

Exploring Black Clinical Psychologists' Experiences of
Racism and its Discussion at Work and in the
Profession.

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ABSTRACT

This research aimed to explore Black Clinical Psychologists' (BCPs') experiences of racism and its discussion at work and in the profession. Within this, there was a focus on how they describe and make sense of their experiences, how they feel they are positioned and perceived when racism is discussed, how they navigate conversations about racism and how they think a sense of safety and support could be fostered within these experiences.

In line with the critical realist epistemological position, the methodology employed a qualitative design. Data was collected through twelve in-depth semi-structured interviews with clinical psychologists who self-identified as Black and practiced in the UK. Interviews were analysed using an inductive approach to reflexive thematic analysis. Five themes were identified:

- *"It is what I am": BCP identity*
- *Whiteness at work*
- *Spotlighting Whiteness; the work of anti-racism*
- *Resistance*
- *"An absolute mess"; what needs to change*

These themes highlight and provide a narrative of the systemic and systematic processes of Whiteness and the ways in which it manifests in BCPs' lived experiences.

The analyses are discussed in relation to the research question and existing literature. Drawing upon the analyses, recommendations for clinical practice, policy, future research and education and training are made.

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LIST OF ABBREVIATIONS

Below is a list of common abbreviations used in the research

BCP- Black Clinical Psychologist

BPS- British Psychological Society

CP- Clinical Psychologist

DClinPsy- Professional Doctorate in Clinical Psychology

GTiCP- Group of Trainers in Clinical Psychology

HCPC- Health and Care Professionals Council

IPA- Interpretative Phenomenological Analysis

NHS- National Health Service

TA- Thematic Analysis

TCP- Trainee Clinical Psychologist

WCP- White Clinical Psychologist

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Figure 1: Systematic Scoping Review Flow Chart

Figure 2: Thematic Map

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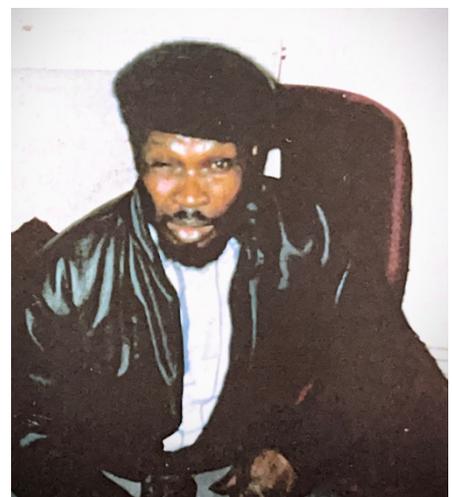
Firstly, I would like to thank the people who participated in this research. Thank you for trusting me enough to share your experiences with me. It has been an honour to witness your testimony. Your courage, humanity, thoughtfulness, kindness, vulnerability, humour and strength will stay with me for the rest of my career. I hope this research does you justice.

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1. INTRODUCTION

This chapter begins with an introduction to, and discussion of, key constructs that are used throughout the literature and this research. An analysis of the operationalisation of Whiteness in the UK's historical context is provided, with a discussion of the impact of that context on the development of the profession of clinical psychology. The literature outlining the impact of, and discourse around, structural racism in the current socio-political context, National Health Service (NHS) and profession of clinical psychology is reviewed. This is followed by a systematic scoping review. The chapter closes with a rationale for this research, an overview of the research aims and the research questions.

1.1. Constructs

1.1.1. Race

The construct of 'race' emerged through the development of western civilisation, with White Europeans using it as a primary means by which to conceptualise the 'other' (Baldwin, 2010; Fanon, 1967; Turda & Quine, 2018; Ryde, 2019). The absence of a biological basis for race and the variability of classifications over time, geographic location and social and political contexts, has led to it being understood as a social construct (Gannon, 2016; Hoover, 2007; Witzig, 1996). Despite its inability to identify distinct groups on the basis of objective criteria, race remains a political, cultural and social signifier (Benedict, 2019; Gossett, 1997).

When the language of 'race' is used, it is often to identify a group of people who "have in common some visible physical traits, such as skin colour, hair texture, facial features, and eye formation" (Takezawa, 2020, p. 1). Within social discourse and academic literature in psychology and other health-related disciplines, the constructs of ethnicity and race are frequently used interchangeably, despite important distinctions in their meaning; race is concerned with phenotypic characteristics, whereas ethnicity also encompasses cultural factors, such as traditions, language and nationality (Santos et al., 2010).

1.1.2. Racialisation

Racialisation refers to the social and political process through which the construct of race is activated in the production of racial subjects, constructing people in such a way that they are assigned a racial identity and come to be designated as belonging to a particular racial group (Tazzioli, 2021). Through this process, race and the associated ideologies become silent factors in the allocation of social resources as a consequence of their entanglement with discourse, places, spaces, institutions and relationships (Gonzalez-Sobrinio & Goss, 2020). The process of racialisation, used to generate and maintain unequal status and power relationships, is dominated by those who are conceptualised as White¹, with their position being validated by mass culture (Guess, 2006). Consequently, racialisation is fundamentally understood as an exercise of power – something detrimental that is done by those conceptualised as White, to those racialised as other (Wolfe, 2002).

1.1.3. Whiteness

Race and racialisation cannot be researched without an understanding of the insidious and pervasive nature of the underpinning ideology: Whiteness. This ideology positions those conceptualised as White as the focal point from which others differ, affording them normative status, social dominance and privilege – with darker skin being understood as a signifier for inferiority (Pappas, 1995; Baldwin, 1969). This ideology “is dynamic and reproductive in maintaining structural advantage and upholding particular structures, institutions and practices, which in turn reproduce and reinforce racialised hierarchies, exemplified in historical and ongoing practices” (Patel, 2021, p. 4).

The operation of Whiteness can be observed in the disparities in outcomes in the health, mental health and criminal justice systems (King & Jeynes, 2021; Phillips et al., 2017; Russell, 2020). Moreover, Whiteness is operationalised in the way that

¹ ‘White’ is capitalised in acknowledgement that this construct relates not just to those who self-identify as being of white race, but also the myriad of people who don't identify in this way but have phenotypic characteristics which confer proximity to Whiteness, and are therefore afforded privileges.

these disparities are understood; through a Whiteness lens where their origins are located in the racialised other using narratives which problematise their genetics, cultures, habits, religions and values (Patel & Keval, 2018).

1.1.4. Discrimination and Racism

There is no universally agreed definition of racism. The UK Equality Act of 2010 criminalises discriminatory acts, whether direct, indirect, harassment or victimisation, on the basis of nine protected characteristics, of which race is one. The focus of this definition on discriminatory behaviours neglects the ideological influence of Whiteness and process of racialisation which underlie racial discrimination (Patel, 2021). Moreover, it is argued that this definition is complicit with, and perpetuates, Whiteness. The location of difference in the non-White 'other', by framing them as having 'race', positions being White as the norm, indicating that Whiteness is operationalised within the Equality Act itself. When the term 'racism' is used in this research, it is referring to "a form of discrimination which is perpetuated by a system of oppression based on racial categories that designate [White people] as superior and [the racialised other] as inferior" (Palmer, 2018, p. 14). This definition acknowledges the ideology of Whiteness, process of racialisation and presence of structural racism.

1.1.5. Structural and Institutional Racism

Structural racism is the most profound and pervasive form of racism, encompassing all operations of Whiteness in hierarchical systems which normalise, legitimise, reinforce and reproduce White supremacy in the various aspects of our societal fabric – including politics, culture, economics and history (Lawrence & Keleher, 2004). As such, when the term 'structural racism' is used, it includes the racism that occurs within and between institutions. Macpherson (1999) defined institutional racism as:

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance,

thoughtlessness and racist stereotyping which disadvantage minority ethnic people” (Macpherson, 1999, p. 49).

Although this definition has been widely accepted, it has been criticised for partially attributing institutional racism to the attitudes and behaviours of individuals, and in doing so, minimising the role of institutional structures in perpetuating the ideology of Whiteness (Bourne, 2001; Patel, 2021). Furthermore, the language of ‘unwitting’ and ‘thoughtlessness’ implies that the Whiteness operating within institutions is unintentional and perhaps even unconscious. This framing potentially facilitates the abdication of responsibility for addressing racism and arguably appeases the conscience of those who are complicit in the operation of Whiteness, facilitating its maintenance and perpetuation. As such, institutional racism is better defined as:

“The reproduction within institutions of practices of power which discriminate against people on the grounds of their perceived ‘race’. These practices maintain the status quo in institutions and can be practices both in the commission of racist acts and in the omission of acts which would redress the situation” (Patel et al., 2000, p. 31).

1.1.6. Terminology Used to Describe the Racialised Other

In the literature, there are many terms that are used to describe racialised people; Black, Asian and minority ethnic (BAME), Black and minority ethnic (BME), person of colour (POC), ethnic minorities, Black, Indigenous and people of colour (BIPOC) to name a few. These terms perpetuate Whiteness and are meaningless; they provide no indication of culture or ancestry and function solely to indicate that those conceptualised in this way are not White, and should be racialised and treated as such (Banglawala, 2019; Fakim & Macaulay, 2020; Singh, 2020). Moreover, these terms suggest that there is homogeneity among the experiences of those who aren’t White, neglecting the nuances in their differential experiences of racism, the different ways in which groups are racialised and the varying degrees of proximity to Whiteness that affect each groups’ experience (Daniel, 2022; Garay et al., 2022).

While some may argue that the term ‘ethnic minorities’ is accurate, as 78.4% of people in UK identify as being of white race (Office for National Statistics, 2021), it is

important to make a distinction between being a minority and being minoritised. Experiences of racism do not emerge as a result of racialised people existing as a minority in numbers, but as a consequence of the operation of Whiteness and its manifestation in the power wielded and inequity and oppression perpetrated in the process of being subjugated by the dominant White racial group (Wingrove-Haugland & McLeod, 2021). Due to the problematic nature of this language, these constructs will only be used where they feature as descriptive terms in the referenced literature.

1.1.7. Black

In 1980s Britain, Blackness² was a hegemonic concept which described the political position of people of African, Caribbean and South Asian heritage; the status transcended ethnicity and heritage in favour of solidarity and political formation in the face of their shared experiences of racism and oppression (Ambikaipaker, 2018; Modood, 1994). This definition of Blackness had been criticised for homogenising the experiences of racialised people, and in doing so, perpetuating the inaccurate assumption that the nature of the racism faced by different racial groups was the same (Andrews, 2016). In the current context, 'Black' is used to refer to people with African ancestral origins (Agyemang et al., 2005). Individuals who identify with being Black, according to this definition, tend to be darker skinned and share other phenotypic characteristics. Consequently, by nature of the way Black people are racialised, they experience the least privilege, exposure to anti-black racism and the unique stigma associated with being Black in White supremacist Britain (Daniel, 2022; Garay et al., 2022; Solanke, 2018).

1.2. Race, Racism and the UK's Historical Context

The UK has a long and complex history pertaining to race and racism, in which the profession of clinical psychology has been both influential and influenced. As such, it

² 'Black' and 'Blackness' are capitalised in acknowledgement of the ancestry, history, identity and experiences of racism that are shared by individuals who are racialised in this way (Kinouani, 2021).

is impossible to adequately explore and understand the current socio-political context, professional context and status of race relations, without an inspection of the history of the UK in this regard.

1.2.1. The Colonial Context

In the 16th century, Britain embarked on its 'empire project': the worldwide imposition of eurocentrism through a system of dependencies, achieved by colonisation and imperialism, cultivated under the sovereignty of the crown of Great Britain and administration of the British Government (Darwin, 2009; Gaur et al., 2013). The scale of colonisation was such that there were British colonies on every continent, with the extent of territorial, constitutional, political, commercial and cultural control being exercised over colonised populations being a source of national pride, upon which Britain boasted that its empire was one "on which the sun never set" (Fordyce, 1931, p. 152).

The functioning of the empire was underpinned, facilitated and perpetuated by the ideology of Whiteness and its manifestation in White normativity, White superiority and race-based oppression. Racialised people, particularly those racialised as Black, were understood to be biologically and culturally inferior to White Europeans, who believed them to have limited 'natural capacity', forming the basis of Britain's conceptualisation of Black people as sub-human (Ramsay, 2013). Consequently, people racialised as Black were denied the legal rights afforded to those conceptualised as White, framing them as prime candidates for enslavement (Morgan, 2007). The chattel principle positioned Black people as property, validating the breeding of enslaved Black people and the use of their bodies and childbearing potential as collateral to secure the riches of White people (Sublette & Sublette, 2015). The commodifying, objectifying and dehumanising of Black people was evident in the brutalisation, trafficking, abuse, displacement and loss of identity that they were subjected to by the British in their pursuit of empire, for Britain's economic benefit (Oldroyd et al., 2008). As such, it is clear that in the case of the British empire "racism [was] the psychology of imperialism, the spirit of empire, because racism supplie[d] the element that ma[de] for the righteousness of empire. Hence racism [was] not simply a by-product of empire but an intrinsic part of it" (Pieterse, 1989 as cited in Rich, 1998, p. 31).

While some may argue that the end of the British slave trade in 1807 and the introduction of The Slavery Abolition Act of 1833 marked the end of Britain's colonial reign, the formation of the British Commonwealth of Nations in 1931, and its continued existence, is evidence that this is not the case. While understood to be equals in the eyes of the Commonwealth, member nations were required to pledge their ongoing allegiance to the British Crown; maintaining colonialism through their continued subordination to the same Crown that played an active role in the dehumanisation and oppression of their populations for generations, on the basis of their race (The Commonwealth, n.d.). Furthermore, when slavery was abolished, the British Government began paying reparations of twenty million pounds to slave owners, the last of which was paid in 2015 (Centre for the Study of the Legacies of British Slavery, 2022). As such, citizens of the UK have continuously reaped the financial rewards of British colonialism, built on a foundation of racism, oppression and the minoritisation of those racialised as Black.

1.2.2. The Post-war Context

In an effort to rebuild the country and address the labour shortage after World War II The British Nationality Act of 1948 was implemented, granting Commonwealth citizens the freedom to live and work in the UK (Deakin, 1969). Prior to this, Black and Asian people constituted less than 0.5% of the British population, but by 1991, 5.5% of the population were ethnic minorities, with Indian, Black Caribbean and Pakistani ethnic groups making up the majority of those represented by that classification (Local Government Chronicle, 1996; Spencer, 2002). This period of mass migration marked the beginning of racialised people forming a substantial and permanent part of the British population; the first time that White people in the UK experienced racialised people in their daily lives (Ellis, 2001).

Commonwealth countries conceptualised Britain as a place of wealth and freedom, leading those who migrated to believe that they would have access to opportunities for themselves and their children. However, upon arriving in the UK, they were confronted with Whiteness and its manifestation in experiences of minoritisation and racism (Akala, 2019; The National Archives, n.d.). Racialised people were denied access to services and accommodation, with signs reading "No Irish, no blacks, no

dogs”, “no coloureds” and “no West Indians” being commonplace (Wood, 2015, p. 1). Racism was so widespread that MPs were elected on the back of slogans such as “if you want a nigger for a neighbour, vote Labour”, and the espousal of rhetoric which framed immigration as a threat to British society, calling for the repatriation of all immigrants (Jeffries, 2014, p. 1; Whipple, 2009). The popularity of this perspective gave rise to far-right, White supremacist populism in the form of political parties like the National Front, whose beliefs included that “niggers, fuckin’ wogs and cunts” should only be respected if they were located in their ‘natural’ territory (Fielding, 1981, p. 9).

In response to the hostile socio-political climate, those who identified with being politically Black began to mobilise in resistance of their shared experiences of oppression, forming activist organisations such as The Campaign against Racial Discrimination and The British Black Panthers, which understood ‘Blackness’ as a conduit for the cultural politics of decolonisation and anti-racism (Angelo, 2009, 2018; Wild, 2015). Experiences of over-policing, discrimination, economic hardship and institutional racism also culminated in riots against the repressive institutions of the state (e.g. those in Bristol, Notting Hill and Brixton) and unsanctioned economic strikes (e.g. Imperial Typewriters, Grunwick and Mansfield Hosiery Mills) (Smith, 2010).

The Race Relations Act of 1968 outlawed race-based discrimination, but failed to make a difference to the lived experience of racialised people. Instead, it created a context that enabled the development of ‘colour-blindness’. This notion operates strategically to perpetuate Whiteness by providing White people with an ideological position from which race, and therefore Whiteness, is no longer the subject of inspection; facilitating the maintenance of their wilful ignorance through the belief that they exist in a ‘post-racial’ society (Apfelbaum et al., 2008; Bonilla-Silva, 2013; Pérez, 2017). The idea that the UK is ‘post-racial’ is nothing more than a well-regarded fantasy, with the Steven Laurence inquiry (Macpherson, 1999), Lammy (2017) review and Snowy White Peaks (Kline, 2014) reports providing evidence that structural racism remains a significant problem in the UK.

1.2.3. The History of Clinical Psychology and Race

British clinical psychology developed in the context of the UK's colonial and post-war periods, and therefore, in alignment with White Eurocentric ideology (Shuttleworth, 2018). Informed by Darwin's theories of evolution and natural selection, psychologists fuelled the eugenicist agenda by developing empirical methods to identify which groups displayed "the highest and lowest levels of evolutionary development" (Oldroyd et al., 2008; Yakushko, 2019, p. 4). These methods included standardised instruments that claimed to assess personality and intelligence, and were systematically employed to 'prove' that Black people were emotionally, psychologically, cognitively and biologically inferior to their White counterparts (Tucker, 2010). This reinforced the colonial ideology that Black people should be afforded sub-human status and provided a justification for their continued subjugation and minoritisation; not because of their race, but on the basis of 'inherent constitutional differences'.

The profession evolving in this way has resulted in empiricism and eugenics being the "twin towers" of its foundation (Pilgrim & Patel, 2015, p. 56). Consequently, throughout clinical psychology's history, the profession has functioned as a conduit for Whiteness, although its methods of doing so have evolved. The psychiatric diagnosis of drapetomania, which pathologised the normal responses of Black people to colonial enslavement, has been replaced with psychometric measures and Eurocentric psychological theories, tools and values that perpetuate Whiteness, privilege White people and (re)produce 'evidence' of White superiority (Bhatia, 2020; Opara et al., 2022). The absence of education, critical interrogation and reflection on this history among clinical psychologists (CPs) has resulted in the legacy of eugenicist ideas and scientific racism remaining powerful and largely unchallenged – thus continuing to influence modern-day British clinical psychology (Pilgrim, 2008).

1.3. Race, Racism and the Current Context

The ideology of Whiteness continues to operate in Britain's current context. Long established race-based inequalities in the provision of, and access to, housing, education, employment and health have worsened over recent decades (Lymperopoulou & Finney, 2017). BAME communities are more likely to live in overcrowded or inadequate housing (McFarlane, 2014; Gulliver, 2016; Haque et al.,

2020), experience higher rates of homelessness (Bramley & Fitzpatrick, 2018) and face structural barriers in their attempts to access social housing (Kowalewska, 2018). BAME households are three times more likely to be in persistent poverty than White households, and are over-concentrated in deprived areas which, due to the association with lower socio-economic status and underfunded public services, culminates in higher morbidity rates, lower quality of life and lower life expectancy (Gulliver, 2016; Social Metrics Commission, 2020; Equality and Human Rights Commission, 2016).

Whiteness is also operationalised in policing and the wider criminal justice system. In March of 2023, an independent review which focused on the standards of behaviour and culture within the metropolitan police service, concluded that “the met [had] yet to free itself from institutional racism” (Casey, 2023, p. 22). Moreover, in England and Wales, Black people are seven times more likely to be stopped and searched and three times more likely to be arrested, prosecuted and sentenced than White people (Institute of Race Relations, 2020; Office for National Statistics, 2022a, 2022b). The operation of Whiteness and subsequent problem of structural racism is not limited to the criminal justice system, but extends into other public services, with the fire service and NHS also being found to be institutionally racist by independent reviews (Afzal, 2022; Kapadia et al., 2022).

The impact of structural racism is not limited to adults. Racialised, particularly Black, children are consistently overrepresented in school exclusion statistics (Demie, 2021). Moreover, an analysis of the experiences of 557 Black and Mixed ethnicity young people revealed that 95% witnessed racist language in school, 78% heard racist language in the workplace, 49% felt that racism was the biggest barrier to educational attainment and 50% believed that racist views were held by teachers. Furthermore, 54% felt that there was prejudice at the recruitment stage of employment, 54% did not trust the police to act without prejudice and discrimination and 27% reported a lack of trust in the NHS as a barrier to maintaining good health (YMCA Youth Advisory Board, 2020). Alongside the cumulative impact of structural racism across the lifespan, racially-motivated hate crimes more than doubled to almost 80,000 between 2011 and 2020 (Office for National Statistics, 2012, 2020),

highlighting the relationship between right-wing government rhetoric and racism, and mirroring the tone of the political landscape in Britain's post-war period (Erel, 2018).

While conversation on the topics of Britain's colonial history and ongoing issues with structural racism have waxed and waned, recent events have spurred the societal discourse. The campaign to leave the European Union was fought and won on the basis of racist conjecture (Burnett, 2017; Cowburn, 2016; Mintchev, 2021). In response, academics, non-governmental organisations and the mainstream media brought discussion around the racist undertones of the Brexit debate into the public domain, publishing articles that highlighted the relationship between Brexit, the resurgence of overt racism and a steep increase in race hate crime (BBC, 2019; Booth, 2019; Bowler, 2017; The Trades Union Congress, 2016; Virdee & McGeever, 2018). These racist undertones have been compounded by the Conservative Government purposely and successfully creating a hostile environment for migrants and refugees (Goodfellow, 2020), resulting in the Windrush scandal – the unlawful denial of public services and deportation of racialised (majority Black) British citizens (BBC, 2021c; Institute of Commonwealth Studies, n.d.; Joint Council for the Welfare of Immigrants, n.d.). A similar fate was suffered by Shamima Begum, an Asian-British woman whose citizenship was revoked – even though the decision to do so constituted a gross human rights violation – following her being groomed by Isis as a child (BBC, 2020b, 2021a; Liberty Human Rights, 2021; Masters & Regilme, 2020). The revocation of Begum's citizenship occurred in the context of Islamophobic and racist media narratives, which prompted further discussion around racism in the UK (Murphy, 2021). The operation of Whiteness in UK immigration policy and within social attitudes held by its citizens has been more recently discussed in the context of the differential treatment of, and narratives surrounding, White Ukrainian refugees and racialised refugees. The British Government opened the 'Homes for Ukraine' scheme (Home Office, 2022), deeming White Ukrainians worthy of asylum, while simultaneously assessing racialised asylum seekers as unworthy by implementing the Rwanda deportation scheme (Kohnert, 2022). This was accompanied by racist media coverage; the sentiment surrounding racialised asylum seekers was devoid of compassion and discussed the use of turnaround tactics (BBC, 2020a; Rajeev, 2021). The media's portrayal of racialised asylum seekers was in stark contrast to the empathetic coverage which humanised Ukrainians on the basis of their

Whiteness; those covering the story highlighted that Ukrainians were “European people with blue eyes and blonde hair”, that Ukraine “isn’t a place...like Iraq or Afghanistan... This is a relatively civilized, European city”, and that “they seem so like us” (Bayoumi, 2022, p. 1).

In November of 2019, a re-enactment of a slave auction was offered as evening entertainment at the British Psychological Society’s (BPS) Group of Trainers in Clinical Psychology (GTiCP) annual conference. This rightly sparked outrage and evoked strong responses from racialised and White psychologists (Patel, 2020; Mintah et al., 2020), catalysing conversation about Whiteness and racism in the profession. This was followed closely by the murder of George Floyd in 2020, as the world, bought to a standstill by the COVID-19 pandemic, watched for nine minutes while police officer Derek Chauvin sat with his knee on Floyd’s neck while he pleaded for his life (BBC, 2021b). George Floyd’s murder sparked outrage that galvanised the international community, resulting in Black Lives Matter protests in more than forty countries and reigniting social and academic discussion about structural racism and the history of colonialism (Smith et al., 2020). In the UK, discourse turned to Britain’s history of colonialism, with debates emerging around the appropriate way to acknowledge our history without inappropriately celebrating racist and colonial actors (BBC, 2020c; Mohdin & Storer, 2021). Despite unprecedented levels of societal acknowledgement of racism, and evidence showing that structural racism resulted in the disproportionate impact of COVID-19 on racially minoritised communities (Haque et al., 2020; Kirby, 2020; Nazroo & Becares, 2020; Public Health England, 2020), the then Prime Minister established a Commission on Race and Ethnic Disparities (2021) which published its highly controversial report that denied the presence of structural racism in the UK.

The events described have culminated in intense and extensive social discourse around structural racism in Britain, from which it can be deduced that the UK is in the midst of a critical period in race relations, placing racism firmly on the agenda both socially and professionally. NHS statements expressing a long-term commitment to racial equality (NHS England, 2019) and the BPS (2021a, p. 1) declaring itself “committed to tackling racism within our profession” have further prompted discussion around racism in the profession and NHS.

1.4. Whiteness and Racism in the NHS

The NHS was established in the post-war period and therefore, in a context dominated by Whiteness and overt racism (Brathwaite, 2018). While expressions of racism have become covert, the underlying ideology of Whiteness continues to be operationalised within NHS structures, and therefore “institutional racism [remains] deeply embedded in its structures and processes” (Kapadia et al., 2022, p. 21). As such, the NHS continues to perpetuate endemic levels of racism and create racial disparities in the experiences and treatment of racialised people who work in the NHS and access its services (Naughton, 2013; Scott, 2012; Symon, 2006). For example, Black people are four times more likely to die in childbirth (Limb, 2021) and encounter structural barriers when accessing genetic sequencing, which is integral for the prevention and early detection of cancers (Hann et al., 2017). Moreover, racialised staff are consistently overrepresented among those reporting discrimination at work (West & Dawson, 2011). The following subsections provide a brief overview of the impact of Whiteness and racism on the experiences of racialised staff and people who access psychological services.

1.4.1. Racism and the Experiences of Staff

Minority ethnic staff are more likely to enter formal disciplinary processes, experience harassment, bullying or abuse from service users, as well as experience discrimination from colleagues. All the while they are less likely to access professional development opportunities or be appointed to very senior management roles compared to their White colleagues (Workforce Race Equality Standards Implementation Team, 2021; Archibong et al., 2019). Moreover, Black staff are more than twice as likely to experience discrimination than their White colleagues, and significantly more likely to be discriminated against than their Asian colleagues; this illustrates that staff who are racialised as Black experience the sharpest end of racial discrimination in the NHS, as well as the associated psychological consequences – namely anxiety and depression (Rhead et al., 2021).

Qualitative exploration of the experiences which underlie these trends highlights that racialised staff find the structures of the NHS to be systemically racist while simultaneously being victimised in instances of racism that are perpetrated by their

colleagues and managers, as well as by patients and their relatives. The racism manifests in multiple ways, including the experience and knowledge of racialised staff not being respected, their work being undervalued and them consistently being overlooked while their White colleagues are supported into promotion (Edeh et al., 2022; Gordon & Weller, 2021; Likupe, 2015). Racism has also been implicated in the comparatively harsh ways that mistakes made by racialised staff are responded to, with awareness of this creating a need for them to be perceived as exceptional (Edeh et al., 2022; Likupe, 2015). Racialised staff also reported experiencing hostility from management and supervisors, who make assumptions about their ability that are based on their internalisation of racist stereotypes (Gordon & Weller, 2021; Likupe, 2015). An analysis of the experiences of Black staff found that being racialised as Black framed them as inferior to others, including their racialised colleagues. Being racialised as Black resulted in questions being raised about their abilities and professionalism, with clients often asking for a second opinion or a 'British' doctor due to assumptions that Black staff were 'foreign' or a 'migrant' (Edeh et al., 2022). The synthesis of these experiences indicate that racialised, particularly Black staff, experience the NHS as a hostile and oppressive work environment (Edeh et al., 2022; Gordon & Weller, 2021).

1.4.2. Racism and the Experiences of People Who Access Psychological Services

The operation of Whiteness and structural racism in psychological services has repeatedly been observed in the racial disparities they create in the treatment of people who access them. Black people are more likely to be diagnosed with psychotic disorders across all age groups (Fearon et al., 2006). This is of marked significance as psychosis related diagnoses have historically been, and continue to be, constructed to equate being racialised as Black with insanity, pathologising Black people and [re]producing racial hierarchies (Metzl, 2010). Moreover, Black people are most likely to come into contact with psychological services through the punitive structures of the criminal justice system (Halvorsrud et al., 2018) and be subjected to involuntary detention on mental health wards (Davies et al., 1996; McKenzie, 2008; McKenzie & Bhui, 2007; Takei et al., 1998). They also experience the longest stays on mental health wards (McKenzie, 2008; McKenzie & Bhui, 2007; Takei et al., 1998) and are more likely to be readmitted to inpatient care following being discharged, when compared to their White and Asian counterparts (Burnett et al.,

1999; Takei et al., 1998). Not only do Black people experience the most restrictive treatment, but they are also the least likely to be offered psychotherapy and most likely to be offered drug treatment, particularly intrusive medications such as the slow-release antipsychotic depot injection (Bhui et al., 2014; Das-Munshi et al., 2018; McKenzie & Bhui, 2007).

Qualitative exploration of the experiences which underlie these trends reveal that, for Black people, inpatient admissions are characterised by a lack of support, the dismissal of their views on their care and treatment, feelings of powerlessness, a lack of opportunities to challenge treatment that they feel is inappropriate and experiences of racism perpetrated by staff and the wider system (Secker & Harding, 2002). Furthermore, the minority of racialised people who are offered psychotherapy often find that White clinicians are unable to understand key aspects of their experience, leading them to avoid discussing racial or cultural issues in therapy (Chang & Yoon, 2011). This implies that when therapy is offered to racialised clients, the lack of racial and cultural sensitivity and awareness among practitioners results in racialised people not being able to freely access, and therefore make use of, the therapeutic space provided within psychological interventions. These experiences result in a vicious cycle of disempowerment and mistrust, which manifests in resistance to, or the passive acceptance of, the interventions offered by psychological services (Lawrence et al., 2021). Moreover, they validate and reinforce the negative relationship to help that the Black community have with psychological services, which is driven by the cycle of fear (Keating, 2009; Keating & Robertson, 2002, 2004); fear of mental health services results in a reluctance to seek help and later presentations to services, increasing the likelihood of individuals being acutely distressed and presenting in ways that are interpreted as aggressive when they do come into contact with services. This thereby increases the likelihood that Black people are subjected to coercive interventions, in turn reinforcing negative perceptions of the NHS and perpetuating their reluctance to engage.

1.5. Whiteness and Racism in the Profession of Clinical Psychology

Whiteness and racism continue to permeate British clinical psychology and contribute to the underrepresentation of racially minoritised people in the profession

(Fernando, 2017; Wood, 2020). Racialised people constitute 13% of the general population and only 9.6% of qualified CPs (NHS Digital, 2013; Office for National Statistics, 2011). Moreover, 25.7% of the wider NHS workforce being racialised highlights that clinical psychology is markedly White when compared to the other helping professions (NHS Digital, 2022). The profession's response to this has been initiatives that prioritise increasing diversity, positioning the presence of racialised individuals as the catalyst for change, while failing to address the structural racism that exists within the profession (Patel, 2021; Smith, 2016; Wood, 2020). This section outlines the operation of Whiteness in the profession of clinical psychology and the associated impact on the experiences of people seeking to join the profession, the process of training and the experiences of qualified CPs.

Qualitative exploration and reflections shared by racialised aspiring CPs demonstrate the dominance of Whiteness and its manifestation in structural barriers and racism, which exclude, oppress and minoritise racialised people seeking entry (Bawa et al., 2019). Aspiring CPs often experience racism in the form of micro-aggressions and overt abuse from service users and staff in their pursuit of the relevant experience needed to gain a training place, with White supervisors and CPs responding from a position of fragility; by minimising, avoiding and being unresponsive to these experiences, this fragility results in the lack of a safe space for reflection and exploration (Ragavan, 2018). Moreover, racialised aspiring CPs experience White normativity as a salient factor in their motivation to moderate themselves in order to fit in, creating conflict and dissonance between their personal and professional identities (Ragavan, 2018; Tong et al., 2019).

Tong and colleagues (2019) reflected on the impact of deficit-based narratives, which attribute the lack of diversity in the profession to racialised aspiring CPs not being reflective enough and lacking skills and experience. This has the impact of locating the problem inside racialised aspiring CPs, rather than in the structurally racist profession. This sits alongside the experience of paying the 'Black tax'; racialised aspiring CPs' lack of access to the privilege afforded to White people creates a need to work harder than their White peers to appear equally 'good enough' (Ragavan, 2018; Tong et al., 2019). In the face of being racialised, and experiencing and observing racism, racialised aspiring CPs often find themselves silenced by their

White peers and seniors; a silence driven by their relative lack of power and fear of confirming racist tropes, such as the angry Black woman or aggressive Black man (Ragavan, 2018). The synthesis of these experiences makes clear that racialised individuals seeking entry to the profession experience being “thrown against a sharp, White background” (Alcock, 2019, slide 1). The inability to counter the ideology of Whiteness within a profession and NHS that collude with and perpetuate it, renders racism an insidious and ubiquitous orienting influence on their experiences.

The higher education psychology curriculum in the UK is “intensely White”, marked by syllabuses that (re)produce structural racism in society and the profession (Gillborn et al., 2021, p. 1); the doctorate in clinical psychology (DClinPsy) is no exception. With the focus being on improving diversity, DClinPsy programmes have failed to “scrutinise [their] theories, methods and practices and training institutions and curricula, for Whiteness and its deleterious consequences for the public, the trainees and trainers” (Wood & Patel, 2017, p. 10). While the shifting socio-political context has led some programmes to begin looking at the Whiteness within, Whiteness remains entrenched, resulting in racialised trainee clinical psychologists (TCPs) experiencing racism in the process of their training (Wood, 2020; Berg et al., 2019).

Sharing reflections on their experiences of being Black TCPs, Adetimole and colleagues (2005) name the insidious nature of the racism that they experienced and their struggles to name their experiences with White tutors and peers, as central components of their training experience. Shah's (2010) analysis of the experiences of BME TCPs highlighted feelings of isolation amid struggles to connect with their majority White cohorts, while engaging in the emotional labour of conforming to a normative cohort image to be common. Some participants described denying aspects of their identities in order to survive training, leading to the splitting of their personal and professional identities. This contributed to difficulties integrating their professional, racial and cultural identities, with some subjugating their cultural and racial identities in order to adopt a professional one. BME TCPs felt that they hadn't been provided with support after experiences of racism during training, leaving them with the responsibility of independently managing the overwhelmingly painful emotions associated with their experiences. When racism was discussed in the

context of training, participants noted the avoidance of their cohorts and supervisors. This led to feelings of frustration, a resigned lack of expectation and the perception that others expected they would carry the burden of issues related to race in academic and clinical contexts. Meaningful dialogue around race was confined to safe spaces with racialised peers, where shared experiences of racism rendered the interrogation of experiences unnecessary in the facilitation of understanding. Moreover, participants spoke of being tasked with the additional burden of assessing if interactions had racial undertones, with some experiences of racism being so subtle that they were left questioning their own experiences and reactions.

Paulraj's (2016) qualitative exploration of the experiences of Black TCPs highlighted that they noticed an absence of themselves in the curriculum, in that their experiences were not being reflected in, or accounted for, in teaching or research. This was noted alongside the denial, reframing and minimising of racism by supervisors and peers. Participants shared insights into the normalised nature of the silencing mechanisms of White privilege and fragility among cohorts when racism is discussed, with the White guilt and shame expressed stifling Black TCPs and positioning them as comforters of their White peers. Participants experienced their positioning as dichotomous; assumed to be inferior to their White counterparts, while simultaneously being positioned as experts in relation to race and difference by their White peers, trainers and supervisors, who expected them to carry the burden of addressing racism. Black TCPs also experienced being positioned as a representation of Black people, viewed through oppressive societal discourses, including the gendered and racialised stereotypes of the 'angry Black woman' or 'strong black woman', in response to which they moderated their behaviours to avoid reinforcing those stereotypes. Participants shared experiences of 'coping with' and 'managing' the way in which they were racialised in order to survive training, with many using the language of 'battle', 'defend', 'backlash' and 'attack' in description of the combative stance that they were forced to take up. While carrying the weight of the constant fight, Black TCPs are also burdened with a heightened sense of responsibility to advocate for racialised aspiring CPs, fight for social justice and dispute tokenistic schemes that are designed to improve diversity in training.

Paulraj's (2016) and Shah's (2010) analyses reveal some commonalities across both samples. Black and BME TCPs experienced their race as something that made them both hyper visible and invisible. Participants in both samples also spoke of the expert status that they were ascribed by White peers, supervisors and trainers, positioning them in the role of flag-bearer on issues related to race, with expectations that they would carry the burden of addressing Whiteness. This also contributed to them being pigeon-holed into pursuing race-related issues and work by those around them.

Patel and Fatimilehin (2005) reflected that in their 15 years of post-qualification practice, race had been their most salient identity in the profession, dictating the way that they had been positioned in the profession; often as experts on all racialised people regardless of their cultural background. Moreover, the experiences shared were characterised by the denial of racism and tensions arising from navigating transparent but sophisticated systems and techniques, which by design resist attempts to address, redress or dismantle Whiteness in clinical, academic and professional arenas.

Desai's (2018) research into CPs' responses to issues of race in supervision highlighted some differences between the supervision provided by White and BAME CPs. White CPs (WCPs), while recognising their responsibility to discuss race, rarely mentioned racism, oppression or racialised dynamics in their capacity as supervisors. This highlighted the ease with which they could avoid talking about racism, with their avoidance being driven by their anxiety around 'getting it wrong'. In contrast, BAME CPs regularly spoke about racism in the context of their own experiences, as well as those of their racialised supervisees and colleagues. While this research provides some insight into the different ways in which White and racialised CPs may discuss racism, directly comparing their experiences in this way could be argued to perpetuate Whiteness, particularly ideas around White normativity. This framing implies that it is not possible for the insights shared by racialised CPs to be conceptualised as credible, significant and impactful, if they are not compared to, or contextualised by, the experiences of those who are White. Moreover, the homogenisation of racialised CPs under the category of 'BAME' fails to attend to the nuances in experience that may exist due to differential experiences of racialisation.

In contrast to the paucity of literature which specifically seeks to understand Black CPs' (BCPs') experiences of discussing racism, there is a growing body of research which focuses on the experiences of WCPs in this regard. Ong's (2021) analysis revealed that WCPs often default to a defensive position categorised by silence, intellectualising and engaging in avoidance strategies. Participants spoke of this being in response to feelings of shame, anxiety, discomfort and fear that they would be perceived as racist. Reflections were shared about the painful realisation of the impact of their own Whiteness and privilege. Some participants commented on the sanitisation of discussions through the use of the language of 'diversity' and 'difference', with framing conversations in this way having a similar impact as the colour-blindness of the 90s. Proximity to racialised clients and colleagues was highlighted as a key influence on WCPs' levels of confidence and the ways in which they responded and engaged when racism was discussed. Participants acknowledged that Whiteness made it easy to disengage from remaining aware of racism, recognising that their learning and engagement in the process of moving towards anti-racist practice, would be a life-long journey.

1.6. Systematic Scoping Review

The focus of the literature on the impact of racism on racialised aspiring and trainee CPs has resulted in the experiences of racialised qualified CPs being neglected. Moreover, while there is a growing body of literature exploring WCPs' experiences of discussing racism at work, the use of BAME samples and absence of equal exploration of the experiences of BCPs, perpetuates epistemic injustice by further neglecting and marginalising their experiences. In response, this systematic scoping review, conducted in April of 2022, in line with Peters and colleagues' (2015) guidelines, centres BCPs by mapping and synthesising the literature which focusses on their experiences of racism and its discussion at work. The orienting question for this search was: How have BCPs' experiences of racism and its discussion at work been examined in the literature?

To identify relevant literature, six databases were searched: PSYCHINFO, PsychArticles, SCOPUS, Science Direct, google scholar and Ethos. Reference lists

were also searched. The following key words were used in order to conduct the search: “psychologist”, “clinical psychologist”, “Black clinical psychologist”, “Black”, “race”, “racism” and “Whiteness”. Search terms initially included references to sample location, however, these terms were removed due to very limited results being returned. Due to the scarcity of literature, publication date search parameters were not applied. The search returned 218 articles; the titles and abstracts were reviewed and articles were screened out of the analysis if:

- The sample included minors (individuals aged under 18)
- The population sampled was outside of the UK
- The article was not related to psychology

The remaining full-text articles were further assessed for eligibility and excluded if:

- The sample included prequalified psychologists
- There were no CPs in the sample
- Less than 50% of participants identified as Black
- Psychologists’ experiences were not the focus of the research
- Race and racism were not discussed

Once this process (illustrated in figure 1) was carried out, and duplicates were removed, only two studies were found to meet the criteria for the review.

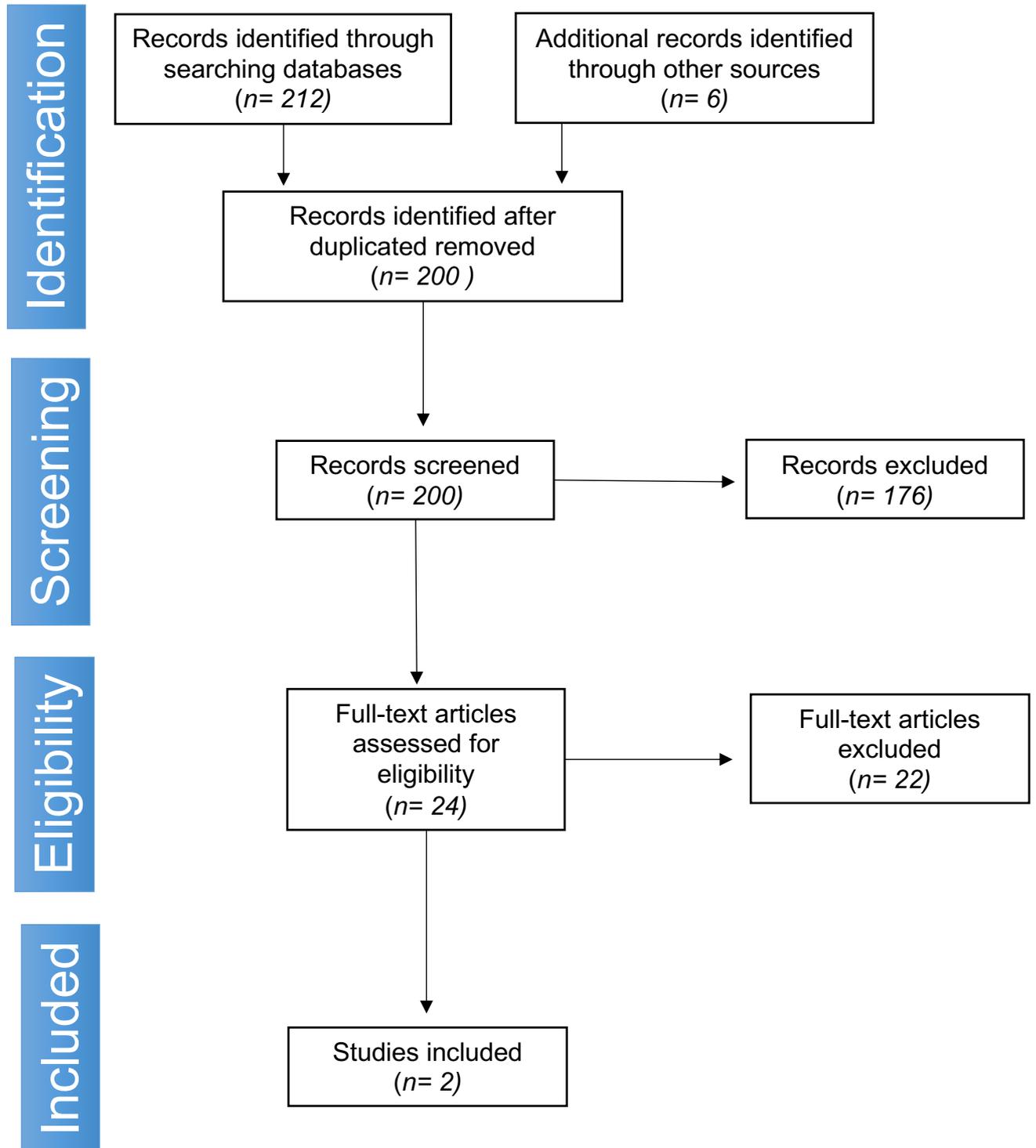


Figure 1. *Systematic Scoping Review Flow Chart*

1.6.1. Odusanya and Colleagues (2017)

Odusanya and colleagues (2017) interviewed six female BME CPs to understand their experiences and the ways they had been positioned in the profession.

Participants experienced racial difference as something that was located within

them, rather than between themselves and others. As such, they felt like outsiders existing on the margins of the profession. Race was also a basis on which they were rejected by clients or viewed as inferior by colleagues, resulting in a perceived need to work harder than their peers simply to be conceptualised as 'good enough'. Whiteness in the profession, psychological theory and ways of working resulted in some being positioned as experts on race and culture, while experiencing a need to moderate their own cultural identities, leading to difficulties in the integration of their cultural and professional identities. Some interviewees spoke of the additional energy expended in the process of being positioned as experts on issues of race and tasked with interpreting interactions through a racial lens in contexts where race and its implications remained unspoken.

1.6.2. McNeil (2010)

McNeil (2010) interviewed eight Black British psychologists with the aim of exploring their lived experience of their roles. Being the lone or first Black psychologist in a service led to participants' feelings of being highly visible and an exception to the rule in the context of a prominently White profession. This was experienced as challenging by some who felt dutybound to represent Black people as a group, while others felt secure in this position, experiencing being the 'first' or 'only' as an achievement.

Participants expressed concerns regarding negative racial stereotypes, cultural expectations and a need to redefine their identity in line with their professional status. Some struggled with balancing their desire to feel accepted by the Black community amid concerns that their professional standing suggested that they had "sold out" (McNeil, 2010, p. 86), with their want to be valued within their respective teams. This involved navigating the "coloured glass ceiling" (McNeil, 2010, p. 87), the intersections of their race and class identities and the threatening nature of dialogue around racial difference. Participants experienced organisations as fearful of opening up dialogues around race. Consequently, the responsibility to skilfully influence the way that difference was managed and navigate discourses to be understood as a 'good doctor' in the context of the racist system, fell to Black psychologists.

1.6.3. Discussion of Findings

These studies highlight the omnipresence of Whiteness in the profession and NHS, and the impact of this on the experience of psychologists who lack proximity to Whiteness. Taken together, they suggest that racialised psychologists are likely to experience: (1) racism in their teams and clinical work, (2) difficulties integrating their personal and professional identities, (3) being positioned as experts on issues related to race and (4) being burdened with the work of navigating discourses around race while existing within structurally racist systems. However, while the participants' experiences of racism and its discussion were acknowledged as an aspect of the wider experiences of their roles, experiences of racism were not explicitly explored, resulting in the insights gained lacking detail.

Odusanya and colleagues (2017) recruited what they describe as a 'BME' sample; which in effect lead to the study failing to attend to differential experiences of racialisation and the resultant nuances in participants' experiences of being a CP. McNeil (2010) explored the experiences of clinical and counselling psychologists and in their analysis they fail to attend to the unique experiences associated with and within each profession. Interpretative phenomenological analysis (IPA) was designed for use with qualitative data arising from homogenous samples (Peat et al., 2019). However, as neither of the samples in the two studies were homogenous, IPA was inappropriately used in both studies, calling into question the credibility of the analyses and resultant findings. Furthermore, IPA is concerned with understanding individual meaning making rather than shared experiences (Peat et al., 2019). As such, it is unclear if the meanings outlined are suggested as indicative of those shared among racialised psychologists, or as unique to the heterogeneous samples of each study. Additionally, neither authors state their epistemological position, and in doing so, fall short in attending to the resultant biases and their influence on the research (Singh & Walwyn, 2017).

1.7. Rationale and Aims

Given the epistemic, methodological, epistemological, conceptual and contextual factors discussed earlier, this research seeks to centre the experiences of BCPs by

exploring their experiences of racism and its discussion at work and in the profession.

1.8. Research Questions

To address the study aims, the key research question explored was:

How do BCPs describe and make sense of their experiences of racism and its discussion at work and in the profession?

Sub-questions this study sought to explore included:

1. What are BCPs' experiences of racism and its discussion in their teams, Trusts, clinical work and in the wider profession?
2. How do they make sense of these experiences?
3. How do they feel that they are positioned and perceived when discussing racism?
4. How do they position themselves in and navigate conversations about racism?
5. What do they feel could foster a sense of safety and support within these experiences?

2. METHODOLOGY

This chapter begins with an outline of the philosophical assumptions that underpinned this research. This is followed by a reflexive exploration of the researcher's position. The study design, procedure and analytic approach are then detailed to facilitate future replication. The chapter closes with a consideration of the ethics of the research, including the details of mitigations employed to uphold high research and ethical standards.

2.1. Philosophical Position

Epistemology is a branch of philosophy that is concerned with the theory of knowledge, seeking to answer questions about how and what we can know (Willig, 2008). Critical realism assumes realist ontology and therefore positions material and social structures, including structural racism, within the existing reality that is independent of mind (Sturgiss & Clark, 2020; Centre for Critical Realism, n.d.; Burr, 2015). In doing so, it acknowledges the ways in which mechanisms of privilege and disadvantage enable or constrain people on the basis of their positionality, impacting on their access to opportunities, resources and choice, while simultaneously affecting how they are treated and perceived by institutions, groups and individuals (Martinez et al., 2014). As such, critical realism acknowledges the social context from which participants may speak and the way in which participants' experiences are constructed to form accounts of the independently existing reality, with experiences of racism being an example of this (Fletcher, 2017; Vincent & O'Mahoney, 2018; Willig, 2016). Consequently, critical realist epistemology in combination with realist ontology constitutes a felicitous philosophical position to occupy, and underlies this research.

2.2. Study Design

In alignment with the study aims and philosophical position, this research employed a qualitative design to facilitate the examination of insights in the process of exploring participants' experiences of racism and its discussion at work and in the

profession (Al-Busaidi, 2008; Lawani, 2020; Vincent & O'Mahoney, 2018). The open nature of the qualitative design allows for new concepts and unexpected insights to emerge from the data, which is essential given the paucity of literature in the field. The qualitative approach promotes a nuanced understanding of participants' experiences that is not inhibited by the findings of the limited research available, or the researchers' preconceived hypotheses (Joffe, 2012).

This research utilised semi-structured interviews, as their ability to be flexible and comprehensive aid their competence in exploring the human experience. Moreover, their conversational nature provides opportunity for the researcher to “modify the style, pace and ordering of questions to evoke the fullest responses... [while] enable[ing] interviewees to provide responses in their own terms and in the way that they think and use language” (Qu & Dumay, 2011, p. 246). Thus, semi-structured interviews are especially valuable when used in research that aims to understand how interviewees understand the social world (e.g., experiences of racism). The study aimed to recruit between eight and twelve participants in line with Guest and colleagues' (2006) findings which suggest that a sample of this size would provide sufficient scope for strong analyses.

2.3. Researcher Reflexive Position

Reflexivity can be understood as the process through which the researcher considers their positionality and the influence that this has on both the process and findings of the research. While this is an important consideration in all research, when qualitative methodologies are employed “the researcher is the primary instrument of data collection and analysis”, with meanings being “negotiated between researcher and researched within a particular social context”, deeming reflexivity essential (Finlay, 2002, p. 531; Watt, 2015, p. 82). Therefore, to maximise the integrity and trustworthiness of the research, it is important to make explicit the researcher's values, life experiences and assumptions as they pertain to the research. In contrast to the rest of this thesis, this section and section 4.5.2 are written in the first, rather than third person. This is done in acknowledgement that the author's reflections are highly personal and idiosyncratic, with the use of the third person potentially de-personalising the reflections shared.

Occupying the position of being a Black female TCP, who is also the granddaughter of Windrush immigrants from the Caribbean, has been integral to the conception of this research and my understanding of Whiteness and racism. Being raised with strong values of community and collective resistance, while hearing the stories of racism and oppression that have been passed down through the generations, has facilitated the development of my critical consciousness and a sensitivity that has enabled me to notice Whiteness in operation and better understand racism in a way that aligns with the core tenets of Critical Race Theory, as outlined by Delgado and Stefancic (2017):

- Racism as normal and ordinary: The author believes racism to be a normal and everyday experience for most racialised people in the UK.
- Interest convergence: The author believes that racism advances the interests of both the White working class and elite. As such, there are large segments of society who have little interest in disrupting or eradicating racism.
- Race as a social construct: The author believes that while race is socially constructed, the way that race is constructed has consequences. These consequences include the racialisation and oppression of those who are not White.
- Intersectionality and anti-essentialism: The author believes that individuals hold multiple potentially overlapping and conflicting identities, which intersect and influence their motivations and positioning. Consequently, it would be reductionist, naïve and problematic to essentialise people by viewing them through the lens of a unitary identity.
- Voice or counter-narrative: The researcher believes that the voices and narratives of racialised people are unique and powerful in their ability to communicate knowledge and experiences that White people are unlikely to be aware of as a consequence of their Whiteness.

While Critical Race Theory emerged from the historical and cultural context of the United States of America, it has wide-reaching implications and applicability, including in the UK. For example, Meghji (2021, p.347) asserts that “Critical Race Theory has the conceptual flexibility to study British society...provid[ing] us with the tools to study the realities and reproduction of racial inequality” in Britain.

Having personally experienced racism and the hostility that can arise when it is discussed in society and in the profession of clinical psychology, the researcher recognises the personal challenges that accompany these experiences, particularly from the Black female perspective. Moreover, as someone who is soon to qualify, the researcher is invested in ensuring that the systems that BCPs operate in understand the nuances of the racism they face and the complexities inherent in discussing racism, in the hope that positive change will follow.

2.4. Method

2.4.1. Procedure

2.4.1.1. *Interview Schedule Development:* The initial draft contained open questions which were designed to explore BCPs' experiences of racism and its discussion at work and in the profession. A pilot interview was then conducted with a Black psychological professional. Following the pilot interview, the researcher's reflections on the interviewee's interpretation of the questions led to the re-wording of some of them. Following the first participant interview and inspection of the anonymised transcript, the interview schedule was further refined, in collaboration with the Director of Studies, to include clarifying and probing follow-up questions. The final interview schedule (appendix A) followed a semi-structured format comprising of open, probing and clarifying questions. This structure allowed for the nuanced exploration of participants' experiences and opportunities for the researcher to gain clarification, making the implicit components of participants' experiences explicit.

2.4.1.2. *Participant Recruitment:* Participants were recruited using opportunity and snowball sampling. This was achieved by sharing the recruitment poster (appendix B) on social media platforms and within closed peer support groups, alongside a message encouraging those viewing the poster to share with others that they felt would be eligible and might like to participate. Recruitment was open for four months between June and September of 2022.

2.4.1.3. *Inclusion Criteria:* Those eligible to participate met the following inclusion criteria:

- Qualified as a CP

- Identified with being of Black race or heritage
- Practice as a CP in the UK

2.4.1.4. *Gaining Consent:* Prior to participation, each participant was given ample opportunities to ask questions and was provided with a participant information sheet (appendix C), which contained details of the research. Participants then gave consent for their participation by signing a consent form (appendix D). Please see section 2.5.1 for further details of this process contextualised within a discussion of the ethical considerations around informed consent.

2.4.1.5. *Gathering Demographic Information:* Following receipt of the completed consent form, participants were asked to complete a demographics questionnaire (appendix E). In an attempt to balance the researchers position of intersectionality and anti-essentialism (see section 2.3) with the expectations of a doctoral thesis, the decision was made to collect very limited demographic information: Gender, ethnicity or cultural background, number of years post-qualification and area of practice.

2.4.1.6. *Interviews:* To avoid logistical difficulties and the challenges posed by the potential for COVID-19 transmission, interviews were conducted using Microsoft Teams video conferencing software. Participants were encouraged to ask questions or express any concerns about their participation prior to starting the interview recording. After each interview, participants were offered another opportunity to ask questions and engage in a verbal debrief with the researcher. Interviews lasted between sixty and ninety minutes, immediately after which, each participant was sent a participant debrief sheet (appendix F) by email.

2.4.1.7. *Transcription:* Microsoft Teams automatically generated rough transcripts of the audio from each interview recording. Once transferred into a word document, the researcher reviewed each transcript while listening to the recording to ensure the accuracy of each transcript. During this process, transcripts were also punctuated to support readability, formatted to enable analysis, and anonymised (e.g., the removal of participants' names, teams and geographic locations) to protect each participants' identity and maintain confidentiality.

2.4.1.8. *Data Storage:* A full data management plan (appendix G) was developed and subsequently approved by the Research Data Management Officer for the University of East London. All of the data collected was stored securely on the University of East London's secure OneDrive in compliance with GDPR. The

anonymised transcripts may be of use after the completion of the thesis for publication or dissemination purposes. To accommodate this, the anonymised transcripts will be stored securely by the Director of Studies and the researcher for three years following the completion of the research.

2.4.2. Analytic Approach

Thematic Analysis (TA) is a flexible and accessible method of analysing qualitative data that benefits from being compatible with many philosophical approaches, including the critical realist position which underlies this research (Braun & Clarke, 2012; Fryer, 2022). In contrast to IPA, which is concerned with the nuances of ideographic experience (Peat et al., 2019), TA “allows the researcher to see and make sense of collective or shared meanings and experiences” (Braun & Clarke, 2012, p. 57). As such, the qualities of TA are congruent with the research aim of understanding shared experiences across the sample, making it the more appropriate method of analysis (Braun & Clarke, 2012). An inductive approach to reflexive TA has been employed; embracing the interpretive role of the researcher and the influence of their positionality on the analytic process, while ensuring that the analysis itself is data-driven, rather than based on the preconceived hypotheses of the researcher (Braun & Clarke, 2006, 2021).

2.4.2.1. *Analytic Strategy*: Braun and Clarke's (2006) six stage approach to reflexive thematic analysis was employed to guide the analysis. While the stages of analysis are presented in a way that is suggestive of a linear process, “each phase is only as useful as the quality of engagement it produces, so returning to a phase, and moving to-and-fro between phases should not be unusual” (Terry & Hayfield, 2020, p. 343). As such, the analysis was as an iterative and reflective process that was contained within the six phases described below:

- 1) Familiarisation with the data: The researcher reviewed the auto-transcriptions the first time each recording was watched; punctuating to support readability, formatting to enable analysis and anonymising to protect each participants' identity and maintain confidentiality. Each recording was then re-watched multiple times and each transcript re-read. During this process, the researcher noted their initial reflections, comments and observations on the

corresponding transcript. See appendix H for excerpts from annotated transcripts.

- 2) Generating initial codes: The researcher went through each line of transcript, systematically generating codes which were analytic in nature (see appendix I). This process was supported using NVivo 12 software. See appendix J for examples of initial codes.
- 3) Searching for themes: The researcher exported and printed the codebook that had been generated in the process of coding in NVivo (see appendix K). This facilitated the clustering of codes that shared unifying features into themes and subthemes (see appendix L). Visual maps were then created, which illustrated the most salient themes arising from the data (appendix M).
- 4) Reviewing themes: The researcher and Director of Studies reviewed the themes and subthemes that had been generated to assess their coherence and the extent to which they accurately reflected the experiences described in the data. This reflexive process continued until both the researcher and Director of Studies agreed that the themes and subthemes were valid.
- 5) Defining and naming themes: This stage overlapped with the previous in that it required reflection on the experiences shared within each theme and what those experiences communicated, in order for each theme to be clearly and appropriately defined. Concise and informative names were generated to represent each theme using quotes from the data where possible.
- 6) Producing the report: The final report was written to provide a coherent story of the data by weaving together vivid and compelling transcript extracts with the researcher's narration. Where transcript extracts are presented from the middle of a sentence, '[...]' is used to indicate the omission of the opening prose. Moreover, ellipses represent the omission of words within transcript extracts and square brackets enclose words that have been added to quotes for readability and clarity. The order in which the themes and subthemes were reported was considered carefully in order to ensure the communication of a clear and coherent narrative (Braun & Clarke, 2006).

2.5. Ethical Considerations

Ethical research prioritises respect for the rights and dignity of participants, ensuring that researchers behave and research is developed, in ways that are morally and ethnically well-constructed. The following subsections outline the consideration of the ethics associated with this research and describes the mitigations employed to uphold high ethical standards. These considerations are primarily informed by the BPS' Code of Human Research Ethics (Oates et al., 2021).

2.5.1. Informed Consent

The participant information sheet (appendix C) outlined the purpose and nature of the research; there was no use of deception. Participants were also provided with opportunities to ask questions prior to, at the beginning of, and after the conclusion of the interview. The information sheet also informed participants of the way their data will be processed and their right to withdraw it from the research up to three weeks after the conclusion of the interview. After reading the information sheet, participants were provided with a consent form, which they signed and returned digitally, facilitating the provision of informed consent.

2.5.2. Right to Withdraw

Participants were informed of their right to withdraw from the research without disadvantage and justification on the recruitment poster (appendix B), information sheet (appendix C) and consent form (appendix D). Upon the conclusion of the interview, participants had a three-week period within which they could request that their data not be included in the analysis. A key document was created that could be used by the researcher to pair pseudonymised transcripts with identifiable information, should any participants wish to withdraw from the research.

2.5.3. Confidentiality and Anonymity

All of the data collected was stored securely on the University of East London secure OneDrive. In order to protect participant anonymity, each participant was assigned a participant number and all identifiable information was pseudonymised in the transcripts. Participant numbers have been used in the write-up of this research. The reporting of participants' demographic information (e.g., gender and area of practice) has been limited and presented as isolated pieces of information to protect participant anonymity by reducing the likelihood of identification. Only the researcher,

Director of Studies and examiners will have access to the pseudonymised transcripts. Please see appendix G for further details.

2.5.4. Participant Wellbeing

Participants were informed by the information sheet and reminded at the beginning of the interview that they could decline to answer questions and stop the interview at any time. If any participants showed signs of distress, the researcher would have ended the interview and proceeded to the debrief. This was not necessary, as none of the participants reported or showed signs of distress in the process of being interviewed. Towards the end of each interview, reflexive questions were used to assess participants' experiences of being interviewed for the research, as well as their emotional states. Informal discussions followed each interview, providing participants with another opportunity to share any negative emotions that they may have experienced during the interview. After the interview, participants were provided with a debrief sheet (appendix F) containing details of organisations that could be contacted should they wish to seek further support.

2.5.5. Researcher Wellbeing

It was acknowledged that hearing about experiences of racism could be upsetting for the researcher, especially given their position and lived experience of structural racism. In order to mitigate against the potential harm, the researcher kept a reflective journal to document any such experiences and sought support from the Director of Studies when necessary.

2.5.6. Ethical Approval

An application for research ethics approval was submitted to the University of East London School of Psychology department (appendix N), from whom ethical approval was granted prior to the collection of data (appendix O).

2.5.7. Supervision

The research was supervised by the Director of Studies, Professor Nimisha Patel and Second Supervisor, Dr Matthew Boardman. These individuals are members of the University of East London Professional Doctorate in Clinical Psychology

programme, and are experienced in conducting and supervising research of this nature.

3. ANALYSES

This chapter begins with a description of the sample, followed by a thematic map outlining the salient themes and subthemes which emerged from the analysis of the individual participant interviews. This is followed by detailing each theme, with extracts from transcripts used to support the researcher's interpretations of the data.

3.1. Sample

Twelve participants were interviewed, all of whom were qualified CPs who practice in the UK and identified subjectively as being 'Black'. Eleven participants identified as being a 'woman' and one as being a 'man'. Post-qualification experience ranged from one to thirty-two years ($M= 7.58$, $SD= 8.75$). Participants' work at the time of participating in this study spanned many areas of practice, including adult mental health, child mental health and specialist psychological services.

3.2. Thematic Map

In line with the TA process, the codes generated were clustered into themes and subthemes. The themes were then refined, resulting in the final thematic map (figure 2).

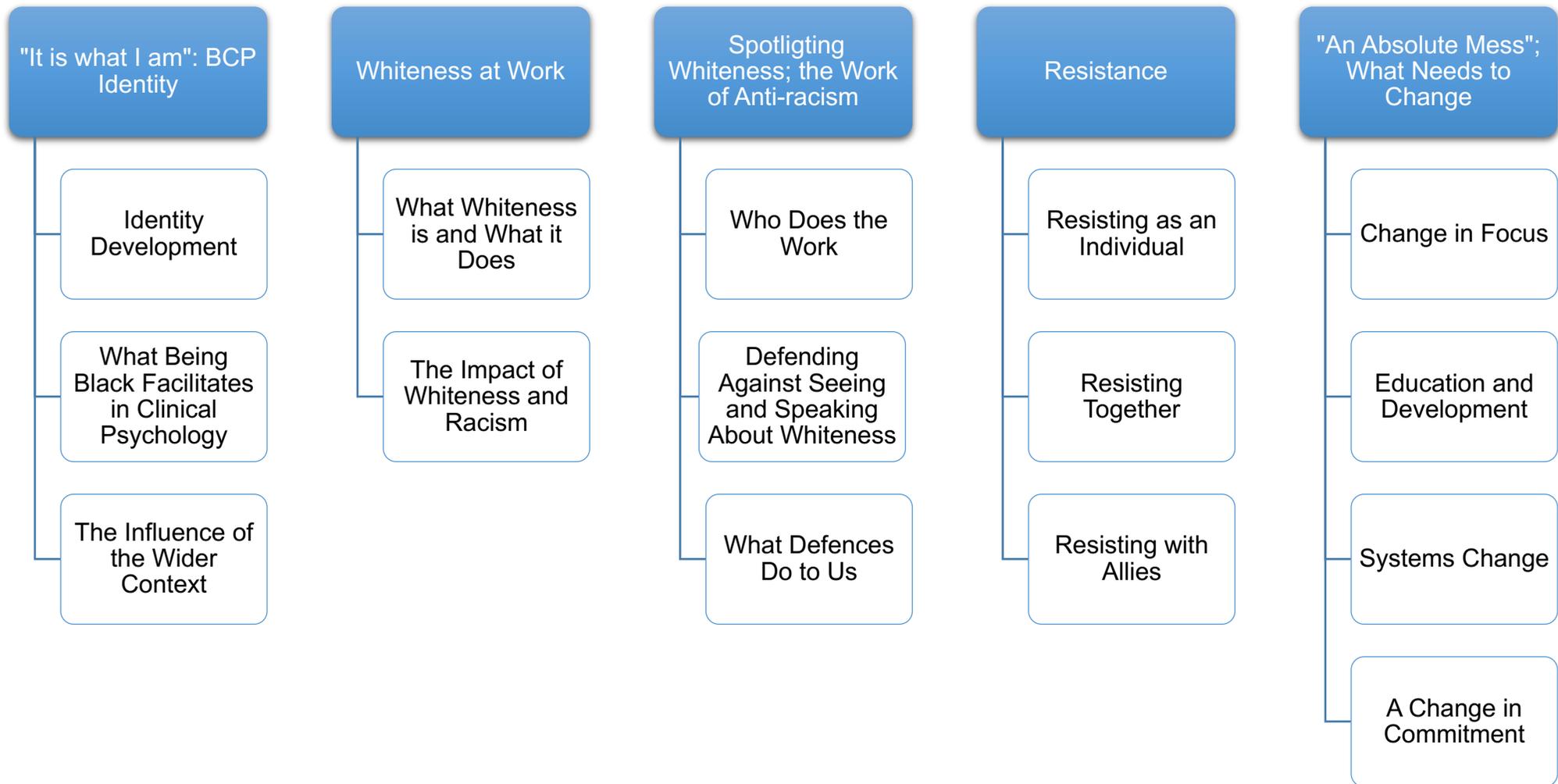


Figure 2. *Thematic Map*

3.3. Theme 1: *“It is what I am”*: BCP Identity

Theme one focuses on how participants described and interrogated their professional identity as BCPs. The quote from which the label of this theme is derived, *“It is what I am... it's this unsaid but really strong felt sense of difference”* (Participant 3), captures the way in which the operation of Whiteness results in the lived experience of BCPs being characterised by existing *“in a space of being othered”* (Participant 10). The following sub-themes provide insight into their experiences of navigating identity development alongside the influence of wider context on their experience of being Black while a CP. Their narratives also highlighted the ways in which being racialised as Black is facilitative of clinical psychology practice.

3.3.1. Identity Development

Participants described being Black while British as existing as an ‘other’ within Britishness.

“It's that assumption that if you're Black, then you're not from the UK and that you've got some kind of ‘exotic’ origin or something like that. And it's that excluding you from being, you can't be Black and British. It's that underlying assumption.”

(Participant 9)

The incompatibility of being Black and British generated internal conflict, with participants struggling to negotiate the dichotomies between how they saw themselves, how the world sees them, and how they were expected to see themselves – leading to challenges in developing a congruent identity.

“There's one thing about how I'm racialised or how I'm seen by the world. Obviously, I have Black skin and I've had experiences of people's responses to my outward presentation and how I'm responded to...But I guess, what that also means to me is what I embrace or what I'm proud of is actually. Yeah, I'm proud to be Black. That is part of my heritage.”

(Participant 10)

“People would ask me, are you British or [African]? And I would just think, ‘Oh my goodness, my goodness, what am I? I have got both passports’, trying to work it out.”

(Participant 9)

The process of developing a congruent identity is further complicated by assuming the identity of a qualified CP. Ideas of meritocracy, whereby it was believed that *“qualifying would purchase me something, like purchase me a level of respect”* (Participant 2), are shattered upon achieving qualification and being met by the realisation that no amount of *“achievement”* (Participant 2) would afford BCPs protection against Whiteness; *“you can’t earn your way or degree your way or speak your way out of being a Black person in a White environment”* (Participant 2), *“the ‘Dr’ will position you right back where your Black ass was before you studied, which is the bottom of the heap.”* (Participant 2).

The consistent nature of the incongruence led participants to describe their identity as multiple component parts that overlap; *“There’s that duality in my existing as a Black psychologist... There’s kind of a coexistence of many things”* (Participant 5).

“One part of me is very, I’m [African] so very cultural...the way people speak, the food that we eat is just completely different. So it feels almost quite separate...that clinical identity I think, again, I think it is separate.”

(Participant 6)

The challenge of integrating these component parts led participants to experience an expectation that they would augment themselves by assimilating, *“oftentimes hiding perhaps aspects of yourself, or the noisiness of your Blackness”* (Participant 2), in order to lean further into the CP identity. This constituted a significant dilemma.

“How do I assimilate? Do I assimilate? Do I want to assimilate?”

(Participant 11)

Negotiating this dilemma led to the realisation that to embody the BCP identity would require them to centre the lived experience of being racialised as Black and reconstruct their CP identity and practice around it.

“Clinical psychology feels more informed by my ethnicity, rather than my ethnicity being informed by the profession.”

(Participant 6)

“[...] I am centring Blackness so I find it really difficult to not think about Blackness in the way I practice, because to me, that's just the way that I wanna work. So it's the centre, really, of my practice.”

(Participant 4)

3.3.2. What Being Black Facilitates in Clinical Psychology

With being racialised as Black being a central component of the BCP identity, participants described the ways in which it orientates and facilitates their practice with regards to what their lens allows them to see and the functions it allows them to perform for clients, racialised communities and their colleagues.

Their lived experience of being racialised as Black provides BCPs with *“insights that maybe my fellow White counterparts don't have”* (Participant 11), describing it as an *“added consciousness...that I know amongst my peers or my colleagues, they don't hold”* (Participant 5).

This lens, acquired through their lived experience, is intrinsically implicated in the way that BCPs view the world and their work.

“I guess that's always been my lens. I come from a very politically Black family, like the lens was always there. And that is why it feels so hard to name it, to remove my lens, because that is all I know. You know, I walk in the world as a Black person”

(Participant 3)

Being Black enabled unspoken understandings with clients. These understandings, borne from BCPs identifying with their Black clients and their assumed shared lived experience of being racialised as Black, facilitates BCPs developing a more nuanced understating of the lived experience of Black clients and the ways in which they experience psychological distress.

“Like I identify with Black clients... They are my community.”

(Participant 3)

“Being a Black clinical psychologist adds that real sense of nuance and understanding mental health as it's manifested and experienced, in well specifically...Black communities.”

(Participant 7)

These nuanced understandings, embedded in psychological formulation, support BCPs to apply inherently White psychological theory in a way that decentres Whiteness and centres the lived experience of being racialised as Black, enabling the provision of racially and culturally appropriate psychological interventions.

“There's a sense of understanding more of the nuances around how we might navigate some services or understanding of mental health etcetera, which I'm able to kind of apply and think about when I'm using kind of more of the Western models”

(Participant 7)

Participants' awareness of the failure of the wider profession to provide appropriate interventions led them to internalise a sense of responsibility to do so. As such, BCPs find themselves *“trying to provide a service to my community that I think is missing”* (Participant 10).

“I think I do probably [feel] more of a sense of responsibility, I think in some ways towards Black people or people who look like me, Black or brown people who enter into the services”

(Participant 12)

The responsibility to provide is accompanied by their felt sense of duty to advocate for racialised communities, while protecting community members from the racism inherent in mental health services, and working to improve the relationship between services and racialised communities.

"[...] the distinction for me is knowing that racism is fundamentally within the system...I feel like I'm there much more to kind of support the community, to support the families, like I fight and I go above and beyond to advocate for the families, advocate about the racism, the racial trauma that they've experienced...I have to be an advocate, I have to be an activist."

(Participant 3)

"[...] someone who's standing in the gap between my culture and community and the world of psychology and mental health. And yeah, trying to facilitate a relationship to a better end for both parties."

(Participant 1)

3.3.3. The Influence of the Wider Context

Participants described their experience of being Black while a CP as one which is largely influenced by the wider context. They spoke about the profession existing within the wider context of structural racism in the UK, with Whiteness in society being (re)produced within the profession.

"The profession here in the UK is not the profession everywhere in the world. And actually, there is a cultural context for this profession here in the UK that means these issues will continue."

(Participant 1)

As such, the significance of being a BCP, was attributed to the operation of Whiteness in the UK with regards to racialised assumptions about ability, whereby being Black is understood as a proxy for incompetence.

"It means a lot because of the context in which we live in terms of race, racism and all of that...[Where] I grew up...everyone around me was Black, more or less...but no one would be surprised at all about me becoming a clinical psychologist. In fact, when I told people that I was interested in being a psychologist, the response was 'why that? Why not go for something at a higher level? Why you lowering yourself to that?'. Whereas here in the UK, they ask 'why are you aspiring to that?' Do you see what I mean?...that's purely contextual."

(Participant 9)

Moreover, the significance of being a BCP is compounded by experiences of being a minority within a majority White profession.

“Rarity is how it feels...I'm the only Black clinical psychologist... Within the [NHS] Trust, it's just me.”

(Participant 8)

Participants described the experience of being a minority as one which has remained consistent throughout their pre-qualified and qualified careers.

“I suppose when I think about the rooms that I've been in from being an assistant psychologist all the way to being a consultant psychologist and team lead, all those rooms are always very White, so I will be the one person, only Black person in the room.”

(Participant 12)

As a consequence of being a minority, participants described being Black as something that made them hypervisible in a way that they experienced as exposing.

“It's also being visible in a way that is very loud...Seen when I've not chosen to be seen”

(Participant 2)

“Like other people seeing that like, like you're a little glowing light in some way.”

(Participant 10)

Their felt sense of visibility intensified in the wake of George Floyd's murder in 2020 and the 2019 BPS's Division of Clinical Psychology's GTiCP conference in the U.K., as discussions around Whiteness and racism within society, the NHS and the profession became widespread.

“GTiCP, then it was George Floyd, It’s been a long time where I felt my skin was so visible. I am Black. I have always been, like there’s no other way that I’ve walked through this world...but there’s context where like those things are highlighted socially, people wanting to talk about it...I noticed that sometimes felt more visible.”

(Participant 10)

Alongside the hyper-politicisation of being Black came the politicisation of the BCP presence, with the growing awareness of Whiteness and structural racism resulting in BCPs being the recipient of the projections of their White colleagues.

“People saw you more but saw controversy. So instead of people seeing a mirror to their own Whiteness and acknowledging their discomfort as belonging to them, you become the source of discomfort... You’re the source of all this kind of disarray...Rather than examining in a nuanced way that actually what we’re talking about here isn’t what’s being done by Black people, but it’s being done to them. I’m seen as a political statement... I think it means you can’t really go unnoticed in the same way.”

(Participant 2)

To this effect, being racialised as Black was experienced as a basis on which BCPs could be rejected to an even greater extent than before.

“Any exposure of your difference or highlighting of your Blackness is going to come with a social rejection.”

(Participant 2)

3.4. Theme 2: Whiteness at Work

Theme two encapsulates how participants’ describe Whiteness and their experience of being subjected to and witnessing *“loads, just loads and loads and loads”* (Participant 4) of *“insidious”* (Participant 5; Participant 10; Participant 11) racism in the course of their duties as CPs. The final sub-theme illustrates the psychological and emotional harm experienced by BCPs as a consequence of Whiteness and racism in the workplace.

3.4.1. What Whiteness is and What it Does

Whiteness was described as an ideology that is based on colonial ideas of White supremacy, positioning racialised people as inferior.

"[...] colonial ideas that Black people are not intelligent, because if we're not intelligent you can enslave us. If not physically, you can enslave us mentally and tell us which jobs that we can have and where we fit in."

(Participant 11)

As such, Whiteness norms White people, resulting in Eurocentricity being embedded in psychological theories and practice, reaffirming ideas around White and western superiority.

"It is a White Eurocentric profession. You know, that's it. I think there is a lot of teetering around the edges but are people really ready to deconstruct fully the psychological models and principles that we teach day in, day out to clinical trainees? No. And so in that sense, until we get to that point, it's always gonna be a Eurocentric endeavour, and because of that, it's always gonna be problematic for Black and brown people."

(Participant 4)

Consequently, power is wielded in the marginalisation of non-western narratives and experiences of those who are conceptualised as the racialised other, including BCPs, disempowering them.

"[...] we're having a conversation about somebody being pregnant and me kind of just broadly reflecting 'oh yes, in my culture you know we wouldn't necessarily touch somebody's belly' and being cut off in like, 'well there's nothing really special about your culture. I'm sure most people wouldn't want to' and being almost told that my own personal beliefs and values around that are irrelevant... it's almost like minimising the importance of that."

(Participant 7)

Whiteness also means that others are racialised. Participants described that Black people, as a consequence of the way in which they are racialised, experience the least access to the status and privilege afforded to White people by Whiteness. As such, Black people, including BCPs, experience anti-Black racism and the greatest degree of dehumanisation from both their White peers and their peers who are racialised differently.

"[...] people of colour but not Black. And so that is interesting because you expect it to come from the White person, right? But this is like an Asian psychiatrist"

(Participant 11)

"I've noticed there is a breaking of like social norms and social rules that apply to Black people. You don't touch other White people in the workplace. You know you wouldn't just grab someone's hair, but in that moment, when someone stroked my hair and felt able to do so, they said to me, I don't think of you as a colleague or as a person. I felt a bit like a zoo animal"

(Participant 2)

While BCPs describe Whiteness in this way, it was perceived that their peers lacked appreciation of Whiteness, differential racialisation and the resulting racism. A core component of this was BCPs' colleagues understanding of racism being limited to its overt form, rendering them incapable of being able to notice more subtle expressions of racial prejudice.

"[...] if there's a big iceberg like this, racism, how people see it is as the tip"

(Participant 11)

Participants described the Whiteness that they witness and experience at work in ways that suggest racism to be omnipresent, insidious and covert, making it difficult to pin point.

"It is so hard to put my finger on it."

(Participant 3)

"I feel like the way racism operates sometimes, it's not always those of acts that I can describe to you...because a lot of it is quite insidious. A lot of it is, umm underhanded. A lot of it happens, I guess in very conspicuous ways"

(Participant 5)

Although racism was a shared experience among participants, there was variation in the ways in which it is experienced, as race intersects with other aspects of identity (e.g., gender, relative proximity to Whiteness and class) influencing the way that racism is experienced by each individual.

"I feel like the intersection between my Blackness and my gender can't be disentangled. I feel like a lot of the conversations that I have at work, the way that I am responded to, relates to both my Blackness and the fact that I am a woman."

(Participant 4)

"[...] I couch in my identity as being a man. Knowing that some of these experiences happen to my female counterparts more often, but also recognising that people seem to respond to what I say, it's slightly different."

(Participant 1)

"There was someone in the [NHS] Trust who's very prominent, and isn't Black, but is brown, Indian background but comes from a very wealthy upper middle class background, is a man and I sort of think, 'of course you can speak to experiences of racial oppression, but I don't know whether the combination of your identifiers means that you are the person that should be leading this type of conversation'... It's the Rishi Sunak, Priti Patel effect 100%."

(Participant 4)

Whiteness is evident in the treatment of Black people who access mental health services through the imposition of Eurocentric ideas, the activation of racist stereotypes in the way that the distress of Black clients is conceptualised and in the allocation of resources.

“[...] some of the ways in which we tell [Black] people that they should understand themselves and they should respond to things aren't they don't align with who we are”.

(Participant 1)

“[...] you know, sat in meetings where Black families are talked about in a stereotypical and negative way.”

(Participant 12)

“[...] actually perhaps we're not getting Black people referred because the people who were referring are making assumptions or don't want them to be referred for whatever reason, or are prioritising the needs of White people.”

(Participant 12)

Whiteness is also evident in participants' day-to-day experiences of their roles, specifically in the vast differences in the way that Black and White CPs experience the workplace.

“I think it's there's a between how myself and the only other minority psychologists are treated versus the White psychologist and that could be in terms of training being offered. That can also be in terms of just flexibility that's given to him that's not given to the rest of us.”

(Participant 6)

These differences were categorised by the marginalisation of their experiences, while being subjected to different standards of behaviour and additional scrutiny.

“[...] marginalising my experience as though my racial experience, my racial identity is less important or insignificant, and assuming that I should hold the same identity and experience and beliefs as everybody else...It's the minimising it in a way that makes you feel uncomfortable to own and to acknowledge your own difference.”

(Participant 7)

"[...] realising that that's not normal to be so anxious that you are worried about what you say and how that might come across. Whereas others than the team can be swearing left, right and centre, and I could never."

(Participant 7)

"I'm very conscious that something that goes wrong for me there won't be the same professional consequence as if something that goes wrong for my White counterpart."

(Participant 2)

Participants also recounted experiences of navigating their colleagues' racialised expectations about their competence and status.

"It's the assumption that, as a Black woman, you couldn't possibly hold the role of clinical psychologist. That you couldn't possibly, perhaps be more educated than the people you're in the room with... So it's about people having an idea that we have an inability to be able to do these roles."

(Participant 7)

These racialised assumptions lead to the devaluation of BCPs' professional expertise and contributions.

"[...] what you said is not seen as something of value or you're not seen as someone who is knowledgeable."

(Participant 6)

"[...] like speaking up in team meetings and constantly being spoken over, or my contributions either being ignored, overlooked, and yet somebody else could say the exact same contribution and somehow all of a sudden it's the most meaningful thing... And it's around ways that your voice is just, when your contributions are considered less than."

(Participant 7)

BCPs also spoke about being subjected to racist stereotypes, with the angry and strong Black woman tropes being frequently referenced.

“I was worried about being seen as an antagonistic person or “you’re being aggressive” or, you know, “you’re being a bully”. But I know there’s, I know they’re all racist tropes [...].”

(Participant 3)

These tropes were implicated in the lack of compassion and thoughtfulness present in the way that BCPs were understood and responded to by their colleagues.

“[...] words such as powerful, strong, etcetera that were often associated with me, which I think dehumanized me in their minds, in the sense of ‘oh, she’s not really affected by it in that way’”

(Participant 7)

“We’ve never had any of those conversations about like, how I’m doing with this because I’m fighting a battle... we’ve never had any of those conversations and I’ve never had anyone ask if it is tough at times, if it feels like too much.”

(Participant 8)

The generalisations encouraged by these stereotypes results in Black people being conceptualised as a monolith.

“[...] they will turn to look at me as if I am the knowledge of the monolith of Black people and should know the answer... like, ‘great. We’re going to have the Black perspective’ before I even said my name. And I thought, ‘oh, interesting. I don’t know what the Black perspective is’”.

(Participant 10)

As such, BCPs were often denied personhood and conceptualised as part of a homogenous ‘other’.

“[...] people insisting I was someone who I said I wasn’t which is bizarre...A completely different person. How on Earth?! And we look very different, you know, apart from both being Black”

(Participant 9)

The inability to acknowledge heterogeneity among those who are racialised as Black results in BCPs being positioned as representing all Black people. For some, this led to fears that their performance would have implications for how other Black staff would be judged.

“[...] you represent how Black people are positioned and seen... if you slip up and you really let loose, all the other Black people behind, around you and for years to come, are gonna sort of suffer with the stereotype because you sounded off in a meeting because you were pissed off.”

(Participant 4)

BCPs not only experience racism in their interactions with colleagues, but also with the systems in which they work. Systemic racism was discussed with regards to the way in which it limits career progression.

“I think there really is something that's quite normalised and institutionalised. And again, I say this quite confidently because we look at the data. So even if you look at the Workplace Racial Equality Standards you know that actually, minorities are less likely, especially Black NHS staff, are less likely to be offered training or less likely to be offered a promotion, all those types of things.”

(Participant 6)

This was attributed to the maintenance of Whiteness being dependent on narratives of Black inferiority, with BCPs achieving seniority therefore posing a direct threat to Whiteness.

“[...] wanted to keep me down at that level, and they found the idea that I might progress quite challenging and frightening for them... so you suddenly found all that support just disappeared. Because I was too ambitious. I was achieving too much... you've risen above your station... you need to just step down and realise your place.”

(Participant 9)

3.4.2. The Impact of Whiteness and Racism

The impact of racism was described by participants in ways that pointed to profound harm. For example, one participant referred to the experience of racism at work as “*psychological violence*” (Participant 7). Being subjected to this violence has devastating emotional and psychological impacts on BCPs, and many participants shared experiences of distress arising from Whiteness and racism in the workplace.

“There's something very raw and painful in that I don't think I quite can articulate that in words. I don't think I've got the vocabulary to explain the intensity or emptiness... like there's a visceral emptiness to that pain. And I guess sometimes it does feel hard to breathe”

(Participant 10)

“Every single day I feel terrified to go into work and the impact on me was like a shaking of my foundational core”

(Participant 2)

“The reaction was visceral. I felt it in my chest, in my gut, all parts of me were completely consumed”

(Participant 5)

The impact of experiencing unrelenting racism is cumulative, with each instance falling on top of previous experiences of racism at work and in wider society.

“The impact doesn't have to be micro, because if that's something you're dealing with every day, the impact is macro in some way... You know my skin has never not been brown, so there's ways that you manage with that every day but actually that toll at different times of these microaggressions or racism, that insidious nature... can take its toll on me or other people in the community.”

(Participant 10)

These experiences “have big impacts on [their] sense of belonging and how [they] conceptualise [themselves]” (Participant 2), leading many participants to consider leaving the NHS in order to escape racism.

“It leaves me feeling sometimes adrift, sometimes lost, like just not knowing what to do. Whether to leave the NHS because it just feels so fundamentally flawed and so institutionally racist and you know, systemically racist.”

(Participant 3)

“I got out of the NHS...I knew if I stayed there my mental health would be at risk because of this, it was bad, I mean it was the best thing I ever did.”

(Participant 9)

3.5. Theme 3: Spotlighting Whiteness; The Work of Anti-racism

Participants’ descriptions of anti-racism work highlighted its core purpose of spotlighting Whiteness; centring Whiteness in order to disrupt it. Their efforts to place Whiteness in the spotlight were multifaceted; they facilitated the exploration of the biases arising from Whiteness, while supporting their peers to engage with anti-racist praxis by oscillating between states of reflection and action.

“Really allowing people to, I guess, explore why it is that they have certain beliefs or attitudes, so asking them questions. I wonder where that’s come from, kind of. How come you have that belief? How come you have that perspective like and what was coming up when you shared that reflection? Where did you get that sort of idea from?”

(Participant 5)

“Driving the conversation forward and trying to make it not just conversation, but also really change and impact the way in which we’re doing things, and our experiences of the service, and our service users’ experiences of us”

(Participant 9)

As explored in the following sub-themes, participants described observing the operation of Whiteness in the process of anti-racism work. Specifically, they spoke

about Black staff being positioned to do the work of anti-racism and the dilemmas and concerns that arose when White people engaged in anti-racist work. Participants also described the defences that arise when Whiteness is spotlighted through discussion, as well as their functions and multiple impacts.

3.5.1. Who Does the Work

Participants highlighted that Black staff are often positioned to do the work of disrupting Whiteness in their organisations.

“The Black and brown people do a lot of work in ensuring that these conversations take place, but then they are responsible and they have to hold that space.”

(Participant 4)

Participants described this having the effect of locating the responsibility for catalysing change within racialised staff, with other staff having an expectation that they will do the work of anti-racism.

“It makes me feel quite responsible. Sometimes it makes me feel, we always have to fix it.”

(Participant 3)

“[...] or the like ‘you do the project. I thought you'd be able to do the project on young Black men,’ and I was like, ‘oh, why me?’ And it's not that I'm not interested or naming some of those things in meetings, but I think some of that was more about like ‘oh, yeah, you're brown, you can do your work’.”

(Participant 10)

“That silent kind of gaze over to you when there is that odd slide that talks about diversity and asks for any contributions.”

(Participant 7)

The work of anti-racism is burdensome and painful, taking an emotional toll which often isn't acknowledged or compensated in their pay.

"[...] it's that exploitation of who's constantly having to do that work and not being reimbursed appropriately, and the psychological violence that come from that in terms of the impact on my own mental well-being."

(Participant 7)

While these expressions may imply that White people doing the work could provide some relief, participants described not trusting White people to do the work of anti-racism. This mistrust stems from scepticism around the nature of White people's motivation to do the work and fears that their attempts could be tokenistic and facilitative of virtue signalling and superficial anti-racist performances.

"I'd also be like very suspicious of someone else who wasn't me doing it because I'd be like, what are you getting? What's going on?...I'd rather do it especially as I'm the only Black person."

(Participant 8)

"I'm such a good person because my Black friend can come to me about racism because I read a book about racism, it is tokenistic... now, like a hot topic across the NHS that we're going to tackle racism in the NHS overnight and like it's become this thing where it's attractive for a service to be like "oh, we're looking at equality, diversity and inclusion". And now because that's attractive suddenly you're looking at that."

(Participant 8)

3.5.2. Defending Against Seeing and Speaking About Whiteness

Participants described a variety of defences that their colleagues use in response to their discomfort when Whiteness is spotlighted in discussion, one of which is silence.

"[...] these are people who are very capable of reflecting, and we've had reflective discussions about very sensitive topics, faith etcetera. But for some reason when it came to that and the racial experience. Silence."

(Participant 7)

BCPs understood their colleagues' silence as a response to their feelings of guilt, shame and fear that they could be called racist.

“I think there's a lot of guilt or shame that people feel about what's going on and we know that guilt and shame as emotions can really attack ones sense of self and ego because we feel bad and I think a lot of people are sitting with that.”

(Participant 5)

“I don't wanna out myself to be a racist even though I don't think I'm a racist and so actually, it's just easier to say nothing then I can't incriminate myself”

(Participant 4)

The fear of being labelled a racist was understood to constitute a significant threat due to the impact that it could have on White staffs' sense of self.

“[...] most people, right, even the general public think they are good people, let alone when you're in a profession helping people, they think they're an even better person because they've chosen to give their lives to other people and support them with their needs and the things they're struggling with. So I think when that becomes identity, if the narrative that you've made in your head is that I'm a good person, its threatening.”

(Participant 8)

While participants understood the functions that silence served for their White colleagues, they described the ways in which they experience the use of silence as a weaponised threat; an act of “*sullen hostility*” (Participant 4) having the impact of shutting down BCPs and the discussion.

“There's also this silence that can be threatening and weaponised. Which I've had to name as this is my experience when I'm sharing something that is clearly vulnerable and the team meeting was silence. Not even a reflection or an acknowledgement... acknowledging what it takes for somebody to be vulnerable and to share”

(Participant 7)

“It's almost like a road block has put up”

(Participant 5)

“The silence as a way of almost creating that awkwardness, putting you off from continuing”

(Participant 7)

Participants also described the many tactics that their colleagues employ to avoid talking about Whiteness and racism. Some spoke about the tendency to talk around, rather than about, racism.

“So the common one is actually just not even mentioning or naming racism. So any other word that can be used to discuss it. Diversity is the one that just irritates me because what does that even mean?”

(Participant 6)

Participants recalled times when their colleagues had, in an attempt to avoid discussing the Whiteness in the room, engaged in “*whataboutery*” (Participant 2) and “*oppression olympics*” (Participant 7), in an attempt to divert the focus.

“You always get stuck into a distraction, so they'll use another marginalisation which is important but the only time they mention that is when you're discussing race to kind of discredit what we're saying or divert the attention.”

(Participant 6)

Colleagues using this defence often fail to employ an intersectional lens, and as such, essentialise people, neglecting the nuances of their lived experience.

“[...] but what about gender? OK, yes. But what about sexuality?...you know what? Black people have genders and sexualities too.”

(Participant 2)

“Actually, everything is rooted in racial experience because everybody holds a racial identity, and we should think about the intersections of that with race rather than stop talking about race and talk about gender. Cause even in gender there's a racial experience too.”

(Participant 7)

This response also creates the illusion of a hierarchy of oppression, within which participants perceived that racism was at the bottom.

"[...] in other areas of identity, if someone was making a complaint or making a comment to a clinician about their sexuality, about any number of other things, we would be responding very differently"

(Participant 1)

Participants also described the ways in which their colleagues avoid discussing Whiteness by engaging in deflection; focussing on BCPs' responses to racism and its discussion, rather than Whiteness, "tone policing" (Participant 7) BCPs in the process.

"People who raised these topics, because of the way they might approach it, they are then seen as the problem. So 'oh I probably would have understood what you're saying if you just change how you're saying it. If you just change your tone, you've been a bit aggressive, you've been a bit confrontational. Maybe if you change how you say something, then I'll hear what you're saying'. But that's not the truth of it. I think even if you say it in, if you adjust your tone, I don't think that necessarily changes what people go on to do"

(Participant 5)

Participants understood being tone policed as indicative of the expectation that they speak about racism as if it is separate to their lived experience.

"[...] we are having really highly academic conversations about highly personal and traumatic topics, and the expectation is that I speak about Blackness and racism and Whiteness as if I'm neither Black nor experiencing racism, or subject to the oppressive nature of Whiteness at the same time. Like to live in this kind of academic fairy tale land where you can talk about everything dispassionately and that is completely OK and completely fine and has no long term or lasting impact."

(Participant 2)

Participants spoke about the way in which racist tropes underly the way that they are characterised when their colleagues deflect in this way.

“It was being very aware of when I want to challenge something, like almost rehearsing it in my head in terms of how's the tone of my voice? Do I sound angry? Do I sound too strong? How's my hair looking today when I'm challenging this? All of those things that are internalized ideas about angry Black women, about strong Black women, about what it means to have a voice...So that's what I mean by posturing myself in those settings.”

(Participant 11)

Consequently, participants experienced a need to moderate and sensor themselves in order to be conceptualised favourably and heard.

“Having to either sanitise or soften my delivery to make it more palatable”

(Participant 7)

Participants recalled experiences of colleagues framing talking about racism as harmful in an attempt thwart discussion.

“They say they notice that everyone's getting really upset, or feelings are hurt, or things are blowing up, so almost like this discussion feels so unsafe that we need to maybe think about if we can continue...So just framing talking about it rather than actually dealing with it as so harmful that they shut it down.”

(Participant 6)

In some instances, colleagues avoid discussions by engaging in the “*battle of the intellects*” (Participant 2), denying experiences of Whiteness and racism by demanding evidence.

“There's the asking for evidence, you need to prove it in order for it to be credible.”

(Participant 7)

The denial of racism in this way is experienced as an act of aggression.

“I experience the reliance on the academic as an almost quite aggressively defensive...countless people, service users, staff members might be telling you their lived experience, but I'm not even gonna even consider what they are saying until I see some hard facts. And it just makes me wanna just literally just tear my clothes off...frustrated like I just get so flipping angry”

(Participant 4)

This “*intellectual posturing*” (Participant 4) forces BCPs to reframe discussions around empirical evidence.

“Having to draw on literature to almost evidence the validity of these experiences, or at least evidence the credibility”

(Participant 7)

This reframing enables avoidance, giving way to highly intellectualised discussions that tend to neglect the Whiteness in operation closer to home.

“How well can you talk about this thing and use fancy language so you can avoid doing anything about it? Very conceptually focused. No action plans, no solutions”

(Participant 2)

Another common defence that participants described was that of White people centring their feelings to detract from the lived experience of racism. This was often achieved by crying and prioritising the intent of White people over the oppressive impact of Whiteness on racialised people.

“[...] a lot of tears, a lot of “I'm not racist” or “I didn't mean what I said in that way” or “I'm so upset that this happens in the space that we're in”, and it's always the person who's not impacted that's crying.”

(Participant 6)

“The tears. You know the tears, the overwhelming guilts that they might feel which completely distracts the focus from what you're saying to, now let's comfort you”

(Participant 7)

“[...] a sense of trying to minimise the experiences by stating that the harm wasn't as much or wasn't intentional and therefore shouldn't be as impactful, [you] should kind of just get over it.”

(Participant 7)

“Putting White people's comfort at the heart of it” (Participant 10) forces Whiteness out of the spotlight and creates a context in which BCPs are expected to deprioritise their own feelings and experiences in order to show compassion to their White colleagues and provide them with validation.

“[...] so there was a sense of we can sacrifice to you for the sake of keeping others comfort centred”

(Participant 7)

“[...] you've been asked to go back into that space to make people feel OK. So they're prioritising their feelings over yours”

(Participant 6)

Participants felt that the only way to eradicate defences is for White people to do the work of confronting their anxieties and leaning into reflections around their own biases, as in doing so, defences would become redundant.

“[...] acknowledge that you have implicit biases, that you have prejudices “

(Participant 8)

“[...] face their anxieties to, to step out into situations that might feel uncomfortable because we know there is a benefit to be had in doing so... stepping out onto this ledge”

(Participant 1)

3.5.3. What Defences Do to Us

The use of the described defences position BCPs as experts; *“the one who was assumed to hold all knowledge”* (Participant 7).

“I am positioned by them like ‘you’re so knowledgeable’... or ‘you’re the expert’ or ‘you know everything about antiracist practice’”

(Participant 10)

These defences also position BCPs as educators for their colleagues, often creating situations whereby BCPs’ lived experience of being Black and associated experiences of oppression and pain, are exploited for the purpose of White education.

“[...] people see me as a source of knowledge, people welcoming being educated which can have its own frustrations. ‘Teach me, teach me. Teach me...I deserve to be taught. If you want things to be better, you should tell me’, which is kind of a neediness and an entitlement”

(Participant 2)

“I’ve almost felt exploited. I felt that the audience is seeking to draw out my story, my pain in my experience, to be like examined like something in a Petri dish and that myself as the host matters very little...there’s almost an entitlement and expectation that I should share... it sometimes feels a bit like trauma porn.”

(Participant 2)

Defences also position BCPs as the designated people to address and disrupt Whiteness.

“[...] noticing that I’m constantly the disruptor or the guide in those circles... the disruptor being like ‘hold on. Are we really thinking about this in a way that is attentive to diverse experiences?’”

(Participant 7)

In disrupting Whiteness, BCPs are often problematised, conceptualised by their colleagues in line with racist tropes: “angry” (Participant 2), “aggressive” (Participant 2; Participant 3 ; Participant 5), “attacking” (Participant 2), “confrontational” (Participant 5), “a bully” (Participant 3), “antagonistic” (Participant 4), “a troublemaker” (Participant 9), “threatening” (Participant 2), “divisive” (Participant 8) and “challenging” (Participant 4; Participant 10). Moreover, their colleagues often perceive that they are always talking about Whiteness and therefore have a victim mentality.

“[...]some people feel that, oh gosh, she always bangs on about those issues”
(Participant 11)

“[...] people position me as playing the victim like an unnecessary complainer, a whiny, immature child. What is it called? Snowflake Millennial...a needy little victim who just wants to complain about stuff and wants to be mollycoddled.”
(Participant 2)

Positioning and problematising BCPs in this way further locates issues of Whiteness and racism within them, and therefore the responsibility for change, leaving participants experiencing the expectation that “somehow [they’re] supposed to be able to fix it” (Participant 7). As a result of these dynamics, the operation of these defences simultaneously threaten, silence and distress BCPs.

“I remember my heart racing, I remember sweating, I remember my voice shaking, I remember not wanting to make eye contact”
(Participant 7)

“[...] so anxious that you are worried about what you say and how that might come across”
(Participant 7)

“I just go numb. I don't really engage. I've become almost like a selective mute.”
(Participant 2)

Participants spoke about the defences and resultant dynamics being typical and therefore expected.

"I'm like, 'Oh yeah, I heard this before. Here we go again'"

(Participant 10)

As such, BCPs have learned to employ tactics to manage the hostility. These include avoiding discussions and self-minimisation.

"Oftentimes it makes me want to withdraw from the spaces."

(Participant 1)

"I had intentionally been like 'I'm gonna take that day off because I can't take the fake reflections around work people assume they've done, all the excuses around what they have done and haven't done.'"

(Participant 7)

"Wanting to be just small in the space and not occupy too much more."

(Participant 11)

Participants felt that their peers failed to appreciate the impact of discussions and their defences on them.

"I don't know if I am thought of because I don't think they're thinking 'actually we're talking to a Black person here. We need to be careful' because I don't think they are aware."

(Participant 12)

Participants also described the negative impact of these defences on their relationships with their teams, Trusts and the wider profession. They described feelings of hopelessness, disappointment, frustration and resentment.

"I have personally lost a lot of faith in, not everyone, but a lot of people that I work with"

(Participant 6)

“Frustrated with the pace. Frustrated with the lack of support and feeling unsupported. Hurt, yeah, really hurt by that cognitive dissonance of these are nice people, but they cause harm.”

(Participant 7)

“I think, to be honest, sometimes my team, I hate them all”

(Participant 10)

“[...] resentment towards colleagues”

(Participant 7)

As a consequence of the dynamics created by the use of defences, BCPs often experience feelings of isolation within the workplace.

“[...] so it was just kind of like a build-up of all of these little things that increased that sense of isolation and feeling different from the team.”

(Participant 7)

Participants described the ways in which their colleagues' use of defences make disrupting Whiteness dangerous, leading them to engage in a “cost benefit analysis” (Participant 5) to assess if the threat outweighs the potential benefit of challenging.

“[...] you kind of make this assessment of what are the benefits for me? What are the costs? What's worth my energy and what isn't?”

(Participant 5)

“[...] if I did address it, will be to the cost of my own mental well-being? So actually, am I willing to do that in order to address it?”

(Participant 7)

“I have to weigh up is that worth it”

(Participant 8)

Participants also spoke about the defences of the organisational and wider systems, and the ways in which they enable the (re)production of Whiteness by threatening BCPs when they challenge.

“I was really careful about raising it in the NHS because that could get really, really toxic and you know, punitive and stuff like that...I know that I deliberately avoided it.”

(Participant 9)

Moreover, when Whiteness is challenged at the systems level through complaints procedures, BCPs are often actively harmed in the process, resulting in them being burned out and feeling unable to sustain or progress with their complaints, thereby shielding Whiteness from challenge and disruption, enabling its (re)production and continued operation.

“[...] we try to make complaints and follow things up the procedures, but they don't go anywhere. They always seem to get brushed under the table. Or the person inevitably becomes so beat down with trying to get this issue to be recognised and dealt with that they themselves leave those institutions for their own well-being, you know.”

(Participant 1)

“[...] when people raise issues that have happened, instead of them being protected in the process, they're almost kind of forced to go to lots of meetings, so lots of meetings, lots of discussions, lots of environments that make it feel unsafe and make that person feel so exhausted that they don't want to take it any further.”

(Participant 6)

3.6. Theme 4: Resistance

Theme four encompasses participants' descriptions of the ways in which they resist Whiteness at work; *“how we keep going and why I stay”* (Participant 11). Participants described the decision to remain in their roles and disrupt Whiteness as one which is revisited on a recurring basis, sometimes as frequently as daily:

“Every now and then I'm like ‘I'm quitting this job and I'm gonna become a high-end escort’. Or sometimes I'm like ‘maybe I'll become a window cleaner’. And then I'm like ‘no, I'm gonna have to manage a hospital or something and fix all of these like racist policies that exist’...day-to-day its different.”

(Participant 2)

The following sub-themes explore the nature of, and mechanisms through which, participants described resisting the Whiteness and racism that they experience within their professional roles.

3.6.1. Resisting as an Individual

Participants described their ongoing presence as a continuous act of individual resistance.

“My very existence as a psychologist is almost like an act of resistance or that visibility within a profession that is predominantly White, just my presence in this profession is political right?”

(Participant 5)

Maintaining integrity by adhering to their values was intrinsic to their efforts to weaponise authenticity in their resistance of Whiteness.

“I show up as myself. You can tell that I'm from South London. I'm not going to put on a fancy accent because my South London-ness, whether I like or not, it will come out.”

(Participant 11)

“[...] if you're very clear about what your values are and what you won't compromise”

(Participant 6)

Participants also spoke about revelling in the joy, pride and strength that they derive from their experiences of being Black as an antidote to the racist narratives that

surround their existence; *“That’s also resistance; joy that cannot be taken away”*
(Participant 11).

“I’m proud to be Black. That is part of my heritage. That’s what’s important to me when you think about family or history or family narratives or what it is that you stand for. I also embrace my culture and how stories are told. My great grandparents and what shoulders I’m standing on in my family or wider. So there’s something that I embrace about being a Black woman. I’m proud of my history and culture and generations in London from a working class background.”

(Participant 10)

“[...] that is strength...I’m proud of being Black, not in response to Whiteness.”

(Participant 10)

Some described their resistance being orientated by their faith in that it provided motivation, reminded them of their purpose and constituted a source of strength and reassurance.

“If it wasn’t for my faith, I don’t know how I’d have survived some of that stuff.”

(Participant 9)

“When Esther got into the palace and her cousin Mordecai or her uncle was like ‘our people are perishing’ and she was probably thinking because she didn’t get in there so that she could have this position, but it was like you’re in that position, what do you want to do? You want to help your people because listen, if we go down, you’ll go down with us. Don’t forget, you’re part of us...I’m in this position, God has blessed me enough to get me here. I can’t take it for granted and begin to assimilate and begin to think that I can’t name that here. I can’t. I I’m not going to entertain that thinking. I’m here for a reason. I’m here to disrupt.”

(Participant 11)

3.6.2. Resisting Together

Participants spoke about the ways in which their resistance was enabled by the communities that they had cultivated with other Black staff. They described the ways in which their shared experiences of racism and the context in which they work allowed for unfiltered discussions and the development of safe spaces in which they could be heard and understood in the absence of interrogation and defensiveness.

“Often, I’ll call or speak to a colleague because I think they understand, you know...they just understand the context. Whereas friends, you know, they could be different, you know, different professions, different jobs, and it’s it doesn’t quite click as clearly with them.”

(Participant 9)

“It’s just nice not to...have to explain to someone who isn’t Black, or from an ethnic minority background, over and over again why this situation is wrong.”

(Participant 6)

“[...] those spaces offered the chance to speak unfiltered. And an ability to be seen and heard and validated.”

(Participant 5)

These spaces are described as *“nourishing and sustaining”*, (Participant 1) as within them, BCPs are afforded compassion and validation – things that are often absent in the other spaces that they occupy.

“[...] it will just always be that ‘I’m really sorry [participant 6] that this had happened’ and there’s really acknowledging that and you don’t really get that in spaces outside of that...I think there’s just, there’s compassion.”

(Participant 6)

“Validation and an opportunity to just let out the emotion to express the emotion that goes with it, the frustration, the anger. So it’s like a safe place to just let rip and you know kind of share that experience and that really helps, that helps enormously. And they’re not gonna say, ‘do you really think that’s what was going on? Do you really think it was about race?’ You know they’re just going to say like, ‘Oh my goodness, that’s terrible’.”

(Participant 9)

These interactions also provide opportunities to generate ideas and plans for continued resistance.

“There is a potential solution or resolution to things that people who are like-minded, who are Black, who not only have thought about these things but lived these things, could begin to kind of forge forward and create and facilitate some change.”

(Participant 2)

3.6.3. Resisting With Allies

Participants spoke about the important role that allies can have in addressing Whiteness and racism, speaking explicitly about the difficulties that arise *“when you don’t have those allies, those staff who will back you to say something because you cannot fight that battle every single day”* (Participant 8). Participants spoke to the difference between allyship and critical allyship, where the latter represents those who perform the functions of allyship while remaining consciously aware of their ability to operationalise Whiteness in the process (Nixon, 2019).

“White colleagues who would explicitly name and acknowledge their Whiteness as a factor. Who would, not just check-in as caregivers, but also acknowledge themselves as potential perpetrators in causing harm. So there was a sense around those listeners, particularly the White listeners acknowledging that they were not free from, or they weren’t kind of different from others in that sense, but they were willing to be brave and have courageous conversations.”

(Participant 7)

Participants described these colleagues having the quality of being able to move through their fragility, rather than being stuck in it. These colleagues *“face their anxieties to step out into situations that might feel uncomfortable because [they] know there is a benefit to be had in doing so”* (Participant 1). Moreover, similarly to racialised peers, those doing critical allyship support BCPs in their resistance by hearing and validating their experiences.

“I think it's just like a sounding board. It's usually just to process what's happened, to vent and be able to be like ‘oh this was crap’ and have them listen to it and also be like... like almost validating your experiences as well.”

(Participant 8)

The presence of the minority of White colleagues who are doing critical allyship allows BCPs *“to hold hope that there is change, that there are some pockets and spaces within the organisation that people are doing the work”* (Participant 7). This hope is generated, not just from what their allyship offers BCPs, but what it also offers their White colleagues by way of modelling.

“I think if more White people could be on it or those White people who have done the work could share some of their journey in a more authentic way that would really help. I can't mirror that... a White person came forward and said ‘you know, it's also made me think of times when I was younger where I was the perpetrator’... You need that like, ‘oh, this is what that looks like’, not behind closed doors in the supervisory space. They need some more role models in that way, then other people will feel brave.”

(Participant 10)

3.7. Theme 5: “An Absolute Mess”; What Needs to Change

The racism that BCPs experience has resulted in the current state of affairs being described as *“an absolute mess”* (Participant 6). Despite this, participants expressed hope that positive change could be made through their recommendations around how their workplaces and the wider profession could confront and disrupt Whiteness. It was felt that change needed to be multifaceted, *“hold[ing] that both and approach”* (Participant 10); being orientated by the aims of facilitating a change in focus, improving education and development, enacting systems change and maintaining a sustained commitment to anti-racism.

3.7.1. Change in Focus

Participants described the need for an inward focus, shifting away from positioning racism as something that exists at a distance towards thinking about the ways in

which individuals, teams, the NHS and the profession perpetuate and (re)produce Whiteness and racism.

“It's not something that is happening to other people. You know, it's not other people. This is happening within our profession, within our locality, within our Borough, within our Trust. This is here, it's prevalent. It's alive. It's kicking.”

(Participant 3)

An honest acknowledgement of where staff, teams and wider systems are with regards to anti-racism was identified as an essential prerequisite for the reflection required to move towards an anti-racist workplace.

“I think if people were really honest about where they are in terms of thinking about racism, then you can start to ask how we can shift and change”

(Participant 6)

Participants highlighted that becoming anti-racist would require an end to colour-blindness as the failure to ‘see colour’ leads to the minimisation of the lived experience of racism.

“I think sometimes in an attempt to be like, ‘we all the same, we are all equal’, people remove the difference and say ‘I don't see colour’...I think having those conversations would then make people realise [that] you actually have a very different life experience, you have different everyday experiences living as someone who's not White, and we need to acknowledge that.”

(Participant 8)

The importance of moving away from the focus on increasing diversity and cultural competence towards disrupting Whiteness was also discussed, highlighting that addressing Whiteness is the only way to cultivate truly inclusive and anti-racist organisations.

“I'm not going to say that there needs to be more representation of Black people in psychology, because I think we need to be aware of the systems that these Black people are walking into... That means it's the White people

who need to reflect on White supremacy, rather than the Black people need to feel more confident...I think it's analysing the White supremacy that also operates in the service...We need those White staff to think about how they're supporting Black and brown people to be their authentic self, be aware of racism and be walking towards being an anti-racism team or service."

(Participant 11)

"Cultural competence isn't an issue... [it's] because of racism."

(Participant 9)

3.7.2. Education and Development

Participants spoke about the need for colleagues from all professional backgrounds to be educated about Whiteness, calling for:

"An overhaul about how we recruit, how we train up professionals, what we train professionals in and challenging individual and group ideology about race and racism as well."

(Participant 6)

It was felt that training could only be effective in disrupting Whiteness if it simultaneously equipped colleagues with an awareness of Whiteness and skills in reflexivity.

"A mixture of light psychoeducation... [and] understanding the multiple ways that people can respond to or take action when they witness and discrimination and awareness around what different forms of racism and discrimination look like...A chance for them to also reflect on their own learning, their own understandings around systemic issues that contribute to racism."

(Participant 7)

Participants spoke specifically about the DClinPsy, identifying the lack of space dedicated to issues of Whiteness and racism within programmes as a core contributor to the racism perpetuated by CPs in their post-qualified practice and interactions with racialised colleagues; this suggests that the introduction of such

spaces could be effective in supporting the profession in training anti-racist practitioners.

"[...] there is something specifically about the training and ways it doesn't always acknowledge those different experiences, or it considers it as an add-on rather than integrated and essential."

(Participant 7)

"Not all of the courses are teaching and training in a way that thinks about diversity, that thinks about difference, that thinks about the role that society has in building certain assumptions about people."

(Participant 12)

Participant responses also suggested that it is essential that Whiteness, rather than experiences of racism, should be the focus of education and training; it was felt that this would reduce the opportunity for Whiteness to operate in training spaces by locating the issue of racism, and by extension the catalyst and burden of change, outside of racialised staff.

"It needs to start with Whiteness as a concept and start there, because then it takes it out of 'you guys have experienced racism' and doesn't then locate the problem in Black people...I think that slight shift, not that these things don't happen, but slightly then doesn't inadvertently, unconsciously, put the onus on brown people having to change or having to share."

(Participant 10)

Participants described the need for education extending beyond BCPs' immediate colleagues to leadership within their organisations, in acknowledgement that leaders are positioned to enact wider change by modelling the expected standards for junior colleagues.

"I think that those who have been qualified for longer, especially who may be less connected to those training spaces, or who may feel that they don't hold as many training needs need to actually be targeted, because they often

occupy leadership positions, so there's something about what they model and what they therefore allowed to happen in their teams.”

(Participant 7)

3.7.3. Systems Change

Participants described a need for change within organisational systems and made recommendations for structural changes they believe could support the disruption of Whiteness within their organisations. One such recommendation was cultivating a commitment to anti-racism among senior staff, who have decision making power, in the hope that this would influence organisational culture towards anti-racism.

“There's only so much bottom-up work that can be done. You still need people at the top who have the decision-making powers to be on board and I feel a little bit stuck on that.”

(Participant 5)

“When it's kind of from the top, then that's the only way I see things changing”

(Participant 5)

Participants described interest convergence existing among senior White colleagues, and as such, felt that recruiting Black people into roles which afford them decision-making power would be essential in disrupting Whiteness among those positioned to enact systems change.

“Also, we just need less White people in positions of power... Often those who are White, it is because if you're trying to change something that someone is benefiting from, most people suddenly feel like they're being stolen from and unfortunately, that's not avoidable. You know, if you've been in a position because you speak a certain way, you make certain jokes and you exploit and exclude certain people, there is no way we can make positive change and you can stay there unless you change also. And if those people don't want to change, then they have to go. Sorry. It's just what it is.”

(Participant 2)

The need for systems of accountability and consequence was also discussed, highlighting that the absence of such systems results in a lack of incentive for organisations to change, deprioritising addressing Whiteness and racism.

“I think for a real systemic change to happen, anti-racist practice and anti-discriminatory practice needs to be elevated to the same level of importance as things like safeguarding...anti-racist thinking should be part of every organisation's key performance indicator, and if they're not performing in that area, then they do not get commissioned...Otherwise, if it doesn't impact their funding, then there is no real incentive to change anything. So for me there's something about it being structurally built into systems and as a way of measuring the quality, the effectiveness, the safety of an organisation.”

(Participant 5)

3.7.4. A Change in Commitment

Alongside the need for systems change, participants spoke about the need for staff and organisations to commit to leading with humanity in their response to racialised staff and incidents of racism.

“It is kind of like just get out of your head and just connect with them as a human being. Stop intellectualising this. You just need to bring your heart to it... So I think it's people, not intellectualising the anti-racism work and actually just being a human being.”

(Participant 11)

Participants also described the need for equal commitment to becoming anti-racist among racialised and White staff, including sharing in the bravery, vulnerability and emotional burden of the work required to move towards becoming anti-racist.

“If some White people could fully lean into that bravery and share some of their own thinking about actually, what did it mean for me to do the work? But naming that not in relation to your Brown colleague, but ‘here where I was the perpetrator’ or, ‘where I did this research thing’ that would free up the conversation.”

(Participant 10)

“I think that there's something about how both White and Black colleagues collaborate. Like it requires everybody kind of navigating this dance.”

(Participant 7)

Participants called for a sustained commitment to the journey of becoming anti-racist, recognising that it will be a career-long endeavour, requiring commitment to incremental change to contribute to long-term transformation.

“If people actually really start from that point and actually are really dedicated, and see this as something that they do throughout their career, not something that they do for one month or two months and then racism is finished, then I think that there can be some change.”

(Participant 6)

“I think it needs to be ongoing, I don't think it's a one off. I think it's something that's taken from moments to movements.”

(Participant 7)

4. DISCUSSION

In this chapter, the study aims and findings are summarised and the analyses are considered in relation to the research question and existing literature. This is followed by a discussion of the implications of the research and recommendations for training, clinical practice, future research and policy. The chapter closes with a critical appraisal of the research and an exploration of the participants' and the researcher's reflections on the experience of the research process.

4.1. Summary of the Study Aims and Findings

Previous research suggests that racialised psychologists are likely to experience: (1) racism in their teams and clinical work, (2) difficulties integrating their personal and professional identities, (3) being positioned as experts on issues related to race and, (4) being burdened with the work of navigating discourses around race while existing within structurally racist systems (Odusanya et al., 2017; McNeil, 2010). This research expands on these insights, while overcoming the earlier identified epistemic, methodological, epistemological, conceptual and contextual factors discussed (see section 1.6.3), by exploring BCPs' experiences of racism and its discussion at work and in the profession. In doing so, this study provides accounts of the operation of Whiteness in BCPs' experiences of racism and its discussion at work, which had been at worst, neglected, and at best, superficially attended to in previous research. Thematic analysis generated five overarching themes:

- *"It is what I am": BCP identity*
- *Whiteness at work*
- *Spotlighting Whiteness; the work of anti-racism*
- *Resistance*
- *"An absolute mess"; what needs to change.*

These themes highlight, and provide a narrative of, the systemic and systematic processes of Whiteness and the ways in which it manifests in BCPs' lived experiences.

4.2. Research Question: How do BCPs Describe and Make Sense of Their Experiences of Racism and its Discussion at Work and in the Profession?

The main research question explores how BCPs describe and make sense of their experiences of racism, as well as its discussion at work and in the profession. The themes titled '*Whiteness at work*' and '*spotlighting Whiteness; the work of anti-racism*', largely address the question. Within theme three, '*resistance*', the ways in which relationships aid the sense-making process is discussed. Given that these three themes are inextricably linked and when combined, address all aspects of the research question, the author will discuss them together. In doing so, the findings will be linked to the existing literature and the author will provide further analysis of their interpretations of participant accounts, with consideration of how their experiences relate to the underlying processes of Whiteness.

4.2.1. BCPs' Experiences of Racism

Considering the analyses alongside the existing literature, it is clear that racism underlies and is a unifying feature of the experiences of racialised aspiring, trainee and qualified psychologists, rendering it a consistent experience across the career path (Bawa et al., 2019; Desai, 2018; McNeil, 2010; Odusanya, 2017; Patel & Fatimilehin, 2005; Paulraj, 2016; Ragavan, 2018; Shah, 2010; Tong et al., 2019). Participants described racism in such terms that it is understood to be ubiquitous, insidious and covert. This makes it difficult to locate while simultaneously being evident in the many facets of their lived experience, the descriptions of which mirror their aspiring (Bawa et al., 2019; Tong et al., 2019), trainee (Adetimole et al., 2005; Paulraj, 2016; Shah, 2010) and qualified (McNeil, 2010; Odusanya, 2017) colleagues.

Participants described racism being a feature of their interactions with their colleagues, describing the active process of being racialised. Within this, BCPs described experiencing the activation of racist tropes and stereotypes in the way that their colleagues perceived and positioned them. As such, BCPs, similarly to their racialised pre-qualified counterparts, described being the victim of racial micro-aggressions that were perpetrated by their colleagues (Adetimole et al., 2005; Paulraj, 2016; Ragavan, 2018; Shah, 2010). These microaggressions are described as serving the function of framing them as 'less than' (Odusanya et al., 2017). Their

accounts highlight the ways in which this framing manifests in their colleagues' racialised assumptions about their abilities, the marginalisation of their experiences, the subjugation of cultural narratives and the relative devaluation of their professional contributions and expertise. The process of being racialised in this way and the resultant conceptualisation of BCPs, was described as integral to their need to work harder than their White peers to be conceptualised as equally 'good enough' (McNeil, 2010; Odusanya et al., 2017).

BCPs described experiencing racism in the form of being treated differently to their White colleagues; being dehumanised through the violation of their bodily autonomy and the denial of their personhood (McNeil, 2010), while simultaneously being subjected to higher standards of behaviour and excessive scrutiny. Alongside this, racism was described as embedded in the structures and systems of the NHS. In alignment with analyses concerned with the impact of institutional racism for aspiring and qualified psychologists (McNeil, 2010; Ragavan, 2018; Tong et al., 2019), participants described this form of racism as inhibitory, curtailing opportunities for development and career progression. As such, participants implicated racism in the presence and maintenance of the "coloured glass ceiling" (McNeil, 2010, p. 87), providing insight into the lived experience underlying the long-recognised issue of a lack of diversity among staff who occupy senior positions in the NHS (Workforce Race Equality Standards Implementation Team, 2021; Archibong et al., 2019).

The racism that BCPs describe experiencing at work extends beyond the ways that they themselves experience racial prejudice to observing racialised clients being subjected to racist processes and practices. Within this, participants' accounts aligned closely with Patel and Fatimilehin's (2005) analysis, further highlighting the racism inherent in the activation of stereotypes, the formulation of distress and the inflexible imposition of Eurocentric ideals on culturally diverse clients. Moreover, participants described witnessing racism within NHS teams manifest in disparities in the compassion, thoughtfulness and resources afforded to White and racialised clients, providing a narrative of the processes underlying the long-reported racial inequities in access to psychotherapeutic mental health care (Bhui et al., 2014; Das-Munshi et al., 2018; McKenzie & Bhui, 2007).

Although there were similarities in the way that racism was described, participants spoke to the intersectional nature of their experiences, describing the ways in which being racialised as Black intersects with other aspects of identity, influencing the way that it is experienced. Specifically, they spoke about the ways in which class, gender and relative proximity to Whiteness moderated the ways that Whiteness is operationalised by their colleagues and the wider system (McNeil, 2010).

Like Black nurses, Black doctors and racialised psychologists, BCPs make sense of these experiences in the context of the continued perpetuation and institutionalisation of colonial ideas of White superiority, which frame Black people as inferior (Edeh et al., 2022; McNeil, 2010; Odusanya et al., 2017). Moreover, BCPs recognise that these values and assumptions are embedded in theory, practice and processes (Pilgrim, 2008), further reaffirming ideas around White superiority and enabling the continued othering and marginalisation of those who are racialised. Similarly to racialised TCPs (Shah, 2010), the process of making sense of these experiences is supported by BCPs' relationships with racialised peers and a minority of their White colleagues who engage in critical allyship (Nixon, 2019). It appears that their relationships with these colleagues facilitate the discussion of their experiences in the absence of interrogation and invalidation. In doing so, these spaces support the reconstruction of their experiences outside of a Whiteness lens, facilitating an understanding of the racism experienced, within which BCPs are not pathologised or problematised.

4.2.2. BCPs' Experiences of Discussing Racism

From the analyses it is evident that BCPs experience a sense of responsibility to address racism through its discussion, describing their colleagues' expectation that they will initiate and contain such discussions. BCPs describe discussions of racism in similar ways to WCPs (Ong, 2021), highlighting that they're characterised by their colleagues' defences of silence, avoidance and centring their own feelings.

BCPs described the defence of avoidance in multiple forms, including avoiding the discussion altogether, the denial of racism, intellectualisation and steering the discussion away from racism and towards other minoritised identities. Participants also described avoidance in the form of deflection, where the conversation is shifted away from racism through the problematisation of the nature of the challenge. BCPs

spoke about the ways in which these tactics of avoidance result in racism and Whiteness being decentred in discussion, and consequently remaining unchallenged. Within these discussions, BCPs also experience the centring of White feelings manifesting in crying and the prioritisation of White intent over the oppressive impact of racism. It appears that BCPs experience the activation of this defence as one that creates a context in which BCPs are expected to deprioritise their feelings, while simultaneously being positioned to support and show compassion to their White colleagues.

When silence is employed defensively, BCPs experience it as weaponised and hostile, often having the impact of silencing them. Their descriptions suggest that this is not the case with silence alone, as the defences are described as each contributing to the generation of an oppressive atmosphere when racism is discussed; one which is characterised by aggression, threat, hostility and silence (McNeil, 2010). It appears that BCPs experience these defences as contributing to them being perceived and positioned negatively. They describe defences positioning them as 'experts' and 'educators' (Odusanya et al., 2017; Patel & Fatimilehin, 2005), locating the responsibility for creating change through discussion within them. They also describe, as a result of avoidance through deflection, being perceived as 'angry', 'aggressive' and 'hostile', which further problematises them (McNeil, 2010).

BCPs, similarly to WCPs, understand these defences and the resultant ways in which they are positioned and perceived, as a manifestation of their White colleagues' attempting to defend their sense of self (Ong, 2021). BCPs make sense of the need to defend in the context of their White colleagues' fear of being labelled racist and the guilt and shame that they experience when confronted with the privilege that they are afforded alongside their ability to weaponise Whiteness by nature of being White (Desai, 2018; Ong, 2021).

Unsurprisingly, the described experiences of racism and its discussion have a profoundly negative impact on BCPs, with the language of "psychological violence" used to encapsulate the perpetual feelings of threat, anxiety, fear and distress that these experiences generate. Overall, these conditions lead to BCPs feelings of isolation and their lived experience being one of existing as an outsider on the

margins of a hostile system (McNeil, 2010), leading many to question their place in the profession and NHS.

4.2.3. The Underlying Processes of Whiteness

The ways in which BCPs describe and make sense of their experiences of racism and its discussion at work and in the profession are indicative of the underlying processes of Whiteness. Their accounts highlight the continued presence of Whiteness in their multiple layers of context, suggesting that society, the profession and the NHS, similarly to the higher education curriculum, remain “intensely White” (Gillborn et al., 2021, p. 1). Consequently, BCPs, like those seeking to enter the profession, find themselves “thrown against a sharp, White background” (Alcock, 2019, slide 1), with institutionalised Whiteness continuing to position being racialised as Black as a basis for othering and a proxy for inferiority.

Institutionalised Whiteness in the NHS means that teams and Trusts are scaffolded around White normativity and superiority in such a way that they racialise their non-White colleagues and clients. This manifests in the views of BCPs’ colleagues being explicitly implicated in their experiences of racism and its discussion (Patel, 2021). Institutionalised Whiteness, by organising the people and systems within around White superiority, compels BCPs’ colleagues to devalue and problematise them as the racialised other (Guess, 2006). These processes are mirrored in participants’ accounts, with BCPs describing being problematised by nature of being racialised as Black through the activation of racist tropes, being problematised for challenging racism, their contributions being devalued and their experiences of racism being trivialised. Moreover, BCPs spoke about continuously being marginalised, subjugated, minimised, dismissed and denied personhood. While participants, in their descriptions of their experiences and how they interpreted and contextualised them, spoke about the values and assumptions of Whiteness, they did not explicitly name it. It is possible that this is due to the silent and covert way in which Whiteness operates and is (re)produced, with the analyses indicating that those who seek to force Whiteness into the spotlight by naming it are often subjected to threats and hostility from the White people and systems around them. On the basis of the synthesis of these ideas, it is argued that the systematic and systemic processes of Whiteness underly BCPs’ experiences of racism and its discussion, with these

experiences arising as a consequence of the operation of Whiteness within the NHS and profession.

4.3. Implications and Recommendations

The findings suggest that Whiteness within the NHS harms racialised staff and service users, positioning disrupting Whiteness as essential in addressing these harms. Within theme five- *“an absolute mess; what needs to change”*- participants provide comprehensive recommendations that represent a multi-pronged approach to developing a critical awareness of Whiteness, and the capabilities to disrupt it, at individual, team and systems levels. The following sub-sections expand on the recommendations made, considering the implications for training, clinical practice, policy and future research.

4.3.1. Training

Recommendations for training are discussed with regards to the needs of TCPs and NHS staff. While the following subsections provide recommendations for training that could be delivered by Trusts and DClinPsy programmes, they do not negate the role of professional bodies in providing continuing professional development, which would serve to complement their efforts.

4.3.1.1. DClinPsy: The failure to integrate anti-racist praxis into DClinPsy programmes was discussed and criticised by participants. Their accounts reaffirmed the role of DClinPsy programmes in supporting the development of the critical awareness and skills necessary to notice and disrupt Whiteness embedded in psychological theory, clinical practice and processes. In doing so, participants lend their support to the many calls made, over a significant number of years, to decolonise the profession, starting with the DClinPsy curriculum (Alvarez et al., 2016; Fernando, 2017; Wood, 2016). As such, the author endorses Ong’s (2021, p. 88) recommendation to decolonise the curriculum in a way that facilitates “awareness of the history and politics underpinning psychological imperialism, and critical evaluation of the underlying assumptions, implications and relevance of dominant psychological approaches.” While the author endorses this recommendation, they argue that it must be extended. It is insufficient for programmes to support the consideration of Whiteness only in the context of

psychological theory and therapeutic relationships, as Whiteness is also operationalised in team, Trust and organisational dynamics. Consequently, the author endorses Patel and Wood's (2017) proposal to embed Whiteness and anti-racism teaching and workshops within DClinPsy programme curricula. The proposed spaces would provide TCPs with facilitated opportunities for education, reflexivity and introspection. As such, TCPs would be offered opportunities to consider their relationships to race, racism and Whiteness, enabling them to become critically aware of their own capacity to operationalise Whiteness and so facilitating its disruption.

The supervision received during the course of training could also play a role in supporting the development of anti-racist praxis among TCPs. It is of note that programmes are responsible for ensuring TCPs are placed with supervisors who can provide them with adequate supervision. As such, programmes may need to take additional steps, for example through further supervisor training to empower and equip supervisors with the skills and confidence to provide supervision that enables critical and reflexive discussions around Whiteness.

To successfully facilitate any supervisory, reflective or educational space that aims to address Whiteness, programme teams and placement supervisors must themselves embark on the journey of anti-racism; only by becoming aware of their own defences and ability to operationalise Whiteness will they be able to support TCPs to do the same.

4.3.1.2. *NHS*: Participants spoke about the need for training in the NHS to support CPs and colleagues from other professional backgrounds to engage with anti-racist praxis. Many trainings have been developed with the aim of addressing racism in the NHS, with these trainings being available to all staff (including CPs) and rolled out across physical and mental health Trusts. The trainings have been predicated on ideas around 'racial sensitivity', 'racial awareness', 'cultural competency', and more recently, 'unconscious bias' (Bennett & Keating, 2008; Pennington et al., 2003). Participants' accounts and the continued evidence of structural racism in the NHS suggest that these trainings have been ineffective. The author argues that this is due to each of the trainings failing to acknowledge Whiteness and people's complicity in its perpetuation, instead focusing on the

attitudes of individuals, and in doing so, failing to attend to the structural nature of racism. Moreover, it is argued that 'racial sensitivity' and 'racial awareness' trainings have been unsuccessful in addressing racism as a result of the trainings themselves perpetuating harmful stereotypes about racialised communities, and privileging the internalisation of this stereotyped education over reflexivity. More recently, attempts to address racism through training have, by endorsing the language of 'unconscious bias', perpetuated the idea that racism is unconscious, facilitating the denial of agency and abdication of responsibility for change, further enabling the continued operation of Whiteness (Noon, 2018).

In contrast to earlier trainings offered, it is recommended that future training should explicitly attend to Whiteness. The author also recommends that Whiteness training be rolled out across all NHS Trusts, and that within the training spaces, facilitators should provide staff with the opportunity to understand Whiteness and develop the reflexive capabilities that enable its disruption in individual, team and organisational processes. In order to support structural change, it is recommended that upon being employed by a Trust, members of staff should be mandated to attend such Whiteness and anti-racism training to orientate themselves to the anti-racist ambition of the organisation, with attendance being a condition of their employment.

4.3.2. Clinical Practice

Multiple themes in chapter three outline the operation of Whiteness in the way that racialised clients and staff are conceptualised and responded to, resulting in services and colleagues failing to meet their client's needs and having hostile experiences in the workplace. These accounts reinforce that anti-racism must become an orienting principle in the work of CPs, their teams and their Trusts, as the failure to do so constitutes complicity with and enables, the (re)production of Whiteness and its harms.

Previous attempts to address racism in clinical practice have utilised training as discussed in section 4.3.1.2 It is recommended that all NHS practitioners are supported to develop a critical awareness of Whiteness and engage with the embodied experience of confronting its operation in all areas of their work (e.g., clinical provision, team functioning, recruitment and policy development). This could be facilitated through a combination of group and supervisory, reflective and

educational spaces, which support staff to engage in anti-racist praxis through reflection, including interrogating instances where they themselves had operationalised Whiteness. Furthermore, it is recommended that consideration of Whiteness is incorporated into supervision and appraisal discussions and templates to prompt ongoing consideration of Whiteness and racism at all levels of organisations.

It is essential that supervisory and team spaces be facilitated in a way that truly enables anti-racism, rather than enacting performative Whiteness. As such, facilitators, service managers and supervisors must themselves be engaged with anti-racist praxis. Only through engaging with their own journeys will they develop the capacity and skillset necessary to simultaneously observe Whiteness, contain their colleagues' defences, manage their own emotional experience and model vulnerability and bravery. In order to prioritise and support the development of the skills needed to create sustainable change among the workforce, middle managers and Boards of Directors must support these spaces to become an integrated component of organisational processes. This could be achieved by issuing a directive that spaces dedicated to Whiteness and anti-racism take place within paid and protected time, and be accounted for in job plans in a way that enables Board oversight and monitoring.

4.3.3. Policy

As evident in the findings of this research, racism harms Black staff. The Health and Safety at Work Act (1974) outlines employers' moral and statutory duty of care to employees to provide a safe environment, and as such, it is incumbent on the NHS to address the Whiteness and racism within. In order to fulfil this responsibility, Trusts must develop anti-racist policies with clearly defined strategies for achieving and measuring progress. It is essential that the strategies outlined aim to disrupt Whiteness, rather than supporting racialised staff to better tolerate or show resilience in the face of racism.

The racism that BCPs experience at work constitutes a threat to staff retention, contributing to and exacerbating the crisis of CP shortages (BPS, 2022). Policies around workforce planning, such as those developed by Health Education England (2021), must move beyond their desire to *diversify*, to contain strategies that are

orientated by the principles of anti-racism and aim to disrupt Whiteness. Failure to do so will likely render these policies ineffective, perpetuating the challenges faced with regards to recruiting, training and retaining racialised and, in particular, BCPs.

In order to achieve structural change, the recommendations made must be taken up by professional and regulatory bodies. As such, the researcher calls for the move away from position statements towards the development and amendment of BPS and HCPC policies to reflect and embed the recommendations; specifically policies that attend to best practice (BPS, 2017; HCPC, 2016), ethics (BPS, 2021b, 2021c; HCPC, 2016), programme accreditation (BPS, 2019; HCPC, 2017) and equality, diversity and inclusion (BPS, n.d.; HCPC, 2021). The recommendations must also be taken up by DClinPsy programmes through the development and amendment of policies which relate to their curriculum, supervisory spaces and programme processes. These policies must provide explicit guidance on strategies for how Whiteness can be disrupted and where responsibility for addressing Whiteness lies, in training, organisations and professional practice. Moreover, these policies should outline systems of reporting and accountability for institutions and practitioners who fail to comply with them.

4.3.4. Future Research

As organisations begin to develop and implement anti-racist policies and practices, there will be an increased need for research that evaluates the utility of the strategies employed. While this research used thematic analysis, future research could employ different methods. For example, a researcher could carry out a conversation analysis (Sidnell, 2011) having observed discussions around Whiteness and racism. These methods could be used to assess the impact of an intervention designed to influence the ways in which Whiteness and racism are discussed by observing differences in the nature of the dialogue pre and post intervention, while attending to the operation of power.

While there are studies that examine the way in which Whiteness operates and influences the experiences of racialised aspiring, trainee and qualified psychologists (Odusanya et al., 2017; Shah, 2010; Ragavan, 2018; Bawa et al., 2019), the use of homogenising language (e.g., BME, BAME) to recruit, describe and sample those who are conceptualised as ‘the racialised other’, leads to analyses and research

findings which neglect differential racialisation. As such, future research that focuses on experiences of racism should attend to differential racialisation by recruiting homogenous samples, enabling their analyses to provide nuanced insights into the different ways in which Whiteness operates and racism is experienced.

4.4. Critical Review

Northcote's (2012) five criteria for high quality qualitative research guided the evaluation of this research, assessing the extent to which it is contributory, rigorous, defensible, credible and affective. Further strengths and limitations of the research are also discussed.

4.4.1. Contributory

This study has furthered our understanding of the ways in which Whiteness is operationalised and racism is experienced and discussed within UK clinical psychology and the NHS. Implications for future research, clinical practice, policy and training are discussed in section 4.3.

4.4.2. Rigorous (in Conduct)

The data collection and analysis was systematic and conducted in fidelity with Braun and Clarke's (2006) six stage approach to reflexive thematic analysis. The research has been conducted transparently, with evidence of each stage of analysis provided in the appendices and illustrative extracts from interview transcripts used to support the researcher's interpretations of the data.

4.4.3. Defensible (in Design)

The way in which the research design attends to the research question is outlined in section 2.2 and evidences the congruence between the aim of the study, epistemological position and methods employed. Moreover, section 4.2 evidences the success of the design in answering the research question.

4.4.4. Credible (in Claim)

The claims made by this research are borne from the data and align with the findings of previously conducted research.

4.4.5. Affective (in Nature)

The research attends to the emotional elements of how the participants and the researcher engaged with the study. Participants' affect and emotional experiences were attended to throughout chapter three, and their emotional experience of the research process are attended to in section 4.5.1. Researcher affect is discussed in sections 2.3 and 4.5.2.

4.4.6. Strengths and Limitations

Sensitivity to context is an essential component of qualitative research as the socio-political context influences the beliefs, objectives and expectations of researchers and participants alike; making it a central component of all meanings made (Yardley, 2000). Sensitivity to context has been displayed throughout the research by situating it in the historical and current context of the UK. Moreover, the influence of racial disparities in COVID-19 outcomes, GTiCP and the murder of George Floyd are attended to in chapters one and three, and the researcher has reflected continuously, in supervision and their reflective journal, on how this context may have influenced participants' responses and the researcher's relationship to the research.

Of the twelve BCPs who participated, only one identified with being a man. As such, it could be argued that the findings may not adequately represent Black men's experiences of racism and its discussion within their roles as CPs. However, clinical psychology is dominated by women, with the sample mirroring the ratio of men to women in the profession (DCP, 2015). Therefore, it is argued that the sample is likely representative of BCPs overall, rendering it suitable and adequate for achieving the intention of this research in answering the research question.

4.5. Reflexive Review

In line with the critical realist epistemological position, it is important to consider that the accounts shared and meanings made represent interpretations rather than universal truths (Alhojailan & Ibrahim, 2012; Fryer, 2022). Therefore, reflexivity constitutes an essential component of conducting ethnical research, making attending to the experience of the research process essential as it influences both the responses given and interpretations made by participants and the researcher

(Attia & Edge, 2017). The following reflexive review attends to the reflections shared by the participants and researcher, considering the effect that each had on the findings, as well as the effect that the research had on those involved.

4.5.1. Participant Reflexivity

Towards the end of each interview, participants were asked questions designed to elicit reflections on their experience of participation. They described receiving the framing of the research, in that it centred the lived experience of being racialised as Black, rather than being “*about the discomfort of White people*”, as an invitation to bring their whole selves. This, combined with the interview space being one in which they felt “*heard*”, “*seen*” and “*safe*”, likely supported them to share their experiences of racism, powerlessness and oppression. Being “*truthful and honest*” in sharing their experiences, led some to feel relief. The experience of safety and feeling able to share freely was attributed to speaking to a researcher “*who might understand or appreciate or value the information*”. The researcher interpreted this as a reference to the way in which they are racialised, and the assumption as a consequence, that they would be well positioned to receive and interpret their experiences in a way that is valid. This mirrors the way in which participants described shared understandings with racialised clients and their racialised peers. While this was described as facilitative of the data gathering process, the researcher remains curious around the extent to which the assumed shared understandings may have led to some experiences not being explicitly spoken. This could have implications for the findings of this thesis in the form of some facets of experience being implied rather than explicitly stated, increasing the opportunity for misinterpretations.

Participants described a desire to protect the researcher from their pain by making their experiences sound “*less bad*”. This was in response to their awareness of the researcher being Black and their positionality as a trainee:

“[...] what is she thinking about these responses? Especially being in the midst of training, where it doesn't always feel like you have the power to challenge things... I was holding space for how you were feeling.”

These considerations may have resulted in the careful consideration, framing or minimisation of the experiences shared. Moreover, participants reflected on the

parallels between them being positioned to do the work of anti-racism and a Black trainee conducting this research:

“It's been lovely, absolutely lovely. So lovely to see you, it's so lovely that you're doing this kind of research. I mean, again, it's a really tricky one because of course the Black people are doing the research on the Black issues”

The awareness of this may have further motivated participants to engage in strategies to protect the researcher, which in turn may have resulted in some experiences remaining unspoken.

4.5.2. Researcher Reflexivity

Throughout the process of conceptualising, conducting and writing up this research, the researcher has reflected on their experience. This was facilitated by supervision with their Director of Studies and the use of a reflective journal.

Throughout the process, I have found myself frequently revisiting Dwyer and Buckle's (2009) discussion of insider-outsider status. When these positions are considered, it could be argued that I have both insider and outsider status; insider on the basis of being racialised as Black, yet outsider due to being pre-qualified. In contrast, my experience of interactions with participants, if placed on a continuum between insider and outsider, align more closely with insider status. While the insider-leaning status likely enhanced and facilitated a depth and breadth of understanding that may not have been accessible to an outsider, my status could be argued to limit my ability to be objective (Kanuha, 2000).

During interviews, I noticed a desire to protect participants from the pain that they felt when sharing their experiences. It is of interest that this mirrors the desire that participants expressed to protect me (see section 4.5.1). Although I feel that this emotional response did not arrest my ability to ask probing questions of participants' experiences, it would be naive not to consider that the feelings could have constituted a potential inhibitor of discussion and exploration that could have impacted on the data gathered, and the analyses and discussion that followed.

While writing up this body of work, I experienced anxiety around the potential of participant anonymity being compromised. One aspect of the anxiety was borne from navigating the tension between the small number of BCPs in the profession, making identification possible, while trying to report sample characteristics and amplify experiences in a way that made the research meaningful and satisfied the criteria of the assignment. The second aspect of the anxiety stems from my own experiences of hostility when addressing Whiteness within professional contexts. I feared that participants being identified, and their identities being exposed alongside their testimonies – which speak to and address Whiteness in frank terms – could make them vulnerable to further hostility and harm, for which I would be responsible.

Throughout the process, I have gained an awareness of the true extent and consequences of Whiteness in operation for those who occupy a professional context that I will soon be stepping into. While hearing participants' accounts evoked feelings of fear and hopelessness, their warm, thoughtful and welcoming nature served as a reminder that qualifying would afford me membership to their community, providing the reassurance that I likely wouldn't have to face racism alone post-qualification.

5. CONCLUSION

To the author's knowledge, this is the first study to explore BCPs' experiences of racism and its discussion at work and in the profession within the UK. Five themes arose from the thematic analysis:

- *"It is what I am": BCP identity*
- *Whiteness at work*
- *Spotlighting Whiteness; the work of anti-racism*
- *Resistance*
- *"An absolute mess"; what needs to change*

These themes provide accounts of experiences that have been neglected in previous research, and in doing so highlight, and provide a narrative of, the systemic and systematic processes of Whiteness as they arise and manifest in the lived experiences of BCPs.

The experiences shared constitute a serious indictment of the NHS and profession. They suggest that Whiteness, embedded in the NHS and professional contexts, means that to be a BCP is to occupy an identity that is conceptualised as inferior, problematised and marginalised. It is also to observe Whiteness in operation in the experiences of racialised clients, influencing the ways in which they are understood, discussed and responded to. To be a BCP is to experience hostility from your employing organisation and colleagues, all while having issues of race and Whiteness, and consequently the catalyst for change, located within you. These experiences arise from, and provide evidence of, Whiteness being operationalised in teams, Trusts, the profession and by colleagues. This context constitutes a threat, generates distress and harms BCPs, motivating them to leave the profession.

Over many years, a multitude of recommendations have been made with the aim of addressing racism. However, the recommendations made here represent a call to action, initiated by BCPs and amplified by the researcher through this body of work. This call to action is for everyone, including racialised people who have been conditioned to sustain Whiteness. The need for inclusive action at all levels is acute; failure to disrupt Whiteness not only perpetuates the harm done to BCPs, but also

forces Black colleagues to continue witnessing the harm that they see done, generation after generation, to each other, their clients and their communities. As healthcare professionals we have a professional and ethical responsibility to prevent racism and its harms within our practice, organisations and institutions by initiating, nurturing and sustaining individual and collective change. As such, the author stands in solidarity with BCPs, imploring our professional and regulatory bodies, colleagues, training institutions and workplaces to abandon performative Whiteness and nurture a sustained commitment to the work of anti-racism— for all of our sakes.

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APPENDICES

Appendix A: Interview Schedule

- What does it mean to you to be a Black clinical psychologist?

Motivation to participate

- What was it about this study “Exploring Black clinical psychologists’ experiences of racism and its discussion at work and in the profession” that interested you and made you want to participate?

Experiences of racism

- I wonder if you can think of and describe any racism that you have experienced in your role as a clinical psychologist at work
 - Follow-up questions:
 - Can you give examples?
 - How did you make sense of that experience/interaction?
 - What impact did it have on you?
 - Were you offered any support? From who?
 - Did you feel able to raise the experience with senior colleagues?
 - How did you manage/cope?

Discussing racism

- So we have talked about some experiences of racism. I would like to understand more about your experiences of how racism is discussed. Could you tell me about your experience of discussing racism in your team/trust/clinical work/ the profession.
 - Follow-up questions:
 - Who initiated the discussion? Why?
 - Who was present?
 - How was the discussion framed?
 - What was it like for you to have that conversation or listen to that discussion?
 - How did you think that you were positioned or perceived in that discussion?
 - How did you manage that conversation?
 - What effect did those experiences have on you?
 - How did that leave you feeling about your team/trust/client/the profession?

Changes

- What do you think needs to change? Prompt: to prevent the racism that you experienced? To change the way that people talk about it? To help your team/Trust have more meaningful conversations towards change?

Ending the interview

- Is there anything that we haven’t talked about that you think is relevant to this topic?

- What has the experience of being interviewed for this research been like for you?

General Prompts:

- Could you tell me more about that?
- Is there anything else you would like to add?
- How did that affect you?
- How did that feel?
- Was there anything that you noticed about yourself in that interaction?

Are you a Black Clinical Psychologist?

Have you experienced racism and/or its discussion at work or in the profession?

If **yes**, you may be interested in this doctoral research

What is this research about?

This research is about Black Clinical Psychologists' experiences at work: Their experiences of racism and of discussions about racism.

What will happen?

You will be invited to have a conversation with me about your experiences, via video call. Everything that you share will be kept confidential and will not be traceable to you. You will not be asked to share anything that you are not comfortable with and you can stop participating without explanation.

Who is it for?

You can take part if:

- You are a **qualified Clinical Psychologist**
- You identify as being of **'Black' race or heritage**
- You practice as a Clinical Psychologist in the **UK**

If you would like to take part, or want more information, please contact:

Reay Stoddart Isaac
(Trainee Clinical Psychologist)

Email: U2075230@uel.ac.uk



University of
East London

Twitter: [@Reay_CSI](https://twitter.com/Reay_CSI)



Appendix C: Participant Information Sheet



PARTICIPANT INFORMATION SHEET

Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Contact person: Reay Stoddart Isaac
Email: U2075230@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Reay. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into Black clinical psychologists' experiences of racism and its discussion at work and in the profession.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have I been invited to take part?

To address the study aims, I am inviting clinical psychologists who identify with being of Black ethnicity of heritage to take part in my research. If you practice in the UK, you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to attend a one-to-one, online conversation of approximately one hour, using Microsoft Teams. Although it will be

recorded, it will be like an informal chat, where we will talk about your experiences of racism and discussing racism at work.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

It is not anticipated that you will be adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, discussing racism can be upsetting and it is possible that your participation – or its after-effects – may feel challenging, distressing or uncomfortable in some way. Please see the below information for supporting agencies.

Samaritans

Free helpline that is available 24 hours a day, 365 days a year, for anyone experiencing distress.

Tel - 116 123

Email - jo@samaritans.org

Or download their self-help app

Website: <https://www.samaritans.org/how-we-can-help/if-youre-having-difficult-time/>

Mind

Charity that provides advice to anyone experiencing distress or mental health difficulties.

Website: <https://www.mind.org.uk>

Infoline providing information and signposting between 9am and 6pm, Monday to Friday:

- Tel- 03001233393
- Email- info@mind.org.uk

GP

It may also be helpful to speak to your GP if you are experiencing difficult emotions following the interview.

How will the information I provide be kept secure and confidential?

All of the information that you provide will be treated respectfully and confidentially.

- You will not be identified in any write-up of the research. This will be achieved by removing identifiable details, using pseudonyms and not presenting your age and ethnic background together.
- Identifiable information will be stored separately to your pseudonymised transcript.

- Only the researcher and the Director of Studies (Professor Nimisha Patel) will have access to your identifiable data (.e.g. raw transcripts and Teams recorded video).
- All of the information that you provide, including raw transcripts and interview recordings, will be stored securely on the researcher's UEL's OneDrive for Business.
- Your personal contact details will also be stored securely.
- Examiners and the Director of Studies (Professor Nimisha Patel) will have access to pseudonymised transcripts and these will be shared securely using UEL's secure OneDrive for Business.
- Following the completion of the research all identifiable data, including your contact details, will be deleted.
- Following the completion of the research pseudonymised transcripts will be stored for a maximum of three years for dissemination purposes.

Confidentiality will only ever be broken in the event that a disclosure is made that leads the researcher to believe that you or anyone else is at risk of harm.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks and blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally and personally identifying information will be removed and your name will be replaced by a pseudonym.

Anonymised research data will be securely stored by the researcher and Professor Nimisha Patel for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Reay Stoddart Isaac
Email: U2075230@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor Nimisha Patel. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: N.Patel@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix D: Participant Consent Form



CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Contact person: Reay Stoddart Isaac
Email: U2075230@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have three weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams.	
I understand that my personal information and data, including video recordings and transcripts from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date

.....

Appendix E: Demographic Questionnaire

Gender

How would you describe your gender?

Ethnicity/cultural background

How would you describe your ethnicity and cultural background? (e.g., Black British, Caribbean descent/ Dual heritage, African and Irish descent)

Years post-qualification: _____

Area of practice

How would you describe your area of practice? (e.g., adult mental health, CAMHS, older adult, learning disability, forensics)

Appendix F: Participant Debrief Sheet



PARTICIPANT DEBRIEF SHEET

Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Thank you for participating in my research study on Black clinical psychologist's experiences of racism and its discussion at work and in the profession. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks and blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you as personally identifying information will either be removed or replaced. For example, a pseudonym will be used in reference to any quotes from your interview that are presented in the write-up and your ethnic background and age will not be presented together.

Anonymised research data will be securely stored by Professor Nimisha Patel for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Samaritans

Free helpline that is available 24 hours a day, 365 days a year, for anyone experiencing distress.

Tel - 116 123

Email - jo@samaritans.org

Or download their self-help app

Website: <https://www.samaritans.org/how-we-can-help/if-youre-having-difficult-time/>

Mind

Charity that provides advice to anyone experiencing distress or mental health difficulties.

Website: <https://www.mind.org.uk>

Infoline providing information and signposting between 9am and 6pm, Monday to Friday:

- Tel- 03001233393
- Email- info@mind.org.uk

Your GP

It may also be helpful to speak to your GP if you are experiencing difficult emotions following the interview.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Reay Stoddart Isaac
Email: U2075230@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor Nimisha Patel. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: N.Patel@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix G: Data Management Plan

UEL Data Management Plan: Full

For review and feedback please send to: researchdata@uel.ac.uk

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).



Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Reay Cashel Stoddart Isaac
PI/Researcher ID (e.g. ORCID)	ORCID: 0000-0001-7309-4536 UEL student number: U2075230
PI/Researcher email	U2075230@uel.ac.uk
Research Title	Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession
Project ID	N/A
Research Duration	February 2022-May 2023
Research Description	Recent events including the murder of George Floyd, ethnic disparities in outcomes related to COVID-19, the Commission on Race and Ethnic Disparities report which denied the role of systemic racism in these dipartites, and the live re-enactment of a slave auction at the Group of Trainers in Clinical Psychology conference under the guise of evening entertainment, have placed racism firmly on the agenda societally and professionally. NHS statements expressing a commitment to equality, and the British Psychological Society declaring itself "committed to tackling racism within our profession" have further prompted discission around racism within

	<p>the profession and NHS; systems that many clinical psychologists operate in.</p> <p>The experiences of Black clinical psychologists have been neglected in the literature. This research aims to augment the limited literature available by situating itself within the current context and explicitly exploring Black clinical psychologists experiences of racism and its discussion at work and in the profession; a pertinent topic given the current context.</p> <p>The experiences will be explored within this study by carrying out 6-12 individual semi-structured interviews with clinical psychologists who identify with being of Black ethnicity or heritage.</p>
Funder	N/A- part of the Professional Doctorate in Clinical Psychology
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	02/12/2021
Date of last update (of DMP)	
Related Policies	<p>UEL's Research Data Management Policy</p> <p>UEL's Data Backup Policy</p>
Does this research follow on from previous research? If so, provide details	No. This is a stand-alone piece of research.
Data Collection	
What data will you collect or create?	<p>Consent forms will collect identifying participant data (names and signatures) but no sensitive data, in word document format.</p> <p>Demographic questionnaires will collect sensitive identifying participant data including ethnicity, years post-qualification, gender and age in word document format.</p>

	<p>Video files and transcripts will be generated from the interviews; these will be generated using Microsoft Teams in .mp4 and word document format.</p> <p>Each participant will be assigned a participant number and all identifiable information will be pseudonymised in the transcripts. A password protected key document will be created that can be used by the researcher pair pseudonymised transcripts with identifiable information should any participants wish to withdraw from the research. This document will be saved in its own folder, separate from participant data.</p> <p>The NVivo file generated from data coding will be saved in .npvx format. The data will be housed within one 'project' in NVivo so only one file will be generated.</p>
<p>How will the data be collected or created?</p>	<p>Personal data will be collected on consent forms (name and signature) and participant demographic forms (age, gender, years' post-qualification and ethnicity) prior to the interview. These will be completed by participants prior to the interview and returned to the researcher by email.</p> <p>Interviews will be conducted, recorded and auto-transcribed using Microsoft Teams. The auto-transcripts will be reviewed and edited by the researcher upon completion of the interview.</p> <p>Each participant will be assigned a participant number and all identifiable information will be anonymised in the transcripts.</p> <p>In OneDrive a folder titled 'Thesis' will be created, in which all data will be stored. Within this folder, a sub-folder will be created for each participant which will be named with their participant number. All data from each participant will be saved in the respective folder.</p> <p>Files will be named in the following format: DocumentDescription_ParticipantNo_Date (e.g. ConsentForm_1_2021-12-03)</p>
<p>Documentation and Metadata</p>	

<p>What documentation and metadata will accompany the data?</p>	<p>The following documentation will accompany the data:</p> <ul style="list-style-type: none"> • Participant information sheets (confidential) • Consent forms (confidential) • Demographics questionnaires (confidential) • Interview schedule • Debrief sheets <p>The participant contact information will be kept confidential and the pseudonymised transcripts will be the data.</p>
<p>Ethics and Intellectual Property</p>	
<p>How will you manage any ethical issues?</p>	<p>Informed Consent Each participant will be provided with an information sheet which will outline the purpose and nature of the research; there will be no use of deception. The information sheet will also inform participants of the way in which their data will be processed and their right to withdraw their data from the research up to three weeks after the conclusion of the interview. Following reading the information sheet participants will be provided with a consent form, facilitating the provision of informed consent.</p> <p>Right to Withdraw Participants will be informed of their right to withdraw from the research without disadvantage and justification on the recruitment poster, information sheet and consent form. Each participant will also be reminded of this at the beginning of their interview. Upon the conclusion of the interview, participants will have a three week period within which they can request that their data not be included in the analysis.</p> <p>Confidentiality and Anonymity All of the data collected will be stored securely on the UEL secure OneDrive. Transcripts will be anonymised and pseudonyms will be used in the write-up to protect participants identities. Participants' age and ethnic background will not be presented together in the write up in order to protect participant anonymity by reducing the likelihood of identification.</p> <p>Participant and Researcher Wellbeing</p>

	<p>Participants will be informed by the information sheet and reminded at the beginning of the interview that they can decline to answer questions and stop or pause the interview at any time. If any participants show signs of distress, the researcher will end the interview and proceed to the debrief. After the interview, participants will be provided with a debrief sheet containing details of organisations that can be contacted should participants wish to seek further support.</p> <p>Hearing about experiences of racism may upset the researcher. The researcher will keep a reflective journal to document these experiences should they arise and seek support in supervision.</p> <p>Ethical Approval Ethical approval will be sought from the UEL School of Psychology department.</p> <p>Supervision The research will be supervised by the allocated Director of Studies (DoS) and Second Supervisor (SS). These individuals are members of the UEL Professional Doctorate in Clinical Psychology programme and experienced in conducting and supervising research of this nature.</p>
<p>How will you manage copyright and Intellectual Property Rights issues?</p>	<p>There are no copyright or intellectual property rights issues.</p>
<p>Storage and Backup</p>	
<p>How will the data be stored and backed up during the research?</p>	<p>Video recordings and transcripts will automatically be stored on Microsoft stream. Once the transcripts are reviewed and identifiable information removed, they will be saved in a password protected word document on the researcher's OneDrive along with the video files.</p> <p>Video files, consent forms, demographic questionnaires and transcripts will be stored on the researcher's secure UEL One Drive where there is a built in backup system. This will also be the case for the password protected key</p>

	<p>document which will be stored in its own folder separately from the pseudonymised data.</p> <p>The NVivo file will be stored on the researcher's OneDrive. The file will be downloaded to an encrypted, password protected, private laptop so that it can be opened within the software for the purpose of data analysis. The file will then be reuploaded to OneDrive and the local copy deleted when it isn't in active use; there will not be any local copies of the file outside of the time when it is being accessed or edited.</p> <p>Automatic synchronising to personal Cloud storage will be disabled for the duration of the thesis so that any local copies are not automatically saved there. Any copies of data or documentation that are downloaded for the purpose of uploading to OneDrive for Business, will be deleted from the downloads folder on my laptop as soon as they are uploaded to OneDrive.</p> <p>There will be no use of hard copy documentation.</p>
<p>How will you manage access and security?</p>	<p>Only the researcher, Dos and examiners will have access to the pseudonymised transcripts. These transcripts will be shared with the DoS using secure links via UEL OneDrive for Business.</p> <p>An encrypted and password protected personal laptop with built in anti-virus software will be used to access UEL storage and Teams.</p>
<p>Data Sharing</p>	
<p>How will you share the data?</p>	<p>Only pseudonymised quotes from transcripts and basic demographic information (e.g. ethnic background, age and years since qualification) will be presented in the thesis, resulting papers and presentations. In order to ensure participant confidentiality, other data will not be shared with anyone outside of the research team.</p> <p>None of the data underpinning the research e.g. pseudonymised transcripts be shared publicly or deposited in UEL's Research Repository due to the sensitive nature of the data and the risk of participants being identified..</p>

Are any restrictions on data sharing required?	Data will not be shared and so sharing need not be restricted.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	<p>All of the data that is saved on the researcher's OneDrive will be deleted once the thesis has been successfully completed and examined.</p> <p>The pseudonymised transcripts may be of long-term value. These will be stored securely by the Director of Studies on their UEL OneDrive following the completion of the thesis. The researcher will also keep a copy of the pseudonymised transcripts in a password protected folder on an encrypted private laptop.</p>
What is the long-term preservation plan for the data?	<p>The pseudonymised quotes arising from the data will be presented in the completed thesis which will be disseminated via the UEL Research Repository.</p> <p>The pseudonymised transcripts may be stored on the Director of Studies' secure UEL server for up to three years for dissemination purposes.</p>
Responsibilities and Resources	
Who will be responsible for data management?	Reay Stoddart Isaac Professor Nimisha Patel
What resources will you require to deliver your plan?	<p>I will need access to the following:</p> <ul style="list-style-type: none"> • Microsoft teams to conduct, record and transcribe interviews • NVivo for data analysis • Microsoft word to save and password protect transcripts • UEL OneDrive to securely save interview recordings and password protected transcripts, consent forms and demographic questionnaires <p>These resources have already been acquired.</p>
Review	

Date 07/12/2021	Reviewer name Penny Jackson Research Data Management Officer
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Guidance

Brief information to help answer each section is below. Aim to be specific and concise.

For assistance in writing your data management plan, or with research data management more generally, please contact: researchdata@uel.ac.uk

Administrative Data

Related Policies

List any other relevant funder, institutional, departmental or group policies on data management, data sharing and data security. Some of the information you give in the remainder of the DMP will be determined by the content of other policies. If so, point/link to them here.

Data collection

Describe the data aspects of your research, how you will capture/generate them, the file formats you are using and why. Mention your reasons for choosing particular data standards and approaches. Note the likely volume of data to be created.

Documentation and Metadata

What metadata will be created to describe the data? Consider what other documentation is needed to enable reuse. This may include information on the methodology used to collect the data, analytical and procedural information, definitions of variables, the format and file type of the data and software used to collect and/or process the data. How will this be captured and recorded?

Ethics and Intellectual Property

Detail any ethical and privacy issues, including the consent of participants. Explain the copyright/IPR and whether there are any data licensing issues – either for data you are reusing, or your data which you will make available to others.

Storage and Backup

Give a rough idea of data volume. Say where and on what media you will store data, and how they will be backed-up. Mention security measures to protect data which are sensitive or valuable. Who will have access to the data during the project and how will this be controlled?

Data Sharing

Note who would be interested in your data, and describe how you will make them available (with any restrictions). Detail any reasons not to share, as well as embargo periods or if you want time to exploit your data for publishing.

Selection and Preservation

Consider what data are worth selecting for long-term access and preservation. Say where you intend to deposit the data, such as in UEL's data repository (data.uel.ac.uk) or a subject repository. How long should data be retained?

Appendix H: Excerpts From Annotated Transcripts

Line No.	Transcript 1 Participant: 7 Setting: MS teams	Reflections/ notes
1 2	So the first question is, what does it mean to you to be a Black clinical psychologist?	
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	What does it mean to me? I think being a clinical psychologist in a field where I'm not visibly represented as frequently. I think that's what amplifies the importance of my race, particularly if I think about clients who have named that sense of additional comfort in knowing that they can talk about aspects of their culture without worrying about being offensive or misunderstood or needing to over explain. Umm, I think it also is encouraging for those who are aspiring to come up to be able to see what's possible. Umm and I think it also helps in kind of communicating messages around mental health to people in my own community who physically look more like me. There's a sense of understanding more of the nuances around how we might navigate some services or understanding of mental health etcetera, which I'm able to kind of apply and think about when I'm using kind of more of the Western models. So for me being a Black clinical psychologist adds that real sense of nuance and understanding mental health as it's manifested and experienced, in uh, well, specifically Ghanaian communities I'm thinking of, but yeah, Black communities.	Shared understanding w/clients representation merging western models with nuance of blackness 4 communities
18 19 20	What was it about this study titled 'Exploring Black clinical psychologists' experiences of racism and it's discussion at work and in the profession' that interested you and made you want to take part?	
21 22 23 24 25 26 27 28	I think it is very kind of direct title that speaks to some real clear experiences in my mind around some of the things I've had to navigate that have been different from what my White colleagues have had to navigate. So it makes me think right from applying to train, on the training and not seeing an example of Black clinical psychologists and being explicitly told "there's no point applying, there's not that many Black people who get on", to training on the course and just distinctively noticing my Blackness and the absence of conversation or acknowledgement around that in a cohort which was primarily White. Also thinking about once qualified how	opportunity to reflect on whole career emotional labour

Line No.	Transcript 1 Participant: 4 Setting: MS Teams	Reflections/ notes
1	What does it mean to you to be a Black clinical psychologist?	
2 3 4 5 6 7 8 9 10	It means a lot and I think the reason why I went into clinical psychology is so intrinsically linked to my Blackness. So it sort of stands to reason that it would be, you know, like a guiding, you know, benchmark in how I sort of practice. I've always worked in psychosis and I think that that's again very much linked to my Blackness and the way that I think about mental health, I think is really culturally laden. You know, I always thought that I want to be the sort of practitioner that I would really want my family to see, you know, or a loved one or a friend and I think that in itself means that I am centring Blackness so I find it really difficult to not think about Blackness in the way I practice, because to me, that's just the way that I wanna work. So it's the centre, really, of my practice.	Blackness as central to practice Practicing to serve our community
11 12	And what does Blackness being in the centre of your practice look like? How is that different to the norm?	
13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29	I think it's been like a graded transition because I feel like, and it's probably not what you wanna hear when you're training, but I feel like when you're in training you're provided with a framework, and I think when I was on training, I was so almost desperate to know how to be a good psychologist and I thought, well, that's what you get when you train, you get the tools to be able to be a good psychologist. And I think it was only sort of after you've got the bit of paper that says you're qualified that I then thought "oh, actually I'm not sure whether this is being a good psychologist because all of these frameworks don't fit the way that I wanna work or the people that I wanna work with." And then I thought "what is it that I'm missing?" And the bit that was missing was pertaining to culture and values and you know, ethics and all of that. And so I think post qualification, it was almost a kind of first, and I know that [name of course] is very much into deconstruction and that was really helpful, but I think post qualification was me reconstructing the kind of practitioner that I wanted to be and then sort of thinking well actually the type of psychologist that I want to be is putting social injustice front and centre, is thinking about the impact of discrimination and marginalization, is thinking about the strength that marginalized communities have and how to embed that into interventions and that's how I've become a decent-is psychologist.	Eurocentricity of models and Blackness remedying that

Appendix I: Evidence of Systematic Code Generation

Line No.	Transcript 1 Participant: 7 Setting: MS teams	CODE STRIPES
1 2	So the first question is, what does it mean to you to be a Black clinical psychologist?	Coding Density
3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	<p>What does it mean to me? I think being a clinical psychologist in a field where I'm not visibly represented as frequently. I think that's what amplifies the importance of my race, particularly if I think about clients who have named that sense of additional comfort in knowing that they can talk about aspects of their culture without worrying about being offensive or misunderstood or needing to over explain. Umm, I think it also is encouraging for those who are aspiring to come up to be able to see what's possible. Umm and I think it also helps in kind of communicating messages around mental health to people in my own community who physically look more like me. There's a sense of understanding more of the nuances around how we might navigate some services or understanding of mental health etcetera, which I'm able to kind of apply and think about when I'm using kind of more of the Western models. So for me being a Black clinical psychologist adds that real sense of nuance and understanding mental health as it's manifested and experienced, in uh, well, specifically Ghanaian communities I'm thinking of, but yeah, Black communities.</p>	<ul style="list-style-type: none"> • Unspoken understanding(clients) • Nuanced understanding in application
18 19	What was it about this study titled 'Exploring Black clinical psychologists' experiences of racism and it's discussion at work and in the profession' that interested you	

Line No.	Transcript 1 Participant: 4 Setting: MS Teams	Reflections/ notes
1	What does it mean to you to be a Black clinical psychologist?	
2	It means a lot and I think the reason why I went into clinical psychology is so intrinsic	Blackness as
3	ally linked to my Blackness. So it sort of stands to reason that it would be, you know, li	central to pract
4	ke a guiding, you know, benchmark in how I sort of practice. I've always worked in psy	ce
5	chosis and I think that that's again very much linked to my Blackness and the way that	
6	I think about mental health, I think is really culturally laden. You know, I always though	
7	t that I want to be the sort of practitioner that I would really want my family to see, you	
8	know, or a loved one or a friend and I think that in itself means that I am centring Blac	Practicing to s
9	kness so I find it really difficult to not think about Blackness in the way I practice, beca	erve our com
10	use to me, that's just the way that I wanna work. So it's the centre, really, of my practi	community
11	ce.	
12	And what does Blackness being in the centre of your practice look like? How is that di	
13	fferent to the norm?	
14	I think it's been like a graded transition because I feel like, and it's probably not what y	
15	ou wanna hear when you're training, but I feel like when you're in training you're provi	
16	ded with a framework, and I think when I was on training, I was so almost desperate t	
17	o know how to be a good psychologist and I thought, well, that's what you get when y	
18	ou train, you get the tools to be able to be a good psychologist. And I think it was only	Eurocentricity
19	sort of after you've got the bit of paper that says you're qualified that I then thought "o	of models and
20	h, actually I'm not sure whether this is being a good psychologist because all of these	Blackness rem
21	frameworks don't fit the way that I wanna work or the people that I wanna work with."	edying that

CODE STRIPES

Coding Density

- Blackness intrinsic to being a cp
- role to provide for community
- Eurocentrism

Appendix J: Examples of Initial Codes

- 'good White person'- seeking validation
- absense of compassionate leadership
- advocacy for Black community
- advocating for disempowered peers
- Angry Black woman
- Anxious about peer's perception of BCP
- augmenting blackness
- Avoidance of virtue signalling- anti-racist performance
- avoiding racism as a limiter on opportunity and career progressi...
- BCP anx around discussions
- BCP attempts to avoid discussion (I know whats coming)
- BCP distress discussing racism
- BCP identity only significant because of racist context
- BCP not afforded compassion or psych consideration
- BCP progress as a threat to whiteness
- BCP wheilding relative power to challenge racism
- Being marginalised
- Black presence as a signal of virtue for team
- Black voice as valuable
- catalyst for change inside BCP
- Centring White comfort
- centring white fragility
- change- accountability
- change- Black experience not just entry
- Change- commitment to incremental change
- change- Dclinpsy acknowldge diff
- change- development needs of leadership
- change- education on whiteness and racism
- change- equal committment to bravery
- change- everyone doing the work
- change- protected spaces for BCPs
- change- reflection on psychology as harmful
- change- self-reflection
- change- societal socialisation
- Change- systems of accountability and consequence
- change- the longhaul
- Compassion in discussion- for White peers
- Complaints dont protect racialised staff
- Conciously countering stereotypes
- Contributions undervalued
- cost-benefit analysis- challenge

Appendix K: Excerpt From NVivo Codebook

Name	Description	Files	References
'Good White person'-seeking validation		6	12
a whole person, not just a black person		3	7
absence of compassionate leadership		1	1
addressing racism for wrong reason or own gain		1	2
advocacy for Black community		2	3
advocating for disempowered peers		1	2
all talk, no change		3	6
Angry Black woman		9	21
anti-black racism from racialized peers		1	1
Anxious about peer's perception of BCP		1	1
avoiding discussing racism through diversion		2	3
application of racist stereotypes		4	5
application of racist stereotypes in formulation		1	1
Assumption that racialized people are a monolith		1	1
Attempts to quash resistance (research)		1	1
augmenting blackness		3	3
authenticity as resistance		2	2
avoidance of discussion spaces		1	1
Avoidance of virtue signalling- anti-racist performance		2	2
avoiding racism as a limiter on opportunity and career progression		2	2

Name	Description	Files	References
BCP and WCP diff positioning and impact on providing space to talk race		1	2
BCP anx around discussions		1	2
BCP attempts to avoid discussion (I know what's coming)		1	1
BCP compromising values and perpetuating whiteness for survival or progression		1	1
BCP distress discussing racism		1	1
BCP facilitating exploration of biases		1	1
BCP identity only significant because of racist context		1	2
BCP identity- two halves that overlap		2	3
BCP moving from denial to acceptance of racism		1	1
BCP not afforded compassion or psych consideration		2	2
BCP not credited for their work		1	1
BCP power and status-experience		7	13
BCP progress as a threat to whiteness		3	5
BCP refusal to accept responsibility for education		2	3
BCP rejecting responsibility for change		1	1
BCP wielding relative power to challenge racism		3	4
becoming thick skinned		2	4

Silence

- White silence (f 5 | r 3)
- White choice: public silence & private support (f 2 | r 8)
- silence: guilt and shame (f 1 | r 1)
- silence: fear of being called racist (f 1 | r 1)
- silence as avoidance (f 1 | r 1)
- accepting white silence (f 2 | r 4)

Focus on challenge

- Deflecting from racism to focus on response (f 2 | r 4)
- moderation of self for possibility (f 6 | r 9)
- acceptability as a pre-requirement for being heard (f 2 | r 2)
- withholding in discussion: self-preservation (f 2 | r 2)
- BCP compromising values and perpetuating whiteness for survival or progression (f 1 | r 1)
- Angry Black woman (f 1 | r 1)
- Expectation that BCP will compromise values or self for possibility (f 2 | r 2)
- my difference on their terms (f 1 | r 1)
- visible vs invisible topics (f 1 | r 1)
- Consciously countering stereotypes (f 4 | r 5)

rep all Black people

Centering W/R people

- White people acting out of fragility (f 4 | r 6)
- white shock: outrage (f 1 | r 1)
- White people centering themselves (f 2 | r 3)
- centering white fragility (f 2 | r 2)
- The absence of an intersectional approach with a woman and therefore oppression not an oppressor (f 1 | r 2)
- prioritizing White men over Black oppression (f 2 | r 3)
- the weaponization of white feelings (f 1 | r 1)
- Realizing you are racism threat to identity (f 2 | r 3)
- good White person: seeking validation (f 6 | r 12)
- Compassion in discussion: for white peers (f 2 | r 3)
- negotiating/navigating/avoiding White fragility (f 4 | r 13)
- Caring White comfort (f 4 | r 12)
- expected to sacrifice self to protect W/P (f 1 | r 1)
- change: confronting white anxiety (f 2 | r 2)
- heroic performance (f 4 | r 7)
- the norms of reaction in the absence of reflection (f 1 | r 1)
- change: spaces to think and discuss rather than rush to action (f 1 | r 1)

Avoidance/Denial

- The White center in discussion (f 1 | r 1)
- speaking around, not about racism (f 1 | r 1)
- talking about talking (f 1 | r 1)
- Racism as the elephant in the room (f 1 | r 2)
- avoiding discussing racism through diversion (f 2 | r 3)
- repression Olympics (f 2 | r 2)
- using other minority identities to minimize racism (f 4 | r 7)
- The racism out there: lack of reflection in terms of play (f 2 | r 3)
- framing talking about racism as harmful (f 1 | r 1)
- responsibility for racism located in dedicated team (f 1 | r 1)
- differential responses to discrimination: racism at the bottom of the list (f 1 | r 1)
- service pressures: deprioritizing discussing racism (f 1 | r 1)
- Racism is not really a priority: time to move on (f 3 | r 5)
- teams not talking about race: race not on the agenda (f 1 | r 2)
- speaking about race is racist (f 1 | r 1)
- weaponizing empathy to center Blackness (and ignore whiteness) (f 1 | r 1)
- neutralization of any through denial of racism (f 5 | r 7)
- the opposite to the antidote: seeking safety (f 5 | r 6)
- white denial of racism: aggression (f 2 | r 2)
- perceived: what always talking about whiteness (f 2 | r 2)
- repression of harm (f 1 | r 1)
- whiteness: having a victim mentality (f 1 | r 1)

Resistance: How do we stay?

- The choice to remain and resist (f 1 | r 2)
- Safety: shared experiences of racialisation: staff (f 8 | r 10)
- racialised peers: support with how to respond or resist (f 2 | r 3)
- understood by racialised peers: don't have to explain to be understood (f 2 | r 3)
- shared experience: racialised leaders: different response (f 2 | r 2)
- validation from family and friends (not psychological problem) (f 1 | r 1)
- validation in discussion w/racialised peers (f 9 | r 18)
- validation of experience through hearing other BCP's stories (f 1 | r 1)
- validation in discussion: W/R peers (f 2 | r 2)
- compassion in discussion with racialised peers (f 1 | r 1)
- unfettered in discussion with racialised peers (f 1 | r 1)
- presence as resistance (f 3 | r 3)
- the importance of understanding professional context in unspiking racism at work (f 1 | r 1)
- isolated with the pain (no black peers) (f 1 | r 1)
- maintaining integrity and values within being a BCP (f 2 | r 2)
- truth as a guiding principle: disruption (f 2 | r 2)
- truth as a mechanism of survival: making safety (f 2 | r 2)
- play as resistance (f 3 | r 4)
- differential responses from white and racialised services (f 1 | r 1)
- Black pride (f 1 | r 1)
- blackness as strength (f 1 | r 1)
- humour as a coping mechanism (f 1 | r 1)
- whiteness as resistance (f 2 | r 2)

Resilience: How do we stay 2?

- strategizing for survival (f 5 | r 11)
- choosing my tribe (f 2 | r 4)
- BCP rejecting responsibility for change (f 1 | r 1)

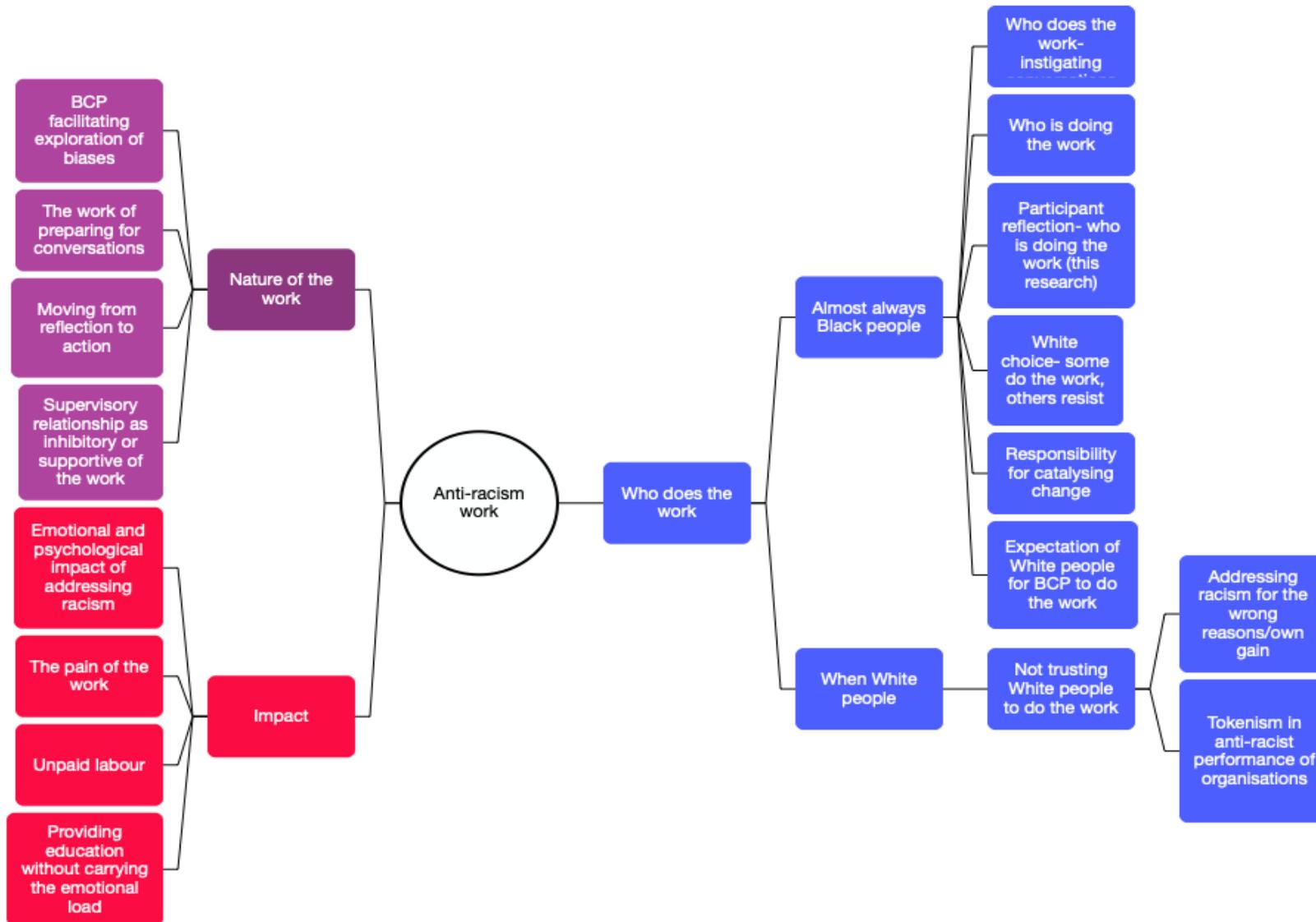
When it gets too much, we don't

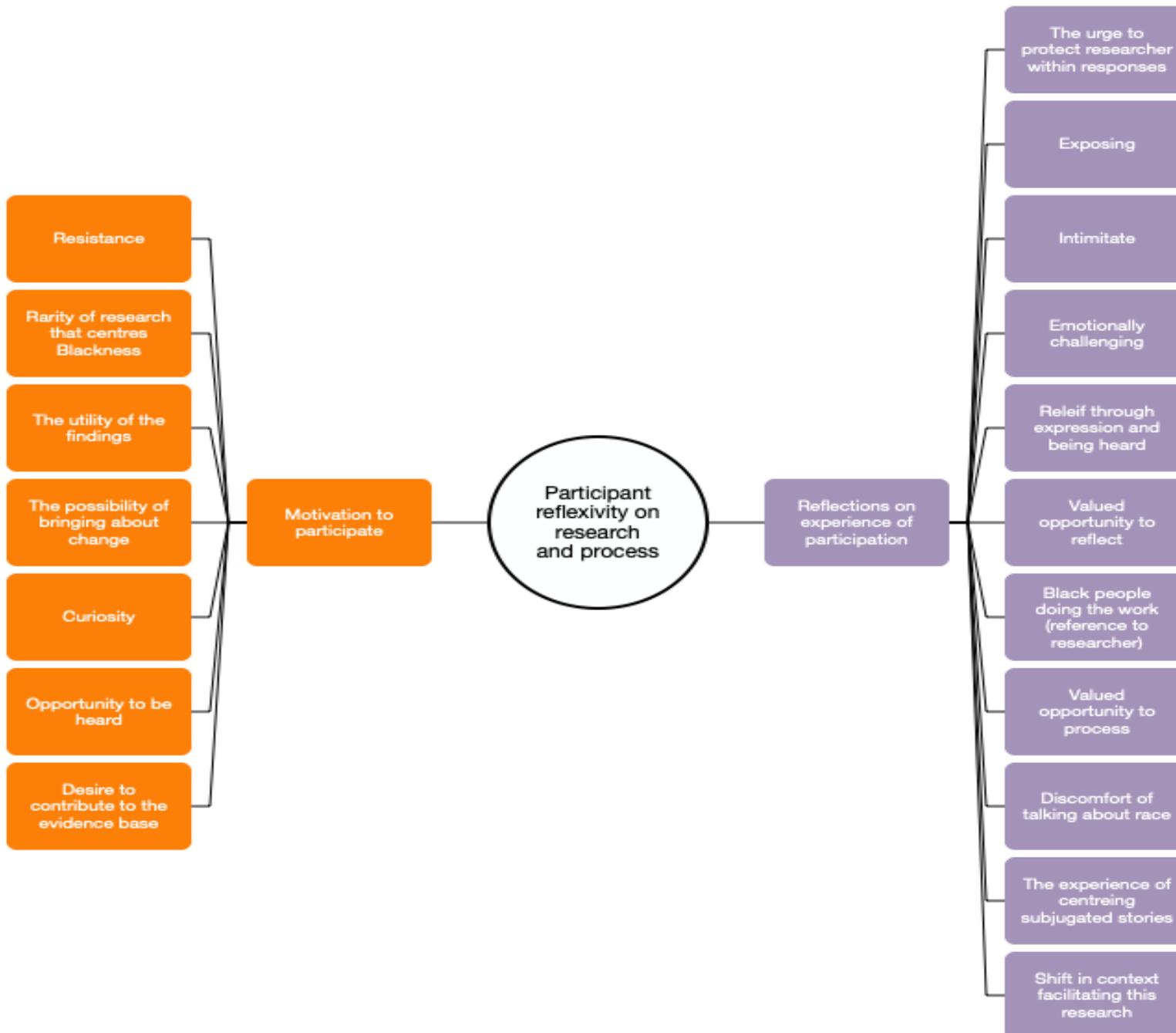
Racism as a spirit return KSW.

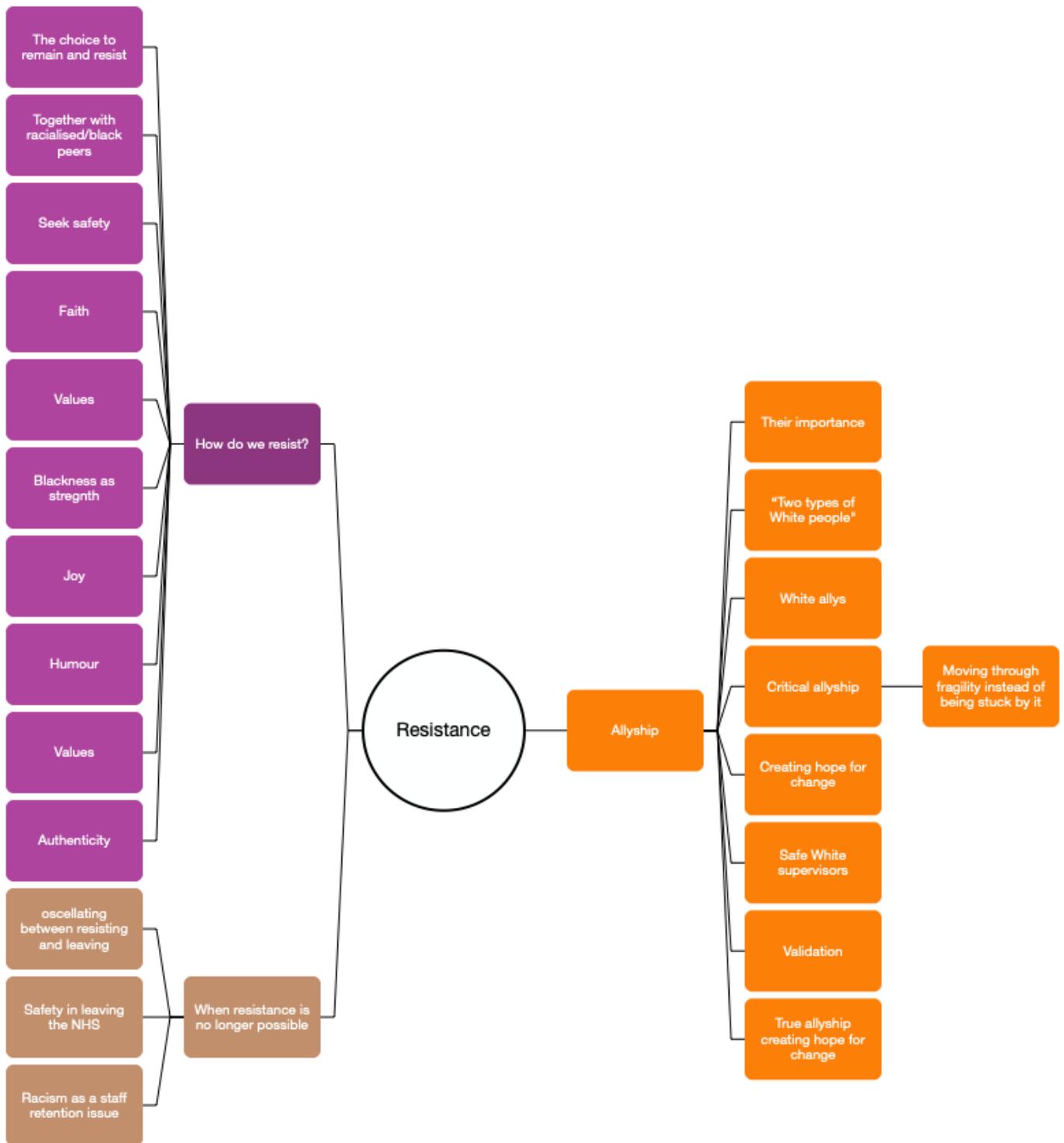
Appendix M: Visual Maps of Salient Themes



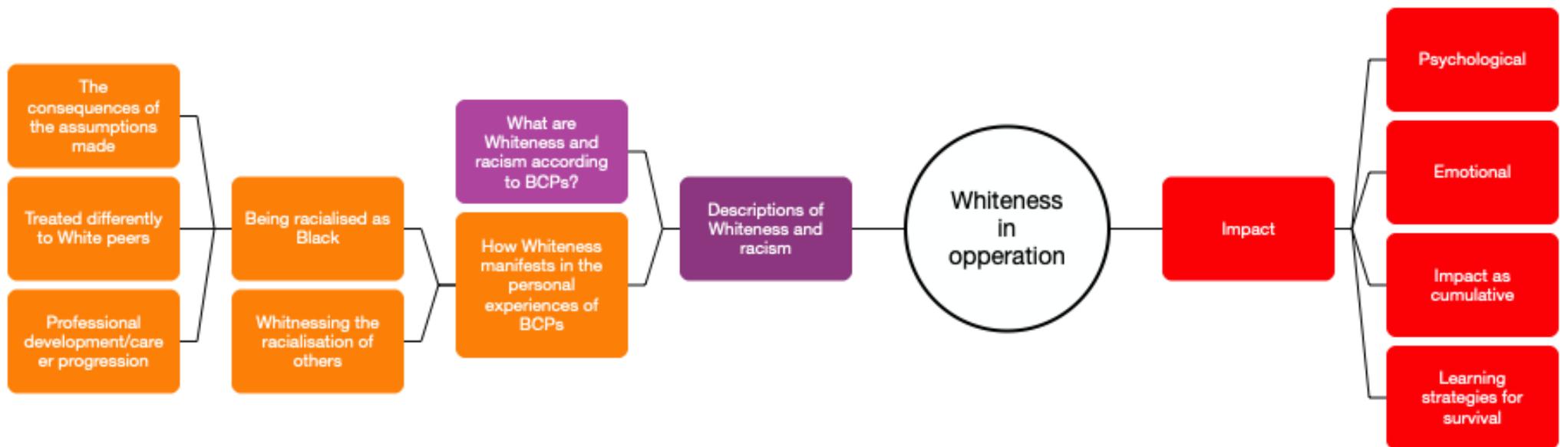














UNIVERSITY OF EAST LONDON

School of Psychology

**APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)**

**FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL
PSYCHOLOGY**

Section 1 – Guidance on Completing the Application Form

(Please read carefully)

1.1	Before completing this application, please familiarise yourself with: <ul style="list-style-type: none">▪ British Psychological Society's Code of Ethics and Conduct▪ UEL's Code of Practice for Research Ethics▪ UEL's Research Data Management Policy▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: <ul style="list-style-type: none">▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance.

	<ul style="list-style-type: none"> ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	<p>If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service</p>
1.7	<p>Checklist, the following attachments should be included if appropriate:</p> <ul style="list-style-type: none"> ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	Your name:	Reay Cashel Stoddart Isaac
2.2	Your supervisor's name:	Nimisha Patel
2.3	Name(s) of additional UEL supervisors:	Matthew Boardman 3rd supervisor (if applicable)
2.4	Title of your programme:	Professional Doctorate in Clinical Psychology

2.5	UEL assignment submission date:	22/05/2023
		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	<p>Study title: <u>Please note</u> - If your study requires registration, the title inserted here must be <u>the same</u> as that on PhD Manager</p>	<p>Exploring Black Clinical Psychologists’ Experiences of Racism and its Discussion at Work and in the Profession.</p>
3.2	<p>Summary of study background and aims (using lay language):</p>	<p>Recent events including the murder of George Floyd, ethnic disparities in outcomes related to COVID-19, the Commission on Race and Ethnic Disparities report which denied the role of systemic racism in these dipartites, and the live re-enactment of a slave auction at the Group of Trainers in Clinical Psychology conference under the guise of evening entertainment, have placed racism firmly on the agenda societally and professionally. NHS statements expressing a commitment to equality, and the British Psychological Society declaring itself “committed to tackling racism within our profession” have further prompted discission around racism within the profession and NHS; systems that many clinical psychologists operate in.</p> <p>The experiences of Black clinical psychologists have been neglected in the literature. This research aims to augment the limited literature available by situating itself within the current context and explicitly exploring Black clinical psychologists’ experiences of racism and its discussion at work and in the profession; a pertinent topic given the current context.</p> <p>This study seeks to address the epistemic injustice in the literature by focusing on the experiences that have been neglected – those of Black qualified clinical psychologists. Moreover, it aims to augment the limited literature available by situating itself within the current context and explicitly exploring</p>

		Black clinical psychologists' experiences of racism and discussion of the topic at work and in the profession; an area yet to be adequately explored in academic research.
3.3	Research question(s):	<p>How do Black clinical psychologists describe and make sense of their experiences of racism and its discussion at work and in the profession?</p> <p>Sub-questions:</p> <ul style="list-style-type: none"> • What are Black clinical psychologists' experiences of racism and its discussion in their teams, clinical work and in the wider profession? • How do they make sense of these experiences? How do they feel that they are positioned and perceived at work when discussing racism? • How do they position themselves in and navigate conversations about racism at work? • What changes do they feel could foster a sense of safety and support for these experiences, at work?
3.4	Research design:	The study is qualitative in nature and will comprise of semi-structured individual interviews with 8-12 participants. To accommodate the pandemic and unpredictable nature of future COVID-19 restrictions, all data collection will be carried out remotely. Interviews will be conducted and recorded using Microsoft teams.
3.5	Participants: Include all relevant information including inclusion and exclusion criteria	Participants will be qualified clinical psychologists who identify with being of Black ethnicity or heritage. Those whose practice solely outside of the UK will be excluded from participating.
3.6	Recruitment strategy: Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited using opportunity sampling. The recruitment poster (appendix A) will be shared on social media platforms through the researcher's and Minority Group accounts. Those who are interested in participating will be able to contact the researcher using the details on the poster, at which point queries can be answered, eligibility checked, information, consent and

		demographics forms shared, and an interview time and date arranged.	
3.7	Measures, materials or equipment: Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Psychometric measures will not be used for this research. However, the following resources have been acquired and will be used in the process of conducting the research: <ul style="list-style-type: none"> • Microsoft teams to conduct, record and transcribe interviews • NVivo for data analysis • Microsoft word to save and password protect transcripts • UEL OneDrive to securely save interview recordings and password protected transcripts, consent forms and demographic questionnaires 	
3.8	Data collection: Provide information on how data will be collected from the point of consent to debrief	Each participant will be provided with an information sheet (appendix B) which will outline the purpose and nature of the research; there will be no use of deception. After reading the information sheet, participants will be provided with a consent form to facilitate the provision of informed consent (appendix C). Demographic data will be collected using a questionnaire (appendix D). Semi-structured interviews lasting approximately an hour will be used to gather rich qualitative data. See appendix E for the interview guide. Data will be managed in line with the data management plan (appendix G).	
3.9	Will you be engaging in deception?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, what will participants be told about the nature of the research, and	If you selected yes, please provide more information here	

	how/when will you inform them about its real nature?		
3.10	Will participants be reimbursed?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? <u>Please note</u> - This must be in the form of vouchers, <u>not cash</u> .	Please state the value of vouchers	
3.11	Data analysis:	An inductive approach to reflexive thematic analysis will be employed; embracing the interpretive role of the researcher in theme development, while ensuring the analysis is data-driven rather than based on the preconceptions of the researcher. NVivo software will be used to carry out the analysis.	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

Please see appendix F for the approved data management plan.

4.1	Will the participants be anonymised at source?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	Are participants' responses anonymised or are an anonymised sample?	YES √	NO <input type="checkbox"/>
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	Transcripts will be anonymised and pseudonyms will be used in the write-up to protect participants identities. Participants' age and ethnic background will not be presented together in the write up in order to protect participant anonymity by reducing the likelihood of identification.	
4.3	How will you ensure participant details will be kept confidential?	Only pseudonymised quotes from transcripts and basic demographic information as appropriate (e.g.,	

		<p>ethnic background, age and years since qualification) will be presented in the thesis, resulting papers and presentations. In order to ensure participant confidentiality, other data will not be shared with anyone outside of the research team. None of the data underpinning the research e.g., pseudonymised transcripts be shared publicly or deposited in UEL's Research Repository due to the sensitive nature of the data and the risk of participants being identified.</p>
4.4	<p>How will data be securely stored and backed up during the research? Please include details of how you will manage access, sharing and security</p>	<p>Video recordings and transcripts will automatically be stored on Microsoft stream. Once the transcripts are reviewed and identifiable information removed, they will be saved in a password protected word document on the researcher's OneDrive along with the video files.</p> <p>Video files, consent forms, demographic questionnaires and transcripts will be stored on the researcher's secure UEL One Drive where there is a built in backup system. This will also be the case for the password protected key document which will be stored in its own folder separately from the pseudonymised data.</p> <p>The NVivo file will be stored on the researcher's OneDrive. The file will be downloaded to an encrypted, password protected, private laptop so that it can be opened within the software for the purpose of data analysis. The file will then be reuploaded to OneDrive and the local copy deleted when it isn't in active use; there will not be any local copies of the file outside of the time when it is being accessed or edited.</p> <p>Automatic synchronising to personal Cloud storage will be disabled for the duration of the thesis so that any local copies are not automatically saved there. Any copies of data or documentation that are downloaded for the purpose of uploading to OneDrive for Business, will be deleted from the downloads folder on my laptop as soon as they are uploaded to OneDrive.</p>

		There will be no use of hard copy documentation.	
4.5	Who will have access to the data and in what form? (e.g., raw data, anonymised data)	Only the researcher, Dos and examiners will have access to the pseudonymised transcripts. These transcripts will be shared with the DoS using secure links via UEL OneDrive for Business. Only the researcher will have access to the raw data.	
4.6	Which data are of long-term value and will be retained? (e.g., anonymised interview transcripts, anonymised databases)	The pseudonymised transcripts may be of long-term value.	
4.7	What is the long-term retention plan for this data?	The pseudonymised transcripts will be stored securely by the Director of Studies on their UEL OneDrive following the completion of the thesis. The researcher will also keep a copy of the pseudonymised transcripts in a password protected folder on an encrypted private laptop.	
4.8	Will anonymised data be made available for use in future research by other researchers?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, have participants been informed of this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4.9	Will personal contact details be retained to contact participants in the future for other research studies?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If yes, have participants been informed of this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

Please see appendix G for the completed risk assessment.

5.1	Are there any potential physical or psychological risks to participants related to taking part?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
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	(e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)		
	If yes, what are these, and how will they be minimised?	<p>Risk: Discussing experiences of racism in the workplace may upset participants.</p> <p>Management: Participants will be informed by the information sheet and reminded at the beginning of the interview that they can decline to answer questions and stop the interview at any time. If any participants show signs of distress, the researcher will ask the participant if they wish to pause for a break or end the interview. If the participant chooses to end the interview, the researcher will end the interview and proceed to the debrief. After the interview, participants will be provided with a debrief sheet (appendix H) containing details of organisations that can be contacted should they wish to seek further support.</p>	
5.2	Are there any potential physical or psychological risks to you as a researcher?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
	If yes, what are these, and how will they be minimised?	<p>Risk: Hearing about experiences of racism may upset the researcher.</p> <p>Management: The researcher will keep a reflective journal to document these experiences and discuss in supervision regularly. The researcher will also seek additional support from the Director of Studies and/or personal tutor, if necessary.</p>	
5.3	If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have	YES <input checked="" type="checkbox"/>	

	attached a GRA form as an appendix:			
5.4	If necessary, have appropriate support services been identified in material provided to participants?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
5.5	Does the research take place outside the UEL campus?	YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>
	If yes, where?	All interviews will be carried out remotely using Microsoft Teams.		
5.6	Does the research take place outside the UK?	YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. <u>Please note</u> - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	YES <input type="checkbox"/>		
5.7	Additional guidance: <ul style="list-style-type: none"> ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, 			

	<p>it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor).</p> <ul style="list-style-type: none"> Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.
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Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	<p>Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?</p> <p>If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project</p>	<p>YES</p> <input type="checkbox"/>	<p>NO</p> <input checked="" type="checkbox"/>
<p>* You are required to have DBS or equivalent clearance if your participant group involves:</p> <p>(1) Children and young people who are 16 years of age or under, or</p> <p>(2) ‘Vulnerable’ people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.</p>			
6.2	<p>Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?</p>	<p>YES</p> <input checked="" type="checkbox"/>	<p>NO</p> <input type="checkbox"/>
6.3	<p>Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?</p>	<p>YES</p> <input checked="" type="checkbox"/>	<p>NO</p> <input type="checkbox"/>
6.4	<p>If you have current DBS clearance, please provide your DBS certificate number:</p>	<p>001702973451</p>	
	<p>If residing outside of the UK, please detail the type of clearance and/or provide certificate number.</p>	<p>Please provide details of the type of clearance, including any identification information such as a certificate number</p>	

6.5	<p>Additional guidance:</p> <ul style="list-style-type: none"> ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.
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Section 7 – Other Permissions

7.1	<p>Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?</p>	<p>YES</p> <input type="checkbox"/>	<p>NO</p> <input checked="" type="checkbox"/>
	<p>If yes, please provide their details.</p>	<p>Please provide details of organisation</p>	
	<p>If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.</p>	<p>YES</p> <input type="checkbox"/>	
7.2	<p>Additional guidance:</p> <ul style="list-style-type: none"> ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation’ or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s. 		

Section 8 – Declarations

8.1	<p>Declaration by student. I confirm that I have discussed the ethics</p>	<p>YES</p> <input checked="" type="checkbox"/>
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	and feasibility of this research proposal with my supervisor:	
8.2	Student's name: (Typed name acts as a signature)	Reay Cashel Stoddart Isaac
8.3	Student's number:	U2075230
8.4	Date:	17/12/2021
<i>Supervisor's declaration of support is given upon their electronic submission of the application</i>		

Student checklist for appendices – *for student use only*

Documents attached to ethics application	YES	N/A
Study advertisement	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Participant Information Sheet (PIS)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Consent Form	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Participant Debrief Sheet	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Risk Assessment Form	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Country-Specific Risk Assessment Form	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Permission(s) from an external organisation(s)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pre-existing questionnaires that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Researcher developed questionnaires/questions that will be administered	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pre-existing tests that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Researcher developed tests that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Interview guide for qualitative studies	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Any other visual material(s) that will be administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
All suggested text in RED has been removed from the appendices	<input checked="" type="checkbox"/>	<input type="checkbox"/>
All guidance boxes have been removed from the appendices	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Exploring Black Clinical Psychologists'
Experiences of Racism and its Discussion at
work and in the Profession

Are you a Black Clinical Psychologist?

Have you experienced racism and/or its
discussion at work or in the profession?

If **yes**, you may be interested in this research

What is this research about?

This research aims to help understand how Black Clinical Psychologists make sense of their experiences of racism and how they are positioned and perceived in discussions about racism, at work.

What will happen?

You will be invited to have a conversation with me about your experiences, via video call. Everything that you share will be kept confidential and will not be traceable to you. You will not be asked to share anything that you are not comfortable with and may stop participating without explanation.

Who is it for?

You may take part if:

- You are a **qualified Clinical Psychologist**
- You identify with being of **'Black' ethnicity or heritage**
- You practice as a Clinical Psychologist in the **UK**

If you would like to take part, or want more information, please contact:

Reay Stoddart Isaac (Trainee Clinical Psychologist)

Email: U2075230@uel.ac.uk

Twitter: [@Reay_CSI](https://twitter.com/Reay_CSI)



**University of
East London**





PARTICIPANT INFORMATION SHEET

Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Contact person: Reay Stoddart Isaac

Email: U2075230@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Reay. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into Black clinical psychologists' experiences of racism and its discussion at work and in the profession.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have I been invited to take part?

To address the study aims, I am inviting clinical psychologists who identify with being of Black ethnicity of heritage to take part in my research. If you practice in the UK, you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to attend a one-to-one, online conversation of approximately one hour, using Microsoft Teams. Although it will be recorded, it will be like an informal chat, where we will talk about your experiences of racism and discussing racism at work.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

It is not anticipated that you will be adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, discussing racism can be upsetting and it is possible that your participation – or its after-effects – may feel challenging, distressing or uncomfortable in some way. Please see the below information for supporting agencies.

Samaritans

Free helpline that is available 24 hours a day, 365 days a year, for anyone experiencing distress.

Tel - 116 123

Email - jo@samaritans.org

Or download their self-help app

Website: <https://www.samaritans.org/how-we-can-help/if-youre-having-difficult-time/>

Mind

Charity that provides advice to anyone experiencing distress or mental health difficulties.

Website: <https://www.mind.org.uk>

Infoline providing information and signposting between 9am and 6pm, Monday to Friday:

- Tel- 03001233393
- Email- info@mind.org.uk

GP

It may also be helpful to speak to your GP if you are experiencing difficult emotions following the interview.

How will the information I provide be kept secure and confidential?

All of the information that you provide will be treated respectfully and confidentially.

- You will not be identified in any write-up of the research. This will be achieved by removing identifiable details, using pseudonyms and not presenting your age and ethnic background together.
- Identifiable information will be stored separately to your pseudonymised transcript.
- All of the information that you provide will be stored securely on the researcher's UEL's OneDrive for Business.
- Your personal contact details will also be stored securely and deleted when the thesis is passed.
- Only the researcher will have access to your identifiable data.
- Examiners and the Director of Studies (Professor Nimisha Patel) will have access to pseudonymised transcripts and these will be shared securely using UEL's secure OneDrive for Business.
- Following the completion of the thesis, pseudonymised transcripts will be stored for a maximum of three years for dissemination purposes.

Confidentiality will only ever be broken in the event that a disclosure is made that leads the researcher to believe that you or anyone else is at risk of harm.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference

presentations, talks and blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally and personally identifying information will be removed and your name will be replaced by a pseudonym.

Anonymised research data will be securely stored by the researcher and Professor Nimisha Patel for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Reay Stoddart Isaac
Email: U2075230@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor Nimisha Patel. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: N.Patel@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix C- Consent form



CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Contact person: Reay Stoddart Isaac

Email: U2075230@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have three weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams.	
I understand that my personal information and data, including video recordings and transcripts from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date

.....

Appendix D- Demographics questionnaire

Gender

How would you describe your gender?

Ethnicity/cultural background

How would you describe your ethnicity and cultural background? (e.g., Black British, Caribbean descent/ Dual heritage, African and Irish descent)

Age: _____

Years post-qualification: _____

Area of practice

How would you describe your area of practice? (e.g., adult mental health, CAMHS, older adult, learning disability, forensics)

Appendix E- Draft Interview guide

Motivation to participate

- What was it about this study “Exploring Black clinical psychologists’ experiences of racism and its discussion at work and in the profession” that interested you and made you want to participate?

Identity

- In clinical psychology, we often talk about identity. What does it mean to you to be Black?
- What does it mean to be a Black clinical psychologist?

Experiences of racism

- Please could you describe instances of racism that you have experienced in your role as a clinical psychologist
 - Follow-up questions:
 - How did you make sense of that experience?
 - What meaning did you make from that interaction?
 - What was the impact on you?
 - Were you offered any support? From who?
 - Did you feel able to raise the experience with senior colleagues?
 - How did you manage/cope?
 - What do you think needs to change to prevent the racism that you experienced?

Discussing racism

- Please could you describe your experience of discussing racism in your team/trust/clinical work/ the profession
 - Follow-up questions:
 - Who initiated the discussion? Why?
 - Who was present?
 - How was the discussion framed?

- How did you experience the conversation?
- What meaning did you make from that interaction?
- How did you make sense of that experience?
- How did you feel that you were positioned or perceived?
- How did you position yourself within the conversation?
- How did you navigate that conversation?
- How did that discussion affect you or leave you feeling?
- What impact did the discussion have on your perception of/feelings about your team/trust/client/the profession?
- What do you think needs to change about these discussions to facilitate a more positive experience?

Ending the interview

- Is there anything we haven't touched upon in relation to your experiences of racism and its discussion within your role that you would like to talk about?
- What has the experience of being interviewed for this research been like for you?

General Prompts:

- Could you tell me more about that?
- Is there anything else you would like to add?
- How did that affect you?
- How did that feel?



UEL Data Management Plan: Full

For review and feedback please send to: researchdata@uel.ac.uk

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Reay Cashel Stoddart Isaac
PI/Researcher ID (e.g., ORCID)	ORCID: 0000-0001-7309-4536 UEL student number: U2075230
PI/Researcher email	U2075230@uel.ac.uk
Research Title	Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession
Project ID	N/A
Research Duration	February 2022-May 2023

<p>Research Description</p>	<p>Recent events including the murder of George Floyd, ethnic disparities in outcomes related to COVID-19, the Commission on Race and Ethnic Disparities report which denied the role of systemic racism in these dipartites, and the live re-enactment of a slave auction at the Group of Trainers in Clinical Psychology conference under the guise of evening entertainment, have placed racism firmly on the agenda societally and professionally. NHS statements expressing a commitment to equality, and the British Psychological Society declaring itself “committed to tackling racism within our profession” have further prompted discission around racism within the profession and NHS; systems that many clinical psychologists operate in.</p> <p>The experiences of Black clinical psychologists have been neglected in the literature. This research aims to augment the limited literature available by situating itself within the current context and explicitly exploring Black clinical psychologists’ experiences of racism and its discussion at work and in the profession; a pertinent topic given the current context.</p> <p>The experiences will be explored within this study by carrying out 6-12 individual semi-structured interviews with clinical psychologists who identify with being of Black ethnicity or heritage.</p>
<p>Funder</p>	<p>N/A- part of the Professional Doctorate in Clinical Psychology</p>

Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	02/12/2021
Date of last update (of DMP)	
Related Policies	UEL's Research Data Management Policy UEL's Data Backup Policy
Does this research follow on from previous research? If so, provide details	No. This is a stand-alone piece of research.
Data Collection	
What data will you collect or create?	<p>Consent forms will collect identifying participant data (names and signatures) but no sensitive data, in word document format.</p> <p>Demographic questionnaires will collect sensitive identifying participant data including ethnicity, years post-qualification, gender and age in word document format.</p> <p>Video files and transcripts will be generated from the interviews; these will be generated using Microsoft Teams in .mp4 and word document format.</p> <p>Each participant will be assigned a participant number and all identifiable information will be pseudonymised in the transcripts. A password protected key document will be created that can be used by the researcher pair pseudonymised transcripts with identifiable information should</p>

	<p>any participants wish to withdraw from the research. This document will be saved in its own folder, separate from participant data.</p> <p>The NVivo file generated from data coding will be saved in .npvx format. The data will be housed within one 'project' in NVivo so only one file will be generated.</p>
<p>How will the data be collected or created?</p>	<p>Personal data will be collected on consent forms (name and signature) and participant demographic forms (age, gender, years' post-qualification and ethnicity) prior to the interview. These will be completed by participants prior to the interview and returned to the researcher by email.</p> <p>Interviews will be conducted, recorded and auto-transcribed using Microsoft Teams. The auto-transcripts will be reviewed and edited by the researcher upon completion of the interview.</p> <p>Each participant will be assigned a participant number and all identifiable information will be anonymised in the transcripts.</p> <p>In OneDrive a folder titled 'Thesis' will be created, in which all data will be stored. Within this folder, a sub-folder will be created for each participant which will be named with their participant number. All data from each participant will be saved in the respective folder.</p>

	Files will be named in the following format: DocumentDescription_ParticipantNo_Date (e.g., ConsentForm_1_2021-12-03)
Documentation and Metadata	
What documentation and metadata will accompany the data?	<p>The following documentation will accompany the data:</p> <ul style="list-style-type: none"> • Participant information sheets (confidential) • Consent forms (confidential) • Demographics questionnaires (confidential) • Interview schedule • Debrief sheets <p>The participant contact information will be kept confidential and the pseudonymised transcripts will be the data.</p>
Ethics and Intellectual Property	
How will you manage any ethical issues?	<p>Informed Consent</p> <p>Each participant will be provided with an information sheet which will outline the purpose and nature of the research; there will be no use of deception. The information sheet will also inform participants of the way in which their data will be processed and their right to withdraw their data from the research up to three weeks after the conclusion of the interview. Following reading the information sheet participants will be provided with a consent form, facilitating the provision of informed consent.</p>

Right to Withdraw

Participants will be informed of their right to withdraw from the research without disadvantage and justification on the recruitment poster, information sheet and consent form. Each participant will also be reminded of this at the beginning of their interview. Upon the conclusion of the interview, participants will have a three week period within which they can request that their data not be included in the analysis.

Confidentiality and Anonymity

All of the data collected will be stored securely on the UEL secure OneDrive. Transcripts will be anonymised and pseudonyms will be used in the write-up to protect participants identities.

Participants' age and ethnic background will not be presented together in the write up in order to protect participant anonymity by reducing the likelihood of identification.

Participant and Researcher Wellbeing

Participants will be informed by the information sheet and reminded at the beginning of the interview that they can decline to answer questions and stop or pause the interview at any time. If any participants show signs of distress, the researcher will end the interview and proceed to the debrief. After the interview, participants will be provided with a debrief sheet containing details of organisations that can be contacted should participants wish to seek further support.

	<p>Hearing about experiences of racism may upset the researcher. The researcher will keep a reflective journal to document these experiences should they arise and seek support in supervision.</p> <p>Ethical Approval Ethical approval will be sought from the UEL School of Psychology department.</p> <p>Supervision The research will be supervised by the allocated Director of Studies (DoS) and Second Supervisor (SS). These individuals are members of the UEL Professional Doctorate in Clinical Psychology programme and experienced in conducting and supervising research of this nature.</p>
<p>How will you manage copyright and Intellectual Property Rights issues?</p>	<p>There are no copyright or intellectual property rights issues.</p>
<p>Storage and Backup</p>	
<p>How will the data be stored and backed up during the research?</p>	<p>Video recordings and transcripts will automatically be stored on Microsoft stream. Once the transcripts are reviewed and identifiable information removed, they will be saved in a password protected word document on the researcher's OneDrive along with the video files.</p>

	<p>Video files, consent forms, demographic questionnaires and transcripts will be stored on the researcher's secure UEL One Drive where there is a built in backup system. This will also be the case for the password protected key document which will be stored in its own folder separately from the pseudonymised data.</p> <p>The NVivo file will be stored on the researcher's OneDrive. The file will be downloaded to an encrypted, password protected, private laptop so that it can be opened within the software for the purpose of data analysis. The file will then be reuploaded to OneDrive and the local copy deleted when it isn't in active use; there will not be any local copies of the file outside of the time when it is being accessed or edited.</p> <p>Automatic synchronising to personal Cloud storage will be disabled for the duration of the thesis so that any local copies are not automatically saved there. Any copies of data or documentation that are downloaded for the purpose of uploading to OneDrive for Business, will be deleted from the downloads folder on my laptop as soon as they are uploaded to OneDrive.</p> <p>There will be no use of hard copy documentation.</p>
<p>How will you manage access and security?</p>	<p>Only the researcher, Dos and examiners will have access to the pseudonymised transcripts.</p>

	<p>These transcripts will be shared with the DoS using secure links via UEL OneDrive for Business.</p> <p>An encrypted and password protected personal laptop with built in anti-virus software will be used to access UEL storage and Teams.</p>
Data Sharing	
How will you share the data?	<p>Only pseudonymised quotes from transcripts and basic demographic information (e.g. ethnic background, age and years since qualification) will be presented in the thesis, resulting papers and presentations. In order to ensure participant confidentiality, other data will not be shared with anyone outside of the research team.</p> <p>None of the data underpinning the research e.g. pseudonymised transcripts be shared publicly or deposited in UEL's Research Repository due to the sensitive nature of the data and the risk of participants being identified..</p>
Are any restrictions on data sharing required?	Data will not be shared and so sharing need not be restricted.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	All of the data that is saved on the researcher's OneDrive will be deleted once the thesis has been successfully completed and examined.

	<p>The pseudonymised transcripts may be of long-term value. These will be stored securely by the Director of Studies on their UEL OneDrive following the completion of the thesis. The researcher will also keep a copy of the pseudonymised transcripts in a password protected folder on an encrypted private laptop.</p>
<p>What is the long-term preservation plan for the data?</p>	<p>The pseudonymised quotes arising from the data will be presented in the completed thesis which will be disseminated via the UEL Research Repository.</p> <p>The pseudonymised transcripts may be stored on the Director of Studies' secure UEL server for up to three years for dissemination purposes.</p>
<p>Responsibilities and Resources</p>	
<p>Who will be responsible for data management?</p>	<p>Reay Stoddart Isaac Professor Nimisha Patel</p>
<p>What resources will you require to deliver your plan?</p>	<p>I will need access to the following:</p> <ul style="list-style-type: none"> • Microsoft teams to conduct, record and transcribe interviews • NVivo for data analysis • Microsoft word to save and password protect transcripts • UEL OneDrive to securely save interview recordings and password protected transcripts, consent forms and demographic questionnaires <p>These resources have already been acquired.</p>
<p>Review</p>	

Date 07/12/2021	Reviewer name Penny Jackson Research Data Management Officer
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Guidance

Brief information to help answer each section is below. Aim to be specific and concise. For assistance in writing your data management plan, or with research data management more generally, please contact: researchdata@uel.ac.uk

Administrative Data

Related Policies

List any other relevant funder, institutional, departmental or group policies on data management, data sharing and data security. Some of the information you give in the remainder of the DMP will be determined by the content of other policies. If so, point/link to them here.

Data collection

Describe the data aspects of your research, how you will capture/generate them, the file formats you are using and why. Mention your reasons for choosing particular data standards and approaches. Note the likely volume of data to be created.

Documentation and Metadata

What metadata will be created to describe the data? Consider what other documentation is needed to enable reuse. This may include information on the methodology used to collect the data, analytical and procedural information, definitions of variables, the format and file type of the data and software used to collect and/or process the data. How will this be captured and recorded?

Ethics and Intellectual Property

Detail any ethical and privacy issues, including the consent of participants. Explain the copyright/IPR and whether there are any data licensing issues – either for data you are reusing, or your data which you will make available to others.

Storage and Backup

Give a rough idea of data volume. Say where and on what media you will store data, and how they will be backed-up. Mention security measures to protect data which are sensitive or valuable. Who will have access to the data during the project and how will this be controlled?

Data Sharing

Note who would be interested in your data, and describe how you will make them available (with any restrictions). Detail any reasons not to share, as well as embargo periods or if you want time to exploit your data for publishing.

Selection and Preservation

Consider what data are worth selecting for long-term access and preservation. Say where you intend to deposit the data, such as in UEL's data repository (data.uel.ac.uk) or a subject repository. How long should data be retained

Appendix G- Risk Assessment

 UEL Risk Assessment Form			
Name of Assessor:	Reay Stoddart Isaac	Date of Assessment:	17/12/21
Activity title:	Interviews for professional doctorate in clinical psychology thesis research. Thesis titled : Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.	Location of activity:	Online- all interviews will be conducted remotely using Microsoft teams.
Signed off by Manager: (Print Name)	NIMISHA PATEL	Date and time: (if applicable)	17 DECEMBER 2021
<p>Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.). If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:</p>			
<p>The research aims to explore Black clinical psychologists' experiences of racism and its discussion work and in the profession. Semi-structured interviews, lasting approximately an hour, will be carried out with 8-12 clinical psychologists who identify with being of Black ethnicity or heritage and practice in the UK. The interviews will be conducted remotely and recorded using Microsoft Teams.</p>			
Overview of FIELD TRIP or EVENT:			
Each interview will be a discrete event with only the researcher and participant present.			

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating
Psychological distress in response to discussing racism.	Researcher	The researcher will keep a reflective journal to document these experiences and discuss in supervision regularly. The researcher will also seek additional support from the Director of Studies and/or personal tutor, if necessary.	1	1	1		1
Psychological distress in response to discussing racism.	Participants	Participants will be informed by the information sheet and reminded at the beginning of the interview that they can decline to answer questions and stop the interview at any time. If any participants show signs of distress, the researcher will ask the participant if they wish to pause for a break or end the interview. If the participant chooses to end the interview, the researcher will end the interview and proceed to the debrief. After the interview, participants will be provided with a debrief sheet containing details of organisations that can be contacted should they wish to seek further support.	2	1	2		2

Review Date



PARTICIPANT DEBRIEF SHEET

Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Thank you for participating in my research study on Black clinical psychologist's experiences of racism and its discussion at work and in the profession. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks and blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you as personally identifying information will either be removed or replaced. For example, a pseudonym will be used in reference to any quotes from your interview that are presented in the write-up and your ethnic background and age will not be presented together.

Anonymised research data will be securely stored by Professor Nimisha Patel for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Samaritans

Free helpline that is available 24 hours a day, 365 days a year, for anyone experiencing distress.

Tel - 116 123

Email - jo@samaritans.org

Or download their self-help app

Website: <https://www.samaritans.org/how-we-can-help/if-youre-having-difficult-time/>

Mind

Charity that provides advice to anyone experiencing distress or mental health difficulties.

Website: <https://www.mind.org.uk>

Infoline providing information and signposting between 9am and 6pm, Monday to Friday:

- Tel- 03001233393
- Email- info@mind.org.uk

Your GP

It may also be helpful to speak to your GP if you are experiencing difficult emotions following the interview.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Reay Stoddart Isaac
Email: U2075230@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor Nimisha Patel. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: N.Patel@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix O: Notice of Ethical Approval



School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	Volker Thoma
Supervisor:	Nimisha Patel
Student:	Reay Stoddart Isaac
Course:	Prof Doc in Clinical Psychology
Title of proposed study:	Exploring Black Clinical Psychologists' Experiences of Racism and its Discussion at Work and in the Profession.

Checklist (Optional)			
	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed account of participants, including inclusion and exclusion criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding participants/target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed account of recruitment strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding recruitment strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear and detailed outline of data collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Data collection appropriate for target sample	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data storage (e.g., location, type of data, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data sharing (e.g., who will have access and how)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, General Risk Assessment form attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, Country-Specific Risk Assessment form attached	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, a DBS or equivalent certificate number/information provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All relevant information included in the participant information sheet (PIS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information in the PIS is study specific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the PIS is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All issues specific to the study are covered in the consent form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the consent form is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All necessary information included in the participant debrief sheet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language used in the debrief sheet is appropriate for the target audience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Study advertisement included	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in

<p>BEFORE THE RESEARCH COMMENCES</p>	<p>the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records.</p> <p>Minor amendments guidance: typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.</p>
<p>NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED</p>	<p>In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.</p> <p>Major amendments guidance: typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.</p>

<p style="text-align: center;">Decision on the above-named proposed research study</p>	
<p>Please indicate the decision:</p>	<p style="text-align: center;">APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES</p>

<p style="text-align: center;">Minor amendments</p>
<p style="text-align: center;">Please clearly detail the amendments the student is required to make</p>
<p>Please remove any comments / changes tracked ! Please indicate the issue of data security with TEAMS recorded video and transcript – will these data be deleted? Will participants be informed about these?</p>

<p style="text-align: center;">Major amendments</p>
<p style="text-align: center;">Please clearly detail the amendments the student is required to make</p>

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Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	If no, please request resubmission with an <u>adequate risk assessment</u> .	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:

HIGH	Please do not approve a high-risk application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	<input type="checkbox"/>
MEDIUM	Approve but include appropriate recommendations in the below box.	<input type="checkbox"/>
LOW	Approve and if necessary, include any recommendations in the below box.	<input checked="" type="checkbox"/>
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	Volker Thoma
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Date:	22/02/2022
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This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Reay Cashel Stoddart Isaac
Student number:	U2075230
Date:	28/02/2022

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required