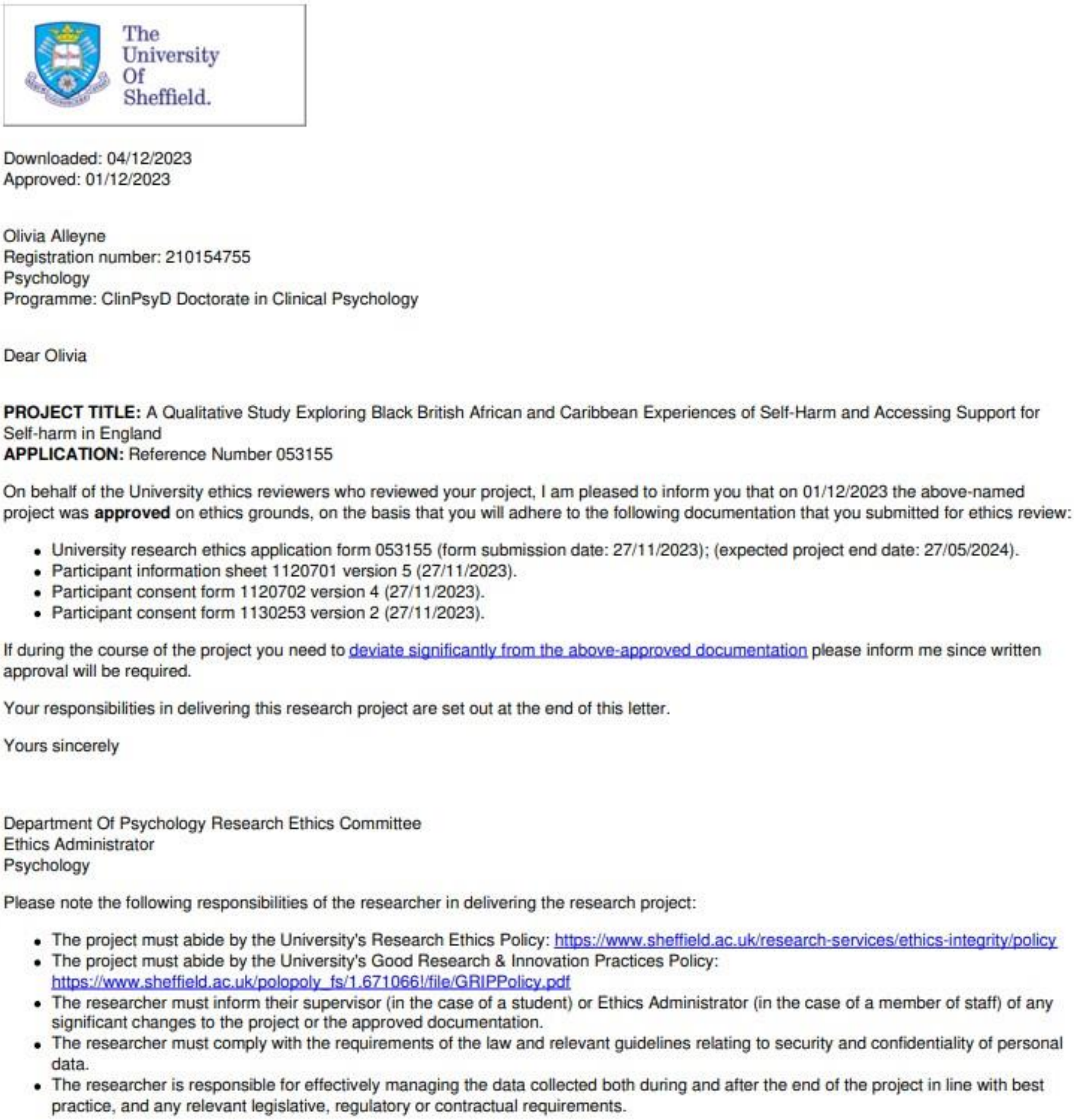
- for the participant to be thanked for their participation before information and signposting is discussed

General comments on the “feel” of the study.

- Respectful and sensitive feel

Appendix E

Letter of Ethical Approval



The
University
Of
Sheffield.

Approved: 01/12/2023

Olivia Alleyne
Registration number: 210154755
Psychology
Programme: ClinPsyD Doctorate in Clinical Psychology

Dear Olivia

PROJECT TITLE: A Qualitative Study Exploring Black British African and Caribbean Experiences of Self-Harm and Accessing Support for Self-harm in England
APPLICATION: Reference Number 053155

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 01/12/2023 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 053155 (form submission date: 27/11/2023); (expected project end date: 27/05/2024).
- Participant information sheet 1120701 version 5 (27/11/2023).
- Participant consent form 1120702 version 4 (27/11/2023).
- Participant consent form 1130253 version 2 (27/11/2023).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

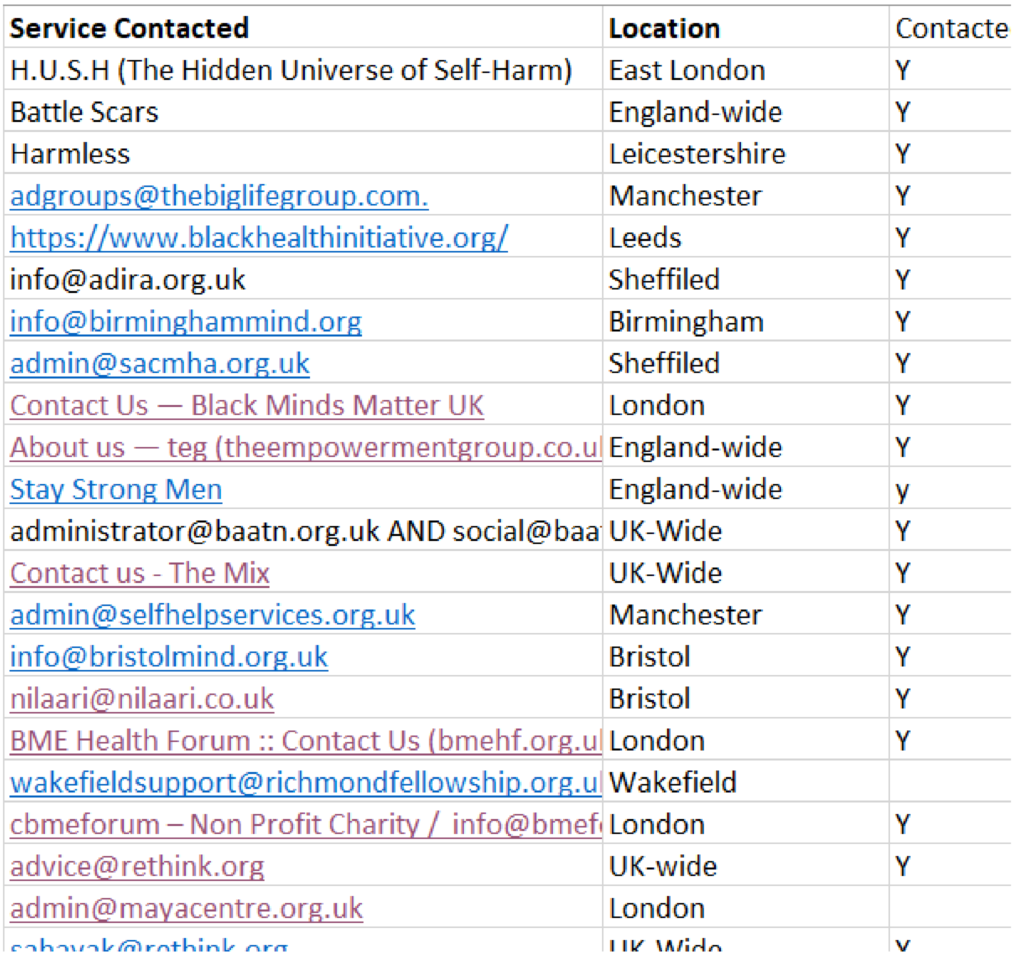
Department Of Psychology Research Ethics Committee
Ethics Administrator
Psychology

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: https://www.sheffield.ac.uk/research-services/ethics-integrity/policy
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix F

Extract of Networking Sheet



Service Contacted	**Location**	Contacte
H.U.S.H (The Hidden Universe of Self-Harm)	East London	Y
Battle Scars	England-wide	Y
Harmless	Leicestershire	Y
adgroups@thebiglifegroup.com.	Manchester	Y
https://www.blackhealthinitiative.org/	Leeds	Y
info@adira.org.uk	Sheffiled	Y
info@birminghammind.org	Birmingham	Y
admin@sacmha.org.uk	Sheffiled	Y
Contact Us — Black Minds Matter UK	London	Y
About us — teg (theempowermentgroup.co.u	England-wide	Y
Stay Strong Men	England-wide	y
administrator@baatn.org.uk AND social@baa	UK-Wide	Y
Contact us - The Mix	UK-Wide	Y
admin@selfhelpservices.org.uk	Manchester	Y
info@bristolmind.org.uk	Bristol	Y
nilaari@nilaari.co.uk	Bristol	Y
BME Health Forum :: Contact Us (bmehf.org.u	London	Y
wakefieldsupport@richmondfellowship.org.u	Wakefield	
cbmeforum – Non Profit Charity / info@bmef	London	Y
advice@rethink.org	UK-wide	Y
admin@mayacentre.org.uk	London	
sahayak@rethink.org	UK-Wide	Y

Appendix G

Recruitment Advert

University of Sheffield

VOLUNTEERS NEEDED FOR RESEARCH STUDY

You are invited to take part in a study which aims to better understand Black British African, and Caribbean people's experiences of self-harm and decisions around seeking help.

Who are we looking for?

- English speaking adults aged 18+
- Identifies as Black British African or Caribbean
- Has self-harmed (e.g., by injury or self-poisoning) regardless of motivation

Whether you have accessed support or not, if you identify as Black British African or Caribbean and have experience of self-harm, we would love to hear from you!

Hello!

My name is Olivia. I am a third-year trainee clinical psychologist at the University of Sheffield.

I am the lead researcher on this project.

What will I need to do?

If you meet the criteria, you will be invited to take part in an online one-to-one interview with Olivia, the lead researcher. The interview will last about an hour. You will be asked about your lived experience of self-harm as well as your experiences of accessing, or not accessing, support.

How can I take part?

If you would like more information or would like to take part, please contact Olivia via email at:

Oalleyne1@sheffield.ac.uk

This research forms part of a doctoral thesis in clinical psychology and has been ethically approved by the University of Sheffield's Psychology Research Ethics Committee

Appendix H

Information Sheet

Information Sheet

A Qualitative Study Exploring Black British African and Caribbean Experiences of Accessing Support for Self-harm in England.

The prevalence of self-harm has increased in the United Kingdom in recent years and is estimated to be 400 per 100,000 individuals. Research has shown that ethnic minority groups are less likely to report self-harm and seek help despite being more likely to face greater life stressors. There is a gap in knowledge of what resources are needed in the community to support adults from Black Afro-Caribbean groups that self-harm, as not much is known about these specific experiences.

Who can take part?

To be involved in this study, you must be over 18 years of age and experienced self-harm (e.g. by injury or self-poisoning). You must also identify as Black British, African and/or Caribbean, or mixed heritage, and be able to speak and read English.

What will happen to me if I take part? What do I have to do?

1. You will be asked to complete an online survey on your background in order to get a better understanding of who you are. It will take less than 5 minutes to complete.
2. You will be asked to sign a consent form to show that you understand the study and are happy to take part. It should take less than 5 minutes to complete.
3. The researcher will arrange a virtual Google Meet interview with you where you will be asked about your experience of self-harm and the help you received.
4. The interview will last approximately an hour
5. Following the interview, you will be sent a debrief form
6. You will be given the opportunity to give feedback

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). You may withdraw at any time up to 1 week following completion of the interview, after which point, data will be anonymised. You do not have to give a reason for withdrawing. If you wish to withdraw from the research, please contact oalleyne1@sheffield.ac.uk quoting your unique ID to withdraw your data.

What are the possible disadvantages and risks of taking part?

- The interviewer will ask you about questions on self-harm which may generate sensitive discussion. You are reminded that you do not have to answer ay questions you do not feel comfortable answering.

What are the possible benefits of taking part?

- Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will inform organisations on how to better support people from Black Afro-Caribbean groups who are self-harming.

What will happen to my information?

- Your participation in this study is voluntary and you have the right to withdraw from the study at any time. You may also request to withdraw your data from the study up to one week after completing the final exercise.
- All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. You will not be able to be identified in any reports or publications unless you have given your explicit consent for this.
- The interviews will be audio recorded. The audio recordings made during this research will be used only for analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings. Once all the data is compiled and transcribed, the audio recordings will be destroyed by being carefully removed from the devices.
- The results of the study will be written up and submitted as a doctoral thesis as part of the Clinical Psychology Doctorate (DClinPsy) at the University of Sheffield. Additionally, the study will be submitted for publication in a scientific journal. Information regarding individual participants will not be included and you will not be identifiable from any reports or publications of the study. You may request a copy of the study results when they are available.
- The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. Further information, including details about how and why the University processes your personal information, how we keep your information secure, and your legal rights (including how to complain if you feel that your personal information has not been handled correctly), can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general
- According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general

What if something goes wrong and I wish to complain about the research?

- Should you wish to raise a complaint about the lead researcher (Olivia Alleyne) please inform Dr Vyv Huddy (research supervisor) by emailing v.huddy@sheffield.ac.uk.
- If your complaint has not been handled to your satisfaction you can contact the head of Department, Gillian Hardy (g.hardy@sheffield.ac.uk) who will then escalate the complaint through the appropriate channels.
- If the complaint relates to how the participants' personal data has been handled, information about how to raise a complaint can be found in the University's Privacy Notice: https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

Who can I contact if I need some support?

- If participating in this study has raised any concerns for you, please contact your GP/ physician or call Samaritans on 116 123 (free 24-hour helpline), Campaign Against Living Miserably (CALM) Call 0800 58 58 58 – 5pm to midnight every day, Papyrus – for people under 35, Call 0800 068 41 41 – 9am to midnight every day or Text 07860 039967.

If you have any questions or concerns about the study, please contact:

Olivia Alleyne - oalleyne1@sheffield.ac.uk

If you are willing to continue, please continue to the consent form using this link: https://qualtricsxmnmffw4blj.qualtrics.com/jfe/form/SV_5aHHbzDkXfQGfdA

Appendix I

Participant Consent and Demographic Form

Start of Block: Unique ID

Hello!

Thank you for taking part in this research. To ensure that you and your information remains anonymous, please create your own unique ID code below.

Your ID should be kept safe and noted somewhere as you will need to quote this ID should you wish to withdraw your data.

The ID should be no longer than 6 figures and can be a combination of letters or numbers (for example 2U5B09). Please **do not** use any letters or numbers that can be linked to your name or date of birth (e.g. BOB992)

If you have any questions about this form, please email: oalleyne1@sheffield.ac.uk

UNIQUE ID: ____

End of Block: unique ID

Start of Block: Consent Form

Q1 I have read the information about the project, as described in the information sheet

○ Yes

Q2 I understand the information about the project and what my involvement is

○ Yes

Q3 I have been given the opportunity to ask questions about the project and my participation

○ Yes

Q4 I voluntarily agree to participate in the interview

○ Yes

Q5 I understand that I can withdraw my input up to one week after taking part in it without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn

○ Yes

Q6 The procedures regarding confidentiality have been clearly explained to me (e.g use of pseudonyms and anonymisation of data etc.)

○ Yes

Q7 I understand that taking part in the project will include completing a demographic questionnaire, being interviewed and being audio recorded.

○ Yes

Q8 I understand that the audio recordings will be transcribed, anonymised and used as part of Doctoral research project which may be published.

○ Yes

Q9 I give permission for the responses that I provide to be deposited in an online research data repository so it can be used for future research and learning.

○ Yes

Q10 I understand that I will not be identifiable in the doctoral thesis.

○ Yes

Q11 I agree to sign this informed consent form.

○ Yes

End of Block: Consent Form

Start of Block: Block 3

Thank you Thank you for consenting to take part in this study.

We will now ask you a few basic questions about you.

End of Block: Block 3

Start of Block: Demographics

General Information Age Category

- ○ 18-25
- ○ 26-35
- ○ 36-45
- ○ 46-55
- ○ 56+

Q15 To which gender do you most identify?

- ○ Female
- ○ Male
- ○ Transgender Female
- ○ Transgender Male
- ○ Gender Variant/Non-Conforming
- ○ Not Listed ____
- ○ Prefer not to answer

Q16 Do you live in the UK?

- ○ Yes
- ○ No

Q17 Which region do you live in? (e.g. West Midlands)

____

Q18 How many years have you lived in the UK?

○ Since Birth

○ Other ____

Q19 What ethnic/cultural background do you most identify with?

○ Black British

○ Black African

○ Black Caribbean

○ Black Afro-Caribbean

○ Mixed Black African or Caribbean

○ Other ____

Q20 Do you have experience of self-harming?
*Defined as any act of self-poisoning or self-injury irrespective of motivation

○ Yes

○ No

Q21 Have you accessed support for self-harm in the UK through a charity, voluntary or community-run organisation?

○ Yes

○ No

Q22 Are you currently receiving professional support for self-harm?

○ Yes

○ No

Q23 What is your first language?

____

Q24 Do you require any support with online meetings and receiving documents online?

____

End of Block: Demographics

Appendix J

Interview Schedule

- Introduction: about me
- Reiteration: Interview will be recorded, and recordings will not be heard by anyone outside of the research. Snippets of the interview may be used but there will be no way of identifying who the contribute on came from.
- Participants do not have to take part and can decline to answer any questions. Can stop at any time.
- Any questions?

Topics

Tell me a bit about yourself

Experience of self-harm

- Can you tell me about your experience of self-harm?
- How did/does it make you feel engaging in self-harm?
- What helps you to cope better with the feelings that lead you to self-harm?
- Can you tell me about me with any experiences or circumstances that influenced self-harm?

  Prompts:
    - Employment
    - Substance misuse
    - Family
    - Environment
    - Media etc.

-What helps you to cope with the feelings around the things you've mentioned?

Construction of self-harm

- What are your perceptions of self-harm?
- Do you think your perception of self-harm is the same or different to someone outside of the afro-caribbean community?
- Was there anything about your ethnicity that makes it easier or harder.
- how? Why?

Experience of community-support

- Can you tell me about your experience of seeking and getting help for self-harm? (have they/haven't they?)

  Prompts:

- Experience of community service
- Awareness and availability of support
- Stigma
- Referral process
- Social influence – did you ever seek or ask someone from the same ethnic background to be involved in your care

- **Have you ever wanted to wanted to access support but didn't? why?**

    - Do you think the support service appropriately met your needs? Examples
    - Do you have any examples of support that you have received for self-harming which you have found particularly helpful?
    - Can you tell me about when the support you received was not appropriate for you?
    - How did the support you receive affect your view of self-harm?

- **What are your views about the services ability to support you?**

    - Would your experience be any different if the clinician was form the same background?

- **what do you feel services need to know when working with people from African and Caribbean backgrounds who self harm??**

Experience of BARRIERS / never sought help:

- Can you describe why you haven't sought support for self-harm?
- Tell me more about what makes you feel that way?
- What are your views about services ability to support you?
- What are your thoughts on community-based services?

Is there anything we haven't talked about which you feel is important to think about or touch on?

END.

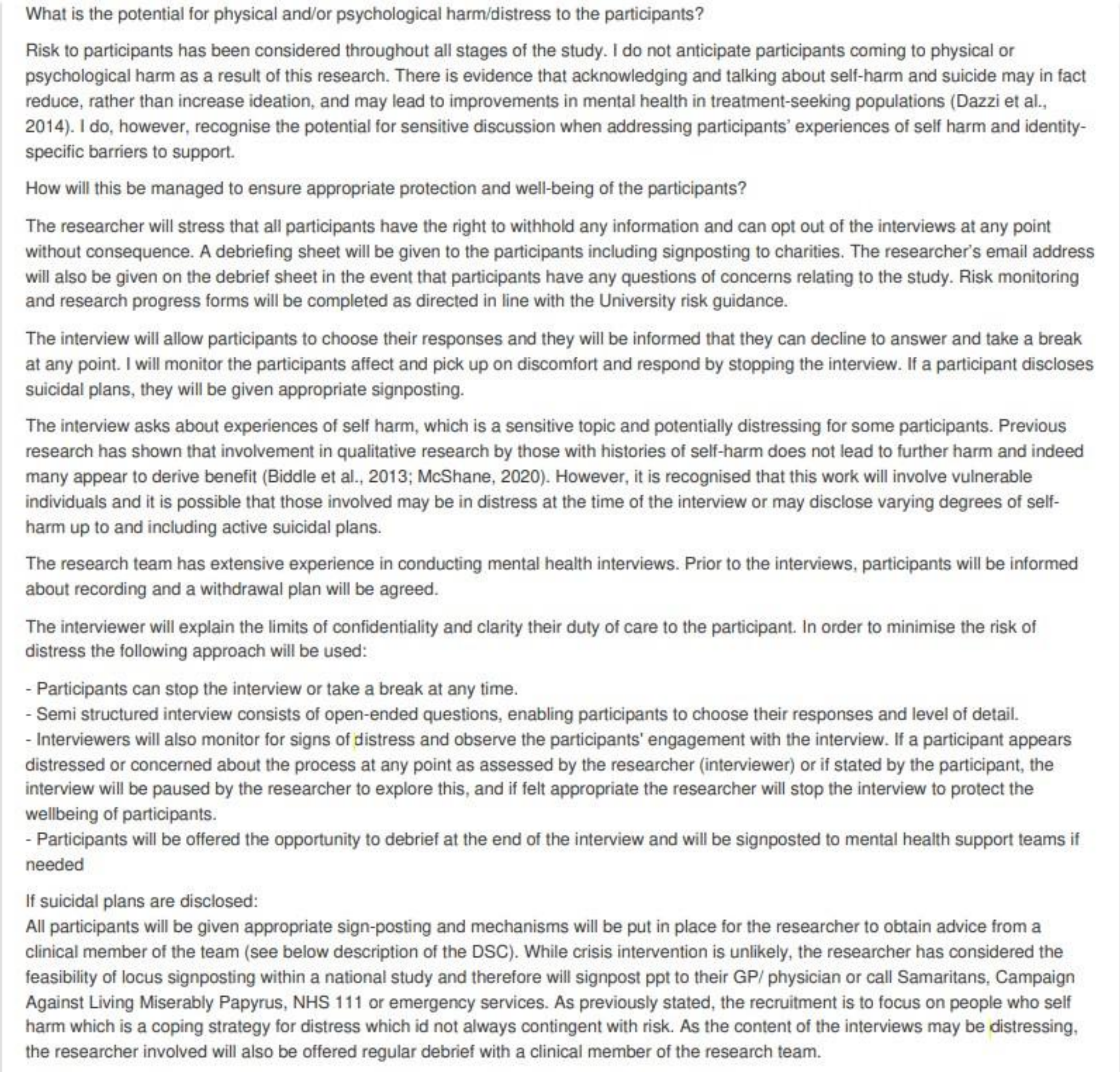
Thank the participant for their time and contribution.

Any questions?

Verbal debrief

Appendix K

Protocol for Managing Distress



What is the potential for physical and/or psychological harm/distress to the participants?

Risk to participants has been considered throughout all stages of the study. I do not anticipate participants coming to physical or psychological harm as a result of this research. There is evidence that acknowledging and talking about self-harm and suicide may in fact reduce, rather than increase ideation, and may lead to improvements in mental health in treatment-seeking populations (Dazzi et al., 2014). I do, however, recognise the potential for sensitive discussion when addressing participants' experiences of self harm and identity-specific barriers to support.

How will this be managed to ensure appropriate protection and well-being of the participants?

The researcher will stress that all participants have the right to withhold any information and can opt out of the interviews at any point without consequence. A debriefing sheet will be given to the participants including signposting to charities. The researcher's email address will also be given on the debrief sheet in the event that participants have any questions of concerns relating to the study. Risk monitoring and research progress forms will be completed as directed in line with the University risk guidance.

The interview will allow participants to choose their responses and they will be informed that they can decline to answer and take a break at any point. I will monitor the participants affect and pick up on discomfort and respond by stopping the interview. If a participant discloses suicidal plans, they will be given appropriate signposting.

The interview asks about experiences of self harm, which is a sensitive topic and potentially distressing for some participants. Previous research has shown that involvement in qualitative research by those with histories of self-harm does not lead to further harm and indeed many appear to derive benefit (Biddle et al., 2013; McShane, 2020). However, it is recognised that this work will involve vulnerable individuals and it is possible that those involved may be in distress at the time of the interview or may disclose varying degrees of self-harm up to and including active suicidal plans.

The research team has extensive experience in conducting mental health interviews. Prior to the interviews, participants will be informed about recording and a withdrawal plan will be agreed.

The interviewer will explain the limits of confidentiality and clarity their duty of care to the participant. In order to minimise the risk of distress the following approach will be used:

- Participants can stop the interview or take a break at any time.
- Semi structured interview consists of open-ended questions, enabling participants to choose their responses and level of detail.
- Interviewers will also monitor for signs of distress and observe the participants' engagement with the interview. If a participant appears distressed or concerned about the process at any point as assessed by the researcher (interviewer) or if stated by the participant, the interview will be paused by the researcher to explore this, and if felt appropriate the researcher will stop the interview to protect the wellbeing of participants.
- Participants will be offered the opportunity to debrief at the end of the interview and will be signposted to mental health support teams if needed

If suicidal plans are disclosed:
All participants will be given appropriate sign-posting and mechanisms will be put in place for the researcher to obtain advice from a clinical member of the team (see below description of the DSC). While crisis intervention is unlikely, the researcher has considered the feasibility of locus signposting within a national study and therefore will signpost ppt to their GP/ physician or call Samaritans, Campaign Against Living Miserably Papyrus, NHS 111 or emergency services. As previously stated, the recruitment is to focus on people who self harm which is a coping strategy for distress which id not always contingent with risk. As the content of the interviews may be distressing, the researcher involved will also be offered regular debrief with a clinical member of the research team.

Appendix L

Debrief Form

Debrief Form

I would like to thank you for participating in this research. Your time and thoughtful responses are greatly appreciated.

This study aimed to explore the ways in which people from Black African and Caribbean ethnic groups view self harm and their experience of seeking support for this. By addressing these diverse experiences, barriers and facilitators to accessing support services can also be identified.

If participating in this study has raised any concerns for you, please contact your GP/ physician or call Samaritans on 116 123 (free 24-hour helpline), Campaign Against Living Miserably (CALM) Call 0800 58 58 58 – 5pm to midnight every day, Papyrus – for people under 35, Call 0800 068 41 41 – 9am to midnight every day or Text 07860 039967.

If you wish to withdraw your data you can do so without reason or consequence, by emailing the researcher listed below and providing details of your unique code. You can withdraw your data up to one week after completing the entire study.

All of your data will be kept securely in a password protected file that only the researcher has access to. None of your details will be identifiable in the write up of the research.

Olivia Alleyne – oalleyne1@sheffield.ac.uk - Lead Researcher

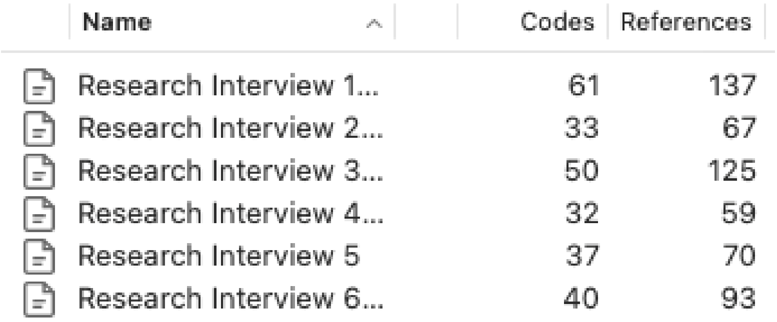
Dr Vyv Huddy – v.huddy@sheffield.ac.uk Researcher Supervisor

Amrit Singh – a.sinha@sheffield.ac.uk Research Support Officer

Appendix M

Exploratory Code Output

Total codes per interview



Name	Codes	References
Research Interview 1...	61	137
Research Interview 2...	33	67
Research Interview 3...	50	125
Research Interview 4...	32	59
Research Interview 5	37	70
Research Interview 6...	40	93

Codebook

Name	Description	Sources	References
Barriers to help		6	55
Awareness	Or lack thereof	4	5
limited coherence	not viewing self-harm as self-harm	1	1
Denying it to others		3	6
help for MH but not SH	SH is not acknowledged	3	5
Economic barriers		2	2
family struggles	Family commitments disallow support	2	2
Fear of medication	Belief held	1	1
lack of representation	“no one in that service looks like me”	3	3
Not enough privilege to be unwell		1	3
other black people's experiences	Learning of vicariously	1	1

Name	Description	Sources	References
professionals won't understand		5	14
Ethnicity unrecognised by professionals		4	5
Not disclosing everything	Not talking about identity of self harm in services	3	5
preferred ethnic matching	GM clinicians can understand me better	2	3
Fear of getting help		3	4
talking takes strength	Emotional capacity	1	1
Stigma	Community and internalised	4	12
neglected		2	2
othered		3	3
rejected		1	1
Shame		3	3
Therapists need training	To cause no further harm	1	1
Constructions of SH		6	38
a cry for help		1	1
a plaster for a broken leg		1	1
Different forms	All intentional	6	22
Alcohol and drugs	Self-poisoning	2	3
big and small instances		2	2
Cutting		3	3
Do not tell anyone		4	6

Name	Description	Sources	References
Excessive exercise		1	1
Making self vomit		1	1
Restrict food	= stomach pain	1	1
suicide attempts		2	2
Disappoints others		1	1
It means you need help		1	1
It's a relationship	Me and SH have a relationship	5	7
everchanging		3	3
it can get better		1	1
you can replace it		1	1
linked to insanity	“crazy”	1	1
opposite of taking care of yourself		3	4
Experiences of SH		6	63
Addictive		3	3
being black		5	10
discourse of strength		4	5
do other black people do this???		1	1
Impact of Racism		3	3
SH linked to hair		2	3
Traditional roles	Triggers related to tradition	4	4
Cant cut deep enough		1	1
Discrete practice		4	7

Name	Description	Sources	References
Done when depressed		4	9
A good pain		3	3
Release		2	2
Distraction - Break		3	4
Done when not coping		6	7
feels productive		2	4
accomplishment		1	1
Gets in the way		1	1
Help when it's bad enough		2	2
just do it	think about it later	1	1
lonely		4	5
regret		2	3
SH as punishment		1	2
for not fitting in	To Eurocentric beauty standards	1	1
Starting young	In childhood	3	3
Stop and start		2	2
Talking helps		1	1
Use of instrument		1	2
Doubling down	Literally rubbing salt into the wound. Compounding pain. Visual.	1	1
Facilitators		2	7
Being with others who do it		2	2
come and go	Flexibility of use	1	3
no pressure		1	2

Name	Description	Sources	References
Online help		1	1
Simple services	Accessible	1	1
Family as support		4	5
Family made referral		1	1
Friends as support		3	3
Generation tension		5	17
risk of rejection		1	1
they dont understand		4	9
Getting honest with myself	Ppts acknowledgement of self-harm	3	4
Good therapy	From community-based service	1	1
Helpful care		6	22
A therapist that is smarter than I am		1	4
go deeper than surface		1	1
acknowledging how hard it is		2	2
Empathy		1	1
exposure to others doing it		3	5
Patience		1	1
telephone check-ins		1	1
Leader from same ethnicity		1	2
freeing		1	1
therapy as a nice break		1	1
therapist from other ethnic group		2	4

Name	Description	Sources	References
ethnicity doesn't matter		2	2
writing things down		1	1
Intersections		3	9
Masculinity		1	3
religion		1	1
Spirituality		1	1
never got formal help		3	7
Decided to stop on own		3	4
Google as therapist		1	1
Tradition impact		3	5
Unhelpful care		5	17
'too close'	Prefer practitioners from outside BBAC group	2	3
Dismissal		1	1
Ethnicity not acknowledged		1	2
not listening		1	1
self-direction		1	1
unachievable solutions	Not appropriate/considering the persons social, emotional, economical position	3	4
we can talk about it... but years after	Have to have strength to discuss	1	3

Appendix N

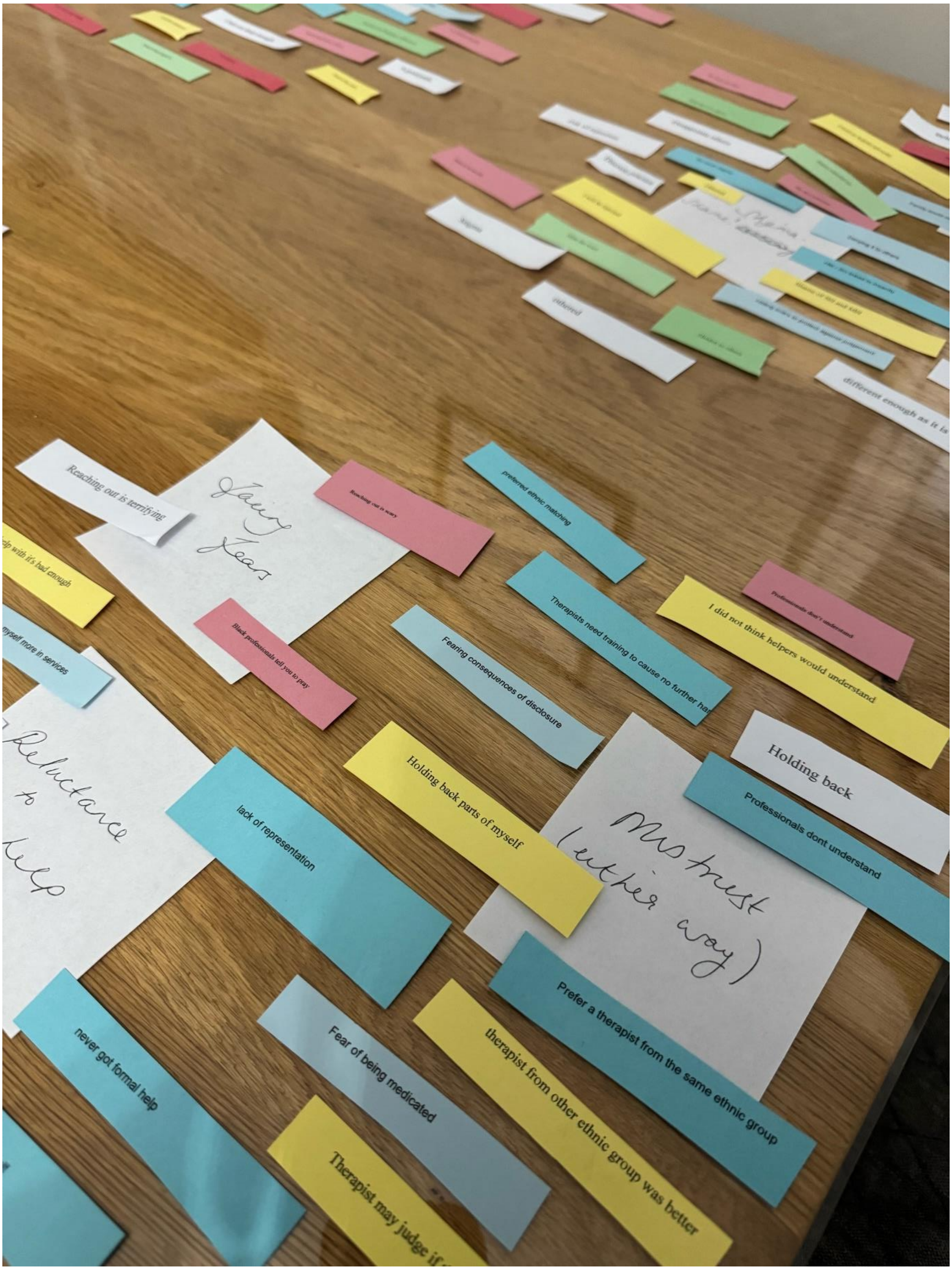
Experiential Statements

Interview 1	**Interview 2**
Isolating experience Stigma stops me I don’t have support Supporting myself Temporary fixes ‘They’ don’t understand me Being black and female is hard Not understood in society Culturally mis-matched care My family struggle Prefer an easy service Frustration around care Black is different No representation Vulnerable and scared. Help in crisis only. One size does NOT fit all Need for culturally appropriate care Withholding information from others Need for cultural representation in services Can they acknowledge strength Silence is protective SH neglected in services ethnicity left out of the discussion easy services are best	Their opinion matters Never got formal help Prefer a therapist from same ethnicity Neglected by my own people Perceived failure of traditional roles Rejection from community Failing masculine gender roles Self-harm is lonely Fear of judgement Attempted suicide Advocacy is helpful Lack of knowledge on help Where are the services? Professionals don’t understand Preference for different-tradition therapist Positive experiences with support Self-sufficiency beliefs Need for community representation in support. Coping through SH Help at crisis. Feeling “othered” Preferred ethnic matching Psychology helps Meaningful care is adaptive I have a duty
Interview 3	**Interview 4**
Fearing consequences of disclosure Preferred ethnic matching Intergenerational differences I am different Limited help options	Vulnerable and overwhelmed Culturally mismatched care SH overlooked A viscous cycle Unacknowledged ethnicity in services Beyond “surface level” conversations

Isolation and disconnection Preference for therapist matching The right time to talk Unreachable services Self-sufficiency Unrecognised ethnicity in help Fearful of service use Theres a safe time to disclose SH as coping Different methods of SH My complex relationship with SH Stigma is real Never got formal help Prefer a therapist from same ethnicity	Lack of cultural sensitivity Love/hate relationship with SH Hide from stigma and judgement Lack of family support Family expectations Evolving relationship to SH Feeling dismissed Intergenerational complexities "On and off" Triggered by stress Identity is ignored in services
Interview 5	**Interview 6**
Cutting is coping Cultural expectations as trigger Fears of community rejection Building resilience and self-advocacy Hiding and concealing self-harm Holding back parts of myself I did not think others would understand Parents have "old-fashioned" thinking Fear and apprehension I enjoyed SH until I didn't Coping in overwhelm Traditional responsibilities and expectations Family dynamics Hope ad improvement Supportive care Valued confidentiality and secrecy Fear of services Fear of rejection from community Self-harm is disappointing others Help when its bad enough	Different ways to harm yourself Harm for control SH is addictive Traditional impact Coping with overwhelm Strength is important Secrecy and shame Self-harm is not considered successful Identity acknowledgement in help Lack of culturally-competent care "Keep it moving" Religion can help Getting help requires privilege Racism affecting sense of self Coping through numbing African worldviews on success Reluctance to reflect on MH challenge Talking is burdening others

Appendix O

Cross-Case Analysis


different enough as it is
Reaching out is terrifying
Fears
Reaching out is scary
preferred ethnic matching
elp with it's bad enough
Black professionals tell you to pray
Professionals don't understand
I did not think helpers would understand
Therapists need training to cause no further ha
myself more in services
Fearing consequences of disclosure
Reluctance to elp
Holding back
Professionals dont understand
lack of representation
Holding back parts of myself
Mistrust (either way)
Prefer a therapist from the same ethnic group
never got formal help
Fear of being medicated
therapist from other ethnic group was better
Therapist may judge if

Appendix P

Additional Extracts for Theme Illustration

Group Experiential Theme	Subtheme	Additional Extracts
Complexities of Self-Harm	More than a Stereotype	*Some things I may not even see as self-harm may have been self-harm, you know. for the answer, yeah, I personally don't think self-harm would literally be self-harm, like taking a knife and cutting yourself so or just putting yourself in dangerous situations, you know … so yeah definitely seen that self-harm can take many different forms as well and its not always just maybe the stereotypical ways that we think of it yeah. (p.6)* *…trying to take more alcohol and drugs so that hopefully I will become an addict and try to hurt myself the most by commit suicide" (P2)* *I just wouldn't eat, and it took me a while to realise that was also a form of self-harm (p.1)* *I first started to self-harm and that was with a razor, so I would use a razor on my thighs or the top of my arms erm where I didn't, where I thought was easier to cover (p.3)*
	Refuge from Overwhelm	*…[self-harm is] seen as maybe coping mechanisms or a side effect of, you know, the really fast paced society that we live in, the fact that we need to keep up (p.6)* *I felt like I had to do it because it gave me some kind of, it was like a sense of release from every, all the emotions and the thoughts that I was keeping in so it actually became that release but something that I felt that I had to do (p.3)* *I think a lot of people that have got into these activities due to upsetting factors and upsetting conditions as well. (P.2)*

		If something bad had happened or if I just got upset or was having like a bad day then that was why I would do it (P.4) *I would just do whatever it took to just keep it moving, you know, Its a case of numbing, its defiantly to keep things moving, I don't wanna be stuck in a place, like I don't, I just don't, I really just don't wanna be stick in a place and slowing down and processing (p6)* *there been a feeling of satisfaction because it felt like I was actually doing something about these feelings… it came with that sense of accomplishment cause I could see the result after it (P1)*
	"It's a love-hate relationship"	*I mean when I did it it kind of felt good but afterwards and that healing process and always having to cover up your arm, that was the annoying bit (p5)* *it's like a short term kind of like way to let go of it but obviously it didn't like solve all my problems like forever (P4)* *I think it started more like experimental and like kind of got worse (P.4)* *then I think it did become a point where it became quite addictive (P.1)* *"Sometimes like I wish I didn't do it just because like those scars, I've had them for ages and they probably won't go away anytime soon" (P4)* *"I think definitely for myself at the time, in terms of romantic relationships, that caused a barrier because I was very much not wanting to show that part of myself to people" (P3)*

Navigating Expectations	Feeling Othered	*I don't think people get how much you notice, erm like how much hidden racism is still around today like people think its gone but its not its just less obvious but just as harmful (P.4)* *I am who I am because of the sh*t I took, you know, the bullying the jokes about liking chicken all of it (P.3)*
	Protecting and Concealing	*I do think there is still a lot of stigma around self-harm just because I think its very, very difficult for people to understand why you would do that to yourself, why you would inflict as they would see it, you know, pain and hurt onto your body in such a way (P.3)* *There was one occasion where my mum did try to speak to me, I had told my sister about self-harm and then she told my mum, but when that happened, I just lied to her. I completely denied all of it." (P1)* *me I think it was almost that stigma of mental health being something that was bad, that was something that was cause an issue, that wasn't really a topic that would be openly discussed but kind of erm shut down or judged, so I think for me, for my family definitely, it didn't feel like a space that I could share that with them for the fear of the response. (P.2)* *I don't want to use the word, but I know they would kind of question "well, you know, are you crazy", you know "why are you doing that", or even make kind of jokes in some kind of way or I know for some family members it would be really kind of shutting it down, not even wanting to have the conversation, erm which I don't think is necessarily a supportive environment shall we say (P.3)* *I think with my friends, we might talk about feeling very anxious, but in terms of more depression or self-harm or addiction or anything like that, it wasn't anything I would discuss (P.4)*

		for my family definitely, it didn't feel like a space that I could share that with them for the fear of the response. (P.3) I think it was almost that stigma of mental health being something that was bad, that was something that was cause an issue, that wasn't really a topic that would be openly discussed but kind of erm shut down or judged, so I think for me (P.1) *"Me and my dad never spoke about it, but my mum (SIGH), like spoke to other parents who could like relate. She did it in secret so I didn't really know, she just told me that she had done it but I don't know what she did. I think for her erm own like mental health she like got support but we never actually like spoke about my depression or self-harm." (P4).*
	Keeping it Moving	*I think that everyone will be regarding to me as a erm influence on society or how I am as a man because deeply I know where I'm coming from (P.1)* *I can comfortably speak about all [names African Country] (LAUGH) that we would rather do things ourselves than ask for help because we can do it (P_6)* *you don't have time to waste talking to you because I can do it myself (p6)* *I remember when they spoke to me about what happened, they were sad and I could tell they cared about me, but the way they spoke about it was in a way where they kind a turned it around on themselves they spoke about how I can't do this to them (P1)* *I never told anybody about the self-harm, I didn't tell friends, I didn't tell family (p.3)* *no one will regard that from you, no one will give you a listening ear and no one will even support you so I tried to do everything myself (P.2)* *I was very avoidant of issues within my family because I really struggled to communicate with them (P.1)* *exactly like you are worried to disappoint, like anything you do you feel like you are disappointing your whole family and stuff like that (P.5)*

		if you have like erm a white family you know, I feel like its very, very different and like having an African or a Caribbean family just say that its your phone or its your friends that you are hanging out with and stuff like that, they won't actually see the real problem that you're telling them. (P.5) *I feel like there is a lot more weight on you being like a female, especially the oldest like there is more responsibilities for you to do, that you didn't sign up for (P5)*
Promoting Equity	Preference - "We're not a monolith"	*I didn't feel like my experiences was really being understood erm as a young woman erm of mixed heritage and how my identity played a part in (P.2)* *Because I come from a West African upbringing and it felt like I would have to explain a lot and that felt exhausting with all the other issues I wanted to talk about so I kind of focussed on the more, let's say, experiences that didn't connect with my identity (P.1)* *P:I think it would be different because I think the care I needed revolved around on learning harmful stereotypes and I think that is more likely to come from a black person.* *T: Why would it more likely come from a black person* *P: Because maybe they would relate and not judge. Like I wouldn't have to explain myself as much about what it, why afro hair is a signature and important. (P.1)* *"Going to like a black professional for help, they will usually mention stuff about religion, for me it was a lot of "just go to church" and stuff like that, but if you speak to a maybe like a White therapist or someone they wouldn't really bring religion into certain things, so yeah I think there is a big difference" (P5)*

	Unaddressed Hardships	*when it came to my family with my mum being stressed also with her being a single parent and also us being a working class family, I felt like me confiding to her about my mental health issues about my self-harm would just cause her more stress and cause her more problems and I don't want to inflict that on her (P.1)* *I remember my counsellor she actually asked me at the end of our group why race was something I never brought up, and I remember telling her because I knew she wouldn't be able to fully understand, and I think having to explain myself from point one is quite exhausting, if there is just like a base level (P.4)* *I have many family members who have been sectioned or heavily medicated, I think for me that was a fear at the time what the consequences or treatment would be, erm so yeah I think that was where my head was at (P.2)* *I don't think I ever saw anything about self-harm so whether that was in, you know, whether that was in a hospital or a GP surgery, I never saw anything about self-harm, erm it would be, I don't know, kind of pregnancy support or you know, get your vaccinations or things like that, I didn't necessarily see things that were like 'okay this is a space where you can come and erm you can talk about self-harm (P.3)* *like I never like cried in there, I just kind of sat there and like do random activities that felt very useless (P.2)* *"The self-harm that was like a little addition, so it was very much overlooked, I cant even remember if it was ever brought up…It wasn't really touched on so I didn't really get help for the self-harming" (P4)*

	Helpful Systems	*I think acknowledgement, erm in terms of okay self-harm, whether it was self-harm or the difficulties that I was having with my eating or depression not being a diagnosis but actually what, what are my experiences in terms of my identity, my heritage, erm and how have these played a factor into the self-harm, erm not them being two desperate things but the fact that they are very intertwined, so I think having that, I don't think it's (LAUGH), I don't think it is a lot to ask but having that basic understanding I think would really have enriched the sessions a lot more and helped me navigate my identity and my mental health in how they do kind of correlate with each other, so yeah I think just having that basic foundation and knowledge would have been hugely beneficial yeah (P.3)* *I would just say you cant approach individuals erm based of people you've already dealt with, right, you have to be able to fully understand what these individuals are going through and how they're coping, (P.6)* *some cultures people wanna help themselves, if you wanna help me, help me, help me find a way to help myself. (P.6)* *"without the help of the therapist I wouldn't be able to apply or to take part in this discussion alongside with you" (P.3)*