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**Abstract:**

In discussing 'Whiteness', a context is provided as to current issues facing British clinical psychology, with an overview of the history of clinical psychology in the United Kingdom (UK), with a particular focus on how issues of immigration, diversity and racism have been addressed. Following this, the constantly changing training context of clinical psychologists within Britain is explored, with lacunae evident around confronting institutional racism and Black trainee experiences. The history of addressing this issue within the University of East London's clinical psychology training programme is outlined, as well as the recent introduction of workshops to focus on 'Whiteness' and 'decolonising' the profession, in response to consistent trainee concerns. This is integrated with respect to focusing on the sorts of psychologists that might be needed to advance and transform the profession positively in the current global political climate.

**Keywords**: Clinical psychology, training, racism, Whiteness

# ON ADDRESSING 'WHITENESS' DURING CLINICAL PSYCHOLOGY TRAINING

**Nicholas Wood & Nimisha Patel**

## Introduction

In this article we will focus on what our goals are, as clinical psychology trainers in the UK context – and face the question as to what 'sort of psychologists' do we want to train, in our current, turbulent socio-political context. Thus, in the UK, pressing issues include neo-liberal policies of 'austerity' and increasingly stark inequalities and poverty (McGrath, Walker & Jones, 2016), and a politically unstable context, where a divisive BREXIT vote is to be enacted. This 2016 referendum result was followed with a dramatic resurgence of xenophobia, overt racial abuse, violence and a sharp rise of 41% in race and religious hate crimes reported to the police in the first month after the referendum (BBC, 2016), amidst further Islamophobia (Bhui, 2016; Robinson & Lawthom, 2017). Dominant discourses in the UK of national security construct terrorists as being mainly Muslim, 'home grown British Muslims' engaged in or vulnerable to radicalisation and committing extremist violence or 'non-violent extremism' – otherwise dubbed as 'thought crimes', expressing extremist ideologies in opposition to 'British values'. Meanwhile evolving counter-terrorism legislation increasingly curtails freedom of expression in schools and universities and has created statutory duties obliging health professionals to report those deemed at risk of being drawn into terrorism (Open Society Foundations, 2016), risking violations of the right to privacy in health services, as well as professional ethical obligations to ensure client confidentiality.

Media, public and politicians have espoused the need for unity, whilst references are made directly or indirectly to the threats posed by (Muslim) terrorists, and of the need for tighter border control to stem the flow of 'migrants' (more specifically, asylum seekers from the recent unprecedented refugee crisis, and migrants from the European Union – not emigrants, British nationals seeking a better life elsewhere). The 'other' has expanded from people from the former colonies to now include religious categorisations, specifically Muslim people.

Part of this socio-political context in the UK is the persistent lack of access to psychological services (let alone appropriate or culturally and context-relevant services) by people from Black and minority ethnic backgrounds, and the continued fear of many Black people towards mental health services (Keating and Robertson, 2004), and decades of disproportionate numbers of Black African and African Caribbean young men in acute psychiatric wards and in detention and under compulsory care (e.g. Care Quality Commission, 2011; Mental Health Act Commission, 2009; Audini & Lelliott, 2002; Bebbington et al., 1994; Moodley & Perkins, 1991).

We start with a general background to the racialized, post-colonial legacy within British clinical psychology and then address clinical psychology training in the UK and explore how equality and racism within training are approached, with specific reference to the history of addressing 'social inequalities' on the University of East London Professional Doctorate in Clinical Psychology, UK. The emergence of a focus on 'Whiteness' (see Terminology section below) is discussed, highlighting the development of a workshop and additional teaching to facilitate conversations and dialogue around 'race' and racism. Finally, we return to the need to keep challenging what and how we teach, in order to train clinical psychologists fit for

purpose in a fast moving, often morally ambiguous, and hostile climate, where new forms of 'othering' and discrimination metastasise with incredible speed and agility.

**Terminology and the UK context**

The UK context has seen many changes in the use of terminology, and the dynamic nuances in the use of terms such as 'ethnic minorities', 'Whiteness', 'Black and minority ethnic'. As background, we focus on the key terms we use here, rather than provide a comprehensive analysis of all terms in usage in the UK. We use the term 'Whiteness' as a social construct, rather than to refer to an essentialised notion of racial categories or colour. The British historical and political context has shaped the use of terminology, where Whiteness refers to the invisible privileges and power relations which systematically maintain structural, racialized and intersectional hierarchies and oppression, via various ideological and cultural practices (Clark & Garner, 2009).

We use the term 'Black and minority ethnic people' as social constructs, understood in the UK as including all those who politically define themselves as 'Black' (oppressed on the basis of colour or assumed racial categories – including African and those of African heritage, Indian, Pakistani, Bangladeshi people) and those from minority ethnic groups in the UK context, who also suffer racism. In the UK, the term 'BMEs' is commonly used as shorthand by clinical practitioners, services and academics. To make present Whiteness and render visible the related norms and privileges this denotes, one could invent and use a corollary acronym: 'WME' – White Majority Ethnic, but here we reject the use of such shorthand as dehumanising and demeaning. We also reject the acronym 'BME', and the term 'non-White', which assumes Whiteness as the norm, because both obscure the heterogeneity of within and between group

differences of experiences, homogenising all as 'other', thereby becoming an apparatus for maintaining 'Whiteness'.

**British clinical psychology**

British clinical psychology developed within the context of a social, democratic and political agenda, aiming to ensure free healthcare to all (Hall, Pilgrim & Turpin, 2015). Nevertheless, the profession's workforce, models, practices and services were Eurocentric, ignoring the casual and systematic racism directed at New Commonwealth arrivals in the 1950s to 1960s from Britain's former colonies in the Caribbean and India, and later from Bangladesh in the early 1970s - which now constitute a significant proportion of the British population - yet still clinical psychology remains anything but 'for all' (Pilgrim & Patel, 2015). Psychological services have been either inaccessible, excluding people from these minority groups, or - if they manage to access psychological services - they are often constructed as culturally backward, psychologically illiterate, lacking in insight and emotionally unsophisticated. Often, they are also dismissed in mental health services as 'somatising' and as intellectually inferior (Fernando, 2010).

British clinical psychology continues to be criticised by minority ethnic communities, service users and clinical psychologists, as essentially Eurocentric, blind to culture and consciously and unconsciously racism-blind, with psychological services as still largely inaccessible, culturally incompetent and overtly and covertly racist; in other words, 'White psychology for White folks' (e.g. Fatimilehin & Coleman, 1998; Patel & Fatimilehin, 2005; Howitt & Owusu-Bempah, 1994; McInnis, 2002). Clinical psychology is also criticised for pathologizing Black and minority ethnic people (e.g. Adetimole et al., 2005; Patel et al., 2000) and as guarding its exclusivity (Fleming & Daiches, 2005). Challenges to the profession came from within the

profession in the late 1980s and in the early 1990s – led by a small group of clinical psychologists, together forming the British Psychological Society's (BPS) first 'Race' and Culture Special Interest Group – not least because the BPS would not allow this to be a 'Section' of the BPS[1], arguing that it had no scientific basis or scholarship (ignoring decades of critical race theory, post-colonial studies and intercultural therapies) and that we were in effect, a political pressure group, with a 'special interest' as clinical psychologists. Indeed, we did have a special interest: our interest was explicitly scholarly *and* professional. Our investment was to see clinical psychology transformed to acknowledge and examine its historical and current racism and Eurocentricity, in order to help future generations of clinical psychologists to be better skilled to work with a multi-ethnic population and to help realise the goal of a health service for all, and one which did not reproduce institutional racism.

The Special Interest Group was more than a decade later recognised as a 'Faculty' of the Division of Clinical Psychology (still not a 'Section' of the BPS), only to be closed down by the Division of Clinical Psychology in 2014, without consultation with the members of the Faculty, and without any formal explanation at the time. Post hoc explanations given included that the emerging 'diversity agenda' (British Psychological Society, 2017) subsumes 'race' and cuts across all structures of the BPS, and that the 'Race' and Culture Faculty was in effect now

[1] The British Psychological Society makes a distinction between sections and what are now called special groups: Sections "exists to further members' specialised scientific interests. They aim to promote psychological research and the exchange of ideas" whereas Special Groups' "exist to further member's professional interests. Focus on training and practice, and aim to develop psychology as a profession and as a body of knowledge and skills". http://www.bps.org.uk/member-networks/member-networks

redundant. Institutional racism however, was not. The absence of meaningful discussion on this significant event in the history of British clinical psychology was the beginning of a re-unveiling of a range of entrenched daily practices and active denial of institutional racism in clinical practice, in services, in training institutions and more widely in the profession, accompanied by acute discomfort by colleagues when invited to examine how it is that Whiteness and related privileges are scaffolded, reproduced and reinforced within clinical psychology.

**Clinical psychology training and the emergence of 'Diversity'**

Clinical psychology training in the UK focuses on academic, research and intervention skills, and developing a range of competencies amongst trainees to a level required for professional suitability – and these 'core competencies' have been listed by The British Psychological Society (BPS, 2014). As their guidelines state: "*Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and research*" (p.5). This initial statement focuses squarely on the original '1949 Boulder Conference' conceptualisation of clinical psychology as a 'scientist-practitioner' profession, requiring both evidence and research training to inform practice (Frank, 1984). The critical issue, however, is that science involves interpretation within specific contexts and as such necessitates the 'subjective' involvement of the trainee practitioner – supportive space is needed to both guide and aid reflection, which also includes negotiating the boundaries between the 'personal and the professional' (Hughes & Youngson, 2009).

The BPS guidelines in the 2014 iteration do go on to state the importance of developing a 'reflective' component to complement the 'scientist-practitioner' approach, whereby the

trainee practitioner is encouraged to learn reflection via "*an effective use of supervision and collaboration with service users and other colleagues"* and the guidelines include, as a direct result of sustained critique and demands by the 'Race' and Culture Faculty since 1991, the wording: "*Importantly, the clinical psychologist will also be aware of the importance of diversity, the social and cultural context of their work… and have the skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their live*s." (pp. 6-8). This corresponds to 'Domain D' in the American Psychological Association (APA) professional curriculum guidance around developing 'cultural competence' (Utsey, Grange & Allyne, 2006).

However, the frequent use of the word 'diversity' was a recent change, reversing earlier gains achieved by displacing the wording and constructions of 'difference' and 'discrimination', as originally advocated by the 'Race' and Culture Faculty consistently since the early 1990s. This recent emphasis on 'diversity' within the BPS guidelines, and formalised in national legislation, was initially intensely debated in the UK, seen by many as the latest sanitisation of explicitly anti-racism and equality discourses and initiatives (acknowledging intersectionality), which in turn were disregarded as 'too political' and one-dimensional. The diversity agenda acknowledged the multiple axes of 'difference' (invariably essentialised), but significantly, without naming power and inequality, and it privileged only 'protected characteristics' in the UK's Equality Act 2010, of which race is one. Importantly, both in the UK more widely and within clinical psychology, race has come to be seen as somewhat passé, as if the policies of multiculturalism and integration had meant that we had somehow dealt with the history of slavery and colonialism and its continued legacies, that racism is a non-issue now and that we should all be 'celebrating diversity'. Celebration, however, extends to little more than exploring the cuisine of the global village, perhaps the fashions and music, and acknowledging different

religious festivals. In academia, there is relative silence on racism within the disciplines of psychology and in professional clinical training programmes. In psychological services, racism has almost vanished from clinical and staff-related discussions, and the reality of institutional racism is cloaked in the language of equality and diversity – which at best translates to building 'cultural competency', at worst, simply denying racism in all its guises.

The capacity to reflect on practice (Cushway & Gatherer, 2003) and the focus on 'diversity' (BPS, 2017, 'Inclusivity' Strategy) are accepted as important components during training, with justifications being that it is now a legal requirement after the Equality Act came into force, given that there is a steady increase in demographic diversity in Britain over the past few decades, and not just limited to the urban environments (Catney, 2015). The demographic impact of the implementation of the 2016 'BREXIT' vote is as yet uncertain – less uncertain, however, is the rise in stigma, prejudice and racism following this vote, all with negative mental health impact (Bhui, 2016). Clinical psychology needs to take an active stance against this development and some argue that we should look for ways to not just foster inclusion and equality, but to develop anti-racism awareness and practices too (Vera, Camacho, Polanin & Salgado, 2016), practices which were very much dominant in the late 1980s and early 1990s in the UK; and to ensure trainers and supervisors of those in training are competent in addressing racism and issues of culture in supervision (Patel, 2011).

The profession of clinical psychology in the UK has attempted to address the challenges posed by the Equality Act and the startlingly consistent statistics which betray decade after decade, a systematic and disproportionate predominance of clinical psychology trainees who are White. Turpin and Coleman (2010) address ongoing initiatives to widen 'diversity' access into the profession, in order to develop a professional group more reflective of the population it serves

(Scior, Williams & King, 2015). One key assumption underlying these 'diversity initiatives', including one named 'Widening Access to BAME (Black and Asian minority Ethnic) to clinical psychology', is that Black and minority ethnic people are not attracted to the profession and that if we are able to get more of 'them' into training programmes and the profession, then we can counter charges of discrimination and Eurocentricity in clinical psychology. A related assumption is that their mere presence in the profession amounts to 'representation' and that this in itself is evidence that the profession's selection processes are not discriminatory, and that the presence of trainees from Black and minority ethnic backgrounds can eradicate Whiteness and racism in the profession, and contribute to learning by trainers and trainees about 'diversity' - perhaps by 'osmosis' (Patel, 2010) – or, more specifically, neutralise criticisms of the profession as being predominantly White, Eurocentric and discriminatory.

The predominance of White and female clinical psychology professionals is not just a UK concern – it remains a transformative focus within clinical psychology training in South Africa too (Pillay & Siyathola, 2008). While these initiatives in the UK are to be acknowledged as efforts by the profession, in and of themselves they are inadequate, however. Daiches (2010) and Patel (2010) both critique the limitations of diversity agendas, without the wider addressing of socio-political structures and systemic and institutional racism within the profession. The examination of Whiteness and institutional racism within the profession and our practices and the potential transformation of the profession, it would seem, do not fit under the 'diversity agenda' or initiatives. The question, it appears, is not about simply getting more Black and minority ethnic people into the profession, but going much further, i.e. scrutinising our theories, methods and practices and training institutions and curricula, for Whiteness and its deleterious consequences for the public, the trainees and trainers. In other words, what is needed is the decolonising of the profession (Alvarez, Liang & Neville, 2016).

Scior, Bradley, Potts, Woolf and De C Williams (2013) note that black[2] trainees have poorer outcomes on research exams than their white colleagues. The issue of targeted academic support, for trainees with poorer outcomes on academic assessments, creates various dynamics, including racism *within* training cohorts (for example, comments made to Black trainees and reported to us as trainers, such as "Black trainees struggle more with the academic side of the training" or "they get special support from tutors and they only got onto the training because of their colour [not merit]"). There is a lacuna in the UK training literature and professional discourse which gives space to trainees' experiences of racism during training. A few recent trainee projects have attempted to address or remedy this (Paulraj, 2016; Shah, Wood, Nolte & Goodbody, 2012; Odusanya, Winter, Nolte & Shah, 2017). Accordingly, the issue of how equality and racism is managed by trainers within UK training programmes is of paramount concern. We thus focus next on providing a brief historical context to these training issues on the University of East London's Professional Doctorate in Clinical Psychology, before moving on to discuss the development of 'Whiteness' and 'Decolonising Psychology' workshops.

**Teaching Social Inequalities and Clinical Psychology**

In 1996, the second author developed a core, compulsory course on social inequalities and clinical psychology (90 hours across three years), the first of its kind in the UK, to be taught on the University of East London's Professional Doctorate in Clinical Psychology. The teaching encouraged a scholarly approach to integrating various aspects of inequalities and their relationship to distress and implications for the role of clinical psychologists. It included components which addressed relevant theories, research, clinical skills, critical thinking skills

[2] The terms 'black' and 'white' are presented here exactly as the authors used in their study.

and personal and professional development. Trainers included some of the staff on the Programme as well as some external lecturers and service user trainers.

Inevitably, this raised many challenges for the team in delivering this teaching, particularly in the areas of both race and gender initially, and latterly in how to continue to attend to racism and sexism without subsuming these areas in general discussions of diversity, or intersectionality. In grappling with questions we posed to the trainees in the teaching, such as 'what kind of psychologist do you want to be and why?', we had to name and confront our own differences in histories, values and experiences of privilege and disadvantage – personally, broadly in society and within the profession, and how this in turn was also reflected in the way we worked as psychologists. Not surprisingly, our common identity as clinical psychologists and academics was often overshadowed by the gulf of differences which characterised our personal and professional identities, histories and ways of working.

Race as a subject matter in particular, became the nexus of our differences, acute discomfort and, at times, seemingly intransigent conflict. This was a critical departure point for us as a team and we decided to confront these issues in a way that could enhance our working relationships, and our teaching and modelling to trainees – whose experiences in their cohorts unsurprisingly quite often mirrored ours. In 2002 we began to have facilitated workshops, team meetings and away days, focussing specifically on racism. These meetings dwindled, with intense team discomfort and we somehow colluded using the discourse of 'busy-ness' to postpone and eventually abandon these meetings, only to resurrect them and keep trying. We agreed as a team to banish the word 'diversity' from our dialogue and committed to struggle to find a language together which names and speaks to the operations of discursive and material power, naming covert and overt racism, individual and institutional racism, turning the lens

towards ourselves, our practices and to the profession. Inevitably, this brought painful encounters, distance, mistrust, fear, closeness, conflict and reconciliation, with a renewed and ongoing commitment to teach together on these issues, rather than locating the responsibility to name and explain these issues to trainees, with the Black and minority ethnic staff. As the staff team changed from time to time and new people joined the team, the dialogue often felt like it began afresh, frustratingly, painfully, the lessons and relationships had to be renegotiated, new learning and new language evolved.

In all, a singularly important lesson for us as a staff team was the need to take risks, to get it wrong, to say the unspeakable, to find words to name the guilt, the pain, the hurt and the rage that exclusion and institutionalised racism engenders; and the need to be kind in supporting each other to 'do their own work' – including examining 'Whiteness'. The 'work', we have learnt, is never done, and this demands that some of us have to actively seek to see what is there all the time, but which privilege renders invisible: Whiteness; whilst some of us have to live with the daily realities of racism, in society at large and within the profession, at work, waiting patiently for colleagues to see what we and trainees from Black and minority ethnic backgrounds live and endure, which we wish was not so painfully visible to us, at all times.

**Focusing 'On Being a White' Clinical Psychology Trainee**

The impetus for the introduction of sessions on 'Whiteness' while training, was the continued anecdotal occurrence within trainee cohorts of racism and micro-aggressions, as well as both authors' supervision of doctoral research projects of trainees from Black and minority ethnic backgrounds (self-identified), evidencing significant difficulties around being marginalised, stereotyped and demeaned within training (Shah et al., 2012; Paulraj, 2016). Given that country-wide training cohorts generally operate with white cohort numerical dominance – and

the attendant, implicitly assumed normalising of white experience (Halley, Eshleman & Vijaya, 2011) – Black and minority ethnic trainees often remarked that they were 'tired of being expected' to lead on discussions around racism and cultural experiences and some, at least, have requested further support confronting and managing (White) racism within training (Paulraj, 2016). One of the original articles outlining the problem of racism on training courses in the UK (Adetimole, Afuape & Vara, 2005) suggested (amongst a number of recommendations) that courses consider: '*Training lectures where white trainers own and take responsibility for 'deconstructing whiteness' and the attendant privileges*" (pp. 13-14).

**The Development of the 'Decolonising White Psychology' Workshop**

The principal author (in conversation with the second author) thus compiled a workshop session for the final year Doctoral trainees (year 3) initially. Given the principal author's history of training and working within South Africa during the State of Emergency and into the early years of a new democracy, some of the illustrative examples used, focused on the historical racist use of fundamental aspects of psychological knowledge and practice, e.g. 'IQ' tests. This was done with the aim to foster critical thinking towards all aspects of 'psychological knowledge', and to allow consideration of the array of other 'indigenous' psychologies operative across the world (Nwoye, 2015; Rochford, 2004).

The workshop aimed to:

1. Discuss the colonial history of 'race' and racism in psychology with examples.
2. Outline reasons for the social-constructionist resilience of racial (and racist) discourse, despite biological discreditation (Devega, 2015).
3. Provide an overview of racism (including structural) and introduce notions of implicit associations, 'unconscious' racism and micro-aggressions – and facilitate discussion.

4. Address the invisibility and meaning of 'Whiteness' for trainees (personal class exercise; with 'what are your experiences of Whiteness?' for Black and minority ethnic trainees).
5. Looking at the issues of 'White privilege' – and how this may impact unwittingly on attitudes and behaviour.
6. What next? The need for awareness to lead to anti-racist action and 'disrupting' Whiteness.

**The Workshop Process**

This workshop required safety ground rules (confidentiality etc.,) at the outset, given the sensitivity of the topic (Davidson, Harper, Patel & Byrne, 2007). In its first iteration (2015) it also initially required a fair amount of modelling of the presenter's own experiences, in order to foster participation, as many of the cohort appeared to find the topic both difficult and threatening. Thus, the need to take respectful risks, to explore and learn from each other, given the need to do this when working with clients and others, was also highlighted (Mason & Sawyerr, 2002).

The issue of 'White guilt' as a deterrent to facing these issues was discussed, as well as the danger that guilt operates to foster this avoidance too - thus further increasing 'unconscious' guilt. 'Guilt' reinterpreted as a 'spur to act', was found to be helpful (Hartley, 2017) by trainees. Finally, the workshop required an active and containing appreciation of all participation, but retaining the need to look carefully at all that was being said. Sue's (2016) guidelines for 'race talk' were useful – such as the need to focus on your own cultural heritage and assumptions in order to understand others - and the need for the facilitator to be both active and skilled at containing heightened emotional expressions, in order to ensure the workshop ran productively

(Cushway & Gatherer, 2013). This was taxing on the facilitator, but the use of supervision with an aim to learning with the support of the second author, was beneficial. The facilitator had also spent years addressing his own 'Whiteness' growing up during apartheid years in South Africa, and Vera et al (2016) note the importance of teachers having done the necessary groundwork on their own 'racial' identity, before undertaking anti-racist work.

**On Feedback and Further Developments**

Feedback on the workshops have been uniformly positive, despite the 'stickiness' of the process, particularly in the first workshop, when it was new to both the facilitator and the trainees. Trainee feedback requested that these discussions start earlier in training – and, as a consequence, an 'Introduction to Whiteness' (Year 1) and a 'Talking Whiteness' (Year 2, with both authors) has been introduced, building on teaching throughout the three years on social inequalities, including racism and its relationship to distress. This has enabled the staff team's expectations to be clear from the outset, that these issues <u>are</u> to be discussed – and support is in place, with the teaching timed before the use of reflective 'Personal and Professional Development' Groups, to help facilitate this.

The second 'Decolonising White Psychology' workshop, run for the next group of third year students the following year (2016), proved to be conversationally more productive, with dialogue between all trainees from different 'ethnic' backgrounds more evident. This had most likely been assisted by:

a. Explicitly acknowledging the nuances involved in trainees adopting multiple intersectional identity positions and that these varied experiences can also be used as 'bridges' to explore issues around racism and prejudice more broadly (Davidson &

Patel, 2008) – for example, the experiences of White European Union trainees of racism after the BREXIT vote (i.e. for Britain to exit the European Union).

b. Dissemination of 'safe talk' guidance from Sue (2016) in advance.
c. The addition of a group discussion around how one might ask about any experienced racism from clients (Beck, 2016). The unified group focus on client issues emphasised similarity, as well as difference, within the cohort.

A caveat on 'White talk' has been stated during the Year 1 Introductory teaching, however, i.e. 'White' voices need to be careful not to control discussion spaces, given that White dominance and the process of positive White 'identity development' is best fostered by a 'listening and learning' attitude (Jensen, 2005; Lyubanski, 2011). Above all, this attitude is needed to maximise openness and the ability to sit and move towards 'safe uncertainty' (rather than dogmatic Eurocentric 'knowledge') – an attitude integral not only to therapeutic and cultural sensitivity, but central to the continued professional development required to keep pace with the demands and complexities of the contemporary world (Mason, 2015).

**Fitness to Practice as a Clinical Psychologist in a Trumpian/BREXIT World**

Socio-political developments constantly challenge the training profession – for example, in the current climate, we continue to ask ourselves in our team 'what sort of clinical psychologists do we need in the UK and are we aiming to develop in our training?' We would argue it is clinical psychologists anchored by values rooted in equality, human rights and social justice for all (Patel, 2003; McGrath, et al., 2016). This necessitates not just a reflective-scientist-practitioner focus, but an ethical grounding that enables a passionate exploration of how we as psychologists can improve psychological health for <u>all</u> - and at all the varying levels of possible intervention. At times, this may require the challenging of systemic injustices, including racism – and, to continue to enable this, we must train professionals who manifest an ethical attitude

not only as learned codes of practice, but as internalised by personal and professional exploration and development (British Psychological Society, 2015). This requires us as trainers to constantly experiment with new ways to challenge both trainees *and ourselves* to deliver best practice (Afuape & Hughes, 2015).

Finally, this may also involve addressing enduring racist practices and structures within psychology as a discipline (Howitt & Owusu-Bempah, 1994) and within the clinical psychology profession itself (Patel et al, 2000). The issue of what exactly needs to be 'decolonised' from our profession is an ongoing and contentious one, but one that needs to be both acknowledged and actively debated, for the continued survival and ethical relevance of clinical psychology (Kessi, 2016; Long, 2016; Pillay, 2017).

Although the focus of this article is on the training context within the UK, given Western hegemony over the emergence of clinical psychology in the twentieth century and beyond, it is likely that these issues are relevant to many countries, both where clinical psychology is established (such as the United States), or is in the process of establishing a professional foothold. Several links have been made to the training context in South Africa, for example, which historically advantaged the training of White professionals, and which is still seeking to redress this inequality in training. The issue of addressing racism, in all its forms within training contexts, is thus likely to be an urgent priority for many courses wishing to pursue the emergence of qualified psychologists who are able to work sensitively across difference and to recognise, name and address discrimination, as well as being open to working constructively with the diversity of approaches and models of 'psychologies' across the globe.

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