Black Men, mental health and oppression
what do we learn when we listen to Black Men's voices?

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Black Men, Mental Health and Oppression: What Do We Learn When We Listen to Black Men's Voices?

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Abstract

The study sets out to gain an in-depth understanding of Black men's experiences of psychosis and oppression. Using Interpretative Phenomenological Analysis (IPA), a qualitative research approach, the study uncovers how nine Black men experience, psychosis, mental health care and mental health services and how they make sense of these experiences.

In the UK, Black men are consistently over-represented in mental health services and are disproportionately diagnosed with a psychotic illness. Black men tend to enter mental health services through the police and criminal justice system, leading to negative and distressing entry into services. Despite Black men's visibility within mental health services, seldom are the voices of Black men heard. This research gives visibility to Black men and centres their voices. Using IPA in conjunction with Iris Young's (1990) framework of oppression: Cultural imperialism, Powerlessness, Exploitation, Violence and Marginalisation; the study captures how Black men make sense of their mental health experiences. Three discrete but interconnected themes emerge from the analysis and interpretation of the men's stories: Becoming Psychotic, Domination and Dehumanisation and Starting Over shed light on the men's oppressive experiences at key stages of their mental health journey.

This study makes three main contribution to knowledge. Firstly, it offers a critical and insider perspective of Black men's oppressive experiences, which goes beyond Young's framework (1990). Secondly, it puts forward a new model for understanding the mental health experiences of Black men that shows how racism, powerlessness, violence and marginalisation intersect and are central to Black men's mental health experiences, recovery and sense of self. The study demonstrates how concepts such as microaggression, intersectionality, internalised oppression and resistance are key features of the oppressive experiences Black men encounter. Thirdly, it puts forward recommendations for an anti-oppressive approach to mental health services that challenges and offers strategies to current mental health practices. Reiterating calls for a holistic, person centred approach to mental health so the structural and material reality of Back men's lives are central and integral in their care.

Introduction

The aim of the thesis

The study set out to gain an in-depth understanding of Black men's experiences of mental health, mental-ill and oppression. Using Interpretative Phenomenological Analysis (IPA), a qualitative research approach, the study uncovers how a group of Black men experience mental health, mental health care and mental health services and how they make sense of their experiences (Smith, Flowers and Larkin 2009:1).

My central research question is:

What are Black men's experiences of mental ill-health and oppression?

Definition of Terms: Mental Health and Mental Ill-health

The concepts of mental health and mental ill-health are widely used throughout the thesis. These concepts influence and are influenced by physiological, cultural, political, economic, sociological, and environmental factors (Hercelinskyj 2020, World Health Organisation 2018). Although their usage is commonplace in our everyday language, these terms can be stigmatising and confusing particularly because there are no universally accepted definitions and variations in terminology are used (Hercelinskyj 2020). The use of mental health in this thesis represents a continuum where people fluctuate between feeling a positive sense of self, satisfying social relationships and the ability to cope with the stresses of life to experience symptoms associated with mental ill-health. (See Figure 1. for a visual representation of Mental Health).

Figure 1. Visual representation of Mental Health

Mental ill-health signifies when a person experiences persistent thoughts, emotions, and behaviour that causes them distress, impacting their ability to relate to others and cope with daily activities (Hercelinskyj 2020, World Health Organisation 2018). Mental ill-health can be short lived or become an ongoing feature in a person's life. In some cases, posing a risk to their personal safety and the safety of others (mental illness, mental disorder, mental health problems are also commonly used). The thesis also refers to specific diagnoses of mental ill-health such as depression, anxiety, psychosis, schizophrenia, and bi-polar disorder.

Black men and Blackness

'Black' and 'Black men' are terms commonly used in the public discourse to signify individuals and groups who are of African and Caribbean descendant; these terms are also used throughout this thesis. Focusing attention on racial identity is necessary for the men in this study as their 'Black' identity is integral to the context in which they live their lives and thus how they experience mental health and mental ill-health. In this thesis Black refers to males and females who are of African and Caribbean descent and Black men refers to adult males who are of African and Caribbean descent.

Whilst Blackness is an obvious visual marker of difference, perceptions of difference goes beyond a descriptor of skin colour. Blackness is a social construct; it donates ideas about racial difference between individuals and groups. Whilst these ideas are not fixed, certain notions dominate and are reproduced over time. This can be seen in how during the era of Enlightenment European scholars used pseudoscience to explain that racial differences were biological, using their power and position they created a racial hierarchy based on inferiority and superiority (Brown 2015, Kendi 2016, Vartija 2020). Africans became categorised as inferior, non-human (Fanon 2008), and hypersexual (Kendi 2016). This notion of inferiority and superiority endorsed within religious ideas and the bible was used to uphold and reproduce the idea of a racial hierarchy. In the Bible, The Curse of Ham, associated with the story of Noah's son Ham and his descendants (Egyptians and Ethiopians) was put forward as an explanation to support slavery (Bashir 2019).

Blackness became viewed as a signifier for evil and sin and Whiteness for purity, goodness, and superiority (Kendi 2016, Yancy and Davidson 2016). Influential Christians encouraged praying for Black people so they could become 'White in their souls' (Kendi 2016: 76). These beliefs cemented Black people's inferiority was both nature's and God's will, producing and reproducing racist ideas to justify the transatlantic slave trade for power and economic gain (Kendi 2016, Olusogo 2016). Although slavery was abolished in the early 19th century, there is a body of work that shows that Blackness continues to be constructed as problematic and a threat and White supremist beliefs persist (Brown 2015, Collins 2009, Curry 2017, Du-Bois 1903, Fanon 2008, Feagin 2006, Gilroy 1987, hooks 2013a, Joint Committee of Human Rights 2020, Kendi 2016, Yancy and Davidson 2016).

'Black' is used as an all-encompassing term, however it is contentious and has many tensions and contradictions. Firstly, there is no single Black identity (Beyers 2019, hooks 2013a). Indeed, the heterogeneity to be found within and between Black communities reflects factors such as history, geography, immigration status, education, employment, religion, gender, sexuality, and political ideas that shape their values and perspectives (hooks 2013a). The notion associated with how we understand Blackness is further complicated as Blackness is not fixed, it is dynamic, shaped by the changing nature of our social and political life which influences how Black people are viewed in society and how they see themselves (Beyers 2019, Du-Bois 1903, Fanon 2008, hooks 2013a).

An example of the changing nature of Black identity is the notion of 'political Blackness', in the 1960's -1980's African, Caribbean, Indian, Pakistani and Bangladeshi communities living in the UK identified a shared struggle to tackle racism. Together they mobilised to resist the systemic racism they were experiencing in education, employment, housing and policing (Field et al. 2019, Gilroy 1987, Sivanandan 1981). Political Blackness as an identity has since declined, concern about homogenisation of ethnic minority communities culminated in a shift in discourse to one that centres on explicating specific issues for different ethnic groups, rather than what was deemed as offering a unifying narrative (Samanani 2019). However, a reoccurring trend is the plethora of reports that reveal in comparison to the White majority, Black people living in the UK experience persistent inequalities, in areas such as education, employment, housing, health and the

criminal justice system (Equality Challenge Unit 2013, Equality and Human Rights Commission (EHRC) 2017, Joint Committee of Human Rights 2020, Khan 2020, Lammy 2017, Ministry of Justice 2018, Mirza 2018, National Health Service (NHS) Digital 2019, Race Disparity Audit 2017). An area that has received much attention is the overrepresentation of Black people in the criminal justice and mental health systems (Independent Mental Health Task Force 2016, Lammy 2017, Mclean Campbell and Cornish 2003, Wessely 2018). Other examples include the Windrush Scandal 2017, in which Black people were illegally imprisoned and deported by the Home Office (Williams 2020). The disproportionate deaths of Black people in police custody (Adebowale 2013, Angiolini 2017), and maternal deaths (Knight et al. 2018). Moreover, at the time of writing this thesis, the disproportionate number deaths of Black people due to COVID-19 (Public Health England 2020) paint a stark picture of the realities of how racial difference has a detrimental impact on Black people living in the UK.

Samanani (2019:2) suggests that our relationship with institutions plays a critical role in generating feelings of belonging; these realities disrupt the sense of belonging and home that as people we all seek. Instead of living in the fair and tolerant society, the UK espouses to be, Black people experience the UK as a place of imagination (Hamaz and Vastas 2009), that generates alienation, fear, a lack of confidence and hostility (Joint Committee of Human Rights 2020, Sainsbury Centre for Mental Health 2002). As previously identified, this is nothing new. Black people have a history of living within racist systems whilst attempting to resist, transform or escape them (Colins 2009, Field et al. 2019, Gilroy 1987, Sivanandan 1981). This has meant demonstrating forms of resistance such as creating ‘Black’ spaces such as churches, hairdressers, barbers, radio stations, journals and social clubs. Spaces that foster acceptance, safety, and trust, all providing a sense of home and belonging.

Having a sense of pride of African and Caribbean history and achievements offers a counternarrative to being constructed as inferior, problematic or a threat (Field et al. 2019, Gilroy 1987). Expressions of Black Pride, Black Power and Black Unity is championed and displayed through language, referring to each other as ‘kings’ and ‘queens’, ‘brothers’ and ‘sisters’, expressing African and Caribbean heritage and identity through fashion, hairstyles, music, poetry, and film.

More recently, the creation of a Black Pound day, a strategy to promote and support Black business rather than businesses that commoditise Blackness whilst having no interest or engagement with Black people and the systemic racism they face (BBC 2020). These examples are testimony to the different ways Black people have and continue to use their power to reclaim Blackness, shaping and defining their own identities. Although they create their own sense of home and belonging this occurs whilst continually navigating spaces that impose Blackness and creates inequalities. DuBois (1903:5) articulated this tension following the abolition of slavery: 'For Black men to attain his place in the world, he must be himself, and not another'. These deeply personal, socio-political tensions and contradictions are shown throughout this thesis.

Background to the thesis

When Black men develop mental ill-health, they find themselves having to contend with two linked sets of stereotypes. Firstly, they have to contend with the negative stereotypes associated with being Black and male where they are viewed with suspicion and perceived as a threat (Angiolini 2017, Brooms and Perry 2016, Curry 2017, Kendi 2016, Yancy and Davidson 2016). Secondly, they have to contend with the stereotypes associated with individuals with mental ill-health: they are viewed as unpredictable and perceived as violent (Fernando 2010, Keating 2007, McKeown and Stowell-Smith 2001, Tegnerowic 2019, Varshney et al. 2016). In the mental health and criminal justice systems, their racialised masculinity and mental ill-health identity means they experience a double discrimination or double stigma (Angiolini 2017, Fernando 2010, Rogers and Pilgrim 2003), with precarious outcomes that seem to place Black men in a reoccurring story of negative experiences in mental health services.

A reoccurring story

Research shows that these outcomes and experiences are a theme in Black people's experiences of mental health services in the post-Windrush welfare state. This study recognises that there is still much research needed to better understand and respond to the mental health needs of Black communities living in the UK. Moreover, it accepts that work is needed that focuses on the specific needs of Black women. In so saying, for both personal and professional reasons, this thesis centres

the voice of Black men. It is the telling of their stories that we are able to capture an insider perspective and understanding of how they experience, mental health, mental ill-health and mental health services.

Reviews detail the negative experiences of Black men suffering mental ill-health who have come to the attention of mental health services paint a grim picture. One such is the story of Orville Blackwood, a Black male born in Jamaica, who migrated to the UK as a child with his mother. Orville was described as quiet and shy when he was young, in his early twenties he developed mental ill-health. He was in and out of mental health inpatient services and the criminal justice system and served some time in prison. In 1987, he was admitted to Broadmoor specialist hospital where he died, aged 31 years old after being placed in seclusion and given an intramuscular injection of anti-psychotic medication by staff (Prins 1993). The 'Blackwood Report' into his death was titled 'Big, Black and Dangerous', a summary of how he and (other Black men) were perceived by mental health practitioners in their care (Prins 1993). Another such story is that of David Bennett, another Black man, who died at the aged 38 years old, on the 31st October 1998, following prolonged physical restraint by nursing staff. The report into his death stated that the staff was frightened of him due to his 'violent and athletic stature' (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003:10).

Both reports show a racialised negative perception of Black men as physically strong and posing a violent threat, which may have heightened staff fears so that they used more forceful, prolonged physical intervention (Bradby 2010, Cummins 2013). Both reports were hailed as watershed moments in relationships between mental health services and Black communities, as they drew attention to the barriers Black men encounter within mental health services and poor and ineffectual mental health care (Bradby 2010, Crichton 1994, Cummins 2013, McKeown and Stowell-Smith 2001). However, despite the high profile of these reports and the recommendations made to improve care and service, Black men continue to experience poor levels of mental health care and negative relationships with mental health services.
The ongoing failure of mental health services to respond to Black men's needs remains a key feature of their experiences when compared to the White British population and other ethnic groups (Barnet et al. 2019, CQC 2015, NHS Digital

2019). Some of those trends are sketched below to suggest that the themes still reoccur.

In the UK, research shows that Black men are consistently over-represented in forensic mental health services and are disproportionately diagnosed with schizophrenia or a psychotic illness (Fearon et al. 2006, Kirkbride et al. 2008, Kirkbride et al. 2012, NHS Digital 2019, Qassem et al. 2014). Black men tend to enter mental health services through the police and criminal justice system, leading to negative and distressing entry into services underpinned by force and coercion (Bhui et al. 2003, Bookle and Webber 2011, Keating 2007, Morgan et al. 2017, Wessely 2018). Research shows that Black men have higher rates of involuntary admission to hospital compared to White men (Barnet et al. 2019, Bookle and Webber 2011, CQC 2018, Keating 2007, Morgan et al. 2005, Morgan et al. 2017, Wessely 2018). When admitted, they find themselves in more secure mental health settings, such as Psychiatric Intensive Care Units (PICU) and secure units, where the doors are locked and their movements restricted (Barnet et al. 2019, Bookle and Webber 2011, Wessely 2018). They experience what Keating (2007:1) refers to as the ‘harsher side of mental health services’. This normally equates to extended periods within these environments, reduced access to the community and their supporters and any meaningful activities (Sustare, Edit and Tarpey 2019). Within these environments, they also experience increased rates of restrictive practices and physical intervention, such as control and restraint and seclusion (Chakraborty et al. 2011, CQC 2018, Wessley 2018).

Black men’s negative outcomes when they come to the attention of mental health services is a reoccurring theme of their experiences of both inpatient services and the delivery of care in community settings (Beck et al. 2019, CQC 2015, CQC 2018, Khan et al. 2017, Mercer et al. 2018, Morgan et al. 2005, Morgan et al. 2017, NHS Digital 2019, Wessely 2018). Black men receive a disproportionate amount of community treatment orders and have one of the highest rates of hospital readmission following involuntary admission (CQC 2015, Khan et al. 2017, NHS Digital 2019, Wessely 2018). In addition, Black men are underrepresented in access to psychological interventions and are less likely to have positive outcomes from the

service (Beck et al. 2019, Mercer et al. 2018). They are locked up and locked down with medication.

There are no simple explanations for these negative experiences and outcomes, however, there have been multiple factors that have come under scrutiny to account for them (Khan et al. 2017, Perkins and Repper 2020). Consideration has been given to socioeconomic stressors in Black men's lives, such as unemployment, poverty and race discrimination in a society which negatively affects Black men's mental health and well-being (Cooper et al. 2008, Keating 2007, Morgan et al. 2017, Nazroo, Bhui, and Rhodes 2019). This work explores the extent to which British society drives Black men to mental distress and how they respond to that distress. It includes the study of Black people's use and underuse of primary care services, an important contributor to their mental health outcomes (Bhui, Christie and Bhugra 1995, Gajwani et al. 2016, Mclean Campbell and Cornish 2003). There is a growing body of work around the relationship between delayed access to support services and worsening mental health outcomes, leading to a greater likelihood of involuntary admission into mental health services and having contact with the criminal justice system (Independent Mental Health Task Force 2016, Mclean Campbell and Cornish 2003). Black men tend not to receive support with their mental health and enter the systems in crisis. In tandem, stigma within the Black community plays a role in silencing conversations about mental health (Alvidrez, Snowden and Kaiser 2008, Watkins 2019) and prevents timely help-seeking, resulting in delays in Black men receiving support for their mental health (Abdullah and Brown 2011, Mantovani, Pizzzolati and Edge 2016). Delayed help-seeking is compounded by Black people's mistrust and fear of mistreatment by mental health services (Chakraborty et al. 2011, Mclean Campbell and Cornish 2003, Sainsbury Centre for Mental Health 2002, Wessely 2018). These explanations argue that Black men delay accessing care and that this delay worsens their mental health outcomes. Whilst Morgan et al. (2005) have challenged such explanations, their work find no evidence of delayed access and treatment, their study only accounts for Black people who had experienced a first episode of psychosis and not those who experienced subsequent hospital admissions, which may have affected the results.

There have been attempts to address some of these inequalities and poor outcomes in the mental health for Black, Asian and Minority Ethnic (BAME) groups. These include policy responses, such as the ‘Inside Outside’ report (Department of Health 2003) and the five year ‘Delivering Race Equality’ policy (DH 2005a).
These policies attempted address the organisation and delivery of mental health care to improve the BAME experience and negative outcomes. However, little progress has been made, as mental health services find it difficult to learn from previous failings and to provide the appropriate and responsive mental health care that Black men require (Cotton 2012, CQC 2020, Fernando 2010, MacAttram, 2008; McKenzie and Bhui 2007). The recent review of the Mental Health Act by Wessely (2018) brought these inequities back into the spotlight. It highlighted (once again) the increasingly coercive nature of mental health services and the negative experiences and outcomes, in particular for Black people (Edge, Salla and Dansa 2018, Wessely 2018).

Understanding Black men’s experiences of mental health services

Theorists’ definitions of oppression shift over time, space and discipline. These disciplines include psychology, politics, sociology, critical social theory and feminist theory (Collins 2009, Crenshaw 1989, Cudd 2006, Frye 1983, Gill 1998, Robbins 2011, Van Wormer 2015, Young 1990). Attempts to establish a formal academic definition of oppression have proven problematic, because of its complexity (Mullaly 2002, Thompson 2016). Whilst academics cannot agree on an overarching definition of oppression, there are common elements (Gil 1998). For example, Mullaly states that oppression as an umbrella term for social conditions caused by systematic institutional processes that perpetuate inequalities through coercion, domination and privilege (Mullaly 2002). For Deutsch (2006) it is often associated with the negative experiences that social groups face in their lives. David and Derthick (2014) consider it an important socio-political factor that negatively influences an individual’s psychological and mental well-being.

Frye (1983) captures the complexity of oppression by likening it to a birdcage. She suggests that when someone steps back from the cage they can see that the individual wires do not prevent the bird from escape, but their connection to a

systematic network of barriers. In these terms, Orville Blackwood and David Bennett experienced an interlocking network of barriers that coerced and restrained them as big, Black and dangerous threats rather than as people in need of care. Focusing on such an understanding of oppression shifts the thinking beyond the individual and community response that Black men may or may not have. The focus turns to the institutional processes of mental health services and how they are experienced (Fernando 2010, Mckenzie and Bhui 2007, Nazroo, Bhui and Rhodes 2019). This study aims to gain an insight into the systemic barriers as they are 'felt' by Black men; how Black men experience oppression and make sense of those experiences. The study uses Young's (1990) five forms of oppression: cultural imperialism, powerlessness, exploitation, marginalisation and violence to uncover Black men's experiences of oppression and mental health. To listen to and amplify Black men's voices and, in so doing, highlight the unique challenges they face in order to identify actions needed to improve mental health practice and policy and inform community support and activism.

The importance of centring on the voices of Black men

Different philosophical assumptions influence and impact on how research is conducted (Lopez and Willis 2004, Sullivan 2010). These philosophical ideas and structures are crucial to research as they determine the appropriateness of the methodological processes used and guide the researcher's approach to data analysis (Mackey 2005). One of the key philosophical assumptions that are important in qualitative research and influences IPA is interpretivism (Smith Flowers and Larkin 2009). Interpretivism is a philosophical belief that human behaviour can best be understood when the context in which it takes place and the thinking processes that give rise to it are studied (Parahoo 2006: 42). To be able to achieve this, interpretivism seeks to answer the 'What?' 'How?' or 'Why?' of a phenomenon (Green and Thorogood (2011:5). It aims to gain access to the complex personal and social world of the participants, acknowledging their diverse nature and complexities (Finaly 2011, Ryan 2018). By taking an interpretive stance in this study my intention is to form a trusting relationship with the men, provide a safe space where they can talk freely and where I can capture their voice and interpret their multiple views, meanings and actions (Dyer 2006, Robson 2011).

Giving voice is often a motivating factor for researchers that take an interpretative stance and conduct IPA studies, who value and want to amplify the voices of individuals or groups who are silenced or are seldom heard (Flowers, Smith and Larkin 2009, Larkin, Watts and Clifton 2006). Giving voice aligns with my personal and professional values as a Black woman and a mental health nurse lecturer. I acknowledge the politics and power dynamics that are intrinsic in the research process (Mazzei and Jackson 2012) and in the notion of giving voice. The men in this study have power, they choose what they want to say; their voice has the power to impact and influence me as the researcher and others to enhance and transform mental health practice. I too have the power, to interpret and shape the findings and share the men's voice inside and outside of the academy to pursue my own research goals. I do not take these dynamics lightly or view 'voice' or 'giving voice' in a naïve way. My positionality and critical aspects of my journey as a novice researcher privileged to be researching Black men as both an 'insider' and 'outsider' is an integral part of this study and is critically explored in chapters 3 and 7 respectively.

Structure of the Thesis

The thesis is organised into seven interconnected chapters. Chapter 1 interrogates the complex nature of oppression. The chapter begins by drawing attention to how Black men encounter a birdcage of racial disparities in their everyday lives. The chapter considers how the work of Iris Marion Young (1990) helps us to understand Black men's experiences of oppression. The chapter critically reviews Young's (1990) five forms of oppression: cultural imperialism, powerlessness, exploitation, marginalisation and violence and highlights both the strengths and limitation of the framework. It suggests that the concepts microaggression and intersectionality, which are absent from the work of Young's (1990), offer a means of capturing and understanding the multiplicity of ways that oppression restrains the lives of Black men. Chapter 2 provides a comprehensive qualitative literature review to capture Black males understanding and experiences of mental ill-health.

Chapter 3 outlines the research methodology of the study. It explores the theoretical assumptions that underpin IPA and justifies its use as the research methodology.

The chapter offers a comprehensive and reflective narrative regarding the decisions and strategies taken to address the overall research aim and answer the research question. In Chapters 4, 5 and 6 the findings of the study and voice of the men are presented. The findings are organised under three distinct superordinate themes: Superordinate theme 1: 'Becoming Psychotic' sheds light on the men's everyday life and the start of their psychotic symptoms. Superordinate theme 2: 'Dehumanisation and Domination' captures the men's contact with mental health services and how they made sense of their mental health care. Superordinate theme 3: 'Starting Over' illustrates the men's transition from the hospital back to the community and reveals the challenges of this transition and how it impacts their mental health. It also outlines the varying nature of their social and therapeutic relationships.

Chapter 7 sets out a critical discussion of the findings. The first part presents an analysis of the men's experiences of psychosis, offering new insights and perspectives based on those experiences. The second section identifies limits associated with Young's (1990) forms of oppression framework and the study itself. The third sets out implications for mental health practice, education and research.

Chapter 8 is the conclusion, it sets out the key learning from the study, the practical, theoretical and methodological contribution and brings the thesis to a close.

Chapter 1: Oppression and Black men: Naming what hurts

"They see me smile, but they don't know how I feel inside" Chronixx

1.1 Introduction

This chapter explores the concept of oppression and its complexity and challenges. This is essential for showing how oppression is implicated in the everyday lives of Black men, especially the Black men in this study. The first section considers the social, economic, political and cultural position of Black men. It discusses the racism, discrimination, exclusion and disparities in their lives and offers examples drawn from educational outcomes, experiences in the criminal justice system and challenges in employment. The second section introduces Young's (1990) forms of oppression model and shows its use to reveal how oppression shapes Black men's lives. The discussion considers Young's limitations, such as her failure to recognise the impact of the everyday microaggression Black men meet and how their lives are shaped and acted upon routinely by multiple systems of power.

1.2 From 'Sambo to Brute to Thug'

Black men experience a myriad of challenges and threats in their daily lives, from employment, education, the criminal justice system to their health and well-being (Young, A. 2018, Long and Joseph-Salisbury 2018, Demie and Mclean 2018, Curry 2018, Angiolini 2017, Gilbert et al. 2016). A key factor that shapes and influences their experiences is their othering and social positioning based on racial and gendered stereotyping (Feagin 2006, hooks 2004a, Howard, Flennaug and Terry 2012). Stereotyping occurs when people are grouped by their differences, such as race, gender, sexuality and disability (Cudd 2006). Stereotypes are fixed and oversimplified generalisations and perpetuate negative, biased, inaccurate depictions and conclusions about people (Hall 2001; Mullaly 2002). They also become entrenched and perpetuated, consciously and unconsciously, in the home, at school, the news, films, advertisements and key institutions such as education, health and the criminal justice system that impact daily life (Feagin 2006, hooks 2004a, Howard, Flennaug and Terry 2012).

The evidence suggests that stereotyping shapes the disadvantages and disparities that Black men face, it underpins their daily encounters and sustains their social positions (Cudd 2006; Mullaly 2002, Feagin 2006). These stereotypes are rooted in the colonisation of Africa and the Caribbean and the transatlantic slave trade. These historical contexts encouraged the development of anti-Black racist ideologies to perpetuate and legitimate Anglo-European superiority (White supremacy) and Black inferiority (hooks 2013, Kendi 2016, Olusogo 2016). The intertwining of economic exploitation, physical and cultural violence alongside domination and self-interest are the foundations for racism as the system of power and domination that harms and traumatises Black men in all levels of society (hooks 2013, Kendi 2016, Olusogo 2016, Smiley and Fakunle 2016).

There are two distinctive, racialised and gendered stereotypes that have historically defined Black men as either a 'brute' or a 'sambo'. The brute defined Black men as primitive, unpredictable, violent, strong and sexually powerful (Hall 2001; Pelzer 2016). The 'sambo' defined Black men as child-like, docile and is often associated with the minstrel character used to entertain their White superiors (Hall 2001, Pelzer 2016, Khendi 2016). While stereotypes shift over time, new stereotypes have appeared such as being homophobic (Glynn 2014, Young, L. 2014). Little has changed for Black men as the perception of the 'brute' or 'thug' has become deep-seated (Young, A. 2018, Smiley and Fakunle 2016) they are viewed as socially destructive, often blamed for their problems and framed as lacking in self-control, a threat to society and in need of control (Curry 2017, Long and Joseph-Salisbury 2018, Young, A. 2018). To illustrate the modern-day reality of Black men's social position, examples from education, employment, the criminal justice system, mental health services are explored.

1.2.1 Education

Mainstream society views education as the means for social mobility, a stepping-stone to achieving aspirations and ambitions regardless of an individual's background (Arday and Mirza 2018, Department for Education 2015). However, for Black boys this is a key place where they experience inequities and disparities in comparison to White boys (Demie and Mclean 2018). There has been concern expressed about the persistent underachievement of Black boys and Black students

particularly in secondary education where they are amongst the lowest groups to achieve five G.C.S.Es graded A-C (including Maths and English) (Department for Education 2015; Equality and Human Rights Commission EHRC 2018). Although underachievement is multi-faceted, Black boys experience a deficit type of educational approach where they are problematised and become 'othered' in their educational experience (Weekes-Bernard 2010, Crozier 2015, Gillborn et al. 2012). In the most recent review that focused on Black pupils' underachievement in schools, Demie and McLean (2018) confirmed earlier studies and showed that Black boys are disproportionally labelled as 'disinterested', 'underachievers', display 'delinquent behaviour' and viewed as trouble-makers (Crozier 2015, Gillborn et al. 2012, Strand 2012). As with most labels or stereotypes, these are difficult to shift and Black boys are given increased scrutiny and sanctions rather than assistance in achieving their educational goals and ambitions (Crozier 2015, Demie and Mclean 2018, Harper and Davis 2012). These labels and stereotypes shape how schools discipline Black boys. Schools tend to give higher rates of disciplinary procedures, such as suspensions and exclusions, to Black boys compared to White pupils (Department for Education and Skills 2006, Department for Education 2020; EHRC 2018) and harsher reprimands for the same wrongdoing (Demie and Mclean 2018, Maylor 2014). School exclusion marginalises Black boys, hindering their ability to keep up with their education, keep contact with friends and supporters (Department for Education 2015) and challenges them to re-engage with schools where they feel unwanted and unfairly treated (Wright et al. 2005).

School reintegration requires Black boys to be extra mindful of their behaviour in comparison to other pupils for fear of reprimand and generates another threat to their re-engagement (Wright et al. 2005, Demie and Mclean 2018). School exclusion and disengagement from education makes them vulnerable to exploitation and grooming by criminals (Department for Education and Skills 2006, German 2010). These experiences highlight inequities in education and the damage to Black boys' ability to build the positive sense of self and belonging, which is important in learning environments and their engagement with them (Gillborn et al. 2012; Howard, Flennaug and Terry 2012). All these factors can damage their ability to attain their GCSEs, future employment prospects and trajectory in life (Demie and Mclean 2018, EHRC 2018, Weekes-Bernard 2010), but many still excel and attend higher

education (Dumangane 2016). These men predominately attend post '92 universities. They are relatively absent from the redbrick universities, even when they have the desired entry requirements (Dumangane 2016; Mirza 2018), and research has explored unconscious and implicit bias and their applications (Equality Challenge Unit (ECU) 2013, Boliver 2018). Black men in higher education continue to experience the disparities that characterise their secondary education, as shown by the education gap: 46% of Black men achieve first or upper second class honours degrees compared to 74% of White male students (EHRC 2018; ECU 2015, Richardson 2018).

1.2.2 Employment

Evidence shows that educational performance and employment prospects are intrinsically linked (EHRC 2018, Khan 2019). This section explores three different aspects of Black men's inequalities in employment: the relationship between educational attainment and Black men becoming segregated into low paid work; inequity in pay and inequity in their ability to progress in employment. Some argue that Black men's academic achievements are a significant contribution to their segregation in low paid work (Barnard et al. 2018, EHRC 2018, Khan 2020) The rates of long-term unemployment are increasing particularly for those aged 16-24 years (EHRC 2018), which may result in reduced options for employment for young Black men alongside increased competition. Their options for employment are reduced the lower their educational achievements: lower grades mean low paid and insecure employment without opportunities for progression, training and wage growth (Barnard et al. 2018, Khan 2020). There is an element of Black men's segregation in the workforce that appears to be contradictory; more Black men attend higher education and secure undergraduate degrees (Arday and Mirza 2018), have difficulty accessing graduate employment compared to other groups (Trade Union Congress TUC 2016, EHRC 2018, Khan 2020). Black men have to contend with scrutiny that blends race, class and gender stereotypes: it impedes their shortlisting and consideration (Khan 2020; McGregor-Smith 2018). They face increased scrutiny at interviews, as employers act on their implicit and unconscious biases, favouring other candidates who they believe will 'fit in', rather than focusing on Black men's competencies and skills (Khan 2020; McGregor-Smith 2018). Black men have little choice but to secure low-paid work to avoid becoming long-term

unemployed and when they do that they have to endure employers suggesting they are ‘helping’ them and treating them ‘equally’, when the reality is the opposite (McGregor-Smith 2018). Although they have the equivalent qualifications to their White colleagues, they earn over 23% less on average if they have a degree and 11% less if they have the same GCSEs (EHRC 2018; Khan 2020, Zwysen and Longhi 2016). It is common for Black men to be overqualified for their jobs (Khan 2020, TUC 2016) and they work hard to challenge the stereotypes associated with them. They are constrained by their employers who might encourage their efforts, but overlook them for further training, promotion and progression (McGregor-Smith 2017, Zwysen and Longhi 2016).

Regardless of where they work, Black men experience a web of structural barriers and constraints that keep them subordinated and limit their ability to earn and develop their talents (Cudd 2006, Feagin 2006). Black men are usually unable to negotiate, refuse offers of employment or change their employers because of their powerless position. They must consider the potential impact of unemployment on their ability to pay their bills and on relationships and family life. This leaves Black men experiencing what Feagin (2006:197) calls a ‘vampire-like’ system that benefits from draining their energy yet gives Black men little benefit and undervalues their contribution. Both Feagin (2006) and Cudd (2006) suggests that this becomes cyclical and shapes the next generation’s ability to accumulate income and wealth and perpetuate the inequality.

These experiences challenge the notion of meritocracy, what Kendi (2016) refers to as ‘uplift suasion’, where Black people work hard in education and employment in the belief that differences in class, gender and race can be overcome and they will achieve their ambitions. Evidence indicates that the ‘uplift suasion’ is not enough to disrupt the institutional systems and processes that work against them (Khendi 2016, Kwate and Myer 2010, Snoussi and Mompelat 2019). The COVID-19 pandemic has triggered a deep recession in the UK and economic uncertainty will make Black men even more susceptible to job losses, increased economic pressures and instability in their lives (Bourquin, Joyce and Keiller 2020, Khan 2020).

1.2.3 Poverty

Socio-economic status is key determinant of Black men's social position (EHRC 2018, Gilbert et al. 2016). Young Black men often experience long-term unemployment or low paid employment, which affect their socio-economic position and denies them access to more well-paid employment. Many Black men in employment experience poverty and struggle to meet basic living costs (Bourquin, Joyce and Keiller 2020, EHRC 2018), because of poor wages growth. They have also experienced some of the largest deterioration in pay and income since 2010 (EHRC 2018; Zwysen and Longhi 2016). These socio-economic trends can cause a loss of self-respect and dignity and provoke shame because they do not meet gender role expectations or those of western consumerist success: homeownership, a successful career and supporting their family (Glynn 2014, Gilbert et al. 2016, hooks 2004a). A devalued sense of self and feelings of unworthiness affect mental well-being and physical health (Collins 2004). Hypertension, stress and depression often track experiences of racial discrimination (Gilbert et al. 2016). Kwate and Meyer (2010) suggest that Black men's efforts to progress when living with racialised inequalities can jeopardise their health and well-being. This is particularly problematic in a society that encourages men to make sacrifices for economic gains (hooks 2004b). Academics and health practitioners rarely consider these interconnections and their outcomes.

1.2.4 Black Men and the Criminal Justice System

Black men are overrepresented in secondary mental health services and in the criminal justice system, in both institutions they continue to face disadvantages and disparities (Glynn 2014, Lammy 2017). The Young Review (2014) and the Lammy Report (2017) and Glynn (2014) detail instances where the police, probation service and prison officers approached Black men with the assumption that they were 'drug dealers', 'yardies', 'gangsters' or 'thugs'. As in Black men's educational provision, even when they are in distress, criminal justice practitioners approached them as a threat to be controlled rather than people in need of support. Both Young. L. (2014) and the Ministry of Justice (2017) found that criminal justice workers neglect Black men's custodial and rehabilitation needs and provide differential treatment.

They observed that when admitted to custody, Black young people had less access to education, behaviour management or support for their mental and physical needs than White young people. This means that they were denied adequate levels of support. On entry to prison, the same pattern occurred: ineffectual decision making by staff denied Black men support whilst in custody and on release. With their needs neglected, the men are subject to racist stereotypes. Criminal justice staff were concerned that about the risks Black men posed to other young people rather than on the support they require (Ministry of Justice 2017, Young. L. 2014).

Criminal justice workers decide who is arrested and charged, who goes to prison and for how long. The Lammy Report (2017) presented a review of BAME individuals who had contact with the criminal justice system and confirmed previous reports: Black men are disproportionately negatively affected compared to White men. BAME men have higher conviction rates for rape and domestic abuse and Black boys are more than ten times more likely to be arrested for drug offences than White boys (Lammy 2017). Even before arrest, the police decide who to stop and search. The police view their stop and search powers as a legitimate crime reduction intervention. They can search anyone if they have reasonable, rational and lawful grounds to do so (EHRC 2010). However, campaigns and evidence show that Black men experience police stop and search practices as illustrations of their everyday powerlessness to resist stereotyping and oppression (Lammy 2017, Young. L. 2014). Black men are between five and six times more likely to be stopped and searched than White men (EHRC 2010, Lammy 2017; Ministry of Justice 2020). The Black men have to prove their lawfulness and legitimacy, regardless of success, economic and social capital (Kendrick, Anderson and Moore 2007, Pieterse and Carter 2007). Studies (Kendrick, Anderson and Moore 2007, Scott and Davies 2006, Aymer 2016) show that this can lead to Black men feeling anxious, intimidated and harassed and humiliated before friends and family. The men also report deliberate provocation by police, creating reasons to arrest them (Kendrick, Anderson and Moore 2007, Demie and Mclean 2018; Keeling 2017).

In 2010 the EHRC review of stop and search said its disproportionate use must stop and pointed to police forces' discriminatory and unlawful misuse of these powers based on stereotypical assumptions about Black people. Stop and search does help prevent and detect crime: it accounts for the reduction of 0.2% crime (EHRC 2010,

Keelling 2007). It is more effective in imposing a police presence in a community or location.

Black men experiencing mental ill-health usually meet the police when they are in crisis and in need of safety and support (Adebowale 2013, Angiolini 2017). However, this contact can become life-threatening. Both Adebowale (2013) and Angiolini (2017) found the disproportionate use of excessive force and the absence de-escalation strategies used by the police when dealing with Black people. They were more inclined to physically restrain Black people than White people and disproportionate numbers of Black people died in custody and following police contact, especially Black people experiencing mental ill- health (Adebowale 2013, Angiolini 2017, Baker 2016; INQUEST 2014). Angiolini (2017) notes the theme in police reports around the physicality of Black men – a physicality that increases the likelihood of restrictive practices and overrides the men's evident distress and vulnerability. The police deployed the same racist narratives in the cases of Roger Sylvester and Sean Rigg, two Black men experiencing mental ill-health killed following being restrained by the police (Angiolini 2017).

As in criminal justice, so in mental health. Black men spend more time in seclusion and physical restraint than being calmed down through de-escalation (CQC 2018; Wessely 2018). This is a long-standing trend that shows the continued devaluation of Black men as perceived threats demanding restraint and control (Long and Joseph-Salisbury 2018, Prins 1993, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003). The devaluation is deepened when the criminal justice system and mental health services are rarely held accountable for their actions or receive penalties for their interventions, despite protest and legal action (Baker 2016; INQUEST 2014). Angiolini (2017) found that when these deaths are investigated by the Independent Police Complaints Commission (IPCC), the reviews do not always explore issues of race and racialisation as part of the investigative process or wider social and political contexts, resulting in a futile investigative process that lacks credibility with family members and the wider community (Baker 2016). The IPCC actions legitimatise violence as an acceptable intervention and show the systematic nature of the violence against Black men (Feagin 2006; Karkazis, Mama and Edu 2016).

Experiencing violence is a distressing experience and knowing that institutions can carry out systemic violence with impunity compounds the distress for Black men and their families (Baker 2016, Curry 2017), as it reinforces their concerns about systemic racism and criminalisation by the criminal justice system (Angoloni 2017, EHRC 2018, Lammy 2017). Social media has increased the exposure of police harassment and killings of Black men in the UK and USA (Aymer 2016). They show the reality that Black men face from public officials, generating a deep sense of anger, hurt and powerlessness (Aymer 2016, Curry 2017).

Violence is part of society and occurs in all groups, but evidence indicates that the mainstream media is fixated on the image of 'violent criminal Black male' as the perpetrator of violence (Curry 2017; hooks 2004a). Counternarratives that consider the physical, verbal and psychological violence against Black men and its effects are rare (Curry 2017, hooks 2004a, Yarrow 2004, Jiang et al. 2018), but these men endure rape, childhood sexual abuse and intimate partner violence as other social groups do (Curry 2017, Eisman et al. 2018; hooks 2004a, West 2007). This is ignored or not considered part of Black men's narrative, because of their stereotyping and the focus on female perspectives (Curry 2019, Curry 2017, West 2007). Where it is difficult to see men as victims, it is even more difficult to see Black men as victims or Black men speaking out about these issues (hooks 2004a, West 2007). This denies Black men the space to articulate their trauma and receive support.

Hate-crime is increasing in the UK, with racially motivated crimes accounting for 76% of all hate crime (Home Office 2019). Black men who express their cultural heritage or wear traditional or religious clothing risk of hostility and attack (European Union Agency for Fundamental Rights 2018) and experiencing violence as victim or witness can damage long after the incident, with Black men reporting feeling anxious, depressed, angry and fearful (Chen 2010; Jiang et al. 2018, Rich and Grey 2005). This can lead Black men to withdraw from social spaces and be more mindful when in an unknown or affluent area, as they can come under scrutiny and targeted for being deemed out of place (Jiang et al. 2018, Rich and Grey 2005; Yarrow 2004). When Black men experience violence and require police intervention their response is not as straightforward as it might be for others. Much racially motivated violence is unreported (European Union Agency for Fundamental Rights 2018), as there is a

belief that the police are unconcerned with Black men's safety or trauma (Snoussi and Mompelat 2018) and they fear that they will be implicated in the offence (European Union Agency for Fundamental Rights 2018; Yarrow 2014). This contributes to their distress and compromises their ability to receive support, whilst the perpetrators live their lives (Jiang et al. 2018).

This study explores Black men's experiences of developing psychosis and how they make sense of their oppressive experiences. This chapter has shown how their lives are circumscribed by systems of power, the policy machinery and the racist behaviours and cultures of public servants. The multiple disadvantages they face are psycho-social stressors that threaten their physical and mental health and wellbeing and their ability to construct positive self-identities (Gilbert et al. 2016, Watkins 2019, Young, A. 2018). Young (1990) offers a way of understanding and articulating experiences of oppression and the next section introduces Young's (1990) forms of oppression model as a framework for understanding these experiences.

1.3 Young's Five Forms of Oppression

Young (1990) contends that oppression is a structural phenomenon where the processes and practices of institutions such as education, mental health services and the criminal justice system inhibits and diminishes individuals because of their differences such as gender, race, class, disability, sexuality and religion. Young's (1990) perspective of oppression was influenced by the social movements of feminism, civil rights and disability in the 1960's and 1970's who challenged the system through protest to raise awareness of social injustices and fight for their right to equal and fair treatment and thus create social change (Clifford 2013, Collins 1990, Gill 1998). Within these social movements, oppression was framed as not occurring because of tyrants and dictators but based on assumptions and reactions of well-meaning people who unintentionally maintain and reproduce dominant and subordinate relationships in everyday life (hooks 2013, Mullaly 2002, Thompson 2016). A common critique of Young's work is that it does not offer an overarching theory of oppression, for example, Fraser (1997) argues that the forms of oppression are ad-hoc, lacking sufficient theoretical engagement. However, for Young (1990) this was deliberate, she argues that no one theory or definition is sufficient to capture the complex nature of oppression because of its multidimensional nature.

In addition, Young (1990) wanted to evade focusing on specific forms of oppression such as racism and sexism and render any one experience of oppression to be more valid or important, therefore avoid focusing on hierarchies of oppression (Zutlevics 2002). Instead, Young (1990) named five forms of oppression: cultural imperialism, powerlessness, exploitation, marginalisation and violence to show how oppression can occur for any group. Within this framework, experiencing any one of these can constitute oppression.

Young (1990) has been complemented for providing an insightful framework and analysis that centres on the social practices and process that produce and reproduce oppression through focusing on the phenomenology of the oppressed (Allen 2008, La Caze 2014, Clifford 2013, Milton 2016). Having a focus on the phenomenology of the oppressed is a significant aspect of the framework as it is in keeping with the interpretivist approach of this study outlined in the introduction. These forms of oppression are used in other studies to explore how different groups experience oppression such as Dubrosky (2013) and Milton (2016) who both used the forms of oppression to explore oppression that exists in the nursing profession and for individuals diagnosed with autism respectively. The forms of oppression have the potential to illuminate people's oppressive experiences in ways that theories may overlook (Clifford 2013, La Caze 2014). The expectation for this study is that the forms of oppression will help enable an exploration of each form of oppression for Black men as well as explore how they relate and connect to each other to reveal new, powerful insights that will contribute to knowledge.

1.3.1 Cultural Imperialism

Culture refers to the meanings, symbols and language used and how we make sense of social reality, it gives a sense of location for people and the communities they live in (Mullaly 2002). Culture also offers what Thompson (2016: 36) calls a complex web of assumptions that influences what is labelled normal and right. Although as Mullaly (2002) states culture can give a sense of location for people and communities, it can also be a source of tension, conflict and inequality (Neville, Viard and Tuner 2014). Cultural imperialism is a concept that covers complex issues that are even more complex when defining culture and imperialism (Tomlinson 2012). Mullaly (2002) provides a starting point to help consider why cultural imperialism is a

form of oppression, he states cultural imperialism occurs when the culture of the dominant group is assumed to be superior, becomes universalised and positioned as the norm at the expense of other groups who inadvertently become inferior and subordinated. Setting the standard in society, pressuring others to conform and view the world from their perspective (Feagin 2006). According to Young (1990), cultural imperialism requires two processes. Firstly, to occur as stated by Mullaly (2002) society imposes their values, norms and habits on another group that creates what Young (1990) refers to as 'invisibility'; secondly the groups also experience becoming stereotyped and othered experience a concept referred to as 'double-consciousness'. Although she describes these processes separately, they occur simultaneously. Thus far, the chapter has explored and provided an insight about how Black men are stereotyped and othered in various aspects of their daily lives, Therefore this section, will explore the concept of invisibility and double-consciousness and how it is applied to the lives of Black men.

> I am an invisible man. No, I'm not a spook like those who haunted Edgar Allan Poe; nor am I one of your Hollywood movie ectoplasms. I am a man of substance, of flesh and bone, fibre and liquids-and I might even be said to possess a mind. I am invisible, understand, simply because people refuse to see me. (Ellison 1952: 3)

Ralph Ellison articulates the essence of invisibility in his novel "Invisible Man", where a Black man reflects on his relationship with White people in1950s America. Ellison's character (1952) shows his awareness of how he is positioned in society and the struggle to be recognised and seen as a valued person. A situation where he has become irrelevant, devalued and overlooked (Curry 2017, Franklin 1999, Glynn 2014). Franklin (1999:761) conceptualised invisibility as a particular syndrome he observed in Black men; a form of inner psychological struggle that their talents, abilities, personality are not recognised and valued because of the racial prejudice and inequalities that they face.

Young (1990) suggest that invisibility is a paradoxical experience that occurs whilst also experiencing double-consciousness. Young (1990) drew on the work of Du Bois (1903) and his theory of double-consciousness, which focuses attention on identity and sense of self. Double-consciousness explains the psychological process Black men experience when they are aware of the stereotypes associated with them.

Du Bois (1903: 2) used it to describe the racialisation of Black people in post-slavery America explaining: 'It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity'. Fanon (1952) also illustrated from his own experiences and observations that as a Black man he wanted to be seen and valued in his own right but had to contend with being despised, hated and being dehumanised.

Black men can experience psychological and behavioural responses to experiencing cultural imperialism (Fanon 1967, Franklin 1999, Tovar-Murray and Tovar-Murray 2012, Neville, Viard and Tuner 2014). These responses include Black men using strategies that challenge stereotypes such as being careful in their language, being mindful of their behaviour, their presentation to others and using humour (Brooms and Perry 2016). It is common for Black men to increase their work-rate in their attempt to prove them wrong (Smith 2003, Brooms and Perry 2016). Attempts at challenging norms and stereotypes can leave Black men finding themselves penalised by institutional structures who wish to keep them subordinated Khendi (2016) and hooks (2004a: 89) aptly articulated this as 'to know their place and stay in it'. The same or similar outcome can also occur if Black men attempt to assimilate into the dominant culture to access privilege and status; acceptance into the dominant culture can be to their detriment as they must adhere to their norms ensuring that they remain in a subordinate position and not pose a threat (hooks 2004a: 89, Khendi 2016). Black men can also feel a sense of powerlessness, which can lead to them feeling vulnerable, have difficulties in expressing themselves and suffering in silence (Du Bois 1903; Itzigsohn and Brown 2015; Mullaly 2002). This sense of powerlessness can also precipitate Black men responding with a potent form of masculinity demonstrated through anger, resentment and rage at the helplessness and despair they may feel (Glynn 2014; hooks 2004a; Tovar-Murray and Tovar-Murray 2012). Although anger and rage are understandable reactions it can prove problematic for Black men as it creates a self-fulfilling prophecy, thus reinforcing the stereotypes associated with them (Franklin and Boyd-Franklin 2000; Glynn 2014).

The concepts of invisibility and double-consciousness provide a valuable and powerful way of showing the awareness Black men have of how they are perceived, highlighting the tension between identity, the basic human need to be recognised for who you are (Neville, Viard, and Tuner 2014). The lack of recognition or what Taylor (2002) refers to as misrecognition contributes to understanding their social, economic and political position of Black men and their psychological responses to it. Both Allen (2008) and Zutlevics (2002) suggest that Young (1990) does not give sufficient attention to the psychological consequences of oppression. An aspect of cultural imperialism that Young (1990) neglects is a form of internalised cultural imperialism or internalised oppression which can further illuminate the nature of oppression. Internalised oppression occurs when people begin to believe the stereotypes about them, leading to a devaluation of their own group and of themselves (Mullally 2002, Taylor 2002). It is insidious and harmful consequence of oppression that lead to feelings of low self-esteem, anxiety, feelings of guilt, underestimating their own value and strengths (David 1990, Pyke 2010). Both Fanon (2008:75) and Friere (1970) determined that it is not uncommon for people experiencing oppression to want to imitate their oppressor and aspire to be like them, adopting behaviours that inadvertently reproduce oppression thus keeping them in a subordinated position. The concept of internalised oppression could be problematic as it could suggest that Black men are responsible for their own circumstances. This will only occur if taken out of context and not seen as a response to oppression and domination (Banks and Stephens 2018, Pyke 2010, Taylor 2002). If internalised oppression is considered as a response to oppression, it may help us to learn if and how it affects and impact on Black men.

Implications for Mental Health Services

In continuing with thinking about the work of Young and cultural imperialism, mental health care in the U.K needs to be seen as part of a Eurocentric system, developed out of and underpinned by a set of structures and thinking processes underpinned by notions of race (Feagin 2006). Current mental health care is dominated by the Eurocentric medical model (Fernando 2010, Mclean, Campbell and Cornish 2003, Pilgrim 2014). It sets out a universal set of Western norms and ideas that dictates the assessment and treatment of mental health. Within this framework, mental ill-health is understood as a biomedical problem, chemical imbalance to be cured or

improved by medication (Beresford, Nettle and Perring 2010, Pilgrim 2014). The medical model characterised by using a deficit approach, marks the men as an 'other', individualising their mental health. The medical model is problematic. Firstly, people hold a variety of belief systems and conceptualisations regarding mental health which may not align with the universal framework the medical model provides and the use of medication to treat mental ill-health (Fernando 2010; Mclean, Campbell, and Cornish 2003). This is one way the medical model creates invisibility in mental health services through the assumption that it is the most suitable way to address mental health problems. Mental health services allow little space for alternative forms of mental health assessment, treatments and ways of thinking about mental distress and coping (Beresford, Nettle and Perring 2010, Fernando 2010; Forde 1998). Additionally, it can be difficult to challenge these taken for granted notions of mental health due to the power and status of mental health practitioners who are positioned as 'superior' and 'experts' (Patel and Tyrer 2011, Pilgrim 2014). In tandem with these issues is the drive to treat all individuals regardless of their ethnicity equally which can mean that mental health practitioners use a 'neutral' or 'colour-blind approach' which inadvertently results in inadequate attention given to cultural, social and spiritual needs of Black men (Fernando 2010, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003, Prins 1993, Wessley 2018). For Black men, this means that their perspective and the cultural context of their lives that include issues such as racism, discrimination and other determinants of mental health are absent from their assessment and treatment and not addressed within their care (Edge, Salla, and Dansa 2018; Secker and Harding 2002; Sewell 2012). Mental health services have been challenged about these issues, notably by the 'recovery' or 'survivor' movement where individuals who had lived experiences of mental ill-health expressed being undermined and not recognised for their expertise regarding their own mental health (Anthony 1993, Coleman 1999, Deegan 1998). In an attempt to address the criticism of mental health care and the domination of the medical model the government proposed to modernise mental health services through the NHS Plan (1999) and move to a recovery model that was underpinned by respectful, person-centred care as the basis for mental health services.

Recovery approaches such as Wellness Recovery Action Planning (WRAP) (Copeland 1997) and the Recovery Star (McKeith and Burns 2009) are two of the most popular models used in mental health care. These models are Euro-American and represent universalist 'one size fits all' approach to recovery in mental health. Just like the medical model, there has been a failure in giving attention to the social inequalities that impact mental health (Harper and Speed 2014) and the cultural and spiritual factors that are integral to recovery (Fernando 2010; Tuffour 2018). Despite the vast amount of mental health recovery literature available Leamy et al. (2011) and Tuffour, Simpson and Reynolds (2019) revealed the limited papers and invisibility of recovery from a BAME perspective. No research to date focuses specifically on Black men's lived experiences, their definitions of recovery, their collective struggles and their stories of success.

This section has explored the different concepts that make up cultural imperialism such as invisibility, stereotyping, double-consciousness, internalised oppression and eurocentrism that helps to explain and interpret the experiences of Black men. Through this exploration of cultural imperialism, Young (1990) illuminates its insidious nature enacted within institutions who she suggests have good intentions and mean no harm. It is this 'good intention and no harm' that compounds the situation for many Black men as when challenged, institutions such as education, criminal justice system and mental health services often deny any wrong-doing, becoming defensive at the suggestion of racial bias and prejudice (Angiolini 2017, Arday and Mirza 2018, Lammy 2017, Singh and Burn 2007). A situation arises where having an open dialogue and being able to address systemic issues never really occurs, thus enabling cultural imperialism to flourish (Arday and Mirza 2018, Feagin 2006, Fernando 2010, Mckenzie and Bhui 2007). Most aspects of cultural imperialism are useful to explore Black men's experiences. However, internalised oppression (internalised cultural imperialism) is beyond Young (1990) and may need considering when exploring Black men's experiences of oppression.

1.3.2 Powerlessness

As a result of cultural imperialism, Black men experience powerlessness. Young (1990:56) argues that most people lack significant power in their life, they are removed from the bureaucracy and policies that govern daily lives. In her analysis of powerlessness, she focuses on class, the dynamics within employment between profession work which has privilege and status and non-professional work. Where the non-professional because of their social position, lack authority, status and respectability. They have reduced power in the sense that they must take orders, they rarely have the right to give them. Young (1990) focused on three aspects that she suggests shows powerlessness: being inhibited from self-development and reaching potential, a lack of decision-making power and exposure to disrespectful treatment.

Many of the situations Black men encounter thus far can be related to Young's (1990) focus on being inhibited from self-development, a lack of decision-making power and exposure to disrespectful treatment such as in the educational experiences, their segregation into low-pay employment and challenges in progressing. Their continued experiences of 'stop and search' is also a demonstration of powerlessness to prove their legitimacy and that they belong. All these scenarios reveal the lack of autonomy, respect and decision-making (Zutlevics 2002) affecting Black men's ability to believe that they can achieve their desires and aspirations through their actions (Feagin 2006). In addition, part of Black men's powerlessness is being able to express their frustrations to those who are willing to listen and take decisive action (Curry 2017). Young (1990) differentiation between professional and non-professional status does not readily apply to Black men as regardless of their class they will be prone to experience cultural imperialism and powerlessness due to being marked out as an 'other' (Arday 2018, Purcell 2014). Arday (2018) a Black male lecturer reflects on how regardless of his social capital he experiences a reoccurring narrative in higher education that he is out of place and does not belong. The respectability and credibility Young (1990) suggests is shown to professionals is not present for Arday (2018) as it is for his White peers. There is an aspect of Young's (1990) explanation of powerlessness that is pessimistic and lacking. She says that the powerless have no or little autonomy, creativity or judgement and express themselves awkwardly, suggesting a passive, ineffective

person (Allen 2008). Young (1990) does refer to justice as coming from enablement and empowerment but does not expand on this to help understand how it can be achieved when experiencing oppression, leaving a key aspect of the dynamics of power relations insufficient (Allen 2008). Black men are aware of the oppressive systems they live within and how they are presented (invisibility and double-consciousness). This can both generate negative emotions and the impetus to challenge, confront and transform the dominant culture (Du-Bois 1903; Freire 1970, Medina 2019). This can occur at various levels: Malcolm X is often associated with protest, resistance and challenging racism (Haley 1965; hooks 2004a, Khendi 2016). He called for Black people to take steps to unlearn the thinking of the White dominant culture and choose their own destiny (Haley 1965; hooks 2004a). The Black Lives Matter movement shows challenge and resistance that has generated a global movement to challenge the social injustices experienced by Black people (Aymer 2016). On a more micro level, acts of resistance include Black men placing themselves around other Black people in environments that provide a sense of acceptance, reduce their sense of invisibility and generate feelings of optimism and belonging (Boyd and Boyd-Franklin 2000; Feagin 2006). Being in supportive environments with others that have similar experiences of oppression can also help Black men make sense of their experiences and develop their own strategies for resistance and change (hooks 2004a, Khendi 2016).

1.3.3 Exploitation

Cultural imperialism and powerlessness create an environment where Black men are at risk of becoming exploited (Collins 2004, Feagin 2006). Young (1990) draws from Marxist's theory of exploitation to help explain this form of oppression, which in essence is a critique of capitalism and neoliberal practices that creates a process of social injustice and exploitation (Hahnel 2006, Sector 2014, Wood 1995). For Young (1990), exploitation refers to the social processes where the dominant group accumulates, maintains their power, status and assets from the energy and productivity generated by subordinate groups, thus ensuring that the subordinate group are placed within an economical weakened position and remains there (Cudd 2006, Feagin 2006, Young 1990). The priority is to generate more wealth, regardless of the negative consequences this has on others. In capitalist societies, it is considered a 'right' achieved through people's effort and willingness to take risks

(Hahnel 2006, Wood 1995). If some, as in the case of Black men do not have wealth or power it is because they are ineffectual and are therefore culpable for their own social and economic circumstances and not because of oppressive social structures and the social realities they have to contend with (Collins 2004, Freire 1970; Feagin 2006, Gil 1998). Young (1990) provides both a racially specific and a female perspective to explore exploitation revealing how exploitation can intersect across class, gender and race and will be experienced differently as a result of these intersections (Collins 2004, Purcell 2014). Young (1990) suggests that segregation and unequal distribution occurs in the labour market that often places Black people in low-paid, low-skilled jobs. She argues that these roles are undervalued and lack status whilst enhancing the status of their customers or employers. When thinking about Black men, Young's (1990) analysis of exploitation has credibility. Issues such as Black men being segregated into low-pay and low skill discussed earlier in the chapter point to how despite their educational achievements, the way inequality is embedded in the labour market produces inequity in pay that can limit Black men's progress in the labour market, producing a lack of respect, autonomy and choice in their life (Purcell 2014, Zutlevics 2002). This also includes working in the grey or shadow economy that is untaxed and unregulated (Facing Labour Exploitation 2017) working in environments that are unsafe, placing themselves at physical risk (Mullaly 2002) where getting appropriately paid for their efforts is not guaranteed, with no recourse for challenge due to the precarious nature of the employment (Facing Labour Exploitation 2017). Black men's economic domination and exploitation are longstanding, both Gill (1998) and Feagin (2006) argue it is an entrenched feature of their lives. Businesses and organisations with power and privilege may appear to make changes to their policies and processes when challenged; in reality they fight to protect and keep the systems and processes that benefit them and maintain their way of life (Feagin 2006, Gill 1998, Khendi 2016).

1.3.4 Marginalisation

Cultural imperialism, powerlessness and exploitation are interconnected with marginalisation (Milton 2016). Young (1990) suggests that marginalisation is the most dangerous form of oppression. Traditionally marginalisation describes the position of individuals or groups who are outside of 'mainstream society' living at the margins or periphery of those who are in the centre of power (Mullaly 2002; Schiffer

and Schatz 2008). Being on the periphery occurs because of social structures and group differences that create barriers and exclusionary experiences that manifest socially, economically and politically (Baah, Teitalman and Riegel 2018). Young's (1990) exploration of marginalisation focuses on groups excluded from the labour market that cannot or will not accommodate them because of their differences, leading to material deprivation and hindering their ability to participate in social life. Marginalisation occurs in different locations and times for Black men; Black men are one of the social groups that are more likely to be unemployed (EHRC 2018, Li and Heath 2020, TUC 2016). The longer someone is unemployed inevitably makes it more challenging to secure work, as employers become more suspicious about gaps in employment and the individuals' potential; this is compounded for Black men who Li and Heath (2020) found are more likely to remain unemployed and experience delayed re-entry into employment when compared to White men.

Black men's experiences of marginalisation do not only occur when they are unemployed; as illustrated earlier in the chapter marginalisation occurs throughout their lives (Watkins 2019, Young, A. 2018). Black men's marginalisation is symbolised by a number of experiences such as their increased rates of exclusion in secondary school (Demie and Mclean 2018) being segregated into low paid unemployment (Khan 2020) their overrepresentation in mental health services (Wessley 2018) and in all aspects of the criminal justice system (Lammy 2017). These are all examples of their displacement and exclusionary experiences. Black men who experience mental ill-health face the kind of exclusion from the labour market and deprivation that Young (1990) suggests. It is well documented that individuals who experience mental ill-health are labelled and discriminated in recruitment and in the workplace; they are also more likely to be long term unemployed (Farmer and Stevenson 2017; Royal College of Psychiatrists 2013) even though employment and having meaningful occupation is beneficial to their mental health (Leff and Warner 2006). For Black men, the intersection of race, gender and mental ill-health compounds these challenges, already experiencing difficulties gaining employment, they face additional scrutiny surrounding their capability and competence, affecting their aspirations for employment and being a valued member of society (Hall and Pizarro 2010, Milton 2016).

For Black men that have been involved in the criminal justice system, particularly those who have served a prison sentence a similar pattern can also occur, where having the label of criminal or offender compounds their ability to find employment and meaningful occupation (Glynn 2014, Robertson and Wainwright 2020). In addition, when released from prison and wanting to reintegrate back to the community there is also the challenge of securing suitable housing and being close to supportive networks (Young, I. 2014). Resulting in a lack of opportunities, limited income and a dependency on the state for survival (Boardman 2011). These situations can also increase stress and isolation as they try to problem-solve their way out the barriers and constraints that they face (Boardman 2011, Glynn 2014, Levy-Pounds 2013). For Black men, this can result in increasing the likelihood of navigating back to criminal activity to survive (EHRC 2016, Glynn 2014, Levy-Pounds 2013).

Young (1990) also considers the relationship dynamics that can occur from statutory services whom she contends subject people to a lack of respect, privacy and individual choice which for her also constitutes marginalisation. Statutory services such as mental health and social services are present to provide support for Black men, they can facilitate access to a number of important resources such as suitable housing, appropriate benefits and community-based activities to help benefit their mental health and well-being and reintegration back into the community (Independent Mental Health Taskforce 2016). These mental health and social care practitioners have power over Black men, they access resources which are important to them which they may rely on. However, Young (1990:54) contends that having a reliance on statutory services should not result in receiving support that is oppressive. In this analysis Young (1990) has merit, often people with mental ill-health can receive punitive practices if they make an error (Snoussi and Mompelat (2018) have interactions with practitioners who are patronising, stigmatising and pessimistic about their circumstances (Independent Mental Health Taskforce 2016, Thornicroft 2006). Practitioners can construct from their perspective what they perceive they need (Mullaly 2002) instructing them on how to live their lives rather than seeing that they have strengths, resources and can make decisions and have a voice in their own lives (Repper and Perkins 2003, Slade 2009).

Without realising they can perpetuate the superior/ inferior dynamic which can increase feelings of low morale and indignity (Mullaly 2002, Snoussi and Mommpelat 2018).

1.3.5 Violence

Violence is a form of oppression (Cudd 2006: 86) often targeted at those perceived as the 'other' to ensure dominance and to keep them in their place (Culley 2006). Young (1990) gives a broad analysis of violence as the action taken to intentionally harm a person or group with physical force (Zutlevics 2002). Violence also includes harassment, intimidation to degrade others (Mullaly 2002; Ruth 1988). Violence is used to exploit people socially and economically, disadvantaging them by destroying their goods, or by keeping them from pursuing opportunities for self-development and prosperity (Cudd 2006, Gill 2002).

Young (1990) accepts that all of these forms of violence outlined are an injustice, in her analysis she focuses on systemic violence that people experience because of being a member of a social group, that stems from fear, hatred and unconscious aversions. In addition, she explores the social context that causes violence to be enacted, repeated and embedded in institutions as the perpetrators do not receive proper punishment and are not surprised by what has occurred. Young (1990) refers to this as a 'social practice'. Yancy and Davidson (2016) appears to support Young (1990) he refers to the historical and present aversion and fear the White dominant culture has towards Black men, that has created a distortion of Black men and pathologised them; making connections to their pathologisation and the violence that has become embedded as part of Black men's lives. In tandem with this is how institutions and the public can become desensitised to the violence and struggles of Black men or explain the violence they incur as something else which can also contribute to the social practice of violence that we see (Medina 2019). For Young (1990) cultural imperialism and violence can occur together. When thinking about Black men violence also interrelates with powerlessness, exploitation and marginalisation, it is not possible to look at violence independently (Medina 2019). Violence is an obvious and visible form of oppression, which is an impactful way to reinforce Black men's powerlessness in society and ensure domination (Milton 2016).

At present, it is in the forefront of our minds when thinking about Black men due to their continued subjugation at the hand of the criminal justice system, which supports Young's (1990) notion of violence being a social practice. The violence experienced by Black men revealed throughout this chapter hurts them physically, economically, socially, politically and psychologically (Feagin 2006, Glynn 2014).

1.4 Microaggression

The aim of the final two sections of this chapter is to move beyond the forms of oppression identified by Young (1990) and put forward a conceptualisation that enhances our understanding of oppression and how it affects the lives of Black men. Microaggression is a concept that can help in capturing an additional way in which Black men's experience oppression. The UK is a very different place today compared to the 1960s, where signs requesting 'No Blacks, No dogs, No Irish' were commonplace and sentiments such as 'Keep Britain White' were explicit and overt (EHRC 2016). Today, these notices are long gone and there is a political commitment enshrined in legislation and policies to equality and fair treatment (Equality Act 2010, EHRC 2016, Joint Committee of Human Rights 2020). However, the chapter thus far has shown that oppression has not disappeared and how it continues to affect Black men, manifesting in open as well as subtle, unconscious but devastating ways. Young (1990) suggests that unconscious actions and reactions can reproduce privilege and oppression. Although she suggests that this calls for attention, she does not include this as part of her exploration of cultural imperialism or sufficiently explore how it is experienced. However, microaggression can help us to illuminate the dynamics of this aspect of oppression and how it can impact Black men's lives (Profit, Mino, and Pierce 2000, Smith et al. 2016, Smith, Hung and Franklin 2011).

Pierce coined the term 'microaggressions' in 1970 and Gerald Sue and colleagues developed the concept (Sue et al. 2007). Microaggressions encompasses verbal and non-verbal communication that often passes under the social radar, such as glances given or omitted, the tone of voice used, the jokes told, the interruption of someone's sentence and the turning away when someone approaches (Profit, Mino, and Pierce 2000, Sue 2010). Although the communication appears to vary on the level of awareness and intentionality by the perpetrator, the defining feature is that it

communicates an offensive message that creates a constant reminder to people of their racialised status (Sue et al. 2007, Sue 2010). Smith et al. (2016: 1200) gives an example of how this might occur during a simple everyday activity for a Black male student at a U.S college:

> You kind of get those looks and stares from students and staff like, 'Why are you in this building?' Basically, because it is for students who are [White] and not knowing that I am a student who is actually in the College, they assume that I'm lost or they assume that I'm not supposed to be in there.

Microaggression is multi-layered in nature so can be insidious and have a negative impact. Sue et al. (2007) offer a useful framework for identifying and exploring how they manifest in three ways: micro-assault, micro-insult and micro-invalidation. Micro-assault forms the blatant racially derogatory verbal and non-verbal behaviour that people can experience; characterised by name-calling, avoidance and discriminatory behaviour. Micro-insult is verbal and non-verbal behaviour that is impolite, insensitive and demeans racial heritage or identity. Micro-invalidation is characterised by communication that excludes and discounts thoughts, feelings or the social realities of racialised experiences. Sue et al. (2007) propose that the interpersonal dynamics of micro-insult and micro-invalidation are more subtle than micro-assault, which may suggest that they are minor and less detrimental. This does not appear to be the case, and micro-insult and micro-invalidation are more stressful to contend with (Smith et al. 2016; Smith, Hung and Franklin 2011).

There are defining features of microaggression that are relevant in gaining an insight into its function and the consequent challenges faced by Black men. Micro-invalidation and micro-assault are perpetrated by well-meaning individuals who have genuine respect, with no malice towards others; whose behaviour and comments are therefore outside of their own awareness (Young 1990). However, for those on the receipt of microaggression there is a visibility and awareness as shown in the example above. Sue (2010) suggests that it is common to have a heightened consciousness, sensing that something is wrong, but unable to locate it exactly. Therefore, Black men may question their reality, finding they are unable to check their perceptions against others. Often, they are silently suppressing their emotions and frustrations (Derthick and David 2014). Silence occurs because speaking up and challenging microaggression can be stressful and not without risks.

Black men are accused of overreacting and misconceiving the situation, as the perpetrator denies wrongdoing, becoming defensive and dismayed at the suggestion of racial bias and prejudice (Lentin 2020). This is a significant aspect of microaggression as attention shifts from the perpetrator towards the Black man (Harvey 1999), who faces disapproval, their experience nullified and silenced. The practice of denial and invalidity can lead Black men to periods of self-doubt and denying their own experiences (Derthick and David 2014; Young 1990). It also leads to a simple acceptance that these racialised encounters are part of their everyday lives (Brooms and Perry 2016). Lillenfield (2017) and Haslam (2017) have contested microaggression; they express concern that is has become a taken for granted experience used in educational and training programmes without adequate research to support it. They suggest that as a concept it requires more development and research about how it is defined, how to assess microaggression has occurred and its impact on the recipient. In addition, they suggest that microaggression does not appear to accept the ambiguous nature of social interactions which can contribute to racial tensions and accusatory environments (Haslam 2017). This analysis brings to attention the real-life challenges that Black people face being heard and validated; being placed in positions where they lack power or credibility to define their own experiences (Lentin 2020). Despite these criticisms there are many that are exploring microaggression as a significant aspect of Black men's racialised experiences (Huber and Solorzano 2014, Smith, Hung and Franklin 2011, Smith et al. 2016) providing the examination and analysis critics such as Lillenfield (2017) and Haslam (2017) are requesting. Using microaggression as a tool to reveal Black men's experiences and illuminating their voice. They suggest that instead of focusing on their life goals and aspirations, Black men find themselves having to use their time and emotional energy in deciphering and coping with racially insensitive and demeaning encounters (Brooms and Perry 2016, Feagin 2006, Huber and Solorzano 2014, Smith, Hung and Franklin 2011, Smith et al. 2016). There are concerns that this comes at a cost and microaggressions may have a cumulative effect leading to what Smith, Danley and Allen (2007) refers to as 'racial battle fatigue'; a physical and psychological response underlined by frustration, disappointment, alienation, anger, anxiety, helplessness, hopelessness and fear (Huber and Solorzano 2014, Smith, Danley and Allen 2007, Smith, Hung and Franklin 2011).

They challenge the notion that Black men's experiences are 'micro', which can potentially minimise how the impact is perceived (Huber and Solorzano 2014).

1.5 Intersectionality

The closing section of this chapter focuses briefly on the concept of intersectionality, to gain further insight into the complexity of oppression and its relevance when thinking about the lives of Black men. Intersectionality is a term coined by Black feminists such as Collins (1990) and Lorde (1984) and later coined by critical race theorist Kimblere Crenshaw (Crenshaw 1989). They offered a different and insightful perspective that encouraged us to consider the interconnections of oppression. The central argument of intersectionality is that differences such as gender, race, sexuality and disability have a multiplying effect: they interlock, influencing and shaping identity and experience, rather than the separate categories of difference (Crenshaw 1989; Collins 1990; Lorde 1984). They reject separate approaches to oppression, suggesting a non-hierarchical structure where no one type of oppression is more important than the other. In contrast, Young's (1990) examination of oppression is less sophisticated; she acknowledges the heterogeneity of groups that can result in what she referred to as multiple aspects of identification; she does not develop and explore the implications of the multiplicity of people's identities and the multiple systems of power to help us understand how it impacts their lives. Intersectionality appears important and relevant when exploring Black men experiencing mental ill-health and oppression, where they can define their own reality and rightly avoid being defined to fit neatly into different groups or categories and where we can appreciate the interlocking nature of oppression. Gilbert et al. (2016), Glynn (2014) and more recently Brown and Grant (2018) have engaged with an intersectional framework to show the multiple systems of power and complexity that Black men encounter in healthcare and in the criminal justice system respectively. Curry (2017) and Oluwayani (2020) contest this, they contend that using an intersectional framework is unsuitable as it assumes that Black men are advantaged by their gender and therefore neglects to fully acknowledge their vulnerabilities and disadvantages they face because they are men. This analysis is unfounded as intersectionality has no intention to privilege or negate any social difference (Collins and Blige 2016, Carbado 2013). It is important that any exploration of Black men's experience acknowledge all aspects of their lives.

Conclusion

This chapter initially provided a synopsis of the social, economic, political and cultural position of Black men, revealing the oppressive reality in their daily lives that is comprised of racialised experiences, exclusion and disparities in education, employment, criminal justice system and mental health services. Instead of having social equality and equal opportunities Black men co-exist with institutional and structural oppression in their daily lives. The multi-faceted nature of oppression enables us to understand why oppression is so pervasive for Black men affecting their sense of self and their mental health and wellbeing. In the second part of the chapter Young's (1990) forms of oppression: cultural imperialism, powerlessness, exploitation, marginalisation and violence was introduced and proposed as an appropriate tool to capture and illuminate the nature of oppression and how it is experienced for Black men. Young (1990) provides concepts that can shape and illuminate our understanding of the complex and interconnected nature of oppression (Clifford 2013, Medina 2019, Milton 2016). To her credit the forms of oppression remain relevant today, however, we can also see that as time moves on, so do concepts and theories; they too progress and develop (Carbado 2013, Curry 2017). The forms of oppression are not single entities as Young (1990) suggest they are interconnected, manifesting in all aspects of Black men's lives in complex ways (Medina 2019). Significant aspects of oppression are not considered or developed by Young (1990), such as internalised oppression (internalised cultural imperialism), microaggression and intersectionality which are examples of the progression of theories and concepts. There seems to be little room in the forms of oppression for exploring resistance and empowerment and how they are interconnected with oppressive experiences (Allen 2008, Collins 2009). So, Young's (1990) forms of oppression model, despite its strengths is insufficient in its current arrangement and needs updating to capture Black men's oppressive experiences. Chapter 2 continues to examine the lives of Black men; a qualitative literature review will critically consider their understanding and experiences of mental health.

Chapter 2: A Qualitative Literature Review of Black Males Understanding and Experiences of Mental Health

We go through a lot of struggles right now that people don't even know about (Lindsey and Marcell 2012: 358)

2.1 Introduction

In chapter 1, I drew attention to a range of social, economic and cultural disparities that Black men encounter in their lives from the institutions they come into contact with and how racism, exclusion and discriminatory processes have a negative impact, not only on their trajectory and goals in life, but also on their health and well-being. I also introduced and proposed Young's (1990) forms of oppression: cultural imperialism, powerlessness, exploitation, marginalisation and violence as a tool to illuminate the divergent ways Black men experience oppression. In addition to considering Young's (1990) forms of oppression, attention was given to microaggression and intersectionality which although outside of Young (1990) framework provide a way to further explore the complexity of oppression and enhance our understanding of the multiple ways that oppression impacts the lives of Black men. In continuing to explore Black men's lives this chapter turns its attention to their mental health which is a central aspect of this study.

The introduction to this study and chapter 1 outlined a number of disparities and concerning scenarios regarding Black men's experience and outcomes in relation to their mental health. The premise of this chapter is to review the qualitative empirical studies that have investigated Black males understanding and experiences of mental health. To date, the literature on Black men has been dominated by quantitative study and professional analysis that focuses on the prevalence of their mental ill-health and the disparities that exist in mental health services (Fernando 2010, Keating 2007, Mckenzie and Bhui 2007, McKeown and Stowell-Smith 2001, McKeown et al. 2008, McKenzie et al. 2001, Sharpley et al. 2001, Watkins, Walker and Griffith 2010). In addition, where there have been studies with Black men examining their mental health there has been a tendency for Black men to be in samples with individuals from BAME background (Bowl 2007, Memon et al. 2016,

Weich et al. 2012), BAME men (Robinson, Keating and Robertson 2011) or included in samples with Black women (Armour, Bradshaw and Roseborough 2009, Edge, Salla and Dansa 2018, Mclean, Campbell and Cornish 2003, Rabie and Smith 2007, Secker and Harding 2002). These studies are of value and bring attention to the shared commonality that Black men have with BAME and with Black women, however, it has culminated in the silence and invisibility of Black men's voices in the mental health literature (Keating 2007, Watkins, Hawkins and Mitchell 2014, Watkins 2019). In contrast, this study has an explicit focus on Black men and their experiences of mental health therefore, this chapter provides a review of literature with this focus. By having a focus on Black men and their perspective the qualitative literature review can examine the current knowledge base, highlighting the gaps and strengths. This is also a requirement for researches using IPA (Smith, Flowers and Larkin 2009). This qualitative literature review attempts to ensure a rigorous approach to reviewing the qualitative research evidence (Ham-Baloyi and Jordon 2016). To go beyond the findings of the original research studies to develop new insights and a deeper understanding of the subject matter (Bearman and Dawson 2013, France et al. 2019, Bettany-Saltikov and McSherry 2016). It is with these motives in mind that a qualitative literature review was conducted, to capture new and valuable insights from the qualitative research that centres on Black males understanding, their experience of mental health and their voices.

An essential step in conducting a literature review is to ensure that there is a clear focused question; this question is vital as it guides key aspects of the methodology such as the search strategy, selecting suitable research papers and the synthesis of the results (Evans and Pearson 2001, Bettany-Saltikov and McSherry 2016). The question is also key as it builds and connects mental health to the previous chapter's focus on Black men's oppression. The qualitative literature review aimed to answer the following question:

What are Black males understanding and experiences of mental health?

2.2 Methodology

The methodology taken to undertake this qualitative literature review includes the search strategy, selecting suitable research papers and the synthesis of the results (Evans and Pearson 2001, Bettany-Saltikov and McSherry 2016).

2.2.1 Search Strategy

To search for suitable papers the Population, Experience, Outcome (PEO) framework is widely embraced in nursing and health research (Bettany-Saltikov and McSherry 2016: 24). Alternatives such as PICO (Population, Intervention/Issue, Comparison, Outcome) and SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research) were also considered. It is widely accepted that PICO is more suited for quantitative based research questions (Bettany-Saltikov and McSherry 2016; Cooke, Smith and Booth 2012). SPIDER has been suggested as an alternative to PICO when searching for qualitative research, however, Methli et al. (2014) and Cooke, Smith and Booth (2012) propose that it may not be as comprehensive as it can miss potentially relevant studies. The PEO framework is well suited to qualitative research questions (Bettany-Saltikov and McSherry 2016: 24), it has value in identifying key aspects of the research question, aiding the design of the inclusion and exclusion criteria of the search strategy and for identifying the key concepts/terms required for the search strategy.

See Table 1. for the PEO framework for the qualitative literature review question.

Table 1. PEO Framework for the qualitative literature review question

Population	Experience	Outcome
Black males	Mental health	Understanding and Experiences

To ensure that only relevant studies were included in the qualitative literature review there needed to be a clear documented inclusion and exclusion criteria that would answer the review question and not my personal interests as the researcher which

would introduce bias (Butler and Copnell 2016, Bettany-Saltikov and McSherry 2016, Centre for Reviews and Dissemination (CRD) 2009). The inclusion criteria specified that all research papers had to include Black males only. Having a focus solely on Black males meant that any papers that contained a sample of males from BAME backgrounds and papers that had samples that contained Black males and Black women were excluded to ensure a sole focus on Black males but also because of the challenges of extrapolating the findings that related to Black males only. (See Table 2. for the inclusion and exclusion criteria of the search strategy using the PEO framework).

Table 2. The inclusion and exclusion criteria of the search strategy using the PEO framework.

Population	Inclusion	Exclusion
Black African and Black Caribbean Males	Males who are of Black African and Black Caribbean origin Black males 14 years old and over	Men who are not of Black African and Black Caribbean origin All females Black males under 14 years old
Experience	Mental Illness Psychological distress Mental Health Services	Physical Health Difficulties Physical Health Services
Outcome	Perceptions, understanding and experiences	Clinical staff perceptions and experience Family and carers perceptions and experiences
Type of studies	Qualitative research studies	Quantitative research studies Mixed method research studies Theoretical papers Commentary papers Discussion papers Literature reviews

The academic databases: Academic Search Complete, CINAHL, Medline, PsychInfo and SCOPUS was used to perform a comprehensive search of the literature in January-May 2019. These databases gave access to peer-reviewed academic journals that included medicine, nursing, mental health, psychology, behavioural science and social sciences. Both keyword searches and Medical Subject Headings (MeSH) were used to capitalise on finding as many relevant research studies as possible. The search strategy using the PEO framework is shown in Table 3. A search was also conducted of the grey literature where online charity websites such as the Kings Fund, Race Equality Foundation, Mind, Social Care online and Mental Health Foundation were searched to strengthen the range of research studies included in the review that might not be accessible in academic databases (Butler and Copnell 2016, Bettany-Saltikov and McSherry 2016, (CRD 2009). The results of the database search can be found in Table 4.

Table 3. Search strategy using the PEO Framework

Population AND	Experience AND	Outcome
1.African American 2.African 3.Afro-Caribbean 4.Black 5.Blacks 6.Caribbean 7.Combine 1-6 using 'OR' 8.Male 9.Males 10.Man 12.Men 13. Combine 8-12 using 'OR' 14.Female 15.Woman	19.Affective disorder 20.Anxiety 21.Depression 22.Mental Disorder 23.Mental Health 24.Mental Health services 25.Mental* 26.Neurotic disorder 27.Paranoid disorder 28.Personality disorder 29.Psychiatric* 30.Psycho* 31. Schizophrenia	33.Attitude 34.Attitude to health 35.MH-Attitude to mental illness 36.Help-seeking behaviour 37.Patient AND (attitude or experience or awareness or understanding or perspective, satisfaction, perception) 38.MH-Patient attitudes 39. Combine 33-38 using 'OR'

16.Women 17. Combine 14-16 using 'OR' 18. Combine 7 AND 13 NOT 17	32. Combine 19-31 using 'OR'	

The last step of the search strategy is to combine steps 18+32 +39 using the term 'AND'

Table 4. Database search and results

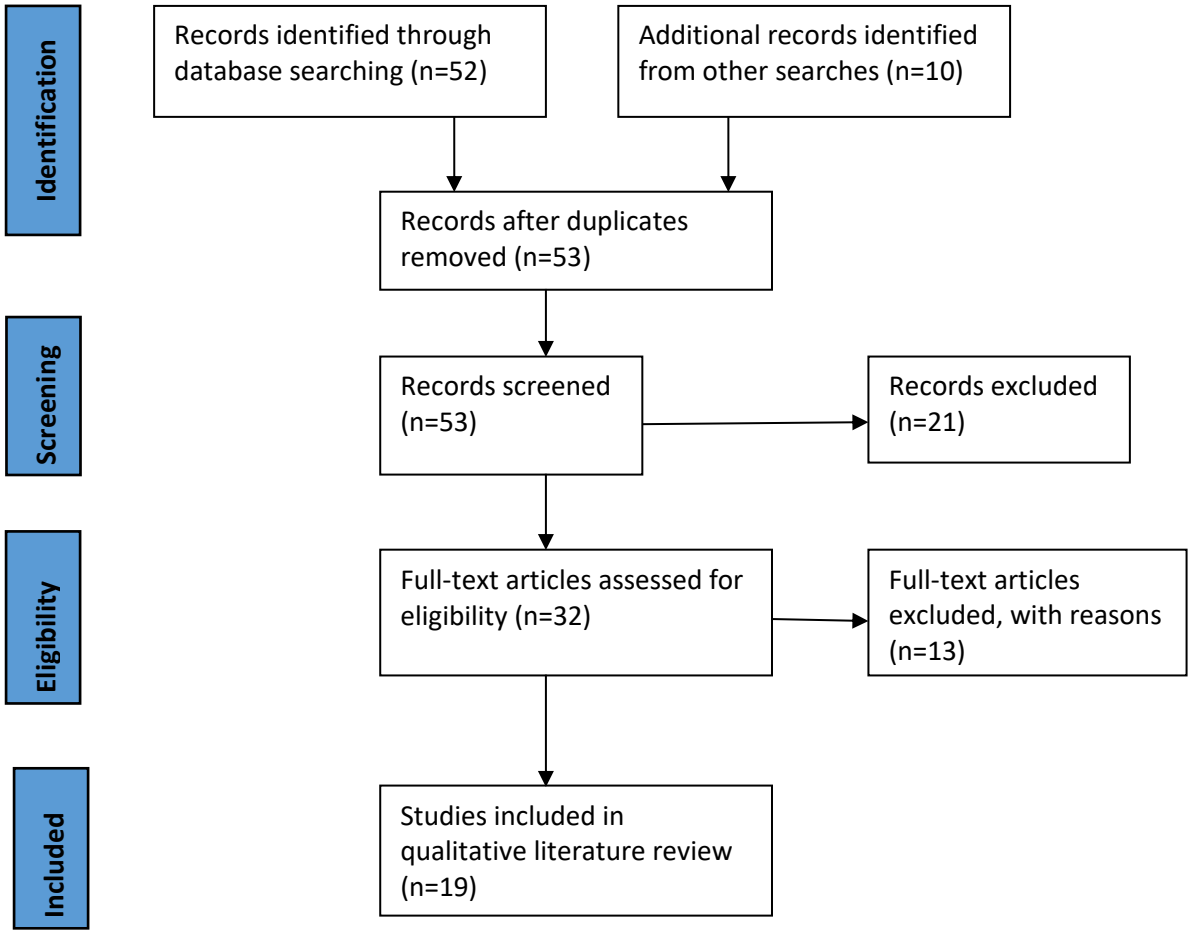
Database	Number of hits retrieved from the search	Number of articles discarded because of irrelevant titles	Number of articles to be retrieved by title and abstract
Academic Search Complete	203	199	4
CINAHL	117	103	14
MEDLINE	205	197	8
PsychINFO	278	272	6
ASSIA	852	738	15
Nursing & Allied Health	632	628	5

The process undertaken to select suitable research studies for the literature review occurred through a number of distinct stages to ensure the review was conducted in a systematic way (Aveyard 2019, Butler and Copnell 2016).

Initially all studies were screened for suitability via their title and abstract (Bettany-Saltikov and McSherry 2016, Joanna Briggs Institute 2014). If the title and abstract was deemed to address the inclusion and exclusion criteria of Black males

understanding and experiences of mental health then the full text study was retrieved. Any study that did not fit the inclusion and exclusion criteria was discarded. Where there was uncertainty about a research study a discussion was held with a member of the supervisory team or the full text study was retrieved to ensure that suitable research studies were not unnecessarily discarded and thus affecting the quality of the literature review. Studies retrieved for full text review were further scrutinised to ensure they addressed the inclusion and exclusion criteria outlined in Table 2. Once this was confirmed, the reference lists of all suitable studies were hand searched to identify further relevant studies that could also contribute to the review, this process continued until all studies were retrieved (CRD 2009, Joanna Briggs Institute 2014, Bettany-Saltikov 2012). See Figure 2. for the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram to show transparency of the search results and stages taken to reach the final number of research studies.

Figure 2. PRISMA flow diagram



2.2.2. Characteristics of the studies

In total, nineteen studies were found that directly examined Black males understanding and experiences of mental health. Fourteen of these studies were conducted in the USA; four in the UK. The majority of the studies (11) used a descriptive qualitative approach that analysed the data using thematic analysis. The remaining studies (8) used specific qualitative methods such as phenomenology, hermeneutic phenomenology, IPA, discourse analysis, grounded theory and ethnography. Nine of the studies were from community non-mental health populations to explore their understanding and perception of mental health, stigma and help-seeking behaviour. Nine studies specifically included Black males that had or were experiencing mental ill-health to explore their first-hand accounts and lived experiences. The age of the participants ranged from 14 years to 75 years old. The sample sizes of the studies also varied from the small sample sizes associated with qualitative study such as seven Black males in Wagstaff et al. (2016) and four Black males in Thomas (2016) to larger samples of fifty-four in (Samuel 2014) and seventy-eight in Dada et al. (2017). A total of 422 Black males were included in the literature review (See Appendix 1 for a summary of the final research studies included in the qualitative literature review).

2.2.3 Appraisal of the studies

The final studies included in the qualitative literature review were individually appraised for their methodological rigor prior to the data extraction and synthesis (Godfrey and Harrison 2015). Quality appraisal is a contentious issue among qualitative researchers who continue to debate the value and appropriateness of appraising qualitative research (Morse 2015). Despite the debate and lack of consensus regarding the best method for undertaking quality appraisal of qualitative research it does have some important and significant benefits when conducting a literature review (Bettany-Saltikov and McSherry 2016). It has been suggested that quality appraisal can help to explain differences in the findings of studies; the process undertaken when appraising qualitative research can also stimulate discussion and learning about issues that might compromise or benefit the findings as well as the research process as a whole (Bettany-Saltikov and McSherry 2016, Manjid and Vanstone 2018).

For me, appraising the quality of the research studies was of particular value for gaining critical insights into the methods used and observing the consideration the researchers took in conducting their research with Black males. To appraise the final research studies the Critical Appraisal Skills Programme (CASP) appraisal tool for qualitative research was used. It is one of the most recommended and commonly used research appraisal tools used in literature reviews commended for its user-friendliness and inclusion of clear supporting guidance. (Bettany-Saltikov and McSherry 2016, Hannes, Lockwood and Pearson 2010, Manjid and Vanstone 2018). (See Appendix 2 for a summary of the appraisal of the research studies using the CASP tool for qualitative research).

All of the papers differed in relation to the rigour they executed in their approach to exploring Black men's understanding and experiences of mental ill-health. They appeared to use appropriate recruitment strategies to contact their target population of Black males such as distributing flyers, sending emails and letters. For studies that focused on Black males experiences of mental ill-health, inpatient and community mental health services were contacted. In these studies, purposeful sampling was used to ensure the desired characteristics were included. For studies that were concerned with Black males perceptions and understanding of mental ill-health various local community organisations were contacted using convenience and snowballing sampling. Although convenience and snowballing sampling is popular way to recruit and has its benefits (Mason 2012) it may have limited these studies by not having a variety of Black male voices being heard and favouring those Black males who were more socially connected (Auerswald, Piatt and Mirzazadeh 2017).

In relation to adhering to sound ethical principles when conducting research, it was found that many of the studies provided basic and minimal information regarding the actions they took to ensure the study was managed in an ethical manner. Leading to a lack of emphasis on the importance of gaining ethical approval and ensuring informed consent was secured. Thomas (2016) made no reference to ethical issues, Dada et al. (2017) and Anderson (2014) made no reference to receiving ethical approval for their studies. In contrast Myrie and Gannon (2013) and Ward and Besson (2012) provided comprehensive information which included ensuring anonymity and providing a debrief following data collection and the provision of mental health support information.

Lindsey et al. (2006), Lindsey, Joe and Nebbitt (2010) and Samuel (2015) included young people and adolescents under the age of eighteen in their respective studies. They ensured parental consent was sought, as well as consent of the young people; however, they made no reference to any additional ethical issues that might have been required in Black young males being research participants. Although gaining parental consent is sometimes a compulsory measure to secure ethical approval from research committees when undertaking sensitive topics with young people it can also be quite contentious and perceived as undermining young people's autonomy and privacy (Goredema-Braid 2010). Dada et al. (2017) also included Black male adolescents in their study; their data were collected by peer researchers where members of the research population become researchers. This was one of the largest studies in the review where twenty-six Black male peer researchers were trained and supported to facilitate focus groups and individual interviews with seventy-eight young Black males aged 14-24 years old. The inclusion of peer researchers has the benefit in being able to reduce power differentials between the participants and researchers and therefore yield deeper insights and rich data (Lushey and Munro 2014). This study was further enhanced by the peer researchers being involved in the data analysis and dissemination of the research findings demonstrating an inclusive open approach.

The preferred method of data collection across the studies was individual face to face interviews, which is not uncommon in qualitative research studies as it is a direct approach that generates rich data about individuals' experiences (Barrett and Twycross 2018). Six studies opted to use focus groups as the main method of data collection which has the benefit of generating multiple perspectives and accessing cultural norms at the same time (Green and Thorogood 2011, Barrett and Twycross 2018). Focus groups also come with a caution as they can also impede participants from being open about sensitive matters such as mental ill-health thus affecting the quality of the findings (Acocella 2012). Thomas (2016), Kendrick, Anderson and Moore (2007) and Hudson et al. (2016) all used focus groups as the main method of data collection in their studies. These studies all highlighted that the Black males commented on the benefits of the focus group and having the opportunity to openly discuss mental health together. This is despite the stigma associated with mental ill-health (Alvidrez, Snowden and Kaiser 2008, Watkins 2014) giving an indicator that

safety and vulnerability was adequately managed in these focus groups to enable this openness to occur. Dada et al. (2017), Thomas (2016) and Kendrick, Anderson and Moore (2007) used triangulation in their respective studies, including both individual interviews and focus groups for their study. This may have had the benefit of enabling extra insights to be explored, adding an additional level of credibility to their studies (Heale and Forbes 2013).

An essential aspect of qualitative research is the recognition that the researcher is part of the research process and that the research is not neutral (Green and Thorogood 2011). Although this is an important aspect of qualitative research, eight studies did not provide any information regarding this. In Wagstaff et al. (2016) and Hack et al. (2017), the data was collected by a White male researcher and a White female researcher respectively; they both articulated a recognition and examination of how this may have affected the interview process and possibly impacted the openness of the Black males. Wagstaff et al. (2016) opted to organise follow-up interviews with six of the seven Black men he interviewed which may have assisted in developing rapport, openness and improve the credibility of the study. Following-up for a second interview can be time-consuming, but also can be a good strategy for gaining clarity and checking salient issues (Green and Thorogood 2011, Mason 2014). Hudson et al. (2018), Ward and Besson (2012) Perkins, Kelly and Lasiter (2014) and Ezeobele, Ekwemalor and Ogunbor (2018) all had what is referred to as 'insider status' in their study where they shared or had similar cultural and/or linguistic characteristics or experiences with Black males. It is considered that the 'insider' status of these researchers may have had advantages in gaining access and trust in the data collection process, it can also give rise to introducing bias in their approach and result in a lack of deep probing (Dwyer and Buckle 2009, McGee 2009). Bryant-Bedell and Waite (2010) Ward and Besson (2012) made efforts to use the recommended reflexive approach to qualitative research by exploring their assumptions and biases prior to the data collection and data analysis, attempting to bracket their feelings to minimise negatively affecting the research process as much as possible (Tufford and Newman 2010).

Overall, the studies provided a variety of detail in how the data analysis process was undertaken. Maynard (2007), Myrie and Gannon (2013) Dada et al. (2017) provided minimal information.

Nine studies were enhanced by having research teams that analysed the transcripts and generated the codes independently before collectively agreeing the final themes to gain inter-coder agreement improving the quality of their respective studies (Morse 2015). Hack et al. (2018) and Wagstaff et al. (2016) coded and analysed the data independently, receiving debriefing and discussion with a more experienced researcher and discussion with service user reviewers. This can be a valuable way to reduce bias, enhance the data analysis and interpretation (Sweeny et al. 2012). Ezeobele, Ekwemalor and Ogunbor (2018) had validation interviews with half of the sample to check for accuracy. Myrie and Gannon (2013) Ward and Besson (2012) and Watkins and Neighbour (2007) all used different forms of participant verification such as reviewing the final report, ensuring at least one participant in each focus group verified the transcripts to improve the dependability of their studies (Morse 2015). Although all studies provided data to support their findings the quality of how it was presented was variable; most of the studies were enhanced by providing rich data from the participants to support their findings and interpretation (Joanna Briggs Institute 2014). Ezeobele, Ekwemalor and Ogunbor (2018), Lindsey, Joe and Nebitt (2010) provided a small range of data to support their findings; Myrie and Gannon (2013) and Ward and Besson (2012) would have been enhanced if they had shown more of a range of participants to support their findings to increase the credibility of their studies.

2.2.4 Limitations of the Qualitative Literature Review

When undertaking a qualitative literature review, it is recommended that there is more than one reviewer, to aid in reducing bias and ensure consistency (Aveyard 2019, France et al. 2019). To mitigate this support was sought from the supervisory team regarding decisions related to the search strategy, data extraction and the synthesis of research papers. I acknowledge that the literature review may have been enhanced by having at least one additional reviewer to enhance all stages, particularly as this was the first time conducting a qualitative literature review in a systemised way. Some of the studies included had lacked depth in their reporting of their findings making it more challenging to provide further interpretation and providing the conceptual insight required, which may have affected the quality of the synthesis (Bettany-Saltikov and McSherry 2016, Cherry et al. 2017, France et al. 2019).

The inclusion of three studies which focused on young Black males could also be viewed as a limitation of the review as it could be argued that young Black males are at a different development point in their life, have different social and emotional needs which require them to be considered separately from Black adult male views and perspectives (Watkins, Hawkins and Mitchell 2014). This argument has value, however, these studies also included adult Black males in the sample, I did not want to omit their inclusion because young Black males were also present. Mixed method studies were not considered in the literature review, this could also be considered a limitation as the qualitative data from these studies could have made a significant contribution to the review. Although useful, the inclusion of mixed methods studies is not an essential requirement in a qualitative literature review (Bettany-Saltikov and McSherry 2016, Cooke, Smith and Booth 2012).

2.3 Data Extraction and Synthesis of Qualitative Studies

The method of data extraction and synthesis used was based on guidance for conducting a meta-ethnography by France et al. (2019) and Britten et al. (2002). Meta-ethnography was one of the first methods of synthesising qualitative research and is recommended for understanding health related behaviours, experiences and responses to illness; this made it an appropriate method to answer the literature review question (Cherry et al. 2017). The synthesis was also based on guidance on thematic analysis by Vaismoradi et al. (2016). Firstly, each study was read individually; notes were made of the concepts, themes and significant ideas that were in the findings that could answer the review question. Particular attention was given to the men's voice and the interpretations of the original authors which was recorded for each study (Britten et al. 2002, France et al. 2019). In the second stage the concepts, themes and significant ideas (which will now be referred to as codes) from each study were compared to each other. Any reoccurring codes were clustered together to create a named theme which represented the essence of the men's experience or understanding (Vaismoradi et al. 2016). Further time was spent ensuring there was a clear relationship between the code and the themes. In the third stage, the themes were compared to each other; some of the themes were relabelled and organised into themes and subthemes.

The subthemes were important as they represented a specific central aspect of the overall theme that was integral to the understanding and experiences of mental health (Vaismoradi et al. 2016:102). In the last stage there was a final scrutiny to ensure a coherent, organised framework of themes and subthemes that would answer the literature review question (Britten et al. 2002, France et al. 2019).

2.4 Findings of the qualitative synthesis

An important stage of any qualitative literature review is the synthesis of the data. The synthesis ensures that the literature review question is answered and aims to present a comprehensive understanding of a phenomenon (Britten et al. 2002, Cherry et al. 2017, France et al. 2019). The qualitative literature review aimed to answer the following question:

What are Black males understanding and experiences of mental health?

The resultant synthesis has been organised around three overarching themes:

Theme 1. Beliefs about mental ill-health.

Theme 2. Coping with mental ill-health

Theme 3. The influence of masculinity.

(See Table 5. for the themes and subthemes of the qualitative synthesis).

Table 5. Themes and subthemes of the qualitative synthesis

Theme 1: Beliefs about mental ill-health	Theme 2: Coping with mental ill-health	Theme 3: The influence of masculinity
Subtheme1: Lay/conventional beliefs about mental ill-health	Subtheme1: Conventional coping strategies and help-seeking Social support	Being strong and in control Self-medication
Subtheme 2: Cultural beliefs about mental ill-health	Subtheme 2: Cultural coping and help-seeking: Spirituality Cultural Mistrust	

Although written as three distinct themes the themes are closely interrelated; they present a complex framework that show how everyday lay/conventional perspectives of mental ill-health, culture and gender intersects to reveal Black male's understanding and experiences of mental ill-health.

Theme 1: Beliefs about Mental Ill-Health

Thirteen studies revealed the range of beliefs Black males had about mental ill-health. These beliefs were influenced by a range of factors such as their own personal experiences, observation of others and the media portrayal of people with mental ill-health. This theme captures how they held both everyday conventional beliefs about mental health whilst also holding culturally specific definitions and beliefs about mental health. The theme also reveals their perception of individuals with mental ill-health. To explore the different aspects of beliefs fully, the theme has been organised into two sub-themes: Lay/conventional beliefs of mental ill-health and Cultural beliefs of mental ill-health.

1.1 Lay/conventional beliefs of mental ill-health: 'It's a sickness'

Six studies highlighted that understanding of mental ill-health appeared to be aligned to common beliefs typically held by the general public. In these studies, the Black males shared their own definitions of depression, their beliefs about what might cause mental ill-health and the potential consequences for the individual. These initial examples relate to their definitions of depression, they show the various levels of beliefs that existed from being a disease that required medical assistance, to having a lack of control in life and requiring help, support and understanding.

> *'It's a sickness, it's something a person can't help, it sometimes depends on how deep it is, it takes patience with those people...(they need) medicine and stuff (Ward and Besson 2014: 375)*
>
> *'Always feeling down and never being able to build yourself back up on your own' (Watkins and Neighbors 2007: 276)*
>
> *You feel like you have no control, bad things are happening to you and there's nothing you can do to change it (Kendrick, Anderson and Moore 2007: 70)*

There was variability in their awareness of the typical symptoms associated with depression; they also revealed their insight into the potential severity of depression.

> *When I think of depression I think of death, when you say the word depression...end result ...taking your life. Too depressed...they don't want to go on. Don't want to live. (Hudson et al. 2016: 131)*

> *I've been walking with him (his brother) going fishing and I've seen him on the bridge looking down and like really see the wheels turning in his head contemplating (Perkins, Kelly and Lasiter 2014: 169)*

Five studies highlighted common, negative, stigmatising beliefs about individuals with mental ill-health who were seen as a threat and to be kept at a distance.

> *You have to be careful around them, they are psycho... (Samuel 2015: 38)*

> *People are scared of them, because some people (who have mental ill-health) get easily angry and like out of nowhere they just flip... (Dada et al. 2017: 30)*

They also expressed what they believed to be the perceived consequences of developing mental ill-health. They continued to reveal stigmatising beliefs, expressing pessimistic views about how life is for someone who develops mental ill-health.

> *They can't have a normal life like me and you...never going to have a normal relationship, stuff like that (Ward and Besson 2012: 375)*

> *If you've ever been depressed...once you get over it...you still don't have the drive or the push that you used to have in your life (*Kendrick, Anderson and Moore 2007:70)

Various concerns were expressed about the challenges in gaining employment and the likelihood that individuals may not be able to fully recover from their mental ill-health and live independently.

Seven studies highlighted a wide range of common psycho-social and socio-economic stressors that can impact mental health. They disclosed their own personal stressors, suggesting that these factors had played an integral role in the development of their own mental ill-health.

> *Not having no money, no money, no place to live...no one to turn to, no place to stay for a long period I'm not talking a week or a month, I'm talking about a year... (Hack et al. 2017: 108).*

> *My family kind of imploded...it was very dysfunctional. Everybody except my mother drank or did drugs. My parents got divorced. So it was really crazy. My father was stressful (Bryant-Bedell and Waite 2010: 2053)*

When you don't have a job you get depressed (Maynard 2007: 37)

In studies where Black males had not experienced mental ill-health there was a variety of personal beliefs about the social circumstances that can impact people and cause them to develop mental ill-health.

> *There are things like losing family members, being sexually abused, things like that can lead to some issues with mental health (Ward and Besson 2014: 372)*
>
> *It's caused by domestic life and just how people get let down from loads of people (Dada et al. 2018: 27)*

1.2 Cultural beliefs about mental ill-health: 'Our depression is different'

In addition to the lay beliefs of mental ill-health outlined above eight studies revealed that Black males also held what has been called culturally specific beliefs about mental ill-health. This sub-theme reveals a number of cultural specific beliefs; these beliefs are significant as they appear to influence and shape their understanding of mental ill-health; these beliefs also impact them as individuals and their relationship with the Black community. Firstly, there appeared to be an underlying disbelief regarding the existence of depression/mental ill-health as expressed in the following extracts.

> *The Black community, their idea of mental health...there isn't really such a thing, it's just feelings... (Myrie and Gannon 2013: 18)*
>
> *Our culture (Nigerian) does not believe in the word depression or whatever you may call it...(Ezeobele, Ekwemalor and Ogunbor 2018: 43)*

Where there was an acknowledgement that depression/mental ill-health existed, their beliefs were framed in a number of distinct ways. These examples capture some of the common beliefs about mental ill-health and the Black community that were present in the studies.

> *Like you get all these labels in this country, ADHD, this and that, so depression is another word that's just thrown out there; that's the mentality that I think a lot of Black people have on depression, it's a White man's illness (Dada et al. 2017: 31)*
>
> *In all honesty, it really is a White people problem! Committing suicide, killing folks in large amounts. Black people are too strong to take their own lives. We face shit like that everyday...(Thomas 2016: 32)*

> *Its roots. The point of black culture is this: we're still here after everything, we've survived...Black people don't have that level of weakness (Watkins and Neighbors 2007: 278)*

By maintaining the belief that depression does not affect Black people and that Black people are innately 'strong' and 'resilient' because of their history and experiences of oppression presents a number of implications for individuals who do develop mental ill-health. The perception of people who fall outside of this framework is demonstrated in the following extracts.

> *We see the person with depressive symptoms as being weak, lazy or of poor judgement* (Ezeobele, Ekwemalor and Ogunbor 2018: 43)

> *People use mental health problems to cover up their weakness (Samuel 2015: 36)*

> *I get the grief from back home cause you know, I am bringing shame to the family and stuff like that (Maynard 2007: 36)*

In addition to the above beliefs, an additional culturally specific perspective also emerged from the studies that suggested that their experience of oppression and the racialised context of their lives outlined in chapter 1 also influenced and shaped their conceptualisation of mental ill-health/depression and how it manifests.

> *African American males think I can just chalk this up to being Black which all of us have done at some point in time (Kendrick, Anderson and Moore 2007: 70)*

They also reveal how being a Black male interfaces with their expression of mental ill-health and the importance of recognising their unique experiences.

> *Our depression is not the same as everybody else's depression. You don't have time to be sad, because you have too much to worry about, I guess that standard of depression is not the same standard of depression that a black man goes through (Watkins and Neighbors 2007: 276)*

> *For a White male, same age group, never been arrested, never been locked up, to study him and to study us and give us the same diagnosis is wrong. You can't do that...(Perkins, Kelly and Lasiter 2014: 171)*

The combination of these cultural beliefs create an extra layer of complexity and influential factors that affected Black males knowledge of mental ill-health and knowing when they might require assistance.

> *I didn't really understand what was going on. I just considered it bad days you know (Bryant-Bedell and Waite 2010: 2054)*

> *I'm sitting here describing to someone how I feel and the things that I'm going through. They're like, "Well you know you may be suffering from depression" I never thought of that (Kendrick, Anderson and Moore 2007: 70)*

> *Suicide in the Black community says 'you can't have those thoughts' but people don't understand how serious it is until its serious beyond repair (Thomas 2016: 33)*

Part of knowing when to seek help is about having open communication with others. Five studies highlighted that Black males do not talk frequently with each other about their own mental health however, when they do they revealed that they use their own cultural defined words and language to express their emotional world.

> *(I was) kind of depressed, kind of in a 'funk', couldn't get out of it (Bryant-Bedell and Waite 2010: 2054)*

> *Usually I'm like an active talkative person but then when I start becoming the 'anti-stuff' then they (family) know that something is wrong (Lindsey, Joe and Nebbitt 2010: 471)*

Other phrases such as being *'in a slum'* and feeling *'beat down'* were used to depict the powerless context of their emotional lives. Phrases such as *'holding it down'* and not being *'messed up'* were used to signify good mental health and that they were in control. By using cultural specific words and phrases they defined their feelings with words that they identify with and were acceptable to them, thus allowing them to connect with others and gain a shared understanding of their personal world without stigmatising themselves. It also ensures that their personal world is hidden and undetected from others outside of their social circle.

Theme 2: Coping with mental ill-health

Black male's beliefs about mental ill-health outlined in theme 1 has a direct influence on the way they coped with the emergence of mental health symptoms and their help-seeking behaviour. Ten studies revealed the different ways that they attempted to cope with mental ill-health, this included common responses and coping strategies others with mental ill-health use such as isolation, taking prescribed medication and social support. In addition, they also incorporated culturally specific coping strategies and help-seeking. Thus, to explore this theme fully it has been organised into two sub-themes: Conventional coping responses and help-seeking and Cultural coping strategies and help-seeking.

2.1 Conventional coping strategies and help-seeking: 'Smiling on the outside'

This sub-theme captures the range of coping strategies used when the Black males began to experience mental ill-health and the impact of their responses. In seven studies they first revealed what it was initially like to experience mental ill-health. The following extracts refer to changes in their behaviour, the physical and psychological symptoms they experienced.

> *I got very tense...and in here it just knots up...I call it in my gut. I get some headaches at times...that came from worry and thinking too much. Situations I can't change. (Bryant-Bedell and Waite 2010:2055)*
>
> *Fear, anger, real sad...sometimes I didn't want to get out of bed...it was a lot of pain (Perkins, Kelly and Lasiter 2014: 169)*
>
> *I feel like I can't put one foot in front of the other (Kendrick, Anderson and Moore 2007: 71)*

This participant referred to the challenges of experiencing psychotic symptoms.

> *Cause I can't distinguish the real from the reality. I mean the fake from reality sometimes. Sometimes it's kind of hard to distinguish the both of them, which is real and which is fake (Anderson 2014: 584)*

This participant referred to the difficulties he was experiencing living life as a Black male and how it affected his mental health.

> *Struggling with my identity, feeling less than compared to my White counterparts. Not feeling like I belonged, day in and day out...(Thomas 2016: 33)*

Eight studies highlighted that Black males responded to the onset of mental ill-health in a common and unremarkable way. Affected by the stigma associated with mental ill-health, there was a tendency for the men to hide and conceal.

> *I think everybody has done something to cover up their depression. Nobody wants to walk around showing that type of emotion on their sleeve (Watkins and Neighbor 2007: 276)*
>
> *I think most people see me as pretty upbeat...most of my friends have never seen that side of me. I don't tell them that I take anti-depressants (Bryant-Bedell and Waite 2010: 2055)*
>
> *Nobody in my family is open about stuff like that. Besides, the way people make having an illness seem, like it's the worst thing in the world-I didn't want that label (Thomas 2016: 27)*

They did not want to attract what they thought would be negative attention to themselves; isolation was a feature in eight studies where the Black males used inward activities as a method of coping with their mental ill-health.

> *I just stay in my room and lock the door, that's it; I don't want to be bothered (Lindsey, Joe and Nebbitt 2010: 470).*
>
> *I try to snap out of it, you know what I mean, or sit up there (in his room) and try to find another angle (Perkins, Kelly and Lasiter 2014: 170)*

The studies found that Black males used a variety of positive coping strategies to address their mental health.

> *Probably write a letter, draw. I will draw, clean up, sleep, eat, something...I would just do something else instead of just keep focusing on that (how he is feeling) (Perkins, Kelly and Lasiter 2014: 170)*
>
> *Usually I'll do things like journaling, exercising, attend group meetings and talk to different people (Bryant-Bedell and Waite 2010: 2056)*

They also used potentially harmful responses such as poor dietary intake and self-neglect. Some recalled times when they sought extreme measures as a way of coping with their distress.

> *I took the trash can liner out of the trash can and wrapped it around my head, they came in the room and saved me because I had stopped breathing (Bryant-Bedell and Waite 2010: 2056)*
>
> *The first time and the only time I ever thought about blowing my own brains out…my little sister happened to catch me right before I pulled the trigger (Perkins, Kelly and Lasiter 2014: 169)*

Four studies referred to their experiences of taking prescribed medication to help cope with their mental health. These studies revealed both positive and negative appraisal of prescribed medication.

> *My medication is stabilising me to the point that I can concentrate better I'm more focused, more goal orientated (Anderson 2014: 583)*
>
> *I came out of that (depression) hailing the Prozac. I love some Prozac, it brought me out of it (Bryant-Bedell and Waite 2010: 2057)*
>
> *These drugs, none of it chills out my mind. None of it (Wagstaff et al. 2016: 161)*

2.1.1 Social support 'Receiving mixed messages'

Eight studies presented the role of social support as an important factor in Black males coping and help-seeking behaviour. Although they were reluctant to disclose their mental ill-health they expressed preferences to seek help from their informal support networks where available.

> *I'd say someone that's really close to you that you can talk to and that can give you advice, your mother, brother, a very close friend (Dada at al 2017: 35)*

> *At first you got to find someone that even gives a fuck; that even cares... (Perkins, Kelly and Lasiter 2014: 170)*

Having social support was presented as an important influential factor in aiding their ability to cope and in facilitating help seeking; the studies also captured that social support it can also have the opposite effect and hinder help-seeking as mental health literacy varies and therefore the quality of advice varies as shown in these extracts.

> *Everyone around me keep pushing, my uncle said you need to take care of yourself and I thought maybe counselling will be good for me (Samuel 2015:39)*

> *All the advice I got from friends, neighbours and relatives that 'You'll get over it', you know, or 'Oh well, you know, live with it' (Bryant-Bedell and Waite 2010: 2056)*

> *Because they (family) feel as though why go to a counsellor when I could come to them (Lindsey et al. 2006: 53)*

Peer support was also highlighted as providing an important aspect in assisting Black males to cope with their mental ill-health and having a positive mindset about their recovery.

> *They (family, friends, health professionals) didn't criticise me, they just tried to help me, to encourage me to do it, made sure I could still do what I was normally doing before (Anderson 2014: 584)*

> *What we do at (peer group) we self-advocate for ourselves and in between we stand up for our rights and we speak to the public and we let them know that we're not gonna sit down and take what's being fed to us about being schizophrenic or being bipolar or having depression (Anderson 2014: 584)*

When positive social support was not present and relationships were strained it increases the likelihood of Black males coping with their mental health in isolation, becoming socially disconnected and marginalised.

I would say look I don't want to talk to you about it, so I was just cutting myself off. You don't understand what I'm going through, I can't talk to you, I can't express myself. The only thing I can do is take it in myself and not try to tell you what I'm going through because you don't understand...you just can't see what I'm going through. That was how things were in my family...(Maynard 2007:33)

2.2 Cultural coping and help-seeking

In addition to the conventional ways of coping and help-seeking the studies indicated that Black males also used cultural-specific coping strategies for the emergence of mental ill-health. This sub-theme focuses on two key components of cultural specific coping and help-seeking that the men used: Spirituality and Cultural mistrust.

2.2.1 Spirituality *'God can fix everything'*

Spirituality was referred to in theme 1 as being part of Black males conceptualisation of mental health. In seven studies it was also shown to be an important culturally specific aspect of their coping strategies. When faced with mental ill-health some of them looked to God or to their spiritual leaders for guidance and support or were encouraged to focus on spirituality by family members.

If something is wrong with me and I don't know what to do about it I'm going to tell it to Jesus first before I go to anybody. I tell you, I'm hitting that bible (Lindsey and Marcell 2012: 357)

My first inclination was to pray and talk to God about it. God then put it on my heart that it was okay to get counselling (Thomas 2016: 27)

My cousin came and took me to this woman who I went to church with and she was there and they were praying and putting their hands on my head and shoulder and praying and praying and praying (Maynard 2007: 38)

Part of their religious practices included attending church, praying, fasting and chanting. Non-religious spiritual practices included reflection, meditation and trying to find meaning and a purpose in life. There were some that solely relied on religion/spirituality for dealing with their depression/mental ill-health. They emphasised the importance of being strong in their faith.

You know God can fix everything. God is the Almighty if you let him be your Lord in everything he will surely help you and take care of your mental health difficulties too (Samuel 2014: 37)

By being faithful to God they ensure they adhered to their cultural beliefs whilst also ensuring they avoided the stigma and shame of using mental health services. Attending church and talking to church members had the added benefit of reducing isolation, enabling them to have support from people that understood their needs, generating a sense of belonging from a spiritual community (Dada et al. 2017, Hudson et al. 2016).

> *My spiritual beliefs help me overcome it (mental ill-health) and talking to close friends, I never sought any psychiatric help (Ezeobele, Ekwemalor and Ogunbor 2018: 43)*
>
> *I'm more into the church that helps a lot, I'm part of fellowships and different men's groups that I can bring those things to the table and discuss and that helps (Bryant-Bedell and Waite 2010: 2056)*

2.2.2 Cultural mistrust 'If you're a *Black person...just put them in the mental institution'*

Six studies reported that Black males had suspicions and doubts other people have regarding mental health services which affected their help-seeking behaviour, such as receiving an inaccurate diagnosis and fear of taking anti-depressant medication. A strong feature found in the studies was the perceived barriers in communicating with mental health professionals.

> *They (psychiatrists) don't say nothing they just sit and write, sit and write, people feel like they're being judged, so a lot of people are not going to speak (Hudson et al. 2018: 132)*
>
> *Like you ain't gonna tell nobody your business if you don't know (them)...You gonna look at them (a counsellor) like, nah, plus I don't even know this person (Lindsey and Marcell 2012: 358)*

The synthesis also revealed another aspect of mistrust which has been interpreted as cultural mistrust. Nine studies highlighted issues that suggested cultural mistrust of mental health professionals and mental health services existed. This was demonstrated in a number of ways that give an insight into the mindset of Black males and another barrier that affected help-seeking behaviour. The Black men were aware of the stereotypes and negativity that is attached to them in society which was an intrinsic part of their lives as expressed in these extracts.

> *You can't change people's mindset and that mindset is what we're battling. We're not battling the law anymore, its people's perceptions (Kendrick, Anderson and Moore 2007: 69)*
>
> *Sometimes when they look at you and see your colour the rules begin to change (Samuel 2015: 35)*

As a result of what appeared to be double-consciousness that Young (1990) described as part of cultural imperialism there was a sense that they would be perceived differently by health professionals. This perception had its own connotations in that it wasn't just about being perceived differently, it was how the perceptions of mental health services would negatively affect the care and support they received

> *Like, a White person with mental health difficulties, issues, whatever, if they went to get help, a doctor, the nurse would be more quick to try resolve things and get to the bottom of it and get them counselling and get them help. Whereas, a Black person...just put them in the mental institution (Dada et al. 2017: 33)*

These examples provide evidence of how oppression intersects and generates cultural specific barriers that make it even more challenging for Black men to approach mental health services and be open to forming the necessary therapeutic relationship. This appeared to be a factor in some of them expressing their preference to speak to a non-White mental health professional or a Black male mental health professional; someone who they perceived they would find easier to identify with and form a connection.

> *They (Black males) don't think that they (White health professionals) can understand where they're coming from (Lindsey et al. 2006: 54)*
>
> *I wouldn't go talk to no old head professor type dudes...I would talk to somebody (who has) been through the same situation that I've been through...so he knows the same mindset I'm going through right now or maybe been through the same mindset...we go through a lot of struggles right now that people don't even know about (Lindsey and Marcell 2012: 358)*
>
> *To be honest it may even be better if you had somewhere specifically to go as a young Black male (Myrie and Gannon 2013:18)*

Being matched by race and gender was not an important for all Black males, some, regardless of gender and race wanted to be approached in a kind and considerate way.

> *Somebody that is understanding, he'll sit you down and talk with you, speak with you and don't get you upset, you know...(Ward and Besson 2012:377)*

> *It's about having someone that's there for you to understand what you're going through and to give you advice, to give you encouragement, to help you sort out things that you're going through. So with me, White or Black doesn't really make a difference (Lindsey et al. 2006: 49)*

In the three studies that included Black males that had contact with mental health services there was more dissatisfaction than satisfaction with their care. Mental health services were perceived as controlling, not listening and not addressing their needs. These extracts also suggest elements of feeling powerless.

> *I can't have any peace in my life with those people around (Wagstaff et al. 2016: 161)*

> *The system never helped me, he (his brother) has seen me actually go worse since coming in here (in hospital) (Maynard 2007: 37).*

> *I really want to disengage from this service, you know that, that's the thing, I really do (Wagstaff et al. 2016: 162)*

Having negative experiences of mental health services may lead to the reinforcement of existing cultural mistrust and that mental health services don't cater for Black male's needs and therefore should be avoided.

Theme 3: The Influence of Masculinity

This final theme presents how identifying with traditional masculine norms is another powerful influence on Black male's experience of mental ill-health. It highlights how adhering to masculine norms negatively affects Black male's coping, impacts their relationship with others and can lead to them delaying receiving assistance for their mental health when they need it most.

3.1 Being strong and in control: *'You gotta be macho'*

As indicated earlier studies have highlighted that Black males conceal their mental ill-health as a way of avoiding the stigma. The studies illuminated another aspect of concealment which was based on a deep sense of gender role identity and masculinity as shown in these extracts.

> *Certain emotions are deemed female emotions. Certain sickness, depression, high anxiety, these are, (female emotions) so to cry or to cut your wrists, or to*

> *be depressed, I feel like that's what females do. You're weak to me (Perkins, Kelly and Lasiter 2014: 169)*
>
> *Being a Black man you gotta be macho, you gotta be strong (Watkins and Neighbors 2007: 275)*
>
> *What is your way to show that you have this tough exterior if you share feelings? (Myrie and Gannon 2013:17)*

Conscious of the pressure to consistently demonstrate that they could cope and live up to masculine norms ten studies found that Black males had a strong sense of self-reliance and independence. They indicated the challenge to adapt and modifying this way of being.

> *I thought that was part of being a man, dealing with your difficulties on your own. You feel me? Finding the solution on your own (Lindsey and Marcell 2012: 357)*
>
> *When I was dealing with my suicidal thoughts, I felt like I COULDN'T go to anyone about it. I always questioned how would it look? Me, a Black man, asking someone to help me with my issues (Thomas 2016: 27)*
>
> *No matter what, you're meant to be for (want of) a better word a soldier (Myrie and Gannon 2013:17)*

Seven studies revealed that when Black males struggled to express themselves despite their desire, they manifested anger and aggression to fight their feelings and manage their frustrations.

> *I might take my anger (about being depressed) out on others because I want them to hurt like I do (Lindsey, Joe and Nebbitt 2010: 471).*
>
> *Most times, most people don't know how to deal with their depression, and it comes out as anger, resentment...(Perkins, Kelly and Lasiter 2014: 169)*
>
> *In a one-on-one intimate relationship I acted out...it (was) just verbal...I started calling them things I never should have called them (Bryant-Bedell and Waite 2010: 2055)*

They also acknowledged that their adherence to masculinity norms was ineffective in their interpersonal relationships, failed to generate positive mental health and was restrictive. A desire was expressed to adapt, break free and facilitate a more effective and beneficial counternarrative.

> *You can't let anybody know that you're soft. I swear it's like being in jail (Lindsey et al. 2006: 54)*

> *If I can come together with other Black men who are dealing with similar issues that I can confide in and physically be there for them to give them a hug and let them know it's going to be ok I think that would be so beneficial to other Black men (Thomas 2016: 35)*

3.2 Self-medication: *'I need to relax'*

Within this sub-theme five studies referred to Black males use of substances, such as cannabis, alcohol, crack cocaine and cigarettes to cope with difficult circumstances in their lives and manage their emotions, this occurred in isolation and with peers.

> *When I feel as though my back is against the wall and I've got a lot on my mind...this may sound crazy but I smoke weed (Lindsey and Marcell 2012: 357)*

> *There's times I drink or smoke, whatever because you know I need to relax (Kendrick, Anderson and Moore 2007: 68)*

There was a perspective that this may not be the best way of coping or an adequate solution for addressing their mental health and accessing the support they might require.

> *Like okay we're stressed, you had a really bad day... you have all these difficulties, but we really don't calm ourselves, instead we go have a drink and just get wasted. That's hiding (Kendrick, Anderson and Moore 2007: 68)*

2.5 Discussion

In this section a discussion of the qualitative literature review will be presented, this will comprise of a summary of the final included studies and an analysis of the themes. In addition, the strengths of the literature review will be presented as well as the implications for this research study. The purpose of the literature review was to examine the qualitative empirical studies that explored Black males understanding and experiences of mental health. Whilst seeking to examine the current knowledge base, I also sought to ascertain what connections existed within the literature review to Young (1990) forms of oppression. Nineteen qualitative research studies were found, nine of which focused on Black males understanding of mental health and help-seeking behaviour and nine that focused on Black males experiences of mental ill-health. The literature review resulted in the inclusion of a wide range of Black males in relation to their age, socio-economic status, education and employment. This was evidenced by the presence of young men who were students at school,

college, some of which had contact and experience of the criminal justice system. Black males are not a homogenous group, they have a variety of experiences and needs (Brown and Grant 2018, Curry 2017, Glynn 2014) therefore, it was a strength to access a range of Black male voices who had experience of different social realities and perspectives.

The studies found were dominated by their focus on Black men's understanding and experiences of depression which represented concern in the U.S.A about the lack of Black men accessing services and being treated for depression. It also became apparent that the experiences of Black men who had received a diagnosis of psychosis and schizophrenia was limited and neglected. This was demonstrated by only three out of the nineteen studies Wagstaff et al. (2016), Maynard (2007) and Anderson (2014) including samples of Black males who had been diagnosed with a psychotic illness. In addition, Wagstaff et al. (2016) and Maynard (2007) were the only studies that explored Black male's experiences of inpatient and community mental health services. However, this does not appear to be uncommon both Ward and Mengesha (2013) and Watkins, Walker and Griffiths (2010) found a lack of studies that explored Black men's experiences of mental health services in their respective literature reviews regarding Black men's health and well-being, signifying a gap in the literature.

The synthesis of the studies resulted in the development of three overarching themes to capture Black males' understanding and experiences of mental ill-health:

Theme 1. Beliefs about mental health.

Theme 2. Coping with mental ill-health

Theme 3. The influence of masculinity.

The findings firstly illustrated the different ways Black males conceptualise mental health, how even though they hold some common beliefs about mental ill-health that is associated with the general public; there is an additional interaction with cultural norms, stigma and masculinity which also influenced their beliefs, coping strategies and attitude to help-seeking. It was of note that in some cases they accepted a bio-medical framework of mental health whilst paradoxically seeming to reject it because of its association with 'White people' and 'Whiteness'.

Instead, they appeared to draw on the historical and present oppressive experiences of Black people and Black males to form their own conceptual framework. Within their own unique conceptual framework there was a tendency to deny the existence of mental ill-health and encourage the belief of an inherent strength and resilience of Black people as well as being influenced by spirituality. There was a strong sense of difference and identity as Black males and the need to be able to define themselves and not have this imposed on them. This was evident in their need for mental health services to recognise the way they are positioned in society and their unique experiences as Black males. This was further evidenced by them suggesting a need for adequate mental health assessment and ensuring that the delivery of mental health care is acceptable to them. Not all of the studies referred to racialised experiences or the social, economic and political context of Black male's lives. Wagstaff et al. (2016) U.K study focused on Black males that had been labelled as being 'disengaged' from mental health services. It was notable that Wagstaff et al. (2016) did not consider the multiple systems of power and disadvantages that Black males with mental ill-health face that may have contributed to their disengagement from mental health services; indicating that a critical aspect of analysis may have been missed in this study.

Young's (1990) forms of oppression has the potential to capture insights into the complex dynamics of Black males with mental ill-health and their oppressive experiences. Although this was not an explicit focus of the studies found, it is clear from the literature review that oppression was very relevant to their conceptualisation of mental health and their responses. There was evidence of cultural imperialism being present, in particular stereotyping and the concept of double-consciousness was evident, clearly showing awareness of how they are perceived and treated in society as Black males. However, there was limited exploration in how oppression interacted and impacted Black male's experiences of mental health services, which was hindered due to the lack of studies that directly explored this. In the studies that did include experiences of mental health services, there was little examination of interactions with mental health practitioners and their experiences of mental health assessment and treatment. Where this was explored their experiences were portrayed as negative, these studies suggested that powerlessness in relation to having a lack of decision making and control was present.

The literature review brought attention to Black males drive to resist and be resilient to counter cultural imperialism, highlighting its relevance to their experiences. This provides support for the observation made in chapter 1 that resistance and its relationship to powerlessness was omitted from Young (1990) forms of oppression and therefore is in need of further consideration. This observation also provides support for this study having an explicit focus on oppression to enable the in-depth analysis that is currently missing but to also provide a revised and updated model of Young's (1990) forms of oppression.

There was a propensity in the literature review to view Black males as being avoidant to help-seeking for their mental health. Multi-factorial perspectives were presented, it was not possible to suggest any one clear reason for avoidance. It seems that their experiences of racialisation, the stigma associated with mental health, masculinity and cultural norms all intersected to generate responses to conceal and be self-reliant to avoid the 'double stigma' of being a Black male and having mental ill-health. These factors appear to have a shared commonality in that they perpetuate a discourse that encourages strength and resilience. They also appear to emphasise the importance of Black males gaining validation and acceptance from Black communities which can become heightened when living in a racist society that 'others' Black males (Khan et al. 2017, Myrie and Gannon 2013, Young, A. 2018). Another worthy and important point, the young Black boys highlighted that their conceptualisations of mental ill-health, the stigma associated with mental health and adhering to traditional masculinity norms appeared to be established from a young age. This also provides a valuable insight, helping us to consider future age-specific mental health promotion strategies and tailored mental health support.

The literature review has illuminated that when conducting research with Black males that we cannot ignore the social-cultural contexts of their lives. This has implications for how research is conducted with Black males and the researcher not taking a colour-blind approach (Collins 2009, Tuffour 2018). Black males are not a homogenous group; therefore we need to ensure that we do not make assumptions about them and ensure a research approach that is open minded and not view them in a simplistic narrow way that is often perpetuated (hooks 2004, Curry 2017, Young, A. 2018). The literature review revealed an unexpectedly small amount of qualitative

studies given that there have been longstanding concerns about Black males diagnosed with mental ill-health, their relationship with mental health services and their negative outcomes as highlighted in the introduction of the thesis and chapter 1.The findings of the literature review make reference and hints of oppressive experiences of Black males and Black people which does appear to be intrinsically linked to Black male's conceptualisation of mental ill-health. However, the literature review does not fully explore or capture a comprehensive understanding Black males oppressive experiences. In addition, the literature review revealed a lack of studies conducted in the UK which is important as the USA has a different policy framework and organisation of mental health care in comparison to the U.K (Myrie and Gannon 2013). The literature review has provided insights that this study can build upon. IPA can access Black male's personal and social world to explore their oppressive experiences. This study can ensure the inclusion of Black males who have been diagnosed with psychosis and schizophrenia so their voices are present and not silenced. This study will also be able to enhance our understanding in how the intersections of oppression, race, culture and masculinity impacts Black male's mental health; these dynamics are clearly interrelated but are yet to be fully understood.

Conclusion

This chapter has provided a qualitative literature review regarding Black male's understanding and experiences of mental health that was conducted after the data collection and analysis of this study. The literature review offered insights that draw attention to the complexities and social realities of Black men lives and how this intersects with their understanding and experiences of mental health. Some notable limitations and gaps have been highlighted. It became evident that these studies were mostly conducted in the US, which has a trend of examining depression and Black males. These studies have value, contributing to the knowledge base about Black males and mental health however, they are not able to provide the unique insight from a U.K perspective. The literature review also lacked inclusion of Black males with a diagnosis of psychosis and schizophrenia and neglected to examine Black male's experiences in mental health services. This was a significant gap and noteworthy given the evidence shown in the introduction of the thesis outlining Black men's continued overrepresentation in mental health services (Keating 2007,

McKeown and Stowell-Smith 2001, McKeown et al. 2008). In contrast to the studies found in the literature review this study includes a sample of Black men who have received the diagnosis of psychosis and schizophrenia, their experiences of mental ill-health as well as their oppressive experiences. This will be of value and enable the creation of new knowledge and understanding in areas that are currently lacking. All of the limitations and gaps highlighted in this literature review provide justification for conducting this research study.

This study will continue to give attention to Black men, mental health and oppression which has a complex relationship. The qualitative research method IPA will be used to gain an in-depth exploration of Black men, mental health and their oppressive experiences using Young's (1990) forms of oppression: cultural imperialism, powerlessness, exploitation, marginalisation and violence. This study will build on the existing knowledge found, exploring the unique features of Black men's oppressive experiences from their perspective. In chapter 3, I focus on methodology, comprehensively outlining the process and decisions taken to conduct this study.

Chapter 3: Methodology

I want to do and hear about research that teaches me something new and ideally, moves me in some way (Finlay 2011)

3.1 Introduction

This chapter comprehensively sets out the methodological decision and approach used to explore Black men's experiences of oppression and mental ill-health. The chapter considers the philosophical assumptions that underpin IPA revealing its appropriateness for this study. I detail the approach at each stage of the research process this includes insight about the development of the data collection tool, issues associated with access and recruitment of participants, fieldwork interactions, tensions and challenges encountered. This is in conjunction with consideration of the quality appraisal of the study and a critical exploration of the ethical considerations.

In writing this chapter, I am mindful to share the centrality of reflexivity to the research process used acknowledging how reflexivity is an essential prerequisite for qualitative studies, particularly in relation to studies that use IPA (Biggerstaff and Thompson 2008, Larkin, Eatough and Osborn 2011). This is because the essence of reflexivity is that it lies in the notion that as the researcher we are present in the work we carry out. As such, it is important to critically scrutinise my role and practice as the researcher alongside the subject under investigation (Green and Thorogood 2011:23). A reflexive stance requires acknowledgement of my influence on the research process and the influence the research process has had on me (Finlay 2002; Shaw 2010). Hence, here I take a critical reflexive stance that captures my approach and journey through the various stages of the research process.

3.2 The Epistemological Assumptions of Interpretative Phenomenological Analysis

The introduction outlined that IPA is influenced and operates within an interpretivist framework, which accepts the premise that research can never be objectively observed from the outside, but must be observed from the inside, through people's actual lived experience (Mack 2010: 8). IPA is heavily influenced by the philosophical

approach of phenomenology, which views human experience and the way in which things are perceived as 'they appear to consciousness' (Langdridge 2007:10). Phenomenology is both a philosophy and a research method. What is more, it is a popular method of choice for research aiming to understand the meaning of the lived experience of a phenomenon (Dowling and Cooney 2012:25; Tuohy 2013). Key contributions by Edmund Husserl and Martin Heidegger has played an important role in influencing it development. The philosopher Edmund Husserl's ideas gave rise to what is referred to as 'descriptive phenomenology' (Smith, Flowers and Larkin 2009). Specific assumptions aligned to descriptive phenomenology contends that experience as perceived by human consciousness has a value and therefore should be a legitimate focus of scientific study in order to bring out the essential facets of the lived experiences of individuals (Lopez and Willis 2004). This directs us to an approach that aims to produce rich descriptions of people's experiences, generalised to produce a universal description of the phenomena of interest (Kumar 2012). Edmund Husserl's uses the phrase "go back to the things themselves", to encourage getting back to the experience of consciousness and finding the 'essence' or 'true meaning' (Van Manen 2016: 28). To do this, researchers are encouraged to adopt a phenomenological attitude, an open non-judgemental approach (Finlay 2011) without trying to categorise and pre-judge in order to make our ideas fit (Smith, Flowers and Larkin 2009; Dowling and Cooney 2012:23). Husserl acknowledged that personal biases could affect achieving the desired consciousness and suggested that to counter this and achieve what he referred to as 'transcendental subjectivity' that as a researcher we must put aside preconceptions, personal views and biases aside (known as bracketing or epoche) (Van-Manen 2016). He suggests, to prevent influencing the analysis and to produce a true description of the world as it appears (Dowling and Cooney 2012:23; Kumar 2012; Lopez and Willis 2004). Bracketing is an explicit feature of Husserlian phenomenology, this concept became significant as I progressed through my study. In doing my research I accepted that is not always possible to completely set aside the preconceptions and biases that we bring to the work we do (Tuohy et al. 2013). The suggestion in IPA is that as the researcher we endeavour to adjust our ideas and assumptions in relation to the subject matter (Larkin, Watts and Clifton 2006: 108) and be open for any preconceptions to be tested and defied (Finlay 2014:77). Practicing self-awareness and being committed to reflexivity is required as a method to achieve this. As Finlay (2011:79) suggests,

this reflective process needs to focus on the 'meanings arising in our research and upon our role as researchers in constituting these meanings'. As a Black woman and a mental health professional, it was essential throughout my research journey that I engaged in a process of reflection. One of the strategies I employed was to ask myself critical questions, recording my views, experiences and feelings in a research journal and as suggested by Finlay (2011). My research diary became an important tool, it provided a framework for supervision sessions, gave me the opportunity to keep a record of my learning and journey as novice researcher, capture the practical aspects in 'doing' my research but equally important the emotional labour that resulted from this work too.

Other influences on IPA is the hermeneutic phenomenology, which is a 'theory of interpretation' (Smith, Flowers and Larkin 2009, Van Manen 2016). This is an important aspect of IPA as it forces us to go beyond the descriptive phenomenological approach advocated by Husserl (Langdridge 2007, Van Manen 2016). Martin Heidegger believed individuals were 'hermeneutic' by nature and able to find meaning in their own lives (Kumar, 2012). The focus of the hermeneutic phenomenology is in how it engages in describing meanings and how meanings influence choices to create new possibilities for understanding subjects under investigation (Benner 1994, Lopez and Willis 2004). This aspect of IPA was important for when thinking about how to approach interpreting the men's personal and social worlds. Heidegger's philosophical focus built on Husserl's ideas, albeit fundamentally quite different. For Heidegger, the preconceptions of the researcher can be valuable and useful in the pursuit of knowledge so therefore there is no need to 'bracket' (Dowling and Cooney 2012:23; Mackay 2005). The preference is for preconceptions and matters influencing the research process to be made explicit by the researcher (Lopez and Willis 2004). An important concept in IPA defined by Heidegger and further developed by other hermeneutic phenomenologists is the belief that the meanings the researcher arrives at are a blend of the meanings of both the participant and the researcher (Lopez and Willis 2004). This is referred to as 'the double-hermeneutic' and/or 'hermeneutic circle'. Smith and Osborn (2008:53) describe this as 'the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world'. To achieve this requires that as the researcher you have both an empathic

approach that attempts to be in the participant's shoes whilst paradoxically retaining a questioning, critical approach in order to gain a deeper understanding and therefore a richer analysis (Smith, Flowers and Larkin 2009). This is not a one-off event, a constant shifting around the hermeneutic circle is required (Smith 2011). It is through a combination of the phenomenological and hermeneutic perspectives outlined that IPA seeks to provide what is referred to as the 'insider's perspective' (Larkin, Watts and Clifton 2006:103).

This was essential, as I believed that capturing the insider perspective was exactly what was required to achieve the aims of the study and answer the research question. The specific aims of IPA in terms of my work were twofold:

1. To understand Black men's social world and to describe 'what it is like'
2. To develop an interpretive analysis of their social world which positions the description in relation to a wider social, cultural and theoretical context (Larkin, Watts and Clifton 2006)

The last important feature of IPA is that IPA is idiographic. This means that the study focuses on the individual level as opposed to a population level as in quantitative research (Shaw 2010). Therefore, as is the case for qualitative studies, there are limits to generalisability. Another aspect of being idiographic is to provide a detailed examination of each participant, whilst simultaneously not losing sight of the commonalities and differences between all of them (Smith, Flowers and Larkin 2009). IPA is a creative, dynamic process that requires the active participation of the researcher to achieve its aims (Smith, Flowers and Larkin 2009). It is best suited when attempting to establish how individuals perceive their situation or event and how they make sense of it (Smith and Osborn 2008: 54). In conclusion, IPA provides the most appropriate route for critical exploration and analysis to address the overall research aim to explore the experiences of Black men's experiences of oppression and mental health.

3.3 Black men in my study

Due to the detailed analysis necessary in IPA studies, the sample sizes are inclined to be small (Shaw 2010, Smith and Osborn 2008; Smith 2011). Smith, Flowers and

Larkin (2009) suggest researchers get the balance between being able to provide analysis that can highlight significant similarities and differences between participants and not too much data where there is a risk that the researcher becomes overwhelmed and affects the quality of the study. IPA studies are required to have a homogeneous sample that ensures that the participants share an experience that answers the research question (Langdridge 2007:58; Smith and Osborn 2008). I used purposive sampling to recruit the participants. Purposive sampling demands that we think critically about the parameters of the population we are interested in and choose the sample carefully on this basis (Silverman 2000). There were a number of factors influencing my decisions; depression is one of the most common mental health diagnosis in the UK however, for Black men they are disproportionately diagnosed with psychosis and schizophrenia (CQC 2018, Keating 2007, Kirkbride et al. 2012, Morgan et al. 2005, Morgan et al. 2017). Therefore, it was important that Black men diagnosed with depression were also included in the study as there is a lack of research concerning their needs. Black men also experience increasing rates of being detained under the Mental Health Act (Barnet et al. 2019, Bookle and Webber 2011, CQC 2018, Keating 2007, Wessely 2018) it was important to capture their perspective of this experience. I also wanted to capture information in relation to their most recent contact with mental health services and their experiences of recent policy changes and changes in service provisions. Based on these factors, participants selected had to meet the following criteria:

- Identify as a Black African or Black Caribbean male
- Receive a diagnosis of schizophrenia, psychosis, depression
- Access mental health services within the last 5-10 years.
- Experience involuntary inpatient admission
- Have the capacity to be able to articulate themselves in an interview situation for at least 60 minutes.

3.3.1 The recruitment of participants

Due to the specific nature of the population, men were recruited via Black-led community-based voluntary mental health organisations within the West Midlands. The reason for this is that these organisations were best placed to support recruitment to the study due to their existing relationships with the study population

and had an awareness of potential support needs and concerns (Rugkasa and Canvin 2010). A letter was sent to organisations outlining the aims and purpose of the study, requesting access to speak to Black men that addressed the participant inclusion criteria (See Appendix 3 for letter requesting access to Black men that addressed the sample criteria). An initial meeting was held with the board of the organisations that responded who were informed of the proposed study, answering any questions or queries in order to gain their permission and advice as to the best way to recruit. Although this was time consuming it was an important step in the process, Beadle-Brown et al. (2012) suggest that sufficient time is set for engagement with organisations to build relationships, obtain co-operation and approval. In addition, I also had to manage the tension and power dynamics of the organisations in terms of recognising the role of gatekeepers who can affect access, recruitment and engagement (Wagstaff and Williams 2014). During meetings, it was important for me to demonstrate openness, credibility and ability to carry out the proposed study and therefore gain their trust (Ruiz-Caseres 2014). I attended two staff meetings, men's social groups and activities where I had the opportunity to talk about the study, meet potential participants and answer any questions. Although this approach was time consuming, it was a valuable way to introduce the study and myself. This approach also enabled me to start the process of immersing myself in the research setting. To familiarise myself with the environment, gain a sense of their values and ways of working. In line with research ethical procedure, Participant Information Sheet (PIS) and consent forms were also distributed. (See Appendix 4 for PIS and Appendix 5 for the participant consent form). The engagement with community organisations helped to demystify the research process and make links between the goals of research and provided additional insights about the mental health needs within Black communities (Williams 2005).

Many researchers refer to the challenges of recruiting participants for their research study. I experienced my own unique challenges and support in respect to recruitment. Wagstaff and Williams (2014) in their IPA study of Black men who disengaged from community mental health services emphasised the importance of building connections with gatekeepers when attempting to access 'hard to reach' groups. Because of the strategies outlined, I had secured the support of the organisations who saw a benefit of the study; without their support I would have

struggled to recruit men to the study and it would have been a much longer protracted process. The support from the staff included making suggestions of suitable participants, helping to organise access to the participants and reminding them of interview dates and times. However, despite the support, recruitment was still quite challenging. In my research diary, I wrote about feeling a sense of disappointment when potential participants identified by staff did not want to meet with me and contribute to the study. I also noted disappointment when having scheduled an interview, a potential participant did not attend. Research highlights that there are specific challenges when recruiting groups to be part of mental health research (Woodall et al. 2010). In relation to recruiting minority ethnic groups to mental health research the stigma of mental illness, distrust of researchers, concerns associated with confidentiality can pose barriers (Bryant, Wicks and Willis 2014). Sometimes potential participants are reluctant to talk about the past, they want to leave the past behind them and move on (Woodall, Howard and Morgan 2011). There can also be a lack of interest by potential participants in the research area and it may simply not be a priority in their lives (Harkins et al. 2010, Rugkasa and Canvin 2011). Having an awareness of these issues helped me not to become discouraged and remain optimistic that I would be able to recruit to the study. Although it was a challenging process, eventually nine Black men were recruited to the study.

3.3.2 The Participants

An aim of the study was to interview Black men with a variety of mental health diagnoses; however, all of the nine men recruited had received the diagnosis of psychosis/schizophrenia. Although initially disappointed, this was to become one of strengths of the study as the participants not only provided the homogenous sample required in IPA, they contributed to the lack of qualitative research that focuses on the voice of Black men diagnosed with psychosis/schizophrenia as shown in the literature review. Driven by my desire for a variety of voices, my initial sampling strategy was too broad to be considered a homogenous sample, highlighting a tension and contradiction. The literature review argued that Black men are not homogenous, they are diverse with different social realities and perspectives (Brown and Grant 2018, Curry 2017; Glynn 2014). Therefore, having to ensure a homogenous sample hindered my ability to show the breadth of Black men and their experiences of mental ill-health, leaving some experiences invisible and unheard.

However, this is not uncommon in qualitative research, Orme and Bell (2015:29) suggests it is a necessity, as it is impossible to represent all realities. For IPA studies, the advice is to focus on the similarities and diversity within the sample (Shaw 2010; Smith and Osborn 2013; Smith 2011).

In line with the idiographic commitment required in IPA there is an important emphasis to have a sense of the participants personal and social world and the context of their lives (Smith, Flowers and Larkin 2009). Providing a brief biography of each participant is a common strategy used to achieve this (Langbridge 2007). See below for a brief synopsis that includes reference to the participants' childhood where appropriate (not all participants referred to their childhood), contact with mental health services and social support at the time of the interview. All participants were given pseudonym names to maintain confidentiality and to not be identifiable. (See Table 6. for the demographics of the participants).

Table 6. Demographics of the participants

Name	Born	Age	Diagnosis	Employment status
Henry	West Midlands Jamaican heritage	42	Paranoid Schizophrenia	Unemployed
Ian	West Midlands Jamaican heritage	28	Psychotic Transient Disorder	Unemployed
Gary	Born in Jamaica Came to live in the West Midlands when he was a child	48	Paranoid Schizophrenia	Employed

Frank	West Midlands Jamaican heritage	51	Paranoid Schizophrenia	Unemployed
Errol	West Midlands Jamaican heritage	48	Schizophrenia	Unemployed
Des	West Midlands Jamaican heritage	48	Schizophrenia	Unemployed
Carl	Born in Barbados	53	Schizophrenia	Unemployed
Barry	West Midlands Jamaican heritage	49	Schizophrenia	Unemployed
Andy	West Midlands Jamaican heritage	42	Schizophrenia	Unemployed

Content redacted from the online thesis on data protection grounds.

Content redacted from the online thesis on data protection grounds.

Content redacted from the online thesis on data protection grounds.

3.4 Data Collection

In order to address the research aims and questions a suitable tool for data collection was required. In IPA, semi-structured interviews are a common method for collecting the in-depth information that is required (Smith, Flowers and Larkin 2009; Smith and Osborn 2008). Semi-structured interviews allow for the exploration of perceptions in complex and sensitive matters, giving participants a voice in debates where their perspective is lacking (Affleck, Glass & Macdonald 2012) capturing their concerns and what has been important to them. To achieve this the semi-structured interview schedule required careful preparation and planning (Willig 2008). The purpose of the semi-structured interview schedule was to provide a guide to enable the participants to tell their story and give a detailed account about their journey of developing mental health problems and their experience of mental health services. The schedule required that I 'think explicitly' about the details required in the interview and to plan for any difficulties that might arise (Smith, Flowers and Larkin 2009:58). The first aspect of developing the interview schedule I took was to review the qualitative research that related to Black men and mental health. Research papers were reviewed for their aims, objectives and methods, results and discussion. Analysis of the papers enabled identification of the following eight themes: childhood/family, mental health, help-seeking/coping, mental health services, community perception, coping, identity and the future. These themes were used as a framework to develop and shape the semi-structured interview schedule for the study. This is a common method used to construct interview schedules (Larkin, Eatough and Osborn 2011) and supports the notion of critical thinking beforehand about what areas are to be covered (Smith, Flowers and Larkin 2009:58). The second step of development was how to phrase the interview questions. A question I asked myself (and had written in my research journal for guidance and inspiration) was "What do I need to ask to understand their experiences?" How could I facilitate entering the men's personal/social life world that is required in IPA? (Smith and Osborn 2008). I spent time reading literature about qualitative interviews and IPA being mindful to ensure that the schedule was aligned

to the research question, as well as principles of IPA. Meetings with the supervisory team was always helpful to discuss the questions and sequence of the schedule. One of the issues discussed in supervision was the challenge of getting the balance of not being too leading with the questions. Silverman (2010) found that researchers sometimes make the error of presenting their research questions directly to participants which is problematic. Smith, Flowers and Larkin (2009:58) support this and suggest approaching the research question 'sideways' where the relevant topics discussed enable the research questions to be answered. After a number of drafts, discussion and review the final interview schedule was produced (See Appendix 6 for the semi-structured interview schedule).

3.4.1 Reflexivity Pre-interview

Researchers are encouraged to be reflexive about their presuppositions prior to collecting data to increase their awareness of how these could interfere with the data collection process (Finlay 2002; Shaw 2010). My clinical background is in mental health nursing, between 1995-2005 I worked in a variety of clinical roles in inpatient services, Accident and Emergency and in community mental health services. Therefore, it is possible to assume that I was entering the field with a number of preconceived ideas and experiences about Black men, mental health and mental health services. I had provided care to many Black men in my clinical career and read many papers on Black men and mental health and therefore would have an awareness of significant issues and have my own views on them. In addition, I am also a Black woman; this provided an additional dynamic to any personal biases and assumptions I had towards Black men and mental health. I explore this later in the chapter.

My standpoint right at the outset of this study was to listen to what Black men had to say about their experiences. I felt that their perspective and their 'voice' was often missing from the literature and was curious about what they had to say. I was also perplexed that the narrative about Black men and mental health has remained the same (Repper and Perkins 2020, Wessely 2018). Phenomenological research starts with this premise: 'The lived experience, with how something appears or gives itself with the aim for the 'thing' to be revealed and seen (Van-Manen 2016:28). Although

this was in keeping with the aim of the research, this premise was also in keeping with my own philosophy of mental health nursing and in how I develop and conduct my teaching and learning strategies as a mental health lecturer. These values reflect a person-centred approach where pre-interview I strived to be open, be empathic and listen to the men's frame of reference (Rogers 1951) and their 'truth' whilst being aware of my own presuppositions and biases I had about Black men and mental health (Dowling and Cooney 2012, Kumar 2012). Although this process sounds straightforward and simple, it was far from it. As detailed previously, I found benefits in using a reflective research journal. In addition, I had critical discussions in supervisory meetings and with other doctoral students who were also using IPA. These strategies were positive in supporting me in exploring and understanding issues that arose in the research process.

3.4.2 The interview process

I conducted most of the interviews at the community-based organisations; the men attended in a private room at an agreed time. I felt it was important to ensure the men were in a setting that was convenient and familiar to them and as suggested by Williams (2005) to help diminish barriers. All interviews I conducted were audio-recorded. My initial focus within the interviews was to ensure that a rapport was established with the men, for them to feel at ease and comfortable enough to tell their story. I was aware of Smith, Flowers and Larkin (2009) emphasis that in IPA studies researchers need to leave behind their 'research world' and focus on entering the 'participant's world' and the 'hermeneutic circle'. In the real world of research away from the books and guidance I wasn't sure what this really meant. Smith, Flowers and Larkin (2009) acknowledge that this is not easy to achieve, their suggestion of focusing on the men's words helped me to focus and not get lost in my own thoughts. I understood the importance of learning the interview schedule before you begin interviewing. I read the interview schedule a number of times and thought I was familiar with it and that it was straight forward however, in my first interview with Henry he began telling me so much information that I felt unsure how to follow up, with the 'right probe' or 'question'. I felt that I had missed opportunities to delve a bit deeper and encourage him to expand on certain points. I felt I over focused on the interview schedule and not enough on what he was saying. On listening to the

interview, I noticed there were things that Henry had said that I had not heard previously or could not remember him saying which made me wonder whether I was really listening to him. Henry spoke about many personal, painful, distressing moments in his life. There were periods of silence and I could sense that I was not sure whether to probe further or whether to back away in case it was too distressing for him. I since learned that my feelings were not uncommon and that novice researchers may find it a challenge to think quickly in the interview process and feel unsure how far to probe regarding sensitive issues (Price 2002). I was also aware of Smith, Flowers and Larkin (2009) emphasis on the importance of a 'good' interview in IPA. I think this made me anxious as I knew the importance of these interviews and that it was not easy to rearrange to see the men if required, therefore, when I had my moment to interview, I had to make the best of it. In order not to be overcritical of myself I also focused on what went well in the first interview with Henry. I thought that he had been open, willing to talk, reflected on his experiences, I noted that I did probe and encourage his perspective and then felt that the interview was not as 'bad' as I initially had thought and contained the necessary requirements of IPA. I took these positive notes to my next interview. I continued to make reflective notes at the end of each interview and listen back to the interviews throughout and discuss with my supervisory team about issues that arose. Each interview was different and warranted different skills in terms of questioning, probing, when to be silent, when to reflect back, when to get more detail and when to move on. I noticed how I began to adapt to these differences and demonstrate the flexibility required to facilitate the interviews. As the interviews continued I began to recognise that the interview schedule was a guide and it was important for me not to be too prescriptive. It was all right for the men to take the lead and say what they wanted to say (Biggerstaff and Thompson 2008) and have a strong role in shaping how the interview proceeded, to tell their story in their own way (Dickson et al. 2007:338). I know now that that part of my anxiety was also about power and me struggling to let go in the interview process. Aware of these tensions Finlay (2014:219) proposes that although challenging phenomenological researchers need to relinquish their power and surrender to whatever emerges.

The majority of IPA studies use semi-structured interviews as the data collection method of choice to be able to elicit the rich detailed accounts required (Langdridge

2007, Smith, Flowers & Larkin 2009:56). One of the realisations that occurred for me was that semi-structured interview is not always suitable method of data collection for everyone and has limitations. Three interviews that I conducted were not completed, the men struggled to express themselves and provide the detail reflection required to be part of the study. Some had cognitive difficulties and were unable to concentrate and keep to the topic. One participant spoke very fast and had pressure of speech that was inaudible on the Dictaphone. This forced me to consider how the research process can be exclusionary. I felt in hindsight, there was a need to consider additional ways screening the men more effectively. However, on reflection I had spoken to the men prior to arranging the interview, so this was an unexpected outcome for me. This was also compounded by me feeling that these men had a journey/story that was not going to be heard and would be lost as they were deemed not suitable for IPA. It also made me reflect about the limitations of semi-structured interviews as a data collection method as it relies heavily on verbal communication through a specific and refined context (Mason 2012). This experience made me want to explore alternative methods for exploring individual's experiences that did not rely so heavily on verbalisation, such as photography, art or music. I later discovered Boden, Larkin and Iyer (2018) who also acknowledged that some aspects of experiences can be challenging to verbalise. To counter this their IPA study also included drawing as part of the data collection to assist individuals to express their experiences. Discovering this encouraged me to think about the use of visual and creative methods in future research for the potentially rich insights that can be found from use of such methods (Nordling and Pugh 2019).

The aim of IPA is to explore the sense that participants make of their personal and social world, in order to achieve this the researcher is required to get 'up close' to the participants. Smith, Flowers and Larkin (2009) state it is essential that researchers are able to engage meaningfully with study participants in IPA and throw them self into the unknown. However, while proximity and getting 'up close' in its various guises was a necessary part of the process, it can raise issues when the research focuses on sensitive matters such as mental health (Dickson-Swift et al. 2007; Shaw 2010). Widowfield (1999) highlighted that it is not uncommon for researchers to become affected by the research they are conducting, this occurred for me at different points throughout the research process. The men talked about distressing

and difficult experiences in their lives such as homelessness, being in prison, spending time in mental health secure units, being restrained, injected with medication without their consent and childhood trauma. This resulted in me experiencing a number of emotions and thoughts about their life and journey.

An unexpected development that I had not been prepared for was that three of the men interviewed I had met previously from working in clinical practice. One participant in particular I remembered had been made homeless, as a result, of his mental health problems and developed infected wounds on his legs whilst homeless. This precipitated his first admission to an inpatient unit in which I worked. I remembered him primarily because of the personal care he received because the wound was badly infected and had a very bad smell. I was particularly interested on meeting again to hear from his perspective what had led up to his recent admission and what had occurred after his previous discharge. The interview was the first contact for a number of years. When he arrived for the interview, he also remembered me. He shared that he had been to an inpatient unit, prison, a medium secure unit and now lived in supportive accommodation. What struck me was that over this period, little had changed. I questioned what value mental health service had been to him and what had been achieved given he had engaged or been forced to engage with mental health services for over 20 years. I came away from the interview feeling a sense of powerlessness and sadness. Indeed, this was not the only time that I came away from the interviews feeling despondent about the men in my study. I reflected on the trauma that they had experienced in their lives and the role that mental health services and my role as a mental health nurse had contributed. Both Shaw (2010) and Dickson-Swift et al. (2007) suggests that researchers may need to distance themselves to let emotive responses subside, leave enough space between the interviews and seek another perspective from someone removed from the situation. Throughout the data collection process, I used these strategies to help alleviate and work through these tensions. Although at times I felt despondent about what had happened to the men and knowing that some of them were still experiencing psychotic symptoms I observed that they did not display despondency. It is of note that at some point during most of the interviews we all found something to laugh about.

3.4.3 Insider/Outsider Perspective

Langdridge (2007) emphasises the importance of researchers' responsibility to ensure that readers are informed about their identity, position and the ways in which this may have influenced the findings. Although I was aware that I was both an 'insider' and 'outsider' in relation to the study, I was unsure how this would affect it. It is recognised that both positions have challenges and benefits, where 'insiders' may be better able to engage with research participants but may find it a challenge to separate their personal experiences and potential bias. 'Outsiders' are valued for their objectivity and emotional distance but may find it difficult to gain access to research participants (Kerstetter 2012:101; Muhammad et al. 2015). However, it has been suggested that this dichotomy is unrealistic, it is possible to occupy both positions (Serrant-Green 2002). Dwyyer and Buckle (2009) suggests there is a multidimensional space, between these positions where the researcher's identity, cultural background and relationship to research participants influence how they are positioned within that space. This is constantly changing and not a fixed entity as initially suggested (Muhammad et al. 2015; Ochieng 2010; Serrant-Green 2002). Prior to starting the interview process, I acknowledged the similarities and differences that may exist between myself and the participants, such as age, education, race, socio-economic status and gender. The difference I was most concerned about related to my gender, being a Black woman interviewing Black men and how this might affect the interview. Familiarising and immersing myself within the research setting by regular visits attending various men's group was a valuable step and may have mitigated some of the issues of me being an 'outsider' as the staff and the members who attended got used to seeing me. Although in hindsight, I also felt like an 'outsider' because of working in higher education, being a doctoral student and no longer working in mental health services. Although I remained an 'outsider' the feeling of being an 'outsider' soon left me as I was well received by the staff and the members who attended.

Green and Thorogood (2011) argue that the more social and cultural similarities there are between the interviewer and interviewee, the more likely there is an assumed shared understanding and meaning. There may be times when the researcher needs to probe and clarify; this can disrupt the flow of the story possibly breaching the assumed 'insider' communality thus affecting rapport and trust (Green

and Thorogood 2011:10). An example of this is, when interviewing Des I asked him about the first time he experienced mental ill-health and why this had resulted in hospital admission. His response to me was "*Me head tek me*" (My head had taken me). I automatically recognised this phrase as it is commonly used in the African Caribbean community to refer to someone who has developed mental ill-health and/or is under a lot of stress; it is usually phrased as "Him head tek him" (His head has taken him). In my response to Des I acknowledged that I was aware of this phrase but wanted to know what it meant to him. This is in keeping with phenomenology, where researchers need to resist any certainty that something "is" and has a definite meaning (Finlay 2013). Des had spoken to me in Jamaican patois on a number of occasions and at times apologised for it in the interview. I reassured him that this was not a problem, I understood what he was saying and did not want to disrupt the natural flow of his conversation. There were other 'insider' words/phrases used by participants in the interviews that assumed my understanding however, where these phrases related to direct experiences, I endeavoured to clarify what it meant to the participant. Another example of this occurred when Carl described how he felt on being discharged from hospital. At first spoke of feeling sedated and experiencing stiffness, when I probed further, he then said:

> Carl*: "I was just 'mash up' really like erm I can't really explain this thing"*
>
> *Interviewer*: *"It's alright, it's alright you have said, so you come out the first time you wasn't feeling right within yourself, as you said you felt 'mash up'"*

The phrase 'mash-up' is used to express not feeling yourself or feeling weary or tired which he used to encompass how he was feeling. I observed that he found it difficult to go beyond this initial description. I reflected back his response to reassure him that his response was good enough, used his words to help him know I was familiar with it and understood that it represented how he felt. These phrases highlighted the participants felt that I was an 'insider' and would have understood these phrases. I am doubtful whether they would have used them had they been interviewed by a non-Black person; or would have spoken in the interview in Jamaican patois. This felt quite natural and indicated that the men were relaxed and comfortable and that there was an element of trust between us, which ultimately was what I wanted.

3.5 IPA Data Analysis

The data collected from the nine interviews were analysed using the IPA framework described by Smith, Flowers and Larkin (2009). Before I could commence using the framework the recorded interviews required transcribing. IPA requires verbatim transcript data to be able to commence data analysis (Larkin and Eatough 2011). Whilst undertaking the interviews I had started to transcribe the completed interviews into text. My director of study stated that transcribing is the beginning of the data analysis however, at the outset I felt differently. The transcribing for me was about ensuring I accurately represented the interviews into text. I found this difficult at times due to some of the pace of their speech and clarity as there was mumbling in places. In addition, some of the men spoke to me in Jamaican patois and I was uncertain how to spell the phrases and words used. There were periods of silence, laughing, crying, interruptions; I had to make sense out of this and decide how to represent this into text. Although IPA does not require the detailed transcription as in other research approaches such as discourse analysis, it is necessary to ensure the precise words are reliably reproduced and not a 'tidied up' version (Green and Thorogood 2011; Langdridge 2007). I also had to ensure that when some of the men spoke in Jamaican patois that I transcribed what they were saying and make sure the context was not lost; but also written so the reader could also understand (Davidson 2009). I noticed how easy it was to either add or miss words when transcribing and was continually rewinding the recording to check for this as I was conscious that an extra word or missing word could change the context and meaning of what was being said. It has been suggested that transcribing is often seen as a chore and devalued by some qualitative researchers (Davidson 2009, Skukauskaite 2012) which I identified with as I found it time consuming and tiring. Tilley (2003) states that transcribing involves more than just replicating words from recording to text as the transcriber can influence data analysis and as a result the research findings. The importance of researcher's doing this task themselves and not delegating to others is also emphasised (Lapadat and Lindsay 1999; Skukauskaite 2012). This made me think whether I was oversimplifying the decisions I was making and not recognising the effect I was really having in the research process. Despite

my act of attempting to have a true representation of the interview, I somehow missed the point or was not aware that the transcript is constructed (Davidson 2009, Skukauskaite 2012) and therefore not as neutral as first thought (Bailey 2008). What at first seemed to be a straightforward task and became a difficult process for me required reduction, interpretation and representation not just to make the written text readable; it was a means of ensuring it was meaningful (Bailey 2008, Davidson 2009). Further reading helped me to understand that the transcription was in fact 'a crucial research activity rather than a step preliminary to research' (Bolden 2015:277), although it was time-consuming, it did have benefits which I had not fully acknowledged and was indeed an important aspect of the data analysis. Following the transcription, I focused my attention on the six key steps outlined by Smith, Flowers and Larkin (2009) to complete IPA data analysis:

- Step 1-Reading and re-reading of the transcript
- Step 2-Initial noting
- Step 3-Developing emergent themes
- Step 4-Searching for connections across emergent themes
- Step 5-Moving to the next case
- Step 6-Looking for patterns across cases

The aim of data analysis in IPA is to "Produce a coherent, third-person, and psychologically informed description, which tries to get as 'close' to the participant's view as is possible" (Larkin, Watts and Clifton 2006:104). To achieve this IPA data analysis calls for a continuous engagement with the text. Although IPA starts with developing a thematic analysis to get as close to the participants view as possible, its aims are to go beyond this (Brocki and Weardon 2007). A process of interpretation is necessary to think about 'what it means' for the participants and go beyond their words in order to make sense of what they have said (Smith and Osborn 2008; Willig 2008). Despite providing a detailed framework for IPA data analysis Smith, Flowers and Larkin (2009) insist that the framework is not a recipe and encourage researchers to be innovative and flexible in how they approach their own data analysis. I discovered that it is not uncommon to use a theoretical framework in conjunction with IPA and use this to "draw upon existing theoretical concepts to assist in the development and elucidation of emergent and superordinate themes" (Larkin, Watts and Clifton 2008:). To further, explore the men's social and personal world Young (1990) forms of oppression: cultural

imperialism, powerlessness, exploitation, marginalisation and violence was used to support the data analysis. The use of Young's forms of oppression ensured that the wider social, cultural context of the men's lives were integral to the analysis which is an essential aspect of IPA (Smith, Watts and Clifton 2006). An important aspect of using Young (1990) was that she offered a particular lens, a tool to view the men's oppressive experiences (Allen 2008, Clifford 2013). Consequently, it was vital that by using it as part of the study that I did not exclude or discount any other important aspects of the men's experiences that would also answer the research question and contribute to knowledge.

Step 1. Reading and re-reading

To maintain its idiographic focus, the data analysis began with focusing on completing one interview transcript first before moving on to the next. The reading and re-reading of the transcript is the first step in qualitative data analysis and developing themes (Vaismoradi et al. 2016). This step enabled me to re-familiarise myself with each of the men and reconnect to their experiences. Smith, Flowers and Larkin (2009) refer to this stage as the researcher attempting to enter the participants' world. I noted in my research journal that my reading and re-reading was at first mechanical, in that I was reading but not connecting to the men. I decided to listen to the interviews as well as read the transcript to help, which naturally led me to step two.

Step 2: Initial noting

Here, I began to make notes of what the men were saying on the transcript whilst both listening to the interview and reading the transcript as outlined above. Smith, Flowers and Larkin (2009) give guidance on the type of comments that can be suitable at this stage. Descriptive comments of the experience and what was important to the participants. Linguistic comments focus on the use of language, how things are said, the pauses, laughter, silence and hesitation. Conceptual comments that attempt to articulate the participants overall understanding of the subject matter and answer the why and how questions of their experiences. IPA requires having both empathy for participants, attempting to walk in their shoes as well as having an element of curiosity (Finlay 2014). These suggestions were helpful and resulted in transcripts that had several exploratory, reflective comments and

questions that challenged the men's statements or as a way to highlight something significant for me to think about further and revisit. These strategies and steps were ongoing throughout the data analysis process.

Step 3: Developing emergent themes from the transcript

Smith, Flowers and Larkin (2009) suggest that in this step the researcher move away from the transcript and begin to work with the exploratory comments in order to generate what they refer to as emergent themes. Emergent themes are summary of the exploratory comments. The purpose of emergent themes is to capture and reflect the participant's words, thoughts as well as the analyst's understanding, interpretation, in essence it is the process of "double-hermeneutic" referred to earlier (Smith 2011). Whilst description and interpretation need to be present in IPA data analysis, it is essential that the themes remain grounded and represent what is important and crucial to the men (Smith, Flowers and Larkin 2009). Working with the exploratory comments aided what I considered as the next level to connecting and becoming more immersed in the data. Finlay (2014:125) refers to this as dwelling, where the researcher slows down, lingers and draw out implicit, layered meanings. For me, this was difficult. I proceeded tentatively as I felt drawn to return to the transcript and struggled with confidence. This was the first part of the iterative and cyclical process that occurs in qualitative research (Mason 2010) where I would move backwards and forwards, a process that would continue throughout the data analysis and the writing up process. Srivastava and Hopwood (2009:77) likens this iterative process to hunting for concepts and themes in an attempt to provide the best explanation of "what's going on". I had already gained an understanding of the men from the interview and transcription. The development of emergent theme felt different as it was committing my interpretations to paper and having to be definitive. Meeting with peers who were also using IPA in their PhD study was a good resource for me to discuss my anxieties and for them to support me whilst also reinforcing what was expected. I began to connect to the exploratory comments and the process of outlining a number of emergent themes, which demonstrated a sense of each of the men (See Appendix 7 for an example of a list of emergent themes)

Step 4: Searching for connections across emergent themes

Once I had compiled a list of emergent themes for the first transcript, I decided to categorise the themes similarly to how the interview schedule was organised. The themes were organised into five categories: social, cultural, thoughts/behaviour, institution and practitioner. These categories gave what Smith, Flowers and Larkin (2009) refer to as contextualisation, a sense of the men's experiences in different key aspects of their life, such as key life events, becoming psychotic, being admitted to hospital and discharge from hospital. I found that the categories accounted for the majority of the emergent themes, if there was an emergent theme that was outside of the categories I added a column so as not to lose sight of this experience. This gave a good sense of the individual, and the world they lived in, keeping to the idiographic requirements of IPA (Larkin, Watts and Clifton 2006). It was also a useful way to show visually the connections within and between the categories, offering me different ways to think about the emergent themes. In addition, I also clustered similar emergent themes together without using the categories taking an experiential, creative stance that is encouraged in IPA to see what else would emerge (Finlay 2011, Larkin, Watts and Clifton 2006). (See Appendix 8 for a list of emergent themes in categories).

Step 5: Moving on to the next case

This step entailed moving on to the next transcript and repeating steps 1-4. The more I analysed each transcript and repeated steps 1-4 the more confident I became with carrying out the process. Whilst repeating these steps, I continued to make notes and reflections, which helped in thinking about the data analysis as a whole.

Step 6: Looking for patterns across cases

After all interview transcripts were analysed, I carried out comparisons across the data from all the men. The flexibility of IPA allowed for comparisons and connections of each interview transcript analysed, particularly where patterns were clear. These 'sparks' or 'illuminations' are common when closely engaging with data (Smith, Flowers and Larkin 2009, Srivastava and Hopwood 2009). The iterative process of returning to the data to check themes, meanings and interpretation continued, becoming more intense and focused (Langdridge 2007). It was at this stage that I

attempted to get a sense of how the men's experiences related to Young (1990) forms of oppression. It was evident that cultural imperialism, marginalisation, violence and powerlessness formed part of the men's experience. It also became evident that some aspects of their experience lay outside of the forms of this model of oppression, such as their experiences of developing psychosis. This was the most challenging step, although I had a good understanding of what was required in the data analysis, it came to my attention that in this final step. I was trying to explain what was occurring for the men instead of describing and interpreting their experience, which was a slight but significant error. This was a turning point and reinforced the benefit of having support (Silverman 2010). Whilst continuing with my analysis I found it useful to continue to read IPA literature, return to the research question so as not to lose sight of the research aim and ensure my focus remained on the 'phenomenon'. I also attended a qualitative data analysis workshop. All these strategies helped with my approach to the data analysis and enhanced my confidence. Finlay (2014:230) acknowledges the challenges of data analysis in phenomenological research, she outlined some useful questions to think about and ask which was also beneficial for me at this stage:

- What does it mean to be this person?
- Where does he/she experience his/her day?
- Are some places safer than others?
- Who are the significant people in the person's life?
- Is there a mood or tone attached to the person's account?
- What is this experience like?
- What's their truth?
- How does this make them feel?

I initially started with five superordinate themes, which I felt encapsulated the men's experiences. Critical discussion in supervision continued to be a resource, helping to shape my ideas, refine and reorganise the themes. Care and thought given to the names of the superordinate themes and sub themes, which resulted in changes and relabelling in an effort to coherently articulate the men's experience; an example of this was in superordinate theme three, which was relabelled from Anomie to Alienation and would change again in the final writing up process. The data analysis process culminated into the development of three overarching superordinate themes that encompassed the men's experience. Once I had finalised the themes I discovered that the data analysis continued during the writing up of the findings.

I continued my immersion in the data, refining and ensuring the verbal extracts clearly reflected the themes and that everything fitted together.

The writing up of the findings was particularly difficult because it occurred shortly after the suicide of a colleague and friend. The first superordinate theme; Becoming Psychotic, contained vivid and rich descriptions of the men's experiences of psychosis, which included their accounts of fear, distress, experiencing suicidal ideas and attempts at self-harm. These descriptions of distress were already challenging to read, however, because of the recent death it made the writing up process challenging as it was an emotional period, which evoked reflections of whether this was what my friend had experienced prior to his suicide. Shortly after this, I commenced counselling to help to process these thoughts and feelings as the writing up process had become entwined with my grief. My thesis is a reminder of how emotions are also embedded in the work we do. The final two sections explore the quality appraisal of the study and the ethical considerations taken.

3.6 Quality Appraisal of the Study

Evaluating the quality of qualitative research has been a source of debate for many years (Mays and Pope 2000). Despite ongoing debates, there is a lack of consensus on a criteria for evaluating qualitative research (Sandewolski 2014). Smith, Flowers and Larkin (2009) stress the importance of IPA studies demonstrating rigour and validity; they endorse the use of Yardley (2000) criteria for assessing the quality of qualitative research for its flexibility and accessibility regardless of which qualitative approach is used. Yardley (2000) focuses on four broad principles that she believes typifies quality in any qualitative research study: Sensitivity to context, Commitment and rigour, Transparency and coherence and Impact and Importance, principles to considered and applied to this study.

Principle 1: Sensitivity to context

Yardley (2000) suggests qualitative studies show a sensitivity to the context of the study. From the outset of the study, I have demonstrated a stance that has been sensitive to the men, the context of their lives, their perspective and concerns. This is demonstrated by the theoretical and research literature that orientated and positioned the socio-political nature of the study. I immersed myself in the field, as

this was important to ensure I established a positive rapport with the community-based organisation and the men in my study. The care and thoroughness given to constructing the interview schedule and my approach to interviews showed empathy, being mindful of language whilst clarifying responses and probing with care; these all show the different ways that sensitivity to context was provided. In addition, taking the time and ensuring verbatim extractions that represent the men's voice but also offer supporting arguments (Smith and Osborn 2008).

Principle 2: Commitment and rigour

I demonstrate my commitment to this work through the attention given to the participants and data analysis. The time spent immersing myself in the data, the iterative process, engaging with supervision, reading and attending relevant research seminars to develop and enhance my skills to become an independent researcher. Rigour is concerned with the care and thoroughness taken in a research study (Morse 2015, Smith, Flowers and Larkin 2009). This is alongside ensuring a clear criterion for the men recruited and meeting the homogenous sample required when conducting IPA. The study based on the views and experiences of nine Black men who had lived experience of psychosis and exposure to mental health services. The quality of the interview, the interview schedule and show reflexivity throughout the process. Rigour has also been shown by ensuring the idiographic focus of each men is included and also ensuring attention is given to what the men share and is demonstrated effectively through their verbatim extracts whilst ensuring that any interpretation clearly articulates meaning (Smith, Flowers and Larkin 2009). I have presented the study at two research seminars, which contributed a critical lens, feedback, sharing of ideas with peers, which helped me to refine and strengthen the study, showing both commitment and rigour.

Principle 3: Transparency and coherence

Transparency is an indicator on how well the research process has been described in the write up of the study (Yardley 2000). I have shown openness and outlined the steps taken in the development of the interview schedule, information regarding the characteristics and recruitment of the sample and the steps taken in data analysis. The rationale for decisions taken have also been described in detail, providing tables and information as appendices to further support transparency. In addition, I have

also been transparent about the changing nature of the study. Through reflexivity, the relational dynamics of the study in terms of how I influenced the research process and how the research process has influenced me has been made explicit. The coherence of a study is also measured in terms of how well arguments are presented (Yardley 2000). Chapters 4, 5 and 6 presents key findings of the study, which offers a rich, comprehensive analysis and interpretation of the men's personal and social world. An important aspect of coherence is also the study's adherence to the chosen research approach (Smith, Flowers and Larkin 2009). The study has clearly engaged and shown the core elements of IPA to answer the research question, what Smith, Flowers and Larkin (2009:186) refer to as 'the thing itself'.

Principle 4: Impact and importance

The final principle by Yardley (2000) is the impact and importance of the study. I have been explicit right from the outset in terms of sharing how this research is something that is personal. An area of work I believe essential if we are to make the changes I believe are important to improving the mental health experiences of Black men. For me, this is a study of relevance and significant importance. The Black voluntary community- based providers such as that in which the men were recruited and Black men who are routinely failed by mental health services also share this belief, they too want to see systemic change. This reflects Yardley (2000) notion that qualitative studies are meaningful to those who participate in the research. However, ultimately it is for the reader to appraise the impact and importance of this study; they will have to decide.

3.7 Ethical Considerations

The dignity, rights, safety and wellbeing of participants must be the primary consideration in any research study (Department of Health (DH) 2005b). An application was made to Coventry University ethical committee for permission to conduct the study which was approved. Although receiving ethical approval is an important step that needs to be satisfied when conducting research, what is more pertinent is the way the actual research is conducted (Ruiz-Caseres 2014). The strategies researchers take when conducting ethical research include balancing the potential disadvantages of participating in the study against the likely benefits for the

participants (Johnson and Long 2006). I have always felt it was important that contemporary research reflected the diversity of the population and that efforts are made to involve a variety of individuals in the research process (DH 2005). This can be challenging with the population of this study who because of receiving a diagnosis of psychosis and schizophrenia and being Black men are considered to "vulnerable" and "hard to engage" (Pyer and Campbell 2011; Beadle-Brown et al. 2012). Although I was aware that there might be challenges in the research process it was important to me not to lose the opportunity to reflect the men's needs within the evidence base, particularly as this was currently lacking (Royal College of Nursing (RCN) 2009; Pyer and Campbell 2011). Given the focus of the study concerned Black men, oppression and mental health I was even more aware of ensuring the research was conducted in a considerate way and that I was not inadvertently being oppressive in relation to my approach and conduct (Williams 2005). This is another area where the research journal was beneficial. The need for continued critical self-questioning and dialogue with others throughout the research process about the dynamics involved when researching sensitive and emotive matters. It is through these processes that I can access what Milner (2007) refers to as the unseen and unforeseen issues that can arise in research that is not taught to you when embarking on this journey. In continuing to explore the ethical considerations of this study I will focus on four central areas: informed consent, participant well-being, confidentiality and researcher well-being.

Informed consent

Informed consent is the heart of ethical research (DH 2005); it is gauged on the principle that individuals are not coerced into research and their participation is voluntary with full understanding of the implications of their participation (Green and Thorogood 2011). When conducting research about sensitive matters, it is much more than getting participants to sign a form, complete a bureaucratic process to satisfy the institution. This was aptly reflected in Dickson et al. (2017: 330).

> "It is so much more than just signing a form to say that they are willing to offer you information, they are actually allowing you into their lives, they are telling you personal information that might be quite hard, so you need to demonstrate a certain degree of discretion, of respect, of appreciation for what they are doing 'cause the reality is that it is more than just words, it's

> more than just what you are going to analyse, it's their life, their experience and you need to make sure that you are aware of that".

This quote represents the responsibility and respect required in conducting this study and the importance of me remaining vigilant and being accountable for my research practice whilst trying to achieve my research aims (Finlay 2014: 220, Milner 2007). All potential research participants were given as much time as they required to consider whether they wish to take part in the study. I also had to ensure that given their history of mental health problems that they also had capacity to make this decision (Royal College of Nursing 2009, Keogh and Daly 2009). In addition, it was important for me to ensure that the men had some understanding of the content of the interview beforehand. This was to ensure that they knew the expectations to talk about their personal experiences. Written information was provided in the form of the participant information sheet which gave full information about the study to complement the explanation and have something for the men to refer back to (see Appendix 4 for the participant information sheet). Once agreement was made a consent form was completed, this was completed with the proviso that the men were free to withdraw from the study at any time without prejudice. (See Appendix 5 for the participant consent form).

Participant Well-being

The wellbeing of all participants is a priority when conducting research, this is particularly significant when interviewing men diagnosed with mental ill-health (Keogh and Daly 2009). It is accepted, that qualitative interviewing can be a cathartic and an empowering experience (Whiting 2008). Whilst this is true for some, it can have the opposite effect precipitating participants becoming uncomfortable and distressed due to reflecting on difficult periods in their lives and emotive topics (Wagstaff 2013; Walls et al. 2010). This was something I was particularly conscious of as the men may not have had the opportunity to talk about their journey to date and share their story that included distressing events, which would need to be handled in a sensitive manner (Johnson 2016). This did occur in one of the interviews, which had to be temporarily paused when Carl became upset when talking about the death of his mother. I reassured him and gave him time, he agreed to continue with the interview. His keyworker was made aware of what had occurred in case future support was required. It was also important for me to ensure at the

end of each the interview that there was a period of time when I switched off the Dictaphone and had a conversation for a debrief (Whiting 2008) the intention was to confirm the men's well-being, to get them orientated, back to the here and now and ensure they were comfortable to leave.

Confidentiality

Maintaining confidentiality and having a right to privacy is central to ethical research practice (Polit and Beck 2006:95). This can also be challenging in qualitative research due to the detailed descriptions used to report the findings as well as when they are unusual stories or events (Kaiser 2009). Within the study a number of strategies were taken to ensure confidentiality and privacy of the men. These included using pseudonyms when using verbatim extracts and throughout the study (Ruiz-Caseres 2014:794). Care was taken in describing the characteristics of the sample, location and the organisation where recruitment occurred (Cresswell 1998; Houghton 2010). In addition, all confidential data from the study was either stored on password protected word document and in a locked cabinet where only me as the researcher could access them (RCN 2009).

Researcher well-being

When undertaking any research study, the Research Governance Framework stipulates that the health and safety of both research participants and researchers are paramount (DH 2005). Therefore, it was equally important when considering the ethical issues of this study to ensure the health and safety of myself as the researcher, which can be overlooked (Dickson-Swift et al. 2007). At the stage of collecting the data and organising interviews safety was observed when making arrangement for interviews by liaising with the staff, who ensured there was somewhere private for us to talk and knew the location of meetings. Seven interviews were conducted at the premises of community organisations and two in the men's home. In one interview a member of staff was present to ensure they adhered to his risk management plan; this was also an indication that they took my safety and the participant's safety and well-being seriously. Throughout periods of my research journey, I have experienced mental upset and distress as referred to earlier in my reflections. Throughout these experiences I have used various strategies to maintain my own well-being and mental health, from using my research

journal as mentioned, also by practicing meditation, walking, exercising regularly and having a period of counselling. Having an understanding supervisory team and support system from family and friends was essential to my well-being and me taking responsibility for me. At times I have had to give myself space away from the study to maintain my own well-being and escape the emotional labour encountered.

Conclusion

In this chapter, I have provided comprehensive information about the steps taken in the research process. I have outlined and explored the underlying theoretical assumptions of IPA, justifying its suitability for addressing the aim of the research study. Alongside justifying IPA, I have been transparent about the steps taken to recruit the sample, develop the interview schedule and shared how I approached analysing the data. I presented an appraisal of the study using Yardley (2000) four principles for assessing the quality of qualitative research and shared ethical considerations of conducting a study that considers issues of race and mental health for the participants and for myself as the researcher. Throughout the chapter, I have taken an honest, critical, reflective perspective in my quest to address the aim of my study and answer the research question in a respectful, ethical way. The next section of the thesis reveals the outcome of the IPA data analysis by presenting the findings of the study.

Findings

The following three chapters presents the findings of the study. Using IPA as the method of data analysis, the findings are organised into three significant superordinate themes: Becoming Psychotic, Dehumanisation and Domination and Starting Over. These three superordinate themes represent three key and significant aspects of the men's journey and are set out in Chapters 4, 5 and 6 respectively.

The three superordinate themes represent what Smith, Flowers and Larkin (2009:98) refer to as contextualisation; each superordinate theme captures key pivotal moments and critical events of the men's experiences such as developing psychosis, having contact with mental health services and discharge into the community. Whilst presented as discrete entities, the chapters are interconnected, there are multiple ways in which the themes overlap and intersect with each other. The men's stories are set out in the form of a timeline, that chronologically captures the men's experiences. Hence, Chapter 4 Becoming Psychotic reflects the men's transition from living their everyday life to experiencing a new social world of psychosis. It reveals the men's attempts to make sense of and cope in this new world, the implications on their relationships and their mental health. Chapter 5 Dehumanisation and Domination captures the men's first contact with mental health services. It details how they made sense of their entry into an institutional environment, the difficult dynamics encountered with staff and how they felt about their mental health care and treatment. Chapter 6 Starting Over continues the men's journey revealing their transition from an institutional environment back to the community. It illuminates the physical, social and psychological challenges the men endured as they attempt to gain a sense of normalcy and move forward with their life. See Figures 3. 4. and 5. for a visual representation of the superordinate themes and subthemes.

Figure 3. Superordinate Theme 1: Becoming Psychotic

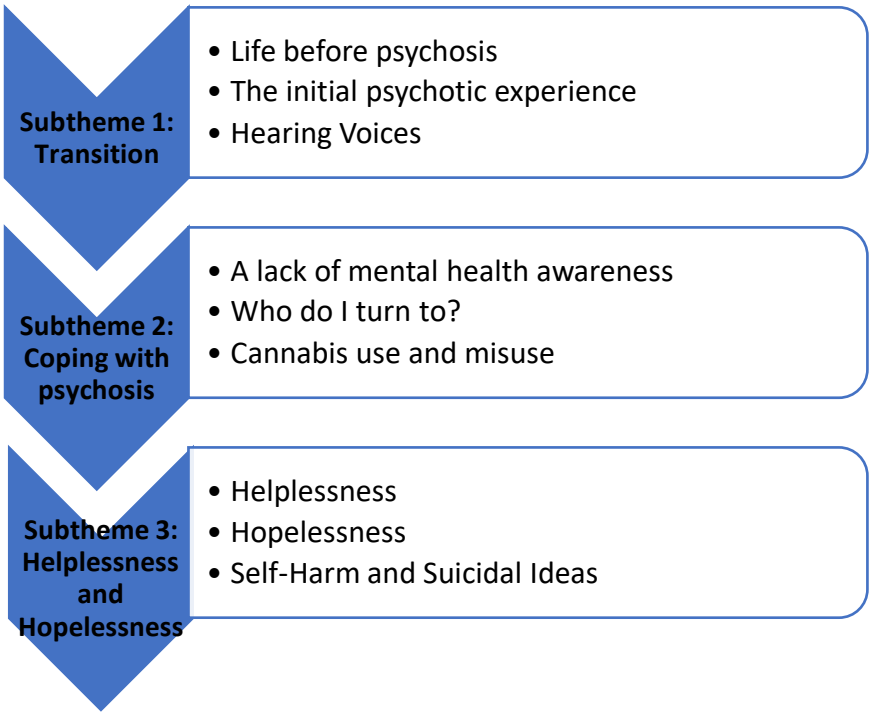


Figure 4. Superordinate Theme 2: Dehumanisation and Domination

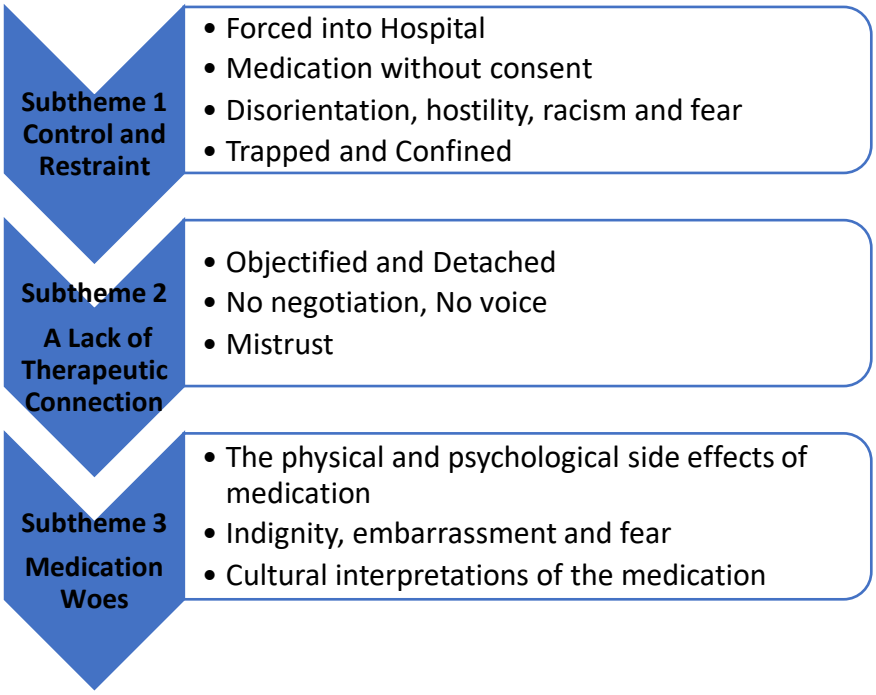
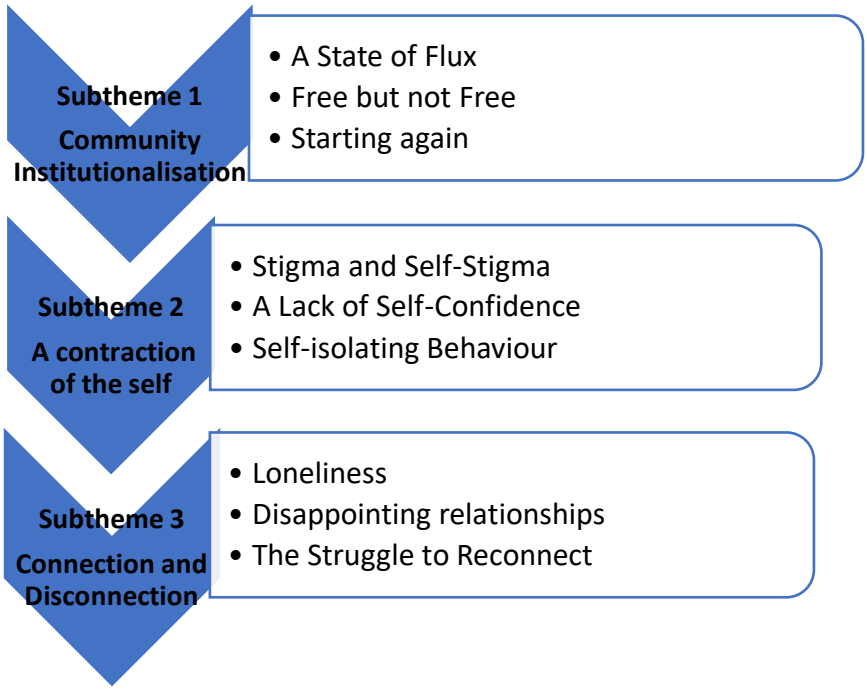


Figure 5. Superordinate Theme 3: Starting Over



Chapter 4: Superordinate Theme 1

Becoming psychotic: "*Me head tek me"*

'Becoming psychotic' was the first important superordinate theme uncovered from the interpretation of the research findings. It provides a starting point in which, we meet the men and are introduced into their personal and social world. This superordinate theme is the beginning of their story; it captures the emotional and behavioural changes that occurred as the men start to experience a decline in their mental health. It represents their journey from a perceived state of normality into a new, confusing and distressing world of psychosis. Within this new world, this superordinate theme paints a vivid picture of how psychosis dominates their lives. The different cultural perspectives and conceptualisations that the men hold are explored alongside how becoming psychotic affected their interpersonal relationships. It captures how for some of the men, becoming psychotic led them to wanting to end their life. Within this superordinate theme, three subthemes emerged showing an in-depth picture into how the men experience a downward spiral of confusion and despair as they struggled to make sense and cope with their descent into psychosis.

The first subtheme, **Transition** describes the men's world before the obvious signs of mental health decline; it reveals the beginnings of their psychosis and attempts to understand their symptoms and the changes that occurred. The second subtheme, **Coping with psychosis** describes the men's responses to becoming psychotic, the various actions taken and the consequences resulting from the men's efforts to reduce their distress and improve their well-being. The final subtheme, **Helplessness and hopelessness** reveals how over time the men find it difficult to cope with their new world, their resilience gradually declining and an emerging sense of despondency. A descent into a life of mental health distress and crisis occurred resulting in a range of self-harming behaviours and, for some men, thoughts of self-harm and suicide.

Subtheme 1: Transition

The men spoke openly and frankly about their journey into psychosis. A common theme is how they describe it as something that appeared to sneak up on them whilst they were living their everyday life. Without any previous indication and knowledge of mental ill-health, their awareness heightened when they attempted to make sense of emotional, sensory and behavioural changes. This stage is represented through three important phases: Firstly, **Life before psychosis,** which offers an insight into their lives before the emergence of psychosis. Secondly, **The initial psychotic experience**, how they experienced the early symptoms of psychosis. Thirdly, **Hearing Voices** in which the men describe the challenges for themselves and others around them associated with **Hearing Voices**.

1.1 Life before psychosis

Experiencing a world affected by psychosis was not always a part of the men's lives. All of the men referred to what life was like before developing psychotic symptoms. They emphasised their 'normality' and placed their life into a wider context. Andy and Frank referred to what they felt was a 'good life' at that time:

> *I had a car, I was probably in my 30's I was getting a regular wage every week you know I could buy anything really within reason like clothes, shoes...(Andy, line 12)... They called me an area manager I had to pick up people and if they had problems, I had to sort it out... (Andy, line 80)*

Frank was a taxi driver in the family business:

> *I bought a car and I was driving to the (taxi) base in my new car (Frank, line 7)*

At a closer view, the reality and 'normality' of the men's lives point towards some living with an undercurrent of psychosocial stress. Henry had endured a traumatic childhood; he had just moved out of a difficult family environment into a new flat. He initially appreciated the quiet and reprieve of living on his own and having his own space:

> *It was just relaxing, oh my word it was so relaxing living on my own (Henry, line 593)*

Ian makes light of his 'normal' situation. On the surface, it appears that he was making plans for the future, but he describes a significant event, failing the second year of his university degree and this leading to a decision to drop out of university. He shared how being unemployed and having encountered some additional significant life events occurred at the same time as a decline in his mental health:

> *Well I had just dropped out of uni, I got engaged and I was gonna get married a year later that we planned and I had a child coming on the way (Ian, line 6)*

The men recounted a range of external factors that negatively affected their lives. Andy's spoke about work and the demands of his job:

> *I was working long hours like 17 hours a day and then gradually like erm they used to call me back to do extra hours and all that I was doing like 7 days a week basically so I didn't have no time off I was overworked... (Andy, line 2)*

Despite his best attempts, Henry was struggling to find his way in life, to secure employment and meaningful occupation:

> *When I left school at 16 I took a course I went to college but that didn't work out, I went on a YTS (Youth Training Scheme) that didn't work out and by 18 I was unemployed on the dole for 5 years...(Henry, line 31)*

Gary had spent several years in prison; his third prison sentence appeared to have a profound effect on him. He had not anticipated the length of the sentence; he started to agonise and fret about the implications:

> *I had done a couple of sentences before that, the last one I got 7 years, that did hit me when the judge said 7 years take him downstairs... I went to bed that night and when I wake up in the morning and I realised...that's when my mind going ten to the dozen how am I going to do this sentence? How am I going to do it? How am I going to survive? How am I going to cope? (Gary, line 169)*

These narratives illuminate that the men's lives were not 'picture perfect'; they all reveal points in which they encountered different demands and challenges in their lives. There is a sense of attempting to keep going and cope despite the challenges

and underlying stress, which they managed to do to some extent until their mental health declined and their lives changed.

1.2 The initial psychotic experience: *'My mind started to go faster and faster'*

The men eventually become aware of the changes occurring during the onset of psychosis. Des' initial reaction to these changes were quite brief, he uses a phrase in Jamaican patois to summarise what happened:

> *To me now looking at it like 'me head tek me' (laughs) if you want put it that way (laughs) (Des, line 155*)

Des refers to a well-known Jamaican phrase used to label someone who is experiencing mental ill-health. It is of note that he changed the phrasing and used humour to signify the irony of him being the focus of the phrase and '*losing his mind'*. Although I was familiar with this, I encouraged him to explain what this was like for him:

> *It's like I find it hard to sleep, finding it hard to wake up, wouldn't want to sleep, wouldn't want to wake up... (Des, line 121*)

Des emphasised, as did the other men, the initial psychological changes and disruption they endured such as an inability to relax and feeling overwrought. For example, Barry explains from his perspective how his psychosis started:

> *I just went into myself, I just went mental and went into myself and started talking to myself and it just come on unexpected (Barry, line 65)*
>
> *Interviewer: It just happened like that?*
>
> *Yes (Barry, line 68)*

Barry refers to the pace of his psychosis indicating that for him it simply came out of nowhere, others echoed this notion of abruptness and disbelief at how they started to lose control. Although it was difficult to pinpoint when these changes began, they noticed in particular changes in their behaviour and acting in ways that were out of character:

I was very active and like erm I'd wake up early go to bed late and it was like I had become a different person really yes it started with the way. I was thinking and then how I conduct myself like throughout the day and I would do loads of different things. It's like it necessarily wasn't a bad thing but someone looking on the outside would think to themselves oh you're overworking yourself and you're gonna have a breakdown ...(Ian, line 46)

My heart start to beat a bit faster and then I start shouting for Jah (the Rastafarian name for God). And I start jump up and down in one spot acting like I didn't know what I was doing then I start to take off my clothes cos I start to say I'm Adam and that, so I took off my clothes (Carl, line 35)

In addition to the psychological and behavioural changes, the men also experienced an increasing inability to control their thoughts and make sense of the world around them. Initially pleased about his role as a taxi driver Frank noticed changes in his thoughts. He began to feel concerned about his passengers and their intentions, denoting the beginning of his journey into fear, anxiety and paranoia:

I was wary of meeting different people, there's so many different people in the taxis business I thought they was all out to get me, destroy me, hurt me (Frank, line 7)

Henry recalls the everyday experience of watching TV and the realisation that he was starting to lose control of his thoughts and felt there was nothing he could do about it:

I bought cable TV and I think that all the channels just mixed up my mind I was watching all sorts of sports and all the fashion and everything but it just mixed up my mind...all the channels everything was fast and my mind started to go faster and faster with the channels on TV...(Henry, line 37)

Hearing Voices: 'I could hear their mind'

Most of the men referred to their experience of hearing voices. One of the key features mentioned was the relentlessness and the intrusion of the voices in their heads and thoughts:

Yea, yes I could hear their mind when they are thinking aloud I could hear peoples mind all the time (Carl, line 350)

It's like the voice was trying to take over me (Errol, line 268)

The variety and changing nature of the voices was also emphasised; the voices could be pleasant but were most notable for causing distress due to the content and relentlessness:

They were polite, kind but some voices were nasty, nasty type of voices... (Errol, line 271)

They keep going around in your head nagging your head and thoughts nagging, bad thoughts and that, things like that...I wouldn't stop talking, I would be doing it constantly for hours and hours (Barry, line 321)

The intensity of the voices was all-encompassing, there was no sense of time or place, this symptom took hold and dominated the men's attention reducing their ability to be aware of others around them and their capacity to focus on daily tasks.

Not all the men spoke about hearing voices as a source of distress, Des explains:

I could hear the brethrens (male friends) talking in my head their voices but it didn't seem bad at the time it was just like telepathy to me... I wasn't bothered by it because it seemed different it seemed new like I never experienced that before...(Des, line 373)

Initially for Des hearing voices was not problematic but a new experience that he was curious about. The voices led to Des believing he had telepathic abilities so the special powers did not initially unnerve him. This was short-lived when he began to the voices became louder and became a barrier in is relationships:

There was a time when I used to hear voices before because when we (girlfriend at the time) used to talk my voice would raise, her voice would raise and I'll be hearing the voices so I'd raise my voice even higher to overcome the voices in my head you know what I mean (Des, line 388)

Des would end up shouting. Fighting to ensure his voice was present and heard he was unaware that his communication was affecting others. Carl also gave an

example of how when doing his usual social activities, hearing voices negatively affected his ability to relate to others and feel relaxed:

> *If I go to a nightclub, I could hear man (other men) talking they would talk about you, I would say 'what did you say?' they would say 'what are you talking about?' cos I could hear their mind you know what I mean... (Carl, line 343)*

For some of the men hearing voices had become a persistent intrusion that had an impact on their daily lives and identity. Errol and Barry continued to hear voices many years after the initial onset. Hearing voices became part of their daily reality, an ongoing experience that continued over time. It was part of their present, their here and now:

> *When you're gone, when you go I'll hear a little bit of voices, they're still here, still here... (Errol, line 275)*

> *I'm ill now I'm ill know cos I hear voices I talk to myself and things like that so I'm ill now...(Barry, line 235)*

This subtheme describes the men's life pre-psychosis and their declining psychological health as they began their journey and descent into psychosis. It highlights the impact of psychosis, how the men grappled with a new reality and how started to changed their lives. Subtheme 2 turns its attention to how the men attempted to cope with this new world and the changes they began to experience.

Subtheme 2: Coping with the emergence of psychosis

Becoming psychotic was a distressing and bewildering time for the men. This subtheme continues their journey, it reflects the level of insight the men had about their experience and the various ways they understand and conceptualise mental health. It also reveals the diversity of responses and actions the men employed on becoming psychotic and the impact these responses and actions had on their mental health. The men's experiences are organised around three key issues: **A lack of mental health awareness,** this illuminates how the men made sense of their experiences and their knowledge base regarding mental health. **Who do I turn to?** This highlights the help-seeking strategies used and the barriers that appeared

to hinder the men's capacity to be open with significant others about their experiences of declining mental health. **Cannabis use and misuse,** this depicts how the men normalise their use of cannabis, capturing the perceived benefits and drawbacks of cannabis as a form of self-medication.

2.1 A lack of mental health awareness: 'We never hear bout these words'

Whilst the men spoke about their experiences of becoming psychotic, the data shows that they had little awareness and understanding of mental health symptomatology to help them make sense of the various changes they experienced, that lead to their psychosis:

> *I didn't think anything of it, I don't know... but I was laughing and talking to myself all the time... (Henry, line 201)*

> *I didn't know what it was...I didn't know what it was (Barry, line 33)*

> *I didn't know about paranoia and all these things another brethren (a man he knew) he said what you're going through is paranoia that's when I first heard that word a lot of these words schizophrenia, anxiety, depression, even bipolar we never hear bout these words (Des, line 13)*

Des indicates by 'we' that it wasn't just him that had a lack of understanding regarding mental health, he suggests that perhaps other Black people also lacked this awareness and therefore was at a disadvantage in not knowing what to do, which contributes to fear and anxiety and also a delay in receiving help. The men had a recognition that something was wrong or that they were unwell, however, they all expressed uncertainty about what they had experienced and whether things would resolve themselves. They were oblivious to the serious nature of the circumstances they were dealing with and its potential consequences:

> *I knew I was unwell but I didn't know I could do anything about it (Barry, line 74)*

> *I knew I was ill but I just thought it was a bit of stress and that I would get over it you know what I mean, but it just stayed with me (Andy, line 122)*

Ian recognised that he was changing in a major way. At first, he was at ease with the changes he was going through perceived this change as a part of his 'growth'. A way to become something new that maybe could be exciting and positive. He does not indicate why but, at some point, he shares that he had a sense that something was wrong and became concerned about the outcome and his future holds when his symptoms appeared to be on going and unresolved:

> *I was going through a big transformation really like a spiritual transformation and erm that it was part of my growth really but then I just thought to myself how is it gonna end, cos I didn't know how it was gonna end (Ian, line 53)*

Ian's inclination was to use a spiritual framework to make sense of what was happening to him. Des, Carl and Barry in keeping with a spiritual framework, made references to Christianity to interpret the new world they found themselves. Des is light-hearted about his beliefs; Barry and Carl reveal sinister and distressing aspects of the spiritual interpretations of their experiences:

> *I even thought I could save (laughs) the world like I was Jesus Christ (Des, line 374)*

> *I put my hand on the door handle it felt hot...I was in hell, my home felt like it was hell (Carl, line 193)*

> *I mainly get messages…I'm talking to the devil...(Barry, line 169)*

2.2 Who do I turn to? 'I sat in the house for a while and I went back to work'

As the symptoms became more intense and problematic, everyday tasks became a challenge. The men were split between being oblivious to what was happening, feeling unsure regarding what to do and even more conscious of who to turn to:

> *I didn't understand what I had you know what I mean... (Andy, line 144)*

> *At first, I thought nah, no it's all bullshit that's what I thought it was...I didn't have a clue...(Errol, line 118)*

Barry continued to hear voices and was at a loss knowing what to do and who to turn to:

> *Interviewer: Did you think anybody could help you?...Did you think there was anything that could be done to help?*
>
> *I didn't know, I didn't know...(Barry, line 77)*

Whilst the men were unsure what to do, the men dealt with how they were feeling on their own. Barry goes on to explain a strategy he used to try to cope with hearing voices:

> *I try to block it out of my mind, try to block it out of my mind and take no notice (Barry, line 248)*

Some of the men did approach others for support; Henry approached his mum; it was unclear if he was open with her about what was going on with him.

> *I talked to my mum I moved in with my mum for 3 months then she chucked me out cos I said I wanted to live with her, she said I can't live with her so I moved out...(Henry, line 43)*

Despite living within a close supportive network of his parents and fiancé at that time, Ian refrained from speaking and revealing to them what he was going through:

> *There was a guy that I did talk to and he would give me like his encouragement and that now at the time but erm he was the only one that I could speak to really (Ian, line 155*)

There is some unease in confiding in others, resulting in the men concealing experiences, feelings and declining mental wellbeing. Andy explained that after losing a confidant it was difficult for him to find someone else to trust even though his brother and sister-in-law were present and had been supportive. He was cautious, unable to expose his vulnerability:

> *I wish I had someone to talk to...before I could go to my mother and have a good talk you know what I mean if things were on my mind when she was gone (she died) there was like nobody who I could really trust to talk to...(Andy, line 230)*

Des recalls a cultural norm within his family of dealing with problems, which may have hindered him in asking for help:

> *My great mother said tell it to Jesus, tell it to God nuh (don't) tell nobody else because they soon will lick you (hit you) with it and that's what the Devil does me know dat and your best and you closest can do that...(Des, line 467)*

For Des, his mother's advice centred on Christianity and, the importance of talking to God and putting God first in all things and, if not, face the consequences of life being more difficult and challenging.

Frank was having a particularly difficult time working as a taxi driver, but continued to work even when feeling extremely fearful:

> *I went to my sisters I drove to (her house) and I says all these cars are following me and I was talking madness to her, I know its madness now but I was saying that they're all out to get me and I drove back home and I sat in the house for a while and I went back to work driving the taxis (Frank, line 14)*
>
> *Interviewer: How were you feeling?*
>
> *I was scared like mad I was really scared (Frank, line 20)*
>
> *Interviewer: You went back to work?*
>
> *I had to work I had to provide for my family (Frank, line 22)*

Frank was in a panic; he pondered his situation and made the difficult choice to return to work. Motivated to maintain his role as a provider for his family he continued with daily life hoping for a positive outcome despite how he was feeling. For the men, this appeared to be the strategy of choice 'hoping for the best'. Although wanting to escape how they were feeling the men's help-seeking was limited. They spent most of their time living in fear and distress, isolated and desperately yearning for a way out.

2.3 Cannabis use and misuse: "It calms my nerves"

Most of the men spoke about using cannabis at some point in their mental health journey. Cannabis use was a normal part of life, used for leisure as well as a method

of self-medication to deal with the daily stresses of life. Carl justified his use of cannabis, which he had smoked from a young age:

> *In the Bible it says God gave man herb plant to share...that's why I smoke ganja cos it's a herb you know what I mean...(Carl, line 626)*

After many years of smoking cannabis when he was young Gary now believes his cannabis use was a catalyst to him developing psychosis.

> *I believe you know drugs got a part to play in this incident (Gary, line 497)*
>
> *Interviewer: Hmm*
>
> *Cos I was smoking drugs cannabis and that's when I think something happened the THC that's in it that's where you're head mess up I think that's what happened to me, that's what started it off (Gary, line 499)*

On reflection, the men acknowledged that their cannabis use had become problematic in terms of noticing various side effects, they were unaware of at the time:

> *I couldn't handle the work, my mind was taking the drugs you know what I mean, me a work and my mind was taking the drugs and it was getting all mixed up (Errol, line 45)*
>
> *When I came down from the weed now I couldn't really cope in like the normal band of society (Ian, line 118)*
>
> *As soon as I take a draw or spliff I used to twitch like this you know what I mean like a twitching like a spirit you know when you get 'the spirit' and I was saying all sort of different things (Carl, line 304)*

Their cannabis use affected them in different ways. Carl refers to what he believed was a spiritual connection and becoming closer to God from his cannabis use. For many Christians getting 'in the spirit' is welcomed, it is a form of peace and joy, at that moment you are impenetrable to others. For Carl, this spiritual moment was moving, paradoxically, it also resulted in him becoming thought disordered and unable to control what he was saying. Barry was open about using cannabis as a form of self-medication:

It calms my nerves; it calms my nerves when I'm ill, when I'm nervous it calms my nerves...It's because of my depression why I smoke you see, I find it hard without it sometime and when I'm depressed I go back to it when I'm depressed I start smoking again and I don't like that really (Barry, line 317)

Although expressing concern about at his cannabis use, Barry shared his dilemma and feelings; he gains relief and believes that cannabis helps him relax and cope with his symptoms. In the absence of other coping strategies and much to his frustration and disappointment succumbs to it. In another attempt to feel some relief from his restlessness and agitation, Andy admits he was smoking cannabis to excess which he later realised was of no benefit to his mental health:

I suppose I was smoking too much ganja at the time you know what I mean I used to smoke a lot of ganja (Andy, line 252)

The men wanted to escape their symptoms and feel the sedative effects of cannabis, which drove the cycle of cannabis use. However, this was a double-edged sword giving short-term relief, but did little to resolve the underlying issues of psychosis. In some cases, it may have precipitated the onset and for others it exacerbated their symptoms, leaving the men in a precarious situation.

Subtheme 2 has featured the men's responses and strategies used to cope with the ongoing symptoms of psychosis in their lives. It reveals how the men interpreted their experiences and attempted to find ways to gain relief and recovery. Subtheme 3 continues their downward spiral; it represents a harrowing period in their lives and the concluding phase of this first superordinate theme.

Subtheme 3: Helplessness and Hopelessness

Despite their best efforts, the men found it increasingly difficult to cope with the world around them. They experienced a devastating reality, a situation that despite their best efforts they felt powerless to change. Not understanding what was happening the men start to feel vulnerable, frightened and unable to make a difference to the quality of their lives. Over time, this continuous downward trajectory left them with a sense of **Helplessness** and **Hopelessness** about the future, at risk of self-harm and in some cases suicidal behaviour.

Subtheme 3.1: Helplessness ‘How long could I live like this?’

Intense fear and anguish enveloped the men as their situation worsened. Their coping strategies began to fade and an impending crisis looms over them. Frank was at a complete loss as to what was happening in his life, he recalls an agonising time when talking to a doctor about his mental health:

> *I was crying in front of her (Doctor) she said don’t cry, don’t cry that’s what she was saying to me don’t cry but I couldn’t understand why I was suffering from mental illness why...? (Frank, line 147)*

Frank was in despair at his situation, like many of the men his resilience began to diminish as he struggled to make sense of his situation. Ian recalls vividly what it felt like experiencing psychotic symptoms and realising that he no longer had control of his thoughts. Entrenched deep within his psychotic world, he believed something else had this ability. Such was the power and frightening effect of this he questions his future and his life:

> *The thoughts went quite rapidly and I felt like entities were probably taking over my mind and that that’s when I thought that ah this could be a problem cos how long could I live like this for really? (Ian, line 106)*

Whilst Ian was questioning his future, Carl already had the answer; it was at the forefront of his thoughts. He had an ever-present feeling of an inevitable disaster; all of us had no way out, we were doomed:

> *It was always on my mind the mark of the beast ah come (is coming) dis and dat ah come (this and that is coming) this is what’s gonna happen and the world is gonna end and ting (things) like that (Carl, line 380)*

These extracts show the men living in heightened states of anxiety, fear and distress. Compounded by a deep sense of not knowing how to resolve their situation and find a way through which further demoralises and debilitates them.

Subtheme 3.2: Hopelessness *'When you're rock bottom'*

The men started to view their coping strategies as futile. As they ran out of options, desperation seeped in; they become overwhelmed by feelings of negativity and a bleak depressing future ahead. Des referred to what this felt like for him:

> *If I'm in a struggle that's a kind of experience you feel when you're rock bottom like you're in the depths of the pit inna total darkness (Des, line 118)*

Des used many metaphors to describe a lack of hope and being in a world where there is no light and only darkness. It was not possible to feel any worse than this. Andy talks about his experience which he describes differently:

> *It was just a breakdown just things getting on top of me I couldn't cope just life...I was unhappy at the time as well I wasn't really happy and I suppose you know I just I just I couldn't take any more you know what I mean, things just got on top of me (Andy, line 260)*

Andy refers to feeling weighed down by his problems, which left him feeling low in mood and unable to cope. He used the word 'just' a number of times as if the way he was feeling was a simple matter, minimising his experience. Gary also described a difficult and disturbing period in prison when he was feeling vulnerable; this event reinforced the desperation that he was already feeling. He shares an experience in which he was taunted by someone who knew about is poor mental health to hurt himself. He describes it as one of the worst moments of his life

> *Somebody pushed a razor blade underneath the door I didn't see who it was whether it was a screw (prison officer) or an inmate I don't know this razorblade come straight underneath the door and I looked at it right, I picked it up...(Gary, line 206)*

Gary looked at the razorblade and recalled the sense of defeat and dejection he endured; the desire to escape the physical setting of the prison compounded by his wish to escape the mental prison he was also living in.

Subtheme 3.3 Self-Harm and Suicidal Ideas 'What if I die…so what?'

Tired of the struggle and consumed by the increased intensity of their thoughts and emotions many of the men had suicidal thoughts and considered hurting themselves:

> *I'd think about harming myself and things like that I was thinking about it (Barry, line 28)*

Henry was hearing voices and having constant arguments with his mother. Looking for a way out of his problems, he contacted his General Practitioner (GP):

> *I told them that I was unwell I told them I felt like attacking people maybe stabbing people so they could put me in hospital and they did they put me in (Henry, line 361)*
>
> *Interviewer: Was that how you really felt?*
>
> *No, no I don't think I would've attacked anybody but I probably would've hurt myself in the end if I hadn't got any help I probably would've just gone home and hurt myself cos I was tired of it all when things just get to you just get tired of it all, you just get tired of it all...(Henry, line 366)*

Henry describes feeling worn down by all of his problems and feeling empty. Although preoccupied with suicidal thoughts he was unsure about whether he would have carried the threat through and harmed himself, as he just wanted some reprieve. Andy also expressed having harrowing and distressing suicidal thoughts:

> *I used to think about stabbing myself with a knife and I used to hold a knife to my throat thinking about it...I used to live on the top floor I used to think about jumping out of the window of my flat and things like that...(Andy, line 152)*

Whilst there are instances shared of distressing suicidal thoughts, Andy went a step further:

> *Sometimes I took a overdose of tablets as well you know what I mean when they used to give me tablets. I used to take an overdose try to kill myself but it never killed me it just made me more anxious the anxiety went more if you know what I mean ... I never really cared about life I never took life serious if you know what I mean, what if I die…so what... (Andy, line 317)*

Andy's repeated incidents of overdose of his medication, albeit unsuccessful in ending his life, induced a cycle of anxiety, low self-esteem and continued suicidal thoughts leading him to stop caring about anything, including whether he lived or died. At the height of distress, Ian made a plan, which he also put into action:

> *I took a knife from downstairs and put it to my chest but I couldn't erm pierce my skin with it because something another force was stopping me as well it was like a spiritual Armageddon... (Ian, line 177)*

Ian illustrates his experience at the peak of psychosis, which he likened to spiritual warfare, a battle for control, not only for his mind but also for his life. On this occasion, he won and did not end his life.

This final sub-theme depicts the men at the peak of psychosis and distress where their lives are at stake. Deeply distraught and falling into helplessness it highlights the raw emotions and thought processes as they desperately try to cope and cling on. Regrettably, their misery continues and they slip further, deteriorating into hopelessness, a preoccupation with suicide thoughts and wanting to end their life.

This superordinate theme 'Becoming Psychotic' details the insidious power of psychosis, how it significantly affected every aspect of the men's lives, leading some to contemplating taking their own lives. It has been explicit in showing how from living everyday life things took a dramatic turn and the men entered a new reality and world of psychosis. A downward spiral of inconceivable twist and turns ensued. At various stages of their journey, the men's coping strategies appeared dominated by the use of cannabis to alleviate these negative feeling and drew on spiritual interpretations as a framework for understanding their experiences. Their reluctance and the difficulties they had knowing whom to trust with such sensitivities led to the concealment of how they were feeling, self-reliance and ultimately facing psychosis on their own. Despite their efforts to cope and find ways to reprieve the way they were feeling, they were unable to halt the decline. They continued to struggle, declining into a helpless state wherein the depth of distress and pushed to their limit they experience suicidal ideas and attempts to take their own life. Death became a resolution, a way out. Becoming psychotic is the primary reason for the men's contact with mental health and statutory services. Their contact with these institutions is the subject of the next chapter.

Superordinate theme 2 details how the men characterise their interaction with these services as one of Dehumanisation and Domination.

Chapter 5: Superordinate Theme 2

Dehumanisation and Domination: ‘They don’t give you a chance’

In the previous chapter, the first superordinate theme Becoming Psychotic was presented, detailing the men’s experiences as they became psychologically unwell and entered into a new world of psychosis. The journey to psychosis was interpreted into three distinct phases: Transition, Coping with psychosis and Helplessness and Hopelessness. Deeply distressed and desperate, the men’s journey inevitably led them to contact with mental health services to receive care and treatment for their mental health. This chapter explores the second superordinate theme: Dehumanisation and Dominance. This theme reflects a further critical point in the men’s story, their contact with mental health services. It captures the men’s first impressions on their entry into a ward environment and their interaction with mental health practitioners charged with their safety and care. The men’s accounts highlight how they made sense of their mental health care and treatment, how it was characterised as a hostile environment that was negative, exclusionary, and oppressive affecting their ability to trust that they were in safe hands.

The dehumanisation and domination the men endured have been interpreted into three subthemes; firstly, in **Control and Restraint,** the men are introduced to the power of mental health services and the institutional world which renders them powerless by forcing their entry into hospital and providing care through coercion and restrictive practices. **A Lack of Therapeutic Connection** depicts the negative relational dynamic that appeared to exist between the men and the staff responsible for their care and recovery, which effected the ability to form a therapeutic alliance. Lastly, **Medication Woes** outlines how the medical model, which resulted in physical and psychological challenges because of their prescribed antipsychotic medication regime, dominated mental health treatment. As well as exploring the difficult side effects of antipsychotic medication, the men also reflected on their concerns about the medication, which appeared to include culturally specific beliefs.

Subtheme 1: Control and Restraint

This sub-theme captures the men's first encounter with mental health services, their admission under the Mental Health Act and their first impressions about their inpatient experiences. The accounts from the men suggested that their care was dominated by force and control. This sub-theme draws attention to how the men made sense of this new restrictive environment and the ineffectual way in which they perceive mental health services, care and support at a time when they are most vulnerable and in need. Their experiences are organised under four key themes; **Forced into Hospital** describe the men's experience of being sectioned under the Mental Health Act and compelled to inpatient mental health units. **Medication without consent** explores how they made sense of receiving physical interventions and forced to have medication against their will as part of their mental health care. **Disorientation, hostility, racism and fear** delves into the initial emotions and anxiety the men felt about hospitalisation and their relationships with the other patients. The final theme **Trapped and Confined** illuminates how the men responded to the reality of being contained and restricted within the hospital environment, unable to come and go as they pleased.

1.1 Forced into Hospital 'They caught me'

The men did not receive mental health care because they went to their GP for assistance and were recipients of a negotiated process of care. All the men shared stories about being compulsory detained, so access to mental health care was outside their control and via detainment and sectioning under the Mental Health Act (2015). The men describe experiences of being detained by the police in their homes, in public spaces or being transferred to a mental health service from prison. Ian and Carl recall their journey to the hospital:

> *I remember the police coming, I was resisting them and they put me in their van, and then I went to the hospital and I was resisting to go into hospital as well (Ian, line 296)*

> *They (the police) hold me up and put my hands behind my back where I couldn't reach you know what I mean, it was hard for me to reach, the police put it there...my hands were handcuffed (Carl, line 86)*

The men did not receive help via the traditional routes such as through a GP or outpatient clinics; instead, they describe their routes via the criminal justice system and a criminalised experience. Des gives an insight into his transfer to hospital, he recalls the travesty and inappropriateness of being in a police cell when he was unwell:

> *Dem (they) go call police never called ambulance; they lock me up in police cell before I knew it bam! (his voice got louder when he said bam) (Des, line 222)*

Gary and Frank were in prison, they recalled their disbelief, fear and anger regarding their transfer to the hospital and medium secure unit which seemed to parallel the sectioning process of force and control:

> *I couldn't believe it I was in shock they came at me, they rushed me, threw the riots shields down grabbed me, restrained me and frog marched me to the hospital unit... Then someone come to see me in the hospital unit and said I have to go to (names medium secure unit) I was scared of that...I didn't want to go to... (Frank, line 120)*

> *The staff came to me that morning and there was about 10 prison officers about 3 nurses and I knew straight away something was gonna happen...Oh, you've got to go to (names medium secure unit), what's (names medium secure unit)? It's a hospital whoa I hit the roof... (Gary, line 27)*

The process of being sectioned did not always involve active resistance; realising their powerless position Errol and Barry reluctantly surrendered and accepted their fate:

> *They got me...they caught me and said I needed treatment... I just took it I agreed with it and just took it on...I didn't struggle cos if you struggle you'll get it worse enit...(Errol, line 186)*

> *I didn't say anything, I just went in, I had to go anyway cos the police was there you see, they took me on a court order or something...(Barry, line 87)*

1.2 Medication without consent 'I felt the needle go in'

Within inpatient mental health services, the administration of medication is permissible without consent, if staff deem it a necessity for the health, safety and well-being of patients. Having faced removal from prison to a medium secure unit, Gary thought he would eventually be returned to prison, however, on the 28th day of his section he recalled an event which continued to anger him:

> *When I go to my room they all boom and jumped on me, they held me down and I felt my trousers getting tugged I flipped now but they was holding me down they all piled on me and I felt the needle go in I said 'you bastards!'...(Gary, line 64)*

Angry and frustrated with his hospital admission, Andy was restrained and placed in seclusion.

> *I lost my temper like so they just restrained me and just gave me an injection (Andy, line 396)*

A common perception is that within mental health services, physical intervention serves as a last resort to manage aggressive and violent situations. In the interviews, the men suggested that the staff had a propensity to opt for control and restraint rather than verbal intervention to de-escalate confrontation. The men perceive a racial dimension to the use of force. Carl explains how he made sense of this:

> *At first, they beat me up, when I first come in every time when I first come in they always beat me up or call for somebody from names another ward) and all over the place some ninja man. You know what I mean? Kung Fu expert man and ting. Push me grab my fist and squeeze it (Carl, line 129)*
>
> *Interviewer: Why do you think that was happening?*
>
> *I don't know if it was racism or what I don't know but erm they beat up everyone that go in there every Black man that go in there they beat them up I wasn't the only one I thought I was the only one but I wasn't the only one because I remember my friend (names a former patient) used to get beat up regular (Carl, line 134)*

Gary held misgivings and raised concerns about excessive and overzealous force targeted at Black men; he recalls a pattern of behaviour, which he views as evidence of institutional racism:

> *Its racism, because I see White guys kick-off and everything and they calm him down give him a cigarette pat him on the back oh calm down and all that, they don't do that with Black people...with a Black man you open your mouth they go oooh they press the buzzer and all sorts of people coming from all over the place jumping all over you and everything, it is like that... (Gary, line 91)*

1.3 Confusion, Hostility, Racism and Fear *'Where am I? What am I supposed to do?'*

Forced into hospital, the men encounter the institutional world of mental health services. The upset of the admission and the medication received created a sense of confusion and disorientation. Whilst trying to become orientated into this new world the men also had to contend with receiving hostility and racism from other patients:

> *I was confused my mum came there and look for me she said I was out for 3 days...I was knocked out for 3 days the injection what they give me knocked me out (Carl, line 133)*

> *I had a lapse of like memory when I went into hospital I didn't really know what was happening there...I kinda blacked out (Ian, line 298)*

Des recalls his first impression of his new surroundings, which was underlined by uncertainty and trepidation:

> *I just wanted to get away from there and when I first ended up there it was like prison to me, it was like one room, it was like where am I? What am I supposed to do? (Des, line 235)*

Drawing on his spiritual framework Carl was troubled that a powerful force lurked within this new environment, which contributed to his apprehension:

> *I thought it was evil up there (in the hospital) (Carl, line 96)*

Having to share living space with other patients on the ward who were also experiencing mental ill-health, meant having to endure an environment that was perceived as hostile and intimidating:

> *A patient he was going to beat me up for just turning over the TV...I didn't like it I couldn't get settled there, I couldn't settle, I couldn't settle in that hospital...(Henry, line 176)*

In addition to having to come to terms with the behaviour of other patients, Henry and Des detailed their experience racial abuse from patients:

> *The patients, they called me Black this, Black that in hospital... (Henry, line 620)*

> *He (another patient) called me a nigger you know what I mean. (Des, line 572).*

Diet is an important aspect of health and a necessity. The suitability of the meals on offer seemed to be unacceptable and subsequently rejected for reasons, which seemed to be a mixture of rejecting the institution, cultural differences and taste:

> *Being stuck in there, having their food (Ian line 341).*

> *I didn't like the food cos the food looked nasty I had to pray and everything first and ask God to bless it you know what I mean before I could eat it... (Carl, line 153)*

1.4 Trapped and Confined '*I say how can I get away from here?'*

After being compelled to be in hospital, the men become aware that they cannot leave without permission. Already consumed by anxiety and fear, tension arose as the men struggled to accept their confinement. Many of them spoke of this initial confinement, which they likened to a prison. Rather than see the ward as a place of safety and a step towards their recovery their first thought and instinct appeared to be to getaway:

> *I didn't want to stop on the ward like I wanted to run off... (Errol, line 154)*

Despite their attempts to leave, there was always an obstacle, a symbol of the institution's power and the men's loss of liberty:

> *I always wanted to escape because when the door would open I would always run to the door and try to get out and one time I did get out but they had another door that you would have to get out so that's when I realised ah there's no point doing this (laughs) I was always trying to get out... (Ian, line 316)*

> *I says how can I get away from here? I pretend…I stand up by the door and press the lift but they saw me (laughs) they supervise by the lift (laughs) they come down (laughs) (Carl, line 122).*

Carl and Andy eventually left the ward only to find their anguish and despondency heightened when forced to return:

> *I escaped ran uptown I got as far as the railway part and the police was after me I ran and they back me up and took me back (to the hospital)...there was nowhere for me to go, there was nowhere for me to go... (Carl, line 210*)

> *I came home and I didn't want to go back you know what I mean so they (the police) came for me kicked off the door and took me back... (Andy, line 361)*

Subtheme 2: A Lack of Therapeutic Connection

As the men attempted to adjust to the shock and confusion associated with their loss of freedom and the traumatic experience of control and restraint they appeared to yearn for reassurance, support and care. This subtheme continues to outline the men's journey of dehumanisation and dominance, it captures the relationship the men had with the mental health practitioners that were responsible for their care. The men revealed that these relationships appeared to be negative. The men shared the difficult dynamics and challenges they experienced with the mental health practitioners and its impact. This is explored under three key areas.
Firstly, **Objectified and Detached** explain the emotional distance that seems to exist between the men and staff. **No negotiation, No voice** shows how the men lacked autonomy in their care and recovery becoming voiceless.

Lastly**, Mistrust** explores the different manifestations of doubt and suspicion felt by the men towards mental health practitioners and, the barrier this presented in developing a therapeutic connection.

2.1 Objectified and Detached *'They just come do their work and go home...'*

Within the institutional environment, mental health practitioners were always present to ensure the provision of twenty-four-hour care. The men recalled their relationship with the staff in a way that suggests some indifference due to the neutral, disinterested responses given, revealing little when questioned. A deeper level of interpretation revealed that the men's indifference was an indication of a detached relational dynamic between them and the mental health practitioners. Carl recalls his initial assessment with a doctor when admitted to the mental health unit. Reduced to a diminished status he encountered a cold, objectified process:

> *At first, the doctor was all right but I didn't know if he was God or what (laughs) you know what I mean? (Carl, 142-143)*
>
> *Interviewer: Why do you say that?*
>
> *Cos he got a book and he writing down what I am saying and ting like that and what he thinks and everything, I don't know if it is the book of life (laughs) (Carl, 144-145)*

Gary and Des' descriptions reflect a distance and remoteness existed between them and the staff:

> *They just come to work do their job and just go home really you know some staff are just laid back you know they just come do the work and go home... (Gary, 406-408)*
>
> *They had a certain character about them, some of them in the job you know is caring why they do the job, some do the job cos they are paying them bills it's like nothing to them... (Des, line 263)*

The men viewed staffs' priority in terms of focusing on their custodial duties, maintaining the routine of the institution and catering to their own needs.

Thus, creating indifference in the men and cementing the distance between the men and staff:

> *They was just there really to observe and give medication and like talk when they needed to yea... Hmm they just wanted to have a most peaceful time at work really they didn't want any erm aggro or hassle... (Ian, line 232)*

> *They didn't tell me anything they just gave me tablets, food that's it (Barry, line 107)*

Andy expressed misgivings and dissatisfaction about the nursing staff who appeared to lack the warmth and compassion he expected:

> *...It's the way that they operated it was a bit clinical like you know what I mean they just like did things on the spur of the moment like and just come inject you and just went and I didn't like that...(Andy, line 224)*

Comments shared by the men suggested that they ceased to be a person in need of care and consideration. They had somehow descended into invisibility, becoming an object to examined, evaluated and 'fixed':

> *I was a subject to them...(Ian, line 234)*

> *The doctors used to come and analyse me... (Andy, line 361)*

2.2 No negotiation, No voice *'Everything was out of your hands'*

The men described a sense of being objectified by the staff and experiencing a sense of distance and detachment. They also described feeling a distinct lack of self-determination in terms of their recovery. This served to reinforce their invisibility, a sense that they did not exist or have control: Addressing their needs appeared non-existent, resulting in frustration and a general exasperation of the mental health system:

> *It was up to the doctors in their reviews to let you know your progress really everything was out of your hands, I come back round to myself in like a month later that's when I was released so there was a lot of frustration in that month cos I didn't really need to be there... (Ian, line 336)*

When I'm back to a balance and I'm still locked in the place that's when the frustration comes through ... (Des, line 551)

The men saw that expressing frustration had a cost; already labelled as at risk of becoming aggressive, in need of calming down and medicating, the men's behaviour may have inadvertently reinforced this pushing them into passivity and suffering in silence:

I do get stressed out when I'm locked up in them places they say I'm intimidating and aggressive or angry well wouldn't you be if you get locked up (Des, line 505)

Everybody (the staff) thought I was anti-authority... (Gary, line 16)

The insensitivities of communication between staff and the men made it difficult to create a therapeutic connection, appearing to create barriers instead:

They talked to me a bit like condescendingly...by the amount of questions and the way they would word them and things like that that's the way they're trained aren't they so... (Ian, line 234)

When important decisions were being made about care, the men felt offered little opportunity for them to contribute their view. Henry's shares his frustration about feeling excluded:

The (staff) said I was laughing and talking to myself, he said that I was worse and he recommended that they put me on higher (dosage of) medication and they did... (Henry, line 192)

Andy recalls trying to assert himself and expressing his perspective to the staff about the difficulties he was experiencing with the side-effects of the depot medication only to find that negotiated care did not appear to exist. He had no say and no voice.

I tried to tell him but he (nurse) wouldn't listen like and he was still giving me injections (Andy, line 169)

2.3 Mistrust *'You don't know who you're rubbing shoulders with'*

The dynamic of the men's relationship with the staff was characterised by an impassive remoteness. Combined with the struggle to feel validated and acknowledged as an integral part of decision making associated with care and recovery made developing a therapeutic alliance challenging. Frustrated and suppressed, feelings of suspiciousness and wariness towards staff seemed to emerge and dominate their thinking. The men disclosed issues that suggested they perceived staff as working against them and that staff could not and should not be trusted. Gary attached a symbolic significance to staff that carry keys within hospital and prison settings:

> *Some staff take their authority too far...Ohh he's got the bunch of keys on him I ain't got no bunch of keys and I used to hate it even in prison when the screw jingle the keys (Gary, line 411)*

This sense of mistrust about the intentions of staff appeared to interfere with the therapeutic process. For example, Errol disclosed that he had deliberately concealed how he was feeling:

> *Like I was too scared to tell the staff that that I hear voices I lied to them and said that I didn't hear it cos I didn't want to tell no one in case it gets worse you know what I mean the treatment gets worse...(Errol, line 285)*

There appeared to be deep-rooted elements of cultural mistrust, Des shared a powerful insight about the pervasiveness of racism in society and therefore within the institution. Wearing a 'white shirt and tie' maybe culturally symbolic of 'professionalism' and 'respectability' however, a seemingly innocent matter such as dress code can be interpreted differently:

> *We know it's there you've got Klu Klux Klan in white shirt and tie now so you don't know who you're rubbing shoulders with, so everywhere is racism...(Des, line 572)*

The cultural distrust and wariness in addition to the difficulties in communication resulted in a barrier and distance between the men and the staff.

This may have also created a deep desire to be able to connect with someone that the men felt could understand them and ultimately provide support in ways they thought acceptable:

> *There's a lack of Black doctors in psychiatry it's ridiculous...if I had a Jamaican doctor that had studied in Jamaica cos my background is Jamaican you see so or even an African doctor, just a Black doctor just to talk to...(Henry, line 382)*

> *They (the staff) was alright they was alright but…because they was White I didn't think they could understand me like you know what I mean...(Andy, line 224)*

Subtheme 3: Medication Woes

Whilst encountering the forces of control and restraint within the institution and experiencing interactions with staff shaped by objectification, detachment and cultural mistrust, the men continued to experience challenges. The final aspect of the men's dehumanisation and domination focuses on their relationship with the antipsychotic medication prescribed. In particular, the subtheme reflects the difficulties they experienced with the **Physical and psychological side effects of medication**. The subtheme continues by depicting the **Indignity, embarrassment and fears** the men endured as a result of the side-effects and lastly **cultural specific interpretations** are presented as the men attempted to make sense of the medication they were prescribed, they express their concerns about the potential impact on their health and well-being.

3.1 The Physical and Psychological side effects of medication '*I couldn't walk properly, I couldn't think, my mind was all mushy mushy'*

The men's treatment regime appeared to revolve around and be dominated by the exclusive use of medication:

> *They didn't give me any counselling I just took medication all I did was take medication...they told me to get me better, to get me well, to get me thinking straight, maybe I could be released into a normal environment (Henry, line 169)*

Just medications down your throat and that's it...medication down your throat gosh...(Gary, line 493)

Taking antipsychotic medication was new to the men, they did not know what to expect; apprehension began to surface when they experienced the unpleasant extra-pyramidal side effects associated with the medication:

The injection in my leg and everything make my foot go stiff (Carl, line 174)

It's terrible, isn't it? When your jaw locks and your teeth grind (Henry, line 247)

I couldn't walk properly (after a depot injection) I couldn't think, my mind was all mushy mushy, I didn't have no clear thoughts so you know I just used to sleep, that's all I could do sleep…(Andy, line 174)

Like Andy, Ian was also having psychological side effects; he noticed the medication having an opposite effect on him. Rather than helping him recover, it had become psychologically obstructive and was blocking his way:

Cos I felt like I couldn't think clearly and the ideas that I used to have erm they weren't coming as freely...I felt like I was kinda trapped in life and in my mind where I couldn't free myself and improve myself because of the medication I was on... (Ian, line 356)

3.2 Indignity, Embarrassment and Fear *'I was just dribbling'*

Initially, when becoming psychotic the men's thoughts were fast and uncontrollable. However, with the initiation of antipsychotic medication, they noticed how physically and psychologically they began to slow down and how things around them came to a halt. The men drew attention to the side effects of the medication how they felt medication stripped away their dignity, leaving them feeling self-conscious and exposed.

It throw me all over the place you know...I wanna sleep, dribbling like a baby, slurred speech, sluggish, all them effects... (Des, line 272)

Hmm frightened of medication...I was dribbling I was just dribbling I was sitting there I could see my mum but I could hardly talk...(Gary, line 429)

The inability and embarrassment of not being able to control their bodies left the men feeling a further sense of fear and helplessness as, once again, they try to make sense of what was happening:

> *I couldn't walk off the bed every time I came off the bed I was leaning and leaning I had to stop on the bed till it weared off it was a bit scary, a bit scary (Errol, line 108)*

Carl recalls his loss of independence as he struggled to do basic tasks he previously had taken for granted:

> *I couldn't do nothing to help myself I couldn't walk after a while I couldn't make a step because of the medication the injection...Erm (silence) I was just 'mash-up' really like I can't really explain this thing... (Carl, line 181)*

Unable to resolve what was happening the men opted to stay in bed hoping that this would soon pass**.** In another example of this sub-theme, Frank refers to his awkwardness and unease with the process of administration of his depot injection:

> *I didn't like the depot I thought that it was embarrassing...dropping my pants every month or every two weeks...(Frank, line 257)*

3.3 Cultural interpretations of the medication 'These things are killing us'

As the men endured the side effects of antipsychotic medication and the embarrassment and indignity linked with it, they attempted to make sense of what the medication was doing to them. In their analysis, they appeared to look to culturally specific interpretations. The men felt that something sinister was occurring because of the medication:

> *It's like polluting my body if you know what I mean if that makes any sense to you... (Andy, line 171)*

> *I don't really want to take it cos to me these things are killing us really to me its poisoning us all this medication if it was left to me I wouldn't take it all even now I wouldn't take it now (Des, line 48)*

> *There's too many to take might mash my body, I'm a bit worried, there's so many of them so many of them they might mash up my body (Errol, line 395)*

The medication was viewed as unnatural, toxic and poisonous rather a route to recovery. Reflecting on his childhood, Des suggests a possible reason for the negative perception about medication is:

> *When we grew up with our mother we just knew about the natural stuff, she used to give us a spoon of honey if had a problem with my throat I would gargle certain things, garlic, olbas oil, she would mix it, she would know what to do or what to take we didn't even question it... (Des, line 51)*

Des was troubled about the content of the injection, which he acknowledged, fed into his paranoia and caused him additional distress:

> *Even that can give you paranoia cos what am I getting injected with the mark of the beast you get me so I'm struggling against all these forces... (Des, line 425)*

Carl was symptom-free; he made an appraisal and disclosure about his treatment. Drawing on his Christian faith, he suggested there were spiritual forces at work assisting his recovery:

> *I don't know if the medication was God I think God got a part to do with it I don't feel like I need the medication, the injection (Carl, line 534)*
>
> *Interviewer: You don't think you do?*
>
> *I just need God that's all (Carl, line 537)*

Summary of superordinate theme 2: Dehumanisation and Domination

This chapter has provided an insight into the men's experience of institutionalised care interpreted as dehumanisation and domination. Vulnerable and in need of mental health care, the men were compulsorily detained in hospital. Within this new world, they faced a hostile, intimidating environment dominated initially by control and restraint, objectification and detachment from the staff and the troublesome consequences of taking anti-psychotic medication. The men's experiences highlighted culturally specific beliefs as well as a strong sentiment and supposition towards overt and covert racism within the institution.

It seems incongruous and hard to fathom that the men were referring to what should be a caring, compassionate environment responsible for facilitating their recovery. Yet, they felt trapped in a negative, discriminatory, dispassionate environment in which they felt alienated from the care and therapeutic connection they expected and deeply suspicious of the people they were reliant on for their care. The third and final superordinate theme explores the next transition in the men's journey, the transition from institutional care to the community, which I have called Starting Over.

Chapter 6: Superordinate Theme 3

Starting Over: *'I didn't want to go back'*

In the previous chapter, the men entered mental health inpatient settings and recalled how they felt dehumanised and dominated within the institutional world. They spoke vividly about being placed in an environment where they were restricted, restrained and medicated against their will. Their mental health care was delivered by distant, detached clinical staff who the men felt did not have their best interest at heart. The men struggled to trust and build the therapeutic alliance that is a critical and central aspect of person-centred mental health care (Wright, McKeown and Thomas 2018). In addition, the antipsychotic medication prescribed was fraught with physical and psychological side effects that slowed them down and generated fear about the long-term consequences for their physical health. The men expressed how they felt a distinct lack of choice and decision-making in their care and treatment, this all culminated into a frustrating and demeaning experience.

This third and final superordinate theme builds on superordinate theme 1: Becoming Psychotic and superordinate theme 2: Dehumanisation and Dominance, revealing the final stages of the men's chronological journey of experiencing psychosis. This superordinate theme continues the pattern of the previous two superordinate themes by encapsulating significant, critical points and events for the men. Within this superordinate theme, attention is given to two key notable events firstly, there is a focus on the men's emotional responses when they become aware that they will be finally leaving the mental health institution and how they make sense of their impending transition to community life. Something that they had been waiting for. The second event captured in this superordinate theme is their actual transition and return to life in the community. This transition, although welcomed is fraught with difficult emotions as the realisation of community living is faced. The men reveal their turmoil, unrest and disappointment as they reflect on the quality of their social relationships, their lives to date and their attempts to gain a sense of 'normality' and essentially try to move on and move forward. These two key events are interpreted as **Starting Over**

To illustrate this, three key elements that appeared to exist within their personal and social world are explored: **Community Institutionalisation** highlights the psychological complexities surrounding their discharge from the inpatient hospital setting and the initial angst and uncertainty of returning to the community. **A contraction of the self,** which depicts the men's reflection of their descent into psychosis, their withdrawal and social disconnection from others as stigma, self-stigma, doubt and fear of self, begins to manifest. In the final subtheme, the men's juxtaposition of **Connection and Disconnection** is presented, this represents their withdrawal as the men become lonely and reveal their struggle to find meaningful relationships and social connections with others; they continue to illuminate the value of having a real sense that they matter and that they belong.

Subtheme 1: Community Institutionalisation

This sub-theme explores the array of emotions and responses of the men to their impending discharge and their initial transition from the controlled confinement of the institutional setting of the inpatient hospital to the community. It reveals the men's first steps back into community life, underpinned by anxiety, feeling unsure and hesitancy. The sub-theme continues by illuminating the men's reflections on their hospital admission that was characterised by control and coercion. Their experiences highlight three key aspects: firstly, the **State of flux** that existed within the men when faced with the prospect of discharge from the inpatient environment. Secondly, the array of feelings experienced on their initial discharge and trying to exist within the community was interpreted as **Free but not Free** and lastly the men's psychological struggles to acclimatise to community living and move forward interpreted as **Starting again**.

1.1 A state of flux *'Don't you want to go home?'*

Within the institution, the men recalled their frustration about their confinement, the negative interactions with staff and difficulties associated with antipsychotic medication. However, there appeared to be an aspect of their inpatient stay that generated a sense of was possibly therapeutic as they eventually acclimatised to the environment and formed social relationships and connections with other patients:

I knew a few people from the outside, you know what I mean, who was ill like (in the hospital) so I used to talk to them, so it wasn't too bad, so I wasn't on my own, I knew a few people in there (Andy, line 378)

… (names someone he knew) and (names someone he knew) I saw them at (names Medium secure unit), I used to associate with them cos I knew them from when I was a kid (Frank, line 130)

It would be like a little social you know, to be around people...even the doctor or nurse would say ohh its time for you to go home now...when I got used to it now I wanted to be up there, you know what I mean...(laughs) (Des, line 340)

Given his negative appraisal of the ward and the staff, Des laughs at the irony of him becoming comfortable and in some way wanting to be in the institutional environment. Given their initial intense desire to leave hospital and the oppressive experiences encountered, discharge too was a time of anxiety and insecurities due to leaving the controlled, confinement of the institution and returning to the uncertainty of community life.

Dr. (names doctor) did say don't you want to go home?... I do, but I wasn't ready...I wasn't ready at all...Because I had to come outside into the big ole world you know... (Gary, line 683)

Interviewer: You were worried about discharge?

I was in a way how am I going to survive, how?... You know what I mean..? (Gary, line 685)

I didn't want to go (be discharged) my mental illness was affecting me (Frank, line
234)
Interviewer: Hmm so what is it that you wanted

I didn't know but I knew that I didn't want to leave... (Frank, line 237)

The men had different reasons for what appeared to be a mixture of anxiety, insecurity and fear of discharge. They each had experienced different lengths of time being in inpatient services, which would have had an impact on how they felt about

their impending discharge. It was evident from their accounts that they did not feel ready, clearly concerned about their ability to cope, make a success of their return to community life and the next chapter of their journey.

1.2 Free but not Free *'I was so nervous'*

Preoccupied with their impending discharge the men described their anxiety and fear about their release. Once discharged, these feelings increased with their attempt to return to some semblance of the everyday routines they had before their experience of psychosis. The men were free from the institution, free from restriction and control, but the reality was very different as they appeared to still be restricted and constrained:

> *When I first got home I was so nervous, walking down the street my heart was racing. You know when you first come out of hospital no wonder they discharge me quickly cos if that had lasted for too long I don't know if I would still be here. Cos when you first come out of hospital it's traumatic because when I was walking down the street my heart was raised I thought people were following me things like that, when I first came out of hospital...(Henry, line 398)*

> *It's hard at first cos I lacked confidence... (Andy, line 426)*

> *I was ok, but I was still scared, really scared... (Frank, line 85)*

These extracts are not indicative of men feeling improvement or having a real sense recovery following their discharge from hospital. Instead, they represent feelings of fear, anxiety and lack of confidence in being able to adjust to life in their communities. In addition, some of the men were impacted by the side-effects of antipsychotic medication which also accompanied them into the community. As such, simple tasks, such as walking to the shop, a task that they previously took for granted were found challenging:

> *I felt slow before I was fast but I slowed down, I noticed I slowed down... (Errol, line 209)*

> *I felt sedated, I went to the booky (betting shop) I went down by the precinct...I had to beg my friend to carry me back home (Carl, line 174)*

There is a real sense of physical limitation, a lack of control of bodily movements, as much as they want to be 'normal', the reality reminds them that they are far from being healed, restored or recovered.

1.3 Starting again *'I didn't want to go back'*

Discharge from the hospital was a significant event, however, it did not signal an end to their challenges. It was a new beginning outside of the routine of the institution, where the men had some sense of being autonomous and consider their future on their terms. Although starting again was welcomed, it was also a source of anxiety. The men were aware of their individual circumstances and how poor mental health had impacted their thoughts and behaviour and resulted in them being sectioned. Therefore, a new way of life was required, to avoid relapse and readmission. Despite these aspirations, community life became a challenge, an inability to be able to adapt meant that for some of the men their return to the community was shorter than they would have liked, admission into the institution became repetitive and cyclical.

> *Strange cos erm...came back here (back to his flat) and it's like you got to start your life back again... (Andy, line 425)*

> *I went to my partners lived with her then went to my parents then got ill again, went to my parents, so it's just always starting over again really... (Ian, line 364)*

> *I was ending up in there (hospital) quite often...I was out for a length of time the same length of time I was in, it was like a cycle... (Des, line 264)*

The transition into the community and the notion of starting again affected the men in different ways. Some of the men were preoccupied with the past and their recent admission, which appeared to have a haunting effect. They did not want to return to an environment of domination and control:

> *So I was trying not to go on the same route, so not to get the same symptoms again like, to be readmitted cos they say if your symptoms show you'll have to go back in…I didn't want to go back you know what I mean...being confined in there where you haven't got freedom to do as you want, like walk if I want to,*

you can't go nowhere, you're there 24 hours a day and you got to obey their rules and things like that you know... (Andy, line 417)

I thought if I start thinking like that (when he became unwell) that I might end up back in hospital and when you're back in hospital you ain't got a date to come out you understand that?... When you go into hospital you ain't got a date to come out... (Gary, line 148)

Ian was trying to focus on his future, he had skills and abilities and used to have a strong sense of direction. He poignantly reflected on how he saw his current life:

I didn't really know where I fitted in really and that kinda played on my mind cos I didn't really know where I was kinda going in life...(Ian, line 416)

Subtheme 2: A Contraction of the self

Discharged from the hospital and the institutional world, the men re-enter the community and return to where their journey with psychosis began. However, they re-enter the community having to cope with a mixture of ongoing psychotic symptoms, feeling sedated and struggling with the side-effects of the antipsychotic medication. Also, fraught with anxiety, uncertainty and fear about their ability to survive and rebuild their lives now they were free. This subtheme continues to illustrate the men's journey outside of the institution where their return to community life continues to be daunting and intimidating. This subtheme reveals how the men want to find a way forward; part of their attempts to move forward is to reflect on their journey to date. Their reflections show how they are overwhelmed by self–consciousness and dominated by a negative self-appraisal about achieving their goals in life and affected by the stigma of having mental ill-health. A consequence is, they retreat and socially detach themselves from others, interpreted as **Stigma and Self-Stigma, Lack of Self-Confidence** and **Self-isolating Behaviour**.

2.1 Stigma and Self-Stigma *'That guy mad, him mad'*

Immersed in an array of emotions since their discharge, the men want to re-establish themselves now they are back in the community. However, they return marked.

Labelled by mental health services, the community and themselves as ‘psychotic’, ‘schizophrenic’ and ‘mentally ill’ which appeared to threaten their identity and generate a fear of self. Trying to come to terms with what had happened they reflected on their experience of becoming psychotic:

> *I started to act weird and think weird things...I think my mind is funny (Barry, line 9)*
>
> *I just wasn’t me... (Andy, line 309)*
>
> *At first, I felt like I had let myself down...cos being mentally ill makes you into a bit of an outcast as well (Ian, line 507)*
>
> *Interviewer: Is that how you felt?*
>
> *Yes, that’s how I felt and I do feel sometimes as well...People haven’t made me feel like that but through my own thinking and what I think people are thinking makes me feel like that (Ian, line 509)*

Carl reflected on his behaviour in the community when he was actively psychotic, in this extract he uses humour to diminish his embarrassment and sense of shame.

> *I took my clothes off and was walking the streets and things like that and people know me, you know what I mean and my body is not that beautiful (laughs) (Carl, line 421)*

The men also reflected on the wider community’s perceptions of mental ill-health. They seemed conscious that negative connotations would be associated with them now labelled as ‘mentally ill’, which can be difficult to shift:

> *And one vibe came to me that people are going to look at me different... (Des, line 123)*
>
> *Bit worried in case they said, ‘that guy mad, him mad’, a bit scared... (Errol, line 300)*
>
> *They think you’re crazy, they think you’re on drugs most of them think you’re on drugs... (Henry, line 525)*

2.2 Lacking Self-Confidence *'I haven't got anything'*

The men engaged in a process of negative self-appraisal, diminishing their sense of self, compounded by the negativity they perceived others held about them. As they attempted to lead a 'normal life' and go forward, they found it difficult to turn their aspirations and goals into reality. This seemed to undermine their self-confidence and generate feelings of inadequacy:

> *I need to set up my life a bit better...financially and things like that...it's hard (Barry, line 310)*

> *It's all money, money, money and that can drive you nuts as well, that's a strain (Des, line 540)*

> *I couldn't sort of go to Jamaica and go to the grave (his mother's) and stuff like that you know what I mean and pay my respects, that's what I wanted to do (Andy, line 238)*

Some of the men made comparisons of their lives to their siblings and the wider community who appeared to be leading the 'normal life' they desired. As much as they desired a 'normal life,' it seemed out of reach, something that they could not quite grasp. They seemed to have a deep sense of separateness; of somehow being on the outside watching others achieve their goals and aspirations whilst they were non-participant observers:

> *Hmm, wanting to live a normal life, cos out there in society when you look around like, it seems like everyone is living a normal life and you want to be a part of that as well (Ian, line 507)*

> *I couldn't find a job cos I'm not educated enough you see unless you have a job unless you have an education you just can't get on...Two of my sisters got degrees, one of my brothers has got a degree and here's me and I was brought up in the same household as them and I don't understand it, how come they're so educated and I'm not, three of my brothers and sisters have got degrees and I haven't got anything... (Henry, line 264)*

2.3 Self-isolating Behaviour *'I didn't want to face nobody'*

Already anxious and living in fear of living in the community, the men lived with a fear of becoming psychotic. This affected the men's attempt to move forward as it seemed to erode their confidence, which may have led to greater levels self-stigma. In trying to cope and adapt to the inner turmoil they were feeling, the men responded by retreating, socially withdrawing themselves from the wider community:

> *Whether you wanna call it going into myself...withdrawn that's the word, sometimes I was withdrawing into myself (Des, line 337)*

> *I didn't want to face nobody I was a recluse; I never want to face nobody at all... (Carl, line 414)*

> *I didn't mess with people or nothing I stayed by myself (Barry, line 9)*

Frank explained the coping strategies he used when discharged from hospital and continued to use.

> *I don't go out nowhere...I keep myself to myself, I'm happy that way, my children come and see me we have a meal together and that's it...I'd lock myself away, I still lock myself away today (Frank, line 329)*

In another example of this sub-theme, the men rationalise their reasons for self-isolation:

> *Sometimes I hear voices; sometimes I can't be around people (Andy, line 416)*

> *I was scared of leaning in front of people and that people would watch you know what I mean, so I stop in, I stop in... (Errol, line 209)*

Subtheme 3 Disconnection and Connection

The stigma of having mental ill-health dominated the men's attempt to start over. Although the men were conscious about what others might think about them, they presented as more preoccupied with their self-analysis and self- perception, which appeared to have a debilitating effect. Their negative self-analysis and the belief that they did not fit in reduced their confidence leading to social withdrawal and

disconnection. This final sub-theme **Disconnection and Connection** explores the consequences of the men's withdrawal and isolation and the challenges they endured in trying to cope and find a positive solution. It also reveals their interpersonal relationships, the quality of these relationships and support systems. The men reflect on how they made sense of their support systems and its impact on their identity and sense of self. Three key aspects include **Loneliness,** which gives an insight into the men's isolation and solitude and how it affected them. **Disappointing relationships identifies** the challenges encountered with support staff and family relationships and **The Struggle to Reconnect** representing the men's desire for social and therapeutic contact and the resultant emotional turmoil they endured whilst hoping and waiting for help and relief. The men reflected on the support they received from the third sector, the value of this support and its significance when attempting to move on.

3.1 Loneliness 'I *was always on my own'*

The men's strategy of coping with their lack of confidence, stigma and self-stigma through self-isolation and social disconnection meant they had a limited social circle and spent prolonged periods on their own. This inevitably led to a deep sense of loneliness:

> *I was lonely, I was very lonely at the time I didn't have a girlfriend I didn't have many friends... (Henry, line 14)*

> *I didn't have much friends to talk to and you now basically, I was always on my own...I was alone, well I felt alone if you know what I mean even though my uncle and aunty used to come I used to feel alone... (Andy, line 315)*

Being on their own seemed to precipitate a chain of negative thoughts and emotions:

> *When you live on your own there's no one to talk to you, all thoughts go through your head, suicide everything goes through your head, you don't know what mood you're going to be in tomorrow and what's going to happen the next day (Henry, line 260)*

Becoming psychotic placed a strain on relationships, this meant that for some their intimate relationships came to an end, which contributed to their loneliness and reinforced their self-stigma.

> *We broke up cos of my mental illness... (Frank, line 30)*

> *That was one of the reasons why we broke up in the end, cos she didn't want to go through a life of in and out of hospital... (Ian, line 283)*

3.2 Disappointing Relationships *'She didn't want to hear'*

Although the men isolated themselves and felt lonely, they were not alone, they had some social connections and the presence of people around them such as family, friends and support from statutory services. The nature of these relationships were perceived to be unhelpful and often not what the men desired. The men shared how they experienced a mixture of undermining, exploitative and perplexing relationships. Ian recalls his relationship with his support worker:

> *Someone would come to see you every week to see how you were doing I don't think that helped either cos the woman's attitude wasn't too good towards me... They would want to always know how I was managing financially really and she (housing support worker) would say that she was there to talk but when I did start talking she didn't want to hear... (Ian, line 487)*

When in hospital and need of consideration and support some of the men recalled being bullied and exploited and the hurt that this invoked.

> *He (his brother) would call me out of the crowd and he used to smack his hand on my backside. I never like him for that you know what I mean and so when my mum brought me some cigarettes (in hospital) I was scared, I never wanted to smoke it in front of him you know what I mean, I think he was going to beat me and that… (Carl, line 289)*

> *My other brother he came when I was in hospital he demanded money for petrol (laughs) he said you must be getting money so he asked me money for petrol, I said can't you just drop me to town, help me out and he said no I need money for petrol... (Henry, line 216)*

In another example of this subtheme, the men continued to refer to the challenging aspects of family relationships.

> *My parents are quite protective and like if I'm away for 2 or 3 days they would always be phoning, texting and things, I would feel a bit claustrophobic. …overall they have been supportive, give me shelter and food and the basics of life but when it comes to spiritual knowledge and things like that they don't really have a clue really... (Ian, line 610)*

> *They're there, but you see one thing with my family when somebody dies or its weddings you see family, but when everything's done, it's back to normal. ...I used to try look for love from my family...when you expect things and it don't happen it's a very low disappointment, you're expecting things and you don't get it (Gary, line 710)*

These narratives portray the different forms of disconnection and disappointment that the men experienced and their wish for support and understanding that was acceptable to them, this included having a spiritual connection and a need for love and affection.

3.3 The Struggle to Reconnect 'S*omebody to talk to, to talk it through'*

Feeling lonely and limited by a lack of social connections the men looked to others to fill their social vacuum. They did not always feel valued by the people around them and shared how they often felt ignored, misunderstood and undermined which created further distance. Paradoxically, the men share how they yearned for meaningful social connections, acceptance and to belong:

> *I wanted to talk to somebody, somebody that's not my family... (Henry, line 355)*

> *After a while, like I wish I had someone to talk to...probably counselling at the time, somebody to talk to, talk it through you know, what I was really going through… (Andy, line 229)*

> *Talk, take time to listen...listen and that (Carl, line 587)*

Struggling to make the quality social connections and the kind of relationships they wanted led to feeling a sense of angst and irresolution. Similarly, to becoming psychotic, the lack of social connection led to uncertainty about their situation and struggling to find a way through:

> *Sometimes the mind gets perplexed, you don't know which way to go, you got choices, the world, church, rasta and you don't know which one is the right path... (Carl, line 603)*

> *I was in disarray... (Des, line 222)*

> *I just used to walk around town and things like that; it just wasn't working...It was all inside me like, like a volcano and in the end I just probably exploded (Andy, line 100)*

Andy's metaphor of a volcano to express his world at this time is apt in representing the men's difficulties. Simmering and bubbling just beneath the surface, there was a sense that no one knew of the inner turmoil that was occurring until the men erupted and burst open.

The final aspect of this last subtheme contains what Smith, Flowers and Larkin (2009:97) refer to as polarisation, where the themes contain oppositional, contrasting, yet significant relationships in the analysis. The men were unprepared for returning to the community. They recalled challenges such as experiencing fear, anxiety, lacking self-confidence and negatively affected by the stigma associated with mental ill-health. This resulted in them socially withdrawing, feeling lonely whilst wanting to connect with others. The strong sense of feeling disconnected was evident in the men's account. However, there was also contrast and divergence. There also appeared to be a form of connection present and prominent revealing an element of the men's journey that reflects the contact and significant relationship they had with the Black community voluntary mental health service they attended. These services appeared to provide the patience, understanding and sense of belonging that they desired. The following extracts demonstrate the range of support offered and the value of the support when moving on and starting again:

> *Well he got me benefits, he made sure I ate, he made sure I changed my clothes and everything…(Barry, line 44)*

I did that (worked in the kitchen) for three years, that's the only job I've ever had, I've never worked before, I did that for three years…(Henry, line 492).

As well as being a conduit for practical support and a means for occupation and valued social roles, the service provided the social contact and interaction that was absent. The service offered the men a pathway for social reconnection and becoming involved in the everyday activities that before becoming psychotic they had taken for granted and did with ease:

I met different Black people, my friends you know what I mean from way back, we play some pool, have media group discussion and things like that…(Carl, line 406).

As well as supporting the men to take steps back into social environments, there was another aspect to their connection that appeared to have a significant meaning to the men; with possible references to what is missing in other environments and spaces:

It's good for Black people to go, to have somewhere to go they can feel relaxed and you can talk to the staff, the members and you can just be yourself (Andy, line 496)

The men's reflection also revealed poignant accounts. Experiencing mental ill-health can be a matter of life and death as revealed in superordinate theme 1: Becoming Psychotic. In this final extract, Andy evidences another example of what it means to receive support from the Black community voluntary mental health service:

I'm glad that I go there (Black voluntary mental health community service) cos if I wasn't there I probably be dead by now...cos it (Black voluntary mental health community service) was like a lifeline you know what I mean…a lifeline… (Andy, line 191)

Andy's metaphor of a lifeline symbolises the significance of the Black voluntary community mental health service. The lifeline generates imagery of the men hanging on but also slowly, tentatively, pulling their way up for air and safety. Sometimes they might slip or let go, but eventually, they make their way back to shore and start over.

Summary of superordinate theme 3: Starting over

This third and final superordinate theme does not necessarily convey a fairy-tale ending for the men. It reveals another significant transition in their journeys, the transition from the mental health institution to community life, interpreted as Starting over. It is in their transition and attempts to move on that the men become trapped at times in another downward spiral dominated by a series of juxtapositions. These juxtapositions reveal their deep desire to slot back into their life, recover from psychosis and move on. Whilst having these aspirations, the men experience barriers due to insecurities, fear, side-effects of antipsychotic medication, public stigma and self-stigma that lead to a lack of confidence and loneliness. Their responses and attempt to cope through social withdrawal and isolation inadvertently leads them further away from their goals falling deeper into disillusionment, despondency and psychological instability.

This final superordinate theme also encompasses a contrasting experience; it captures the Black community mental health voluntary services that they attend, the pivotal role these services have in their starting over. These services provide a safe space for the men, the kind of environment where amongst other Black people experiencing mental ill-health, they can come together, feel at ease and not be cautious, anxious or fearful as they were in inpatient services or when they were unwell. In these environments, they have the prospect of rebuilding and regaining the positive sense of self and have culturally sensitive support system they would like. Starting over is part of their journey, a process which for some of the men is repeated as they experience repeated relapses, readmission to inpatient services and discharge back into the community. Each time this occurs, they experience a new transition, a new journey, a new starting over.

Chapter 7: Discussion

It is only after the deepest darkness that the greatest light can come
Malcolm X

7.1 Introduction

Chapters 4, 5, and 6 presented this study's findings as three superordinate themes that explored three distinct features of the men's lived experiences and journey. Superordinate theme 1: Becoming Psychotic outlined the men's transitions from their 'everyday' lives to new worlds of psychosis, where their levels of distress required them to have contact with mental services. Superordinate theme 2: Dehumanisation and Domination explored their initial contact with those services, contacts that revealed a pattern of domination and dehumanisation from practitioners charged with their safety and overall care. Superordinate 3: Starting over captured their experiences transition as the men were discharged from hospital and attempted to reintegrate back into community life and recover from their psychosis.

This chapter offers a critical examination of the findings and their relationships to the social, cultural and theoretical context, as required in IPA studies (Smith, Flowers and Larkin 2009). It is organised into five sections: a revisiting of the study's initial aim and research question; a critical application of the findings to Young's (1990) forms of oppression and the new model that emerges from it; a discussion of the insights gained from the men's lived experiences of developing psychosis; a review of the study's implications for improved mental health practice, education and research; and a critical reflection of researching Black men and oppression followed by an examination of the limitations of the study.

7.2 Initial aim and research question

The aim of the study was to gain an in-depth understanding of Black men's experiences of mental health and oppression. The central research question for the study was: What are Black men's lived experiences of mental ill-health and oppression?

The study used the qualitative methodology IPA in combination with Young's (1990) forms of oppression (cultural imperialism, powerlessness, exploitation, marginalisation and violence) to explore Black men's experiences of developing psychosis. The following section applies the men's lived experiences to Young's model (1990).

7.3 Black Men's lived experiences of psychosis applied to Young's (1990) Forms of Oppression

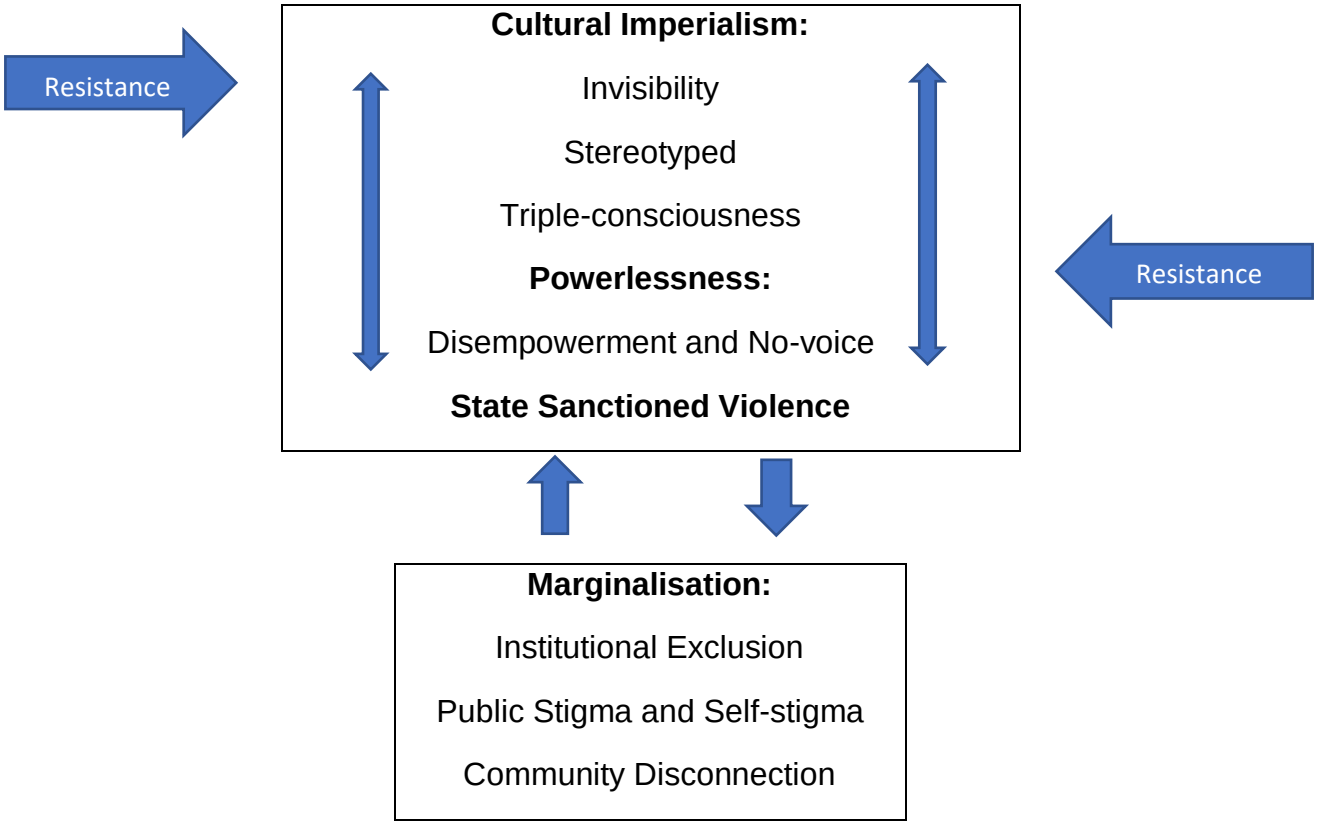
Young (1990:40) contends that all oppressed groups experience an inhibition of their ability to develop, exercise their capacities and express their thoughts, feelings and needs. Her forms of oppression provide a valuable starting point to examine Black men's experiences of oppression. Frye's (1983) metaphor of a birdcage shows the complex interconnected nature of oppression and the network of barriers that prevents the bird from leaving the cage. It suggested that Young's work (1990) was unable to encompass fully the interconnections of oppression for Black men. Based on the findings, a new model of the forms of oppression model was developed, as Mullaly (2002) suggests, no one model or theory can account for the multiplicity of oppression. Although it is important to acknowledge Young's strengths and her contribution to our understanding of oppressive experiences, there are limitations in her model we cannot take it for granted that it will be applicable to all groups or will be experienced in the same way.

The findings of this study show that cultural imperialism, powerlessness, violence and marginalisation are the forms of oppression that dominated the men's experiences of mental health services. Exploitation did occur for some of the men however, it did not dominate their overall experience. See Figure 6. for Young's (1990) Forms of oppression and Figure 7. for the Revised model of oppression.

Figure 6. Young (1990) Forms of Oppression

Cultural imperialism: Invisibility Stereotyped Double-consciousness
Powerlessness
Exploitation
Violence
Marginalisation

Figure 7. Revised Forms of Oppression



The new model makes four significant changes to Young's work (1990). The first is that double-consciousness becomes triple-consciousness. The second is that cultural imperialism, powerlessness and violence occur simultaneously rather than separately and are interconnected and mutually reinforcing. The third is that the men use different strategies to survive and resist their oppression by mental health services. The fourth is that they still experience what Young called marginalisation in 'care' and in the community, but this is better understood as institutional exclusion in mental health services and community disconnection based on their experiences of public stigma and self-stigma.

7.3.1 A new model of Cultural Imperialism

Young (1990:58-59) describes cultural imperialism as a paradoxical oppression, where the dominant meanings of a society render the perspective of one's own group invisible, whilst at the same time stereotyping groups and marking them out as 'the other'. The findings show cultural imperialism as a key feature of the men's oppressive experiences in mental health services. Invisibility and stereotyping as explained by Young (1990) remain in the new model, shown in the domination of the medical model and the men's racialised experiences. This leads to the new concept of triple-consciousness.

In chapter 1 the medical model was identified as a universal, deficit approach to understanding mental health that renders invisible different conceptualisations and their treatment. The findings show that when the men notice changes in their mental health, they express those changes through their own belief systems. They referred to experiencing "family difficulties", "having a spiritual transformation" and the "stress of being in prison". Theme 1 of the qualitative synthesis in chapter 2 also shows the range and variety of beliefs Black males held. These were underpinned by lay/conventional perspectives of mental health, culturally specific belief systems, spirituality and views, such as racism in society. Many of these belief systems do not align with the "universal" framework provided by the medical model and leads to mental health services both rejecting the men's definition of their own lives and needs and labelling those definitions as deviant which they use as further evidence of their illness. When asked about their treatment in mental health services, antipsychotic medication symbolised the men's experience, what Gary called:

“Medication down your throat”. Gary’s statement indicates the powerlessness created by the compliance and control model of their treatment and contradicted the men’s wishes for natural remedies, an integral part of their Caribbean culture and lifestyles, but irrelevant to mental health services.

Previous studies of Black men and Black women’s experiences of mental health services have been critical of the domination of medication and the medical model to reduce their distress (Edge, Salla and Dansa 2018, Maynard 2008, Mckeown et al. 2008, Wagstaff et al. 2018). This domination is at the expense of more holistic and less invasive approaches and interventions, such as social and psychological interventions, consistently absent not only in Black people’s mental health care but for other minority ethnic groups too (Beck et al. 2019, Bignall et al. 2019, Memon et al. 2016, Mercer et al. 2018). Whilst Young’s (1990) notion of invisibility is significant, the findings question the “one size fits all” approach to mental health that disregards individuals’ perspectives and the complex social realities of their lives, including discrimination and exclusion (Edge, Salla and Dansa 2018, Memon et al. 2016, Sewell 2012). The capacity of mental health services to connect with Black men’s lived experiences is a central feature for their recovery and the findings show that its absence is a defining feature of their experiences.

The second significant aspect of cultural imperialism in the men’s oppressive experiences is their stereotyping and “othering”. This is a fundamental part of oppression and its legitimation (Cudd 2006, Mullaly 2002). Coined by DuBois (1903) double-consciousness describes the dynamic of being “Black” and having an awareness of how you are defined by two cultures, the dominant “White” culture and your own culture. DuBois (1903) said that Black people live with this ever-present sense of this two-ness in their daily lives, this idea captures the racialised experiences of the men and its impacts on them. Young’s (1990) use of DuBois’s concept of double-consciousness helps explain how the men were othered and its impact on them. However, their experiences suggest a new way to think about double-consciousness.

Many have focused on the negative outcomes for Black men experiencing mental ill-health (Fernando 2010, Keating 2007, McKeown and Stowell-Smith 2001, McKeown et al. 2008) but fewer have investigated the essence of their experiences as revealed

in the qualitative literature review in chapter 2 and in this study. The findings indicate that the concept of double-consciousness (Du-Bois 1903) is useful and relevant but does not fully capture the men's experiences. The 'two-ness' of double-consciousness is too narrow and restricted; it does not allow for more than one identity and other forms of domination affecting the men at the same time. The men experienced an additional layer, what I have named triple-consciousness, the awareness of living as a Black man with psychosis in a racist society. In hospital to receive care and treatment just like everyone else, the men become aware that their status and treatment are somehow different. Throughout their interactions with mental health practitioners and other individuals with mental ill-health they are constantly reminded of their inferiority and devalued status as Black men diagnosed with psychosis.

hooks (2013) contends that living with racism is a fact of life for Black people and for the men their racialised experiences were significant in their othering. They were treated differently to White patients: mental health practitioners opted for physical restraint rather than de-escalation techniques and used violence to keep them in their place. The everyday communication and attitude from mental health practitioners showed the men that they were neither valued nor cared for. This maintained a distance between them, as did their experiences of racial abuse from other patients. Devalued and uncared for, they were unable to focus on their recovery, they were preoccupied with how they were viewed and their devalued status.

The literature around the racialised experiences Black people in mental health services suggests that the men's experiences are not new (Edge, Salla and Dansa 2018, Keating 2007, Sewell 2012, Wessely 2018). These experiences have also been found in studies that include minority ethnic groups living in the U.K (Bhui and Mckenzie 2007, Bhui 2002, Memon et al. 2016). The findings suggest that they have become the norm and social practice that Young (1990) refers to, providing insights into their hidden personal worlds in mental health services. They show the challenges Black men face in maintaining a positive self-image whilst making sense of psychotic symptoms and racist encounters that erode their confidence and sense of self. These challenges and dynamics are not often revealed in the mental health literature.

There is little about the therapeutic value of treating Black men as people who want to be recognised as men and feel valued and supported. This is also absent from Young's discussions (1990) around groups experiencing double-consciousness often maintaining a positive sense of identity. Maintaining a positive sense of identity can and does occur; it is observed in individuals with mental ill-health who share their experiences to inspire others (although, such Black role models are hard to come by and appear invisible). These narratives show that a positive sense of self is not a fixed way of being, but is fluid and fluctuates (Deegan 1996, Gray 2006, Hart 2017, Linton and Walcott 2018) and sometimes does not occur. It is extremely challenging to attain, particularly when experiencing oppression and mental ill-health simultaneously. This triple-consciousness can lead Black men to believe and internalise racist perceptions, questioning their "manhood" and whether they are a valued person. This internalisation is a detrimental consequence of oppression that presents itself in the men's negative self-analysis and preoccupations about their mental health status. This is confirmed following their discharged from hospital and explored further below.

7.3.2 Powerlessness: Disempowerment and No Voice

Within the new model, powerlessness is still a central aspect of how the men experience oppression. The findings suggest that the men experience powerlessness when they develop psychosis; as Des put it: "Me head tek me" (My head has gone. I've lost my mind). They also have to contend with being made powerless by the mental health services, which, as Young says (1990:56) acts to take away their authority, status and sense of self and expose them to disrespectful treatment. The findings show the men's powerlessness in their disempowerment and denial of voice: no power and no voice. The men have no power to define their own mental health or subsequent treatment and are disallowed from effective decisions about their care and treatment. As Ian said, "It was up to the doctors in their reviews to let you know your progress really, everything was out of your hands". Deemed mentally unstable, mental health practitioners believed the men did not require information or have any autonomy. Even when the men improved, there was no expected shift in the balance of power in their care; the approach from mental health services remained inflexible. This appears to be a common experience in inpatient services (Akther et al. 2019, Laugharne 2011, O'Brien and Golding 2003).

There are parallels between the men's experiences and those found in other studies of Black people who report disrespect and disregard in their own care (Edge, Salla and Dansa 2018, Myers and Ziv 2006, Secker and Harding 2002, Wagstaff et al. 2016). Similarities were also found for other minority groups living in the U.K who express more dissatisfaction with inpatient care (Weich et al. 2012) and spoke of racialised experiences (Bowl 2007, Memon et al. 2016).The theme is that mental health services and practitioners struggle to put person-centred care into practice and to demonstrate the effective partnership working required of them.

The findings show another aspect of powerlessness in the men's oppressive experiences. Young (1990:56) refers to powerlessness as a social position that gives little opportunity to develop and exercise skills and the findings show that services and practitioners have no interest either in helping the men to learn about their own mental health and to develop coping strategies for their own recovery. These skills are important aspects of mental health care and reintegration, but the men left hospital and returned to the community experiencing psychotic symptoms, anxiety and lacking in confidence. The findings show that apart from taking medication, there appears to be limited guidance and support provided to Black men leaving mental hospitals. This situation maintains the men's powerlessness, as they are ill-equipped to understand and control their psychosis, which is critical to their recovery and reintegration back into the community (Deegan 1996, Gray 2006, Linton and Walcott 2018). They rely on mental health services who situate themselves as the 'experts' and have the 'key' to their mental health needs, when in reality for these men they increase their powerlessness, making it even more of a challenge for them to recover and survive outside of the institution.

7.3.3 State Sanctioned Violence

Violence is still a significant aspect of the men's oppressive experiences. Based on the men's experiences, the violence they experience is called state sanctioned violence because mental health services enable, perpetuate and tolerate violence**.** Studies of violence in mental health services usually focus on the violent acts of individuals experiencing mental ill-health towards those around them, mental health staff and others with mental ill-health (Blue, Glue and Carlyle 2014, O'Rourke, Wrigley and Hammond 2018).

They seldom focus on the violence perpetuated within and by mental health services, such as coercion, physical restraint in mental health services and the impact on individuals (Rose et al. 2017, Sashidharan, Mezzina and Puras 2019). Both Young (1990) and Culley (2006) suggest that it is common that violence is used to keep the 'othered' in their place and to ensure dominance.

The findings show examples of violence against the men encountered. They were detained under the Mental Health Act (2015), forced to leave homes and the communities they lived in; 'overzealous' staff were quick to use physical interventions, to force injections of anti-psychotic medication and to seclude them. In the few studies that interviewed Black people about their experiences of mental health services, there is a theme around the unnecessary use of force and cruelty by mental health practitioners, particularly in inpatient care (Edge, Salla and Dansa 2018, Mckeown et al. 2008, Secker and Harding 2002). Munshi, Bhugra and Crawford (2018) also express concern about coercive practices used in inpatient care across BAME groups. The threat of coercion continues outside of the hospital, following them into the community if they do not comply with treatment (Akther et al. 2019, Laugharne et al. 2011). Mental health services have been criticised for their increasing use of coercive practice and poor approach to risk management, characterised by O'Rourke, Wrigley and Hammond (2018) as over-reactionary and inflexible. The government definition of good practice requires the least restrictive practices (Department of Health 2014) and the men did not appear to have experienced this.

As suggested in chapter 1, mental health practitioners might declare an increased sense of intimidation from Black men and perceive them as more prone to violence and aggression (Tegnerowicz 2019). Keating and Roberson (2004) propose that such perceptions of dangerousness and unpredictability lead to staff avoidance, which makes it more challenging to build a rapport and reduce the barriers between them (Keating and Robertson 2004). The violence reported in the findings are indicative of a theme: violence is normal in mental health services; little responsibility is taken for the oppressive realities mental health services perpetuate.

Here the findings both support and rework themes in the existing literature through its focus on the seldom heard impact on the men. Experiencing psychosis in a

controlling hostile environment leaves the men feeling threatened and intimidated. Experiencing control and restraint are demoralising and humiliating experiences that undermine the men's dignity and masculinity. Experiencing restrictive practices either as a victim or a witness can result in sleeping problems and excessive worries (Akther et al. 2019). Edge, Salla and Dansa (2018) found that it affected Black people's ability to feel safe in hospital and Keating and Robertson (2004) found it generated fear, which is not what we should associate with mental health care. Physical restraint can be traumatising in itself and trigger previous traumatic events (Akther et al. 2019, Rose et al. 2017). Rose et al. (2017) suggest that the violence and trauma experienced in mental health services tends to be viewed from a female perspective. There is a lack of literature around the traumatisation of Black men, Black women and other minority groups by mental health services, indicating a failure to recognise that they require sensitivity. They too can be traumatised and retraumatised by the violence they experience (Collier and Kalathil 2011, Curry 2017, hooks 2004), violence underpinned by control and domination, that also damages the relationship between them and the staff that they rely on. Generating trust, a therapeutic alliance and feeling safe are important aspects of mental health services (Laugharne et al. 2011, Singh and Burn 2006, Wright and McKeown 2018) the findings highlight why this is hard for the men to attain.

7.3.4 Resistance and Survival Strategies

According to Collins (2000), where oppression is present resistance is present, they are intrinsically linked and influence each other in many different ways. Resistance is not part of Young's (1990) forms of oppression and is included in the new model as an important and relevant aspect of the men's oppressive experiences. It also highlights an unexplored area of Black men's relationships with mental health services. The literature tends to focus on the inequalities of mental health services, what is done to the men or its outcomes rather than their resistive responses to and efforts to survive the cultural imperialism, powerlessness and violence they experienced simultaneously. Amidst the distress and damage, the men survive and resist as best they can, drawing on their cultures and communities.

This is shown in diverse ways. It includes questioning mental health services, being assertive, expressing their needs and silence, even though it can come at a cost.

Harvey (1999) suggests that the power differences mean that those who resist are always vulnerable to reprisals and the findings illustrate this. Franklin and Boyd-Franklin (2000) and Fernando (2010) argue that mental health services and practitioners pathologise Black men for their assertiveness, view them as lacking insight into their own needs, responding to their assertiveness with physical or medical interventions. As Errol put it, “If you struggle, you’ll get it worse ennit”. The men are also pathologised for their strategy of silence, a common self-protection response to domination and power asymmetry (Myers and Ziv 2016).

The findings suggest that the men actively tried different strategies. This included avoiding particular mental health practitioners, disengaging from any ward-based activities and making their own “safe spaces”. In these spaces they could talk openly about their experiences and be free to express themselves with other Black men without being labelled as a threat. Such acts of resistance rarely do stop oppression (Reynolds 2020) but they do allow the men positive images individually and communally. This section is not about whether the resistance strategies are successful in changing the behaviour of mental health practitioners, the White patients or the institution or whether they have their desired impact. It notes a significant aspect of their experience and allows us to see that whilst mental health services render the men invisible and stereotype them, the men adapt, making attempts at different times not to be dismissed or degraded. They are not always passive: they may feel like victims at times, but they also contest the process, attempt to retake some control and restore a sense of self and dignity. Their actions and these dynamics encompass the complexity of their oppressive experience in mental health services. Their responses to their care by mental health services can be routinely misconstrued as confirmation of mental illness or “disengagement” rather than reasonable strategies of human resistance or survival. The findings indicate the need to look beyond how mental health services might label their behaviours and their assumptions to coerce and control (Reynolds 2020) and acknowledge that the men have agency that they will use in different ways to recreate senses of self and community to help themselves.

7.3.5 Marginalisation

Cultural imperialism, powerlessness and violence mean that the men are regularly denied their right to supportive, compassionate mental health care. They work to resist and survive this marginalisation and institutional exclusion. Young (1990: 53) argues that marginalisation is the most dangerous form of oppression because social structures and processes reduce options and opportunities for people to live and have a useful participation in social life. She says that it exists in different forms, although mostly frames it as community exclusion. Mowat (2015:457) says that marginalisation is both a "state of existence" and how people feel about it, an important point that Young (1990) does not consider. In the new model, marginalisation is multi-layered, underpinned by institutional exclusion in mental health services, community exclusion and self-stigma.

The findings highlighted the challenges the men faced returning to the community after their inpatient admission. Their heightened anxiety and lack of confidence highlight the importance of discharge preparation and adequate support systems from mental health services and the wider community. The qualitative literature review showed that the social support that Black men receive is a key factor in their ability to cope with their mental health as it is for others who experience mental-ill health (Independent Taskforce for Mental Health 2016, NHS 2019, Weich et al. 2012) This is also crucial given their experiences of mental health services where trust is broken and coercive practices promote fear (Keating and Robertson 2011, Laugharne et al. 2011). The support systems the men require and want are not always available to them when needed. Circumstances, such as difficult family relationships and an inability to find employment or meaningful activities, contribute to the men feeling estranged and disconnected from the community. Their experiences are similar to those found in other studies of Black men with mental ill-health (Maynard 2007, Myers and Ziv 2016, Wagstaff et al. 2016). When compared to other minority groups Morgan et al (2017) found Black people had increased levels of social isolation and exclusion; these factors all underline the challenges of community reintegration.

A key aspect of these challenges is their experience of stigma. The stigma associated with mental health is powerful and effects all communities, however some

argue that the sense of shame is more potent for Black people (Alvidrez, Snowden and Kaiser 2008, Keating and Roberson 2004) and other minority ethnic groups leading to social exclusion and isolation (Knifton 2012, Mantovani, Pizzolati and Edge 2016, Shefer et al. 2012).The findings and the qualitative literature review suggest that stigma poses particular challenges for Black men with mental ill-health. Tegnerowicz (2019) suggests that stigma could be heightened for Black men when given a diagnosis of psychosis or schizophrenia, given the specific negative stereotypes attached to them. The findings indicate a strong sense of self-stigma which is in the new model of oppression as a significant feature of the men's experiences of marginalisation. It is not part of Young's (1990) forms of oppression. Many people with mental health problems are aware of how others perceive them, what Corrigan and Watson (2002) refer to as public stigma, and self-stigma occurs when individuals internalise and believe those negative perceptions. This is not something that Young (1990) considers, but instead argues that people experiencing cultural imperialism maintain a positive state of identity without acknowledging the immense challenge to achieve and maintain this. The men's stories provide insights into these challenges and their implications. They confirm other studies that show individuals diagnosed with psychosis and bipolar disorder have increased rates of self-stigma (Burke et al. 2016, Oliveria et al. 2015, Ritsher and Phelan 2004).

Both stigma and self-stigma are associated with reduced confidence, low self-esteem, isolation and social withdrawal (Corrigan et al. 2015, Oliveria et al. 2015, Brohan et al. 2010) all of which are in the findings. The findings also confirm Corrigan et al.'s (2015) suggestion that stigma and self-stigma can lead to the 'why try' effect: individuals with mental ill-health lose their motivation to achieve their goals, hindering their relationships with others and reducing their capacity to recover. The men's negative feelings associated with public stigma and self-stigma contradict traditional masculine norms and further erode their sense of self. Alvidrez, Snowden and Kaiser (2008:884) in their study of stigma of Black individuals experiencing mental ill-health found that some of the Black men expressed feeling weak, flawed and "less of a man". The combination of failing to live up to your view of manhood, experiencing public stigma and attempting to cope with their mental health undermines men's agency and positive self-image thus promoting self-stigma and self-isolating behaviour. Even so, Corrigan and Watson (2002) suggest that these

responses are situational and fluid and the negative effects of stigma do not occur in all cases. Anderson's (2014) study of Black men diagnosed with schizophrenia found that they made efforts to challenge the stigma both in hospital and the community: they wanted to prove mental health practitioners and the wider community 'wrong'. These men had strong support systems, including peer support services. Mckeown et al. (2008) suggest that advocacy services for Black men could provide the necessary support. The recent review of the Mental Health Act 2015 by Wessely (2018) also emphasises the importance of BAME groups accessing culturally sensitive advocacy which is lacking at present. The men in this study attended Black voluntary community mental health organisations where they had space to be themselves and rebuild more positive self-identities. Access to support systems centred around their needs rather than the need to control can counteract self-stigma and community disconnection (Collier and Kalathil 2011, Georgaca and Zissi 2018). This takes time and not all Black men with mental ill-health will have access to these community-based services or receive the psychological support that could help to address self-stigma. The findings shed light on how public and self-stigma shape Black men's community marginalisation and the challenges they face in reintegrating with a sense of power and agency in their lives. This changes the understanding of their unique issues and the community support required to promote their mental health and wellbeing.

Conclusion

This section has outlined a revised model of Young's (1990) forms of oppression based on the men's lived experiences of developing psychosis which is a significant contribution to knowledge. Oppression is often said to be so woven into the fabric of society that it is difficult to pinpoint and see (Mullaly 2002; Young 1990). These men were far from being blind to their oppression, they revealed varying levels of insight and awareness of their own oppressive experiences in mental health services. They do not use the language of Young's forms of oppression or academic language, but their understanding is clear and concise, as shown by Des: "So, I'm struggling against all these forces". Des's "forces" are summarised in the new model of oppression. The combination of cultural imperialism, powerlessness and violence increases distress and overwhelms. It gives limited scope for Black men to connect with the staff, gain a sense of what has happened to them and work through what to

do next – these are central aspects of mental health care (Independent Taskforce for Mental Health 2016, NHS 2019). The model includes the men's resistance and use of survival strategies, their experiences of marginalisation both within mental health services and the community. It sheds light on the why there is dissatisfaction with mental health services for Black men and their families and the need for avoidance and disengagement as logical and a rational response to their experiences. The findings also indicate the difficulties of reintegration and recovery, offering new ways to think about and respond to Black men's experiences that are hidden and beyond the well-known statistics and negative outcomes. Connections to Black women and other minority ethnic groups are highlighted, shared experiences and concerns are revealed. The discussion now shifts to a more detailed examination of the men's experiences of psychosis.

7.4 Black Men's Experience of Psychosis

This section discusses the men's experiences of psychosis and the wider literature. Black men's overrepresentation in forensic and restrictive settings in mental health services has been well documented and discussed by practitioners and academics for over thirty years (Fernando 2010, Keating 2007, Mckenzie and Bhui 2007, McKeown and Stowell-Smith 2001, McKeown et al. 2008, McKenzie et al. 2001, Sharpley et al. 2001). These debates silence the voices of Black men diagnosed with a psychotic illness. The qualitative literature review shows that most qualitative research conducted to date is conducted in the U.S.A and focuses on Black men's understanding and experiences of mental health and depression. There is little discussion of their experiences of psychoses. The findings of this study show the men openly sharing stories of developing and coping with psychosis, a significant contribution to knowledge. These stories indicate that like most of the general public (Evans-Lacko, Henderson and Thornicroft 2018) the men lacked mental health literacy - they underestimated what was occurring and were unsure about what to do to improve their mental health. Mental health literacy is an important concept that includes the knowledge and actions individuals require to aid their own and/or other's mental health (Jorm 2012, Furnham 2018). It involves a number of discrete and interrelated factors, such as (a) the public's knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help

strategies for milder problems and (e) first aid skills to support others affected by mental health problems (Jorm 2012: 231).

The qualitative literature review in chapter 2 shows different aspects of mental health literacy in the Black men and offers insights into everyday lay beliefs about mental health. The literature review also highlights unique insights into their belief systems concerning their stress/distress. Some believed their symptoms to be the direct result of being a “Black man” rather than any existing or potential mental health difficulty, because Black people are strong and have an innate resilience that protects them from developing mental ill-health or that mental ill-health has a spiritual foundation. The multiple layers of Black men’s conceptualisation of mental health are significant as they demonstrate a potentially unrecognised and unexamined complexity. They share a similarity with Black women who also adhere to narratives of strength and resilience (Donavon and West 2014, Edge and Rogers 2005), however Black women paradoxically contend with gendered identities that encourage being subservient (Collier and Kalathil 2011). Black men also have commonality with other minority ethnic groups who hold spiritual beliefs about mental health (Mantovani, Pizzolati and Edge 2016, Twining 2019). Intersections of race, gender and oppression shape how Black men cope, their help-seeking behaviour, feel stigma, and willingness to accept and adhere to treatment. This allows for a better understanding, grounded in our capacity to learn from their experiences.

The literature presents the ‘lack of mental health literacy’ as a barrier for Black people and other minority ethnic groups as a matter of concern (Memon et al. 2016). Studies of Black people such as Mclean, Campbell and Cornish (2003) and Ward and Besson (2012), found little capacity in identifying mental ill-health and little knowledge about accessing help. The findings in this study show that none of the men approached a GP for help for their mental health. This is not unusual, BAME groups do not readily access primary care (Bignall et al. 2019). Memon et al. (2016) study of individuals from BAME groups found language barriers, mistrust, and discrimination as barriers. In Myrie and Gannon’s (2013) UK study, many of the nine Black men interviewed were unaware of role of GPs for accessing mental health assistance, because they believed GPs dealt with medical problems. This combined with their belief that their stress came from “living as a Black man” (rather than a medical problem) to ensure that GPs were irrelevant to their needs.

These experiences highlight the importance of building trust, community-based mental health education and “myth busting” to ensure timely, holistic and effective support and interventions.

There is a danger that mental health campaigns privilege the practitioner perspective as more scientific and valid than the public (Furnham and Swami 2018). The literature and findings show the perceived implicit superiority and domination of the medical model and the tendencies to reproduce cultural imperialism (Bhui 2002, Keating 2007, Nazroo, Bhui and Rhodes 2020, Sewell 2012,). Community-based mental health literacy may be able to limit the ability for mental health practitioners to devalue and disregard the cultures, beliefs and experiences of BAME communities (Bignall et al. 2019, Memon et al. 2016). Positive changes require listening and adapting to their beliefs systems to develop tailored interventions that provide information and support in a timely manner. This means educating mental health practitioners to be more flexible and culturally competent in their approaches to mental health assessment and delivery of mental health care and to be able to work outside of the medical model (Bhui 2002, Edge and Lemetyinen 2019, Fernando 2010, Keating 2007). Although the men were unfamiliar with mainstream mental health symptoms, diagnoses and language, they knew they were changing. The findings of this study show how they made sense of those changes. Three key areas around that coping: Cultural and Masculine Self-reliance and Concealing, Cannabis and Self-medication and Spirituality are explored next.

7.4.1 Cultural and Masculine Self-Reliance and Concealing

The findings show the men using a variety of coping strategies when becoming psychotic. One key aspect of that was the need to be self-reliant, to try to continue as “normal”, which included concealing their emerging psychotic symptoms. This may seem insignificant, as people experiencing mental ill-health often do this and men use more avoidant behaviours and are more resistive to being open about their mental health and seeking help than women (Athanasiadis, Gough and Robertson 2018, Ridge, Emslie and White 2011, Seidler et al. 2016,). The qualitative literature review suggested that cultural influences exert pressures on Black men to adhere to behaviour associated with masculinity such as self-reliance and concealing behaviours. Stigma sanctions their appearance as “weak” and displays of

vulnerability. Together these factors shape how Black men and other minority men with mental ill-health cope but tend to be examined separately rather than cumulatively (Robinson, Keating and Robertson 2011). In practice, their complex interactions make it difficult to discern the triggers for particular responses and behaviours (Seidler et al. 2018, Watkins, Walker and Griffiths 2009). In their study of BAME men and mental health Robinson, Keating and Robertson (2011) found generational differences, diverse expectations and identities. These factors all increase the challenge to tailor specific strategies and interventions to their needs.

Watkins et al.'s (2016) work with Black men with mental ill-health highlights their tendency to "suffer in silence". This silence is contradictory, as Black men paradoxically want a connection with others, but they justify their concealment in terms of the challenges finding someone to trust with sensitive matters. The qualitative literature review and the findings of this study highlighted concerns around confidentiality and the quality of the relationship. Robinson, Keating and Robertson (2011) also found trust was a key factor for BAME men seeking help. These are amplified by the difficulties of developing trust whilst experiencing perceptual disturbances, such as hearing voices and other symptoms associated with psychosis that can perpetuate fear and a mistrust in others. These barriers to openness need to be considered in offering support before their symptoms become publicly problematic rather than simply personally distressing. Focus group studies in the qualitative literature review found Black men reporting the benefits of talking to other Black men about mental health and sharing their stories rather than symptoms (Dada et al. 2018, Kendrick, Anderson, Moore 2007, Myers and Ziv 2006) and the findings confirmed the men's openness and ability to show vulnerability. Therefore, Black men do not always conceal vulnerability or resist openness; they are simply cautious and selective and this has implications for facilitating trusted environments or "safe spaces" where they can be open and speak to others on their own terms about what is important to them and not what is wrong with them. These spaces and environments could be face to face, use social media and online technology. Pathing a way for Black men to develop mental health literacy, challenge the tendency for self-reliance and concealment and encourage health promoting behaviours.

The literature indicates that masculinity is an important aspect of the social determinants of mental health and mental health outcomes (Hoy et al. 2012, Seidler

et al. 2018). Mental health services seem to give it limited attention and even less to the complex ways masculinity affects Black men who develop mental ill-health (Robinson, Keating and Robertson 2011, Seidleret al. 2018). The findings and the qualitative literature review demonstrate this complex relationship. Seidler et al. (2018) recommend a masculinity model for mental health services to ensure that men's unique needs are integrated into their care. However, this would be unnecessary and impractical if there was a real and sustained focus on 'person-centred care' that recognises gender and cultural differences. Existing mental health services are meant to deliver such care, but the literature and the findings indicate that this is hard to find and inconsistencies occur. Given the strength of cultural imperialism and the deficit approach that stereotypes and pathologises men, the adoption of a masculinity approach could lead to the simple questions: 'What is wrong with men?' and 'What is wrong with Black men?' (Young, A. 2018, Kiselica and Englar-Carlson 2010). A real and sustained person-centred model for Black men would account for the contexts of their lives and provide cultural and gender sensitive approach that promoted proactive and creative ways of working with Black men over their life-span.

One response is Watkins and Jefferson's (2013) recommendation for the use of online support for Black men in the first stages of mental distress. This has the potential for preventing Black men presenting to mental health services in a crisis. Although to be successful, Black men will require access to the internet and appropriate information technology (I.T) support. Khan et al. (2017) evaluated programmes that used the arts and theatre with young Black men to build resilience and reduce the stigma of mental health. These programmes had positive benefits but tend to be ad-hoc with short-term funding, so long-term implementation and funding strategies could sustain the benefits of prevention and intervention at the early stages of mental health distress. These are necessary, as are the need for creative, tailor-made support programmes for Black men with ongoing mental ill-health. Edge et al. (2017) is an example of a tailor-made psychosocial therapy support programme, drawing attention to the possible benefits of culturally adapting family interventions specifically for Black people diagnosed with schizophrenia. The men in this study could access services at a Black community voluntary mental health project.

Such support and advocacy services are not uniformly available locally or nationally; years of austerity has affected access to funding and resources, leaving many Black men and their families to contend with mental health services on their own.

7.4.2 Cannabis and Self-medication

The findings show that most of the men used cannabis as a method of self-medication. The use of cannabis by individuals diagnosed with psychosis and schizophrenia is both usual and well documented – it is believed to help relieve anxiety and to have relaxation and sedative effects (Kolliakou et al. 2010, Mane et al. 2014). Wagstaff et al. (2018) specifically reviewed cannabis use by Black men diagnosed with schizophrenia and they found that it was linked to perceived benefits, such as helping the men think more clearly and elevating their mood.

The qualitative literature review noted cannabis use as a means for coping with the everyday stresses of being a Black man, as well as for experiencing mental ill-health. The literature review also outlined cannabis' significant functions beyond its psychotropic effects. Maynard (2008) found the Black men diagnosed with schizophrenia tended to smoke communally rather than individually and both Wagstaff et al. (2018) and Codjoe et al. (2013) found that cannabis helped restore a sense of "normality" and social connection. It offers a way to reduce the men's sense of difference and the exclusionary experiences they meet because of cultural imperialism. However, the literature review suggests that lone cannabis use can encourage concealment behaviours and undermine the ability to seek help (Kendrick, Anderson and Moore 2007).

Cannabis use in individuals diagnosed with psychosis is a double-edge sword. There are positive benefits. There are also negative psychosocial outcomes associated with cannabis use, such as homelessness, poorer adherence to medication, contact with the criminal justice system and increased relapse and contact with mental health services (Department of Health 2002, Manrique-Garcia et al. 2014), and often overlooked negative physical health consequences (Centre for Social Justice 2018). The findings show that the men were aware of the negative impact of cannabis but continued with its use to reduce their distress. Motivational interviewing and cognitive behavioural therapy (CBT) may be suitable interventions to support cannabis use and mitigate its disbenefits (Gates et al. 2016, Kolliakou et al. 2010).

However, the literature indicates that there are concerns that BAME groups are denied access to psychological interventions in mainstream mental health services (Beck et al. 2019, Mercer et al. 2018). It is important that Black men can access these interventions as part of their care and made aware of their availability, given their lack of access to such services this may well prove problematic, becoming an unmet need.

The findings of this study and the qualitative literature review show the often overlooked divergent functions that cannabis has for Black men experiencing mental ill-health. Mental health services need to be aware of these to ensure they gain a whole picture rather than limiting it to symptom relief. Having a holistic view allows mental health practitioners to appreciate the challenges Black men and others might face reducing their cannabis, especially when normalised within their social circle and promoted as a natural herb that is not harmful. Insight into Black men's perspective can help mental health practitioners work in partnership with them to devise tailored support and interventions.

7.4.3 Spirituality

In the findings of this study and the qualitative literature review spirituality played a role in Black men's conceptualisation of mental health and formed part of their framework for making sense of their experiences. Spirituality has been identified as being integral in recovery from mental health ill-health, as it can assist in providing meaning, purpose and hope, essential prerequisites for recovery (Chidarikire 2012, Leamy et al. 2011, Tuffour, Simpson and Reynolds 2019). There is a lack of recovery papers from a BAME perspective, the studies suggest that individuals from BAME backgrounds identify more with spiritual aspects of their mental health and might need an increased emphasis of spirituality in their recovery (Bignall et al. 2019, Collier and Kalathil 2011, Leamey et al. 2011, Tuffour, Simpson and Reynolds 2019). Paradoxically, spirituality can also negatively impact mental health and increase distress and delay help-seeking (Kao, Peteet and Cook 2020, Tuffour, Simpson and Reynolds 2019).

The findings supplied insights into the functions spirituality played for the men, such as forming part of the men's psychosis and how they made sense of their experiences.

This phenomenon is usual and appears in other studies where spirituality and mental health symptoms become enmeshed (Dein and Littlewood 2011, Tuffour, Simpson and Reynolds 2019).

The men used their spiritual frameworks to make sense of their experiences: Carl spoke of the devil and evil being present in the hospital, Ian defined his mental ill-health as a “spiritual transformation”. These expressions could be part of their psychosis but might also be “culturally specific expressions” of distress and discernment, misconstrued by mental health practitioners and have a negative effect on the care received. Although the men were open about their spiritual beliefs and interpretations, people from BAME groups experiencing mental ill-health often hold back from professionals for fear of being misunderstood, dismissed or pathologised (Twining 2019). Instead, they might look to their own spiritual practices on their own and/or seek out other forms of support and understanding from spiritual/religious leaders and church members they trust (Keynejad 2011, Mantovani, Pizzolati and Edge 2016). Such practices appeared in the qualitative literature review, these forms of support can be catalysts for seeking help or for avoiding and preventing it. Influenced by spiritual/religious leaders and church members level of mental health literacy and their perception of mental health services (Keynejad 2011).

The findings confirm the importance of spirituality to mental health practice. Wykes and Callard (2010) suggest that mental health practitioners need to be aware of the sociocultural contexts in which mental ill-health experiences occur, be able to interpret these experiences and respond appropriately. The findings show the challenges in achieving this, especially where mental health practitioners are unfamiliar with the person’s history and the different socio-cultural phrases and language that Black men or other minority groups might use to express themselves. The Royal College of Psychiatry (2013) and Nursing and Midwifery Council (2018) recommends taking a spiritual history or spiritual assessment to decipher the person’s spiritual beliefs and practices. The findings of this study suggest that this is a good starting place where appropriate, as it provides a step to understanding an individual’s ways of coping with their distress, can highlight important issues that may not have been uncovered (Chidarikire 2012, Huguelet et al. 2011) and allow entry into their personal world to help make sense of their experiences. However, this is uncommon practice within mental health services, with the domination of the

medical model and a mental health care system that does not seem to recognise spirituality (Twining 2019, McSherry 2019) alongside a tendency to prescribe medication for Black people's mental ill-health (Edge, Salla and Dansa 2018, Keating 2007, Maynard 2008, Mckeown et al. 2008, Wagstaff et al. 2018). Key parts of peoples' lives are neglected and made invisible, even though there is evidence that individuals experiencing mental ill-health can respond well to conversations around spirituality (Keynejad 2011, McSherry 2010, Twining 2019).

However, mental health practitioners lacked confidence and were uncomfortable with such conversations. These spiritual conversations were perceived as too complex, too personal and not part of their role (Chidarikire 2012, Huguelet et al. 2011, Keynejad 2011). Mental health practitioners require guidance and support about the relevance and value of spirituality in mental health and the integration of spirituality into mental health practices. Mantovani, Pizzolati and Edge (2016) suggest that community faith-based organisations hold positions of trust in Black communities and are an underutilised resource for mental health services. There is space for mental health services to develop collaborative relationships with these organisations for guidance and support on how to integrate spiritually into mental health care. In addition, a collaborative relationship with faith-based organisations could enable Black men experiencing mental ill-health to access support from mental health services in a timely manner (Keynejad 2011, Mantovani, Pizzolati and Edge 2016).

This section has discussed four key areas from the findings that address the second aspect of research question to gain an understanding of Black men's experiences of mental health: Mental health literacy, Cultural and Masculine Self-reliance and Concealing, Cannabis and Self-medication and Spirituality. The discussions offer a deeper understanding of how Black men coped with psychosis in light of the literature. Each area shows the importance of understanding the complex socio-cultural contexts of Black men lives and how these contexts interrelate and influence their beliefs and responses to their mental ill-health. The discussions also shed light on why Black men delay contact with mental health services; how Black men can be better supported through developing "safe spaces", where person-centred approaches can be co-created and co-delivered.

The following section focuses on the implications of the findings related to education, mental health practice and research.

7.5 Implications for Mental Health Practice, Education and Research: Where do we go from here?

The findings from this study show the result of having an open dialogue with Black men experiencing psychosis. The combination of IPA and Young's (1990) forms of oppression proved to be a powerful tool for accessing Black men's insights into their psychosis and their experiences with mental health services. The literature suggests that for some academics and practitioners, the focus on Black men, mental health and oppression is contentious (Bhui 2002, Singh and Burn 2007) for the men, the focus is not contentious, it is their lived reality. The men were eager to know what will happen because of this study and whether other Black men share their experiences. They knew that there is no one magic bullet to address the issues they raise, but the findings and the discussion do point to two key recommendations: a transformation of mental health services and a range of community support initiatives to strengthen mental health literacy and well-being.

There is evidence in the findings that suggests that mental health services are in a crisis. They are supposed to help people at their most vulnerable points in their lives, but do not do so when it is Black men experiencing mental ill-health who are in need of compassion and care. These vulnerable men received a mental health service dominated by medication, coercion, ignorance, racialisation, and violence instead. Given the oppression and microaggression Black men experience in their daily lives, they may well need increased levels of care and understanding from mental health services rather than control and chemical coshes. These experiences are not unfamiliar, similarities also occur for Black women (Collier and Kalathil 2011), and other minority ethnic groups who experience mental ill-health (Bignall et al. 2019, Edge and Lemetyinen 2019, Memon et al. 2016, Robinson, Keating and Robertson 2011). Policy initiatives and professional standards specify working in partnership, being culturally sensitive, adopting recovery and person-centred care (Independent Mental Health Taskforce 2016, Nursing and Midwifery Council 2015, NHS 2019). The findings show that these values and basic requirements of mental health care

were absent. It is problematic to encourage Black men and their families to seek assistance and support for their mental health from a system that, at best, fails to recognise their needs and, at worst, punishes them for their illness. This leaves the men and their families in the precarious position of being damned if they contact mental health services and damned if they do not.

The 2018 review of the Mental Health Act recommended a new policy initiative to develop a Patient and Carer Race Equality Framework (PCREF) and organisational competence framework (OCF) in mental health services to improve access, experiences and outcomes for BAME people in mental health services (National Health Service 2019:14). Although the recognition of the need to improve experiences of mental health services for BAME communities is welcomed, as is the increased investment in these services proposed as part of the NHS plan, the evidence indicates that significant change is unlikely if the same structures and processes remain. Mental health services need fewer frameworks and more transformation to deliver mental health care that can achieve its aims of providing safe, compassionate, person-centred care.

Singh and Burn (2006:650) assert that mental health practice requires trust, individuals experiencing mental ill-health and their families need to know that mental health services are on their side. A method to deliver the required transformation is through an explicit focus on anti-oppressive practice, a person-centred approach with the potential to deliver culturally appropriate and recovery focused care. To address structural inequalities such as racism, sexism and ageism experienced by those in contact with health and social care services (Hutchison 2015:2, Thompson 2016, Mullaly 2002). To attend to institutional power dynamics; confront and change social processes and practices that benefit the dominant group at the expense of subordinate groups (Mulally 2002:193). An anti-oppressive approach draws attention to the men’s oppression and addresses their experience of cultural imperialism, powerlessness, violence, and marginalisation.

The literature suggests that inclusive and effective mental health services can only be created by challenging the structures and practices that damage Black men’s lives and recovery (Bhui 2002, Keating 2007, Mclean, Campbell and Cornish 2003, Nazroo, Bhui and Rhodes 2020, Sewell 2012).

This requires on-going vigilance in mental health services and Harvey (2010) suggests the privileged have a duty to understand the life experiences of the oppressed. She stresses that this is no ordinary learning, as services and practitioners may resist the labelling of their everyday practices as reproducing oppression and injustice. Some want to ensure that domination and power remains in their hands (Johnstone and Kanitsaki 2008) and others with strong beliefs about equality want to ensure they avoid the label of 'agents of oppression' (Young 1990:42). These issues are compounded by institutional and individual sensitivities around race and racism in mental health services. The literature shows that mental health services can shy away from actually examining their everyday racialised practices through colour-blindness, personal offence or matters being simply too complex and beyond their control (Fernando 2010, Nazroo, Bhui and Rhodes 2020:271).

Careful management of anti-oppressive practices is required despite the sensitivities or defensiveness that may be expressed. Individuals who experience mental ill-health and their families' racialised experiences should not be ignored or explained away to make them more palatable to mental health services (Lentin 2020). Such transformation needs an environment that allows open, critical conversations that, as hooks (2013:36) suggests, move past blame and accusations to explore with Black men how mental health services can incorporate anti-oppressive perspectives into their care, to be part of the solution rather than the problem.

As well as suggesting the transformation of mental health services, the findings also revealed the importance of preventative mental health strategies and community support for Black men and their families. This requires investment in community support and an emphasis on those services collaborating with Black community groups to provide a range of culturally specific interventions. Black community groups have expertise in working with Black men and their families and are in positions of trust in the community. These initiatives have been successful, but tend to be ad hoc with short-term funding, although some groups have long histories of service and deliver mental health services in the community subject to the requirements of their funders. Both types of groups could be pilots for a more long-term strategy to increase Black men's access to a range of community-based resources and support systems depending on their needs.

The proposals involve personal, structural responses and active engagement with Black men, their families and community groups. It is vital that they have an integral role in the changes that they want to see, to create inclusive and effective mental health services.

Recommendation 1: **A culturally specific community and well-being programme for Black African and Caribbean families.**

The study shows a lack of mental health literacy. The first recommendation is for a culturally specific community health/mental health programme to improve knowledge about health/mental health, coping strategies, resources and access. It is imperative that the programme makes space for the different belief systems and coping strategies and promotes open and confidential discussion that focuses on the well-being of Black men and their families. The programme aims to equip people to cope with everyday stresses and ensure that if mental ill-health arises support is available to prevent deterioration and hospital admission.

Such a programme would challenge the stigma that surrounds mental ill-health, stigma that affects all communities. Black African and Caribbean individuals and families affected by mental ill-health will have space to share their stories and access resources and recruit and train community-based mental health ambassadors to challenge stigma and signpost support. The evidence suggests that a strict focus on mental health might be less beneficial and fruitful than a focus on community health and well-being. A holistic public health model incorporates physical, mental (and spiritual) health to promote better mental health literacy, early support, intervention and tailored care.

Recommendation 2: Mental health practitioners to receive education and training about oppression and support to implement anti-oppressive perspectives into mental health practice

The transformation of mental health services involves the more rigorous and extensive education and training of all mental health practitioners in anti-oppressive practices. The adapted forms of oppression model developed in the study is a useful framework for such education. It provides a platform for critical self-reflection and discussion about the norms and habits of everyday mental health practice and how it

impacts the care that Black men receive. Although individual practitioner behaviour is important, the education needs also to focus on the conditions that create the norms and habits in mental health services that perpetuate inequality and poor outcomes for Black men.

The focus is on compliance with existing legislation and frameworks rather than "special treatment" for Black men and their families. Even so, the study indicates that staff will require support to open about their racial and gendered biases, assumptions and stereotyping, whilst they explore how they can use their power to advocate for Black men experiencing mental ill-health (Corneau and Stergiopoulos 2012, Scammell 2016). No one is powerless to make changes.

This education can easily be built into medical school, mental health pre-registration nursing, post-qualifying mental health nursing courses and occupational therapy and integrated into the suite of mandatory continuous professional development programmes. Those responsible for curriculum development need to consider how best to work with Black men and their families to ensure their lived experiences are integral in their teaching and learning practices and resources. I have read one mental health nursing textbook with a dedicated chapter on issues that relate to race, oppression, difference or BAME communities. Again, the aim is simple compliance with the requirements of existing definitions of "best practice".

Recommendation 3: The implementation of a recovery programme specifically designed to meet the needs of Black men experiencing mental ill-health

Recovery is a fundamental aspect of mental health policy and mental health care (Independent Mental Health Taskforce 2016). The study adds to the literature that calls for change in recovery practices. The aim is "best practice" recovery becomes a reality facilitated in partnership with Black men and their communities, on their own terms rather than prescribed for them or professionally-led and dominated (Fernando 2010, Harper and Speed 2014, Perkins and Slade 2012). Recovery programmes should be based on recovery principles defined by those with a lived experience of mental ill-health, existing equalities policy and professional "best practice". To do this, an emphasis could be given to the BAME recovery literature, including the voices of Black men and their families and communities, to enable a more

personalised interventions to meet Black men's socio-cultural needs. The proposals below sketch such a recovery programme.

Peer support can be a valuable part of a successful recovery programmes (Anderson 2014, Repper and Carter 2011). In this programme it can be provided in inpatient settings and in the community from Black men with experience of mental ill-health. Already Black men in hospital with other Black men often offer informal peer support through friendships, communal living and sharing stories, resources and hope. Any recovery programme for Black men needs to consider the diverse nature of Black men's identities and oppression they face in their daily lives. In an environment where open dialogue can occur about how oppression affects their mental health, recovery and their identity as Black men and their coping and help-seeking behaviour. Such discussions could support the men to develop personalised coping strategies for their specific difficulties, which might include spiritual conversations, problem-solving techniques, relapse prevention strategies and the inclusion of family/carer/supporter resources. The focus is building strategies for self-determination and resilience that strengthen Black men's ability to identify when and where to seek help.

Recommendation 4: Mental health services and the communities that it serves to work collaboratively to build trust and challenge the 'othering' that exists in mental health services.

A structural transformation is not going to occur by Black men alone or from mental health services alone. It is more likely to occur when collective or collaborative approaches are present (Thompson 2016). This recommendation focuses on the development of a specific forum where Black men who have lived experiences of mental ill-health and/or their family/carers/supporters regularly meet with mental health services. The aims are to develop culturally and gender sensitive policies and practices in mental health and to hold mental health services to account for their delivery of mental health care. This could be a sub-group of a larger BAME group and contribute to other strategic groups, where alliances can be formed, energy and ideas shared and strategies developed to address oppression in mental health services.

Recommendation 5: The implementation of research initiatives that focus on each of the above recommendations.

The study supports the notion that Black men are not homogenous, they are diverse and have complex lived realities that are made invisible or irrelevant by mental health services and in mental health research conducted in the UK. There is a need for culturally and gender sensitive research into inclusive and effective interventions for Black men. This programme should explore both a health promotion and preventative work and how mental health distress can be mitigated and managed when it occurs.

An action research framework based on collaboration with Black men and their supporters is a suitable method for developing such interventions and reviewing the impact. This framework could also be fruitful in devising an anti-oppressive framework for mental health and exploring its impact on the delivery and experience of mental health care.

Recommendation 6: The implementation of recommendations from previous reviews, reports and best practice

There are previous reviews, reports and best practice guidance to address the inequalities and disparities that BAME groups face in mental health services (Joint Commissioning Panel for Mental Health 2014, Race Equality Foundation 2015, Wessely 2018). In these documents, recommendations for improvement and systemic change are made. This recommendation suggests that these recommendations such as ‘Better practice in Mental Health for Black and Minority Ethnic Communities’ by the Race Equality Foundation (2015), ‘Guidance for commissioners of mental health services for people from Black and Minority Ethnic Communities’ (2016), the recent review of the Mental Health Act (2018) be fully implemented to support the transformation that is required.

This section has outlined implications of the study that include exploring how mental health services could transform and achieve its purpose through a greater focus on anti-oppressive practice. This is necessary to address the longstanding issues that Black men face in mental health services that have become “normal” social practice.

The section also explored how we can strengthen mental health literacy and well-being for Black men and their families through collaboration and community support initiatives to ensure their access to culturally specific support. Transformation of any service is not a quick fix, there needs to be considered focus and commitment to work with Black men and their families to ensure mental health services provide inclusive and effective mental health care. The discussion now turns to personal reflections on the research and the limitations of the study.

7.6 A Reflection on Researching Black men and Oppression

This section offers a critical reflection on the research as a Black woman and mental health nurse. The qualitative research literature is clear that the researcher influences the research process (Finlay 2014, Shaw 2010). There are several things about me that both helped and may have hindered the study.

I got on well with the men and there was an openness in our individual and collective discussions. The study showed the importance of environmental conditions to the willingness of Black men to talk openly about what is important to them and share their vulnerabilities. In some ways this contradicts any practitioner and academic beliefs that masculinity and stigma around mental health make Black men experiencing mental ill-health more “resistive” and/or “difficult to engage” than other groups (Keating 2020, Wagstaff et al. 2016). A number of factors were at play in our interactions for open dialogue to occur.

The most obvious factor was that me and the men shared the same ethnic and cultural background. Men spoke with me with in a mixture of English and in patois (Jamaican dialect) in ways that demonstrated their ease and non-defensiveness. My years of experience as a mental health nurse had honed my interpersonal and interview skills – I focused on listening and being curious about what they had to say with no other agenda. I see now that the men knew this and allowed me the trust integral for this open dialogue to occur. These factors could also paradoxically be hinderances (Ganga and Scott 2006, Kerstetter 2012). Sometimes the men assumed I understood what they were saying from both a mental health perspective and by using culturally specific phrases. They believed that I was fully a member of their “insider” group. I wondered whether I should have clarified their meanings, at the

risk of highlighting my “outsider” status. I also questioned whether my nursing background encouraged me to unconsciously adopt the role of nurse, asking “clinical” researcher questions rather than the social science researcher version. How much this affected the quality of the interviews and the information gained is difficult to gauge.

Widdowfield (2000) argues that the researcher shapes the research process and is in turn shaped by it. This is the first time I have been involved in research as an insider and I recognise the truth of Widdowfield’s observation. I noticed my emotional investment in the study, which became an added pressure to deliver well. I wanted to ensure the men’s voices were present and that I had something substantial to present back to the men and the organisations they attend.

Gilbert (2018) suggests that the literature tends to frame Black men in a one-dimensional way, as victims to oppression. I wondered if my work actually perpetuated rather than challenged this myth, confirming this narrow view. Gilbert’s paper made me consider the challenges of locating positive narratives of Black men experiencing mental ill-health, of their recovery and promoting a perspective that shows their capacity to redefine themselves amidst difficult challenges. This was a pivotal moment for me. The men sometimes saw themselves as victims, their experience of psychosis and mental health services overpowered them. This feeling was not permanent, they survived and found ways through and this is what is left out of the literature. There is a need to represent the different narratives of Black men, especially the ones that demonstrate their vulnerability, openness, resilience and integrity (Curry 2017, Young, A. 2018).

Gender was an added dynamic. Whilst reading and interviewing, I became aware of my position as a Black woman. Smith and Osborn (2008:51) refer to the “double hermeneutic” as a relational dynamic required in IPA studies. Participants try to make sense of their world, whilst simultaneously the researcher is trying to make sense of the participant’s trying to make sense of their world. There is another layer to this, a ‘triple hermeneutic’ where I also worked to understand my own world as a Black woman and Black men in general. Certain points in the study, such as the writing of chapter 1 focused on oppression and Black men, resonated with me as they related to my brother, nephew, uncles, friends and their families.

The dynamic of living with the reality of oppression became more potent as I became more sensitive to the oppression built into everyday occurrences. This continues to shape how I view the world.

The study became more than just a thesis or an academic exercise to gain a PhD. It was not abstract concepts and data removed from my experiences, although it may have started that way. The more I became immersed in the study the more it connected with me. Learning about oppression has helped me develop my insight into the systemic issues in our institutions and my role in reproducing cultural imperialism. Labelling the first superordinate theme “Becoming Psychotic” might make me complicit in the medicalisation and pathologising of the men. It would have been more appropriate to use Des’s definition, ‘Me head tek me’, rather than the diagnostic label to represent their experiences.

Collins (2000) states that structures and processes are so familiar that they are unnoticed. This is true for me. I was born into and shaped by White British cultures personally via Eurocentric educational systems and professionally in mental health nursing and mental health services. The oppression perpetuated by those cultures is not “out there”, something that other people do, I have oppressed too. As stated in chapter 3, I was part of the oppressive mental health system the men experienced, which is difficult to accept. This recognition allows me to see it more readily in everyday life, whether watching a TV programme or speaking to a student nurse about their experiences on clinical placement. I notice its impact; it troubles me and I wish to support individuals to cope. This is also noteworthy. A theme in the literature and practice encourages individuals suffering oppression to work to understand their own oppression and then build resilience and coping strategies (Phillips, Adams and Salter 2015). This approach leaves institutions and their structures and processes largely unchallenged and when they are challenged they deflect, dismiss and nothing changes (Baker 2017, Nazroo, Bhui and Rhodes 2020).

At times throughout my journey of conducting my study I have felt a sense of inadequacy as I acknowledge the enormity of enabling institutions to reflect, without defensiveness and resistance that results in an immobility that changes nothing. This has also translated in me reflecting on my study and asking myself openly and honestly about what realistically it can achieve for Black men and their families. I am

conscious that although reflection in research is important and necessary (Finlay 2014, Shaw 2010) simply reflecting on realities without intervention will not lead to the change that is needed (Gill 1998, Lorde 2007, Thompson 2016). Whilst I have reflected and debated the theoretical, methodological and political issues of Black men, as so many of us have done and continue to do in the current climate, the lives of Black men and their families who have contact with mental health services remain the same.

7.7 Limitations of the study

In any research study there are limitations and improvements and I have noted four such limitations in this study. I conducted a qualitative literature review of Black male's understanding and experiences of mental health. I felt it strengthened the study and provided me as a novice researcher with the opportunity to develop new research skills, an important aspect of doing a thesis (Silverman 2010). It focused on the empirical qualitative research on Black males, but whilst this stringent focus ensured access to a specific group of research studies that focused on a Black males' perspective, it excluded other data and theory that could have further developed my understanding of Black males and mental health and may have limited the study.

This study used IPA as the qualitative research methodology. It was deemed suitable because of its explicit focus on the lived experiences of participants from their perspective and how they made sense of their experiences (Flowers, Smith and Larkin 2009, Smith 2018). Tuffour (2017) who used IPA in his study of Black Africans' beliefs of recovery questions whether its underlying Eurocentric philosophy is compatible when researching different racialised groups. This could be viewed as a limitation of this study. Even though I made efforts to ensure a culturally sensitive approach to the study, it might have been enhanced by using a specific culturally sensitive research framework to ensure consistency (Tilman 2006).

A key aspect of IPA is the ability to discover and/or uncover the participants' meanings. Smith (2011) states that the level of digging or uncovering needed to get at those meanings depends on the circumstances. This concerns the second limitation of the study, my ability as the sole researcher to gain the 'right' level of

interpretation required. There is a concern that there is ambiguity and a lack of standardisation in IPA, which can be problematic. Rettie and Emiliussen (2018) suggest that IPA warrants more guidance and definition around the meaning and practice of interpretation. This might be more significant for researchers new to the approach. Aware of these tensions Finlay (2014:120) contends that there are no hard and fast rules in interpretation, it is a continuum that varies between studies.

In addition to feeling uncertain about the level of interpretation required in IPA, I also found a tension in interpreting, getting the balance right to ensure that my voice did not overshadow the men's voices. I believe it is for the reader to decide this matter. I could have considered a more participatory research approach, such as working with a peer researcher. This could have been a Black man with experience of mental ill-health, to co-design the study, its data collection and analysis and to bring more balance to the work (Lushey and Munro 2014). This could address the limitations of the sole researcher and harness socio-cultural insights and perspectives that could have strengthened the interpretation of the findings and the study as a whole (Nordling and Pugh 2019).

Like most qualitative studies, this study used semi-structured interview as the main method of data collection. Semi-structured interviews are widely used in IPA studies for their ability to give rich detailed first-person accounts (Langdridge 2007; Smith, Flowers and Larkin 2009:58). They rely on participants' ability to concentrate and reflect on their experiences (Smith 2018). This is challenging for some individuals experiencing mental ill-health; their voices are silenced. This is the third limitation of the study. I could have considered more creative and inclusive methods, such as poetry, or visual methods such as drawing or photovoice to explore the men's lived experiences in alternative and insightful ways (Boden, Larkin and Iyer 2018, Rainford 2019).

This study like most qualitative studies used a small sample. By working with a small sample, the men's voices and their stories have provided a depth, revealing insights previously unknown. However, the men are not representative of all Black men that experience psychosis. Firstly, the sample are of Caribbean heritage, most of whom were born in the U.K or arrived at a young age. They therefore do not reflect the diverse nature of Black men in the U.K who have different identities and lived

experiences (Brown and Grant 2018, Glynn 2014) such as men who are new arrivals to the U.K, are of African heritage, have different immigration status, faiths and gendered identities. In addition, because of their diversity Black men may access support through different pathways to the men in this study. It is anticipated that this study has transferability (Lincoln and Guba 1985, Ryan, Coughlan and Cronin 2007), where the multitude of issues presented can be applied and deemed relevant to other Black men experiencing psychosis and have contact with mental health services. Encouraging research that reflects the diverse nature of Black men and different narratives.

This section has provided a personal reflection of the experiences I encountered as a Black woman and mental health nurse conducting research for the first time as an insider and outsider; highlighting some of the complex dynamics that surfaced in the study. It has also explored the study's limitations and areas for improvement. The next section outlines how the study contributes to knowledge and brings it to a close.

Chapter 8: Conclusion

Phenomenological research sets out to make new discoveries of the phenomenon of interest; to see the world from a different or new perspective (Finlay 2014). The stories shared by the men in my study offer new perspectives on the experience of psychosis, schizophrenia and mental health services. They offer unique contributions to our knowledge of how such difficulties can be better managed and how services can be better directed. These claims will be substantiated through a review of the study's aims, its strengths and key themes and their potential impact in relation to Black men, their families, mental health care and research practice.

The aim of the study was to explore the oppressive experiences of Black men who developed mental ill-health. This focus reflected my personal and professional interest to better understand both the contemporary and historical disparities that Black men experience in mental health services and the silencing of their voices in the mental health literature and in-service development. In both cases, those with power do not allow Black men to speak for themselves, to define their own realities, hurts, strengths and care needs. To access these voices and the personal and social worlds of Black men the qualitative research approach Interpretative Phenomenological Analysis was used to ascertain the men's lived experiences and how they made sense of them. In addition, Iris Young's (1990) forms of oppression framework (cultural imperialism, powerlessness, exploitation, marginalisation and violence) was used as a starting point to capture and explore the men's oppressive experiences.

The need for such a focus is unquestioned. In Chapter 1 I illuminated the social, economic, and political position of Black men and how the policies and processes in key areas such as education, employment, mental health care and the criminal justice system produce and reproduce racism, exclusion and disparities in their lives. By charting the prevalent and pervasive nature of oppression, which manifests across the life-course as Black boys become men, I provide context to the reality implicated in Black men's lives, albeit in different ways. It sketches the wires of Frye's (1983) birdcage and how they become connected in the men's experiences. Chapter 2 continues to underline the importance of recognising this system of

oppression in the daily lives of Black men and how it shapes Black men's sense of self and health and wellbeing. This includes how historical and present oppressive experiences influence their conceptualisations of mental health, coping and help-seeking. The qualitative literature review shows the interconnected nature of lay, cultural perspectives and masculinity on mental health, distress and illness. Such insights offer a firm foundation for mental health services to improve experiences and outcomes for patients, communities and staff across all areas of work. From the ideas shaping mental health knowledge and how this informs and shapes the engagement, assessment and treatment of Black men who come to their attention.

Chapters 4, 5 and 6 presented the findings of the study with the rich accounts associated with phenomenological research (Finlay 2014, Van Manen 2016). Henry, Ian, Gary, Frank, Errol, Des, Carl, Barry and Andy's experiences were analysed and organised into three super-ordinate themes that represented three significant aspects of their journey: *Becoming Psychotic, Domination and Dehumanisation and Starting Over*. Their stories brought to light their hidden worlds of control, distress and resistance beyond the statistics and trends in negative outcomes. The depth of distress they voiced at different stages of their journey revealed a vulnerability and a need for appropriate care and compassion inside and outside of inpatient services**.**

In 'Becoming Psychotic' we see into their experiences of living with declining mental health and the role that cultural, spiritual interpretations and masculinity play in how they make sense of their declining mental health and their coping strategies. These interrelated factors were significant throughout the men's journeys and their complexity supports the qualitative literature review findings that warns against treating Black men in a simplistic way. In 'Domination and Dehumanisation', the findings painted a damning picture of the men's experience of mental health services. These experiences should not be associated with mental health services. Basic therapeutic engagement skills were missing from their care: to listen, recognise them as human beings, acknowledge their vulnerability and sense of agency. Apparent in the findings is the impact of oppressive experiences, how they create and contribute to fear, frustration, hurt, mistrust and indifference to mental

health services. These both traumatise in the moment and promote avoidance of mental health services and future engagement.

The study highlights a complex, relationship between oppression, masculinity, stigma and cultural norms and their influence on Black men's communication. However, it does not mean they cannot be open and vulnerable, as demonstrated in chapter 2 and in the findings. The requirement for 'safe humanising spaces' became an important concept in the study and sketches a way for Black men to come together, be at ease and support each other without fear of domination. This was a space the men could breathe, as they were able to 'be' and 'see' themselves and their lives without the restrictions of negative, stigmatising labels that are attached to them and their lives. Such spaces can be supported by mental health practitioners who value them and help to establish relationships of trust and build therapeutic alliances.

The findings also point to difficulties the men experience returning to their communities, with public stigma and self-stigma playing an integral role in this. Urging a need for funding and commitment to community partnership with, for example, faith-based organisations and Black voluntary community mental health projects to implement the culturally specific community support Black men and their families require to remain in the community.

A significant aspect of the study is the combination of IPA and Young's (1990) form of oppression. This provides an original, powerful way to illuminate the phenomenology of oppression. The study delineated the limitations of Young's (1990) model of oppression framework and its inability to fully account for Black men's oppressive experiences. I put forward a model in which concepts such as microaggression, intersectionality, internalised oppression and resistance are viewed as part and parcel of Black men's lives and central to understanding their experiences of oppression not accounted for by Young (1990). This highlights a need to scrutinise critically frameworks that purport to be universal and applicable to all groups. This study presents a means of understanding oppression through revealing the interconnected nature of oppression, in which the reality of Black men's oppressive experiences is central and to the forefront of the analysis. It demonstrates what hooks (2004) refers to as 'living theory'.

We see how cultural imperialism, powerlessness, violence and marginalisation all play a part in devaluing Black men's identity and sense of self. They are all wires in the birdcage (Frye 1983) of being a Black man in the UK in the twenty-first century. These are interlaced with the challenges these men face in recovering from psychosis and schizophrenia, a monumental task in itself.

The model offered a new way to think about Du Bois's (1903) double-consciousness. The concept of triple-consciousness is offered as a recognition of the additional domination and 'othering' Black men experience when they develop mental ill-health. Stereotypes and coercion are compounded by criminal justice and mental health services. The model of oppression put forward also talks to Black men's resistance, offering a way to show how Black men's agency exists simultaneously alongside contending with oppressive experiences. It also recognises that these experiences can become internalised and undermine individuals and communities. The significance of public stigma and self-stigma is also shown to contribute to the men's marginalisation within the community. The new model offers an important way to view the impact of oppression on individuals who develop mental ill-health. It highlights the need for us to consider the tailored support they require as needs grow and services contract. In this, it provides a tool for education to question mental health practice and seek how to address the answers found for the benefit of all stakeholders**.**

A significant aspect of the study has been my relationship to the research process. In chapter 3 and chapter 7, I presented a reflexive narrative detailing my personal and professional connection to the work. I share my connection to the work as a Black woman and a mental health lecturer. In these reflections I offered my unique 'insider/outsider' dynamic to the study and outline how my status as an 'insider' made a positive impact on the men's ability to tell their story. I offered 'triple hermeneutic' as an extension of Smith, Flowers and Larkin (2009) double-hermeneutic to explain the multi-layered dynamic that occurred when attempting to make sense of my own world as a Black woman who has also experienced oppression, in tandem with the men trying to make sense of their world. I aimed to capture the complexity that occurs when conducting 'insider/outsider' research and

to underline the importance of talking through these dynamics with others who can understand.

My narratives also offer a way to think about the complex power dynamic in research and the importance of researchers being vigilant and accountable for their own research practice and not to reproduce oppression. I shared the impact of the research process on my own emotional well-being and the emotional labour when undertaking research that focuses on sensitive issues such as mental distress and researchers receiving suitable support, which can be neglected or overlooked in pursuit of research goals.

The study emphasised the importance of mental health services using a holistic and person-centred approach to ensure that the social, cultural and gendered context of Black men's lives are integral to all aspects of their mental health care. This contradicts historical and contemporary oppressive practices that contribute to and compound Black men's distress and alienate families and supporters and hinder their ability to recover and scar their sense of self.

Based on these observations, the research proposed that mental health services require transformation to address their 'taken for granted' and unofficially sanctioned social practices. It puts forward a number of recommendations for mental health practice, education and research that would facilitate this. These include having a focus on prevention and health promotion for Black men and their families and mental health services embedding anti-oppressive approaches in their policies and practices.

Although the focus of the study has been specifically on Black men and the unique issues they face, I would advocate that the adapted forms of oppression can be used as a framework to think about how other individuals and communities experiencing mental ill-health experience mental health services. The changes to improve experiences of Black men around people-centred and community-sustained and accountable services could open the way for the improvement of services for everyone. This demonstrates the transferability of the study (Ryan, Coughlan and Cronin 2007) and an inversion of the usual formula where the restraint of Black men is a model of bad practice. This is a unique contribution to knowledge derived from the research.

In bringing this study to a close, I know this is not the end of my journey. Lorde (2007:141) states that each of us must find our work and do it; it is in that spirit that this thesis is written. My interest in Black men and mental health started many years ago as a mental health nurse working in inpatient services where I observed their over-representation in mental health services and the poor levels of care they were given. I felt an imperative to learn. I did not know then that I would have the privilege and opportunity to undertake doctoral study that would focus on Black men and mental health. The title of this thesis asks: What do we learn when we listen to Black men's voices?

When I listened to Henry, Ian, Gary, Frank, Errol, Des, Carl, Barry and Andy, I was able to see beyond the statistics and negative outcomes that is associated with Black men who come to the attention of the mental health system. I learned about their darkest days and vulnerability, how they navigate, adapt, resist and survive in difficult, often hostile mental health system. It is because of these experiences that they can teach us about the complexities of developing and coping with psychosis and how to improve mental health services. We need to continue the dialogue, work collaboratively with Black men and their families; to go beyond the labels and challenge what we think we know if we are to bring about 'real' change.

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Appendix 1

Summary of the final qualitative research studies in the qualitative literature review

Author **Year** **Title** **Location**	**Study Design**	**Sample**	**Aims**	**Data Collection method**	**Findings**
Hudson et al. (2018) “Down in the sewers”: Perceptions of depression and depression care among African American men USA	Qualitative Thematic analysis	26 black men Average age 41 years	To examine perceptions of depression and barriers to treatment for black men	4 Focus groups	Common everyday beliefs of depression, some beliefs about depression not existing or is a choice Barriers to receiving treatment include masculinity norms, mistrust of mental health services and affordability
Ezeobele et al. (2018) Depression and perspectives of Nigerian immigrant men in the US USA	Applied Ethnography Thematic analysis	18 Nigerian born men living in the USA 25-63 years	To explore Nigerian born men’s perception of depression	Individual Interview	Depression does not exist Cultural and masculinity influences on their perception of depression Stigma Coping strategies-spirituality framework

					Avoidance of formal help-seeking
Wagstaff et al. (2016) Black men's experiences of disengaging with mental health services UK	Interpretive Phenomenological Analysis	7 black men diagnosed with schizophrenia	What are the black men's experiences of mental health services, reasons for disengagement	Semi-structured interview x2	Feeling persecuted by mental health services Negativity about medication No choice in treatment Stigma/identity issues
Dada et al. (2017) Perceptions: Peer research into the needs and perceptions of young black men on mental health and wellbeing. U.K	Qualitative Thematic analysis	78 young black men 14-24 years	What are the attitudes and perception of mental health and illness of young black men?	Focus groups	Mixture of levels of mental health literacy Stigma of mental health Masculinity issues Cultural mistrust Different coping strategies Help-seeking preferences

Hack et al. (2017) Mental illness aetiology belief among black men with serious mental health problems USA	Qualitative Thematic analysis	26 men diagnosed with mental illness 32-58 years 26 support network	Ascertain the beliefs from the Black men about the cause of their MH problems Beliefs from the support network	Semi-structured interview	Psycho-social stressors: stress-difficult childhood, family conflict, poverty, prison, military Causes of MH: stress, physical injury, inherited, drug and alcohol use, no explanation Support network – causes of MH same as above
Thomas (2016) Black men, are you too masculine for mental health treatment USA	Qualitative study using Common sense model as a framework	4 black men 18-30 years	Perceptions of black men on mental through a lens of masculinity	Individual interview and focus group	Definitions of Black masculinity Cultural conceptions of mental health Help-seeking behaviour Coping with distress
Samuel (2015) Utilization of mental health services among African American male adolescents released from juvenile detention: Examining reason for within-group	Qualitative Thematic analysis	54 black men 15-17 years	To examine the influence of culture on the attitudes and help-seeking behaviours	Individual interviews	Racism as a cause of mental health problems Environmental /community issues as a cause of mental health problems Alternative beliefs that depression doesn't exist

disparities in help-seeking USA					Influence of masculinity in coping and help-seeking Faith Mistrust of mental health services Barriers to help-seeking Community Stigma Influence of family and peers on help-seeking
Anderson (2014) African American males diagnosed with Schizophrenia U.S.A	Interpretive Phenomenology	5 Black men diagnosed with Schizophrenia 21-57 years	To investigate what it's like living with Schizophrenia	Individual interviews	Four overarching themes: They know they are mentally ill They test reality They assert their autonomy They see their illness as a gift Benefits of peer support in their recovery
Perkins, Kelly & Lasiter (2014) Our depression is different: experiences and perceptions of depression with young black men	Qualitative Thematic content analysis	20 black men 18-35 years	To explore perceptions and experiences of depression	Individual interviews	Anger and negativity Depression and weakness Invisible depression Masculinity Various coping strategies

with a history of incarceration USA					Our depression is different
Myrie & Gannon (2013) "Should I really be here?" Exploring the relationship between black men's conception of well-being, subject positions and help-seeking behaviour UK	Foucauldian discourse analysis	9 Black men 23-29 years	To explore the relationship between black men's concept of well-being and help-seeking behaviour	Interview	Oppression and discrimination as factors affecting black men's mental health and help-seeking Masculinity The influence of community cultural norms Professional systems and mistrust
Lindsey (2012) "We're going through a lot of struggles that people don't even know about" U.S.A	Qualitative Thematic analysis	27 Black men 15-26 years	Explore black men's perceptions of help-seeking for mental health problems	4 age appropriate focus groups	3 identified themes which help and hinder black men. Emphasises interventions that focus on multiple levels beyond the individual

Ward & Besson (2012) African American men's belief about mental illness, perceptions of stigma and help-seeking barriers. U.S.A	Descriptive qualitative study that used the commonsense model (CSM)	17 Black men 24-74 years old	Examine black men's belief about mental illness, perceptions of stigma and barriers to help-seeking	Individual interviews	Men identified with aspects of biopsychosocial model of mental disorder. They did not perceive stigma as a barrier to help-seeking They had stigmatising ideas Open to receiving help and treatment.
Bryant-Bedell & Waite (2010) Understanding major depressive disorder among middle-aged African American men U.S.A	Descriptive qualitative study Thematic analysis	10 Black men 40-59 years old	Examining the experience of depression, identifying depression and impact on their lives	Individual interviews	Life events that precipitated the onset of depression Experiencing depression Cultural nuances Various coping strategies Masculinity
Lindsey, Joe & Nebbitt (2010) Family matters: the role of mental health stigma and social support on depressive symptoms and subsequent help-seeking among	Mixed method design Regression and Descriptive Qualitative	18 young men (Qualitative) 69 young men - (Quantitative)	To explore their experiences of experiencing depression focusing on recognising depression, social support, coping and help-seeking	Individual interviews Survey questions	Qualitative results/themes: Experiences of depression Family identifying mental health difficulties Coping strategies-Family first Distrust of peers and mental health professional Stigma

African American boys U.S.A		Average age 15 years old		Mental health stigma Social support Depression	Masculinity
Maynard (2008) An ethnographic study of black men with an inner London area to elicit relatedness between black human condition and the onset of severe mental illness UK	Qualitative Grounded theory approach Thematic analysis	11 adult black men diagnosed with severe mental illness No ages given	To explore the process of becoming mentally unwell from their own perspective	Individual interviews	Themes included: Social instability Strained relationships Being detained under the Mental Health Act Absence of psychological intervention Reliance on medical model Coping Use of substances Masculinity influences
Kendrick, Anderson and Moore (2007) Perceptions of depression among young African American men	Qualitative Ethnography and participatory methods Thematic analysis	28 black men 18-25 years	Perceptions of depression among young African American men	Focus group and individual interviews	Themes included Identifying with stress rather than illness Depression as a fact of life Police interactions

USA					Depression is different Coping strategies
Watkins and Neighbors (2007) An initial exploration of what 'mental health' means to young black men USA	Qualitative Thematic analysis	46 black male college students 18-26 years	Exploration of what 'mental health' means to young black men	Focus group	Identifying with stress rather than depression Use of cultural nuances Community stigma Masculine influences Coping strategies Help-seeking issues
Lindsey et al. (2006) Help-seeking behaviours and depression among African American adolescent boys USA	Qualitative Thematic analysis	18 adolescents 14-18 years	To examine the help-seeking behaviour of depressed black adolescent	Individual interviews	Importance of family support Coping strategies Stigma Masculinity influences on coping and help-seeking

Appendix 2 Summary of appraisal of research studies using CASP Tool for qualitative research

CASP Qualitative Research Appraisal Questions	**Ezeobele et al. (2018)**	**Hudson et al. (2018)**	**Wagstaff et al. (2016)**	**Dada et al. (2017)**	**Hack et al. (2017)**	**Thomas (2016)**	**Samuel (2015)**	**Anderson (2014)**	**Perkins, Kelly & Lasiter (2014)**
1. Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.Was the research design appropriate to address the aims of the research?	Yes Applied Ethnography	Yes	IPA	Yes	Yes	Yes	Yes Phenomenology	Hermeneutic Phenomenology	Yes
4.Was the recruitment strategy appropriate to the aims of the research?	Community organisations Snowballing	Flyers, community agencies	Recruited from community mental health services	Various community organisations	Sample identified from another study Phone calls and letters	Limited information provided	Targeted mental health service, sought gatekeeper consent	Flyers, community agencies, mental health services	Recruited from a community programme

5.Was the data collected in a way that addressed the research issue?	Individual Interviews until data saturation. Variety of convenient locations	Focus groups	Individual Interviews	Focus groups and individual interviews facilitated by Peer researchers	Individual Interviews, convenient locations	Individual Interviews and Focus group	Individual Interviews	Individual Interviews until data saturation	Individual Interviews
6.Has the relationship between researcher and participants been adequately considered?	No attention given to this	Black man facilitated the focus group Acknowledgement of the potential for bias and lack of deep probing	White male researcher Examined how this may have affected the interview process	Implications of using Peer researchers examined	White female graduate interviewed sample Examined how this may have affected the interview process	Little attention given to this	No attention given to this	No attention given to this	Black female researcher Examined how this may have affected the interview process
7.Have ethical issues been taken into consideration ?	Ethical approval gained Informed consent	Ethical approval gained Informed consent	Ethical approval gained	Yes but not fully examined Informed consent	Ethical approval gained Consent Right to withdraw	No information provided	Study approval Parental consent	Minimal information provided Informed consent mentioned	Ethical approval gained Informed consent
8.Was the data analysis sufficiently rigorous?	Yes Explained process in detail Minimal data used to	Yes Explained process Data supported findings	Yes Explained process	Rich data provided that supported findings	Yes Explained process	Explained process Rich data provided to support findings	Yes Explained process Data supported findings	Detailed explanation provided	Detailed explanation provided

	support findings	Independent analysts	Data supported findings	Little information provided of the data analysis process	Data supported findings			Minimal data used to support findings	Data supported findings
9.Is there a clear statement of findings?	Discussion related back to research aims Some participant validation Research team independentl y analysed data	Discussion related back to research aims Research team involved to support analysis	Discussion related back to research aims Clarifying interviews held	Discussion related back to research aims	Discussion related back to research aims	Discussion related back to research aims Assistance from two independent researchers in data analysis	Discussion related back to research aims	Discussion related back to research aims Research team involved to support analysis	Discussion related back to research aims Author and co-author analysed data independentl y
10.How valuable is the research?	Implications to practice and further research highlighted Cultural based screening and assessment Engaging churches and religious group	Implications to practice and further research highlighted Culturally appropriate assessment and treatment Patterns of diagnosis in services	Implications to practice made. Addressing stigma Tailor made intervention s	Implications to practice made. Importance of accessing mental health services locally and having a variety of treatment options	Implications to practice made Cultural context and its impact on assessmen t and treatment of black men	Implications to practice and further research highlighted Cultural competent clinicians Understandin g the relationship between identity and	Implications to practice and further research highlighted. Influential factors in help-seeking Traumatic experiences and mental health	Implications to practice Benefits of peer support and partnership working	Implications to practice and further research highlighted Anger as a cultural specific issue in depression Masking of depression

						help-seeking behaviour			Development of interventions

CASP Qualitative Research Appraisal Questions	Lindsey & Marcell (2014)	Myrie & Gannon (2013)	Lindsey, Joe & Nebbitt (2012)	Ward & Besson (2012)	Bryant-Bedell & Waite (2010)	Maynard (2008)	Kendrick, Anderson & Moore (2007)	Watkins & Neighbors (2007)	Lindsey et al. (2006)
1. Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.Was the research design appropriate to address the aims of the research?	Yes	Discourse analysis	Descriptive qualitative	Descriptive qualitative	Descriptive qualitative	Ethnographic, grounded theory approach	Ethnography and Participatory methods Participant observation	Yes	Yes
4.Was the recruitment strategy appropriate to the aims of the research?	Recruited from community organisations flyers	Recruited from community organisations flyers Snowballing	community mental health services	community organisations local businesses	Local papers, clinics Public locations	Inpatient wards approached	Local church Snowballing	Emails Snowballing Direct contact	community mental health services, flyers
5.Was the data collected in a way that addressed the research issue?	Focus groups	Individual Interviews	Individual Interviews	Individual Interviews	Individual Interviews	Individual Interviews	Focus groups facilitated by participants and Individual Interviews	Focus groups	Individual Interviews

							Focus group informed development of interview questions		
6.Has the relationship between researcher and participants been adequately considered?	No attention given to this	No attention given to this		attention given to this reflection on prior beliefs and biases bracketing	Some attention given to prior assumptions	Limited attention given to this Bracketing mentioned	Neutrality Supervision	No attention given to this	No attention given to this
7.Have ethical issues been taken into consideration?	Ethical approval gained	Ethical approval gained Informed consent Debrief following interview Service Information provided	Ethical approval gained Informed consent Parental consent	Ethical approval gained Informed consent Anonymity Debrief	Ethical approval gained Informed consent	Ethical approval gained Informed consent	Ethical approval gained Informed consent	Ethical approval gained Informed consent	ethical approval informed consent Parental consent
8.Was the data analysis sufficiently rigorous?	Yes Explained process Data supported findings	Minimal information provided of data analysis Data supported findings	Yes Explained process in detail	Yes Explained process in detail	Yes Explained process Data supported findings	No information provided of data analysis Data supported findings	Yes Explained process Data supported findings	Yes Explained process Data supported findings	Yes Explained process Data supported findings

			Data supported findings	Data supported findings					
9.Is there a clear statement of findings?	Discussion related back to research aims Research team involved to support analysis	Data supported findings Participant validation	Discussion related back to research aims Research team involved to support analysis	Discussion related back to research aims Two participant invited for validation of final report	Discussion related back to research aims Supervisor involved to support analysis	Discussion related back to research aims	Discussion related back to research aims	Discussion related back to research aims Participant validation one from each focus group	Discussion related back to research aims Research team involved to support analysis
10.How valuable is the research?	Implications to practice and further research highlighted. Engaging community to support help-seeking	Implications to practice Community approaches that are open about attitudes to MH & MHS Differing models of distress	Implications to practice and further research Working with families Stigma Race matching /barriers	Implications to practice and further research Differences in beliefs in those with and without mental health difficulties Adapting interventions to suit black men's needs	Implications to practice and further research Cultural specific language Positive engagement to reduce mistrust	Implications to practice Assessment in relation to context of men's lives Person centred care	Implications to practice Need to understand more re their perceptions and understanding Investigating mistrust	Implications to practice and further research highlighted. Stigma Cultural specific language	Implications to practice and further research highlighted. Assessment of depression Target stigma and help-seeking Impact of the race of provider

Appendix 3 Letter to Black community voluntary mental health services requesting access to Black men

Faculty of Health and Life Sciences

Health and Social Care Unit

Priory St

Coventry

CV1 5FB

5th March 2015

Black community voluntary mental health service

West Midlands

Postcode

Dear XXXXXX

I am writing to ask if XXXXX would grant me permission to interview up to 10 Black African and Caribbean men as part of my PhD study at Coventry University. Please find attached detailed information about the study. If you require further information in order to make your decision please let me know.

Thank-you for considering my request and I look forward to hearing from you.

Yours sincerely

Yvette Brown

Content redacted from the online thesis on data protection grounds.

Appendix 4 Participant Information Sheet (PIS)

Participant Information Sheet

Study Title: Black men's experience of mental health

Primary Researcher: Yvette Brown, Senior Lecturer in Mental Health Nursing and PhD student

Supervisor: Dr Tony Colombo, Coventry University, Content redacted from the online thesis on data protection grounds.

We would like to invite you to take part in a research study. Before you decide if you want to take part it is important that you understand why we are doing the research and what it will involve. Please read the following information carefully and contact the researcher Yvette Brown if you have any questions about the study.

What is the study about?

The study aims to gain a detailed understanding about how black men experience mental health problems and how this has affected their life. It is hoped that that the results of the study will help services have a better understanding of the issues that are important to black men who come into contact with mental health services.

Why have I been invited to take part?

You have been invited because I want to interview men from a Black African or Black Caribbean background who have had experience of mental health problems in the last 5-10 years. The reason is because there are very few studies that look at the views of Black men who experience mental health problems.

What will happen if I agree to take part?

If you complete and give the attached reply slip to your key worker or a member of staff at ACCI, I will contact you to arrange an interview at a time that suits you. I will describe the study and go through the information sheet with you. If you decide to take part, you will be given this information sheet to keep. You will also be asked to sign a 'consent form'. By signing the consent form, you will be declaring that you are mentally well to take part in the study and that you agree to have the interview recorded. You will be given a copy of the consent form to keep. If you decide to take part, you are still free to stop at any time without giving a reason.

No questions will be asked if you stop. Taking part in this study will not change any input that you have from any service.

The interview will be at ACCI in a private room. The interview will last for about an hour and will be like a conversation in which I will ask you to answer some questions about your experiences of living with mental health problems. You do not need to answer any questions you don't want to.

What are the possible disadvantages or risks of taking part?

You may be asked to answer questions about your personal beliefs and experiences which may or may not be linked to a difficult time in your life. The interview may involve discussing sensitive issues which you may find upsetting.

If you feel upset after the interview and need help dealing with your feelings, it is very important that you talk to someone at ACCI right away. If you would prefer to talk to someone from outside of ACCI, they will support you to find other options for example, speaking to a health care professional.

What are the possible benefits of taking part?

The information I get from the study will help to increase the understanding about black men and their experience of mental health problems and mental health services.

Will my taking part in the study be kept confidential?

All information you provide will be kept confidential. Only members of the research team will have access to it. Any information will have your name removed so that you cannot be recognised. The consent form will be filed separately from all other information. Information will be stored in a locked cabinet in a locked office, accessed only by the researcher. Electronic information will be stored anonymously on a password protected computer known only by the researcher. Audio recordings of the interview will be disposed of in a secure manner as soon as they have been transcribed (typed up) and analysed. All other information about the study will be stored securely and destroyed by the university in 5 years.

I must however inform you that if you disclose information that may result in you or anyone else being put at risk of harm I may have to inform the appropriate authorities. An example of this may be if a person were to talk about causing physical harm to another person. If this situation arises I will discuss all possible options with you before deciding whether or not to take any action.

What if I decide to withdraw after the interview has taken place?

You are free to leave the study at any time during the interview. If you decide to leave after the interview has taken place, all tapes and the typing of your interview would be destroyed. You will have up to 2 weeks after the interview to withdraw from the study.

What would happen after the interview?

I will label the interview with a code number and type out everything you said in the interview. The tape and the typed up record (transcript), identified only by the code

number, would be kept in a locked cabinet at the School of Nursing, Midwifery and Health at Coventry University. I will send you a copy of the interview transcript if you would like to read it, you can think about if there is anything you would like to change or remove and let me know. I can remove any section that you do not want me to use.

What will happen when the study finishes?

The results from this information will be presented in the thesis for my PhD. The results will also be presented at conferences and in academic publications. Some of your words will be used but it will not be possible to identify you personally in any reports or articles.

Who has reviewed and ethically approved the study?

This study has been reviewed and ethical approval has been granted by Coventry University Ethics Committee.

Contact for further information

Content redacted from the online thesis on data protection grounds.

Thank you very much for reading this information sheet.

Yvette Brown

Reply slip

Black Men's Experiences of Mental Health

Name.....

Telephone number.....

Email.....

Appendix 5: Participant Consent Form

Participant Consent Form

Title: Black men's experiences of mental health

Purpose of the study: The aim of the research is to improve understanding and awareness of black men's experiences of mental health and what is important to them when they have mental health problems and use mental health services.

I have read the participant information sheet for the research study and agree to the following (please tick):

1. I consent to participate in this study. ☐
2. I have had the opportunity to ask questions about this study and I know how to contact the researcher or her supervisor if I need to. ☐
3. I understand that I have the right to withdraw at any time during the study and within two weeks after I participate. ☐
4. I agree to the interview being recorded and understand that the recording will be kept in a secure place, accessible to the research team only. ☐
5. The interview will be destroyed when it has been transcribed (typed up) and analysed. All other information about the study will be stored securely and destroyed by the university in 5 years. ☐
6. I am taking part in this study voluntarily. ☐

Name (Please Print)

.....Signed.....

Telephone number.....Date.....

Researcher Name .....

Researcher Signed .....Date.....

Appendix 6: Semi-structured Interview Schedule

Demographics: Age? Country of Birth? How long have you been in UK? Diagnosis?

1) PERSONAL WORLD - Black men's experiences of their own behaviour/thoughts

1a) Their interpretation of own behaviour and

1b) Their experiences of coping/adapting to own behaviour;

Questions: When would you say that you or others started to be worried about your behaviour? What were you doing?

Can you tell me about what was happening in your life at the time?

What did you notice? What did you think was going on?

What did you do?

2) SOCIAL WORLD - Black men's experiences of other's reactions to own behaviour/thoughts

2a) Their experience of how community/society reacted to their behaviour;

2b) Their experience of how more intimate groups (family, employees, friends) reacted to their behaviour

Questions: What was your relationship like with your family? Did they notice anything about your behaviour? What did they say/do?

What about your friends? Did they notice anything about your behaviour? What did they say/do?

What about your work colleagues? Did they notice anything about your behaviour? What did they say/do?

What did you think about (family, friends, work colleagues) reactions to you at that time?

3) INSTITUTIONAL WORLD - Black men's experiences of interactions with practitioners and secure settings;

3a) Their experiences during times within institutional settings (police cells, prison, inpatient secure settings, length of detention, involuntary and voluntary experiences)

Questions: Who did you first see about your behaviour? How long was this after it all started? What did you think was going on? What happened? What was that like?

3b) Their experiences during encounters/interactions with: GPs, police, psychiatrists, nurses;

Questions: How did you find the staff you first came into contact with:

GPs? What were they like with you? How did you feel about them?

Police? What were they like with you? How did you feel about them?

Psychiatrists? What were they like with you? How did you feel about them?

Nurses? What were they like with you? How did you feel about them?

4) THERAPEUTIC WORLD - Black men's experiences of treatment and on-going care

4a) Their experiences of medication - side-effects, informed consent, support;

4b) Their experiences of Psychotherapeutic support - sorts of therapy, helpful or not;

4c) Their experiences of social support - community care, 3rd sector

Questions: What treatment/care did you first receive from mental health services, what was involved? What did they say?

Probe for any particular treatments if not mentioned- what was that like? how did you feel about it?

2nd Phase of interview: What happened next?

PERSONAL WORLD - Black men's experiences of their own behaviour/thoughts

So what happened next? Did you or others still have worries about your behaviour? What was happening in your life at the time?

What did you notice? What did you think was going on?

What did you do?

SOCIAL WORLD - Black men's experiences of other's reactions to own behaviour/thoughts

What was your relationship like with your family at this time? What did they say, do?

What was your relationship like with your friends? What did they say, do?

What was your relationship like with your work colleagues? What did they say, do?

What did you think about (family, friends, work colleagues) reactions to you at that time?

INSTITUTIONAL WORLD - Black men's experiences of interactions with practitioners and secure settings

Did you spend anytime in inpatient settings, police cells, prison? What happened? What was that like?

Did you have any contact with the police, nurses, psychiatrists, GP?

What happened? What were they like with you? How did you feel about them?

THERAPEUTIC WORLD - Black men's experiences of treatment and on-going care

What treatment/care did you receive from mental health services at this time, what was involved? What did they say?

Probe for any particular treatments if not mentioned- what was that like? how did you feel about it?

3rd Phase of interview: What's happened in the last few years?

PERSONAL WORLD - Black men's experiences of their own behaviour/thoughts

What would you say your behaviour/thoughts have been like in the last few years?

Have there been any concerns about you? What's happened? What did you do?

SOCIAL WORLD - Black men's experiences of other's reactions to own behaviour/thoughts

What's your relationship been like with family, friends, others in the last few years? What have they said/done?

What did you think about (family, friends, work colleagues) reactions to you?

INSTITUTIONAL WORLD - Black men's experiences of interactions with practitioners and secure settings.

Has there been contact with prison, police cells, inpatient units in the last few years? What happened? What did you think about this?

Has there been contact with the police, psychiatrists, nurses in the last few years? What were they like with you? How did you feel about them?

THERAPEUTIC WORLD - Black men's experiences of treatment and on-going care

What kind of treatment/care have you been receiving in the last few years?

Probe for any particular treatments if not mentioned- what is that like? how did you feel about it?

4th Phase of interview: What's happening now?

PERSONAL WORLD - Black men's experiences of their own behaviour/thoughts

-What would you say your behaviour/thoughts are like now?

SOCIAL WORLD - Black men's experiences of other's reactions to own behaviour/thoughts

What's your relationship like with your family now? Do they notice anything about your behaviour/have concerns now? What do they say, do?

What's your relationship like with your friends now? Do they notice anything about your behaviour/have concerns now? What do they say, do?

What's your relationship like with your work colleagues now? Do they notice anything about your behaviour/have concerns now? What do they say, do?

What did you think about (family, friends, work colleagues, others) reactions to you now?

INSTITUTIONAL WORLD - Black men's experiences of interactions with practitioners and secure settings;

Has there been contact with prison, police cells, inpatient units recently? What happened? What did you think about this?

Has there been recent contact with the police, psychiatrists, nurses? What are they like with you? How do you feel about them?

THERAPEUTIC WORLD - Black men's experiences of treatment and on-going care

What treatment/care do you receive now?

Probe for any particular treatments if not mentioned- what is that like? how do you feel about it?

If not mentioned: Have you experienced any racial prejudice during this time? What happened? What did you do? What do you think about this?

Is there anything else you would like to say about your experiences?

Thank-you.

Appendix 7: Initial Emergent themes

"What do the exploratory comments represent?" "Capture and reflects an understanding"

Emergent themes	**Location**
Anger, frustration & aggression towards mum	3-5, 45-47, 49-50, 52, 57-58,61-63, 74-77, 107-108, 113-119, 287-288
Left out; an outsider	4-5, 7-9, 265-269, 271-272, 445-447, 496
Struggling to find a job	11-12, 21-24,265
Lonely/isolated/no friends	14-15, 17-18, 51-52, 223-224, 264-265
I'm not educated- feeling inadequate	21, 24-29,31-33,166-167, 265-269, 271-272
Psychotic symptoms	37-41,135-136,138-139, 193-196, 200-202, 314, 393-395
Preoccupied with the past	3-9, 45-47
Went to his mum for support	43-45
Wanted information about his dad	45-46, 77, 113-119, 290-292, 512-514
Hospital admission	55-56,
Felt justified about his aggressive behaviour	66-67
Mum is his main contact/support	81-83, 437,
Difficult relationship with his mum	96-100, 113-119, 290-292, 313-314, 422-423, 450-451, 513-518, 553-558, 564
contact with police	104-105, 107, 112
If only i had met my father	113-119, 512-514,
Felt threatened and intimidated-hospital-patients and staff	126-127,130-131, 133-135,148-149,152
Threatened and intimidated-childhood	555-558, 566-568, 570-572, 578-582
Unable to settle-hospital	126-128, 130-131, 133-135, 148-149, 152, 154-156, 176-178
Unusual behaviour/out of character	135-136
Inability to cope	138-139, 340-342, 365-367
Psychiatrist were ok	145-146, 148, 382, 374, 382, 393-394, 481, 483
Medication-no counselling	158, 174, 195-196, 252-253, 380, 398, 408-409, 411-415
Side effects of medication	160-162, 247-248
'Its to get you better'	166-167, 169-170
Never thought it would be life-long	171-172, 511-512, 525-526
Older brother wasn't supportive	216-221
Nervous/anxious on discharge	229-230, 399-403, 405-406
Hostel	229-230,236-237,239-241
There's uncertainty when you're on your own	260-262
Routine of taking medication	274-275, 481
Identity crisis?	297-303, 305-307, 357-359
Relapse	313-314, 323-325, 365-367
Cry for help-	315-321,323-325,340-342, 344-345, 353, 355, 361-363, 365-367
Fear of being with family	327-328, 330-331,333-334
Wanted to speak to a black psychiatrist	382-388, 390-391
Things might have been have been different for me...	415-416,418-420, 512-514, 518-520

Thinking more positively, things have improved	422
Has friends, not lonely...	439-441,
ACCI Support	485-486, 490, 492-494,
Racism from other patients	501
No father figure	512-516, 518-520, 522,
Stigma-people judge	525-527, 529-533
Difficult childhood	536-539, 541-54, 549-550,553-558, 578-582, 588-589
At first i was so relaxed...then it started	591,593, 595, 598-600

Appendix 8: Emergent Themes in Categories

Social/cultural	Thoughts/Behaviour	Treatment	Institution	Practitioner	Left out/an outsider
Preoccupied with the past Feeling left out/excluded Threatened and intimidated as an adult and child Physically abused - childhood Difficult relationship with his mum Wanting support from his mum and not receiving it Returning home to nothing –empty flat Struggling to find a job Lacking confidence Lonely/isolated/no friends At first i was so relaxed...then it started There's uncertainty when you're on your own	Preoccupied with the past Childhood-'pressure cooker' Wanting information about his dad **Anger, frustration & aggression towards mum** Felt justified about his aggressive behaviour/no regrets Feeling frustrated... What about me? What about what i want? (victimised) Experiencing Psychotic symptoms-everything became mixed up and fast Believing it was normal to hear voices Unusual behaviour/acting out of character Struggling to make sense of what was happening in his mind Feeling overwhelmed	Wanting an alternative to medication I didn't get no counselling No explanation about the side effects of medication Living with side effects of medication 'Its to get you better' If you take them maybe you could be released (its their hands not yours) Never thought medication would be life-long No say in the increase of medication (No choices)	Feeling threatened and intimidated-hospital-patients and staff Staying in a hostile environment (Fear) Unable to settle/relax-hospital (Agitated) Nervous/anxious/paranoid on discharge Anxious when in contact with the police Didn't want his picture taken –uncomfortable They took me, i didn't know who they were...(No choices) Racism from other patients	Felt threatened and intimidated-hospital-patients and staff (Fear) Psychiatrist were ok Wanted to speak to a black psychiatrist They were ok with me They were nothing extraordinary –they talk to me ok	**Marginalised** All family members have degrees, educated he isn't Couldn't read family funeral he wasn't invited Brothers used to beat him up Couldn't find a job Lonely no friends Doesn't take drugs-others do Rejected What about me?

Blames his mum for his lack of contact with his dad Fear of being with family Wanting support from his brother and not receiving it Mum is his main contact/support Stigma-people judge you Wanting a father figure Has friends, not lonely... Has friends, i'm still on the outside They do drugs, i don't Maybe i could get a part-time... **Feeling let down** **Spent time in care** **Family life was a pressure cooker** Feeling on the outside	I'm not educated- feeling inadequate I'm small, i'm quiet Feeling misunderstood There's uncertainty when you're on your own Fear of being with family Things started to look strange again Inability to cope Cry for help-wanting an escape Feeling confused about his identity Wanting to talk to someone **If only i had met my father Things might have been have been different for me...** **Wanting a male role model** Thinking more positively, things have improved	Life became a routine of taking medication	Apprehensive about being in a mixed environment Liked having others to speak to Third sector Support Felt good about the only job he has had Initial knowledge of mental illness –black man was killed via police		

Themes using Young's Framework

Powerlessness **No voice**	Marginalisation	Violence/victimisation /intimidation	Cultural imperialism racism, stereotyping, double-consciousness, invisibility/stigma	Discrimination	MH Literacy	Coping/Response to issues
At first i was so relaxed...then it started **Struggling to cope** Feeling overwhelmed Struggling to make sense of what was happening in his mind Unusual behaviour/acting out of character Experiencing Psychotic symptoms-everything became mixed up and fast	**Lacking confidence** **Feeling inadequate** **No job, no money, no nothing** I'm not educated-feeling inadequate **Feeling lonely** Lonely/isolated/no friends There's uncertainty when you're on your own **On the outside** **Wanting someone to connect with** **Wanting support** Has friends, i'm still on the outside Liked having others to speak to	**Feeling like a victim** **Feeling let down** Blames his mum for his lack of contact with his dad Physically abused – childhood Childhood-'pressure cooker' Threatened and intimidated as an adult and child Felt justified about his aggressive behaviour/no regrets	Stigma-people judge you **Wanting a male role model** Feeling confused about his identity Feeling misunderstood Racism from other patients		Believing it was normal to hear voices Initial knowledge of mental illness –black man was killed via police	**Angry; frustrated** **Anxious; nervous** **Fear** Fear of being with family Cry for help-wanting an escape Unable to settle/relax-hospital Thinking more positively, things have improved Maybe i could get a part-time...

What about me? What about what i want? Feeling tired of everything No say in the increase of medication If you take them maybe you could be released They took me, i didn't know who they were...	Felt good about the only job he has had					
Trust/mistrust	**Treatment**	**Help seeking**				
Feeling let down Brother tells his mum things... Nervous/anxious/paranoid on discharge Unable to settle/relax-hospital	Never thought medication would be life-long Living with side effects of medication No explanation about the side effects of medication Wanting an alternative to medication	Wanting a father figure				

Staying in a hostile environment They were nothing extraordinary – they talk to me ok Wanted to speak to a black psychiatrist	I didn't get no counselling					

Appendix 9: Application for Ethical Approval-Embedded File

Content redacted from the online thesis on data protection grounds.