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Journeys and experiences accessing trauma support for Black adults with complex trauma: a qualitative study

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1. Introduction

Complex trauma, a condition originally defined by Herman (1992), is characterised by chronic, cumulative, and prolonged exposure to trauma often stemming from childhood. Experiences of complex trauma, such as childhood abuse and neglect, are frequently associated with poorer adulthood mental health outcomes (Copeland et al., 2018) and can disrupt a person's sense of safety, identity, and worldview (Cook et al., 2005). Elevated rates of traumatic life events have been well documented among Black and racialised minority groups (Hatch and Dohrenwend, 2007). These patterns reflect more than individual vulnerability; they emerge in the context of structural inequalities that shape exposure to adversity. Experiences of racism and discrimination, in particular, contribute to the burden of trauma and deepen its psychological impact (Comas-Díaz et al., 2019). These intersecting harms accumulate over time, shaping how complex trauma is experienced and how racialised minority groups interact with systems of care.

In the United Kingdom (UK), mental health services are primarily delivered through the National Health Service (NHS) with care organised through primary, secondary, and tertiary care levels. Secondary care includes specialist services such as community mental health teams, crisis services, as well as inpatient psychiatric care, services that typically become involved with service users with more acute and complex needs. There is substantial evidence that many individuals accessing these services have disproportionately high rates of complex trauma (Mauritz et al., 2013). Yet, paradoxically, these services also have great potential to become sites of re-traumatisation for service users due to the use of restrictive practices (e.g., restraint and seclusion), which may emulate prior traumatic experiences (Cusack et al., 2018).

Service utilisation data has frequently depicted an over-representation of Black adults within acute and secondary care mental health services (Bignall et al., 2019). Evidence shows Black individuals are more likely to be compulsorily admitted to mental health services as well as receive more coercive and adversarial treatments relative to other ethnic groups (Barnett et al., 2019; Singh et al., 2007). These trends highlight the influence of institutional harms in shaping access to care and mental health outcomes. For Black adults with complex trauma though, repeated encounters with coercive services may deepen feelings of powerlessness and mistrust, compounding rather than alleviating trauma.

While complex trauma is a key contributor to distress, it is often overlooked within mental health settings, particularly in acute and secondary care settings. For instance, symptoms of trauma can overlap with those seen in acute psychiatric conditions, including schizophrenia-spectrum disorders (Varese et al., 2012). When trauma is not adequately recognised, care may focus narrowly on symptom management rather than addressing underlying or root causes. This lack of awareness of trauma can contribute to fragmented or misaligned care and elevates the potential for re-traumatisation, particularly where coercive measures are employed. As such, a crucial need for trauma informed approaches embedded within these settings and beyond is therefore warranted to sensitively respond to the needs of service users (Sweeney and Taggart, 2018).

Over the years, efforts to establish more trauma informed care within routine healthcare practice have grown (Menschner and Maul, 2016). Despite an evolving awareness of the impact of trauma on service users, prior literature has often overlooked the interplay of race and culture when supporting those with complex trauma. There is a small but growing evidence base exploring cultural adaptations to trauma care for racialised minority groups (Ennis et al., 2020; Naseh et al., 2020), with recent meta-analytic evidence showing that adaptations in trauma care are effective in reducing trauma symptoms (Benjamin et al., 2025). However, little evidence exists exploring adaptations tailored specifically to Black adults with complex trauma, leaving a gap in

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understanding how such adaptations might support recovery for these groups.

Overlooking the cultural needs of Black service users sustains ongoing cycles of inadequate care and upholds structural harms within services. Crucially, understanding what culturally competent, trauma-informed care may look like for Black adults is therefore critical. Cultural competency, for instance, can operate at multiple levels within services, such as (1) at the organisational level of services which may refer to institutional policies of equity and anti-racism, (2) at the relational level through culturally attuned practitioner-service user interactions and (3) at an intervention level, culturally adapting treatments and methods (Kirmayer, 2012). Without such shifts, services risk continuing to offer care that is poorly aligned with the needs of Black groups and may unintentionally reproduce racial injustices and harms through everyday practice.

This qualitative study therefore aims to tackle the current gap in literature by understanding the lived experiences of Black adults with complex trauma in seeking support, examining their journeys in services to address complex trauma, as well as their experiences and views of care. Critically, the study aimed to explore how mental health services are responding to the specific needs of Black adults with complex trauma. The research questions were:

What were the journeys Black adults had when seeking support for complex trauma?
What were the experiences and views of mental health services and support shared among Black adults with complex trauma?

2. Methods

2.1. Study context

This qualitative study formed part of a broader NIHR funded project titled PATHWAY (NIHR award: 203947). PATHWAY utilised mixed methods to explore the development of a trauma-informed care pathway for service users with complex trauma in UK mental health services. The lead researcher on this study was also embedded within the PATHWAY study, however led a standalone qualitative sub-study as part of their doctoral research project exploring the experiences of Black adults with complex trauma who had sought support from statutory and voluntary mental health services. While the overarching infrastructure and ethical approval were provided through PATHWAY (IRAS: 314403), the recruitment, interviews, and analysis presented within this study were independently designed and conducted by the lead researcher as part of a separate line of inquiry and their doctoral thesis.

The lead researcher for this study was a Black researcher with a clinical background in psychology and experience working in mental health services. They were part of a multidisciplinary team that specialised in health inequalities research, comprising clinical academics from disciplines such as psychology, mental health nursing, and mental health services research. The research team comprised members from a range of racialised backgrounds, including both minoritised and non-minoritised academics. Ongoing reflection on positionality and reflexivity was included across the research process. This involved attention to how identities, lived experiences, and professional training shaped decisions related to data collection and interpretation, particularly in relation to power dynamics and racialised experiences shared by participants.

2.2. Advisory group

A Lived Experience Advisory Group (LEAG) was established to guide the study. The LEAG comprised Black adults with lived experiences of complex trauma and of using mental health services. LEAG members contributed to multiple stages of the research, including co-developing recruitment strategies and materials, shaping interview questions and the topic guide, visual aids, as well as reviewing preliminary analyses of data. These contributions enhanced the cultural sensitivity and ethical design of the research, and ethical approval for the adaptations was obtained via a PATHWAY study amendment (REC Reference: 23/EM/0024).

2.3. Theoretical framework

The study was underpinned through a critical realist framework which recognises that whilst individuals experience and interpret the world subjectively, these experiences are shaped by real, often invisible, underlying structures (Archer et al., 2013). With this study in mind that focuses on Black adults' lived experiences, this approach supports an exploration of how personal narratives reflect both lived realities and broader systems, including structural racism and institutional harm, that influence Black adults' engagements with mental health services.

2.4. Participants

Black adults (including those of mixed ethnicity) aged between 18 and 65 and residing in the United Kingdom were eligible to take part if they self-identified as having experienced complex trauma and attempted to seek support through either statutory mental health services or voluntary (not-for-profit) mental health services. The age limit was based on the study's focus on adult mental health services, which typically operate under different models of care from those for older adults (65+).

Complex trauma was defined using Herman's (1992) framework, which encompasses trauma that was prolonged, chronic, and/or involving multiple experiences. To ensure inclusivity, we also acknowledged that both social and cultural aspects of trauma extend beyond Western medical labels (Ray, 2008), and thus no formal diagnosis of post-traumatic stress disorder (PTSD) or complex PTSD was required to participate. This definition and inclusive approach were communicated within the study's recruitment materials and in participant information sheets. Participants were invited to take part if they recognised their experiences as prolonged, chronic, or involving multiple traumatic events that negatively impacted their wellbeing, acknowledging the principle that trauma survivors are experts of their own experiences (Isobel, 2021).

A total of ten Black adults with complex trauma took part in the

Table 1
Demographic table depicting socio-demographic characteristics of participants.

Pseudonym	Ethnicity	Gender	Age	Gender/sexual identity	Disability declared
Amir	Mixed Ethnicity	Male	40s	Heterosexual	Yes
Maureen	Black Caribbean	Female	40s	LGBTQ+	No
Amani	Black African	Female	40s	Heterosexual	Yes
Tony	Black Caribbean	Male	50s	Heterosexual	No
Ava	Black African	Female	20s	LGBTQ+	No
Dominique	Black Caribbean	Female	20s	Heterosexual	Yes
Jamila	Black African	Female	30s	LGBTQ+	Yes
Elliott	Mixed Ethnicity	Male	20s	Heterosexual	No
Deborah	Black African	Female	30s	Heterosexual	Yes
Audrey	Black African	Female	50s	Heterosexual	Yes

Note. LGBTQ + includes individuals identifying as lesbian, gay, bisexual, transgender, queer, or other gender/sexual minority identities.

study. A summary of the demographic characteristics of participants is provided in Table 1 below. To protect the privacy and confidentiality of participants, pseudonyms have been used.

2.5. Data collection

Targeted recruitment was used to capture a diverse sample of Black adults to take part with particular attention to recruit those underrepresented in research. The lead researcher cultivated relationships with Black-led community organisations across different UK localities, some of which had a direct focus on mental health, while others focused on celebrating cultural identity or supporting specific communities such as Black LGBTQIA+ networks and Black disability advocacy groups. These partnerships supported recruitment efforts and helped build trust with communities historically marginalised within the research landscape.

The target sample size was between 8 and 15 participants. Due to the exploratory nature of this study, the focus was on achieving depth and richness of participants' experiences. Sample size adequacy was assessed through ongoing discussions with the research team and LEAG to establish when thematic saturation was reached (Hennink and Kaiser, 2022).

The lead researcher conducted the interviews, and interviews were split into two parts. Interviewees had the option to conduct these in one go or over separate dates as well as the option for breaks during interviews. The first interview part used narrative techniques (Ricoeur, 1991), lasting up to 60 minutes to understand journeys in seeking support for trauma within statutory mental health services and the voluntary sector. As trauma may disrupt a person's sense of chronology, optional creative aids such as visual mapping were used to support storytelling (e.g., depicting a visual timeline with prompts of experiences of each stage of the participants' journey). The second interview part involved a semi-structured interview lasting up to 60 minutes exploring experiences and outcomes of mental health services. Interviews were conducted either in person or via Zoom online platforms in line with participants' preferences. Participants were compensated £25 for each interview part completed.

Informed consent was obtained through a two-step process, first by reading participant information sheets that outlined the aims of the study, what participation involved, as well as their rights to withdraw and confidentiality. After reading these materials, participants provided written informed consent (in person or signed via email) prior to commencing interviews. An optional self-report demographic form was also completed by participants, collecting information on ethnic group, gender, age, sexual orientation, and disability status.

2.6. Data analysis

Thematic narrative analysis was used to explore commonalities and differences across experiences (Reissman, 2008), underpinned through a critical realist framework (De Souza, 2014). This analytic approach was used to aid our goal of exploring how Black adults construct and communicate their journeys and experiences while also attending to the broader structural conditions, such as racism, that may shape these experiences.

The analysis process was led by the lead researcher and involved several iterative and reflexive phases. The first involved transcribing audio-recorded interviews and anonymising the transcripts. The researcher immersed themselves in the data by reading transcripts and making initial reflective notes about tone, language, and content. Following an initial familiarisation, data was coded inductively, attending to both explicit references to trauma and racism, as well as more implicit cues (e.g., "being treated differently"). Codes were then grouped into initial thematic patterns across the dataset. Themes were generated and reviewed through constant comparison with the data and debriefing with LEAG members. This process helped identify where experiences may be racially situated, even when not explicitly framed by participants. The LEAG at this stage thus offered insights into the cultural subtext, validating the relevance of racialised interpretations and further credibility of findings. Finally, after contextualising and defining themes, they were organised and presented in the write up to reflect Black adults' experiences and journeys through services, with direct quotes to illustrate and ground each theme.

3. Results

A total of six themes emerged from the data and are listed in Table 2 alongside subthemes and descriptive summaries. A cross-cutting experience evident throughout participants' narratives was a pervasive sense of not being fully seen or heard by services. While this did not constitute a standalone theme it was consistently embedded, both implicitly and explicitly, across the six themes identified in this study: (1) a fragmented mental health system, (2) alternative support systems, (3) culturally inappropriate or inadequate assessments, (4) overly clinical and medical focuses, (5) cultural matching, and (6) improving person-centred care. This recurring sense of invisibility shaped how Black adults engaged with services and influenced their perceptions of being understood or dismissed.

3.1. Theme: A fragmented mental health system

The first theme that emerged from the data exposed the consequences of a fragmented mental health system and highlighted systemic barriers and inconsistences Black adults experienced when seeking support. While some of the systemic issues described may impact many service user populations, participants' narratives made clear that for Black adults, these challenges were often amplified by racialisation. The consequences and shortfalls reflected a deeper sense of not being seen, nor understood, and ultimately excluded by the system when navigating support for complex trauma.

Participants described care journeys marked by frequent referrals and repeated assessments, often leading nowhere. Amir described a demoralising 18-month journey:

> *Continuity of care. It's so important, and the amount of people I've seen and then you get to the end of the process and one person will say, 'This person will help sort you out and redirect you', and then you go to the next person, and they say, 'Yeah, I'll signpost you and do that, I refer you to the next one.' And, then what happened at the very end was like, 'Oh, no, we can't do anything.' You just accept that it's just so under resourced.*

For others, long waitlists and surface-level interventions further eroded trust in the system. Ava described reaching a point of disengagement after multiple failed attempts to access meaningful care:

> *I just thought … you've had, like, a lot of trauma, like, trying to get help. I just think we need to manage this internally. And I just felt like, until I can afford to consistently fund privately - I just have a lot of, I guess, PTSD regarding accessing health just because it just hasn't been a streamlined process at all.*

Beyond frustration, the instability of service provisions sometimes caused emotional and iatrogenic harm. The sense of being retraumatised by the very system expected to support emerged across accounts and how this undermined confidence in the system. Maureen reflected on this disruption and how it ultimately led her to withdraw:

> *The care coordinator kept changing. I found it really destabilising. I just find it sometimes with the mental health system … you're vulnerable anyway and you take a chance to get help. And it can leave you in a worse state than before. I know with the mental health system two years ago I just discharged myself because I just think it wasn't helping … My GP spoke to me recently and said, 'Oh, let me refer you to the mental health team again.' And I just said to her, I always feel misunderstood when I go there.*

Table 2
Summary of themes, sub-themes, and descriptive examples from the data.

Themes	Sub themes	Description
A fragmented mental health system	**Continuity of care**	Depleted resources in statutory services hinder consistent and long-term support. For Black adults, this lack of continuity compounds existing distrust in services that have historically failed their communities, reinforcing a sense of invisibility.
	Iatrogenic harm	Barriers to accessing trauma support frequently result in unmet needs, leaving Black adults feelings abandoned during critical periods. This exacerbatesdistress and perpetuates wider systemic neglect.
	Forced self-reliance	What was offered from statutory services felt incomplete or inadequate, forcing self-reliance or to disengage entirely from services.
Alternative support systems	**Religion and spirituality**	Religion and spirituality offer culturally grounded coping strategies that frequently compensate for services failing to acknowledge spiritual and holistic dimensions of healing. These systems also provide validation for trauma experiences in ways that statutory services often do not.
	Peer support	Peer spaces foster authenticity and belonging often missing in statutory settings. Peer support can also buffer experiences of racism and harms within services, providing both validation and a sense of community safety.
Inadequate or inappropriate assessments	**Impersonal practices**	Assessments lack depth and curiosity. Assessments ignore the role of culture, such as coping mechanisms through religion or how culture may influence experiences and management of trauma.
	Experiences with questionnaires	Long, standardised tools feel rigid and alienating. However, questionnaires may be helpful to conceptualise the extent of distress.
Overly clinical and medical focus	**Disempowerment and agency over own care**	Exclusion from care decisions reflects a broader lack of power in navigating systems. This disempowerment is exacerbated by systemic racism and histories of having voices minimised in institutional contexts.
	"Quick fixes" and medicalised treatments	Defaulting to medication overlooks the social and cultural dimensions of trauma. A notable preference for relational and community-based interventions, but systemic barriers limit access to these alternatives in statutory care, deepening feelings of neglect.
Cultural matching	**Preferences and choice**	Having the option of working with a practitioner from a shared cultural background plays an important role on building rapport and meaningful therapeutic relationships. Lack of choice often replicates broader power imbalances and alienation in services.
Improving person centred care	**Experiences of Cognitive Behavioural Therapy (CBT)**	Experiencing CBT as too rigid with little room for collaboration and partnership working which is desired.
	Task-focused mentality	Feeling like "just a number" is particularly pronounced when racialised service users are already navigating invisibility and marginalisation in healthcare, reinforcing alienation and disengagement.
	Environment	Standard clinical environments and hospitals may feel unsafe or hostile to those with complex trauma. Alternatives that centre comfort, cultural safety, and relational engagement foster better access and trust in healthcare.

While not explicitly referenced in terms of race, this sense of being misunderstood by services was echoed across participants' narratives and may be understood, particularly for Black adults, as connected to feeling culturally misrecognised. This repeated sense of being misread, even subtly, adds to the psychological burden placed on Black adults navigating services.

The culmination of these systemic failures, from discontinuity to iatrogenic harm, was a pattern by which Black adults reported being forced to become self-reliant. However, this self-reliance was not always framed as an empowered choice, but rather as a reluctant and exhausting outcome. For example, Elliott shared a sense of resignation after services failed to provide a meaningful resolution:

> *But last thing I remember, is to me it still felt incomplete. So, it's more like from that point on, it was more like trying to figure out the rest myself.*

Others shared similar accounts of withdrawing or becoming self-reliant out of necessity. This pattern of self-reliance is rooted within a long history of racial exclusion from care, forcing Black adults to navigate their healing without adequate support.

Within this theme, participants' accounts illustrate more than just service inefficiency. For Black adults with trauma, systemic barriers were experienced as gaps in service that also created deeply personal ruptures in care, reinforcing feelings of marginalisation. The recurring sense of being misunderstood within care may not always have been framed explicitly in terms of race, yet it was felt in ways that were *racialised*, shaped by broader histories of racial exclusion and unequal treatment.

3.2. Theme: Alternative support systems

In response to failures of statutory services, Black adults turned to more informal spaces that felt more affirming. One notable commonality between participants was expressing value around peer support in managing trauma. In some cases, this related to informal peer support such as through the community (e.g., social gatherings, local neighbourhood events) accessible to anyone. Peer spaces in the community allowed for mutual connections to be made and instilled a sense of belonging:

> *And so there's a lot of isolation around that and connecting with other people who've been through similar things, and you know, how they're managing was quite helpful to understand ways of, you know, ok, so I'm struggling, but it's ok because they did that, you know? That kind of thing. So I think the difference is that it made me feel connected and also felt cared about and supported at times when I felt particularly low or isolated. – Maureen*

When people attended peer group spaces and shared experiences, this often led to positive impacts on wellbeing for participants as it allowed them to feel validated and seen. For example, Amir shared the impact of this on their mental health:

> *I only attend one class a week that's it, right, but it's a regular group. You get to know each other. People take an interest in your life and how you're doing and whatnot. And, yeah, that has massively lifted my spirits for sure … people get their comfort, and it becomes a safe space where you trust each other. And just being part of that community and support does make a big difference.*

These spaces operated outside of formal services, yet they provided the relational safety Black adults felt was needed to heal. Whilst these spaces had benefits for many Black adults, several participants expressed a further need to seek out more direct culturally resonant support networks, ones where religious and spiritual backgrounds were acknowledged. Maureen talked about their experiences of peer support finding an LGBTQIA + group for racial minorities in the voluntary sector, which offered space where her cultural background was recognised, not overlooked:

> *But with this therapy group, there was a lot more things I can explore. Because my background is from Jamaica, and there's a lot of spirituality within Jamaica itself. And I think, I've seen ghosts in the past, and when I mention it I always feel awkward about it. Whereas if I mention it to people in Jamaica, it's a normalised thing. So there's all that kind of translation that might get a bit lost.*

Common experiences within these more culturally affirming peer networks allowed Black adults to express greater authenticity and vulnerability when discussing mental health, and 'fully show up' as themselves, rather than concealing important aspects of their identity or experiences due to fears of being judged from statutory services. Maureen reflected on this:

> *It was a short space, but we spoke about spirituality. And there's just a wealth of experience that I have in terms of my mental health and life in general that I've never really gone into with, you know, sort of westernised therapy. So that just said to me that there's something here, because it wasn't only just about spirituality it was more as well about people's experience of being isolated, that sense of not belonging.*

Beyond cultural spaces, participants described how creative and somatic approaches also supported healing. These included acting groups, art spaces, and somatic practices that offered non-verbal ways of processing trauma. For instance, Elliott shared the impact of attending a community-based acting group:

> *But I went to a place … it was essentially like a little acting place. Because I wasn't really good at using my voice then. I was very quiet. It taught me, how to speak up and like talk to people, and not always be so silent when it comes to things like this. And even though it was mainly, just primarily just like acting out scenes, it did teach me like there are always people who do want to talk to you and who do want to hear your own opinion on things and matters. And it did help me to open up a little bit more.*

For Elliott, acting was more than a creative outlet, it became a form of emotional expression, a space for interpersonal connection, and a catalyst for confidence. His story, along with others, demonstrated the importance of spaces that affirm one's voice and identity, offering both healing and community. These spaces and approaches were particularly valuable for those who had felt silenced or dismissed by traditional talk therapy models offered within statutory services.

3.3. Theme: Inappropriate or Inadequate assessments

Black adults often reflected on the inappropriateness and inadequacy of assessments when accessing mental health services. Assessments often felt too short or were too generic. In particular, participants noted a lack of curiosity toward the racialised dimensions of their experiences, such as coping strategies informed by culture (e.g., collective prayer), which left them feeling overlooked or devalued. Assessments were often the first point of contact with services and participants felt they set the tone for a care journey that overlooked their lived realities of Black adults navigating complex trauma.

Ava explained how their negative interactions with the assessor who made a culturally insensitive remark led to disengagement with the service and mental health system entirely:

> *It's just been so frustrating because understanding the generics or understanding the genesis of my culture will help you to understand the genesis of my problem.*

INTERVIEWER: And what was the impact of that experience when they said that to you?

> *Well, I didn't continue. I dropped out. And this is a person that has come to you with trauma, saying 'I need support.' But no one is understanding of me. So it constantly feels like it's a vicious cycle of being penalised.*

In reflecting on what they needed, they shared a simple but powerful suggestion:

> *I guess just a better understanding of me, maybe assessment should begin with: 'Introduce yourself before you introduce your trauma because you are not your trauma'.*

Rather than a reaction to the structure of the assessment itself, Ava's disengagement was prompted by a lack of cultural understanding and a sense that her background and identity were being overlooked. Amani also expressed their thoughts on the importance of cultural awareness among assessors:

> *It would have made a huge difference … I think it would be very helpful because they would obviously have an idea or have some experience of some of the experiences [of what] it's like to be an ethnic minority, and that's helpful.*

Some participants criticised assessment methods such as the extensive reliance on questionnaires. Black adults shared that administering assessment tools *before* any human connection felt impersonal and inappropriate, particularly during vulnerable periods of accessing support:

> *I like the fact that somebody has to contact you before you do like your questionnaires. It's like, 'How have you felt in the last three months?' It's the *GAD-7 score and all of that. And I like the fact that, that's not flung in your face, you have to speak to a professional first. That doesn't always happen. Sometimes you literally call and you're like 'I'm depressed' and they're like, 'Really? Answer 50 questions on how depressed you **really** are.' It's like, this is inappropriate. – Ava*
>
> *GAD-7: Generalised Anxiety Disorder Questionnaire.

While the impersonal nature of these tools was a concern for many, not all participants dismissed their usefulness entirely. For Jamila, questionnaires helped her contextualise the severity of her experiences, even if it initially seemed reductive:

> *I think for me, it was more - kind of really put into words like how serious this was in terms of low scores. And I think at the time I kind of saw it as, like, 'Wow, it's just a questionnaire, like, doesn't really mean anything.' Um, but because of the scores that I had, it was kind of - it made me*

> *realise, OK, this is more serious. And the doctor was taking it quite seriously as well.*

And so, while questionnaires may help articulate distress, they are not a substitute for relational, sensitive engagement in the context of trauma. When deployed without care or cultural sensitivity, they risk reinforcing feelings of invisibility and mistrust that Black adults may already hold at such a pivotal moment in their care journey, potentially leading some to disengage entirely from the system. When assessments became inadequate here, they often acted as barriers rather than gateways to healing. These early experiences often ushered Black adults into an overly medicalised and standardised mental health system that prioritised symptoms over stories, a dynamic explored in the following theme.

3.4. Theme: Overly clinical and medical focus

Beyond the initial point of access to services, many Black adults shared how the ongoing delivery of care remained dominated by narrow medical models. Rather than progressing into more relational and holistic forms of support, desired by many, Black adults encountered systems that continued to prioritise diagnosis and symptom monitoring. Maureen shared:

> *And sometimes when I go and I talk about my mental health in terms of, I don't know, the bipolar, and I know that's not the true picture of everything, it's just an aspect of me. But then I'm seen through this lens of, 'How are you sleeping?' And that's not the full picture that they're getting, but that's the picture that they take and accept.*

This sense of disempowerment led to some participants feeling service providers generally lacking genuine interest in them, or even not wanting to listen nor trust service users' perspectives or desires. The emotional toll on participants of not feeling listened to caused frustrations navigating what was deemed an already unjust system, with their needs feeling ignored:

> *When I try and, I'm unwell and I need to seek the services … I feel disempowered. Sometimes like psychiatrists, they don't listen to you. It's almost like you're an unreliable narrator of your own story and your own needs … And I always find that in terms of the mental health system … there's just no investigations or curiosity about me or my life. It's this kind of tick list of symptoms, ok so you're going through this, here is the medication and then get on, you know, are you looking for therapy – Maureen*

Others spoke to a desire for alternative or complementary approaches that were more in tune with their values and ways of healing:

> *You know, medication … I don't take them all the time. Now, I've moved into more natural therapies, which I really like … they ground you. It's a mind, body, and soul treatment option – Amani*

However, participants shared how these more integrative and meaningful approaches were absent from their treatment pathways. What they encountered instead was the dominance of a biomedical framework throughout the care pathway, one that focuses on pharmacological treatment and diagnosis, which was often seen as misaligned with the needs of Black adults.

3.5. Theme: Cultural matching

Participants described how access to practitioners who shared similar cultural backgrounds deeply influenced their ability to engage with services. For many Black adults, cultural matching was not simply a preference, but a factor that shaped their sense of being understood and emotionally safe, especially when disclosing racialised trauma and racism.

A common frustration though was the lack of availability of diverse practitioners within statutory services. This often left Black adults feeling disillusioned or forced to accept care that didn't align with their needs or identities. Tony reflected on this after inquiring about cultural representation in one service:

> *That was one of the early questions is … What cultural backgrounds are your therapists coming from? And it was very clear that it was, primarily white and primarily women, and I said, "well, you know, if I wanted a Black therapist. Ideally male, you know, 40 to 50 with some life experience from London. How long would I need to wait? And the answer was, well, we don't really have anybody like that in our system at the moment. So, would you like to take what we've got? I never asked the question again after that because I then started to read and learn about that service and I realised that in order to get that type of profile, you'd need to be very lucky or wait a very long time.*

Tony, like many others, attempted to seek support elsewhere when realising their preferences were unlikely going to be met through statutory services. This created additional emotional and logistical burdens, with Black adults describing the need to research and navigate services independently while unwell. However, when eventually finding practitioners who they deemed relatable in other sectors, cultural matching fostered a deeper sense of feeling understood and valued. For example, Tony shared their experiences of finding a suitable practitioner through a community organisation after disengaging from statutory services:

> *I've signed up with an organisation called BMM. Black Minds Matter. They have just gone out to market with a free service, which I still can't believe. Offering 10 1 to 1 sessions with a counsellor, a practitioner of colour … they've just connected me with my therapist, and I've checked her out online on LinkedIn and her profile looks absolute bang on match for me. And I couldn't be happier.*

Ava shared a similar journey and their experiences of eventually finding another Black woman through the same organisation who they could choose to work with, and the profound emotional shift:

> *It was everything. Because at that time, that was the help I needed … And I just remember, 'I don't know what to do.' I needed a Black woman to come and say, 'This isn't your job. This isn't your fight to fight, you know?' And that she did say. So, it was so important. It was everything in that particular season of my life.*

INTERVIEWER: What was the impact of having that choice and being able to make that choice?

> *The impact on me was just - I feel like it honestly, improved my overall wellbeing. I wholeheartedly believe that because it just felt like I'm really being heard. And it's like healing me from the inside out. Yeah, it boosted my self-esteem. It boosted my morale, increased my self-worth. It was amazing, you know, just to be honoured by being listened to.*

Participants also described how working with practitioners who did not share similar backgrounds could limit the depth of therapeutic engagement, particularly when it came to discussing experiences of racism and discrimination. Maureen shared:

> *So at the time when I went to see the therapist that I was seeing, like some of the things I brought up … it just fell short. It wasn't explored in a way that I was doing with my friends. There wasn't any depth as much as I would have liked to have gone into … there was stuff happening at work as well at the time. You know, I think that was racial discrimination … when I spoke to my friends, they would give me more information about what I could do about it or, you know, understand. But I felt that wasn't really an avenue that I could sort of explore with my therapist.*

For those seeking cultural matching who had financial barriers to affording therapy elsewhere, often support was sought through existing informal networks (e.g., friends and family). These informal networks had great value in acknowledging shared understandings of some of the racialised difficulties that exist for Black adults, such as managing racism, which led to more practical advice and support. However, these networks lacked the necessary clinical intervention needed to manage psychological aspects of trauma (e.g., nightmares), which many Black adults were seeking to manage as part of their distress:

> *It's more of a kind of an understanding that when you do explore a sense of connection, belonging, spirituality, those elements as a black woman living in Europe, it's just … there's more of an understanding with my friends, but there's some things that I don't tend to go into with my friends, because, they're not mental health professionals – Maureen*

While most participants (notably all Black women) viewed cultural matching as critical, a few male participants held a more neutral position. Amir, for example, acknowledged its importance for others, even if it wasn't essential for him:

> *I know some people have the whole thing of what's it called, a cultural … culturally appropriate therapy … Me personally, I don't really care for that, but I know it does have an effect.*

Findings within this theme ultimately emphasise how cultural matching between Black adults and practitioners shaped both access to and quality of therapeutic engagement. While not universally prioritised, for many, the option to choose a practitioner with a shared cultural background was central to feeling understood, particularly navigating the impacts of racism and trauma.

3.6. Theme: Improving person centred care

This theme highlights how participants experienced care that often felt rigidly standardised and inattentive to their lived experiences as Black adults with complex trauma. While person centred care is widely upheld as best practice, Black adults described a common disconnect between this ideal and the realities of statutory care. Rather than feeling recognised as individuals, Black adults spoke to being treated as data points within a system structured around efficiency and targets, that left little room for relational and cultural understanding.

This sense of detachment was most expressed during experiences of Cognitive Behavioural Therapy (CBT). Black adults felt that care was reduced to pre-set tasks where relational engagement was minimal. Deborah explained:

> *Sometimes she will finish the session early, and she just didn't seem she cared. It was just like a checklist … it was like I was just another number, and I am not that important.*

This structured model left participants feeling like passive recipients rather than active participants with agency in their own care. This often reflected a pattern of feeling unseen or undervalued within therapeutic spaces. Tony shared a similar sentiment:

> *I had never, ever had felt any level of partnership throughout any of my CBT sessions. For me, it was just a tick box exercise. And it was just a matter of statistics and data. You know, you're just another number.*

Participants' accounts expanded beyond critiques of therapeutic style to highlight the institutional logic underpinning these interactions. For some, this repetitive emphasise on targets and outcome measures came to symbolise care that failed to treat them as full people with lived experiences. Ava expands on this:

> *We really downplay the power of communication, the power of interest, you know, like genuinely just being interested and just caring, not being so task-focused. Because I don't think when it comes to the lives of people we should be saying, 'Oh, obviously KPIs* matter and that, but you're making your boxes green on Excel but making people's actual life red.*
>
> *KPI – Key Performance Indicators

In this context, person centred care was actively displaced by service cultures that continued to prioritise procedural compliance over connection. Ava went on to discuss the importance of person-centred care which is purpose-driven, not task-driven, with them critiquing the systemic structures in mental health services that prioritises 'tick boxes' at the expense of understanding people's unique needs:

> *You can't be task focused with people's life in your hands. You can't tick boxes and assume you've done a good job. That's not how it works. So, we have to change the structure and the systems in place because nobody's life is an Excel document. It's a lot more intricate than that.*

In contrast to the rigidity of task-focused care, participants expressed a desire for more collaborative, flexible approaches. They offered practical suggestions, such as greater use of whiteboards and visual tools, that could enhance engagement. Tony elaborated on this:

> *One thing that absolutely surprises me is that in these therapy rooms, there isn't a white board. I'm about facilitating … I want to be able to engage. Those 45 minutes might be the only 45 minutes I'm going to be with a professional for the next 14 days. So, I want to be able to go in there with some ideas, and I want to be able to talk through those ideas. This is what's happened to me. This is how I dealt with it. Let's brainstorm.*

Tony expanded further on the role of collaborative treatment practices, and the impact when such tools are missing:

> *We have got be more creative here. You have got to be able to use the technology, use the whiteboard, get up, put a pen in your hand, talk, get your thoughts out. Because when I come out of those sessions with this guy, unless I'm doing the same as he is, which is writing down stuff, then what do you get? You get two guys who are writing but not communicating … and then 6 sessions later, I'm coming out thinking, "actually, what did I accomplish?" Not a heck of a lot really.*

Without opportunities for collaboration, participants described therapy as something that was done *to* them, not *with* them, a dynamic that mirrored wider disempowerment experiences Black adults shared across care pathways.

Beyond the structure of care, the physical environment also emerged as a key component of person-centred care. Participants discussed how traditional clinical spaces, such as hospitals, often felt impersonal, and ill-suited to the needs of those with trauma. In contrast, more community-oriented, informal spaces were perceived as healing environments. Maureen shared their experiences of a community-based crisis house, and how these spaces were deemed more supportive. They discussed the impact of the surrounding area, the comfort of the space, as well as the absence of rigid professional roles:

> *It's this house in, somewhere in Bristol where they've got charity shops nearby and cafes. And then the house is actually big. It's comfortable, there's a garden and they have like, carers who, I mean, some of them have had experience working in the NHS, and some of them haven't. So they don't have you know … if you're in hospital somebody would say to me, 'Oh, I'm the HCA* or 'I'm the nurse. I'm the kind of special … There's nothing like that within the crisis house. It's everyone is kind of equal in a way … it's more of a community.*
>
> *HCA – Healthcare Assistant

Their experiences highlight how informal environments with fewer visible hierarchies can create a stronger sense of emotional safety and belonging when navigating trauma. Maureen contrasted this to nature of hospital environments, sharing how they felt 'cold' and clinical:

> *I think at the time, I think I just definitely needed warmth. I didn't want to go into a clinical space, you know, with all the kind of no windows situation and uncomfortable chairs. It just, yeah, it just felt very cold and clinical.*

For Black adults with complex trauma, these interactions and spaces discussed in this theme held particular emotional weight. Many adults, as shared, had already navigated systems where their distress and identities have been overlooked or misinterpreted. When entering services that offered minimal connection and environments deemed unwelcoming, participants felt like past harms were being repeated. Person centred care, in this context, was missing the integral elements that were needed to respond and acknowledge the full complexity of Black adults' lives and support needs, something rarely experienced in practice. As a result, many Black adults were left feeling marginalised within their own care, deepening feelings of exclusion.

4. Discussion

This study provided insight into the unique experiences Black adults with complex trauma have when accessing and navigating mental health services. We explored through qualitative interviews the journeys Black adults had when seeking support for complex trauma including their experiences and views of mental health services. Several themes emerged from the data, which included a fragmented mental health system, alternative support systems, inadequate or inappropriate assessments, overly clinical and medical focuses in care, cultural matching, and improving person-centred care.

A recurring thread across Black adults' accounts was a sense of invisibility within mental health services. An experience that, while not coded as a discrete theme, powerfully illustrated how statutory services often failed to acknowledge or validate their identities and needs. This reflects wider work on epistemic injustice in healthcare, where the voices and experiential knowledge of marginalised groups are routinely dismissed or devalued (Carel and Kidd, 2014). Such systemic disregard has serious consequences for both the quality of care and the erosion of trust between marginalised groups and the healthcare system.

While some challenges faced by participants may mirror those of other service user groups, the experience of complex trauma among Black adults was distinctly layered and racialised, shaped by both interpersonal harms and systemic harms. These intersecting dynamics help explain why statutory services were so often experienced as culturally incongruent, and thus, emotionally unsafe and unhelpful. These findings closely align with the work of Bryant-Davis (2019), who argues for trauma recovery models that are culturally grounded and responsive to spiritual, communal, and embodied dimensions of healing. When these dimensions are ignored, and when care remains narrowly clinical, it widens the risks of further harms placed on Black adults and alienating those in need, as found in this study.

Black adults frequently experienced fragmented and disrupted care journeys and often faced 'closed doors' whilst in times of need. The trauma support they sought, such as relational, comprehensive, and culturally grounded practices, was generally considered beyond scope of what was available in statutory services. These systemic shortcomings placed a disproportionate burden on Black adults to co-ordinate their own care, often through informal support or self-reliance. While these alternative strategies reflect resilience among Black adults, they also expose structural neglect. As a result, Black adults commonly reported experiences of iatrogenic harm: often re-telling traumatic histories to several clinicians, receiving impersonal short-term interventions, inappropriate assessments, and 'bounced' between services, often without meaningful support. These fragmented encounters and disruptions eroded trust, further distancing them from systems that already felt unwelcoming or unsafe. These findings together echo evidence that discontinuity in care disproportionately harms those with complex trauma (Adair et al., 2005), and the urgent need for trauma informed systems that are capable of sustaining meaningful therapeutic relationships (Courtois and Ford, 2012; Slade and Holmes, 2019). Crucially, such systems must be culturally attuned and responsive to socio-cultural needs of service users in order to not inflict further iatrogenic harm (Sweeney et al., 2022).

In response to fragmented and impersonal care, many Black adults turned to alternative systems of support which were more validating and affirming. Black adults' signalling value towards creative arts-based approaches, peer networks, as well as spiritual and community practices may reflect a desire for trauma healing that is relational and expressive by nature. Such approaches may be particularly important in the context of complex trauma which often disrupts self-agency and emotional expression (Shepherd and Wild, 2014). Further, spirituality and religious practices have been long documented as protective factors to mental-ill health for racialised groups (Nguyen, 2020). Religious and spiritual gatherings provide spaces where communities can collectively discuss their experiences with others who may share similar struggles. And so, these collective spaces may shield experiences of isolation that are often manifested in complex trauma experiences (Dagan and Yager, 2019). This level of cultural understanding and solidarity provided by others who follow similar values and customs may extend beyond what is typically offered within statutory mental health services (e.g., individual talking therapy).

A critical finding from this study was that many participants felt their care was centred too explicitly on clinical and medical management with little room for exploring alternative solutions. This may speak to larger criticisms of Western psychiatry and medical practices which centre a biomedical model (Deacon, 2013). Cross-cultural studies have cited concerns that Western psychiatry and medical models of illness tend to individualise and pathologize distress without factoring wider socio-cultural and political manifestations of distress, such as racism or systemic oppression (Morrow and Weisser, 2012). It is therefore important for practitioners to engage meaningfully with the sociopolitical realities and structural harms that shape Black adults' experiences, including an awareness of potential prior experiences of silencing or discrimination Black adults may have had in healthcare. Efforts made here may help combat medical distrust and the ongoing sense among Black adults that their needs are routinely overlooked (Brown et al., 2024).

Preferences for cultural matching were also nuanced. While all Black women in this study expressed a desire for practitioners who shared their cultural background, this was less evident among all Black male participants. This suggests the importance of considering how racialised and gendered experiences of trauma intersect (Collins and Bilge, 2020), and how these intersections inform care preferences. The findings support institutional efforts to diversify the mental health workforce, providing greater *choice* for service users, which becomes particularly important for trauma survivors whose histories are often marked by disempowerment (Sweeney et al., 2018). Indeed, expanding and retaining a racially diverse workforce remains a key global priority in health services (Hussain et al., 2020; Rao et al., 2018).

Black adults in this study found great therapeutic value in collaborative and partnership work between themselves and providers. These participatory approaches in care may work favourably with Black adults, particularly when factoring for the disempowering nature of racism and systemic oppression (Corneau and Stergiopoulos, 2012). In contrast, CBT was often perceived as too structured and rigid and left little room for the collaboration Black adults wanted. And so, while CBT has established evidence in reducing trauma symptoms for many (Lewis et al., 2020; Bisson et al., 2007), more research is needed to explore experiences of unmet needs in treatment, particularly for Black adults with complex trauma where the evidence base remains scarce. Additionally, those exposed to complex trauma may have had prior experiences of chronic invalidation (Cook et al., 2005). Therefore, it is crucial that services do not maintain these experiences and instead pay particular attention to collaborative, validating approaches within assessments and treatments.

The preferences for less clinical spaces to do therapeutic trauma work as shared by Black adults in this study is in line with trauma-informed approaches that emphasise the need for comfort and safety (Sweeney et al., 2018). Black adults reported having assessments and interventions often in busy and loud general practices or outpatient hospitals, which were sometimes considered unsuitable places to access trauma support. Empirical work also questions the suitability of these environments when factoring for historical and cultural concerns, whereby Black adults may find traditional clinical environments (e.g., general hospitals) stigmatising due to historical marginalisation and medical racism (Feagin and Bennefield, 2014). Taken together, service providers should remain aware of the environment and therapeutic spaces that are available to service users to avoid re-traumatising those who access care.

Rather than proposing these adapted practices replace statutory services entirely, findings suggest an opportunity for integration and collaboration. Mental health services would benefit from moving beyond narrow biomedical models by working alongside culturally congruent services or existing community networks valued by Black communities. This includes developing referral pathways to trusted, community-based support and funding culturally adapted interventions. Integrating statutory and community responses could improve both the accessibility and acceptability of care for Black adults with complex trauma.

The findings further highlight the need for trauma-informed care that is both culturally attuned and responsive to the racialised dimensions of trauma. A truly effective model of care must centre clinical expertise alongside an active responsiveness to the lived realities of those it serves, especially Black adults navigating the impacts of complex trauma. This requires embedded anti-racist, healing-centred frameworks in clinical training programmes ensuring practitioners are equipped with relational and reflective skills, cultural awareness, and a critical understanding of the systemic forces that shape how trauma is experienced and expressed among Black groups. Ultimately, improving outcomes for Black adults with complex trauma requires systemic reform that aligns care and training practices with principles of dignity and cultural belonging, and are consequently grounded in a sustained commitment to ethical, culturally responsive care. These reforms are crucial for ensuring timely access to effective trauma-informed support that honors Black adults' cultural identities and lived experiences, and reducing the racial disparities they face in accessing care.

4.1. Limitations

Whilst this study offered rich and valuable insights into the experiences of mental health services Black adults with complex trauma had, several limitations exist. Firstly, the study focused on experiences accessing statutory mental health services and the voluntary sector in the United Kingdom. Statutory NHS mental health services have specific structured pathways to care and policies that may limit transferability of findings to other global health systems. Another limitation of the study was that the study focus was not on exploring previous or ongoing traumas Black adults had, but more on how mental health services can best support this population. It felt important to adhere to trauma informed principles (Reeves, 2015) and create safe and supportive environments for participants to not risk re-traumatisation by probing on trauma histories. This though, may have limited our understanding of how specific traumas may have influenced experiences and how they may relate to specific needs of Black adults navigating services.

5. Conclusion

Significant challenges exist for Black adults with complex trauma in accessing and receiving trauma support. This study highlights the pressing need for trauma-informed care that is tailored and adapted to the unique cultural needs of Black adults. By addressing these challenges services become more inclusive and responsive to the needs of Black adults with complex trauma and strengthens the potential for improved experiences and outcomes for this population. Our findings reinforce the imperative for structural reform within services, reform that dismantles existing barriers and expands access to culturally informed, appropriate pathways of care.

CRediT authorship contribution statement

Lewis Benjamin: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Steve Gillard:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Jessica Jones Nielsen:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Camila Graterol Munoz:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Jacqueline Sin:** Writing – review & editing, Supervision, Methodology, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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