A PHENOMENOLOGICAL ANALYSIS OF BLACK AFRICAN WOMEN'S EXPERIENCES OF ENGAGEMENT IN COUNSELLING IN THE UK

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ABSTRACT

This study explores Black African women's experiences of engaging in counselling in the UK, which was achieved by exploring participants' lived counselling experiences. The study also explored whether the participants' experiences will impact future engagement with counselling. This study used Interpretative Phenomenological Analysis (IPA) as the methodology. The six participants recruited for this study had all migrated to the UK from Africa.

The findings from this study describe participants' experiences of engaging in counselling, as interpreted within the three emerging master themes, namely; Preconceptions, stigma, skepticism about attending counselling and preferred ways of coping, The important characteristics within the counselling experience and Post counselling reflections on the therapeutic process and changed perceptions. The first master theme groups together the participants' cultural beliefs about counselling before they began. This included preconceptions, scepticism about the therapist, stigma associated with counselling engagement, and the participants' preferred ways of coping with psychological distress as an alternative for counselling. The second master theme describes the participants' experiences of being in counselling and present with a therapist. This was influenced by the therapist's characteristics, the therapist's way of working, and the quality of therapeutic relationship established. The third master theme encapsulates the participants' post therapy reflections, where they described the end of their counselling journey. This included their comments about aspects of the counselling that they felt needed changing to make counselling a more positive experience for them, should they require it in the future, including the counselling pathway and the counselling environment. All six participants expressed a change of perception about various aspects of counselling after they had completed their counselling journey. Overall, this was found to be a good experience despite two participants being dissatisfied with their counselling.

The findings from this study highlight that different factors influence this group of Black African women's engagement with counselling. These include personal, structural, and institutional factors. The study offers suggestions for policy makers, health care providers, and the practice of counselling, to consider providing services more tailored to meet the needs of Black African women in the UK.

ACKNOWLEDGEMENTS

My aim in doing this study was to offer my contribution to the field of counselling psychology by specifically looking at Black African women's experiences of engaging in counselling in the UK. Although under-researched, this has been a topic very close to my heart. It took longer than expected to complete this thesis, due to life problems and challenges that included physical, emotional, and socioeconomic factors, but what held it together for me was the recognition that everything is possible when one puts their mind to it.

During my write-up, I have come across so many wonderful authors who have committed their lives to studying participants' experiences of psychotherapy, counselling, and Black, Asian and minority ethnic (BAME) mental health issues. This has broadened my knowledge base regarding this topic. I would like to express my appreciation to authors such as Professor Kamaldeep Bhui, Professor Dinesh Bhugra, and Dr Dawn Edge, and some of the post-colonial thinkers, such as Paul Gilroy and Homi Bhabha, who provided the knowledge and understanding about some of the sociopolitical issues that have impacted BAME mental health issues.

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Contents

INTRODUCTION

i. Background to BAME engagement with mental health

When Black African women and mental health in the UK are discussed there is a general tendency to associate this group with severe mental health issues and poor engagement with mental health services that are offered to them, (Woodward, White, Kinsella, & Robinson, 2016)

According to the Mental Health Foundation (2013a), reporting mental illness has been identified as one of the major health concerns in the UK. According to World Health Organization (2016), it is estimated that one in four adults in the UK will experience at least one diagnosable mental health problem in their life.

However, although this is the case in the UK's general population, in comparison to this percentage, and other Black, Asian and minority ethnic groups (BAME), African people living in the UK pose a higher risk of developing mental health issues (Browne, 2013; Mental Health Foundation Review, 2015). Furthermore, Care Quality Commission (2011) reports that Black African women are more likely to receive a severe mental health diagnosis, such as schizophrenia, than White women who present with similar symptoms (Gajwani, Parsons, Birchwood & Singh, 2016).

Despite a higher rate of diagnosis of mental health in comparison to the general population, the majority of African people, specifically Black African women, do not receive the appropriate care they need (Bhui, 2001; Wagstaff, Farrell & Williams, 2011). Lubian et al. (2016) claim that this group is overrepresented in inpatient mental health services and underrepresented in primary care services and mental health services such as counselling (Browne, 2013; Sewell, 2012; Woodward & Kinsella, 2016), suggesting that African people have been difficult to engage when invited to attend such services. For those few who have engaged in therapy, there is a tendency for them to discontinue or prematurely leave services that could have helped them to sustain better

psychological well-being (Cooper et al., 2012). Premature discontinuation, or therapy dropout, has been described as a significant problem that limits the effectiveness of the psychological interventions that are offered, and leads to poorer treatment outcomes (Wagstaff, Farrell & Williams, 2012).

Poor treatment outcomes due to nonengagement or poor engagement with mental health services remain a significant problem that need to be explored, with the view to finding a solution that will ensure that the services offered reach the targeted population (De Maynard, 2009; Whitley, Kirmayer & Groleau, 2006).

Literature suggests that Black women's low access to psychological therapies in the UK has resulted in them being labelled as a 'hard-to-reach' population (De Maynard, 2009). Edge and MacKian (2010) argue that such a label may imply that the failure to access mental health services and treatment lies with the women themselves, suggesting that these women have made choices not to attend services that they have been offered.

On the contrary, it has been suggested that, for those few Black African women who seek therapy, barriers such as negative stereotypes, cultural assumptions, and culturally insensitive therapeutic approaches contribute to poor engagement and premature service discontinuation; something that these women may have no control over (Whitley, Kirmayer & Groleau, 2006).

Furthermore, Knifton (2012) argues that the counselling services developed from primarily European models of thought may not be suitable for people from different ethnic backgrounds. Hence, some necessary steps need to be taken to ensure that the services offered meet the needs of people from different cultural backgrounds. Harrison (2017) has suggested different reasons why Black women have been underrepresented in research. These reasons might be that Black women are unable to make accurate judgements, are not aware of the usefulness of therapy, and may have difficulties with articulation and expression due to different factors such as language barrier. Furthermore, Harrison (2017) has suggested that the same factors that impact Black women's poor engagement in services might be similar to those factors that cause them not to want to engage or participate in research. Edge and MacKian (2010) identify those factors, including personal, social, and institutional barriers, that people of colour need to overcome before they can access care from

statutory mental health services. These factors will be critically discussed in the literature review chapter using relevant research and literature.

ii. Rationale for doing this research

In spite of the concern about Black African women's high presentation in mental health inpatient services and low presentation in psychological therapies, there seems to be limited research in the UK that has investigated the reason for Black African women's poor engagement in counselling and other psychological therapies, through asking those women about their lived experiences of counselling.

The counselling definition used in this literature review is closely related to a definition given by The British Association for Counselling and Psychotherapy (BACP Publication, 2015) (definition cited by Netto, 2006). This definition describes the purpose of counselling as providing clients with the opportunity to discuss their problems with a qualified practitioner or counsellor. The counsellor is not judgemental and does not give advice or share information about a client's distress to anyone else, but tries to understand a situation from the client's perspective and helps them understand the problems in a new light. This practice can help clients to cope better with problems and bring about positive changes in their life. The words 'counselling', 'therapy', and 'psychotherapy' have been used interchangeably in different parts of the thesis to mean professional help that people seek as a way of coping with psychological distress. These words have been used widely by participants in this study.

Sisley, Hutton, Goodbody and Brown (2011) posit that the ethnic, culturally based, social, and historical explanations of mental health and illness that shape the experiences of Black people's attitudes towards help-seeking behaviours, need to be explored to ascertain the reasons for engagement or nonengagement in such services. This will help practitioners to have more insight and to consider those factors when working with clients from such populations.

Lack of exploration of this issue may have resulted in the lack of understanding of how Black African women experience different forms of psychotherapy and counselling, and the views they hold about the therapeutic processes that are involved in such services. Bachelor (2013) argues that involving clients and exploring clients' experiences of different aspects of their care, can be useful in gaining an understanding about what can be done in terms of better service provision. In

psychotherapy and counselling, this may mean taking the necessary steps that will allow more engagement and access to services for the hard-to-reach population, such as Black African women (Ochieng, 2012).

iii. Epistemological stance

The study will use an Interpretative Phenomenological Approach (IPA) (Smith, Flowers & Larkin, 2009) as a research methodology, and take a phenomenological (Husserl, 1927), hermeneutic (Heidegger, 1962), and critical-realist (Merleau-Ponty, 1962) epidemiological stance.

Qualitative methodology was considered appropriate for this study as it better captures the phenomenon under investigation. Hammersley (2008) claims that, with an increase in demand for evidence-based practice and brief treatments as a result of limited resources in healthcare in the UK, the focus of many therapy services seems to be on outcomes and measurements of specific symptoms. This has resulted in the use of, and overreliance on, quantitative research methodologies to measure clients' progress (Hays & Wood, 2011). Even though this is useful, there is still a need to use qualitative investigations to provide an in-depth understanding of clients' feelings, how they experience the different phenomena, and how they make sense of their experiences (Levitt, Pomerville & Surace, 2016).

Given the identified gaps in the literature, this study will explore factors that may be impacting Black African women's engagement with counselling by exploring experiences of those women who had previously engaged in counselling, and whether these might impact their future engagement with counselling when offered.

Through this exploration, this study aims to address four key research questions:

1. How did Black African women perceive counselling and the therapist before they engaged in counselling?

2. What were their experiences of counselling in the therapy room?

3. What were their post counselling reflections?

4. What would they recommend for future practitioners and policy makers to consider if they offer counselling to Black African women in the future?

Through the analysis, it is anticipated that the findings from this study will contribute to the existing knowledge by identifying factors that may influence Black African women's engagement with counselling services. In addition to this, the findings may highlight what can be done to encourage or empower Black African women to engage with counselling and other mental health services available to them.

iv. Reflexivity

I chose to focus on Black African women (BAW) in this study, as they are a relatively homogeneous group of settled migrants here in the UK, with a reported high prevalence of psychological distress that impacts on mental health (Woodward, White & Kinsella, 2016).

Based on my observations as a psychologist in training, during my training I have noticed a significantly low number of Black African women attending different forms of therapy compared with other ethnic groups. Literature suggests that, despite the government's efforts in developing and expanding counselling services, such as transcultural counselling, multicultural counselling, and intercultural counselling, all aimed at addressing issues of race, gender, ethnicity, culture, and reducing inequalities in accessing counselling services among the BAME population, in general, the uptake of Black and Minority groups, specifically women from African origin, remains low compared to women from other ethnic groups (Knifton, 2012; Moffat, Sass, McKenzie & Bhui, 2009; Netto, 2006).

My motivation to undertake this study was to gain some understanding into BAW's lived experiences of counselling and to gain an understanding of the various factors that may have impacted upon their engagement in these services, from their perspective. As a Black woman, I have a preoccupation and desire to 'give a voice' to Black women in therapy; to make therapy a positive and empowering experience for them. As a trainee psychologist and a researcher, I relate to the importance of exploring clients' experiences with counselling services or therapy, which is an essential part of counselling and psychotherapy practice (Macran, Ross, Hardy & Shapiro, 1999).

On reflection, I felt that doing this research was a brave move to make, bearing in mind that there appears to be very limited research into Black African women's experiences of engaging in counselling in the UK. Exploring such a complex matrix was not an easy task, considering the

many challenges that I encountered at different stages of my enquiry. This being a qualitative study, my reflectivity as a researcher is very important. It will unravel how, and to what extent, I have impacted upon the findings of this study, and is interwoven fluidly throughout the chapters.

My interest in doing this study stems from my interest in exploring the reason for Black African women absence in counselling and psychotherapy services based on my observation and experiences of working within the mental health services. Being a woman of colour myself, I was very keen to explore the reasons for Black African women's absence in these services. To me, nothing feels more important in my work as both a researcher and a prospective therapist than ensuring the clients' psychological well-being, their satisfaction with services, and taking seriously the regular feedback that the clients give practitioners about the treatment and care they experience through the use of counselling.

As a researcher and trainee psychologist, who worked within mental health services in the UK, I found myself holding a dual position and this created tension within me. My stance as a psychologist was to see the patients as the experts, whereby I positioned myself as an observer of their distress, but at the same time I was very keen to provide counselling as a way of helping them deal with their distress, with a view to helping them sustain better psychological well-being. As a researcher, being a Black African woman and coming from the same cultural background as my participants created tension. I believe I projected feelings onto my participants, whereby they perceived me as being high achieving and thriving as opposed to being 'ill'. Even though I was interested in deeply exploring my participants' experiences, I was concerned about balancing therapeutic and professional boundaries, which felt challenging when the participant was reluctant to share their experiences fully without the fear of being judged. My main challenge was to strike a balance between my stance as a researcher and a trainee counsellor. The use of reflexivity was useful in considering where I stand in my research and also my clinical practice. I acknowledge that a qualitative study should focus on accommodating and maintaining all the positions and tensions that I was holding. In the methodology and analysis chapters of this thesis, I address how these tensions and prior experiences might have impacted the construction of data, and possibly the findings, of my study.

CHAPTER ONE

LITERATURE REVIEW

1:1 Introduction

This literature review discusses factors that may impact Black African women's (BAW) engagement with counselling as a way of coping with psychological distress. In this literature review, a critical evaluation of different factors that may impact BAW's engagement with counselling is highlighted with the aid of literature and research that was undertaken within the field of clients' experiences of therapy in the context of a more extensive body of literature and research that covers BAME communities. This is due to the limited research and literature that has explored BAW's engagement with counselling, especially their lived experiences of counselling in the UK.

While BAME covers a range of different communities, such as Asian, African Caribbean, and other non-British populations, this study focuses on engagement with counselling by exploring experiences of counselling of BAW who migrated to the UK. Bhui and Bhugra (2002) have defined the term 'Black African' to describe Black people born in Africa, or with parents born in Africa, who migrated to the UK.

For this literature review, 'Black people', 'Black women', 'people of colour', and 'people of African origin' will be used throughout to mean Black women and men of African descent. Combining these groups in this way is assumed unproblematic. In the UK, literature identifies two significant issues pertinent to Black people of African origin. These are: high prevalence of mental illness and nonengagement with mental health services, especially counselling and other psychotherapy services (Browne, 2013). Although the focus of this literature review is on BAW's engagement with counselling, I acknowledge that the issues pertaining to engagement cannot be explored in isolation without understanding the factors that have contributed to a high prevalence of psychological distress and poor mental health within the BAME community, particularly African women, as these are very relevant to the discussion.

1:2 BAME and mental health in the UK

Lubian et al. (2016) explain that, although there are different rates of mental health diagnosis among the general population in the UK, in general, people from BAME are more likely to be diagnosed with mental health issues; be admitted to hospital; experience poor treatment outcomes; and be more likely to drop out of mental health services that were offered (Kirkbride et al., 2008). In turn, this leads to further deterioration in their mental health compared to other ethnic groups (De Maynard, 2009; Sainsbury Centre for Mental Health, 2002).

In comparison to their demographic proportion of the general population, there is a high prevalence of mental health issues reported by Black people of African origin, with admission rates to hospitals at least twice as high for Black Africans as other ethnic minority groups (Care Quality Commission, 2011; Sewell, 2015). The Mental Health Foundation Review (2015), which explored the relationship between ethnicity, mental health problems, and socioeconomic status, found that people from a BAME background have a higher prevalence of mental health issues compared with the White majority population.

This group is two to five times more likely to receive a misdiagnosis or a severe mental health issue, and to be admitted to hospital under the Mental Health Act, than White British and people from other ethnic minority backgrounds who present with similar symptoms (Gajwani, Parsons & Birchwood 2016; Mann et al., 2014; Mind, 2013a).

In 2014, the adult Psychiatric Morbidity Survey reported a significant variation in prevalence of common mental health issues for women but not for men. According to this survey, non-British White women were the least likely to have common mental health problems, (15.6%) followed by White women (20.9%) and Black British women (29.3%) (Clark, Bebbington, Jenkin & Hinchliffe, 2016).

Looking at the above statistics, it is clear that there may be different factors that cause a higher prevalence of mental health diagnoses for people of African origin that appear not to be shared with other BAME groups here in the UK (Cantor-Graae, 2007).

Literature reports a strong correlation between economic, social, economic and institutional factors, and mental health problems among Black people in the UK (Stewart-Brown, 2016; Woodward, White & Kinsella, 2016).

1.3 Social factors and BAME mental health

Keating and Robertson (2004) and Bhui and Nazroo (2018) suggest that Black people have several disadvantaged statuses of being socially excluded; are denied access to various rights and resources that are available to other members of society; and are facing social deprivation (Cooper et al., 2012). Social deprivation creates a vicious cycle that presents Black people, particularly women, as socially disadvantaged and not considered as active members of society (Edge & MacKian, 2010). Social deprivation appears to have been contributed to by poor education, unemployment, poor health, and lack of aspirations (De Maynard, 2009).

1:4 Economic factors and BAME mental health

According to a report from the Institute of Race Relations (2019), people from BAME communities are more likely to experience poverty, and have poorer educational outcomes and a higher unemployment rate. Powell (2019) reports a higher rate of unemployment amongst 16 to 24-year-olds from a BAME background; with 26% of African origin and 23% from a Pakistani or Bangladeshi background, in comparison to 11% from White counterparts. Barnard and Turner (2011) report unequal pay rates between different groups. For instance, on average, men and women from a BAME background get paid less than those from other ethnic groups with similar qualifications and experience. Other economic factors include high levels of poverty and homelessness amongst people from Pakistani, Bangladeshi, and Black African communities. For instance, in 2013, 37% of statutory homeless households were people from a BAME background. A combination of these social and economic factors places Black people at more significant risk of severe mental illness, such as anxiety, depression, and other mental health difficulties (Browne, 2013).

However, De Maynard (2009) argues that other ethnic minority groups are also disadvantaged by social and economic factors, but these groups do not appear to exhibit the same incidence of mental illness as Black people of African origin on their first contact with mental health services. Due to the lack of evidence to support the view that Black African people are more at risk of developing mental health issues than other minority ethnic groups, as previously outlined, Bhui and Nazroo (2018) conclude that institutional factors may be able to explain the high prevalence of psychological distress and poor mental health for Black people in the UK (De Maynard, 2009).

1:5 Institutional factors and BAME mental health

Black people in the UK have held multiple disadvantaged statuses, including a history of social and political oppression originating from slavery and colonialism from the 16th to the 19th century (Lovejoy, 2012; Veracini, 2010). Gilroy's (2005) post-colonial theory describes the legacy of colonialism in contemporary society and the influence of the slave trade and colonialism on Black people's identity. He has claimed that, through colonialism, which was regarded as a civilising mission, many people from African descent lost their culture and identity (Gilroy, 2000).

Although slavery and colonialism have ended, a particular form of colonial mentality or colonial discourse continues to inform contemporary attitudes of race and ethnicity in the post-colonial era in the UK, through the ideologies of discrimination, racism, and prejudice (Gilroy, 1993).

In other words, the social interaction between different ethnic groups, and the current organisation of social, political, and economic structures that exist in the UK have created, in some instances, a binary position based on the notion of 'otherness' between majority and minority groups (Gilroy, 1993). This system seems to favour powerful groups and disadvantages less powerful groups such as people of African origin (Cooper et al., 2012).

To some extent, the idea of a multicultural society in post-colonial UK is aimed at establishing a society where there is no social division or class, though the ideologies of prejudice, discrimination and racism between different ethnic groups seem to have been abandoned (Bulmer & Solomos, 2015; Mathew, 2018).

1:6 Theories of race, racism or racial discrimination

Just to mention, racism has been viewed as a major problem in contemporary society because most social problems such as poverty, unequal distribution of resources, prejudice, discrimination, hostility towards different members of society, and other related problems are caused by the issue of race or racial discrimination.

However, despite the fact that the psychological literature has paid significant attention to the concept of racism, over the years the basic question remains as to how people view and understand racism. To date there has been some debate whether racism is heavily biological or understood to be a socially determined phenomenon (Martin & Parker, 1995). For the purpose of this discussion,

a focus will be on understanding the social and psychological aspects of racism, as these seem more relevant to the current discussion. First and foremost, racism has been explained as behaviours that lead to unequal treatment of an individual based on membership of an ethnic or racial group (Essed, 1991).

A variety of explanations for prejudice, discrimination, and racism have been postulated by social psychologists over the years. These explanations have shifted over time depending on historical various factors such as; social, political, and paradigmatic positions that has been used to explore and discuss these factors (Brown, 2008).

All things considered, the concept of racism, race, and ethnicity has been examined through the following major and interrelated perspectives. These include: intergroup theories, cognitive theories, and critical psychological theories.

In retrospect, it is worth understanding that more than one theory is needed to describe racism because racism is engrained within the fabric of society and therefore cannot be explored and discussed in isolation. These theories explain how power relation shapes the lives of everyone in contemporary society, whereby the minority group identities are shaped by broader institutionalised forms of racism, while the majority or dominant group accrues benefits because of its privileged position in society (Moreton-Robinson, 2004).

1:7 Inter-group approaches

Within an intergroup explanation of racism, two theories have been put forward: conflict theory (Marx, 1954) and social identity theory (Tajfel & Turner, 1986).

Conflict theory describes how power and dominance between different social groups contributes to the development of intergroup hostility. According to this view, intergroup hostility arises because of competing resources in different areas such as economic, social, and cultural. Marx (1954) believes that, in society having regular conflicts and disagreements over limited resources are basic facts of life because human needs are unlimited and resources are limited. As different groups are competing for limited resources, the power dynamic exists whereby the most powerful group or people continue to maintain their dominance by pulling down those without power.

However, the social identity theory (Tajfel & Turner, 1986) argues that the intergroup hostility and conflict can also occur, even in the absence of competition for scarce resources. According to this theory, an individual place a psychological significance in his or her group membership whereby an individual evaluates themselves and others as 'us' or 'them', in-group' and 'out-group' according to social categorisation, social identification, and social comparison based on ethnicity, gender, social class, physical characteristics, and related factors. Tajfel and Turner's (1986) social identity theory claims that evaluation of oneself and others is a normal social and cognitive process. In order for group members to increase their self-image, they tend to enhance the status of their own group (in-group), by discriminating and holding prejudiced views against the out-group or the group they don't belong to. Hence, in prejudice, competitive hostility between groups can be viewed as not only competing for resources, but also competing for identities (Tajfel & Turner, 1986).

However, some of the critics of social identity theory believe that social categorisation of people into different groups can lead to intergroup discrimination and prejudice, which can impact individual or group identity, where one group may feel inferior or superior over the other group. Ellemers and Haslam (2012) believe that a group can still maintain a positive social identity without threatening the social identity of others, and therefore social categorisation may not be necessary.

1:8 Cognitive theories

Furthermore, the social cognitive theories offer a very important explanation of the origin of racial bias within social groups. Allport (1954) describes what role social categorisation and stereotyping play in perpetuating cognitive processes that cause racial bias. According to this theory, categorising people into different group memberships based on race, gender, and age is believed to be driven primarily by our limited cognitive capacity to process an overwhelming amount of stimuli or information we receive on a daily basis; therefore, categorising people into respective groups enables us to process the information quickly and efficiently.

However, categorising people based on one's perception is viewed as distorting reality and causes racial bias, whereby people are not viewed as individuals in their own right but are placed in prototypical groups in which they may not belong (Nosek, Hawkins & Frazier, 2011). In addition, social cognition theories have been scrutinised for encouraging racism and prejudice by viewing

racial categories as a natural cognitive process rather than social and ideological constructs that create inequality in society (Hopkins, Levine & Reicher, 1997).

1:9 Critical psychological theories

Critical psychological approaches have discussed racism and prejudice practices that justify and legitimise relationships based on the power exploitation of an inferior group by a superior group (Augoustinos & Every, 2007). Furthermore, Bonilla-Silva (2010) views racism as a socially constructed phenomenon. He believes that racial difference and classification are human-made categories rather than eternal and essential categories. He believes that the notion of racial structure and categories award systemic practices that reinforce White privilege and disadvantage people of colour.

Critical race theory

Critical race theory (CRT) is one of the relevant theories within the critical psychological approach. Over the years, CRT has been used as a broad theoretical approach to study social inequalities and racism in contemporary society. This theory was popularised by Crenshaw and Bell in the 1980s and has its origin in civil right movements and legal studies in the USA in 1960. It also draws upon some post-colonialism, social-political philosophy, and feminism concepts. CRT clarifies the individual and institutional nature of racism and examines how the current economic and political structures encourage White privilege and White supremacy. In this literature review CRT has been used an important framework that summaries all issues pertaining diversity, differences, the politics of power and oppression between groups.

Using CRT, Stefencic (2001) and Bonilla-Silva (2015) describe four main tenets that explain the nature of racism and how racism operates contemporary society.

Tenet one: Racism has a material foundation;

This tenet describes how racism controls the political, social, and economic aspects of contemporary society. According to this perspective, the origin of racism today can be explained as a result of two dimensions: the capitalist mode of production and imperialism.

In the capitalist mode of production, the main motive was obtaining profit and privilege that favors the dominant group through exploitation of economic resources from minority groups. On the other hand, imperialism refers to the policy of extending a country's power and influence through the use of power, force, and other means to benefit the superior group. The material exploitation of the inferior group has led to social inequalities, making the inferior group vulnerable to mental health due to poverty and low economic status.

Tenet two: White supremacy

This tenet describes racism to be firmly embedded within society through the ideology of White supremacy. White supremacy operates in different areas of society; for instance, in education, employment, politics, health, and many more. To this effect, Bell (2000) purports that racism escalates exploitation of people of colour, denying them opportunities for progression. Furthermore, Bell (2000) explains that White supremacy ideology is used as a negotiating power, and policies that favour White people compromise the rights of Black people.

Tenet three: A critique of law and legal institutions

Since the CRT originated from legal studies and civil right movements, a closer look of the law and legal institutions is one of the dominant areas of CRT. This tenet recognises White people as sole beneficiaries of civil rights legislations and policies, and therefore the racist policies that perpetuate social inequality are ignored. The mechanism of colour blindness is used whereby racism is subtly recognised but ignored, pretending that it does not exist (Crenshaw et al., 1995; Delgado & Stefancic, 2000, 2001).

Tenet four: Use of language as part of social construction

This tenet acknowledges how language has been used as a resource to reproduce and justify racist outcomes in contemporary societies. The current power relation of dominance and privilege is maintained through overt racism, whereby the contradictory statements that seem to favour equality, freedom, and individual rights for all are wrongly used to mean the opposite; in other words, they don't mean what they say (Wetherell & Potter, 1992).

However, in spite of CRT being a very useful framework that has been used to describe social inequalities, amongst others, one of the criticisms has been its overreliance and focus on racism as

one the major factors that facilitates prejudice, discrimination, and other forms of inequality in the contemporary society (Bonilla-Silva, 2015).

Harell (2000) argues that, in addition to racism there are other factors that impact everyone within a social group these include gender, sexuality, ethnicity, religion, health, education, and social class. All these factors play a part in the system, in producing good and bad intersectional consequences. Due to the fact that all human beings share the same social structure, the societal problems that arise as a consequence of such an interaction are also related. Hence, racism cannot be studied without considering these factors. As such, Arriola (2000) believes that to study inequalities in society, one should include convergence of many factors as stated above.

In retrospect, there are many more racism related factors that impact Black people of African origin's mental health and psychological well-being. Particularly relevant to this discussion is the concept of perceived racism. This refers to the individual's subjective interpretation of an event, a situation, or an experience as harmful, unjust, or undignified as a result of one's racial background (Pieterse et al., 2012). The subjective experience of racism and discrimination appears to have led some Black people to interpret life events as negative events in the absence of actual racist and discriminatory events. De Maynard (2009) purports that, as a result, this seems to create a constant fear and paranoia about race-related rejection and denial of goods or services. To a larger extent, this belief may impact upon self-esteem, where Black people feel vulnerable; hence leading to psychological distress and increased risk of developing mental health problems (Ochieng, 2012) because of perception of being inferior to the majority group even in the absence of actual discrimination, prejudice, and racism (Gilroy, 1994).

To date, there is a large body of research that has found a relationship between perceived racism on both psychological and physical health outcomes (Clark, Anderson & William, 1999). For instance, meta-analyses and systematic reviews on African American adults in 105 studies by Paradies (2006), Pascoe (2009), and Pieterse et al. (2012) concluded that perceived racism positively related with higher levels of psychological distress as well as poor physical health.

The concept of perceived racism is closely related to the Black Western archetypes concept. Using this concept, Mavinga (2012) describes how racism as a cultural phenomenon can have an impact on Black people's psyche or mind. This process occurs when Black people internalise the portrayed negative images or negative stereotypes that have been imposed upon them by the

society. The portrayed negative stereotype can have an impact on the collective Black people psyche, causing internalised racism. For instance, Mavinga (2012) describes how the Western archetype of Lazy Black Boy still impacts the lives of Black men, whereby some Black men may act in accordance to what they have been made to believe in, while others still strive against institutional racism in different areas of their lives, causing more stress, anxiety, anger, depression, and other related mental health issues.

For Black women, internalised racism can be linked to the concept of internalised sexism, whereby a woman may act in accordance to stereotype and the role assigned to them by dominant male role models and patriarchal society and also inherited through slavery and colonialism (Collins, 1990). For individual women, internalised or perceived racism has a negative impact if not addressed; they may cause low self-esteem, depression, and anxiety.

Furthermore, (Mavinga 2009) describes the Black woman gaze stereotype originated from Black women's negative life experiences during colonialism and slavery. During slavery, Black women were overworked, physically and sexually abused, and were seen to have no emotions or needs. As a result, Black woman internalised a negative gaze from the slave family. The internalisation of the Black woman gaze created a blueprint of negative emotions and behaviours. Some of the behaviours include portraying themselves in self-demeaning ways, defences that distort concepts of identity, and the use of derogatory language about their physical characteristics towards self or other Black people (Mavinga, 2009). In addition, Black women have been viewed as aggressive rather than progressive when they express their feelings and challenging the status quo. Generally speaking, a combination of these responses has been described as a negative Black gaze. The manifestation of this negative stereotype can impact Black women's physical health, mental health, and psychological well-being.

On reflection, Mavinga (2012) urges the White therapist to work with Black issues in the therapeutic settings. This can be achieved by the therapist's understanding of internalised racism and the concept of Black Western archetypes. In other words, if the therapist understands Black people's history the therapists can support clients to hold positive images from their heritage and develop an identity that aligns with current multicultural society. Within counselling psychology, several practices have been identified; these include transcultural counselling, multicultural counselling, and intercultural counselling; all aimed at addressing issues of race, gender, ethnicity,

culture, and reducing inequalities in accessing counselling services for BAME population (McKenzie, Bhui & Netto, 2006).

In addition, Pieterse, Neville and Carter (2012) have identified the tension and psychological challenge that Black people face, as they struggle to fit in to a multicultural society such as the UK while still retaining their African heritage, as one of the contributory factors that impacts on their psychological well-being. Gilroy (1993), who cited the work of Du Bois (1898), cited in Pieterse et al. (2012), describes this as the concept of 'double consciousness'.

From a social psychology perspective, Tajfel (1981) also discussed the problems resulting from an individual's participation in two cultures, as this can be problematic for identity formation in ethnic group members, because of the conflicts in attitude, cultural values, and behaviours between their own group and the majority ('the other') group. The internal conflict occurs as a result of trying to negotiate two conflicting identities or to establish and adapt to a biocultural identity. Tajfel (1981) claims that, for most Black people, this conflict may contribute to psychological distress such as anger, depression, and anxiety.

However, Bhabha (1994) argues that culture is not a static entity. It is not an essence that can be fixed in time and space. It is an ever-unfolding process characterised by change, transformation, and most importantly, it is underlined by the essences of mixedness or connectedness regularly transforming our cultural identities. Bhabha (1994) terms this notion 'cultural hybridity'. This means there is no pure African or British culture that one can be returned to. Contextually, the difficulties or internal conflicts that Black people may have, seem to be caused by the unconscious and constant return to problematic ideals of static cultural essences that are unattainable in the contemporary societies in which we live.

In retrospect, over the years, cross-cultural psychologists have explored what happens when individuals who have developed in one cultural context, attempt to live in a new cultural context. Do they keep their original culture, do they abandon their culture and adapt into the new culture, or do they do both?

1:10 Acculturation, assimilation and adaptation

Relevant to this discussion is the concept of acculturation. Berry (1980) describes acculturation as the contact between individuals or groups from different cultural backgrounds, and the adaptation

that takes place as a result of such contacts. Acculturation also involves the cultural changes that occur as a result of receiving society coming into contact with the new immigrant groups (Berry, 1997). To describe the concept of acculturation, Berry (1980) developed an acculturation model. Berry described four acculturation strategies that an individual from a different culture employs when in contact with a new culture.

The first stage of acculturation occurs when an individual from a different culture does not wish to maintain their cultural identity and seeks to pursue interaction with other cultures. Berry (2000) defines this as assimilation strategy. In contrast, separation alternative occurs when individuals place a value on holding on to their original culture, and at the same time wish to avoid interaction with others. When an individual is interested in maintaining one's original culture, while maintaining daily interactions with other groups, integration is the option that occurs.

The fourth stage of acculturation is marginalisation. This occurs when an individual has little or no interest in the new culture, often for reasons such as denial of opportunities and feelings of being rejected. Marginalisation or social exclusion has been a major cause of vulnerability and mental health issues for people of BAME background (Berry 1997).

However, Schwartz, Unger, Zamboanga and Szapocznik (2010) argue that Berry's acculturation strategies appear to be based on the assumption that the individual members from the non-dominant culture are free to choose how they want to acculturate. Unfortunately, because this is not always the case when the dominant group enforces certain constraints through marginalisation, an individual may choose the separation option. In the event of individuals being required by the dominant culture to acculturate, segregation occurs.

Similarly, Bhabha's, (1994) concept of cultural hybridity occurs when individuals choose to assimilate to a new culture. This notion is known as the 'melting pot' or integration. However, when people are forced to integrate or assimilate, marginalisation or 'pressure cooker' occurs.

Schwartz, Unger, Zamboanga and Szapocznik (2010) believe that integration can only be achieved by non-dominant groups when the dominant society is inclusive and open towards cultural diversity (Berry 1991). This involves the process where non-dominant groups are prepared to adapt to the basic values of the larger society and, at the same time, the dominant group must be prepared to adapt in meeting the needs of the individual from the non-dominant group. These include in

both groups the acceptance of the societies of cultural diversity, such as a positive multicultural ideology, with less racism and discrimination, or identification with the larger society by all groups (Kalin & Berry, in press).

As discussed earlier, generally speaking, it is clear that racism, prejudice, and discrimination have been the main cause of psychological distress amongst people of African origin.

To develop this further, in any society where Black men are not yet free from the vicious circle of psychological distress caused by the above factors, Black women are even less free because they are further disadvantaged due to their race, gender roles, and social class (Lewis, Williams, Peppers & Gadson, 2017).

1:11 Theoretical framework used

I will now introduce theoretical frameworks that I have adopted to discuss Black women's unique position in society. I believe the frameworks I have adopted are relevant to my research study as they capture some of the issues that impact Black women. For instance, in the UK and other high income countries, there are various issues and stressors arising from both personal and institutional factors that impact Black women's psychological well-being that are rarely discussed within mainstream research (Nash, 2008).

1:12 Feminist theory

One of the influential theories relevant to this discussion is feminist theory. It refers to a systematic idea that defines women's position in society (Collins, 1990). Feminist theory highlights social problems that specifically affect women and how these have not been truly represented in studies and research (Davis, 2008).

Among others, the feminist theory has focused in the following areas: discrimination and exclusion on the basis of gender roles, power, stereotypes, oppression, objectification, and structural and economic inequality (Nash, 2008).

1:13 Criticism of feminist theory and methodology

One of the critiques of feminist methodology is its main focus on studying women. Hammersley (1992) has argued that both men's and women's lives are so closely related that it is impossible to

explore one without the other. Exploring the experiences of women only would mean ignoring the social context that produces these experiences (Hammersley, 1992).

The second characteristic of feminist research is its prime focus on the validity of personal experience using the qualitative method as opposed to the quantitative method (Hussain & Asad, 2002). Hammersley (1992) has argued that in research there is no one method of getting access to truth or reality; therefore, both qualitative and quantitative methods have their own important contribution in social science research, and each should be utilised when appropriate in order to avoid being over reliant on one research method.

The main focus of feminist research is the interest in empowering women. Hammersley (1992) questions the reason why empowerment of women should be the main focus of feminist research. He argues that, in the contemporary world, there are various sources of discrimination in the context of race, ethnicity, sexuality, and class that need to be explored; therefore, it is extremely challenging to build research on a single model of oppression.

Furthermore, some feminist theorists have been criticised for largely focusing on how different social issues have exclusively impacted White women without Black women's viewpoints (Collins, 1986). For instance, Davis (2008) advocates that earlier articulations of the feminist theory did not address how race, gender, and ethnicity impact upon Black women's life experiences.

1:14 Intersectionality theory and Black feminist theory

To fully explore intersections of gender, ethnicity, and social class, and how these relate to Black women's experiences in society, some researchers have developed intersectionality as a theoretical approach.

The concept of intersectionality, originally developed by Crenshaw (1989), has its roots in Black feminist theory (Cole, 2009; Collins, 1990). This framework offers an understanding of how society has constructed the existence of multiple identities such as gender, ethnicity, race, and other discriminatory factors; how their interactions have shaped experiences of exclusion, oppression, subordination and inequalities; and its impact on Black women's mental health issues (Collins, 1990; Nash, 2008).

In the 19th century, the intersections of different forms of oppression that Black women faced were termed as 'triple jeopardy' (Cole 2009); the jeopardies being at the intersection of gender, race, and class status. These forms of oppression go against the protected characteristics of the UK (Equality Act 2010), which emphasise the individual's right to protection against different forms of discrimination.

1:15 Concepts of intersectionality

Choo and Ferree (2010) argue that, although the intersectionality framework has been useful in exploring the complex nature of inequalities arising in the areas of race, class, and gender (Collins, 1998; Davis 2008), this concept has not yet accomplished its full merit as a research methodology, as it has been rarely utilised in other areas of research. For instance, key sociological issues and stressors that arise from both individual and society level, and how these impact Black women's mental well-being, have not been addressed by this model.

In a recent study, Perry, Harp and Oser (2017) used a sample of 204 low economic status (LES) African American women to explore the interaction between social stressors and individual stressors that occur in six social context areas, namely: loss of social network, motherhood, employment, personal injury and accidents, adult victimisation, and child victimisation, and how these impact Black women's mental well-being.

In this study, Perry, Harp and Oser (2017) incorporated Choo and Ferree's (2010) inclusion-centred approach, and Pearlin, Menaghan, Lieberman and Mullan's (1981) model of the stress process to intersectionality theory. Choo and Ferree's (2010) inclusion-centred approach focuses on social processes and patterns, and reveals how the mechanisms of inequality based on gender and race operate in the lives of Black women (Collins, 1990). On the other hand, Pearlin et al.'s (1981) stress model explains the role of individual stressors (e.g. divorce, job strain, serious illness) and social stressors (racism and sexism) in both physical and mental health. Findings suggest that both individual stressors and social stressors increase the risk for poor physical health and mental well-being.

Particularly relevant to this study is the concept of gendered racism. Essed (1991) defines gendered racism as the simultaneous experience of both sexism and racism. In counselling psychology research, the majority of quantitative research on gendered racism has concluded that these

intersecting forms of oppression experienced by Black women were found to contribute to the development of greater psychological distress (Lewis & Neville, 2015; Thomas, Witherspoon & Speight, 2008).

Based on research findings from a focus group with Black women undergraduate and graduate students, Lewis and Neville (2015) developed a model to measure how different forms of gendered racial microaggressions impact Black women's psychological well-being. Sue et al. (2008) have defined racial macroaggressions as everyday verbal and nonverbal behavioural expressions of oppression, based on the intersection of one's race and gender.

According to Lewin and Neville's (2015) model, there are three core types of gendered racial macroaggressions that are experienced by Black women: (a) projected stereotypes; (b) silenced and marginalised; and (c) assumptions about style and beauty.

'Projected stereotypes' are forms of gender macroaggression that often occur on the interpersonal level; for example, Black women have been stereotyped as overworking and obedient 'mammies', dominant matriarchs, dependent on government funds, and sexually promiscuous Jezebels (Lewis et al., 2013). Sue (2010) claims that these images seem to have been created in society to oppress and subordinate Black women in the context of their race and gender.

'Silenced and marginalised' is another type of gendered racial macroaggression experienced by Black women in different social institutions, such as the workplace, colleges, and professional settings. In these institutions, Black women experience a struggle for power and respect. Lewis et al. (2010, 2017) claim that Black women have been made invisible in their work or professional settings and have been denied the opportunity for progression, impacting on their self-esteem and psychological well-being.

Another gendered racial microaggression is in the form of assumptions about Black women's ways of being, based on their cultural backgrounds. This includes pathologising cultural values, such as style and beauty, and communication styles in verbal and nonverbal ways; for example, Black women are regularly assumed to be loud, aggressive, and dangerous (Constantine, 2007). In Lewin et al.'s (2015) study, Black women students reported being criticised because of their physical appearance, and research has confirmed that a cumulative disadvantage of these intersecting forms of oppression are related to adverse mental health (Lewis & Neville, 2015; Thomas et al., 2008).

However, Negy et al. (2003) claim that social support, mastery, self-esteem, and one's identity are some of the resources that may neutralise the impact of the above stressors and cumulative disadvantages, and reduce their impact on health and psychological well-being. Helms (1990) and Phinney (1996) have commented that one's ethnic identity is important to the self-concept and psychological functioning of an individual, as it can act as a buffer against the negative impact of perceived or actual forms of different oppressions. Owing to the importance of ethnic identity, different models have been created to describe how ethnic identity develops and forms (Cross, 1991; Helms, 1990; Phinney, 1996).

According to Phinney (1996), there are four stages for ethnic identity development. In the first stage, ethnicity is not examined and is not considered important for the individual. This usually happens during childhood or young adolescence. At this stage, values and attitudes of one's environment that are associated with a group where individuals belong are easily acceptable. The second stage of identity development is a period of exploration in which an individual becomes more curious in exploring issues pertaining to their ethnic group. This may include a need to understand the traditions and history of their group. According to Phinney (1996), the exploration about the history of one's group may reveal information about discrimination and racism and other forms of oppression faced by the group. As a result, this may activate anger. During the final stage, an ethnic minority individual has already developed a secure, positive sense of themselves or a higher level of ethnic identity. Phinney (1996) claims that higher levels of ethnic identity cause an individual to develop higher levels of self-esteem, to understand well their purpose in life, and to have an increased level of self-confidence. In turn, these contribute to an individual's acceptance of their own group and of other groups, hence better intergroup relations, and reduces psychological distress and the impact of different forms of oppression (Phinney, 1996).

Similarly, Helms (1984) claims that positive multicultural interactions, cross-cultural relationships, and personal adjustments are hypothesised to result from the development of higher levels of ethnic identity.

1:16 Problems with BAME engagement with counselling and psychotherapy services

In this literature review, different factors that have contributed to BAME psychological distress, with particular reference to Black African women, were discussed. As a result of their experiences

of institutional factors such as racism, discrimination, and prejudicial remarks, and, doubtless, other reasons, it may be that Black women have become desensitised and therefore reluctant to seek help (Edge & MacKian, 2010).

Everett, Hall and Hamilton-Mason (2010) describe four types of coping strategies that Black women use as an alternative to engaging in counselling or therapy as a way of coping with psychological distress. First, women attempt to engage in behavioural efforts to deal with the situation; second, they tend to resist or avoid doing anything about the situation; third, they seek support from friends and family; and finally, they may use alternative ways of coping, such as religion and spirituality.

Wagstaff (2012) and Browne (2013) report that the majority of people of African origin, including BAW, do not receive the appropriate care they need. This group is underrepresented in psychological therapy services because they are less likely to be referred. Instead, they are admitted to psychiatric hospitals (Gwajani, 2016). Also, for the low number of those who are referred to counselling and psychotherapy services, there is a tendency for them to engage poorly or terminate these services prematurely (Edge & MacKian, 2010; Knifton, 2012; Wagstaff, 2012).

1:17 What is psychotherapy engagement?

Client engagement with services has been viewed as an important aspect of all therapeutic modalities, and this has been related to positive treatment outcomes (Holdsworth et al., 2014). Although literature and research have discussed engagement and disengagement concepts, unfortunately there is no single, formal definition. Lister and Gardner (2006) and O'Brien et al. (2009) define engagement as adherence to treatment, but Thurgood (2004) understands it to be clients' experience of the 'acceptable, accessible and positive' services.

Consistent with this idea, client disengagement, premature discontinuation of therapy, or therapy dropout, can occur when a client starts an intervention but discontinues before completing treatment of the 'presenting problems' that led him or her to seek treatment (Edge & MacKian, 2010; Wagstaff, Farrell & Williams, 2012).

Although theoretical and empirical research identifies the BAME community's engagement with counselling and psychotherapy as a significant concern among healthcare providers in the UK, it hinders the effectiveness of the interventions that are offered, leading to poorer treatment outcomes

and the chronicity of mental health issues (Browne, 2013). In the UK, there is still a dearth of research that specifically explores the reasons why BAW do not engage in counselling.

To understand these factors, the ethnic and culturally based explanations that shape Black women's experiences and their attitudes towards help-seeking behaviours need to be explored. Edge and MacKian (2010) and Sisley, Hutton, Goodbody and Brown (2011) suggest these factors include socioeconomic factors, social causation explanation, and personal factors.

Factors impacting on BAW's engagement with counselling

1:18 Social causation explanations

Black women's understanding about their central role, family responsibilities, and their cultural expectations of strength, may minimise the possibility of Black women seeking support (Sisley, Hutton, Goodbody & Brown, 2011). Black women's experiences and expressions of distress may be shaped by the stereotype of the 'Strong Black Woman' (SBW) (Lindsay, 2014). As discussed by various feminist researchers, the origin of the SBW concept can be traced from the race-gender schema concept (Beauboeuf-Lafontant, 2007). This concept describes the struggles that Black women experience, including economic hardship, caregiving, multiple roles and responsibilities, racism, and sexism (Beauboeuf-Lafontant, 2007). As a result, this concept has encouraged Black women to persevere amid obstacles and limited resources, promulgating a belief that Black women should handle situations without relying on others for support (Lindsay, 2014). This has elicited feelings of self-efficacy in the presence of difficulties (Beauboeuf-Lafontant, 2007; Watson & Hunter, 2015).

However, the core expectations of strength negatively affect Black women's overall mental health, whereby they become reluctant to seek help (Edge & MacKian, 2010). Such behaviour may increase the likelihood of further deterioration, causing more severe mental illness (Woodward, White, Kinsella & Robinson, 2016). Furthermore, the failure to exhibit self-reliance leads to feelings of failure, and being inadequate and weak. As a result, this may contribute to psychological distress, which is also linked to poor mental and physical health (Watson & Hunter, 2015).

Consistent with this notion, Sisley, Hutton, Goodbody and Brown's (2011) IPA study explored African Caribbean women's conceptualisation and experiences of personal distress in the UK. This

study also examines these women's help-seeking choices and help-seeking behaviours from mental health services. The study concluded that gender roles and a cultural expectation of strength influenced participants' beliefs about managing personal difficulties, whereby these women avoided seeking help, believing this would display signs of being weak.

1:19 Mistrust of the therapist

In most therapeutic settings, clients prefer to work with therapists with whom they can establish a working relationship (Bachelor, 2013). Most Black women trust therapists who appear to be similar to them (Cabral & Smith, 2011). According to this view, people tend to engage with those they identify with and perceive to be similar to themselves. This suggests that clients and therapists of the same race and ethnicity are assumed to be more likely to trust one another and more likely to believe a shared world view.

It has been suggested that having understanding between client and therapist improves clinical outcome (Watson & Hunter, 2015). However, clients and therapists of the same cultural background and ethnicity may be different, because of different interpersonal variables such as socioeconomic status, religion, and other factors (Cabral & Smith, 2011). Thus, assumptions of similarity based on ethnicity and race alone may result in disappointment and this may have a negative impact on the therapeutic relationship (Davanzo and Errázuriz, 2018).

1:20 Clients' preferred ways of coping

Religious and spiritual practices and rituals, such as organised worship, attending religious events, praying, reading holy books (i.e. Bible, Quran), and having a relationship with a higher power, have been part of the culture for many people from different cultural backgrounds (Ward & Brown, 2015). Religious coping has been reported to be associated with better psychological well-being and better physical well-being by helping an individual to maintain self-esteem, emotional comfort, hope, and a sense of meaning and life purpose (Brownie, 2013; Hefti, 2011).

Ward and Brown (2015) and Smith, Barts and Richard (2007) highlight that religious practices have some similarities to evidence-based psychological interventions, such as cognitive behavioural therapy (CBT), solution-focused therapy, mindfulness, and the 12 Steps of Alcoholics Anonymous. For instance, (a) in religious practices, the believer becomes aware of their thoughts of the flesh that are contributing to sin and distress. Similarly, in CBT, maladaptive and

dysfunctional beliefs that are maintaining one's feelings and behaviours are identified; (b) in religious practices, the believer is introduced or reintroduced to the word of God, similar to psychoeducation on negative thoughts, and thought processes that are taught in evidence-based interventions; (c) in religious practices, through the belief in a higher power, the believer is able to challenge his or her thoughts of the flesh and focus on productive thoughts and behaviours. This is similar to cognitive restructuring that includes the reframing of negative thoughts and development of healthy thought processes and behaviours; (d) in religious practices, the believer continues their spiritual growth through prayer, meditation, worship, and so forth. This is similar to evidence-based intervention, where a client is encouraged to maintain healthy psychological well-being by applying those principles that they have learned in therapy.

Despite the usefulness of religious practices as a way of coping with psychological distress and treating mental health, integrating spirituality into mental health services and other health care settings remains controversial, due to the possible negative impact of religion in mental health (Hefti, 2011).

Exline, Yali and Sanderson (2000) claim that religious coping may have a detrimental impact on mental health if not closely monitored; for instance, the use of religion can involve beliefs and activities that attribute negative life events as God's punishment, expressing disappointment with God, and questioning God's decisions as a way of coping. This has been suggested to cause more distress (Lobel, 2000). Unfavorable religious convictions from the community can also intensify people's self-blaming behaviors and perceptions of sinfulness. Prayer and some religious activities can become compulsive and interfere with overall daily activities and routines causing more stress and anxiety (Bargament, 2002). For this reason, collaborative working between religious leaders and mental health providers has been suggested to have the potential to positively impact upon the mental health and well-being of individuals, their families, and their communities, through offering religious support that is closely monitored to ensure that the service is more supportive rather than having a negative impact on mental health (Hefti, 2011).

Furthermore, religious leaders (clergy) might act as the first point of contact in developing and providing provision for psychological care in which spirituality is incorporated for individuals and their families to receive the support they need (Vander-Waal et al., 2012).

In recent years, there has been a reintroduction of faith within counselling; for example, faith-based CBT for depression and anxiety. Anderson, Heywood-Everest, Siddiqi, Wright, Meredith and McMillan (2015) conducted a systematic review and meta-analysis that looked at the clinical effectiveness of faith-based intervention in comparison with standard treatment for common mental health disorders such as depression and anxiety. The systematic review included 16 studies, with eight studies in the meta-analysis. Adaptations in the faith-based interventions incorporated a discussion of religious teachings to challenge irrational thoughts, and to promote positive coping and a helpful belief system. The faith-based interventions also incorporated activities such as prayer, in comparison to the standard CBT that did not include the above. The review concluded that faith-based CBT was more effective than standard CBT in the treatment of anxiety and depression.

1:21 Stigma and counselling engagement

The fear of stigma may have been a major concern that impacted on BAW's help-seeking behaviours and attitudes towards professional mental health services such as psychological counselling (Ochieng, 2012).

Mantovani, Pizzolati and Edge (2016) describe mental health to be occurring on two interacting levels: self-stigma and social stigma.

Self-stigma occurs when an individual with mental health issues internalises a perception of discrimination from society. Self-stigma can significantly affect one's feelings of shame and embarrassment because of their mental health diagnosis. As a result, the individual avoids seeking help. This leads to poorer treatment outcomes (Gajwani, Parsons, Birchwood & Singh, 2016; Knifton et al., 2009, 2012).

Social stigma, on the other hand, occurs when a society collectively holds negative attitudes towards an individual with mental illness, as a result of the psychiatric label they have been given. These attitudes are characterised by prejudicial attitudes and discriminating behaviour (Mann et al., 2014).

People from BAME communities, such as BAW, have been perceived to be holding negative attitudes towards seeking psychological and other mental health interventions because of the belief that using such services would confirm society's negative perceptions of them (Watson & Hunter,

2015). Others have suggested that Black women's attitudes towards help-seeking may have been shaped by their experiences of being confronted with ethnically based prejudice, discrimination, and stigma when seeking help from mental health services (Knifton, 2012).

1:22 Practice related factors

Therapists' understanding of clients' culture or cultural competence refers to the therapists' ability to understand the cultural values of members of different cultural backgrounds (Chang & Beck, 2009). This is considered an important part of counselling and psychotherapy service practice as it may improve therapeutic alliance outcomes when working with culturally diverse clients (Cabral & Smith, 2011; Olivera, Braun & Gómez Penedo, 2013). Therapists' understanding of clients' culture, and readiness to incorporate this into therapy, frequently leads to positive therapeutic outcomes (Lee & Horvath, 2013). On the other hand, if a client does not feel that the therapist genuinely understands their problem, they are less likely to engage in therapy and will eventually terminate prematurely (Qureshi, 2007; Whitley, Kirmayer & Groleau, 2006).

Therapist ethnocentricity is a term used to describe the act of evaluating others' cultures according to preconceptions originating in the standards and customs of one's own culture (Lee & Horvath, 2013). Richeson and Shelton (2007) warn that therapists who do not understand clients' culture are at risk of believing that their own morals, behaviours, and the values of their culture are superior to others, and therefore may have difficulty connecting with clients from other cultures (Chang & Beck, 2009; Lee & Horvath, 2013).

Bhugra and McKenzie (2000) have debated whether providing separate specialist mental health services that are culturally specific will meet the needs of people from BAME communities and encourage this group to engage in those services and overcome systemic inequalities and barriers to access mental health services.

On the other hand, the case against separate service provision comes from the opinion that the solution to improved access and engagement in mainstream service provision must consider issues around social inclusion and Anti-Discriminatory Practice (ADP) principles, whereby people from BAME communities and those with other protected characteristics such as age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation under the Equality Act (2010) cited in Campbell & Martin (2019) should be encouraged to feel part of

society rather than be more excluded by the setting up of marginal initiatives that may emphasise segregation or social exclusion of the BAME community (Bhui & Sashidharan, 2003).

Similarly, Vandevelde, Vanderplasschen and Broekaert (2003) have used mixed method research to investigate how clients perceive their substance abuse in relation to their cultural beliefs. This study found that participants had difficulties in articulating themselves emotionally when talking about their cultural and religious backgrounds. Both the clients and their therapists formulated ways whereby services could work together more efficiently and effectively to facilitate engagement. Some of the suggestions were focused on adapting approaches that would involve minority clients' cultural awareness within a general treatment plan, rather than developing a separate service that will encourage segregation. The study highlighted the importance of delivering services that will meet the clients' specific needs.

In counselling and psychotherapy services, attempts have been made to ensure that all clients receive equal treatment. This has been implemented by applying the principles of Anti-Discriminatory Practice (ADP) (Campbell and Martin, 2019). These principles underpin the basic philosophy and values of counselling practice as highlighted in the Code of Ethics & Practice for Counsellors (1996). These principles emphasise the importance of counsellors, psychotherapists and other healthcare professions to be able to engage with their own cultural attitudes in order to develop knowledge and skills to enable them to work in a culturally sensitive way.

The multicultural counselling competencies model (MCC) (Sue, Arredondo & McDavis, 1992) aims to establish new counselling standards for counsellors to have culturally competent skills, knowledge, and attitudes necessary to work with clients from minority groups, particularly in relation to issues associated with difference and diversity (Sue et al., 1982, 1998).

However, McRae and Johnson (1991) believe that, although cultural competency is crucial when dealing with diversity issues in clinical practice, in addition to counselling skills such as empathy, respect, and genuineness, counsellors are required to have self-awareness to enable them to work with clients from different cultural backgrounds. Moodley and Murphy (2010) purport that a therapist who is unaware of their own cultural beliefs and values poses a danger of lacking the capacity to engage in meaningful conversations around cultural differences. As a result, they may deliver their interventions based on their own belief and value system (Vasquez, 2007).

Furthermore, Sue and Zane (2009) suggest that, although the knowledge of culture is relevant and necessary, it is not always the most important contributor to a satisfactory and effective counselling experience in the context of difference and diversity and, therefore, paying attention to the counselling process is necessary. Strawbridge and Woolfe (2003) describe the counselling process to include six key principles; namely understanding and appreciating the client's subjective experiences; encouraging and facilitating the client's growth; empowering clients; establishing a non-hierarchical relationship between client and therapist; treating the client as a unique being; and understanding the client as a social and relational being; therefore acknowledging the possibility of the client experiencing discrimination and prejudice (Cooper, 2009).

Since these principles are based on counselling psychology, philosophy, and humanistic values, in essence, they also provide the foundation of ADP (Moller, 2011).

To this end, this literature review has provided a useful contribution to the understanding of different factors that may explain high levels of psychological distress among the BAME community, particularly BAW women. The factors that influence clients' engagement with counselling have been highlighted.

1.23 Identified gap in the literature

The literature review suggests that there is a lack of research that has focused on BAW's lived experiences of engaging in counselling to determine whether their experiences will impact future engagement with counselling and other psychotherapy services.

Browne (2013) has identified the reason for limited research in this area as caused by the challenges encountered while recruiting participants from BAME. These include resistance, nonattendance, and limited disclosure. It is suggested that the factors that cause lack of participation in research may be the same factors causing the absence of BAME clients from psychological therapy, as discussed previously in this literature review.

1:24 Rationale for current study

My study aims to explore BAW's lived experiences of engaging in counselling from their own perspective, and the meaning they assign to these experiences.

Concerning the magnitude of this research, the current study explores different dimensions of Black Africans' lived experiences of engaging in counselling in the UK. In addition to exploration of women's experiences of engaging in counselling, the participants in this study have been given an opportunity to suggest better ways of service provision that will appropriately meet their needs should they need counselling in the future.

Given the identified gaps in the literature and research, this study will address four fundamental research questions.

1:25 Research questions

1. How did Black African women perceive counselling and the therapist before they engaged in counselling?

2. What were their experiences of counselling in the therapy room?

3. What were their post counselling reflections?

4. What would they recommend for future practitioners and policy makers to consider if they offer counselling to Black African women in the future?

CHAPTER TWO

METHODOLOGY

2:1 Introduction

This study uses Interpretive Phenomenological Analysis (Smith, Flowers & Larkin, 2009) as a research method within a qualitative paradigm. A critical discussion of my chosen methodology and philosophical underpinning adopted for this inquiry will be discussed to demonstrate how my epistemological stance and research aims inform my methodology.

A snapshot of various methodological paradigms and philosophies relevant to counselling psychology research will be made explicit to provide an insight into why IPA was the appropriate methodology for this enquiry. Morrow (2005) highlights why the researcher should describe the research methodology adopted, as this becomes a guide by which a reader can identify the procedural framework within research.

In this chapter, I will also offer a description of how this study was conducted, and how the data collection method was created and developed, with some consideration given to the ethical procedures and approval. A detailed explanation of evaluative criteria employed in this case (Yardley, 2000) will be highlighted to describe how these principles were used to ensure that the study met the required standards of trustworthiness and validity.

2:2 Nature of the study

Due to the nature of this enquiry, qualitative methodology was considered appropriate for this study. Qualitative methodology differs from quantitative methodology in many ways. McGrath and Johnson (2003) describe the fundamental distinction between the quantitative and qualitative method paradigms to be their philosophical difference; a contrast of epistemological as well as a difference in methodological positions.

Ponterotto (2005) states that it is not advisable to simply classify studies as quantitative or qualitative, with no understanding of their theoretical or philosophical differences; in other words, their underlying assumptions. Furthermore, Hays and Wood (2011) state that researchers should approach their research projects, both implicitly and explicitly, via different assumptions,

philosophies, attitudes, and beliefs that are embedded in their thinking. Without this, it is difficult to determine the studies' relative merits.

Ponterotto (2005) termed these assumptions 'paradigms' or 'philosophical ideas'. Paradigms are essential in research in two ways. First, they help researchers to reflect how they understand and view the social world and how these are also understood by others. Second, paradigms also guide research practices and methods. This, in turn, raises awareness about the influence of research paradigms on knowledge production (Schwandt, 2000).

Denzin and Lincoln (1994), Guba and Lincoln (1994), and Schwandt (1994) state that there are many ways of describing research paradigms. These reflect different views about the nature of reality (ontology), construction of knowledge (epistemology), the values of the researcher (axiology), the role of the researcher and participants in the research (rhetoric), and scientific rigour (methodology).

For this discussion, I will adopt those ways suggested by Ponterotto (2005), adapted from Guba and Lincoln (1994). Ponterotto (2005) classified major research paradigms to include positivism, post-positivism, constructivism-interpretivism, and critical realism. In this discussion, I will consider those relevant to qualitative research, and more importantly, related to my current study.

In hindsight, it is worth acknowledging the distinction between quantitative and qualitative research methodology to gain some understanding about how these two methodologies differ, and also to understand the rationale for not using quantitative methods in this study. The quantitative method, also known as scientific method, is useful in the process of knowledge acquisition (Guba & Lincoln, 1994). Positivism is a philosophical idea linked firmly to scientific methodology (Ponterotto, 2005). Positivist ontology contends that there is a single and true reality that is apprehendable, identifiable, and that can be measured (Guba & Lincoln, 1994).

Positivist epistemology assumes that the researcher, the objects of research, and the topic under investigation are different from one other, and that, by following standard and procedures, the topic under investigation can be explored by the researcher without any bias (objectivism) (Ponterotto, 2005). As a result, the quantitative method involves systematic observation of a phenomena and its description explained within a model or theory. Inferential statistics are used as a way of testing hypotheses, and to interpret the statistical results in light of the original theory (Ponterotto, 2005).

Willig (2006) argues that the quantitative method's overreliance on hypotheses generated by existing theories forecloses the possibilities of generating new theories. Consequently, the results and conclusions drawn from many quantitative studies are thought to be difficult to apply in clinical practice (Potter & Hepburn, 2005). For instance, in clinical practice, statistics from using a questionnaire only, although useful, may not provide enough information about what happens in the therapy room between therapist and client. This may result in the therapist not getting enough feedback from the client to help them improve their practice (Camic, Rhodes & Yardley, 2003). Furthermore, one of the challenges encountered by therapists who are also researchers is to find a research method that fits with their clinical practice and their goals as clinicians (Morrow, 2005).

On the other hand, according to Smith, Flowers and Larkin (2009), the purpose of qualitative research is to explain complex situations that people undergo within their everyday lives. This offers the researcher the opportunity to develop an idiographic understanding of participants' experiences of various phenomena under investigation; for instance, what it means to them to live with a particular condition or be in a particular situation (Bryman, 2008; Larkin, Watts & Clifton, 2006). To a greater extent, qualitative paradigms aim at acknowledging the role of historical, social, and cultural factors in knowledge production (Smith & Osborne, 2008). In counselling psychology practice, the use of qualitative methodology thus facilitates an understanding of the complexity of biopsychosocial phenomena that is useful in informing clinical practice (Denzin & Lincoln, 1994).

The present study is concerned with exploring BAW's lived experiences of engagement with counselling. The aim of the study is not to measure the phenomena in question, but to explore and make sense of the experiences and processes that are involved in counselling. I believe this exploration could reveal different elements of the participants' experiences that were previously unknown, such as the preconceived notions that they held before attending counselling, their experiences of being in therapy, and post counselling reflections. In order to uncover these experiences as a researcher, I need to use a research methodology that will enable me to be more reflexive and interpret data using different levels of interpretations to ensure that the research findings are not influenced by myself.

For this reason, this exploration leans towards a qualitative inquiry, and this will allow me to uncover more fully the phenomena under investigation. Therefore, a qualitative methodology that can engage in phenomenology and hermeneutics was considered appropriate for this study.

Alternative qualitative methodologies such as Narrative Analysis (NA), Discourse Analysis (DA), and Grounded Theory (GT) were considered but not utilised. Although useful, NA was not used in this enquiry due to its primary focus on understanding how people create meaning in their lives as a narrative, in comparison to IPA, where the main focus is on exploring participants' experience of a given phenomenon at a given time.

Furthermore, even though DA could have been appropriate for this study, it was not utilised because of its focus on the use of language rather than participants' experiences (Langdridge, 2008). However, Willig (2012) has pointed out that one of DA's shortcomings is that it excludes the 'person-in-context' and instead it places a priority on the use of language (Langdridge, 2008), which the current study was not intending to focus on. Even though the two approaches could have taken a phenomenological approach to explore the research questions, they would not provide the richness of the hermeneutic circle, which emphasises the belief that the object under inquiry cannot be fully understood without examining the object in its context (Smith & Osborne, 2008). Instead, these methods would have shifted the focus from fully exploring the phenomenon under investigation to focusing on participants' life histories, narratives, or discourse (Hammersley, 2008). GT (Glaser & Strauss, 1967) was also considered but not used, because the current study is not concerned with generating theory. The primary focus of this study was to seek out and allow participants to talk about their experiences of engaging counselling and the meaning they assign to these experiences, rather than generating new theories.

To summarise, IPA was chosen for this study due to its primary stance that knowledge or reality could be accessed through the interaction between the participants and researcher. This method was also used because of its multilayered approach that allows the researcher to engage with data at different levels of analysis in an attempt to understand participants' experiences at a deeper level.

2:3 Rationale for using IPA

IPA (Smith, Flowers & Larkin, 2009) was the methodology chosen for the current study. IPA has been described as a research method with an idiographic focus; its aim being to explore how a

given person, in a particular context, makes sense of a specific experience of some personal significance (Reid, Flowers & Larkin, 2005), including major life events or situations. IPA has its theoretical origins in phenomenology and hermeneutics, with key ideas originating from the work of philosophers such as Husserl, Heidegger, and Merleau-Ponty (Smith & Osborne, 2008).

IPA has been described as being different to other qualitative approaches because of its focus on ideography, phenomenology, and hermeneutics components (Smith, 2007). IPA is dedicated to the ideographic analysis commitment of each single case, and allows a line-by-line analysis of a text before moving to another case. The use of a smaller sample in this method is an advantage as it allows a researcher to use in-depth semistructured interviews that facilitate a detailed study of participants' first-person accounts of experiences (Pietkiewicz & Smith, 2014; Smith, Flowers & Larkin, 2009).

IPA's commitment and focus on engagement with phenomenology means that the participants' experiences and concerns are deeply elicited by the researcher. This allows the researcher to gain better insight into the participants' experiences, and recognises that the participants' experience of a given phenomenon is best constructed by the interaction between the researcher, the participants, and their social world (Larkin, Watt, & Clifton 2006; Smith & Osborne, 2008).

With regard to the hermeneutic interpretation, IPA's subjective nature of the descriptive account allows the researcher to get as close as possible to the participants' life worlds. While doing this, the researcher is engaged in the process of interpretation. Smith, Flowers and Larkin (2009) describe three levels of interpretation involved in IPA: Descriptive, Linguistic, and Conceptual. As a result, this approach to interpretation allows a nonreductionist development of higher level theories and understanding (Pietkiewicz & Smith, 2014), meaning that the findings obtained from IPA studies are original, and are highly engaged with the rich data.

2:4 Epistemological standpoint

Guba and Lincoln (1994) highlight the importance of the researcher engaging fully and understanding the philosophical assumptions underlying their chosen methodology, as without this, it is difficult to determine the authenticity of the study or, rather, to determine if the study has met the required standards.

For the current study, my epistemological stance rests heavily on both Husserl's (1927) phenomenology philosophy and Heidegger's (1962) hermeneutic theory, and also leans towards critical-realist philosophy. I believe the traditions I adopted fit in with my theoretical ideas about my research study and my role in the research process, just as I am a significant part of the therapy process in my current practice of psychodynamic theory.

I describe below how the traditions or epistemological stances I have adopted relate to IPA principles and how these influence the methodology for my current study.

2:5 IPA and phenomenology

Phenomenology has been defined as a study of experience (Larkin, Watts & Clifton, 2006). Hammond et al. (1991) describe phenomenology as the 'description of things as one experiences them'. It refers to how people experience different phenomena and the meanings they assign to their experience. I draw upon Husserl's phenomenology, which claims that there is one true reality out there that is constructed as a true world influenced by a range of factors. My research is interested in exploring how participants experience the world within particular contexts; in this case exploring BAW's lived experiences of counselling and the meaning those participants assign to these experiences. I acknowledge that each participant's lived experience is subjective, and so is the meaning that participants ascribe to these experiences. These experiences are also the product of their interaction with the social world. For instance, during my interviews, I noticed that the way the participants described their experiences of counselling varied. These were influenced by the context of the situation, such as where the counselling took place, the pathway to counselling, their expectation of counselling, their perception of their therapist, and other factors. Despite the research participants describing their experiences in different ways, in line with my epistemological stance, I consider each account to be a valid representation of each participant's experience.

2:6 IPA and hermeneutic philosophy

My research is also influenced by hermeneutic philosophy (Heidegger, 1962). Heidegger acknowledges that in order to gain access to one's experience it is dependent upon what the individual says about their experience, and therefore, in order to understand, the researchers need to interpret the participant's account of their experiences.

Smith, Flowers and Larkin (2009) describe different levels of interpretation. The descriptive level of interpretation acknowledges and describes things 'as they are', while the linguistic component focuses on how people ascribe meaning to their experience. The conceptual level of interpretation allows the researcher to take a step further in exploring the participant's account by prompting and asking further questions.

Pietkiewicz and Smith (2014) claim that using different levels of interpretation fosters the researcher's understanding by trying to make sense of what the participants are saying, and at the same time, by helping the participants to understand their inner worlds. Smith, Flowers and Larkin (2009) describe this process as double hermeneutics, meaning that the researcher is trying to make sense of the participant trying to make sense of what is happening to them. This captures the dual role of the researcher, whereby the researcher's view of reality is considered to affect the study as well as the perspective of those reading it (Reid, Flowers & Larkin, 2005). Thus, it can be said that IPA requires a combination of phenomenology and hermeneutic insights. It is phenomenological in a sense that it attempts to explore, as closely as possible, the lived personal experiences of participants, but recognises that this unavoidably becomes an interpretative attempt for both participant and researcher (Larkin, 2009). This means that without phenomenology, there would be nothing to interpret, and without interpretation the phenomenon would not be seen or understood (Smith & Osborne, 2008).

Smith, Flowers and Larkin (2009) urge that the researcher's point of view, biases, and personal experiences that impact on the study are not seen as biases, but must be explored and addressed rather than being ignored. They are seen as important preconditions for understanding another person's experiences. The knowledge produced by IPA is also reflexive in so far as it acknowledges it is dependent upon the researcher's standpoint (Smith & Osborne, 2008).

In this study, I acknowledge the impossibility of gaining direct access to participants' accounts to uncover the meaning of what the participants were telling me without interpretation, because meaning is embodied in language, and language is the way in which the participants attempt to communicate their experiences to the researcher.

Willig (2006) argues that language creates, rather than describes, reality; that the words the researcher uses to explore participants' experiences, and the language that participants choose to describe their experience of a particular phenomenon, construct particular versions of that

experience. For instance, during the interviews, one of the challenges encountered was the language used by participants to describe their experiences. Most participants seemed to have problems with expression because English was not their first language. This issue is demonstrated by looking at some of the extracts from participants' transcripts within the analysis chapter.

2:7 IPA and critical-realist

As mentioned earlier, from a philosophical standpoint, I share a critical-realist approach perspective purported by Merleau-Ponty (1962), who shares Husserl's and Heidegger's commitment to understanding our being and existence in the world. They all emphasise the situated and interpretative quality of our knowledge about the world. Whereas Heidegger emphasises the worldliness of our existence, Merleau-Ponty addresses and describes the embodied nature of our relationship to this world (Smith, Flowers & Larkin, 2009).

Merleau-Ponty (1962) has described human beings as body-subjects that are embodied and embedded in the social world's cultural and historical context. He believed that the lived experience of being an existing body in the world cannot be fully captured but, equally, must not be ignored. This perspective describes the existence of bodily sensations when one experiences certain situations and emotions, and these sensations can tell us something about our experiences (Larkin et al., 2006; Smith, Flowers & Larkin, 2009). According to Merleau-Ponty's point of view, the body reminds us that emotions are essential to our human understanding of experience. From a phenomenological perspective, emotions and cognition are interrelated aspects of our engagement in the world, and are also a powerful indicator of the personal resonance of cultural and physiological experiences. Therefore, a particular task of IPA from a critical-realist approach perspective is to examine how people attempt to understand their embodied experiences that are also linked to their emotions (Smith, Flowers & Larkin, 2009).

In addition, Merleau-Ponty (1962) focuses on how the subjective nature of embodiment relates to our perception of others, which, according to him, always develops from an understanding of our own embodied perspectives and experiences. Smith, Flowers and Larkin (2009) emphasise the importance of researchers understanding the embodied nature of their own experiences in order to be able to understand the experiences of others, and relate to them critically, constructively, and sometimes affirmatively; for instance, drawing on psychodynamic theory (Klein, 1946). Object relations, particularly the transference and countertransference concepts during the interviews,

helped me to understand the dynamic that existed between myself and the participants, and how these were likely to have influenced the research process and the study's findings.

2:8 Personal reflexivity

As a researcher, I believe that, by studying these conversations and transcripts, I may have constructed a different version of reality through my interpretations. For that reason, instead of positioning myself as an objective outsider, I believe I was part of what I was researching. Furthermore, throughout the data analysis process, I acknowledge that my interpretation might have been influenced by my preconceived ideas, my view of reality, my biases, and my personal experiences, and these may have impacted on the research process and also the findings. In line with this thinking, my identity as a Black African woman and a trainee counselling psychologist, who is also receiving counselling, might have influenced my choice of research topic in several ways. As a Black woman, I have a preoccupation and desire to 'give voice' to Black women in therapy and make their therapy a positive and empowering experience, and as a trainee and a researcher, I relate to the importance of exploring clients' experiences of therapy for better treatment outcomes. As a counselling service user, based on my own experiences of being in counselling, I may have my own preconceived ideas, knowledge, and expertise about counselling. These might have affected the participants in either a positive or a negative way. For instance, my questioning and prompting may have been influenced by my knowledge of CBT and also the psychodynamic way of thinking.

Heidegger (1962) acknowledges the impossibility of ignoring subjective experiences. Therefore, an IPA researcher who has subjective influences in the construction of research data is required to bracket these influences. However, Heidegger argued that such bracketing, as suggested by Husserl, is not easily achievable in the context of discovering new phenomena. The researcher using IPA methodology should therefore reflect on their possible influence on the data (Larkin et al., 2006).

Furthermore, Finlay (2008) proposes that preconceptions themselves are changing in the process of interpretation, making the process dynamic, which calls for a more enlivened form of bracketing that can only be partially achieved (Smith, Flowers & Larkin, 2009). These will be reflected further in the analysis chapter.

Procedure

2:9 Participants' selection

IPA suggests that a small and homogenous sample should be selected, as it offers an insight into particular experiences. Smith (2007) describes a homogenous sample as a sample whereby the group of participants share some characteristics, experiences, and an experience of a particular phenomenon. The participants in this study were six women who were purposefully selected according to the criteria relevance to research questions. The participants were recruited on meeting the following criteria:

Women who describe themselves as Black African first generation migrants to the UK and who had lived in Africa. These women would have lived in the UK for a minimum of two years, have a reason to require counselling that may or may not relate to them being in the UK, and are aware of the availability of counselling services. The decision to interview women who were first generation migrants is centred on the notion that when people live in a different culture, there is a tendency for them to go through a process of acculturation or adaptation to that culture, compared with people who have lived in that culture for a shorter period of time (Edge, 2013). I believe this adaptation might allow them to talk about their experience of engaging in counselling without feeling judged.

Participants must have attended a minimum of four counselling sessions. I presume that the four sessions would be sufficient for the women to be able to describe their counselling experiences. In addition, due to the tendency for BAW to leave therapy prematurely, I was concerned that setting a higher number of sessions to be attended as a criterion for recruitment might not have been realistic.

Women who were able to speak English to a level that is understood by the researcher. This is to enable them to communicate and be able to talk about their experiences. Bryman (2008) warns about the use of an interpreter in the interview process, as this may affect the flow and reliability of information. In this study, I had a phone conversation with all the participants before the interview to establish the level at which they could communicate in English.

Exclusion criteria included women who are currently in therapy, friends and family. These were excluded for ethical reasons.

2:10 Situating the sample

Demographic characteristics of participants that include different aspects of their lives have been described below to enable the reader to understand and evaluate the interpretations made by the researcher throughout the data analysis stage (Table 1). To protect the participants' anonymity, pseudonyms have been used.

Table 1. Participants' demographic characteristics

NAME	AGE	ECONOMIC STATUS	LENGTH OF THERAPY
Lyn	53	Migrated to the UK 15 years ago. She works as a nurse.	Attended five sessions before disengaging.
Beatrice	32	Migrated to the UK 14 years ago. She studied psychology at university and works as a volunteer in a nongovernmental organisation.	Attended eight sessions before disengaging.
Georgia	45	Migrated to the UK 16 years ago. She works as a senior psychiatric nurse.	Attended five sessions before disengaging.
Edna	51	Migrated to the UK 15 years ago. She works as a senior nurse.	She attended all 10 therapy sessions.
Tina	54	Migrated to the UK 25 years ago.	She attended all eight therapy sessions.
Daisy	35	Migrated to the UK seven years ago. She is currently working as a supervisor in a supermarket.	She attended seven sessions before disengaging.

2:11 Recruitment of participants and challenges encountered

At the initial stage, recruiting participants from the targeted population was a key concern due to the following factors: first, there were very few Black African women attending therapy in the geographical area where I had initially planned to recruit from – South East London Psychotherapy and Counselling Centre, which is a nongovernmental organisation that has some clients paying a small fee for their therapy through government funding, and Women's Therapy Centre (WTC). Second, although some participants agreed to participate in my research, the majority were reluctant. Two of my prospective participants withdrew their participation at the final stages.

Third, for those participants who I managed to interview, it was a struggle to confirm a date, time, and location for the interview, and, as a result, the data collection took a lot longer than anticipated.

Reflecting on these issues, I suspect that the reasons for the participants' reluctance to take part in the study may be similar to BAW's reluctance to engage in therapy, which were briefly discussed earlier in the literature review. These include mistrust issues, the fear of being judged negatively, not wanting to be viewed as weak, and the perceived stigma surrounding engaging in counselling. I assumed that, as an African woman myself, the participants might have regarded me as being judgemental on learning that they have attended counselling for additional support because they could not cope well with their problem/s. For this reason, the participants were subsequently recruited from different locations in London through local adverts and snowballing.

2:12 Ethical considerations

Braun and Clarke (2013) suggest that, in research, most concerns revolve around the issues of deception, harm, consent, privacy, and confidentiality of data. In this study, to protect participants, I abide by the ethical principles of beneficence, nonmaleficence, autonomy, and justice as set out by the British Psychological Society Code of Ethics and Conduct (2009).

2:13 Informed consent and information about research

Before the data collection stage, I contacted the potential participants by phone and letter to confirm their interest in participating in the study. Following their confirmation, an information sheet and consent form were sent by post and email. One of the challenges encountered was the fact that, even though the participants received all the information beforehand, some of them misplaced it. What I found useful was to check with all the participants before the interview to ascertain whether they had received the information and were still willing to participate in the study.

This went well, with the exception of one participant (Georgia), who asked me what the purpose of my research was after we had finished the interview. After the interview, I met with her to check whether she had received and read the information that I sent to her. She confirmed that she had received the details of my study but could not recall much of the detail due to her busy schedule. I checked that she was happy for me to keep the transcript. All the participants agreed for me to keep their transcripts.

2:14 Research information

The participants were fully informed about the purpose, method, and intended possible uses of the research, what their participation would involve, and the possible distress that could arise, such as discomfort or anxiety. This information was provided in a written form signed by me. I did not encounter any difficulty in this area.

2:15 The right to withdraw from the research

The participants were informed about their right to withdraw from the research at any time, and they could refuse to answer any questions that they did not wish to answer. Despite the problems that I had with recruitment, none of those who participated in the research withdrew, which enabled me to recruit six participants.

2:16 Confidentiality

Throughout the research, the process by which I ensured that participants' anonymity, and all the confidential information they supplied, were protected against use by third parties, was in accordance with the British Psychological Society's (BPS) Code of Ethical Principles (2009) when dealing with human participants.

However, even though I used pseudonyms to protect the identity of the participants, during the interview it was impossible to prevent some of the information from being disclosed. For instance, some of the participants revealed their real name during the interviews. I have subsequently taken all necessary steps to ensure that the transcripts are not accessible to anyone who is not intended to have such information.

After the interview, a debrief took place to discuss the research experience with the participants and to monitor for any unforeseen negative effects. Throughout the interviews, I was fully aware that the interview might evoke some powerful feelings in participants. To some extent, I was aware that this was unavoidable. In this case, none of the participants reported any signs of distress.

2:17 Data collection method and analytic strategies

The semistructured interview was the method of data collection used. The participants were interviewed during a face-to-face interview, after having signed and returned the consent form (Appendix 4). The interviews were scheduled for approximately 30 to 60 minutes. Using open-

ended questions, the participants were asked about their experiences of counselling. The interviews were recorded by a digital tape recorder.

I found the interview method advantageous as it provided a greater breadth and allowed myself and the participants to have more control over the flow of information. The flexibility that the semistructured interview offers enabled me to pursue new and potentially creative lines of enquiry whereby prompts were used to further explore what the participants had disclosed. For instance, in addition to the 11 questions in my interview schedule, I had the opportunity to include more prompts such as: 'How do you feel about that?'; 'What did you do in that instance?'; 'Can you explain that?'; 'Tell me more about that'; 'Let me clarify that', etc.

The interview schedule was constructed after reading and consulting several articles that have used IPA to explore client experiences of counselling and psychotherapy. The interview schedule (see Appendix 5) used in this research was piloted with two colleagues. Through an iterative process, the interview schedule, specifically the language, was simplified to avoid technical terms or jargon that would have made it difficult for participants to understand and answer the questions appropriately. The data from the pilot study is no longer available as it was destroyed upon pilot participants' requests.

The interviews collected were transcribed shortly afterwards. The data (transcripts) were stored in a safe place in a secure cabinet to protect participants' confidentiality. On reflection, I found the process of transcribing challenging and time-consuming. In some parts of the transcripts it was difficult to understand what participants said, as they came from various parts of Africa where different languages are spoken, and words are pronounced differently. For instance, one of the participants (Tina) used words or phrases from her local language, which I did not understand. This made it difficult for me to transcribe them. These words have been highlighted in italics within the transcript. After the interview, I met with the participants to clarify any information I had not understood, which was useful because I was able to clarify important issues.

The verbatim transcripts were then analysed individually, as informed by IPA principles (Smith, Flowers & Larkin, 2009). This included reading and rereading the transcripts to develop some familiarity with the data. To facilitate and simplify the data analysis process, I used Microsoft Word (see Appendix 6) and Microsoft Excel computer programs. While reading the transcript, initial responses (initial notes) that I found meaningful were identified and highlighted. A

descriptive comment of each highlighted note was then written on the right-hand margin of each transcript.

These notes were then copied and transferred to the Microsoft Excel spreadsheet (see Appendix 7). The spreadsheets were organised in different columns in a manner that allowed all the necessary information to be recorded, such as the pseudonym of the participants, and the participants' responses or comments (notes) made while being interviewed. There is an explanatory note (definition or interpretation) for the initial notes and the page number where the notes can be easily found.

The Excel spreadsheet also contained my reflexive accounts to demonstrate how I have influenced the research or how this research has affected me. This is in line with the IPA principle whereby researchers' thoughts and feelings are not to be excluded, but reflected upon (Husserl, 1927).

In the next stage, I compiled (grouped) the initial notes and gave them a label or definition. The notes that had similarities were grouped and allocated codes. Each code was then transferred onto coloured index cards (see Appendix 8). The index cards were used to enable the data to be more visible or visual and also to allow for moving things around. Each index card contained the participant's pseudonym, the interpretation of the code and the page number, and the line where that particular code can be found on each transcript.

In the next stage, the codes that were recorded on the index cards were grouped together, according to their interconnections, to form subthemes. These subthemes were then defined, interpreted, and given a label or a name. The subthemes were grouped together to develop connection and similarity between them. The subthemes that were similar were grouped and defined and given a name or a label. These formed the superordinate themes or master themes.

After this process, the links between concepts or themes were mapped out diagrammatically with an explanation of the meaning of the data (see Figure 2). In summary, the whole process of data analysis was cyclical and iterative. It involved moving back and forward, pulling apart, reorganising, and regrouping information (data) to come up with the findings.

During this process, some challenges were encountered. Because of the richness and complexity of the data, part of the problem was organising and presenting the data or key findings in a way that could be easily understood by the reader. As a result, this process was repeated for each

transcript, and it involved moving back and forward several times between transcripts whenever necessary.

2:18 Trustworthiness, reliability, and rigour

With regard to the validity and trustworthiness issue, Elliott, Fischer and Rennie (1999) explain that qualitative methodology has been criticised in recent years, due to a lack of 'excellence' in published research (Morrow, 2005; Morse, 2015). As a result, all qualitative researchers are required to meet certain criteria to ensure that their studies are credible and authentic (Morrow, 2005).

Yardley's (2000) evaluative criteria, which pay attention to the issue of sensitivity to content, rigour and commitment, transparency, and coherence, were adapted in this study to ensure that my findings are authentic, original, reliable, and trustworthy. These criteria were chosen due to their consistency with my epistemological standpoint, and are also consistent with the IPA principles as a chosen methodology for this study.

Sensitivity to content in this study was achieved by the analysis and interpretation of sensitive data, bearing in mind the social context in which these data emerged. This was accomplished by consulting all literature relevant for my study that provided insight into the phenomenon that I was investigating, where my study positioned itself within the body of literature and research.

Furthermore, to protect the sensitivity of information, I was also cautious about the relationship that I had with my participants, as this would determine the authenticity of the data. In this respect, I ensured that I was abiding by ethical principles in dealing with human participants throughout the study's duration. What was useful was being attentive, empathic, and building a rapport with my participants in an interview situation to obtain honest and open responses to ensure that reliable data was collected. Some of the strategies used included some counselling skills, such as restarting or summarising information to determine accuracy.

The criteria of rigour and commitment were achieved by paying attention to the unfolding account of participants' experiences during the data analysis stage, whereby completeness of data analysis was undertaken to ensure sufficiently interpretative accounts of the participants' interviews were conducted by moving beyond a simple description. Verbatim extracts were made from participants' material to support interpretation, and were then used to give participants a voice in

the study and to allow the reader to check for the meaning of the interpretations made after the interviews. In addition, the transcript was examined by colleagues (ex-trainees) who were familiar with the IPA method. We went through all the emergent themes to ensure that there was a true reflection of the participants' live words. Throughout the research process, I underwent supervision, whereby I met with my supervisor on a regular basis to audit my work to ensure that I followed all the necessary steps and met the requirements of the university's research guidelines.

To ensure transparency, I was committed to Smith, Flowers and Larkin's (2009) data analysis steps during the data analysis stage. In my write-up, I have also fully described the various stages from beginning to end; for instance, how the participants were selected, how the interview schedule was constructed and the interview conducted, and what steps were used in analysis. As part of being transparent throughout my research process and write-up, I have also included a reflexive account on how my past experiences, motivations, and interests may have shaped and impacted the research process and the study's main findings.

Yardley (2000) describes coherence as a degree of fit between the completed research and the underlying theoretical assumptions of the approach being used. This was achieved by ensuring that my study was consistent with the principles of IPA. This is reflected by several examples, as given throughout my write-up, to demonstrate how IPA is the best fit for my study. To ensure coherence during my write-up, I revisited the final draft, and also ensured that it was proofread by a professional proof-reader to point out any contradictions and so forth, and for these to be amended whenever necessary. To this end, the current study has addressed the issue of impact and importance. It is anticipated that the outcome of this study has practical implications for policymakers, health workers, stakeholders, and most importantly, for the practice and teaching of counselling psychology and related disciplines.

CHAPTER THREE

ANALYSIS

3:1 Introduction

The study's major findings are presented in the following chapter. These were obtained through the data analysis process using the IPA principles (Smith, Flowers & Larkin, 2009) as described in the methodology chapter. The analysis process started by analysing the interview transcripts of each individual participant's experience of engaging in counselling in order to understand fully how their experience may impact on their future engagement. In an attempt to fully understand fully the participants' experiences of engaging in counselling, an exploration of the participants' journeys through the counselling process was necessary. This exploration gave rise to findings that were grounded in the context in which the participants' experiences of engaging in counselling occurred.

This included what participants thought about counselling and the therapist before they engaged in counselling, based on their cultural beliefs; what it was like for the participants to engage in counselling and be with the therapist; and finally, what their thoughts were after they had engaged in counselling. The analysis process produced overlapping themes that were not mutually exclusive. Some themes were closely related, while others were more distinct. At the initial stage, this process gave rise to 172 codes that were clustered into 27 themes. These themes were reviewed and categorised under the three master themes: cultural beliefs; the counselling experience; and post counselling reflections.

Each master theme was defined by three subthemes, except for master theme 1, which contained four subthemes. Therefore, a total of 10 subthemes were formed.

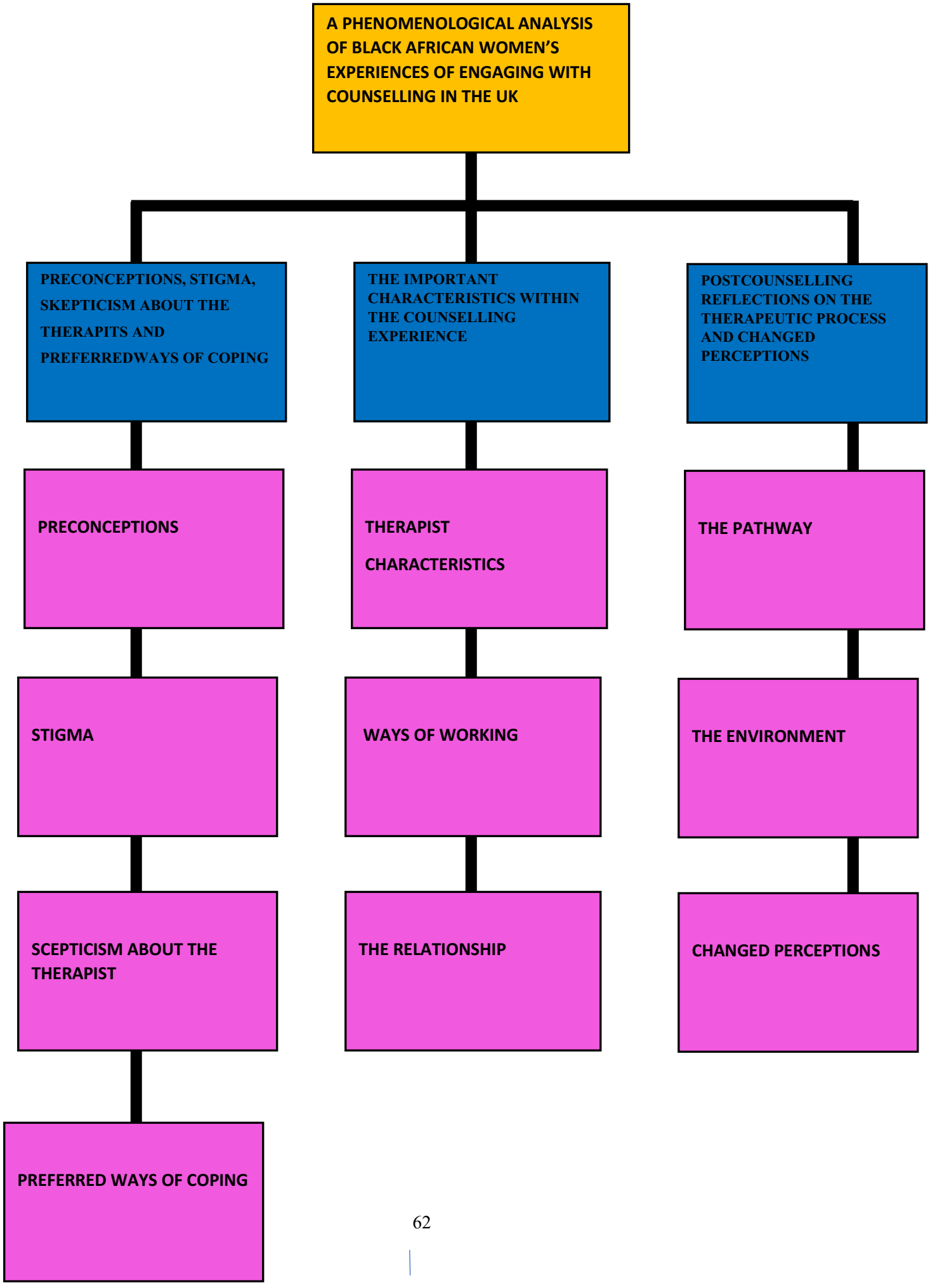
The first master theme groups together the participants' cultural beliefs about counselling before they embarked on it. This included preconceptions, stigma, scepticism about the therapist, and preferred ways of coping.

The second master theme describes participants' experiences of engaging in counselling and being with the therapist. This was described in the following subthemes: therapist characteristics, ways of working, and the relationship established.

The third master theme encapsulates the participants' post counselling reflections, where they describe the end of their counselling journey. This includes recommendations about aspects that need changing in order to make counselling a more positive experience should the participants require it in the future.

Post counselling reflections are discussed under the following subthemes: the pathway, the counselling environment, and changed perceptions. Changed perception is a reflection on the reason why participants changed the preconceptions they held before engaging in counselling. These included what they thought about counselling and the therapist as a result of their cultural beliefs.

These findings are summarised in Figure 1 below:


A PHENOMENOLOGICAL ANALYSIS OF BLACK AFRICAN WOMEN'S EXPERIENCES OF ENGAGING WITH COUNSELLING IN THE UK
PRECONCEPTIONS, STIGMA, SKEPTICISM ABOUT THE THERAPITS AND PREFERREDWAYS OF COPING
THE IMPORTANT CHARACTERISTICS WITHIN THE COUNSELLING EXPERIENCE
POSTCOUNSELLING REFLECTIONS ON THE THERAPEUTIC PROCESS AND CHANGED PERCEPTIONS
PRECONCEPTIONS
THERAPIST CHARACTERISTICS
THE PATHWAY
STIGMA
WAYS OF WORKING
THE ENVIRONMENT
SCEPTICISM ABOUT THE THERAPIST
THE RELATIONSHIP
CHANGED PERCEPTIONS
PREFERRED WAYS OF COPING

3:2 Master theme 1: Preconceptions, stigma, skepticism about the therapist and preferred ways of coping.

This master theme describes participants' cultural beliefs and views that they held before embarking on counselling. These were described in four subthemes: preconceptions, stigma, scepticism about the therapist, and preferred ways of coping.

As a result of their cultural beliefs, all six participants reported having perceived counselling as a Westernised concept, meaning that, in their culture, formal and professional counselling is not a preferred way of coping with psychological distress. The participants reported that, in African culture, there have always been different effective and traditional ways of providing emotional support when a person is in distress. Most people would turn to their elders or the head of family, close family members, and friends for support concerning issues that are likely to have impact on their psychological well-being.

3:2:1 Subtheme 1: Preconceptions

This subtheme demonstrates how participants' preconceptions contributed to their reluctance to engage in counselling. In this study, preconceptions or preconceived notions were beliefs that participants seemed to have formed beforehand without adequate evidence. These included what they thought about counselling and the therapist and seem to have been influenced by their cultural beliefs.

Because of their cultural beliefs, Black women are frequently expected to exhibit strength and handle life challenges without relying on others. Engaging in counselling may therefore be interpreted as an inability to cope with life's challenges. This belief is closely related to a commonly held SBW stereotype, as discussed in the literature review, and seems to contribute to BAW's inability to seek help, which may contribute to poor psychological well-being.

Tina is 54 years old. She is a senior nurse in a mental health unit. She has two daughters aged 22 and 19. She migrated to the UK at the age of 25 and attended all eight counselling sessions that were offered.

P: What I will do most of the time… leave family alone I just tend to bottle things I just tend to keep it to myself …

P: and then continue to ruminate on them and after a while it will become… a aah.. it will become so heavy that I'm going to … I'm just going to sort of … you know… low in mood and .. well after a while I come out of it and carry on.. . [Tina p. 4: 2–7]

In the above excerpt, Tina demonstrates the importance of coping with distress and what it means to her. This seems to stem from her cultural belief of strength, whereby women are expected to 'carry on' without relying on others or getting professional help. Her use of the phrase 'tend to bottle things' seems to suggests that distress is contained behind closed doors or hidden and not shared with others, even though she acknowledges that not sharing distress can be counterproductive. This is demonstrated by her use of the words 'will become so heavy'. For her, it seems that sharing her distress with people outside, or even to some family members, may demonstrate a sign of weakness.

Another participant, Edna, seems to share a similar view with Tina: the importance of self-reliance and coping with emotions without the use of professional help.

Edna is 51 years old and works in the NHS as senior staff in a nursing team. She migrated to the UK at the age of 15. She attended all 10 counselling sessions.

P: Oh. ...and that how we are genetically built and...yeah... engineered… well umm… we or I am a very strong woman, and I am a very strong African woman in the sense that I .. I can uphold my own anywhere, anytime and eeh in dealing with things emm we are used in dealing with things within ourselves, within our families. [Edna p. 12: 11–20]

Edna's choice of the phrase 'we are genetically built' seems to suggest she believes that Black women have the natural ability to survive in the midst of adversities. The word 'engineered' may demonstrate how the concept of strength has been instilled in some BAW's minds from an early age. In this study, all six participants seem to fear being labelled as weak. It seems that this concept has developed into a core belief that may be difficult to shift. As a result, they work hard to resolve their own issues without relying on others.

Another participant, Georgia, commented on how she perceives counselling, based on her cultural belief.

Georgia is a 45-year-old senior psychiatric nurse who migrated to the UK at the age of 16. She attended five counselling sessions.

P: You know …and usually that is more than enough to support you in going through whatever you are going through ..you know..... that is usually the concept of counselling therapy instead of frown upon(…)
P: Frown upon in a way that… you know.. I think that is not something that is not just considered. [Georgia p. 13: 24–30]

In the above excerpt, Georgia seems to suggest how she perceives counselling, based on her cultural beliefs. Her use of the words 'frowned upon' may indicate her preconception that counselling is a Westernised concept that is being offered by the Western world and not accepted in Africa and, therefore, in her African culture, people who attend counselling are 'frowned upon' or not approved, as the type of support available within the African community is considered sufficient.
Georgia repeats the words 'you know' many times, to emphasise her point, which may indicate that she might have positioned me as an insider and therefore welcomes me to contribute or agree with her. It might be that she was assuming that being an African woman myself, there is a possibility that I may share a similar world view to hers.

3:2:2 Subtheme 2: Stigma

In this subtheme, significant emphasis was placed on how the fear of stigma that is associated with engaging in counselling and psychiatric labelling acted as a barrier to participants accessing and engaging in counselling services. All six participants seem to suggest that engaging in counselling is associated with mental illness. The fear of being judged as mentally ill seems to be a key concern and the reason why participants were reluctant to engage in counselling.

P: Ordinarily, I would…. and I tell you what ... the first session I had … I went home and I was quiet about it, I didn't want to tell anybody I was going into therapy (…) I felt mmph… by saying that you know how Blacks interpret all these therapies in this country … As soon as you go to therapy, it can translate into … maybe you are crazy or you are that... [Tina p. 11: 9–14]

In the extract above, Tina reported that she kept her counselling attendance a secret. Her use of the words ‘maybe you are crazy or you are that’ indicates her fear of being labelled as mentally ill by people from her community. She emphasises using the phrase ‘how Blacks interpret all these’, which may mean that being labelled as mentally ill might not only bring shame and embarrassment to herself but also to her family.

Participant Lyn holds a similar view to Tina about sharing her distress.

Lyn is 53 years old. She currently works in a forensic unit. She migrated to the UK 15 years ago.

P: I could not talk about… you know.. about such things to a man but to be honest these are some of the things I was getting worried about and then eeh .. the other things was also like if I get mad what would everybody else say? The stigma that is attached to mental illness and eeh there were so many things that were coming to my mind. [Lyn p. 11: 10–16]

In the extract above, Lyn seems to be worried about being judged by others as mentally ill – ‘what would everybody else say?’ – and the stigma attached to mental illness. What she says seems to suggest she was internalising engaging in counselling as being associated with mental illness, and was worried about the implication of that in her life; for instance, her self-worth.

P: Yeah, as I said before, in my culture people do not attend therapy so anything like therapy/counselling you knows… people are going to see ... judge you and think you are crazy or you are not coping well with your life and … yeah… or you are not strong enough which is a bit derogatory. [Edna p. 6: 10–15]

What Edna says above seems to suggest that attending counselling not only involves the stigma associated with being ‘crazy’ (mentally ill), but also a belief that when someone attends therapy, they are perceived as being dysfunctional and weak. Edna's use of the word ‘derogatory’ may suggest her strong feelings and resistance towards being labelled as weak, something that she seems to be working hard to avoid.

P: Is as if you are not coping well…I didn't want to say…. They are all born here… so I'm (…) even looking ...I'm looking at them as White…because they have taken up the culture … you know… so when she said ...ooh ...why didn't you…. I was quiet because I had already attended one (…) I was only saying that you know…. It wouldn't be my children it will be like family members who will say ...emm.. What is she going to therapy for?! Has the bereavement now turned her mad? … [Tina p. 12: 1–8]

In the transcription above, Tina highlights and describes two main issues:
First, her fear of being judged negatively by her family, as she conceptualises engaging in counselling to signify being weak and not coping well, a judgement that was likely to come from her family but not her children.
Second, Tina uses the phrase 'I'm looking at them as White', which may mean that she categorises her children as similar to White people because they were born in the UK, and therefore are likely to have adopted some aspects of the culture, and will conceptualise counselling in a more positive way, in comparison to others who were born outside the UK.
The notion that counselling is more acceptable by BAW who have come into close contact with Western culture is also supported by the participant, Beatrice.
Beatrice is the youngest of all the participants at 35 years of age. She studied for a degree in psychology and is currently working in a voluntary organisation. She attended eight counselling sessions and disengaged.

P: Do people even like... seek therapists in African countries? Do they even…? What is the percentage of people actually go see therapist in African countries? But here is more acceptable and I think that is …and then obviously here we live in England and is more acceptable... [Beatrice p. 20: 5–8]

In the transcription above, although Beatrice seems to emphasise her belief that counselling is a Westernised concept, she still holds a belief that there is less stigma here in the UK when it comes to therapy or counselling engagement, and that counselling services are readily and easily available.

It may be that Beatrice's belief system has been shaped through the process of acculturation. Bhui and Bhugra (2002) define acculturation as 'the process of cultural and psychological change that results following a meeting between cultures'.
As a result, she may perceive counselling more positively than someone who has not gone through this process.
To conclude, this theme suggests that the fear of psychiatric labelling and the stigma associated with it has been a main contributing factor for negative attitudes towards help-seeking behaviour and premature therapy discontinuation for some Black African women.

3:2:3 Subtheme 3: Scepticism about the therapist

In this study, the participants' reluctance to engage in counselling seemed to be not only caused by the fear of being judged negatively by others but also by their perception and scepticism about the person who would be delivering counselling; in this case, the therapist. The result revealed that the participants who internalised their therapist positively reported to be satisfied with counselling and reported more positive therapy outcomes than the participants who did not.

P: Because of my… my… my… initial thoughts was she can't know me what does she wants to talk to me about? She can't know me, you know, she is from a different background, she is from a different culture, how can you counsel a Black woman when you are a White woman… [Tina p. 15: 24–26]

From what Tina describes above, it seems that because of her cultural belief and her preconception that White therapists lack understanding of her culture, she was reluctant to work with a White therapist and therefore was already predicting negative outcomes from her counselling. This is demonstrated by the words, 'she can't know me … she is from a different background, she is from a different culture'.

P: I suppose many women they feel that... you know their cultural or… their religion will not be accepted as they go through therapy perhaps if you mention that you believe in Jesus or you believe in whatever, you will be seen as mad, then you'd rather stick to the people that you are used to, or rather than going to strangers who may not be that helpful. [Lyn p. 20: 3–8]

Lyn seems to share a similar view to Tina. She expressed her concerns that her culture and religion, which seem to be an important aspect in her life, will be ignored if she embarks on counselling with a White therapist from a different culture to her African one. She also expresses a fear of being judged as mentally ill because of the religious or other cultural beliefs she may hold – 'you believe in whatever'.

As a result, Lyn reported having withheld vital information from the therapist, whom she describes as a 'stranger'. It seems that Lyn's mistrust of the therapist, and her fear that the therapist may judge her negatively, contributed to her disengagement from counselling that was delivered by a White male therapist, as she prefers to 'stick to the people that you are used to' – probably her family or significant others.

What Lyn said seems to highlight an important issue about some BAW's preference of having a therapist similar to them; in other words, a therapist from the same cultural background and ethnicity. As already discussed in the literature review, clients initially trust therapists whom they perceive to be similar to them more than they trust those they perceive to be different. Research on the patient and therapist relationship has suggested that matching therapists with clients of the same race or ethnicity may result in a stronger working alliance and a positive outcome from therapy (Cabral & Smith, 2011).

However, Davanzo and Errázuriz (2018) have argued that the therapist and client match may be necessary for some, but not all, clients, and does not necessarily guarantee a positive therapy outcome.

This is indicated by what Beatrice says below:

P: I had the opportunity I think I have gone for … a White therapist (….) I don't know guess is just kind of .. I don't know.. There is a reason behind it I think I could not work it properly … em.. I don't know I guess is just kind of feeling more comfortable with... I feel more comfortable with … because as I said it seems like going back to the whole like a taboo like it's not bad. [Beatrice p. 19, 9–16]

What Beatrice said seems to emphasise the point that not all clients will prefer to have a therapist from the same cultural background, race, or ethnicity. Beatrice has a personal preference to having

a White therapist whom she feels comfortable with because of there being less taboo surrounding engaging in counselling.

To conclude, this subtheme indicates that the participants' reasons for not engaging fully in counselling at the onset of their difficulties may be determined by the preconceived ideas they held about the therapist.

3:2:4 Subtheme 4: Preferred ways of coping

In this subtheme, participants describe their preferred ways of coping with psychological distress without the use of psychological interventions, particularly counselling. Participants revealed how their cultural beliefs and their identity as strong African women defines what is an acceptable reaction and response to mental health issues and agreeable coping mechanisms.

In this subtheme, the participants' preferred ways of coping are described by different strategies they employed to cope with psychological distress. These included occupying themselves and avoiding dealing with their distress, self-isolating, and their use of social support, as demonstrated by what Daisy says below:

Daisy is 35 years old. She currently works at a supermarket as a supervisor. She migrated to the UK seven years ago. She attended seven counselling sessions and disengaged.

P: Well I've got different ways of dealing with the problems at the moment first is more kind of exercise I take at least an hour or two and (...) from the help I got as well err the lady who helped me she gave me some kind of website to access online studies (...) then sometimes I used to cook as much as I can put in the fridge I go to church and also is more of kind of .... I really like going to the libraries just to make my time more useful by means of accessing internet, books and everything else just to keep myself busy ... [Daisy p. 4: 30–40]

From what Daisy has said, above, it seems that physical exercise and keeping occupied by doing physical activities is Daisy's preferred way of managing psychological distress.

Daisy seems to be transferring her distress into physical activities in order to gain a sense of control, rather than focusing on her distress as this may indicate a sign of weakness. She seems to conceptualise focusing on her distress as less important, as indicated by her use of the words ‘just to make my time more useful’. Although Daisy conceptualises these coping strategies as useful in

the long run, it seems to have resulted in emotional avoidance whereby Daisy might have continued to ruminate on the very problems that she was trying to avoid dealing with. As a result, Daisy decided to seek counselling when other coping resources seemed to have failed.

Self-isolating was described as another preferred way of coping that participants use to cope with psychological distress, as demonstrated by Georgia, below:

P: Other ways of coping will be just to be alone, you know, away from people and mulled over...
I: What do you mean mulled it over?
P: You know think about it you know think about my problems you know … and... yeah think about whatever issue is... [Georgia p. 7: 7–11]

Georgia uses the metaphor 'mulled over', which may indicate that she prefers to think about her distress from a different perspective and find her own solution, rather than seeking professional help or help from others. It may be that she fears sharing of her distress with others as being seen as overreliance on others, which may indicate a sign of weakness. This is demonstrated by the use of the phrase 'away from others'.

The participants in this study demonstrated how they view a social network as a safe and supporting structure for psychological support. The participants have demonstrated the use of social support as an opportunity for discussion of problems and finding solutions before seeking professional help. The use of social support includes family support, friends, the use of religious leaders and others who share the same religion or faith, and socialisation with others within the Black African community.

P: .. if is something to do with family I kind of seek my mum's emm support if is just personal thing, my friends are always there and I always ask them how did they think, so I could just kind of get someone else's opinion cause I don't think I can cope well with problems in general. [Beatrice p. 4: 17–21]
P: Normally because I am from a larger family I… I usually just reach for the phone and call my sister or call my mom and talk about it ...you know…. It's kind of my coping method or I... I … speak very openly I'm a very open person so I speak with friends, colleagues... Speak with my family especially about anything ... [Edna p. 2: 10–14]

Beatrice and Edna describe their close family members, preferably their mothers or siblings, as their source of support and strength when experiencing some psychological distress. It seems like both seek support from kinship first for issues that they perceive to be more sensitive. For instance, Beatrice says 'if it is something to do with family…I seek my mum's support'. It seems that both perceive family members to be helpful and less likely to be judgemental compared to other people outside the family, who may perceive them as weak and not coping well. They both use friends and colleagues as a second resort when the other resource fails. However, social networks and the use of others could also be interpreted as a barrier in two ways, either through their absence or their presence.

When a social network is absent from one's life, there is a likelihood that the person will feel lonely, isolated, and not supported (Pernice, Biegel & Kim, 2017). This may impact on their psychological well-being. On the other hand, the overreliance of a social network or the use of others may act as a barrier, whereby some Black African people may use a social network as an alternative for professional support, and therefore avoid seeking help when needed (Memon et al., 2016). All six participants in this study described how they resort to social support when personal resources fail.

Spiritual beliefs and religious practices were described by participants as their preferred ways of coping with psychological distress. Although spirituality can have broad relevance for coping with emotional difficulties in many cultures, it could have particular importance for people of African origin because of their strong beliefs in the existence of a higher being as a source of help or support (Okello & Neema, 2007).

In this study, five participants described themselves as Christians and reported to have been practising Christianity as a faith. This includes reading the word of God, talking to religious leaders, and socialising with others who share the same religious faith.

P: Yes, I do it's more kind of being close to Him and just feel like they are certain things or you learn from the Bible, that tell you like how to stay positive (...) not like giving up things it's like more encouraging each other, just more loving and all these kind of things so it's not just ... you won't feel more isolated than you are if you are not going to interact with people (...) and read

what says inside the Bible I think that is really … really… important and it did help me a lot … [Daisy p. 5: 21–28]

Daisy describes how useful her faith in God is, and her practising of religious activities gives her a sense of belonging and hope. This seems to play an important role in her life. It seems that she resorts to God, to whom she refers as 'Him', as her source of strength and encouragement and hope about staying positive and focused.

P: amm usually like I mentioned, I've got eem my pastor who is my religious leader and the other elders in church, the other women I fellowship with in church, if I have any problem I discuss with these people and they give me counselling and they counsel me according to the scriptures from the Bible, by giving me examples of how other women in the Bible, how they coped when they... [Lyn p. 4: 5–11]

Furthermore, religious faith seems to be playing a significant role in Lyn's life as well. From what she said above, it seems that Lyn places an emphasis on the use of others who share the same religious faith for support. This is demonstrated by the phrase 'my pastor who is my religious leader and the other elders in church'; whose main role involves presiding over specific rituals and teaching about their religion's doctrine and practices. These are also known as clergy.

However, one observation to be noted here is that the participants have conceptualised the use of a social network for emotional support to include family members, friends, and also the use of religion. This may indicate that culturally based understanding of mental health and illness influence whether, when, and from whom, individuals seek support. It is evident that some BAW prefer to seek relational help and religious support rather than professional support and advice in the first onset of psychological distress, in comparison to the general British population, where people seem to rely more on the use of all available resources such as therapy, medication, and family doctors (GP), and also religious or spiritual beliefs and practices.

In this theme, above, it can be assumed that most participants in this study would not have utilised counselling as their preferred way of dealing with psychological distress in the first instance of their difficulty and distress because of the existence of other means of coping. However, it is unclear as to why participants decided to engage in counselling in spite of the other preferred ways

of coping stated above. For instance, in the transcript above it is unclear whether Lyn was fulfilling a requirement of her work place or her GP's referral, or if she was keen to engage in counselling and it was her personal choice, as evidenced by what she said below:

P: If I would be off sick for more than six or seven days then they would require a GP note to warrant my emm… off days from work. So eeh yeah, I referred myself to the GP and went and explained what...how ... I was feeling ... [Lyn p. 5: 1–5].

To conclude, since the participants in this study engaged in counselling, it could be assumed that their preferred ways of coping were not as effective as they expected, and therefore attending and engaging in counselling was their last option.
In the following master theme, an exploration of participants' experiences of engaging in counselling or being with a therapist is presented.

3:3 master theme 2: The important characteristics within the counselling experience

In this master theme, participants described the important characteristics that the therapist possessed and how these impacted their experiences of engaging in counselling; in other words, their experiences of being with a therapist.
The participants' experiences of engaging in counselling varied. Four of the six participants (Edna, Tina, Daisy, and Georgia) described their counselling experiences as positive, while two of the six participants (Lyn and Beatrice) described their experiences as negative. The participants described their counselling experiences as having been influenced by the therapist's characteristics, the therapist's ways of working, and the quality of working relationship that was established with their therapist.

3:3:1 Subtheme 1: Therapist characteristics

Therapist characteristics was described by all six participants as one of the factors that impacted upon their counselling experience.
Participants described therapist characteristics to include demographic characteristics such as age, gender, ethnicity, and social class. The characteristics also included personal attributes, such as

being kind, understanding, and a good listener. In spite of different therapist characteristics described by participants and how these impacted the counselling experience, the analysis revealed that all participants have one thing in common: they all preferred to work with a therapist they felt comfortable with and who was someone they could relate to.

P:.. because the person is always young just like you, ... so they must understand you better than the person who is matured, because those generations and this generation is different. [Daisy p. 9: 14–16]

Daisy, above, emphasises her personal preference for a therapist who is of a similar age. Her use of the word 'generation' may imply the age difference between herself and the therapist. Daisy seems to prefer a younger therapist in order to feel understood. It seems that she believes that a therapist from her generation ('always young just like you') will have an empathic understanding of her problem, something that she seems to be valuing most.

P: I really wanted a man 'cause I thought what I'm going through something let me kind of see what he has to say from a man's view, 'cause I was thinking 'obviously men are all stupid'... but that's something... sorry men are not stupid... eemm... yeah I'm very bitter so amm...so yeah I was ... I wanted a man maybe next time ... [Beatrice p. 27: 8–14]

On the other hand, Beatrice prefers a male therapist. She seems to be expressing her desire to see her problem through the eyes of others; in this case, the opposite gender to herself – 'let me kind of see what he has to say from a man's view'. The way Beatrice describes her preference seems to suggest that she may be going through an internal conflict whereby she is caught between her belief that men are not good (based on her bad experience of a relationship breakdown, which was the reason she went for therapy), and believing that men are good because of her love for her father, which she may want to compensate through building a positive relationship with a male therapist. This dilemma is evidenced by her contradicting statements: 'men are all stupid' and 'men are not stupid', and as demonstrated by what she said below:

P: She asked me to talk about my father and my relationship with my father which I thought was a bit I mean obviously she is a professional but I kind of ... I was kind of confused to why is she bringing up my father (...) [Beatrice p. 10: 7–10]

Reflections

At this point, I began to wonder how she felt having to work with a female researcher (me) who also comes from the same cultural background as her, when she has categorically stated that she prefers to work with a male therapist. As a result, I felt that I was not good enough. To some extent, this impacted the type of prompts and my questioning techniques, fearing I may offend her and cause further disappointment. I deduce that this impacted the types of data or information I obtained from her because of my reluctance of asking further questions.

Furthermore, Lyn, below, prefers a female therapist because of the shame and embarrassment of disclosing her inner distress to a male therapist whom she viewed as a stranger. This may be as a result of cultural differences, whereby in most Western contexts, self-disclosure is considered central to the quality of therapeutic relationships and has been associated with positive therapy outcomes (Thompson & Akbar, 2004), while for many people of African descent, talking about their private business with people outside of the family is taboo (Qureshi, 2007).

P: I didn't want my husband to touch me (...) if this continues perhaps my husband will end up divorcing me because my libido was very low ... and I could not say this to this therapist because he was a man, I could not talk about... you know, about such things to a man but to be honest these are some of the things I was getting worried about. [Lyn p. 11: 6–11]

Another participant, Georgia, seems to take a neutral position whereby she believed that the therapist's characteristics, such as gender or ethnicity, were not an important determinant or predictor of her therapy experience. What was important to her were the benefits that she gained from counselling.

P: It was a man at the beginning it was a man ... a White male... the one yeah.... the one who did the sessions with me.

I: Mmmm ...and how did you feel about that? About having a male White man?

P: Mmm whatever ethnicity they were at the end of the day there was somebody there you know listening to what I have to say (...) you know I think that was the most important thing… [Georgia p. 19: 1–6]

As part of therapist characteristics, the participants described the therapist's personal attributes to include the therapist's level of politeness, caring, congruence, and understanding.
In this study, the therapist's personal attributes and the way the clients internalised the therapist seem to have impacted upon the participants' counselling experience.

P: Like I said… she was very professional (...) She was warm… She was emm... she listened to me very attentively, without interrupting me, she allowed me talk (...) and even though she was not an African, she was a White lady (...), she was able to kind of relate to what I was saying (...) she was really calm (...) was reassuring because that made me know that she knew what she was doing ... yeah... [Edna p. 8: 18–25]

From what Edna has said above, it seems that the perceived benefits of counselling that she described were related to the way she was satisfied by the therapist's personal attributes and the way she related to her in therapy. Edna's description of her therapist's qualities in the above excerpt is closely related to Rogers' (1957) conditions of empathy, congruence, and unconditional positive regards that the therapist should have towards their clients to make therapy a useful and beneficial experience.

P: To the person who is receiving the counsel. I … suppose you know the counsel that I'm used to is like the person is trying to put themselves in my shoes and they try and understand what is going on but then this one he didn't seem like they were any emotional attachment, you know, it was too flat or too blank you know ... [Lyn p. 15: 1–5]

In contrast, Lyn seems to suggest that her therapist was insensitive, emotionally distant, and lacking empathy, based on his interaction with her in the therapy room. '…he didn't seem like they were any emotional attachment you know, it was too flat or too blank…'

What Lyn said above highlights the importance of a therapist having empathy. This is the ability to walk in another person's shoes and to experience life as the other person by entering their world of thoughts, feelings, emotions, and meanings (Beck, 2011). The absence of this seems to be one of the reasons for therapy dissatisfaction. For instance, as a result of what Lyn described as her therapist's lack of emotional attachment, she said she prefers to use a social network and her religious beliefs as a way of coping with psychological distress. It seems that this type of support made her felt safe, understood, and not judged negatively.

Reflections

I felt discouraged by Lyn's comments. I felt as if I was caught in-between two worlds: the world of a researcher and the world of a trainee counselling psychologist. As a researcher, my mission was to explore participants' experiences and the meanings they assign to these experiences. At the same time, from a practice point of view as a trainee, what I wanted to hear was positive comments and appreciation about the work that the therapists do. My interpretation of what Lyn said was that it may be possible Lyn was using a cautionary tale to inform me that I was not caring as I did not comment or offer suggestions. As a researcher, my role was to explore her experience of counselling rather than explore her difficulties. In my mind, it was not very clear whether the therapist did not possess good qualities, or if this was Lyn's own perception about the therapist. In accordance with my epistemological stance, the bottom line was that whatever participants were telling me about their experience was very useful, as I consider that as a true reflection of their counselling experiences. As such, I consider the data obtained from Lyn as a true reflection of her experience.

3:3:2 Subtheme 2: Ways of working

The therapist's understanding of the culture, and their willingness to incorporate this in counselling, has been described as an important quality for a therapist to have (Thompson & Akbar, 2004). The therapist's ways of working, as described by participants, included the way the therapist delivered counselling. These included the therapist's acknowledgement and understanding of the client's culture and their willingness to incorporate this in therapy; the therapeutic or modality approach used; and the language that the therapist used.

Following their experiences of being with a therapist, the participants in this study described the differing opinions and experiences with regard to their therapist's understanding of their culture. As Lyn says below:

P: Perhaps it works (...) when: one you trust the person who is giving you the counselling when you understand the language that is being used ...When you can openly disclose your feelings to the person whom is giving you the therapy but it becomes difficult when those things are not fulfilled... you know... or like the trust ... the language or the culture of the person who is giving you the therapy amm... you sort of go through it in an artificial way, just to fulfil that you have been asked to do but I feel mmm ...I don't think it will be my first choice you know… [Lyn p. 12: 5–13]

Lyn seems to be describing conditions that need to be met by the therapist working with clients from a different cultural background. From what Lyn has said, it seems that she was not satisfied by the therapist's lack of understanding of her culture, and felt that the therapist was imposing his own culture on her, to the extent that she attended therapy but was not fully engaged; evidenced from what she said here: 'you sort of go through it in an artificial way, just to fulfil that you have been asked to do'.

P: So yes. You know… someone who understand your culture will be preferable (...) but I think on this occasion it was difficult and I don't know whether they are many of my culture who are being trained or are taking out the … the... training. [Lyn p. 19: 17–19]

With Lyn's use of the words 'I don't know whether they are many from my culture', I wondered whether she was suggesting that she would have preferred someone from her own culture, meaning an African therapist, but acknowledged that there may be few trainees from Africa, from what she said above. However, being an African therapist should not suggest that they can work with any African client. Africa is a very large continent, with many countries, tribes, diverse cultures, languages, and traditions, which an individual from a different African country to their own may not be aware of.

As part of the therapist's ways of working, participants described their experience of the therapeutic modality used. The analysis suggests that most participants did not clearly understand the treatment modality used to treat their difficulties. On reflection, as a researcher, I believe that the participants' lack of understanding of the therapeutic approach used may suggest two issues: first, this information might not have been given to participants, and second, the information that was given to participants may not have been clear enough for them to understand, considering that, for most participants, this was their first counselling experience.
This is demonstrated by Beatrice:

I: mm... so... emmm... can you recall what approach she used was it CBT or…
P: aah God honesty to God amm I don't even know I think when she was talking I think …. I think it was CBT from when what she was like saying (…) from what I can recall ... in not a really good ... I didn't really remember things very well and I try block things out of my head that are of irrelevance to me and I think I block that whole thing out of my head 'cause I think it was un...you know absolutely emm... not useful … [Beatrice p. 13: 4–12]

Beatrice seems to disregard the therapist's work; she seems not to have been aware of the type of therapeutic approach used during therapy. It is unclear whether she was given any information about what to expect in therapy before attending, as evidenced by her reluctance to answer my question above. It may be that the information about the type of modality used was not relevant to her, as demonstrated by what she said above – 'I try to block things out of my head that are not relevant'.

Reflections

Thinking about this now, the question I asked Beatrice seems to have created a hidden tension between us. Beatrice may have felt embarrassed by her lack of knowledge about the modality that her therapist used, considering that she had told me that she was a psychology graduate. As a result, she defended herself by being critical about how irrelevant counselling was to her. I felt criticised somehow by her comments as a trainee psychologist and wondered whether there was a power dynamic between us.

It may be that Beatrice was trying to disqualify my position as a Black woman and a therapist. This is evidenced from what she has been saying all along about her preference for a White therapist rather than a Black female therapist.
Borrowing Klein's (1946) object relations psychodynamic theory helped me to understand the dynamic that existed between Beatrice and myself. It seems like Beatrice was projecting her negative feelings towards me. At this point, I felt that Beatrice had not been engaging well in answering the questions that I asked her, and at the same time I was reluctant to prompt for more information from her. I believe that this could have affected the information I obtained from her, and hence limited the amount of data I could have obtained for my study
Another participant, Daisy, seems to have been struggling to express herself clearly when asked about her understanding of the therapeutic modality used.

P: I think it was more kind of cognitive behavioural by the means of I didn't … I had a lot of negativity in my head at times and she really tried to put eeh a lot of positivity to me (...) she is more kind of putting me to want to do things the one that I wanted... [Daisy p. 18: 14–30]

What Daisy said demonstrates the possibility that she may not have been given enough information about the therapeutic modality used prior to commencement of therapy, or did not understand the concepts clearly because of the language used by the therapist.
As part of the therapist's ways of working, the participants commented on how the language used by the therapist acted as a barrier to communication. As a result, this also negatively impacted their counselling experiences.
For instance, Lyn described her difficulties in understanding the questionnaires that were presented to her during the assessment:

P: Also the language was eem difficult for me yes I went through the questionnaire long though it was really long (...) it was not very clear to me but anyway he just said to me you are out of the dangerous zone eeeh you could be having a mild depression or so anyway but I told him that I... the questionnaires was not clear to me and my answers were in-between they were not that accurate... [Lyn p. 81: 7–16]

In general, the language used in the Western treatment models of therapy or research may not be understood or shared by other cultures (Sue & Sue, 2008). For instance, some people within the BAME community who migrated from non-English speaking countries may not be able to communicate adequately in English if they are recent immigrants. Their lack of ability to effectively communicate with healthcare professionals seems to prevent individuals from accurately explaining their problems and they are therefore reluctant to seek help.

3:3:3 Subtheme 3: The relationship

The quality of relationship or the therapeutic relationship is an important aspect of counselling and psychotherapy practice. It refers to a professional working relationship that exists between a client and counsellor. In therapy, the strength of the therapeutic relationship is considered as the key to positive therapy outcomes (Gilbert & Leahy, 2007).

In this subtheme, the participants reported having had different experiences of the therapeutic relationship. Some participants were satisfied by the way their therapist established a bond with them, while others described the relationship with their therapist in a negative way.

P: But then when you go there at first you need even to understand just to learn a little bit about the person before you open up about how exactly you feel about everything but if you feel like the person is blocking you a little bit that means you hold back some of the information which is not good because it's not gonna help you in the long run. [Daisy p. 9: 36–38 then p. 9: 1–4]

From what Daisy has said above, it seems that she was reluctant to share her distress with the therapist at the initial stage because the relationship between them was not yet established. This is demonstrated by 'but if you feel like the person is blocking you…means you hold back some information'. What Daisy said seems to emphasise the need for the therapist to establish a working relationship with a client, and for the clients to feel safe to open up about their distress. In order to get help, they need to make therapy more useful.

Contextually, the Western counselling models rely upon clients being willing to reveal sensitive information to the therapist so that the therapist can provide help.

Reflections

What Daisy said above reminded me of my first experience as a trainee. One of the issues I struggled with while working with older clients was to ask them some sensitive questions during the process of information gathering. To some extent, I felt somehow uncomfortable hearing different embarrassing issues that the clients brought to therapy because of my cultural beliefs about respecting and maintaining the dignity of people who are older. To some extent, this was also transferred to my experience as a novice researcher. As part of my research inquiry, there were times when I avoided asking some important questions and prompts that could have helped to explore participants' experiences in depth. On reflection, I noticed that I felt more comfortable asking questions to the younger participants (Beatrice and Daisy) than the older participants (Edna, Tina, Lyn, and Georgia). I feel that I have obtained more in-depth data from the younger participants than the older ones. As a result, my research finding may not have been a true reflection of BAW experience of counselling but rather a reflection of younger BAW.

In the transcription below, Beatrice describes how she was not satisfied by the relationship that existed between herself and her therapist, as she emphasises her right to choose the therapist she wants to work with.

P: That's what I said the importance of getting the right therapist is brilliant point 'cause it just felt like she was more of a teachers: Like a teacher... child relationship there and I just kind felt that and it just wasn't happy... I wasn't happy...With her... I just think I should have had the right to choose my therapist. [Beatrice p. 13: 1–6]

Her choice of the words 'the right therapist' may mean the therapist she feels comfortable with and someone with whom she can establish a relationship where she feels safe and secure. Beatrice used the metaphor of a 'teacher … child relationship'. This metaphor may stipulate her perception of the relationship that exists between herself and the therapist, where she feels controlled and undermined by being told what to do, as in a classroom situation. Beatrice's feeling about being controlled by a therapist highlights the concept of the power imbalance that may exist within the boundaries of a therapeutic relationship. Upon reflection, from the conversation I had with Beatrice during the interview, it was my understanding that CBT was used as a treatment modality to help

Beatrice to work on her issues. CBT assumes that the cause of client distress is maladaptive thinking (Wills, 2013). The therapist is therefore given authority to change these maladaptive thoughts through the use of knowledge they have acquired during their clinical training. In this case, it appears that Beatrice may have interpreted this way of working as being controlled.

Reflections

At this point I began to feel the tension that existed, not only between myself and Beatrice, but also between myself and the other participants. I was wondering if participants were struggling to trust me or if they felt undermined and challenged by my perceived authority over them as a researcher and also a trainee psychologist, in spite of my being a Black African woman. I believe that the participants avoided telling me their honest opinions or giving me sensitive information for the fear that I may judge them or share this information with other people within the Black African community. This may have resulted in them avoiding expressing their true feelings and also withholding some important information that could have given me rich data for my study.
As a result of limited information given by participants, the findings from this study may not be a true presentation of BAW.

Unlike Beatrice, Edna seems to have had a positive experience of the therapeutic relationship. What she described below indicates that the therapist was able to establish a good relationship where Edna felt supported, reassured, and understood.

P: Like I said… she was very professional.. She was very… very professional. She was warm… She was emm.. she listened to me very attentively without interrupting me she allowed me talk, she allowed me … give my emm my .. say my and even though she was not an African she was a White lady a therapist she was able to kind of relate to what I was saying she was able to understand what I was saying and where I was coming from. So yeah.. she was really professional and she was calm when I was getting stressed out or nervous .. you know breaking down she was very calm about it which was reassuring. [Edna p. 8: 18–25]

3:4 Master theme 3: Post counselling reflections on the therapeutic process and changed perceptions

This master theme describes participants' reflections after they have engaged in counselling. In addition to exploring participants' experiences of engaging in counselling or being with a therapist, the participants reflected on their counselling journey and gave feedback on aspects that went well. For the aspects that did not go well, participants reflected on what needs to be changed to make counselling a more useful and satisfying experience should they require it in the future. These reflections are discussed under the following subthemes: the counselling pathway; the counselling environment; and changed perceptions.

3:4:1 Subtheme 1: The pathway

This subtheme describes participants' experiences of the therapeutic process or route that brought them to counselling. This also included the professionals who were involved in referring participants to counselling. The pathway includes the counselling route, information given, and waiting times. The analysis revealed that the counselling pathway impacted on participants' counselling experiences. Those participants who were satisfied with the counselling pathway reported positive experiences, while others who were not satisfied described counselling as a negative experience.

In this subtheme, the participants reflected on different routes that were used to refer them to counselling. Some participants reported to have been referred to counselling by their GP, while others were referred by occupational therapists and psychologists.

One participant, Daisy, self-referred via the GP after counselling was recommended by her friend.

P: The GP keep asking me ... the reason why I'm stressed that way… and when I explained to him he was the one who referred me to the therapy… and then at that time I remember the GP also printed some kind of leaflets to go home and read them and some of them to do with online (…) he gave me the telephone numbers to do with Samaritans as well to call and talk to them but then emm the therapist phoned me. [Daisy p. 7: 7–13]

Daisy's description of the referral pathway suggests that she was satisfied by the referral process. From what she said above, it seems that Daisy was given all the support that she needed from her GP.

On the other hand, Beatrice, below, seems to express some concerns and dissatisfaction about the lack of clarity of information during the referral process. Reflecting on her use of high emotional expression, her body language, and the tone of her voice as she was talking, Beatrice appeared to have been left frustrated and confused by the referral process:

P: Basically like saying please... please help me and them saying okay I'll do a referral for you (...) and they like ooh by the way in the next four months get it in by yourself and it's like ooh if I can get it in by myself I would not have made the referral in the first place ... you know... I mean I didn't know how it works if the GP refer you but then I was told there is no difference between GP referral and self-referral so... Does it really make sense to have that long waiting? Sorry... [Beatrice p. 26: 18–23]

What Beatrice said seems to represents a failure; a lack of clarity and inconsistency of information within the pathway service into counselling, and it represents her feelings of being let down by the gatekeepers. These are the professionals that come into first contact with the patients; in this instance, the GP.

Based on her experience, Beatrice recommends that the referral pathway is one of the issues that needs to be looked at by the gatekeepers. Generally speaking, this seems to be a common experience for most service users within health services, which may have been caused by limited resources within the mental health service.

As part of their reflections about their pathway to counselling, participants reflected on how they felt about the information given. Most participants reported that they were not given enough information about the therapy itself or what to expect in counselling. This was considered important, considering that, for most participants, this was their first experience of being in counselling.

P: I think I think many African women they should enlightened about therapy you know… Spoken to about therapy and educated about therapy, what it is there for, why is there, for you know… [Edna p. 10: 3–8]

From the above excerpt, Edna identified an important issue that needs to be considered. Her use of the words 'enlightened' and 'educated' seems to suggest that, like most clients, she prefers to have been given information about what to expect in therapy before engaging in counselling. This practice is consistent with many psychotherapy services' requirements about users' involvement in issues regarding their care. It is common practice that, before commencement of any treatment, patients should be given enough information about what to expect in their treatment to allow them to make an informed decision.

As part of the referral pathway, participants reflected on the length of time they waited before they received counselling, which varied. Some reported to have waited for a few days, while others waited for between one and four weeks.

Five of the six participants described long waiting times as a barrier that may prevent them from accessing counselling services. The participants also expressed some concerns that services were not able unable to offer help to their psychological needs quickly enough.

P: .. but I do understand because I'm a nurse myself and I know this waiting list I know how it goes with the NHS … you know… so… but I would have thought what could have been done differently at that point was to do a quick referral if you see… I mean looking at someone that depressed you know… you … I was crying so... I did not think that referral should have taken a week. [Tina p. 22: 5–9]

What Tina said in the extract above demonstrates that, even though she seems to have had a positive counselling experience, the waiting time for her referral was one of the factors that she would have recommended changing.

Beatrice, below, used the metaphor 'my heart is no longer kicked… squashed or like shattered in little pieces' as she expressed her dissatisfaction with the long waiting times. As a result, she felt frustrated and had given up. This indicates that when clients are left in distress and not given help that they need, there is a tendency for them to use other resources available to them. This may

include the use of significant others for support. Her expression above may indicate that psychological distress is somatised and also embedded in the physical expression. The use of other coping strategies and resources minimises the need to attend therapy.

P: That's another thing, it's the waiting time, sorry (...) I referred myself it's taken... it's taken this long for them to get back to me and now I'm thinking 'Do I really need that?' because I'm actually… you are right I think my heart is no longer kicked… squashed or like shattered in little pieces, so now I think I'm alright … [Beatrice p. 27: 15–19]

Lyn, on the other hand, appears to have made her mind up and set an ultimatum that she will not attend counselling in the future. This is based on her negative experience, whereby she reported to have waited longer than expected to receive counselling because of the delay in the initial stage of the counselling pathway.

I: Okay... So, based on your experience, how do you feel about attending therapy in future?
P: Aaah ... I think I would ask to be referred early enough if at least I see the therapist within the week when I'm really distressed... I think I could you know ... go for it but if it so happen that the referral is made and it takes such a long time before you see the therapist then I would not go. [Lyn p. 18: 1–9]

The participants described waiting times as a significant part of their counselling experiences. Those who waited less were satisfied by counselling, unlike others who waited longer.

3:4:2 Subtheme 2: The environment

In this subtheme, participants reflected and provided their views about the environment where the counselling occurred. This refers to the physical characteristics of the environment where they were seen for counselling and how this impacted upon their experiences. Edna said:

P: There (...) wasn't any distractions but the thing is that if you are going in and out of the place people will see you… you know your colleagues will have seen you ... You probably didn't want them to know (...)

I. So you didn't want that many people to know.
P: Yeah.
I: So was it because of … yeah… do you have any reason for that you know thinking that emmm. I don't want people to see me really when I'm going to counselling. [Edna p. 11: 10–19]

Furthermore, Lyn shared a similar opinion with Edna, above:

P: and where possible if you can be seen by a woman therapist and also if you can be seen not necessarily at the GP centre but you know… some other convenient place rather than go to the GP where people will rather start to you know…. Thinking that they could be something wrong with you… [Lyn p. 18: 18–22]

From the extracts above, it seems that neither participant was satisfied by the environment where counselling happened because of the fear of being judged or perceived negatively. This may indicate a fear related to the stigma of being labelled as mentally ill, something that some Black African people work hard to avoid. As discussed previously in this analysis (master theme 1; subtheme 2), the stigma of being labelled as mentally ill has been one of the factors that contributed to participants' negative views about engaging in counselling. They reported that, should they be attending therapy in the future, they would like to be seen in a more therapeutic environment; a suitable physical space where they would not only feel safe and comfortable, but also have a reassurance that their confidentiality is respected.

3:4:3 Subtheme 3: Changed perceptions

As part of their post counselling reflections, the participants in this study reported to have changed their preconceived notions about what they initially thought before they embarked on counselling. Five of the six participants reported to have changed their views in a positive way, with the exception of one participant, Lyn, who reported to have the same views about counselling before and after she embarked on it.

P: ... Initially when I went ... like I said it was a White woman (...) my thoughts at that moment…was 'can you keep short… you are a White woman I'm a Black woman you don't even

know me… how can you… how can you… now speak to me…? this is my culture'(...) During therapy she went to… I just …what I found out later was that it wasn't a colour thing… It was not a colour thing (…) I could see that they have been training they are experts at what they do (...) she touched my culture… my traditional and so on and everything, I was amazed... [Tina p. 15: 9–16]

From what Tina said above, it appears that she had initially been contemplating not engaging in counselling. Tina reported to have perceived the therapist as intrusive and possibly not having an understanding about her culture, and she was therefore reluctant to engage.

However, after she had engaged in counselling, Tina seemed to have changed her perceptions based on her good experience with a White female therapist. This is demonstrated by her use of the phrase 'what I found out later was that it wasn't a colour thing', meaning that this experience seems to have opened a new horizon for Tina whereby she now understands that a White therapist, or a therapist from a different cultural background to herself, having gone through the right qualifications and training, can offer equally good therapy to a Black therapist.

Tina reported that, based on her positive experience, she will be attending therapy or counselling in the future should the need arise.

Furthermore, Beatrice, below, seems to suggest that she will attend counselling in the future, in spite of what she perceived as a negative experience with the therapist.

P: … so even if I had like not had such a good experience the last time... This doesn't… has not put me off at all, it's just like life... it just like life really... it's like going to the shop one day and stepping in the puddle it doesn't mean you never gonna go to the shop again you mind that you not gonna step in the puddle again. [Beatrice p. 24: 1–5]

Beatrice described a negative counselling experience based on the relationship that existed between herself and the therapist (described in master theme 1; subtheme 3). Her use of the words 'just like life', and 'stepping in the puddle' may indicate that she was viewing a rupture in the therapeutic relationship as a life challenge that can be overcome and not ignored. Beatrice seems to acknowledge that there are times when ruptures happen in the therapeutic relationship but this will not stop her from attending therapy in the future. This may indicate that, in spite of her

dissatisfaction with the therapist, there may be some aspects of counselling that she has benefited from; for instance, conceptualising challenges in a more positive way and seeing counselling in a new light. This way of thinking seems to have helped her to change her negative perception about counselling.

Conclusion

To conclude, this chapter has aimed to explore how Black African women experienced engaging in counselling. Through the process of data analysis, the study's main findings were obtained. To some extent, the study's main objective was achieved; that is to explore BAW's experiences of engaging in counselling. The participants' experiences of engaging in counselling were described through three main research themes.

In the first master theme, the participants described how their cultural beliefs impacted upon their engagement in counselling. The cultural beliefs included a reflection on how participants' preconceived notions, their perceived stigma about engaging in counselling, and their scepticism about the therapist, impacted how they felt about embarking on counselling. As a result of these factors, the participants also described how they use their preferred ways of coping with psychological distress without the use of counselling.

The second master theme described participants' experiences of being with the therapist. All six participants described how therapist characteristics, their ways of working, and the quality of the working relationship established between themselves and their counsellor impacted their counselling experiences.

Post therapy was also reflected upon, whereby the participants were able to look back on their journey. Those who reported a positive experience were relieved to find that their problems were not as insurmountable as they had previously imagined; those who reported a negative experience expressed a sense of optimism about attending therapy in the future. The issues that participants reflected upon included the counselling pathway and the environment where counselling happened. To some extent, all six participants expressed a change of perception about various aspects of counselling, offering a good reflection of their experiences, in spite of two participants being dissatisfied. This chapter also gave the opportunity for clients to give useful recommendations about what aspects needed changing to make therapy more useful for women of Black African origin. This feedback may have implications for policy makers, providers of mental

health services and, most importantly, the teaching and practice of counselling psychology. These issues will be highlighted further in the discussion chapter.

CHAPTER FOUR

DISCUSSION

4:1 Introduction

My study aimed to explore BAW's experiences of engaging in counselling. This study is among the few that have specifically attempted an in-depth inquiry into BAW's experiences of engaging in counselling in the UK.

The findings presented in this study have highlighted how BAW's engagement with counselling services is influenced by client-related factors, therapist-related factors, and institution-related factors. These have been critically discussed in the literature review chapter.

Structured around research questions in this chapter, a synthesis of the study's findings extracted from the interview transcripts and analyses will be presented. This provides an attempt to make sense of the research findings, and how these can be interpreted and disseminated within the wider context of the existing body of literature and research. This will involve discussion about the study's possible implications for policy makers, stakeholders, future research, and, most importantly, for the teaching and practice of counselling psychology and related disciplines.

4:2 Synthesising the participants' experiences of engaging in counselling and a summary of the study's findings

This section discusses all aspects of the participants' experiences of engaging in counselling, as interpreted within the three emerging master themes, namely; Preconceptions, stigma, skepticism about attending counselling and preferred ways of coping, The important characteristics within the counselling experience and Post counselling reflections on the therapeutic process and changed perceptions.

4:3 Preconceptions, stigma, skepticism about attending counselling and preferred ways of coping,

Partly as a result of cultural beliefs, participants in this study described their preconceptions about how they internalised the therapist and their thoughts about counselling before they embarked on it. This seems to have impacted their engagement with counselling.

Literature suggests that one barrier to counselling engagement that some people of African origin face is mistrust of therapists and other health care professionals, as some may continue to base their help-seeking attitudes on perceptions about racism, prejudice, and discrimination, and therefore women trust therapists who appear to be similar to them, and with whom they can establish a therapeutic relationship (Suite, La Bril & Primm, 2007). Furthermore, Watson and Hunter (2015) claim that clients and therapists from the same background are more likely to trust one another and are more likely to have a mutual understanding. This understanding reduces the client's concerns about being misunderstood and judged; therefore, improving clinical outcome.

However, Cabral and Smith (2011) have investigated how similarities between a client and therapist impact on therapy outcome. The study found that therapy outcome does not differ when the client and therapist are similar or dissimilar. In other words, a match between a client and therapist is neither a necessary nor important enough condition to yield a positive outcome (Cabral & Smith, 2011).

In a more recent study, Davanzo and Errázuriz (2018) also explore, using a sample of 28 therapists and 547 clients who engaged in therapy for depression, whether the therapeutic relationship is impacted by similarities and differences between therapist and client. The study gathered information about the gender, income, and age variables of both the clients and the therapists and concluded that having a therapist of either the same or different gender to the client did not make a difference to the client's rating of the therapeutic alliance.

The current study has found varying opinions among participants with regard to their preferred therapist. Two participants (Tina and Lyn) mentioned that they prefer to work with a Black female therapist, one participant (Beatrice) reported to have preferred a White male therapist, and another participant (Daisy) preferred to work with a younger therapist, irrespective of their cultural background, provided that she feels connected to them. Finally, Edna and Georgia reported not to have a preference for a therapist as long as the therapist is able to fulfil the therapeutic outcomes.

In hindsight, the findings from this study have demonstrated that a therapist who is similar or dissimilar to them is a client's personal preference. Similar cultural roots and ethnicity between a client and a therapist does not guarantee a better bond, understanding, or better clinical outcome.

With regard to a client's preference for a therapist, this study has implications for the practice of counselling psychology in two areas: the client's perspective and that of the therapist.

For counselling psychology practice, even though the majority of clients may prefer to have a therapist similar to them, in reality, due to limited resources, it may not be possible to offer all clients their preferred therapist. To some extent, this remains a dilemma for the providers of counselling services.

Moffat, McKenzie and Bhui (2009) emphasise that government policies should consider having strategies focusing on expanding the role of BAME professionals within mental health services, to help and provide more culturally based interventions that will build a trusting relationship between individuals from BAME communities and mental health services, and encourage them to engage with services.

From the client's perspective, this study has demonstrated not all clients prefer to work with clients from similar culture, background, and ethnicity. As discussed in the literature review, Watson and Hunter (2015) purport that clients and therapists of the same ethnicity and cultural background may not guarantee appositive therapeutic outcomes because of different interpersonal variables such as socioeconomic status, religion, and other factors (Cabral & Smith, 2011). Thus, assumptions of similarity based on ethnicity and race alone may result in disappointment and this may have a negative impact on the therapeutic relationship (Davanzo & Errázuriz, 2018).

Furthermore, even though some participants preferred to work with a therapist from the same cultural background, this study has demonstrated that there is some degree of acknowledgement and understanding about the shortage of Black African therapists within the NHS. This was commented on by two clients, Tina and Lyn, who acknowledged the shortage of Black African therapists due to their observations of working within the NHS system. However, one can argue that experiences and opinions may be different for someone who does not have experience of working within the NHS or who works in a different geographical location.

In the current study, participants described stigma as one of the barriers to seeking and accessing counselling. Based on their cultural beliefs of strength and the fear of being judged negatively, the participants in this study expressed how mental health was often viewed as a socially negative concept within the Black African community. In the Black African community, mental illness

seems to be associated with negative attributes and behaviours, leading to discrimination and isolation of the individual who suffers from mental illness from the rest of the community (Ochieng, 2012). As a consequence, people from Black African descent may conceal symptoms, delay seeking help, or fail to engage in treatment, potentially leading to further deterioration in their mental health (Mantovani, Pizzolatto & Edge, 2016).

For the practice of counselling psychology, it may be beneficial that this issue is given particular attention: first, for the counsellors who work with BAME, specifically Black African women, to consider raising awareness about mental illness; for example, by delivering programmes to de-stigmatise mental illness to their clients to enable them or their families to seek help before further deterioration of mental health issues; and second, for the counsellors to empower individuals from the Black African community to engage in treatment by incorporating culturally specific interventions through collaborative working between client and therapist.

As a result of their preconception about counselling, their scepticism about the therapist, and stigma of engaging in counselling, participants in this study spoke about their preferred ways of coping with psychological distress as an alternative to seeking counselling or therapy.

Religious coping and the use of social support have been described by most participants as the preferred ways of coping with psychological distress. In this study, five participants reported to have been using predominantly different aspects of their religious faith and practices as a way of coping with psychological distress. These include reading the word of God, seeking advice from religious leaders, and socialising with others who share the same religious faith. Vander-Waal, Hernandez and Sandman (2012) suggest how collaborative working between religious leaders and providers of mental health services has the potential to positively impact upon mental health provision.

Smith, Barts and Richards (2007) suggest that improving access to psychological services though religious leaders might act as a first point of contact in the development and provision of psychological care in which spirituality is more incorporated for those Black African women, their families, and their communities, who believe in and practise religious faith in their lives.

With the recent developments in counselling and psychotherapy, the recourse to religion, particularly reading scriptures and seeking advice from religious leaders and fellowship, has been

found to have a positive outcome in helping clients from African descent to deal with issues that have an impact on their psychological well-being. Ward and Brown (2015) have conducted a quantitative study on the use of a culturally adapted depressive intervention – 'Oh Happy Day Class' (OHDC) – for African American adults experiencing major depressive symptoms. The main tenet of this intervention was the inclusion of the client's religious faith as part of the treatment. The results revealed a 73% reduction in depressive symptoms after the intervention, where religion and spiritual dimensions were included.

The prominent role of social networks such as family and friends were identified by most participants as a preferred way of coping with psychological distress. This was used as an alternative to seeking help from healthcare professionals and was demonstrated by all six participants; for instance, Tina did not want to tell her family that she was attending counselling, Lyn preferred to talk to church elders and other church members, and Beatrice preferred to talk to her mother and immediate family first.

However, even though the use of social support may be a preferred way of coping for some Black African women, to some extent it can be limited by the individual delaying support until their mental health issues deteriorate. For instance, one participant, Tina, said she wished she could have attended counselling and sought support earlier, before her distress escalated.

A recent study conducted by Memon et al. (2016) concluded that people from a BAME background are less likely to contact their GP at the early onset of mental health issues. As a result, they seek support from friends and family first, rather than seeking professional help because of stigma related to the use of mental health services and the lack of trust in such services.

4:4 The important characteristics within the counselling experience

With regard to participants' experiences of engaging in counselling, the findings from this study reveal a duality of participants' experiences. Four participants described positive counselling experiences, while two described engaging in counselling as a negative experience. These experiences were influenced by the therapists' characteristics, the therapists' ways of working, and the quality of relationship that was established between participants and their therapists.

The quality of relationship that was established between client and therapist was one of the key factors that impacted participants' experiences of engaging in counselling. The findings from this

study demonstrate the dynamics that may exist within the context of a therapeutic relationship when a therapist and client come from different cultures. Lee and Horvath (2013) suggest that when the counsellor and client come from different cultures, and if the therapist does not respond to clients' cultural needs, there is a tendency for the client to feel misunderstood, which therefore poses a negative transference towards the therapist. This, in turn, can impact the therapeutic relationship and be the reason for the client to terminate therapy.

In the current study, this was demonstrated by one participant, Beatrice, who described her relationship with her therapist as one of teacher and pupil. She described the therapist as insensitive and controlling. As a consequence, she was not satisfied with counselling, although therapeutic processes are complex and a plethora of issues may be present.

Padesky and Mooney (2012) describe the consequence of power imbalance as causing the clients to no longer feel responsible for resolving their own problems, and as a result, feeling disempowered. Gilbert and Leahy (2007) propose that, rather than the patient receiving expert advice from the therapist, the therapist should foster a relationship in which both participant and therapist contribute equally.

Consistent with the current study's findings, Elliott, Westmacott, Hunsley and Rumstein-McKean's (2014) qualitative study on mental health services describes some of the common findings on helpful therapy factors, which include: a positive therapeutic relationship, whereby the therapist is a good listener; being empathic, affirming, or validating; and the therapist offering specific techniques for dealing with clients' difficulties. In contrast, common findings on hindering therapy factors include therapists being judgemental, invalidating and imposing their views on clients.

For the practice of counselling psychology, this study demonstrates that the process of change can be managed well when clients feel safe within the boundaries of a therapeutic relationship. For instance, in the current study, two participants (Beatrice and Lyn) reported that if they get the 'right therapist', they will engage in counselling in the future.

In this study, as part of the participants' counselling experiences, language was described as a barrier to communication by most participants. For instance, due to the fact that all participants migrated to the UK from Africa, they reported that they found the English language limiting, as

they could not express and articulate themselves the way they wished. As a result, this impacted on their counselling experiences as they did not always fully understand the therapist and felt frustrated and misunderstood by them.

One participant (Lyn) reported to have had difficulties in understanding the questionnaires that were used during the assessment phase. She reported that the language used was complex, and contained some words and phrases that she was not familiar with.

In hindsight, language in counselling or other mental health services has been used as a tool that constructs diagnostic labels. These labels or diagnoses may be used intentionally to allow service users to get access to appropriate services, as without these, the issue of referral and pathways to counselling services becomes complex. Furthermore, Sue and Sue (2008) have argued that the language used within different therapeutic modalities, such as CBT, psychodynamic counselling, person-centred counselling, and so forth, is more based on a Westernised model of care and therefore may contain complex words, phrases, and jargon that may not be fully understood by clients from other cultures; in this instance, the African population.

The therapist's lack of understanding of their client's culture was one of the issues commented upon by four of the six participants. To some extent, this negatively impacted their counselling. This was demonstrated by Lyn, who described her therapist as insensitive and uncaring due to his perceived lack of understanding of her culture.

Memon et al. (2016) claim that lack of understanding of a client's culture and insensitivity within healthcare services is viewed as a barrier to accessing services, whereby clients are left feeling rejected and their needs are not met via their counselling. For the practice of counselling psychology, this issue highlights the importance of counselling psychology training and practice to incorporate cultural awareness training in order to avoid therapists becoming ethnocentric, where they believe their culture is superior or applicable to all, and unconsciously imposing this onto clients (Qureshi, 2007; Whitley, Kirmayer & Groleau, 2006).

For the four participants who reported a positive counselling experience, they described counselling as a learning curve whereby they learned better ways of coping with issues that caused them distress. This enabled them to change their lives in a more positive way. These participants expressed relief that they were able to conceptualise life more positively using the skills that they

acquired through counselling. As a result of their positive experiences, they reported that their symptoms of distress were significantly reduced.

Most participants reported that counselling helped them to discover their inner strength and realise that each individual has some element of control of how they feel and how they perceive life's challenges. Through counselling, they were able to challenge their ways of thinking, particularly on those issues that caused their innermost distress. This realisation seems to enable them to conceptualise their lives in a more positive way. In other words, some participants reported to have learned to become their own therapists, meaning that in the future, when faced with life's challenges, they can utilise what they have learned in counselling.

Following the establishment of successful counselling relationships between participants and therapists, the participants reported that they were able to bring out into the open those issues that had been the main cause of their distress; in other words, issues they felt uncomfortable to talk about before attending counselling. They were able to express themselves freely in terms of the difficulties that brought them to counselling without the fear of being judged negatively.

4:5 Post counselling reflections on the therapeutic process and changed perceptions.

Post counselling reflections included both positive and negative comments. This was a reflection of the participants' overall counselling journey. In this reflection, the participants also commented on factors that impacted on both their present and future engagement with counselling. Their recommendations might be useful for practice, policy makers, and providers of counselling services.

As part of their post counselling reflections, all six participants in this study reported issues that were of concern to them. These included the waiting times before they received counselling, the length of therapy sessions or contracts, and their pathways to counselling. The length of time the participants waited before receiving counselling varied between participants. Some reported not having to wait for long before commencing counselling, while others complained about having to wait too long.

Generally speaking, the waiting times for therapy, the length of therapy, and other services within the NHS remains an uphill struggle because of high demand and limited resources. Nevertheless,

these factors may also affect, not only those from the BAME community, but also the general population, irrespective of their ethnic background.

The counselling pathway was described by participants as the route that led them to counselling; this included the referral process and the people that they first came into contact with. Most participants reported having felt let down by the gatekeepers, specifically their GP, because of lack of clarity and lack of enough information about what counselling entails and what to expect over the course of their treatment. These were the key complaints that participants reported as contributing to negative counselling experiences.

In hindsight, the issue of lack of clarity and information can be resolved, whereby the clients can be given enough information about their care and what to expect in their treatment prior to attending. This is in line with user involvement as part of the good practice guide recommended by The National Institute for Health and Care Excellence.

The study also revealed two unexpected findings that could not be accounted for:

First, changed perception. All six participants in this study were reluctant to engage in counselling initially because of their cultural beliefs and negative preconceptions. Surprisingly, after the participants engaged in counselling, they reported having changed their negative preconceptions or perceptions in a positive way. On reflection, this may suggest that clients' perceptions or preconceived notions are not rigid, but can change anytime over the course of therapy. One possible explanation for some participants changing their perception compared to others is based on the way they are able to negotiate the process of change; in this case, the process of acculturation or adaptation to the new culture.

As previously described in the literature review chapter, Phinney's (1996) ethnic identity development theory claims that when an individual grows older and develops a higher level of ethnic identity, their self-esteem, purpose of life, and self-confidence will increase. These, in turn, help an individual to accept themselves as well as people from other ethnic backgrounds than the individual who does not.

However, contrary to Phinney's theory, it seems that a higher level of identity development varies from one individual to another. For instance, in the current study, the older participants would have expected to have developed a higher level of ethnic identity and therefore be more accepting and

accommodating and willing to engage in counselling than younger participants. Surprisingly, Beatrice and Daisy seem able to accept their therapist more; to accept the White culture, and feel more positive about engaging in counselling than older participants. To some extent this highlights that ethnic identity development may not be a linear progress, and also that other factors such as personal characteristics, individual life experiences, and how they internalise others may impact on an individual's ability to accept change.

Mantovani et al. (2016) explored the relationship between stigma and help-seeking behaviour from African communities. This study also explored whether attitudes towards mental illness differed among British-born participants in comparison to those of African or Caribbean origin. The study concluded that, for some participants, acculturation tended to change perceptions of mental illness and therapy attendance, whereby people who have been exposed to UK culture perceive therapy attendance in a more positive way in comparison to those who were not exposed to the culture.

Another unexpected finding that I had difficulty in interpreting was that all six participants who reported that counselling was not their preferred way of coping with psychological distress still engaged in counselling despite having different ways of coping.

Previous literature suggests that people who seek help seem to have attempted to resolve their problems using different methods and have probably failed (Manthei, 2006). On the other hand, Olivera, Braun, Gómez Penedo and Roussos (2013) describe four steps that individuals go through before they seek psychotherapy: accepting that there is a problem; believing that therapy might help; deciding to seek therapy; and contacting the appropriate service.

In contrast to the above findings, the current study seems to suggest that participants attended counselling for different reasons; for instance, one participant, Lyn, attended counselling in order to fulfil the requirement of her work place following an episode of unauthorised absence from work. Other reasons reported by participants include counselling being initially recommended by friends and family.

Looking at these findings, it becomes apparent that there is a question that needs to be asked: 'What is the motive behind participants' counselling attendance?'. In hindsight, it could have been useful to include a question to explore the reason why the participants made the decision to undertake counselling. I believe having an indication of which clients are more likely to disengage

in counselling will allow the practitioner to make some provisional arrangement in terms of service management; for instance, providing shorter and more specific interventions that will better suit clients' needs, rather than offering a long-term therapy whereby the clients will disengage and not receive the full benefit of interventions offered. As this question was not explored within this study, it may be something to consider in future research.

Finally, the fact that participants agreed to participate in this study in spite of their preconceptions, offers an important indication to the gatekeepers of counselling to continue offering opportunities for BAW to engage in counselling by making more referrals to allow them to make an informed decision, rather than not offering services by making assumptions that they will not engage.

4:6 The study's limitations

Although this study makes several important contributions to the understanding about factors that impact BAW's engagement with counselling, as in any research, data from this study should be considered within the context of these limitations and weaknesses, and how these may have affected my findings.

First, following the tradition of qualitative enquiries that require a smaller sample, a six-participant sample size for this study was relatively small. Therefore, although the data was rich and descriptive, six participants may not offer enough explanation of the factors that impact on BAW's engagement with counselling.

Demographic characteristics of the sample may appear problematic in several ways:

The women who participated in the study came from different countries within Africa, so there is a possibility that every woman's experience of counselling was different based on the culture they came from, their life experiences, their expectations, and much more.

Although limited diversity in this sample is an advantage for homogenous purpose, it may be considered as a limitation due to the fact that the sample was overly represented by women with reasonably higher levels of education. Five of the six participants who participated in this study came from a nursing background and also worked within the NHS, with the exception of one participant, Daisy, who worked as a supermarket supervisor. In terms of familiarity with counselling, it may be that the six participants who worked within the NHS were more familiar

with how therapy works than Daisy, who did not have an idea about what therapy entails, although this was not explored and may not be the case. If it is the case, however, Daisy's knowledge of counselling before engagement may be unique in comparison to others. Thus, the sample used cannot offer a representation of the experiences of all Black African women but may represent the unique experiences of these six Black middle-class women. On reflection, this sample has been used partly because of the difficulties in recruiting, as described previously in the methodology chapter.

Due to the varying age gap between participants, the sample may not be considered homogenous enough. For instance, there is a 20-year gap between younger participants, Beatrice, Daisy, and Georgia, and the older participants, Tina, Lyn, and Edna. The age gap may or may not have been a contributory factor to the way the participants experienced and perceived counselling. For instance, Beatrice described the relationship between herself and her therapist like a pupil and teacher relationship, in which she felt controlled by the older therapist. On the other hand, Daisy, who had a younger therapist, reported to have felt connected and understood, hence describing a positive counselling experience.

As mentioned earlier in the methodology chapter, the study was piloted by two women (colleagues) of Jamaican heritage, in the assumption that perhaps they would offer something different or an insight to the research. On reflection, even though the pilot study were also Black women, their experience of engaging in counselling may be different due to their peculiar ethnic and racial identity in comparison to African women. Even though the sample was not used in the study, to some extent there were some limitations for using this sample because it was not homogenous enough to give a true presentation of BAW's experience of counselling.

Due to the data from the pilot study no longer being available, it can be considered as a limitation. Assuming that the pilot data was made available, it could have offered some useful insight into the Black women's experience of counselling across the board.

For implications for the practice of counselling psychology, even though this study offers a valuable contribution, it may not be appropriate to generalise the study's findings beyond this particular group of BAW's experiences of counselling in the UK. Further research with different populations or samples needs to be conducted to support and expand on these findings, offering an explanation as to what extent BAW's experience of engaging in counselling has been impacted

by different factors, as discussed by different theories covered in the literature review. To a greater extent, this will allow practitioners to formulate interventions that are more suitable to cater to the needs of BAW.

4:7 Implication for research, practice and study's original contribution

In spite of the study's limitations above, this study has met its objective by attempting to answer its key research questions, and might contribute to our wider understanding about different factors that may be responsible for low engagement rates and premature therapy termination for BAW in the UK.

Due to the possibility that this study may be one of the few to explore BAW's experiences of engaging with counselling – an area that does not appear to have been much explored by research in the UK – it may offer an original contribution to the existing body of literature and research, and also the practice of counselling psychology.

As part of their post counselling reflection, the participants also offered some useful recommendations to be considered. The recommendations offered by participants might be valuable to policy makers, providers of counselling services, and the practice and teaching of counselling and counselling psychology. Some of the recommendations include: the waiting times before they received counselling, their pathways to counselling, language used, the need for practitioners to be culturally aware, the need for therapeutic environment; and the possibility of given choices regarding their treatment.

With regard to the waiting times, most participants reported to have waited longer before they were offered counselling. Although the waiting times for therapy and other services within the NHS remains a challenge due to limited resources, this study highlights the importance of counselling services providers to formulate ways of ensuring that the counselling services are provided in a timely manner in order to meet not only the needs of BAW but also the general population.

In this study, the participants reported their dissatisfaction with the pathway that led them into Counselling. This included the referral process and the professionals that they initially came into contact with. Most participants reported having felt let down by the gatekeepers, specifically their GP, because of lack of enough information about the process of receiving counselling. For the practitioners, this feedback can provide useful insight for them to reflect and change their practice;

for instance, the problem of lack of clarity of information by giving the clients sufficient information about what to expect in their treatment prior to attending any service. This practice complies with the recommendation to involve clients in their care as part of the good practice guide recommended by The National Institute for Health and Care Excellence.

Due to participants not being satisfied with their therapists' ways of working, they recommended the need for the practitioners to have culture awareness training to be able to provide more culturally based interventions that will build a trusting relationship between individuals from BAME communities and mental health services. In hindsight, this will encourage them to engage with services.

The environment where counselling happened was one of the participants' key concerns. As a result, they recommended the counselling services to be delivered in an environment that does not encourage stigmatisation. This is one of the recommendations for the counselling service providers to consider.

In summary, the study offers an insight to policy makers to try and ensure that services are more flexible and tailored to meet the individual needs of women from African groups. It offers directions on what provisions need to be put in place to increase access, and to ensure that all the necessary mental health services are easily accessible for Black African women.

4:8 Researcher's reflections

In this study, I believe that I held dual positions, as a Black female researcher of African heritage and also as a trainee counselling psychologist. I acknowledge that the two positions that I held might have impacted the findings of this study in several ways: being a Black African woman and also being in therapy, I had my own preconceptions about counselling. I believe this unconsciously impacted the type of questions that I asked participants and, hence, the data I obtained.

On many occasions during the interviews, I unconsciously protected participants by avoiding asking some questions that could have given me richer data, fearing that the participants may feel undermined or judged. At the same time, I felt that some participants did not give a true reflection of their experiences for the fear that I may judge them negatively or share the information they gave me with other people within the African community.

As a trainee counselling psychologist, I believe that my interpretation of the data was more informed by my experience of psychodynamic and CBT theories where the use of self is paramount. Therefore, I feel that I might have unconsciously overanalysed some text; as a result, this may have impacted the amount and quality of data obtained. It may be that the data was impacted by my own unconscious feelings and experiences rather than the participants' overall experiences.

I acknowledge that it was difficult for me to be a trainee psychologist and a researcher at the same time. There were many times when I felt more empathic, wanting to further explore participants' difficulties and offer support, but I was limited due to my role as a novice researcher. Looking back, if I was to do this study in the future, I would exclude any question that may give the participants an opportunity to talk about their distress; for instance, the question *'Could you tell me what brought you in to counselling … how did this problem impact your life?'.* Although this allowed participants to talk about their distress, it was something that was not the main focus of this study.

In terms of participant recruitment, I will revisit the recruitment criteria to ensure that the sample used is homogeneous enough for instance, I will be more specific about the participants age, the length of time they had lived in the UK, their social-economic status and previous experience of engaging in counselling. If the pilot sample will be used it has to be the one that fit in with the recruitment criteria for the actual sample.

4:9 Conclusion and final remarks

To conclude, this study has aimed to encapsulate the factors that impact upon this group of BAW's engagement with counselling. Upon reflection, this could not have been possible without exploring individual women's experiences of counselling. Through this exploration, the different aspects of the participants' experiences that may have impacted their engagement were identified, described, and interpreted within the study's three master themes. Through these themes, the participants described their overall journey into counselling. Their journeys started prior to commencing counselling, where they shared their preconceived notions about what they thought about counselling and also their therapist, which may have been influenced by their cultural beliefs. The participants also discussed the different methods they employed as a way of coping with distress without the use of counselling or therapy.

Through further exploration, the participants described their experience of moment-to-moment interaction with the therapist and how this may impact upon their future engagement with counselling. These include different factors such as the therapist's way of working, the therapist's characteristics, and the quality of therapeutic relationship established.

Post counselling experience was also reflected upon, whereby the participants were able to reflect on their counselling journey. Those who reported a positive experience expressed a sense of improvement that things were not as bad as they once were. The two participants who reported a negative experience expressed a sense of uncertainty about attending therapy in future. To some extent, all six participants expressed a change of perception about various aspects of therapy that happened to be a good reflection of their experience, in spite of two of them being dissatisfied with counselling.

This study also gave the opportunity for clients to make useful recommendations about what aspects needed changing to make therapy more useful for women of African origin. This feedback offers implications for future research to consider, and also an insight into some of the implications to practice.

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APPENDICES 6.0

APPENDIX 1: A COPY OF ETHICAL APPROVAL AND CHECKLIST

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Mike Chase **ASSESSOR:** Max O'Neill

STUDENT: Lillian Shundi **DATE (sent to Assessor):** 28/06/2013

Proposed research topic: **Phenomenological Analysis of Black African and African Caribbean Women's Experiences of Counselling**

Course: Professional Doctorate in Counselling Psychology

1. Will free and informed consent of participants be obtained?	YES
2. If there is any deception is it justified?	N/A
3. Will information obtained remain confidential?	YES
4. Will participants be made aware of their right to withdraw at any time?	YES
5. Will participants be adequately debriefed?	YES
6. If this study involves observation does it respect participants' privacy?	N/A
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically?	N/A
8. Is procedure that might cause distress to participants ethical?	YES
9. If there are inducements to take part in the project is this ethical?	N/A
10. If there are any other ethical issues involved, are they a problem?	N/A

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON-APPROVAL:

Assessor initials: MO'N Date: 01/07/2013

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Mike Chase **ASSESSOR:** Max O'Neill

STUDENT: Lillian Shundi **DATE (sent to Assessor):** 28/06/2013

Proposed research topic: **Phenomenological Analysis of Black African and African Caribbean Women's Experiences of Counselling**

Course: Professional Doctorate in Counselling Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

1 Emotional YES

2. Physical NO

3. Other

(e.g. health & safety issues) NO

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: LOW

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON-APPROVAL:

Assessor initials: MO'N Date: 01/07/2013

For the attention of the assessor: Please return the completed checklists by email to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
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School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
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e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

APPENDIX 2(a): CHANGE OF TITLE FORM

From: ResearchUEL
Sent: 24 June 2019 09:17
To: Lillian SHUNDI
Subject: Change project title - Miss Lillian Shundi

ResearchUEL

Change project title - Miss Lillian Shundi

The Psychology Research Degrees Sub-Committee on behalf of the Impact and Innovation Committee has considered your request. The decision is:

Approved

Your new thesis title is confirmed as follows:

Old thesis title: Phenomenological Analysis of Black African women Experience of counselling in the UK

New thesis title: A phenomenological Analysis of Black African Women's Experiences of Engagement in Counselling in the UK

Your registration period remains unchanged.

Change project title - Miss Lillian Shundi

APPENDIX 2(b): CHANGE OF TITLE ACCEPTANCE FORM

From: ResearchUEL <phdmanager@uel.ac.uk>

Sent: 12 January 2018 04:27:53

To: Lillian SHUNDI

Subject: Change project title - Miss Lillian Shundi

ResearchUEL

Change project title - Miss Lillian Shundi

The Psychology Research Degrees Sub-Committee on behalf of the University Quality and Standards Committee has considered your request. The decision is:

Approved

Your new thesis title is confirmed as follows:

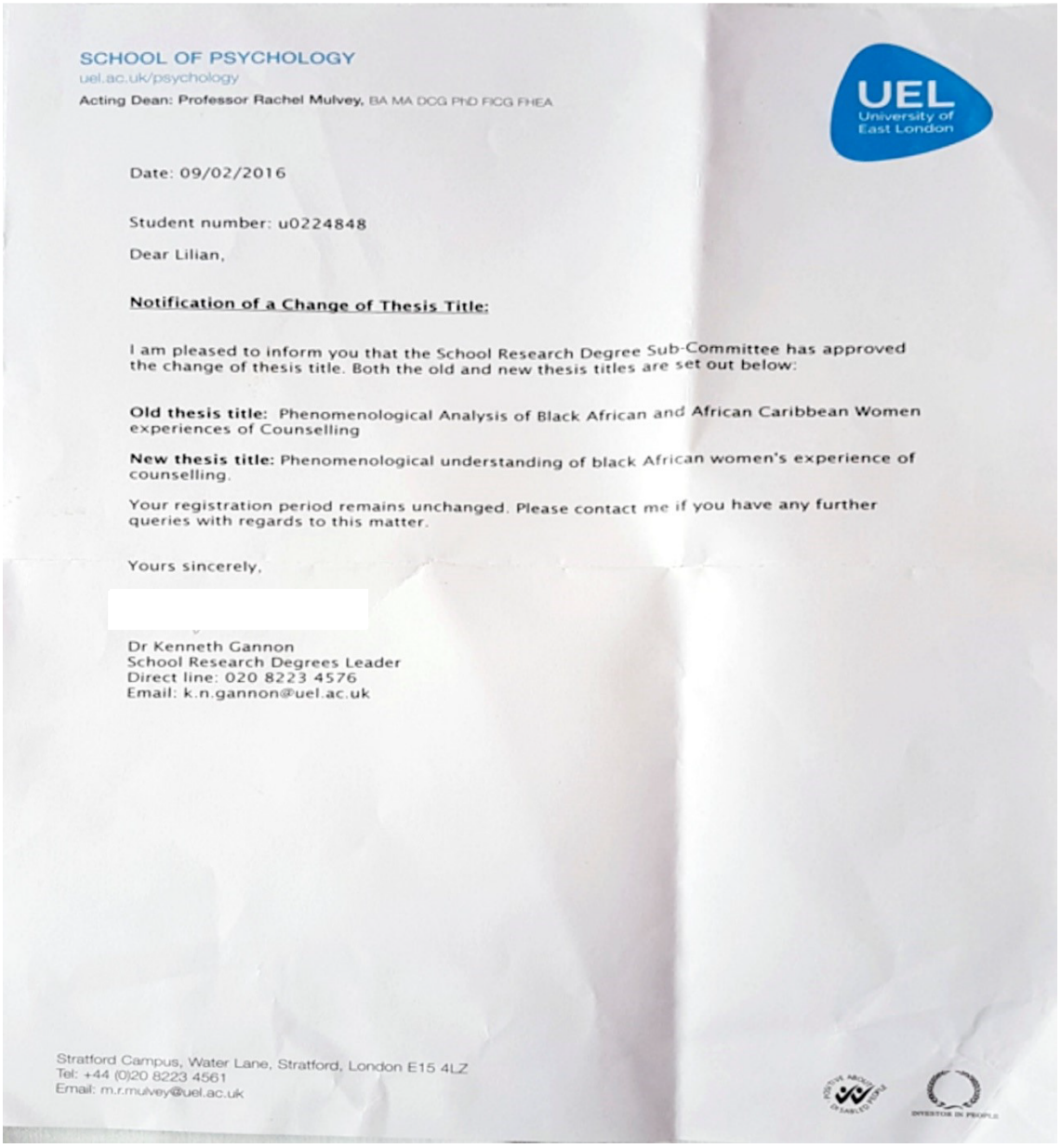
Old thesis title: Phenomenological Understanding of Black African Women's Experiences of Counselling

New thesis title: Phenomenological Analysis of Black African Women's Experience of Counselling in the UK

Your registration period remains unchanged.

Change project title - Miss Lillian Shundi

APPENDIX 2(c): CHANGE OF TITLE LETTER



SCHOOL OF PSYCHOLOGY
uel.ac.uk/psychology
Acting Dean: Professor Rachel Mulvey, BA MA DCG PhD FICG FHEA

UEL University of East London

Date: 09/02/2016

Student number: u0224848

Dear Lilian,

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: Phenomenological Analysis of Black African and African Caribbean Women experiences of Counselling

New thesis title: Phenomenological understanding of black African women's experience of counselling.

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

Dr Kenneth Gannon
School Research Degrees Leader
Direct line: 020 8223 4576
Email: k.n.gannon@uel.ac.uk

Stratford Campus, Water Lane, Stratford, London E15 4LZ
Tel: +44 (0)20 8223 4561
Email: m.r.mulvey@uel.ac.uk

APPENDIX 3: PARTICIPANTS' INVITATION LETTER

UNIVERSITY OF EAST LONDON
School of Psychology
Stratford Campus
Water Lane
London E15 4LZ
The Principal Investigator(s)
[Lillian Shundi]
[l.shundi@uel.ac.uk :) and

Information About My Project

The aim of this letter is to give you some information to help you decide whether to participate in my study. This research study is being carried out as part of my Professional Doctorate in Counselling Psychology degree at the University of East London

Project Title

Phenomenological Analysis of Black African Women's Experiences of Counselling in the UK

Project Description

My research aims at exploring your experience of engaging in counselling as an intervention to help you maintain your psychological well-being. I am also interested to find whether as a result of your experiences of counselling you will consider engaging in counselling in the future and if not what will be the reason for this. Finally, I would like to hear from you if there is a better way that you felt you would love to have been treated while you are receiving counselling to make counselling a more positive experience.

This research will include the use of an interview that will include approximately 12 open-ended questions with prompts where necessary to help you describe your experiences of counselling. The interviews will be scheduled to last for approximately 30 to 70 minutes depending what you want to share. In the event where the interview causes distress because of nature of the questions asked, please feel free to let me know so that we can take a break or stop the interview at any time. I will also have to hand contact details of possible support if you need them. The interviews will be recorded and transcribed shortly after.

Confidentiality of the Data

After the interviews the data (transcripts) and your personal details will be kept safe on a personal password protected device to ensure confidentiality of information and this means that where sensitive material is communicated, care should be taken to avoid the information being used by third parties. On completion of the study the audio recordings will be erased and a copy of transcript will be anonymised and stored for further analysis if needed.

Location

The study is to take place at a location that is mutually convenient to yourself. This could be: a quiet room in the library, an office or your own home.

Remuneration

No remuneration is offered, although reasonable transport cost may be covered if deemed necessary.

Disclaimer

You are not obliged to participate in this study and should not feel persuaded. You have the right to withdraw from the study anytime should you wish to do so without giving any explanation. [Include if relevant to you: in the event when you decide to withdraw your participation, the researcher reserves the right to use your anonymised data to carry on with the write-up of the study and any further analysis that may be required.]

Please feel free to clarify any issues of concern. If you are happy to proceed you will be kindly required to sign a consent form to confirm your participation. Please retain this invitation letter for future reference.

If you have any queries please contact the study's supervisor: Professor Rachel Tribe, The School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: r.tribei@uel.ac.uk or Chair of the School of Psychology Research Ethics Sub-Committee: Dr Lisa Fellin, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4493. Email: l.fellin@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Lillian Shundi

Date

APPENDIX 4: CONSENT TO ENGAGE IN A RESEARCH STUDY

UNIVERSITY OF EAST LONDON

Phenomenological Analysis of Black African Women's Experiences of engaging in Counselling in the UK.

I have the read the information provided in the information sheet about to the above research study and have been provided with a copy to keep. The nature and purposes of the study have been fully explained to me, and I have had the opportunity to ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

It is my understanding that my involvement in this study, and particularly data obtained from this research, will remain confidential and will only be accessible to only the researcher(s) involved in this study. The researcher has explained fully the next steps once the research study has been completed.

I hereby consent to participate in the study, which the researcher has fully explained about its aim and its nature. Having given this consent I understand that I have the right to withdraw my participation from the study at any time without giving any explanation. [Include if relevant:

I also understand that should I withdraw; the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be required].

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

LILLIAN SHUNDI……..

Researcher's Signature

Lillian

……

Date: ……..…….

APPENDIX 5: INTERVIEW SCHEDULE

1. Could you tell me what brought you to counselling?

2. How did this problem affect your everyday life?

Prompt: work, interests, relationships.

3. On a day-to-day basis, how do you deal with life problems?

Prompt: Did you have particular strategies for helping you overcoming your problems?

4. Could you tell me how the referral process was carried out?

Prompt: How did you feel about it?

5. In your own words could you describe what happened in therapy?

6. If you had to describe how useful therapy is to you what would you say?

Prompt: What words come to mind, what images? Do you have another name for it?

7. How did you feel about the counselling as a therapy?

Prompt: What do you think about counselling?

8. Do you see yourself differently now than before you had therapy?

9. Have you changed your views about counselling?

Prompt: In what ways?

10. Based on your experience how do you feel about having therapy in the future?

11. Based on your experience is there any other way you would have loved to be treated to make therapy more useful to you?

Prompt: Would you recommend counselling to others?

APPENDIX 6: EXAMPLE OF INITIAL DATA ANALYSIS USING WORD

P: Yeah… because it… it works for me like I said initially I didn't want to go to because…. Primarily because it's not my culture... we don't believe in therapy

I: Mmm

P: We don't believe in therapies as a Black woman…. What will I be going to therapy for... but strangely enough … it worked for me and if it works for me that I had this sort of … eh perception in the past that I will never … and the I was able to go and the… for… and I was able to go … and emm… benefited... from that eer experience then why not… I've actually said... eer just a while ago I have introduced people... even I have counselled people myself and supported them to go into… Eeemm… therapy

I: Mmmm

P: You know so…

I: So based on that experience that you are talking about so if you have any problem in the future do you think you will attend therapy? Based on your experience…

P: I would… I would….God forbid I have any problem in the future…

I: Mmm ... Will you attend therapy?

P: I will… [distraction noise from outside the interview room]

I: Sorry about that…

P: It's okay…

I: So yeah… what I was trying to explore ... you have spoken about a lot of things you know… a lot of good things about therapy based on your experience if you have any problem in the future do you think you will... Actually attend therapy in the future?

P: God forbid I have any in the future but if it happens yeah I will be attending

I: ok so… from everything that have said emm... was quite useful but I was gonna ask you now... my next question… will be what did you think about your therapist herself?

P: Mmm

I: Because you mentioned before this is a White woman giving you therapy what did you think about that? …

P: Initially…

I: Tell me a little bit about that…

P: Initially when I went … like I said it was a White woman when I went … she started... my thought's at that moment…was can you keep short... you are a White woman I'm a Black woman you dint even know me… how can you… how can you… now speak to me… this is my culture...
I: Mmmm
P: And then she even … during… During therapy now she went I to… I just …what I found out later... was that it wasn't a colour thing… It was not a colour thing
I: Mmmm
P: It was not a colour thing
I: I could see that they have been training their expert at what they do they … they… they... counsel you based even upon where you are coming from
I: Mmm
P: Your cultural your traditional she went… she touched my culture… my traditional and so on and everything I was amazed
I: Mmm
P: Because of my…my… my… initial thoughts was she can't know me what does she wants to talk to be about She can't know me you know she is from a different background she is from a different cultural how can you counsel a Black woman when you are White woman ... Born here I was not even here you know…. But then they… they quite good in what they do … quite good my perception immediately after the second session in fact it was in the first session I went back home and did a reflection you know the whole process and then yeah….
I: So… the therapist was good...
You… Yeah
I: That's what you are …
P: Yeah… she was good…
I: So... emmm… in everything that has happened and you know so if I… ask you know ... I think I've asked if you gonna recommend counselling to other people
P: mh …mh…
I: And you mentioned that you find it useful so you'd like to recommend … But is any other way at all you think you think the whole process you know the whole counselling could have been done differently from the process whereby you had the referral… then you had the therapy itself and

you completed therapy, do you have any comments at all, you know what could have been differently to make therapy more useful for a Black woman?

P: eemm I'm just… I'm saying this [pause] I had already spoken … The therapist herself was well trained good but what could have been better done would have been … For the Black eeh... eeh… For the Blacks … Africans to Counsel Black Africans…

I: mmmm

P: why I'm saying that it's because they know the… They know the... the they know the cultural they know your tradition they can deal… that's what … that's what I'm thinking I think they can understand and deal better with the counselling I'm not saying that the one I went to… she was quite good

I: mmmm

P: she has been trained to do that but Black to Black is automatic… They understand where we are coming from...

I: mmm

P: even without training to say ooh when you see the Nigerians this how you present … When you see the Ugandans this is how you present they have been trained I mean without training they know the culture and they know the tradition

I: mmmm

P: but that is not to say that … the ... the Whites do not understand perse but they were trained to understand my culture

I: mmmm

P: they were trained to understand my culture ... so that what I think could be… could be eemm … be improved on but then is… is … a choice I'm saying get more Black into counselling but what about if a Black does not want to be in the business

I: mmmmm

P: is a choice but I still find it very useful and I find the therapy very good or the job she is doing but I would encourage I will still say that we should have more… you know this country I tell you the lots and lots… They say the ethnic minority I dint know because the Black community is large

I: mmm...mmm

P: The Black community is large let me tell you as a nurse

I: yes…

P: who works within the mental health setting... I find that most of Blacks young… young men are in castrated and they are in castrated because of their culture lets… ok I'm Nigerian say in Nigeria you find a boys taunting on the streets doing this and that … feeling big and ding all these nonsense and they come I to this country this cultural does not permit you to act irresponsibly … As soon as they do that what happens they band them into mental illness for this and that and that is not following the cultural they act like that in Nigeria I'm not excusing the ones that have committed grievous err offences and all that I'm talking about ... you see all these smocking on the streets of … eeer… everywhere it's not a big thing… You don't in castrated people for that and that is because they do not understand the culture you find that a lot of Black young men are in castrated through foolishness which is accepted from where they are coming from …

I: Mmmm

P: That foolishness is a day-to-day thing with us but coming to this country and why is this happening because the White do not understand where the Black are coming from

I: Mmm

P: So that's that's that's that's basically it… And then if… you find that if you have a Black consultant they do better with the Black you know eeh patient because they know and understand the culture and tradition than a White consultant looking at a young Black man making eeh ga ga ga…

I: Mmm

P: Before they… they speaking over them you say ahh ahh that's not right … that is not right is mentally unwell but sometimes it's not the case...

I: Mmm

P: So you think it's the lack of understanding of the culture?

I: It's the lack of understanding of the culture…

P: So you prefer …you know… to have a Black therapist who you understand your culture?

P: yeah… Who understand the culture more than anybody…and the you… you are … if you find somebody of your kind you gel quickly and you are able to express yourself quickly because you know that they understand where you are coming from

I: Mmmm

APPENDIX 7: EXAMPLE OF DATA ANALYSIS USING EXCEL

Participant	Pg. no.	Code 1 without definition	Notes	Code 2 with definition THEMES
TINA	3	Family support as a way of coping with distress	Family available to offer support	1. WAYS OF COPING WITH DISTRESS
TINA	4	Avoidance as a way of dealing with distress		
TINA	4	Ruminating about problems as a way of coping with distress		2. AVOIDANCE TALKING ABOUT FEELINGS
TINA	4	Use of substance as a way of coping with distress	Was using a glass of wine to aid sleep	
TINA	4	Was referred by GP	Referred by GP	3. REFERRAL ROUTE
TINA	5	Waiting times before receiving therapy	Perceived referral process as straightforward. Took a week to receive counselling	4. WAITING TIMES

APPENDIX 8: DATA ANALYSIS USING INDEX CARDS