

**Exploring supervisor responses
to issues of race, culture and ethnicity
in clinical psychology supervision,
and the systemic factors
influencing this**

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A thesis submitted in partial fulfilment of the requirements
of the University of East London for the degree of
Professional Doctorate in Clinical Psychology

July 2018

Acknowledgements

Many thanks to my participants, who so generously gave up their time to allow me to discover more about a topic which continues to fascinate me. Thanks must additionally go to all those who wrote and participated in research projects which highlighted the need for this one, or spoke up in other ways about the importance of exploring these issues. I am aware that this was not always easy.

Maria, I cannot thank you enough for your kindness, endless patience and careful reading of drafts. Also for thoughtful supervision which included putting race on the agenda from our first supervision meeting. And Nimisha, you have been much more than a second supervisor over the course of training, and brought wisdom and experience of the subject area to this project.

Thank you to Jonathan Buhagiar and Matthew Jones Chesters, who so kindly took the time to participate in pilot interviews and provided valuable feedback, and to Ben Fell for useful discussions around quantitative analysis.

Thanks must also go to my family, friends and colleagues who are too many to name individually, but each of you made a unique and valuable contribution to the completion of this project, sometimes by providing a much-needed distraction from it. A particular thank you to Nini, and to other cohort friends, for being my 'environmental resilience' during the last few months. Finally, a special thank you must go to my mum. The importance of her role in keeping me well fed and rested during the writing of this thesis cannot be underestimated, and it was much appreciated!

Abstract

Racial inequality is an ongoing challenge for clinical psychology, with its effects being felt within and without the profession. The supervisory relationship is an important space in which racism-related distress in supervisees and people accessing services can be impacted for better or for worse.

This study interviewed twelve clinical psychologist supervisors from a range of backgrounds about their experiences of discussing issues of race, culture and ethnicity with supervisees. Among other topic areas, interviews particularly probed supervisors on their comfort and confidence during these discussions, and on wider systemic influences on these conversations. Thirty-six clinical psychologists were additionally recruited to anonymously complete an online questionnaire to enrich qualitative findings.

Qualitative interview data were subjected to a thematic analysis from a pragmatist epistemology, yielding three main themes: *The blue whale in the room: Racism and oppression (in clinical psychology)*, *It's not like talking about the weather*, and *Professional structures, discourses and practices as sites of power*.

These themes are discussed alongside quantitative data from the online questionnaires, and recommendations for the profession are made. It is hoped that the study's findings may influence guidance and training for supervisors in responding to issues of race, culture and ethnicity.

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1. CHAPTER ONE - INTRODUCTION

This chapter outlines the literature search strategy, identifies key terminology, and reviews the relevant literature base, before presenting a rationale for the study and outlining its research questions.

1.1. Literature search and review strategy

Literature searches were conducted on all major psychology, healthcare and social science databases via EBSCOHost, Ethos and Google Scholar, using combinations of “clinical psychology”, “supervision”, “race”, “racism”, “culture”, “ethnicity”, “minority”, “minorities” and “ethnic minority”. Publications from the British Psychological Society (BPS), Department of Health and Social Care (DoHaSC; formerly DoH), Equality and Human Rights Commission, Health and Care Professionals Council (HCPC) and Public Health England, were also searched. This was supplemented with searching through reference lists and using Google Scholar’s “cited by” function.

Searching yielded a handful of results specific to Clinical Psychology in the United Kingdom (UK). Therefore, United States (US) counselling and psychology literature, and UK and US family therapy literature, were also included. I notify the reader where this is the case and attention is paid to the challenge of generalising from these contexts.

1.2. A note on language

Key terminology is discussed in this section and section 1.4, with additional terms being defined in footnotes as they are introduced. I use the first person throughout, with the pragmatic aim of wanting to increase engagement with the research via more personal writer-reader relationship (Gergen, 2007).

1.2.1. Race

The term ‘race’ has a particularly painful history of being constructed to oppress by implying a now discredited biological essentialism (Fernando, 2010). However, while discrimination on the basis of skin colour and other ‘racial’

features continues, the use of the term is a necessary part of attempts to challenge this. Therefore, I refer to race without apology; referring instead to people's 'heritage', for example, while perhaps more comfortable, would often be inaccurate and sanitising the reality of racism.

1.2.2. People of colour, non-White, BME and BAME

Psychologists have noted challenges with the linguistic unification of those oppressed by race. Paulraj (2016) rejects 'non-White' for its perpetuation of White-centredness. Several psychologists have instead referred to themselves as politically 'Black', here using Black as an identity descriptor signifying membership of groups who are discriminated against due to their colour, rather than necessarily a description of one's ethnic background (e.g. Patel *et al.*, 2000; Adetimole, Afuape & Vara, 2005; Paulraj, 2016). However, Shah (2010) notes that not everyone oppressed by race thinks of or defines themselves as Black.

Although "Black and Minority Ethnic" (BME) or the closely related "Black, Asian and Minority Ethnic" are typically favoured by government reports (Aspinall, 2002), one of Paulraj's (2016) participants points out that globally it is White people who are in a minority. There is also some inconsistency over whether these terms include White 'minority' groups such as people of Irish or Jewish descent (Bhopal, 2004).

Therefore, where possible, I choose to privilege people's chosen identities (Black, Asian, Dual Heritage, etc.) or use the politicised 'of colour' as a unifier for people who do not identify as White, although this is admittedly too close to the derogatory 'coloured' for some. Where I reference other authors' research or discussion pieces, I employ their terminology to maximise reporting accuracy. 'Black', unless otherwise stated, refers to an ethnic background, rather than the political unifier of those oppressed by race.

1.2.3. Ethnicity

Fernando (2010) suggests that, unlike race, ethnicity is partly determined through choice and a *sense* of belonging. Bhopal (2004, p.443) defines ethnicity as

“The social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry, and physical features traditionally associated with race.”

1.2.4. Culture

D’Ardenne and Mahtani (1999, p.3) define culture as

“The shared history, practices, beliefs and values of a racial, regional and religious group of people.”

However, cultures and subcultures can also be linked to class (Bennett, 2010), sexuality (Dyer, 2012), preferred genre of music (Hesmondhalgh, 1999) and any number of groupings and identities. Cohen (2009, p.194) notes that defining culture is “exceptionally tricky”, and suggests that this ambiguity warrants attention in the interpretation of psychology research. When used alongside race and ethnicity, culture predominantly relates to racial or ethnic groupings, and in practice the three terms are often used interchangeably (Fernando, 2010). However, this definition of culture is not explicit in the current study, an issue I return to in the analysis.

1.3. Key socio-political contexts in brief

Based on the last census, 14% of England and Wales’s population are from BME backgrounds (Office for National Statistics, 2011). Being from a BME background is linked to having an increased risk for several resource-limiting social outcomes, including overcrowded housing, statutory homelessness, unemployment or insecure employment (Tinson *et al.*, 2017; Cabinet Office, 2017). The effect of ethnic background on psychosocial outcomes has been particularly heightened following the last decade of austerity policies (e.g. Hall *et al.*, 2017).

The United Nations’ special rapporteur on racism recently raised concerns about an increase in reported hate crimes and shifts in attitudes around race in the UK following the recent European Union referendum (Dearden, 2018). She warned that the government’s immigration policies created a “hostile

environment for all racial and ethnic communities”. More hearteningly, this is also the climate within which a book by a Black British Nigerian woman exposing structural racism in British society, and the risks and responsibilities in talking about it, last year became a Sunday Times Bestseller (Eddo Lodge, 2017).

1.4. Racism: Manifestations and consequences

1.4.1. The rise of insidious racism

Racism is often separated into its overt (or direct, or explicit) and covert (or indirect, or implicit) forms. Obvious, public displays of hatred (i.e., overt racism), have, in many contexts, been replaced by a subtler, more disguised, and often, harder to combat ‘everyday’ (i.e. covert) racism (Essed, 1991). ‘Micro-aggressions’ and ‘colour-blind’ approaches to race are examples of indirect or covert racism (Rollock, 2012).

Racial microaggressions are verbal, non-verbal and environmental humiliations that intentionally or otherwise communicate hostility or negative messages to people of colour. The term highlights their damaging impacts, especially when cumulative, despite the fact that they may not automatically be perceived as threatening or aggressive, particularly by those without lived experience of racism.

Colour-blind approaches attempt to avoid discrimination by treating everyone equally, but end up obscuring, for example, experiences of racism, and strengths in marginalised groups, or cultural differences between groups. Everyone is therefore inevitably treated according to the White (British) norm, thus failing to provide culturally and racially sensitive responses to those falling outside it.

1.4.2. Institutional racism

Patel *et al.* (2000, p.31) define institutional racism as

“[T]he reproduction within institutions of practices of power which discriminate against persons on the grounds of perceived ‘race’. Individuals within these institutions may not necessarily

hold overtly racist views. These practices maintain the status quo in institutions and can be practices both in the commission of racist acts or in the omission of acts which would redress the situation.”

Institutional racism has been implicated in inquiries into the deaths of several Black people who have died while under the care of mental health services, particularly on mental health wards, in the UK (Griffiths, 2018). The inquiry into the death of Rocky Bennett¹, described institutional racism as “a festering abscess, which is at present a blot upon the good name of the NHS” (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003, p.58). Institutional racism in clinical psychology shows no signs of abating (Daiches & Golding, 2005). It also continues across other public-sector institutions which are relied upon by many people accessing services², including the civil service, police force and local authorities (Wright, 2015; MacPherson, 1999; McCallum, 2017).

1.4.3. Racism as a trauma

Links between racial disparities or racism, and a range of mental and physical health difficulties in minority groups, are well documented (Fernando, 2010; McKenzie, 2003; Griffiths, 2018). Fleming and Daiches (2005) point out that racism negatively impacts majority populations too. Therefore, it is perhaps surprising, and unsurprising, that racism is not given greater prominence as a major public health concern in the UK (McKenzie, 2003; Afiya Trust & Race On The Agenda, 2010).

Racism-based distress is increasingly being conceptualised as an individual and collective trauma³ due to it being experienced in conjunction with shock and strong negative emotions, often re-lived, and frequently having long-term effects (Lowe, Okubo & Reilly, 2012; Carter, 2007; Bryant-Davis & Ocampo, 2005). In a qualitative US study investigating what psychologists could do to support people

¹ Rocky Bennett was an African Caribbean man who died from being physically restrained with excessive force for an excessive length of time while on a medium secure mental health unit. This was following his response to an incident of racial abuse from another inpatient.

² ‘People who access services’ or ‘people accessing services’ is used where possible as it is the preferred term identified by The People’s Committee. The People’s Committee consults to my clinical psychology doctorate programme and is made up of people who access services and carers of people who access services. However, ‘client’ is sometimes used when in relation to a supervisor, supervisee or therapist (e.g. ‘the supervisee’s client’).

³ Itself a culturally-bound conceptualisation (Fernando, 2010).

experiencing everyday racism, Lowe *et al.* (2012) confirmed covert racism as no less consistent with a trauma conceptualisation, and not necessarily any less extreme in its psychological impacts, than its overt forms. It frequently came with an additional layer of secondary trauma when participants confided in others and were dismissed, questioned, accused of hypersensitivity, 'making a big deal out of nothing', misinterpreting events, or even blamed for them. This is consistent with findings from other studies which suggest considerable emotional and physical health impacts and pressure to privilege the micro-aggressor's reality over one's own (Alleyne, 2004; Constantine & Sue, 2007).

1.4.4. Intersectionality

Intersectionality is a conceptual framework offered by feminist and critical race theories for the interactive, rather than additive, impacts of one's position on different axes of power and identity such as gender, race, sexual orientation and social class (Cole, 2009).

For example, Paulraj (2016) noted that for her trainee clinical psychologist participants, homogenisation obscured intersectionality, and that the salience of their Blackness⁴ during training came at the cost of other identities. In some cases, she noted particular intersections of participants' race with gender, class, or material wealth. Although not necessarily by name, intersectionality is also being considered, for example, when focusing on the particular experiences of Black men in the mental health system rather than assuming this would be covered via the exploration of men and Black people accessing services separately (e.g. Griffiths, 2018).

1.5. Race and the NHS

1.5.1. Staff experience

The DoH commissioned Dawson (2009) to use NHS staff and patient surveys to investigate links between clinical outcomes and staff treatment. He concluded that

⁴ Paulraj uses 'Black' (and its corollary, 'Blackness'), as an identity descriptor signifying membership of groups who are discriminated against due to their colour throughout her study.

“[t]he staff survey item that was most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background.” (ibid, p.7)

West, Dawson, Admasachew and Topakas (2012) also used NHS staff survey data and found similar links. However, Salway *et al.* (2013, p.3) expressed concern over an “ambivalence at national and local level regarding the importance of addressing ethnic inequality”. This is supported by findings from the Commission for Racial Equality of a consistent failure on the part of the NHS to implement the minimum employment standards needed to comply with the 1976 and 2000 Race Relations (Amendment) Acts (DoH, 2005).

Kline (2014) detailed findings from a survey of London NHS Trusts, which aimed to evaluate their progress against The Race Equality Action Plan (DoH, 2004) ten years after its launch. He noted that the proportion of BME staff in senior, very senior and board roles had in fact fallen slightly in recent years. Kline (2014, p.66) concluded that his findings mirrored national patterns with regards to a “widespread, deep-rooted, systematic and largely unchanging discrimination”. He also observed that the weakening of specific requirements for collecting and analysing data on ethnicity between the Race Relations Amendment Act (2000) and the Equality Act (2010) seemed to have already led to less publicly available information on race discrimination. Finally, following Freedom of Information requests to the DoH and NHS England, Kline (2014, p.64) revealed a “deep confusion at the heart of the NHS” about who is responsible for workforce racial equality and “defensive and vague” ministerial responses (ibid, p.59). National policy now dictates that NHS commissioners and healthcare providers implement the Workforce Race Equality Standard to measure their progress in staff racial equality.

Although these policy developments may seem far removed from the day-to-day work of the average clinical psychologist, the confusion regarding responsibility and lack of clear, effective strategy may filter through to the profession.

1.5.2. The experiences of people who access services

People from BME groups are less likely to be referred for or to access psychological intervention (Karlsen, 2007; Keating, Robertson, Francis & McCulloch, 2002), more likely to be deemed to require harsher and more restrictive psychiatric and forensic intervention (Griffiths, 2018), more likely to have their children taken into care (Singh & Clarke, 2006) and, unsurprisingly, more likely to have negative experiences of statutory services (Williams, Turpin & Hardy, 2006). Hoping to provide a qualitative counterpart to these statistics, Keating *et al.* (2002) interviewed people accessing services, staff in mental health services, community members and voluntary organisations, and described reciprocal ‘circles of fear’ between mental health services and Black communities. They raised concerns about inadequate support and supervision in the area of influencing mental health outcomes for Black people. However, the NHS Confederation (2012) found little measurable change in the area of racial inequalities in mental health despite numerous local and national initiatives in the intervening decade.

Although people of colour who access services have less explicitly discoursed (in the literature, at least) their experiences of racism in mental health services as traumatic, we have also failed to engage with them as researchers (Memon *et al.*, 2016). Nonetheless, their descriptions of the harsher end of the psychiatric system as traumatic (Keating *et al.*, 2002), and services as racist (Griffiths, 2018), are clear enough. In the absence of invitations to provide professionalised accounts of a race-based trauma⁵, or other means to effect change, they have found alternative methods of resistance, including walking away from services or refusing to approach them in the first place (Memon *et al.*, 2016).

1.6. Race and clinical psychology

1.6.1. The history of clinical psychology and race: A brief overview

British clinical psychology, and the NHS, which is an integral part of the clinical psychology context in this country, both have an uncomfortable history with race

⁵ ‘Race-based trauma’ is trauma resulting from racism as described in subsection 1.4.3. The term is used interchangeably with ‘racial trauma’ in the literature.

(Attenborough, Hawkins, O'Driscoll & Proctor, 2000; Bashford, 2013). Pilgrim and Patel (2015, p.56) painfully acknowledge empiricism and eugenics as the “twin towers” of the foundations of British clinical psychology and, through this, the profession’s undeniable complicity in slavery and colonisation. A significant aspect of this was the systematic ‘proving’ of Black people as inferior through the use of intelligence testing. The authors describe how even in (post)colonial⁶ times, the profession’s theories and practices continue to position immigrants from former colonies and their descendants as inferior to their White British counterparts.

There is little awareness of this history within the profession, and a lack of space given to reflect upon it (Pilgrim, 2010). Paulraj (2016, p.16) describes this silence as “deafening”. Yet it is a key context informing what it means for the profession to continue systematic practices of cultural oppression and colonisation (of the psyche and experience), and is therefore important for our understanding of the current distress experienced by psychologists of colour and people of colour accessing services.

1.6.2. Clinical psychology’s demographics

The dissimilarity between the demographics of the profession and the population it serves has been a longstanding concern, with Davenhill, Hunt, Pillay, Harris & Klein (1989) observing a mismatch between rhetoric and sustained action almost thirty years ago. Over two decades later, Turpin and Coleman (2010, p.19) recognised a sense of “déjà vu” in reviewing progress in this area. Several initiatives have attempted to remedy this by trying to raise awareness of the profession to school-aged young people, undergraduate psychology students and pre-training psychology graduates, as well as frame the profession as a credible and attractive career option (Cape *et al.*, 2008; Turpin & Fensom, 2004). Despite these efforts, there is no stable trend towards closing the gap between the increasing numbers of people from BME backgrounds living in the UK and either acceptances onto clinical psychology courses or numbers of qualified clinical psychologists practising in the NHS (see Appendix A).

⁶ Bell (2016) uses the term ‘(post)colonial’ to question our distance from the colonial order in situations where social conditions remain suggestive of racial hierarchy and colonisation.

Patel (2010) posited that this is related to a set of flawed assumptions which unhelpfully present increased diversity within the profession as the solution to more uncomfortable issues of power and racism. She suggested that the profession instead turn inwards and examine the Eurocentricity⁷ and cultural irrelevance inherent in many of its models, as well as the environments which lead Black, Asian and other minority ethnic trainees to question their survival in a profession in which they feel alienated and discriminated against.

This is supported by Bender and Richardson's (1990) findings of a significantly higher drop-out rate of Black students in comparison to Caucasian⁸ students when they surveyed British clinical psychology courses. Adetimole, Afuape and Vara (2005, p.15) also spoke of other trainee clinical psychologists at unknown institutions leaving their training programmes "to survive with their identity and dignity intact". Patel's (2010) suggestions are additionally backed by Meredith and Baker's (2007) and Helm's (2002 as cited in Cape *et al.*, 2008) findings that undergraduate psychology students, even when considering clinical psychology as a potential profession, are dissuaded by the disadvantage faced by BME applicants *en route* to and at recruitment, and the clash between the needs of BME psychologists and people accessing services with the provision of 'White' courses and services. Meredith and Baker (2007) also noted that contrary community expectations, such as an expectation to provide financial support to one's family rather than pursue honorary or low paid positions to gain relevant experience, can act as a deterrent to potential applicants.

Given the relative power of community in many majority world⁹ cultures, the profession would perhaps do well to further examine its treatment of and relevance to current trainee and qualified psychologists of colour as well as people of colour accessing clinical psychology services, rather than simply targeting groups of potential applicants. For Daiches (2010) this would include

⁷ 'Eurocentricity' and its counterpart, 'Eurocentric', are used throughout due to the significant influence of theory originating in countries such as Germany, France, Austria and Italy on UK Clinical Psychology today (Hall, Pilgrim & Turpin, 2015). An exception to this is when I discuss professional values, as these values are particularly 'Anglocentric'. However, the distinct absence in UK clinical psychology theory and practice of psychologies from some parts of continent, for example, Mediterranean and Eastern European regions, needs acknowledging, and the term 'Eurocentric' is not intended to obscure this absence.

⁸ This is the term used by the researchers, although a similar study conducted in more recent times might instead use 'White'.

⁹ 'Majority world' is used instead of non-Western to avoid definition in opposition to a Western 'norm'.

ceasing to equate difference with deficit. Paulraj (2016) echoes Patel's (2010) concern following findings from her own research, and concludes that efforts to diversify the profession are in fact unethical, until the marginalisation of Black trainees and psychologically damaging consequences of this are adequately addressed.

1.6.3. The experiences of trainee and qualified clinical psychologists

This subsection reviews the strikingly similar themes identified in the qualitative literature on the experiences of trainee and qualified clinical psychologists of colour¹⁰. All studies referenced draw from interviews with trainee clinical psychologists, apart from Patel (1998), who interviewed trainee and qualified clinical psychologists, Buyson (2010), McNeill (2010), Odusanya (2016) and Pethe-Kulkarni (2017) who interviewed qualified clinical psychologists (bar one of McNeill's participants, who was a counselling psychologist), Adetimole, Afuape and Vara (2005), who wrote a courageous piece about their experiences of racism on a training course, and Wood and Patel (2017), who describe their experiences of supporting trainees as tutors and research supervisors.

Regrettably, the literature suggests that for trainee and qualified clinical psychologists, the threat of race-based trauma is a proximal and heightened one (e.g. Patel *et al.*, 2000; Adetimole, Afuape & Vara, 2005). This issue has particularly been highlighted by trainees, perhaps due to the growing emphasis on personal and professional development in training courses, and the additional power dynamics arising from continuous assessment during training (Horner, Youngson & Hughes, 2009; Wheeler, 2004).

Trainee and qualified clinical psychologists of colour are marginalised, pathologised, stereotyped and undermined by the profession, frequently leading to feelings of 'deviance', isolation and being simultaneously hyper-visible and invisible (e.g. McNeill, 2010; Paulraj, 2016; Wood & Patel, 2017). This is partly due to their being othered and constructed as inferior by institutional thinking,

¹⁰ This literature utilises a range of terms, including 'Black' (as a political unifier, e.g. Patel, 1998; Adetimole, Afuape & Vara, 2005; Paulraj, 2016), 'Black British' (e.g. McNeill, 2010), 'British Asian' (e.g. Pethe-Kulkarni, 2017), 'South Asian' (e.g. Thakker, 2009; Buyson, 2010), 'Black and minority ethnic' (e.g. Patel *et al.*, 2000; Wood & Patel, 2017; Rajan & Shaw, 2008), and 'BME' (e.g. Goodbody, 2009; Shah, 2010; Odusanya, 2016). Therefore, I use 'psychologists of colour' to refer to the findings of this literature base as a whole.

power dynamics and psychological literature, which has been critiqued from within and without the profession for its White, middle-class, male, heterosexist and individualist norms and assumptions (Patel, 1998; Rajan & Shaw, 2008; Paulraj, 2016; Dennis & Aitken, 2004). They may additionally experience worry or conflict regarding collusion with institutional prejudice or Westernised models and values (e.g. Thakker, 2009; Buyson, 2009; Pethe-Kulkarni, 2017).

Participants in these studies also describe being unhelpfully positioned as expert on all things race and culture, often at the expense of their own learning needs around these issues, and/or positioned as struggling and needing 'special help' (e.g. Adetimole, Afuape & Vara, 2005; Rajan & Shaw, 2008; McNeill, 2010). Disruptions to identity formation is a recurrent theme in this context of continually being (dissonantly) defined by others, or feeling obliged to Whiten themselves (e.g. Goodbody, 2009; Shah, 2010; Paulraj, 2016).

Regular experiences of discrimination and prejudice are described, (e.g. Patel, 1998; Adetimole, Afuape & Vara, 2005; Paulraj, 2016), and Patel (2010) notes that this happens across training courses. However, there has been a reluctance to call these experiences discriminatory, both by the systems around them and sometimes by the recipients themselves, even in instances of blatant racism (Patel, 1998; Odusanya, 2016). Therefore, participants found these issues very difficult to highlight or challenge, report little or no support from training courses, and note difficulties with even using the word 'racism' (e.g. Rajan & Shaw, 2008; Shah, 2010; Odusanya, 2016). Odusanya (2016) reports a consistent thread of participants relating certain experiences to their ethnicity, but then having this questioned by others, or remaining unspoken, leaving participants doubting themselves and struggling to make sense of their realities; this echoed other studies (e.g. Adetimole, Afuape & Vara, 2005; Paulraj, 2016).

These difficult experiences of training and qualified life often remained unspoken, especially within formal reflective spaces, which sometimes led to the creation of minority peer support that, among other functions, served to validate the cultural identities concealed by the profession (e.g. Patel, 1998; Goodbody, 2009; Odusanya, 2016). Attempts at speaking up outside these peer support spaces often resulted in experiences of being further isolated, marginalised and labelled (Adetimole, Afuape & Vara, 2005; Rajan & Shaw, 2008).

Strengths and ‘silver linings’ have also been identified in this body of research. Shah (2010) noted the versatility that came from navigating different identities, while Adetimole, Afuape and Vara (2005) highlighted the skills gained from managing ongoing insidious racism. Odusanya’s (2016) participants reported feelings of privilege resulting from having made it as a clinical psychologist. Many of Paulraj’s (2016) interviewees spoke about how their own experiences had raised their awareness of these issues for their clients. However, some also spoke of the difficulties caused by supervisors denying the importance of these topics. Similarly, Patel’s (1998) participants highlighted a reversal of power dynamics between their clients and themselves as compared to wider society, which would have been helpful to explore in supervision. Instead they experienced a lack of support from supervisors, particularly when supervisors were themselves part of an oppressive system.

As is the case for people accessing services and survivor groups, aspiring and qualified clinical psychologists have explicitly called for change, often specifically with regards to supervision (e.g. Joof, 2009; Griffiths, 2018; Adetimole, Afuape & Vara, 2005; Rajan & Shaw, 2008; Paulraj, 2016; Odusanya, 2016; Pethe-Kulkarni, 2017).

1.6.4. The policy context

The importance of attending to issues of race, culture and ethnicity was emphasised by all key clinical psychology policy documents reviewed (see Appendix B for a breakdown of key messages contained in these). However, there is a noticeable absence of ‘race’ or ‘racism’ in some of these, reflecting the split in the literature of discourses of ‘cultural competence’, ‘(celebrating) difference’ and ‘diversity’ as contrasted against calls from psychologists, mainly those of colour, to instead make visible discourses of ‘power’, ‘racism’ and ‘oppression’ (e.g. Akamatsu, 1998; Paulraj, 2016; Wood & Patel, 2017).

1.7. The role of supervision

1.7.1. Supervision research and models

Despite a limited evidence base in the UK, the role of supervision is attracting increased attention (Beinart, 2004). This is partly due to its potential role in operationalising the clinical governance agenda. It is also recognised that in

clinical psychology, at least 50% of an expensive training is spent on placement, developing skills under the supervision of a qualified practitioner, who, in the vast majority of cases, is a clinical psychologist. Courses are obliged to organise regular supervisor trainings (BPS, 2017), although supervisors are typically encouraged rather than mandated to attend all but the introductory workshops (Fleming, 2004).

US studies, prioritising client care as the ultimate goal of supervision, have attempted to identify constituents of supervision which lead to improved outcomes for people accessing services. However, due to the number of potentially confounding variables, this has been with little success (Beinart, 2004). In light of training courses' and employers' duty of care towards trainees and qualified clinical psychologists, and a growing concern about levels of burn-out and distress, perhaps positive supervisee experiences of supervision should have value and be emphasised as ends in themselves (Paulraj, 2016; Rhodes, 2016). Kuyken, Peters, Power and Lavender (1998) noted that clinical psychology training is highly stressful, even without the racism and/or acculturation stress described in subsection 1.6.3. The authors found that trainees' ability to adapt to work related difficulties was associated with their satisfaction with emotional support provided in training. Similarly, Cushway (1992) found supervision to be one of the top five causes of stress, as well as one of the top five coping strategies for trainees.

Studies into supervisee satisfaction reliably give the supervisory relationship primary importance (e.g. Kilminster & Jolly, 2000; Magnuson, Wilcoxon & Norem, 2000). For Weaks' (2002) participants, this was delineated as 'equality', 'safety' and 'challenge', with other studies identifying similar factors, particularly 'empathy' and 'trust'. Moskowitz and Rupert (1983) point to the inhibition of learning following supervisory conflict. Further, without a robust supervisory relationship, the validity of supervisee evaluation should also be questioned (Bernard & Goodyear, 1998; Neufeldt, Beutler & Banchero, 1997), especially as supervisors have been found to be less objective evaluators than independent observers (Najavits & Strupp, 1994). If we are to place any faith in the value of supervision at all, one might hypothesise that both supervisory conflict and feedback to supervisees which has been clouded by it would impact their clients detrimentally in the long run.

Although the overall picture that supervisees appreciate empathetic, trustworthy supervisors and secure supervisory relationships is unsurprising, the subjective and abstract nature of these qualities perhaps elucidates why ‘good’ supervision requires some skill to teach. Nevertheless, good supervisory experiences need to be actively fostered by the profession in accordance with a more contextualised understanding of competence and ‘resilience’, rather than one which positions these as qualities residing within individual supervisees (Harper & Speed, 2012).

Supervisors may not necessarily rely on a specific model or approach, and often learn supervision skills through their experience of being supervisees or adapting their therapist skills (Wheeler, 2004). However, attention to issues of race, culture and ethnicity is consistent with all major supervision models and therapy approaches in clinical psychology (see Appendix C), although Banks (2001) and Patel (2004) warn of many of their inherent cultural biases.

1.7.2. Race, culture, ethnicity and supervision

There is, nonetheless, a distinct lack of literature focusing on issues of race, culture and ethnicity in UK clinical psychology supervision. There is far more research on cross-cultural supervision in the US, often in psychology or counselling contexts. However, it has been suggested that counselling supervision is more process focused than clinical psychology supervision, which is more goal-oriented (Lawton & Feltham, 2000). Furthermore, there is a particular dissimilarity between the structure, supervision and monitoring of placements in the US and UK, and cultural difference may be more of a threat in the US with its distinct history, focus on mass assimilation and nationalism (Beinart, 2004; Brubaker, 2001). Therefore, rather than lean too heavily upon this literature, one might use these studies as useful illustrations of the ways in which race, culture and ethnicity *may* be important in the UK clinical psychology context.

The research suggests an overall discrepancy between the views of supervisees regarding the importance of supervision discussions on race and culture to the supervisory alliance (e.g., Gatmon *et al.*, 2001; Howell, 2016), and their infrequent nature (e.g., Hird, Tao & Gloria, 2004; Duan & Roehlke, 2001). This seems to stem, in part, from supervisors’ colour-blind approaches, as

contrasted with the racialised and/or culture-dependent experiences of their supervisees. This is consistent with findings from Phillips, Parent, Dozier and Jackson (2017) that the depth of discussion is higher with ethnic minority trainees, and Hird *et al.* (2004) that all-White supervisory dyads talked about these issues less. Supervisees report an explicit avoidance from White supervisors in discussing these issues, and even instructions to ignore them or criticism for wanting to address them in their clinical work (Burkard *et al.*, 2006; Helms & Cook, 1999).

Constantine and Sue (2007) suggest that many supervisors may not have reflected on their unconscious or conscious biases and, therefore, a colour-blind stance seems justified. Nonetheless, it often results in unexplored racial micro-aggressions, stereotyping, and the invalidation of supervisee experiences. Supervisees report feelings of shock, disbelief, anger, confusion, disappointment, outrage, isolation, discouragement and mistrust in response (Constantine & Sue, 2007; McNeil, Hom & Perez, 1995). They may also experience a betrayal or violation due to the integral nature of trust in the supervisory relationship (Bryant-Davis & Ocampo, 2005). Further, in a pilot study investigating minority supervisees' ratings of supervisor cross-cultural competency, Wong and Wong (1999, cited in Wong, 2000) report that three of their participants felt that their supervisors' treatment of them amounted to psychological and professional abuse.

Duan and Roehlke (2001) reported that supervisees were more sensitised to racial and cultural issues and perceived less effort on the supervisors' part in addressing them than the supervisor reported. Some authors also suggest a 'generational training gap' between supervisors whose own training may have placed less emphasis on race, racism, ethnicity and culture, and supervisees who may have been exposed to a more nuanced understanding of these issues (e.g., Burkard *et al.*, 2006; Inman *et al.*, 2014).

Fukuyama (1994), Paul and Croteau (2000, cited in Wong, 2000), and Dressel, Consoli, Kim and Atkinson (2007) compared positive and negative supervisory practises with regards to these issues and arrived at similar findings. Positive practices included: Supervisors addressing these issues in supervision, showing sensitivity towards both individuality and culture, conveying an open, supportive attitude, working to develop their own multicultural competencies,

consulting others, appreciating ethnic minority supervisees, providing culturally relevant clinical guidance and resources, and admitting their own bias or ignorance. Negative practices included: Supervisors negatively evaluating supervisees based on racial stereotypes of ability, pathologising supervisees or clients, tokenistic multiculturalism, utilising over-generalised or inaccurate racial or cultural assumptions about supervisees, a lack of cultural awareness, questioning supervisees' wish to address these issues in clinical work, and a failure to address issues of race and culture.

These significantly overlap with the themes highlighted in Constantine and Sue's (2007) study of racial micro-aggressions within supervisory dyads, which were: Invalidating issues of race or culture, stereotyping clients or supervisees, reluctance to give performance feedback for fear of being viewed as racist, focusing primarily on clinical weaknesses, blaming clients for problems stemming from oppression, and recommending culturally insensitive treatment. The authors additionally acknowledged the time, energy and affective labour required of the trainees to process and cope with these microaggressions, and wondered about the impact on others who may not have had those resources available to them.

Ladany, Constantine and Hofheinz (1997) also observed that cross-cultural supervision research overwhelmingly focuses on dyads comprising a White supervisor and a supervisee of colour. This may reflect the general positioning of clinicians of colour as the ones in which race, culture and ethnicity 'reside' (Patel *et al.*, 2000), leading to their being seen as a problem to be taught or solved. In contrast, Sato (2014) explored the distinct experience of racial and ethnic minority supervisors and noted significant strengths as well as challenges deriving from their positions, and the importance of support and mentorship.

Ayo (2010) noted that race, culture and other issues of difference and inequality have become a part of systemic thinking and training in recent years, in line with the increasing influence of social constructionist ideas on the field. Regardless of whether those within the discipline consider these advances sufficient or not, the UK and US systemic literature base may have something to offer.

Boyd (2010), while noting the intellectual richness of systemic theory on these issues, wishes to make them 'real' within a supervisory relationship. Similarly,

Laszloffy and Hardy (2000) distinguished between racial awareness and racial sensitivity (translation into action), which is echoed by Dhillon-Stevens' (2001) assertion that anti-racist practice does not automatically derive from cultural knowledge or awareness, but requires a more proactive approach.

In line with this, several authors, particularly those informed by systemic or social inequalities frameworks, have offered lists of possible questions to guide discussion or reflection on these issues in the supervisory context (e.g. Killian, 2001; Patel, 2004; Singh & Chun, 2010). Divac and Heaphy (2005) discussed the use of Burnhams's social GRRAACCES model (Burnham, 1993), while Hardy and Laszloffy (2014) and Watts-Jones (1997) explored the sharing of cultural and African-American genograms respectively as tools which may be used to support supervisor training or supervision discussions. One of Ayo's (2010) participants suggests the sharing of relevant literature, and allowing supervisees to position themselves in relation to the literature depending on their level of interest/shared stance with the author as a starting point for further discussion.

These open-ended dialogical exercises contrast with much of the US counselling and psychology literature, which favours research into competency frameworks and models of identity development (e.g. Bhat & Davis, 2007). Lawless, Gale and Bacigalupe (2001, p.191) warn that discussion around these issues does not entail "a neat and tidy conversation" and can be missed by supervisors without due attention. Therefore, the US approach may have been an attempt to 'neaten and tidy' the addressing of these issues, and keep them on the agenda¹¹.

Other findings from the systemic literature acknowledge the avoidance of, and discomfort in, managing race talk, as well as the fear of raising these issues, coupled with the unequal responsibility on those who are visibly different to do so (e.g., Ayo, 2010). Boyd (2010) noticed the consequent 'giving up' when this becomes too challenging, which echoes Constantine and Sue's (2007) finding of some supervisees giving up their hope of culturally relevant help from supervisors. Bond (2010, p.249) suggested that mentioning racism in any form

¹¹ Although there has also been some resistance from the US to this 'neatenening' (e.g. Helms and Richardson, 1997; Howell, 2016).

is often “a sure way of losing people’s interest” due to people’s tendency to avoid the powerful feelings of guilt, discomfort, blame, shame and anger that it can evoke. She also warns of the impact of the institution on the supervisor-supervisee relationship, and the possible isomorphism that may occur. Messent (2016) similarly notes the importance to supervision across ethnic difference of an organisation that is welcoming, appreciative and facilitative of learning for all. However, he also highlights the potential to build through supervisory relationships “the kind of organisations and world that we wish to be a part of” (ibid, p.62).

1.7.3. Supervision, clinical psychology, and issues of race, culture and ethnicity: Power as a common theme?

Patel (2004) draws on a Foucauldian understanding of power to make sense of the ways in which issues of cultural difference and racism interact with the already complex dynamics of supervisory relationships. Foucault (1988) understood power as being manifested and, crucially, resisted, through discourse, relational activities and routine practices, particularly via the privileging of some knowledges at the expense of others. Patel observes that supervision is, therefore, one of the key sites in organisations where power imbalances and social inequalities operate, are experienced, are challenged, and require addressing. Supervision also offers an opportunity for reflection on wider (such as institutional or professional) manifestations of power and resistance. Patel notes a lack of guidance on incorporating current understandings of power relations into supervision, which may partially explain the observation that integrating this into the training and practice of supervisors “remains a matter of choice in Britain, rather than an ethical and professional obligation”¹² (ibid, p.110). This highlights the power of professional bodies and training courses as the providers of supervisor training and guidance.

Wider power relations inevitably interact with the supervisor-supervisee hierarchy to impact on the supervisory relationship. For example, male supervisees have been found to be given less direction and asked for their opinion more than twice as often as their female counterparts, and female supervisees to relinquish more power to their supervisor (Granello, Beamish &

¹² This is noteworthy given the highlighting of issues of power in the BPS’s (2018) Code of Ethics and Conduct.

Davis, 1997; Nelson & Holloway, 1990). Holloway (1995, p.76) notes the often-subtle nature of issues of power and race, and their tendency to remain “inside the participant’s head”, while Green and Dekkers (2010) found a significant impact of attending to power and diversity for supervisees, but not supervisors. Given the strong possibility of supervisees having had previous discouraging experiences of raising these issues, supervisors hold considerable power in whether these issues are addressed, and it is generally agreed that it is incumbent upon supervisors to raise them (e.g. Adetimole, Afuape & Vara, 2005; Patel, 2004).

Race and ethnicity provide a lens through which we view ourselves, others and relationships, including the supervisory relationship (Wieling and Marshall, 1999). Meanwhile, culture profoundly impacts many of the skills assessed during training, including use of language, emotionality, expressiveness, communication styles, values, relationship to conflict, the giving and receipt of feedback, self-disclosure, boundaries, assertiveness, hierarchy, self-appraisal in the context of a supervision meeting, expressions of distress and requests for support. Some of these cultural differences have been shown to lead to difficulties if not addressed (e.g. Daniels, D’Andrea & Kim, 1999; Gardner, 2002). Patel (2004) also noted the lack of space given to exploring, for example, the ethnocentric cultural norms against which the supervisee is being evaluated.

Similarly, Messent (2016) described an example where, despite both supervisor and client being White¹³, these cultural norms could have been to the client’s detriment due to missed opportunities for the enrichment of the therapeutic relationship with the supervisee’s more ‘Bangladeshi’ engagement style. Messent (2016, p.38) initially perceived this engagement style as “(to [his] White Anglo-Saxon eyes) ‘over-effusive’ thanks for [the client’s] attendance, pleasure about meeting them, and close attention to their needs for their coats to be taken off and securely hung up.” He initially suggested that his supervisee rein in some of these ways of being, before later realising how positively clients responded to them, and acknowledging the “particularly White and middle-class” nature of the style of greeting typically used by the service.

¹³ Messent describes himself as ‘Anglo-Saxon’. No further details are offered regarding the client’s ethnic or cultural background other than ‘working-class’.

Supervising trainees carries additional power implications. Blocher (1983) recognised supervisees' tendencies to start the supervisory relationship with feelings of inadequacy and vulnerability, and how this may be exploited or compounded by supervisors. Patel *et al.* (2000) also acknowledged the reality of possible scapegoating or being failed as a trainee, and the deterrent effect on voicing issues of discrimination. Meanwhile Dennis and Aitken (2004) noted the potential disempowerment of the supervisor relative to training courses as the supervisor may need to introduce (de)stabilising critical thinking around race and culture, but feel restricted by the trainee's need for certainty and stability to get through the demands of training.

The supervisor-supervisee relationship also impacts upon the way power operates with regards to the client, for example via the replication of harmful aspects of the supervisory relationship in parallel processes (Dennis and Aitken, 2004). Clients' realities are additionally vulnerable to stereotyping and pathologisation in supervisory discussions, and any intervention decided upon during these discussions has great potential for harm or healing. For example, Kareem and Littlewood (1999, p.16) warned that therapeutic work "can only fragment" a person if it fails to consider race or culture. (The experiences of supervisees described in subsection 1.6.3 would suggest that this may also be true for supervisee identities). Meanwhile, Patel and Fatimilehin (1999) described 'secondary colonisation' processes whereby western psychological approaches are inappropriately (but extremely commonly) applied to groups for whom they are culturally incongruous, further-disempowering communities by colonising their experiences and/or sense-making frameworks. In contrast to these cautions, Soheilian, Inman, Klinger, Isenberg & Kulp (2014) report ways in which due attention to issues of race, culture and ethnicity have positively impacted clinical work.

Patel (2004, p.110) recommends a "sustained, committed and sophisticated social, political and psychological" analysis over tokenistic one-off gestures in the face of this complexity. This would aim to maximise opportunities for the supervisory dyad (collaboratively with clients where appropriate) to intervene in an emotionally, socially, politically and culturally meaningful way.

1.7.4. Comfort and confidence

Patel (2004) highlighted the need for supervisors and supervisees to develop their confidence and competence in addressing issues of race, culture and ethnicity. For an individual supervisor or supervisee evaluating themselves, feelings of confidence and perceived competence are likely to be closely linked, although subtle distinctions between the two concepts may remain. These distinctions may be particularly pertinent in the case of raising issues of race, culture and ethnicity. For example, a supervisor may feel *confident* in bringing race, culture or ethnicity into a supervision discussion due to a belief that the supervisory relationship is strong enough to withstand, for example, any potential clumsiness of expression, however, they may not feel that they are necessarily *competent* at doing so.

Stone (1997) also emphasised the ease with which we can avoid cultural factors in supervision, particularly if we experience cultural or ethnic differences as threatening or are uncomfortable addressing them. Therefore, there is a need to develop comfort with 'race talk' (Boyd-Franklin, 1989). Comfort in the context of supervisors discussing issues of race, culture and ethnicity with supervisees can be broadly conceptualised as freedom from undesirable feelings such as anxiety, guilt, frustration, pain and fear¹⁴.

Additionally, supervisor comfort should not automatically be positively or negatively valenced without a thorough exploration of the meanings and consequences of that discomfort in any particular situation. Patel (2004) acknowledged that anxiety and discomfort can lead to supervisor and supervisee colluding to avoid sufficient exploration of issues of race and culture. She warned that this can lead to crises involving mistrust, a lack of reflection, and a deterioration in the supervisory relationship. She notes that "learning comes to a halt for both supervisor and supervisee with inevitable implications for clinical work and clients" (ibid, p.118). However, Messent (2016) also identified the creativity and growth afforded by moments of 'relational danger' in inter-ethnic supervision. Similarly, Cabrera, Watson and Franklin (2016)

¹⁴ It should be noted that this construct is being used in the lay sense with regards to supervisors of any background; it does not refer to ideas of "white comfort", or "white comfort zones" (Leonardo & Porter, 2010, p.139) commonly referred to in critical pedagogy, although they are, of course, related.

cautioned against the emphasis on creating 'safety' in pedagogic settings if this implies an absence of discomfort and, instead, argue for the reframing of discomfort as 'growing pains' necessary for the advancement of racial equality.

Comfort and confidence are, therefore, used flexibly in this study as participant-defined constructs to tap into and make sense of supervisor experiences. This focus on experience removes some of the challenges of self-definition associated with attempts at objectivity. The remaining limitations of employing constructs which may be interpreted differentially by different supervisors will be attended to in the discussion.

1.8. Summary of study rationale

Despite clear legal, professional and ethical imperatives to prioritise issues of race, culture and ethnicity, policy and guidance remain disconnected from implementation and impact. This cuts across experiences, outcomes and approachability for those accessing services, as well as trainee and qualified clinical psychologist experiences, and access to the profession.

The supervisory relationship bears significant responsibility in maintaining, heightening or alleviating racism-related distress, and in the development of professional practice. However, the scale of the problem, painful history, and lack of clear, effective strategy for tackling it may leave supervisors, tutors and trainers of supervisors unable to fully confront these issues, and contribute to a cycle of discomfort, lack of confidence and inadequate training passed on from supervisor to supervisee.

Patel (2004) provided well-developed suggestions for attending to these challenges in clinical psychology, while UK and US systemic therapy and US counselling and clinical psychology literature offer wider literature bases of research, theory, discussion and practical strategies. However, supervisors' experiences of discussing these issues have yet to be qualitatively researched in the context of clinical psychology in the UK.

The failure of broader initiatives, and resistance to accountability at a national level, also suggest that these strategies might need to be combined with a bottom-up analysis and approach. Analysis at the level of supervisory

discussions in a specific profession, particularly one that prides itself on its expertise in the psychological aspects of change processes, may provide vital granularity to enrich our understanding of some of the difficulties noted at wider levels.

1.9. Research aims and questions

In engaging in this research, I seek to better understand the helps, hindrances and systemic factors in clinical psychologist supervisors' capacities to respond openly and reflexively to issues of race, culture and ethnicity by asking the following questions:

1. What are the experiences of supervisors discussing issues of race, culture and ethnicity with supervisees?
2. How comfortable and confident do supervisors feel during these discussions?
3. What are the systemic factors influencing these experiences?

I hope that this might influence future support, guidance and training for supervisors.

2. CHAPTER TWO - METHODOLOGY

This chapter outlines my epistemological position, methodology and methods, before addressing ethical issues.

2.1. Epistemology

This study takes a pragmatic epistemological stance. I initially explored social constructionist (Burr, 2006) and critical realist (Trochim, 2001) positions, and although both held value, pragmatism was a better fit with both my intuitive approach to this topic and more reasoned philosophical position. Rather than search for the ‘truth’ of beliefs and knowledges (theoretical or otherwise) or their connection (or not) to an objective reality, pragmatism prioritises their functional consequences (Pierce, 1905; Rorty, 1982). This is not necessarily because objective realities or truths *do not* exist, or because we *cannot* have contact with them, but because we have no way of proving or disproving this to ourselves or others (McDermid, 2006). This stance resembles social constructionist philosophies in some ways, and certainly acknowledges the instrumental power of language (Rorty, 1989), but also maintains clear distinctions. One is that a pragmatic approach may choose to emphasise theories of material reality over social or discursive ones. This may be pertinent when, for example, considering links between material poverty and ethnicity in the UK, or numbers of Black psychologists in the profession and its impact on client care. A second is that, due to its emphasis on functional ends, pragmatism actively encourages and necessitates the prioritising of some ‘truths’, beliefs or knowledges over others. For example, the study begins with the assertion that ‘comfort’ and ‘confidence’ are useful concepts for exploring the topic area, but may end with the conclusion that they are, in fact, not so helpful. Concepts such as these (and other beliefs and knowledges) will be evaluated against their usefulness in contributing towards the broader aim of reducing social inequalities, particularly those related to race, culture and ethnicity, within and beyond the profession of clinical psychology.

2.2. Methodology

2.2.1. A qualitative approach

My first research question was far from categorical, and my literature review suggested that the second and third would benefit from nuanced investigation. The potentially emotive nature of the topic, and often concealed nature of power dynamics, suggested that a dialogical approach which allowed for the sensitive probing of responses was fitting. A qualitative analysis of semi-structured interviews was employed to prioritise this exploration over measurement.

Due to the limited literature and research in this area, the study was very exploratory and in the first instance sought to make sense of shared patterns in supervisors' responses to the topic area. I wanted a methodology which would allow me to 'zoom in or out' of my data set according to the level at which findings could be usefully analysed, rather than assuming, for example, that experiences, discourses or narratives alone would be most pertinent. From my pragmatist epistemological position, a 'useful' analysis would be one which helped identify patterns which maintained the status quo with regards to racial inequalities in the profession, as well as areas of resistance, whether potential or successful.

Thematic Analysis was therefore chosen for its flexibility in attending to broad themes over a larger number of participants than other qualitative methodologies (e.g. Smith, Flowers & Larkin, 2009), while simultaneously allowing for a more detailed interpretive analysis of any particularly striking discursive elements. A 'contextualist' Thematic Analysis was specifically adopted to allow me to focus on the influence of individual meaning-making and societal discourses as well as material and other 'realities' in line with my epistemology (Braun & Clarke, 2006). My approach to the study was also pragmatic in the everyday as well as the epistemological sense as I wanted to be able to easily disseminate results from an analysis which would be accessible to psychologists who were less familiar with the less common qualitative methodologies.

2.2.2. A quantitative approach

An online survey arm of the study was used to gather quantitative questionnaire data to enrich the interview findings. I was aware that I was unlikely to reach

enough psychologists for the questionnaire arm of my study to achieve any meaningful representation of the national picture and that statistical power might be limited, but hoped that the reporting of categorical data might provide an indication of whether attempts at quantifying and/or comparing aspects of comfort and confidence were useful in gathering information on this topic. Due to concerns regarding normality, which are discussed further in the Analysis chapter, Wilcoxon Signed-Rank tests were used to compare medians against a criterion value of the midpoint using a significance level of $p=0.05$.

2.3. Method

2.3.1. Recruitment

Word-of-mouth was used for recruitment to both study arms. A very active online clinical psychology community was used to supplement this for the survey arm of the study.

Inclusion criteria:

Qualified clinical psychologists who have provided clinical supervision to a clinical psychologist, or aspiring clinical psychologist (e.g. trainee clinical psychologist, assistant psychologist), for a period of at least six months in their role as a clinical psychologist.

Psychologists who were supervising me during the data collection period were excluded.

2.3.2. Participants

2.3.2.1. *Interviewees*: Twelve participants were interviewed. When the richness and detail expected from qualified clinical psychologist participants is considered, this sample size was towards the upper end of the suggested range for a professional doctorate project using Thematic Analysis, thus maximising the range of perspectives informing my analysis (Clarke, Braun & Hayfield, 2015). Reaching data saturation after ten participants confirmed this decision (Guest, Bunce & Johnson 2006; Ando, Cousins & Young, 2014).

Participants were actively recruited from a range of ethnic backgrounds, specialities, and years spent in the profession since qualifying. This was for pragmatic reasons, as I hoped that any analysis might inform future training or

guidance for any supervisors, in which case it would ideally find common ground, as well as highlighting differences between a range of perspectives.

These strategies led to the recruitment of an equal balance of White supervisors and supervisors of colour being recruited, as well as a good spread of service contexts and levels of experience (see Appendix D). Homogeneity was otherwise maintained by recruiting only qualified clinical psychologists working in London.

2.3.2.2. Survey respondents: The additional use of the online forum as a recruitment strategy, and my prioritising of a larger sample size led to a convenience sample which was less balanced with regards to ethnic background and gender (see Appendix E).

2.3.3. Data collection

2.3.3.1. Semi-structured interviews: Face-to-face interviews were chosen to facilitate relational safety while discussing a subject which may engender feelings of personal or professional vulnerability (Josselson, 2013; Proctor, Kyle, Lau, Fefer, & Fischetti, 2016). Focus groups were considered for their potential to support the construction of shared themes, however the risk of replicating dynamics of inequality or segregation was too high. Particular concerns were the possibilities of psychologists of colour being silenced or re-traumatising by any accounts of racism being denied. A semi-structured interview schedule (Appendix F) was created to ensure the centring of my research questions while allowing me to probe points of interest or uncertainty. Two pilot interviews led to minor changes to the wording of one question, but confirmed the appropriateness of the data collection method. Supervision discussions around the feedback from pilot interviews led to my preparing both abstract and concrete follow up prompts for each main question, so that I could adapt them to the leanings of the interviewees.

Qualitative approaches are traditionally seen to be particularly intertwined with researcher influence. Therefore, I actively aimed to minimise my influence, for example, by maintaining some structure and uniformity of questioning in my interviews. However, I also recognised my influence as potentially positive at times, in line with Clarke & Braun's (2018) 'Big Q TA' approach. For example, some of my Black and Asian participants suggested that my ethnic background

allowed them to speak more freely, which is further explored in the Analysis chapter. A research journal, supervision and peer discussions aided this reflexivity, which is explored in more depth in the Further Discussion, Evaluation and Implications chapter.

2.3.3.2. Online questionnaire: My first eleven survey questions aimed to provide categorical data to complement the qualitative main arm of the study (see Appendix G). The free text response at the end was included specifically to contextualise this categorical data. I additionally anticipated it aiding my evaluation of the extent to which interview participants felt inhibited by my presence, especially as a trainee in the same profession and region, by providing an anonymous online comparison. I also remembered Rajan and Shaw's (2008, p.11) comment that few people were "curious enough to ask" about trainees' experiences of discussing issues of race, culture and ethnicity. I hoped that a condensed online format would afford the option to voice their opinions to some who were prohibited by time, location or an interview format, as well as the several psychologists whose offers I had to turn down after reaching my agreed interview arm sample size.

2.3.4. Procedures

2.3.4.1. Qualitative data: Interviews took place in quiet, private, comfortable rooms which were convenient for and accessible by the participant. Interview times were similarly chosen for convenience and largely dictated by participants. Interviews lasted between 50 and 85 minutes.

A digital voice recorder was used to record interviews, which were transcribed in line with Braun and Clarke's (2006) minimum orthographic transcription requirements (see Appendix H).

Braun and Clarke's (2006) six phases of thematic analysis were closely followed:

I. Familiarising yourself with your data

I noted down my initial thoughts while listening to interviews and added to these while checking transcripts for accuracy.

II. Generating initial codes

NVivo software was used to generate initial codes (see Appendix I).

III. Searching for themes

I experimented with different ways of sorting codes into themes and used early-stage thematic maps (Appendix J) to assist with the latter part of this process.

IV. Reviewing themes

Themes and thematic maps (Appendix J) were compared to extracts and to the whole data set and revised regularly following space for thought and supervision discussions.

V. Defining and naming themes

The scope and essence of each theme was defined in relation to their corresponding set of data extracts. Themes were named to try and capture their essence, in two out of three cases by paraphrasing participants' own language.

VI. Producing the report

The write-up is contained in the Analysis chapter. Participants were asked to choose pseudonyms for the write-up; some preferred that I choose one for them. Participants will also be provided with a brief summary report.

Analysis was primarily semantic and inductive, as I was open to as yet untheorised connections in the data, but also deductive, due to the inevitable influence of clinical psychology and other theories in my sense-making.

2.3.4.2. Quantitative data: The survey was optimised for access on a desktop or mobile device allowing for completion at participants' convenience, including the option to start and then return at a later date. The questionnaire was estimated to take approximately ten-to-fifteen minutes to complete. Qualtrics® software was used to collect questionnaire data.

2.4. Ethics

Ethical approval was granted by the School of Psychology Research and Ethics Committee (Appendix K).

Potential participants were given information sheets for the interviews and online survey (Appendix L and Appendix M respectively) and the opportunity to contact myself and/or my supervisor prior to consenting. Interview participants were given additional opportunities to ask questions in person before and during the interview. Prior to being interviewed, interview participants signed a consent form (Appendix N). Survey participants indicated consent by clicking on a 'Yes' button at the end of the online consent form (Appendix O), which activated the online questionnaire.

Participant names, contact details and consent forms were stored securely and separately from audio-recordings and transcriptions. Audio-recordings were transferred to password-protected files on password-protected computers immediately after collection and will be erased when no longer required for examination purposes. All other anonymised data which may be required for publication will be stored securely for five years, after which it will be destroyed or deleted. I transcribed recordings alone and altered identifiable information before further use. Anonymised transcripts will be accessible only to the study supervisors and examiners.

Information collected about participants will be kept strictly confidential. Interview participants were asked to refrain from sharing identifying information about supervisees as per their supervisory contract, local policy and/or practice guidelines. They were reminded that, for example, referring to a "Black male trainee clinical psychologist" may identify them due to the small number of trainees sharing this identity within any given region. My wish to instead explore the *supervisor's* experience was emphasised. If participants had concerns at any stage of the interview about identifying themselves or others, I gave them plenty of time to consider this and audio-recorded their response as part of the interview. If I was at all unsure about identifiability, I verified with them via email the combination of quotes I intended on including.

Interview participants were reminded that they could take breaks, reschedule, or withdraw from the study at any time. Some interviewees did find reflecting on these issues distressing, but not to the extent that further intervention from me was necessary other than allowing them space and stepping out of the 'researcher' role for a few moments to make my support or empathy more explicit in a few words or a less 'neutral' facial expression. I ensured sufficient

time was allowed for post-interview debriefs which included opportunities to ask questions and raise concerns.

A debrief sheet (Appendix P), which included sources of support and the research team's contact details, was emailed to interview participants and included in the online survey. Interview participants were additionally given a paper copy of the debrief sheet immediately after the interview if they wished.

3. CHAPTER THREE - ANALYSIS

This chapter describes three main themes (Table 1). Discussion of the literature is incorporated into the analysis to avoid repetition and facilitate a more detailed analysis of extracts (Braun & Clarke, 2012).

Table 1. *Themes and subthemes*

Themes	Subthemes
The blue whale in the room: Racism and oppression (in clinical psychology)	Supporting supervisees
	The race person
	Subtle and unspoken
It's not like talking about the weather	Risk and avoidance
	Distress, (dis)comfort and confidence
	Power and difference
	(In)escapability
	Enriching
Professional structures, discourses and practices as sites of power	The dominance of Whiteness and Eurocentricity
	Incorporating race and culture
	Whose responsibility?
	Barriers
	The role of training

3.1. The blue whale in the room: Racism and oppression (in clinical psychology)

There was a sharp contrast between participants of White backgrounds and those from Black, Asian or Mixed backgrounds with regards to this theme. Apart from the specific situations described by Daniel, Brian and Hannah below, White participants did not mention these issues. The transcripts of supervisors of colour, however, tended to regularly reference racism, oppression and racialised dynamics experienced by themselves, their supervisees and/or their

colleagues in the profession. These transcripts were sometimes saturated with the pain of these experiences, which is consistent with other literature (e.g. Adetimole, Afuape & Vara, 2005; Paulraj, 2016).

One participant described a particular issue of culture as “an elephant in the room” (Chiara), contrasting its unspoken nature with its obvious size and impact. In the context of the Grenfell tower fire, race (and class) has been referred to as not just an elephant, but a blue whale in the room (Grenfell tower inquiry, 2018), perhaps suggesting it has become a larger, more obvious unnamed problem, but one that might be even harder to shift than previously thought. Given the obvious impact of within-profession discrimination, the longstanding silence on this from some sections of the profession and in certain spaces, and the links with wider societal issues as highlighted in the wake of the Grenfell fire, racism and oppression in clinical psychology similarly felt like a blue whale rather than merely an elephant in the room.

3.1.1. Supporting supervisees

Supervisors of colour’s own experiences and observations strongly informed their supervision, for example in their prioritising of creating safe enough supervisory relationships for supervisees of colour to be able to share their experiences (as emphasised by Patel, 2004), or insisting their supervisees attended to these issues in their work. Fariha’s trainee seems surprised by their experience of racism in the profession, in a way that suggests their experience in wider society may be different:

I remember quite recently, a trainee said ‘I actually didn’t think people still feel like that, people can be so racist’ [...] we spent quite a lot of time talking about that [...] it’s something that we’re going to face, unfortunately, a lot of. [...] I could talk about a lot of my experiences, and [they] found that really helpful [...] I really love supervising trainees from sort of minority backgrounds because, you know, I think I have something particular to offer that supervisory relationship [...] at the same time I kind of feel well, it would also be good to be able to sh- to have, you know, someone [...] perhaps White, so that I can perhaps use that to then help them think

about these things in a way that they might not [...] but I think the first one is easier probably, and the second one might be a bit more difficult.

The anecdote supports Wheeler's (2004) suggestion that supervisors have traditionally learnt to supervise from their experience as supervisees and clinicians rather than through models or training, as well as literature linking supervisor self-disclosure and supervisee satisfaction (e.g. Ladany & Lehrman-Waterman, 1999). However, as Fariha notes in the second part of her extract, this approach to supporting supervisees around issues of race and culture may be easier in the case of supervisor-supervisee similarity. Fariha's suggestion that the introduction of difference may aid supervisee learning resonates with Wieling and Marshall's (1999) survey findings that most of their US marital and family therapist respondents who had never been supervised by someone from a different racial and/or ethnic background thought that it would have benefitted them. Respondents cited increased awareness and sensitivity around multicultural and diversity issues as reasons for this.

Abbie, Sophia and Zoya also describe situations where supervisees discussed experiences of prejudice with them (extracts omitted to preserve confidentiality). These were typically accompanied by significant distress and often happened in groups where, as is described in other literature, the supervisee either felt unable to say anything or experienced further distress from the repercussions (e.g. Odusanya, 2016; Paulraj, 2016; Adetimole, Afuape & Vara, 2005). Abbie reflected on her supervisee's account, and the fact that discrimination remained alive and well in the profession, albeit in different forms:

...implying that somehow, they're not so- psychologically sophisticated is still another way of just sa- of talking about certain cultures being inferior [...] as opposed to even questioning or challenging your ideas about what that is, what is psychologically minded anyway, and is that even a good thing. It's actually this idea that some people are more advanced than others.

Using the example of "psychological mindedness", Abbie illustrates how the deconstruction of taken-for-granted concepts in the profession might reveal distinctly Eurocentric, middle-class values (Dennis & Aitken, 2004; Rajan &

Shaw, 2008). As well as the potential for this to perpetuate cultural hierarchies, she further suggests that it may be unhelpful in itself. This may be because it deprioritises communality, spiritual values or physical methods which are more prevalent in majority world approaches to emotional well-being such as yoga (Webster, 2002; Fernando, 2010).

3.1.2. The race person

Hannah, alongside several participants of colour, referred to the unequal pressures and responsibilities placed on psychologists of colour to address these issues:

...do you have to have more conversations about being a Black psychologist than a White psychologist has to have? And do you have a responsibility to do that, and is that fair on you, and does that inform the type of work you end up doing, whether it's your interest or not [sigh] [...] because of the overwhelming Whiteness of the profession, you know, a trainee who is Black might feel [...] a sort of pressure to be [...] an advocate for other potential clinical psychologists who are Black, which, you know, might be someone's preference, to an extent, but not for it to become, to overshadow their other work, and feeling that, because colour is the, is a visible difference that it's im- it's not possible to step in and out of those conversations, so, when you're in a team which is predominantly White, you can't, step out of it, and just not have that conversation that day because it's happening anyway, whether you're talking about it or not...

Bobby highlights the unequal distribution in affective labour resulting from this, and the pain of considering this imbalance:

...it can be easy to become known as that person who talks about race all the time [...] where either you're made to feel like you're the spokesperson for everybody of every race [laugh], or you just end up being pulled into it somehow, because it's annoying, or it's frustrating [...] I wish there was a way in cohorts or year groups [...] that you're able to kind of talk about difference without being like, oh, what do you think, person who

is different [laugh] [...] It would be nice if the people in the profession who were BAME didn't have to feel forced to take up that emotional labour basically, that OK well, this, I need to speak about this, because you know, I'm Black, or whatever or whatever. Like it would be nice if other people felt that responsibility too [...] I have to say it's been quite jarring how even with those people who have been willing to have those conversations, how easily they can just let it go, because it's not their life, it's not their deal, like, it doesn't have to be their deal, they can just let it go, yeah. Even just talking about it is quite upsetting...

As Bobby notes, the difficulties with being positioned as a 'native informant', including the homogenisation of people of colour, is a widely recognised theme in clinical psychology, critical race theory and pedagogy, and wider literature (e.g. Rajan & Shaw, 2008; hooks, 1994). Hannah's and Bobby's extracts also reveal an unspoken benefit of Whiteness in clinical psychology as it facilitates the avoidance of the "emotional labour" required for meaningful race talk. As well as benefitting White psychologists on an individual level, this avoidance contributes to the maintenance of the status quo, which is in their interest as a group holding more power in the profession.

This positioning by others was contrasted with many participants' identification of their own learning needs with regards to issues of race and culture (resonating with Pethe-Kulkarni's, 2017 findings), and/or their conviction that they should be held to the same standards as White psychologists when it came to their potential for discrimination:

(Abbie) ...what I'm conscious of is that by virtue of being Black, and talking about race in supervision, I'm positioned in a positive light, if you know what I mean. And I guess I'm just conscious also of that, what are the ways in which I might also be, unhelpful, harmful, oppressive...

3.1.3. Subtle and unspoken

Many participants discussed the subtler nature of racism in clinical psychology:

(Cyrus) I've kind of personally have had the experience of trying to come through the ranks in the profession and how, some of the opportunities and the barriers have been very subtle, but clearly noticeable, except they're so subtle it's difficult to make them explicit [...] psychologists don't do prejudice in a very explicit way. [...] And these are stuff you cannot put your finger on. You know, you walk into a room, you notice stuff, and I've lived long enough to trust what I notice. I can't always say exactly what it is, but you notice, you notice things shift. Sometimes it's more explicit. [Laugh].

(Brian) ...there's a certain sort of [sigh] how to say, blaséness about it [...] most clinical psychologists are pretty liberal, quite left wing. I think, I don't recall ever meeting a kind of, a racist psychologist. So, which is great, but then there's a certain hiddenness [...] the issue could be, just taken for granted that, you know, we're all the good guys. Where, I think, you know, issues of race often are quite subtle, and the things that you do, mistakes you make [...] so if you don't reflect on it, you could just carry on doing it.

(Bobby) I feel like so far in this conversation I've talked a lot about safety, and I just think that's really important, yeah, I think that's the main thing. Because you never know how people feel about race really [...]. I've worked with lots of people kind of coming up through the NHS [...] and it just really made me realise that actually at work, people are their work selves, but when you find out about people's private lives, you realise that actually a lot of people are rather racist [laugh], like a lot of people are rather openly racist, and a lot of people are kind of racist in a really sensible middle-class sort of way [laugh] [...]. So it's not the sort of person who's kind of saying 'go back to your own country, you don't belong here'. But is the sort of person that is just kind of quietly judging you, and already doesn't think much of you, and probably expects you to work really, really hard to kind of win them over, and is the sort of

person that is like 'I think you're a great person, you're a great work person', but you could never [date their child], like that just would not ha- you know, that sort of racism. So it's not like hatred, it's just, it's like you're not good enough somehow [...]. And I think those sorts of attitudes are really hard to shake, and I think in a profession like ours which is quite middle class, actually, I think some of those seep into us without us realising, I think it happens all the time. I think sometimes I'm like I have to work really hard to not just get caught up in the ideas about these particular groups.

This is consistent with accounts of insidious racism in clinical psychology (e.g. Odusanya, 2016; Adetimole, Afuape & Vara, 2005). As Bobby implies, this may be due to a 'middle-class' culture in the profession, which stifles more explicit expressions of prejudice. Other participants similarly linked their and/or their supervisees' experiences to the interacting effects of race, culture and/or ethnicity with class, sexuality and/or gender in the profession (extracts omitted to preserve confidentiality), which again accords with previous literature (e.g. Paulraj, 2016; Adetimole, Afuape & Vara, 2005). The subtleness of some of the discrimination encountered often seemed to make it harder to articulate and share experiences, which is consistent with Paulraj's (2016) findings that negotiating one's identity as a Black trainee was typically a lonely journey.

Brian also presents "good guy"/racist and liberal/racist dichotomies, which is a common discourse within and beyond clinical psychology (e.g. Lentin, 2018). However, this may make the task of reflecting on prejudices harder for psychologists (D'Ardenne & Mahatani, 1999), as it would entail viewing themselves as the 'bad guy', leading to their favouring defensiveness and denial over exploration and learning. The end of Brian's account seems to move beyond this dichotomy, as it acknowledges that racism can be subtle and unintentional.

Brian and Daniel nonetheless described instances where their supervisees had accused them of racial/cultural prejudice following negative evaluations as painful. This is a common situation described in supervisory literature (e.g. Patel, 2004):

(Brian) I was a manager there, senior person, but, you know, I just thought they were underperforming, and so I think what happens sometimes is there's these more subtle problems going on, that relate to race, and culture, but often it's seen in a very bland way, as just, oh, 'ah God, it's just Nigerian nurses, they're always causing problems', or, you hear things like that said, you know, 'the Mauritian mafia', I mean, you know, because there was a time where there are a lot of Mauritian nurses. And, so, you hear these things, and I think, I don't think it necessarily leads, as far as I know, to, sort of, real discrimination or anything. [...] I had one Black trainee, female Black trainee, who had real issues and accused me of being racist [...] The weird thing about her was that she had tons of conflict on her placement, all with Black people, particularly with these, with those Nigerian nurses that I'd mentioned [...] I presume, for her, that she was, that she'd been victimised in the past, and this was why she was so sensitive to it.

Brian's story allows consideration of the subtlety of racial discrimination. For example, I wondered whether Nigerian or Mauritian supervisors would view the way these nurses were described by colleagues as "bland" or not "real discrimination", or whether they would have experienced the comments as derogatory slurs. This differing judgement about whether a particular incident might be racist or not reminded me of Fariha's response to a trainee reporting a painful incident on placement:

I had this feeling of tremendous kind of sadness that this is still going on you know because it just felt like this is kind of almost blatant, [...] the saddest thing was, it was like and they don't even realise they're being racist [...] on one level it felt really sad and shocking, and on another level I thought well, you know, I'm glad that I can be here to facilitate what is the reality of our working life...

Fariha also described the more embedded, ongoing discrimination she faced as a psychologist, such as White standards of professionalism:

[A colleague] had noted that they felt what I wear is having an impact on how people, because I do a lot of work in [certain organisations], how the professionals in [these organisations] view me [...] if I'm dressed in a more Muslim, more Asian way, I have less of a professional persona, whereas if I dress in a different way, I have more of a professional persona, and I actually think that's quite shocking, because I shouldn't have, I should be seen in the same way regardless of what I'm wearing, as long as I'm not turning up wearing inappropriate clothes I should be seen in the same way, but I think it still exists, that still exists, it's that how professional do you look.

Fariha's demonstrates how cultural (and religious) differences can be embodied as well as ethnic and racial ones, an issue explored in the supervision literature by Messent (2016) and others in the same volume. Bobby, however, also discusses his initial denial of the embodiment of difference and refers to the 'colour-blind' approach which remains widely used (e.g. Odusanya, 2016; Pethe-Kulkarni, 2017; Wood & Patel, 2017):

I think I went through the profession trying to be like colour-blind, you know, myself, and be like 'oh, people don't really see my race, and stuff', but I think they really do. They really, really do and I can think of opportunities now where I feel like I wasn't given opportunities because people made lots of assumptions about me, about my competence...

Bobby's account seems to suggest that at times the prejudice he has experienced was subtle enough that it is only following time, reflection (and perhaps training) that he himself might view it as discrimination. Zoya, who had recently been exposed to conversations about racial dynamics in the profession for perhaps the first time, was unlike other participants in feeling as though she had not experienced discrimination as a psychologist of colour. However, she did discuss concealing aspects of her cultural identity as a supervisee and, therefore, wanting to emphasise safety and openness as a supervisor herself:

I don't think I've ever talked about my race, in rel- or my culture in relation to supervision [...] but I feel like it does play a role,

and, there are things that maybe I haven't talked about or haven't said that does feel relevant. [...] For example around things like when they would ask about my fam- my life and my upbringing, maybe I wouldn't talk about certain things, [...] that might be to do with my, sometimes my own maybe, judgements about what people might do with that information or how relevant it was given the context [...] when I'm with different groups of people those things feel like actually more, I don't know, normal topics to talk about...

As is described in other studies (e.g. Odusanya, 2016), Zoya was questioning whether her silence was down to *her* judgements. It seemed that our professional obligation to 'be reflective' and the predominant tendency to individualise, could both empower in the face of unfounded worries about prejudice, but also potentially *disempower* by encouraging us to take responsibility for what we intuitively know to be 'unsafe' spaces in which to discuss these issues. Zoya's account was consistent with several participants' reflections about sanitising or hiding their experiences for White colleagues, and that their supervisees of colour had reported doing the same:

(Fariha) ...when I have, supervisees who are not White, [...] it feels very comfortable, [...] you feel well you can let, you can say stuff without it being, without someone being shocked at [laugh] what you're saying almost, because you, because it can be quite shocking sometimes to say things. [...] I'm happy to talk about these things to anyone, really, but I might, the way I might say it, I might change [...] it might be unconscious, I think unconsciously I might tone it down a little bit, just so I'm not shocking anybody too much...

These patterns suggest a prioritising of the feelings of White colleagues, which may lead to supervisory spaces becoming 'White comfort zones' (Leonardo and Porter, 2010). This resonates with Paulraj's (2016, p.50) report of participants "watering down" conversations about race for fear of being assessed unfavourably. Paulraj describes how White fragility in the profession may lead to this silencing and sanitising (DiAngelo, 2011).

Some participants discussed the impact of my colour on their ability to speak frankly during the interview itself. Although Abbie was not sure how she would have answered had I been White, she noted that any differences may have included non-verbal, embodied responses (Afuape, 2016):

Like when you asked the question about my training, and would I have smirked in that way, or would I have just done it inside, I don't know, or would I have, yeah, I don't know, maybe not.

(Bobby) I'm not sure that I would have been as real [...] I don't think I would have gone as in-depth.

As with their experiences of prejudice in the profession, it seemed as though the differences in how Bobby and Abbie might relay them to psychologists of different backgrounds were subtle, but significant.

3.2. It's not like talking about the weather

The name of this theme was a paraphrasing of a quote from Abbie:

It's not like talking about the fact that it's snowing or something, it's really a thing.

Participants described talking about race as uncomfortable, necessary, rewarding, interesting, and potentially risky, which sounded wholly unlike talking about the weather. Again, there were some differences between participants whose colour allowed them to "just let it go" (in Bobby's words) and those for whom their colour meant that these conversations were inescapable, often emotive, personal, and sometimes deeply distressing, as has been described by those within and without clinical psychology (e.g. Wood & Patel, 2017; Eddo-Lodge, 2017).

3.2.1. Risk and avoidance

Participants of colour talked about the particular risks of talking to people who were disconnected from experiences of racism, regardless of their background, and how they often resorted to 'secret' conversations:

(Zoya) ...if I was to share something, or things that have happened, maybe feeling that it could be explained in other

ways [...] you might try to have a conversation about something, but then it becomes about, actually well it's not about race, maybe it's about something else, there are so many other factors that play a role, that then race gets diluted sometimes...

(Abbie) ...I find that, not harder to talk about with the person because it feels very private, and somewhat, almost secret. [...] But then trying to bring that into a public sphere, and it, helping people to engage with each other, I think that's very tricky...

(Fariha) I find myself in meetings bursting to kind of say something, but holding back, you know bursting to say something about the whole race, culture, whatever it is and kind of holding back thinking, mm, I don't know if I want to say this, you know, should I, should I not, and then the moment goes [laugh].

Race talk was evidently difficult, even in a profession that specialises in the careful facilitation of difficult conversations. There seemed to exist a double-bind where participants were simultaneously expected to have these conversations and had to manage 'bursting', 'having secrets' or dealing with discrimination alone if they did not, but also feared negative consequences from raising these issues. The literature would suggest that Zoya's worries about the denial of racism is a concern within and outside clinical psychology, and, as described in subsection 1.4.3, has been linked to secondary trauma (e.g. Adetimole, Afuape & Vara, 2005; Lentin, 2018; Lowe *et al.*, 2012).

Several participants discussed the risk of 'getting it wrong', often with regards to language. This sometimes, but not always, led to the loss of confidence and reluctance to raise issues of race or culture that Cardemil and Battle (2003) described:

(Gary) There may be kind of a little bit of anxiety around when these things come up. And maybe that's linked to, [sigh], again to, the value that I put, or to the importance that I see in these issues, and therefore, you know, wanting to get it right, in inverted commas.

(Brian) I was scared of being branded racist.

(Sophia) So it was curiously absent on the supervisory agenda and I don't think that was a good thing, [...] I think maybe there was some fear on my part that I might get it wrong or say it wrong [...] which is a shame, because I'm sure that [issues of race, culture and ethnicity] were alive for that person and I imagine that they were thinking it through quite a lot.

Getting it wrong seemed to both risk negative consequences for the supervisee, who might be offended, and the supervisor, for whom "being branded racist" might threaten their perceptions of themselves as good, moral and decent as discussed in the previous subsection (Sue, 2003). Some of these dynamics played out in the interview itself, with participants actively reflecting on whether the interview would have been different had I looked White. Getting it wrong in this context typically led to (shared!) laughter:

(Casper) ...standard White, ooh dear, that's a little bit pejorative isn't it, a White [laugh] trainee...

(Gary) ...who would identify as being from a different, [laugh] different to the mainstream. Mainstream? You know what I mean, the dominant culture in the UK.

For some, however, acknowledging the possibility of getting it wrong seemed to *reduce* their anxiety:

(Daniel) I think we will get it wrong. [Laugh] I think knowing we'll get it wrong is quite, liberating, really [...] I often say that at the start [...] there may well be times where I don't kind of quite get it right or understand things.

Daniel may have been freed up here by his move away from a binary getting it right/getting it wrong dichotomy towards a more flexible conceptualisation of his 'performance' in race talk. Given the potential complexity which may arise from meaningful engagement with the subject, his may be an approach which means that supervisor expectations, capabilities and reality are more realistically aligned (Bandura, 1977). However, at the end of the extract, Daniel highlights the importance of also *setting up* the relationship or conversation to tolerate

mistakes, echoing the literature which emphasises supervisor proactivity and the importance of relational safety in this area (e.g. Dhillon-Stevens, 2001; Patel, 2004).

Chiara highlighted the particular risks of venturing into the territory of personal beliefs:

...but it was very difficult to bring it up, because I felt like I actually didn't really know much about this area, how much do you probe your supervisee about their own belief system, especially if they hadn't volunteered it. I think if she'd said to me, I believe, xyz, but all I knew was that she went to church, and she was quite surprised by this family's views...

Other participants similarly referenced issues of sexual orientation, faith and class, thus employing a broader definition of culture. For Fariha, racism and islamophobia were closely linked, echoing wider literature (e.g. Hussain & Bagguley, 2012). While these sorts of links may have been in the minds of other participants, focusing on culture may also have been an unintentional means of avoiding the riskier issues of race and racism (DiAngelo, 2011). Hannah, by contrast, had a noticeable fluency, and perhaps comfort, in referring to race and colour. She linked this to her personal context and training, which seemed to have emphasised the relevance of the 'personal' in the professional arena:

I've got sort of recollections of lecturers talking easily and openly about their own identities and [...] I suppose modelling being able to talk about your own identity and write about your own identity [...] and think about your own identity in relation to supervisees and families and clients [...] because I guess if you haven't had those conversations previously, it's just [...] having familiar words in your mouth, and feeling clear about how you talk about yourself, and being able to reflect on yourself, and who you are, and where you come from [...] and our child is mixed, and, I suppose that helps me, [because we] talked a lot about, being different colours [...] that probably made me more used to I think talking about my identity in that way.

3.2.2. Distress, (dis)comfort and confidence

There were a range of feelings about distress, (dis)comfort and confidence in relation to these conversations, including reflections about the impact of lived experience and previous conversations, and bravery in the absence of confidence. Abbie provided a striking metaphor of her experiences:

...bringing up issues of race to people who aren't oppressed by race has been almost always a painful experience [...] I've felt attacked or silenced, or rubbished, or ridiculed, or ignored, or spoken over, or dismissed, or it's invited, it's made me feel like it's invited more prejudice. It's a bit like, or even sometimes not as obvious as that [...] I've got an image in my mind of like a well, that you kind of you throw a stone into, it's dark and you can't see the end of it, and you listen for the, you know, when the stone kind of hits something, and it never does. A bit like that, you can kind of open up something and it sometimes feels as though it goes into this void, and doesn't have anything, you don't get anything back, and that can be just as painful as the more kind of obvious sort of, being dismissed, or being challenged, or being, whatever, when you say something and then nobody responds, or you, or the response you get back is, doesn't feel it's in comparison to what you've said, can be, yeah. Or, even more painfully, people being hurt by it, and so then y- feeling as though you've hurt someone by mentioning racism, or them [...] literally getting upset [...] how that can yeah, becomes then about their pain, as though you've done something to them, which is, yeah, in some ways harder than the more attacking responses. [...] I find it a combination of very freeing and very, at times I can feel very distressed by it, [...] when people, talk about, things that I can really relate to, and I think God, there's no change, [...] things are still crap, [...] it can make me feel very sad, in the kind of heartfelt way, or soulful w- I can't quite explain it really. [...] I might kind of just go home just feeling a bit like I want to crawl or, you know, crawl under the covers, or I

feel anxious around [her child] and the life that [they], you know, that's going to have...

Zoya also experienced conversations about race as uncomfortable:

If we don't become aware of that then [...] in therapy we talk about this all the time, the risk is you fall into patterns of acting out stuff that you haven't really explored I suppose and so it certainly feels important in supervision and in the workplace to find ways to cultivate having conversations like that, even if they are quite uncomfortable, yeah, and they can be uncomfortable, [laugh].

Both Abbie and Zoya's extracts highlight the personal-professional interplay in this area, challenging traditional notions of a 'boundaried' psychologist (Paulraj, 2016; Goodbody, 2012). Abbie seems to have no choice but to take these conversations home with her, and Zoya highlights the importance of bringing into consciousness what one 'brings' to the job to avoid unconscious enactments (Tummala-Narra, 2004). Abbie describes being the one left 'listening' or being implicitly urged to prioritise others' pain or realities despite her evident distress, while Zoya flagged another risk, which is perhaps easier to ignore for a predominantly White profession, that of *not* exploring these issues. She additionally suggests that our 'psychologist' skills should be deployed in supervision and the workplace, not just our roles as therapists (BPS, 2010). Similarly, Cyrus calls for integrity and coherence in clinical psychology practice:

Confidence is a function of getting into it on a regular basis. So the answer is yes, but that's developed over time [...] there's something about that kind of putting your money where your mouth is, there's no point talking about these things and then not actually, bringing them up at the time. So, no, it's not even a confidence, it's just necessary, yeah? [...] Because that's actually what we're asking you to do, that's also what you're asking your clients to do. If you notice something, it's uncomfortable, you need to step into it.

Brian also highlights the need to prioritise necessity over any discomfort:

I don't think it's anything to be uncomfortable about quite honestly. I don't quite get that. I understand that people can be uncomfortable, but I think it's unwarranted. Even if you are a White bloke from, you know, from Watford, and you're treating another White bloke from Watford, there are cultural issues involved in that, even, so, you know, you should be doing this. [...] If you are from a minority group, and you feel that you've perhaps been victimised, and you feel particularly sensitive about it, I can get that. If it's missed, if the issues are missed you might find that harder to tr-, I can get that. But you should be able to raise it, you should be able to talk about it. And if your supervisor can't talk about it then there's something wrong, there's, you know, and you should be able to talk about that. But I get they are real, power relations are real, etc, etc, so I do get that.

Two participants shared detailed memories of difficult conversations around issues of race and culture on training, which accords with explorations of trainee clinical psychologists' experiences (e.g. Adetimole, Afuape & Vara, 2005). Bobby's account spoke to multiple points of disadvantage experienced by psychologists of colour, the threat to cohesion of race talk, pain and defensiveness overtaking the subject matter, and the worry that oneself rather than the problem may be positioned as problematic:

...it could just spiral into something. So even like in my training, and I feel like this happens every year. We had a year where we had a supervision group and then there was like a massive split in our group, because of race basically. [...] I just remember being like, urgh, this is really frustrating because you have so many sides to this issue, and all everybody's just thinking about is how hurt they feel [...] you had some trainees were crying, some people were like, oh, I've upset this person, oh, I'm not a racist, oh, oh, I can't even remember what we were talking about [...] all I remember was like the aftermath, like the aftershock, it just rippled. Like, it changed the dynamics of the group so much, it changed all these friendship groups [...] with

training, it can be tricky, but you have your own groups or whatever, and then you know you're going to leave training soon. What if you're in a job that you particularly like, and then you start talking about something that somebody else perceives as problematic, what are you going to do then, are you going to stay in this situation that's really, really horrible. Are you just going to hope you're going to ride it out? Do you move jobs? [...] It's almost like it's not worth it. It's hard enough to become a clinical psychologist. It's hard enough to be taken seriously and to be thought of as competent. Without then adding other stuff in there...

3.2.3. Power and difference

Participants regularly framed these issues in terms of similarity and difference:

(Hannah) I would be encouraging someone to think about, how their identity might be perceived by that family within the room, and what their identity brings to the room, and if, where there's difference [...] what that might mean to the family. And where there's similarity, equally, what that means and what that will bring to the family. [...] But the issues of race, culture, identity, ethnicity would be, would come up in lots of ways [...] I can think of conversations about similarity and difference within professional teams, and talking about that, and talking about how supervisees have been positioned there.

The dominance of discourses of difference fitted with the literature, but these discourses were questioned by some participants for their role in positioning the other as different, or obscuring issues of power, as has been highlighted by other authors (e.g. Paulraj, 2016). These critiques are implicit in Gary's reflection:

One of the key things for me I suppose is helping people to understand that difference isn't located in the other, and that difference is always between people [...] sometimes people will have this kind of idea of difference as being located in the other,

but they're only likely to do that [laugh] if they're from the dominant culture, aren't they?

Other participants managed to contextualise issues of difference with those of power/powerlessness, dominance/subjugation or voice/voicelessness, as can also be seen in previous literature (e.g. Wood & Patel, 2017):

(Daniel) Sometimes it's more of a challenge if you come from the same cultural background as your supervisees, because then there might be [...] a client from a different background, or a family from a different background, there's more of a danger that we start to see our worldview as the dominant one, so I think that in some ways requires m- although the supervisory relationship might feel comfortable, what- there's more of a danger there that our responsibility towards the kind of client doesn't get met.

Hannah's, Gary's and Daniel's extracts suggest a degree of proactivity and discipline is required to prevent oneself from falling into dominant ways of thinking, whether this involves pre-session hypothesising with every family, carefully listening for how difference was constructed by supervisees and its implications, or looking out for where supervisors and supervisees hold one shared identity and clients another. This discipline is perhaps similar to that which is encouraged by reflecting on particular lists of questions in supervision (e.g. Patel, 2004).

3.2.4. (In)escapability

Participants were keen to emphasise the theoretical inescapability of these issues, and their close relation to clinician competence, as professional guidelines would suggest (e.g. BPS, 2017; HCPC, 2015). Casper notes their centrality to all members of the supervisory triad (supervisor, supervisee and client), and speaks to some of the complexity of these issues (Ryde, 2009):

...how power functions, and where one's identity is, and where one's picked that up, and where one stands in relation to that. And, of course, all of these things are very relevant in terms of sort of being a supervisor, and helping someone else be in a room where all three parties have all of that stuff operating all of

the time...

Meanwhile, Daniel notes the ways in which inattention to these issues might coincide with the predominantly individualist culture in the UK in such a way that distress is decontextualized and maintained:

...if you don't bring these kind of issues into the room, somebody might kind of continue to hold a kind of sense of personal, being personally responsible for their distress rather than it being something that they have been, emerged from kind of dominant messages around groups that they belong to...

Cyrus was keen to emphasise that just as these issues necessarily should come up when relevant, they also should not come up when irrelevant, as that in itself may be discrimination, similar to Leong and Wagner's (1994) noting of instances of racial or cultural factors being *overemphasised* at the expense of other contexts:

In the nicest possible way, I don't care what it feels like, because it is necessary to the conversation [...] But it's always in the context of the clinical presentation, and the relevance to the person's well-being [...]. If it's just brought up for its own sake, [...] I think that's prejudice.

Interestingly, participants also felt these conversations could be all too easily avoided or become tokenistic, which accords with the experiences of UK clinical psychology supervisees (e.g. Shah, 2010). Some participants reported avoiding these issues themselves, albeit not necessarily consciously, which was reminiscent of Zoya's idea of enactment in subsection 3.3.2. Sophia observed that she did not raise these issues equally often with all trainees, and acknowledged her responsibilities as supervisor to encourage cultural curiosity:

...do I have those conversations with the blond trainees?
Probably not, no. But should I be? Probably yes [...] some of those trainees, I don't know where they're getting their sort of training in terms of being culturally competent, or being culturally kind of curious or culturally aware [...] it's a conversation that you need to be having with all trainees really...

Here Sophia implicitly questions ‘cultural competence’, as have more critical authors (e.g. Paulraj, 2016), with ‘curiosity’ and ‘awareness’ perhaps feeling more realistic or suggestive of ongoing learning. Her reflections also emphasise the extent to which decisions around raising these issues or not may be based on visible characteristics.

As well as it being a difficult topic, lack of time and reflective space were cited as reasons for avoidance, an illustration of the subtler ways wider austerity policies may unfairly disadvantage already marginalised groups such as people of colour who access services (McGrath, Walker & Jones, 2016):

(Bobby) ...I remember in supervision starting to talk about how it just feels very like frustrating, upsetting, really difficult to just see like another Black man just kind of be wheeled off and sectioned. And he was somebody that showed so much promise [...] and then he just totally unravelled. And there just wasn't space to talk about that, and I wasn't sure whether it was because my supervisor at the time, didn't have maybe the capacity because of their work, or didn't have the knowledge, or the training, or the capacity to talk about it in terms of race or whatever, I'm not sure, but it left me with a question mark, I was like actually, what was that about, I don't really know, you know.

In contrast to Bobby's example which suggests a lack of space for these issues when talking to his own supervisor, Fariha described difficulties in encouraging some *supervisees* to focus on race, culture and ethnicity:

I have had trainees [...] from White backgrounds, and I've often found it quite tricky just having, where we're talking about a family and I'm of the feeling that race or ethnicity or cultural background is actually quite important, and the trainee is just not seeing it, it's just, sees it as that's not really very important and I'm thinking about this, that and other thing, and when I try to bring it in it's sort of brushed off, so that's, it's felt a bit more, tricky...

Fariha's experiences suggest an interesting reversal of power dynamics, which contrasts with literature reporting a significant anxiety for trainees around

assessment by placement supervisors (e.g. Wheeler, 2004). However, it echoes findings from studies which suggest that supervisors of colour sometimes felt that their White supervisees struggled to accept their competence or authority (e.g. McRoy, Freeman, Logan and Blackmon, 1986).

Abbie and Gary suggested that there may be a long way to go even in supervisory relationships where these issues are discussed frequently:

(Abbie) I feel like there's this kind of assumption that because people who aren't oppressed by race, who are privileged by race, feel as though race gets talked about a lot, that somehow that means it's equivalent to being talked about in an effective or meaningful or sophisticated way, and just saying the word race, race, culture, culture, culture, doesn't mean you're talking about race necessarily.

(Gary) certainly with every trainee [...] they've come up to some extent, on several occasions [...] these issues are important, and because [...] I want to address them, I sometimes worry that that can actually make you complacent, and you can think you're doing it when actually you're not [laugh] if that makes sense.

Abbie seemed to be suggesting that even when race *was* being talked about, something could still go unspoken. This may be due to the sanitised or watered down conversations discussed in section 3.1, tokenism, or conversations dominated by those without experience of racism, thus ignoring the epistemic privilege of psychologists or people of colour (Narayan, 1988). Abbie's bored repetition of "race, race" and "culture, culture, culture" was also reminiscent of the sense of *déjà vu* which has been noted in the profession (e.g. Turpin & Coleman, 2010). Abbie and Gary's reflections therefore raised questions of reflexivity, soliciting feedback, how one might know whether race is being talked about meaningfully, and who gets to decide that.

However, Sophia's and Chiara's reflections on how easily these issues could go unnoticed also contained some hope as they demonstrated how easily they could also be brought back into view and an interest in them sparked:

(Sophia) It's good to talk about it, because it makes me think about those issues again, and I think they can, for me anyway, it can quickly fall off the radar...

(Chiara) ...right now I cannot think of a thing. Which is actually quite sad, it's making me think oh, I just want to go away and read stuff. [Laugh] [...] I think it's definitely an area that I have potentially a bit of a blind spot for...

3.2.5. Enrichment

Some participants noted that these conversations could also be rewarding and enriching. There seemed to be a circularity between this and welcoming rather than problematising difference. When questioned, all participants felt that any interest in or understanding of these issues partly stemmed from personal experiences or significant family scripts. Three White participants particularly spoke of having partners and/or children from different racial, ethnic and/or cultural backgrounds, and the impact of this on their understanding of these differences.

While there is a tension which was less explored by participants between valuing the knowledge and experience of supervisees or people who access services and not wanting to place undue responsibility on them to educate others, some participants constructed these conversations as more of an exchange of ideas rather than one-way imparting of learning. Casper's transcript hinted at an intellectual reward resulting from this endeavour, whereas Daniel's approach sounded more spiritual and suggested the absence of a distinct personal-professional boundary:

(Casper) ...probably a very rewarding conversation [...]. If somebody comes and it's, you know, all last century and your teaching is beyond that, or just you on a personal basis, that challenge is absolutely welcome.

(Daniel) ...it's a privilege to kind of work with people from many different backgrounds and to learn about the different ways of making sense of life. [...] cultural competence is that I will be interested enough to listen for little, for where this is significant [...] that they can feel attended to in terms of their, as fully as a

person as possible [...] that beyond the kind of just the interpersonal attunement there's a wider respect and reverence for their whole being. And then I think hopefully one gets to a point where although all of, we might continue to be interested about these things, it becomes a source of kind of excitement and inspiration, and me discovering things about myself and [...] the client discovering things about themselves, or the supervisee [...] this process deepening the connection rather than it kind of getting in the way.

This echoes Wieling and Marshall's (1999) participants, who, thinking about their roles as supervisors, framed as positives gaining insight into the experience of being a minority working or training in mental health from supervisees of colour, and having to address their own stereotypes and biases with them. In line with previous research, several participants also viewed racial or cultural differences between themselves and other colleagues (not just supervisees), or their own 'mixed' cultural experiences, as enriching (e.g. Shah, 2010):

(Brian) People that have worked in certain places and know the local population well definitely contribute that to the sort of clinical life of the team, the thinking. So certainly when I worked in [borough] and in [area], there were nurses there, some were people who lived in that community, and, some [...] were married to people in that community. They would contribute that into the conversation...

(Cyrus) From time to time, I'm grateful that my background allows me to understand certain things differently, or see things other than I've seen otherwise. But it does alert me to the fact that I'm, when I'm sitting a room with someone say from, Eastern Europe [...] if I think I understand, I don't, because of course I'm missing that viewpoint [...] if you don't know, ask. Even if you think you know, ask. [Laugh].

Taken together, Cyrus and Brian's extracts emphasise the need to balance the opportunities afforded by similarity against risks of over-identification. One might

guess that this balance could be more easily achieved with a more heterogenous profession which relied less upon 'native informants'. Cyrus' example of working with an Eastern European client or colleague also highlights less visible racial and cultural difference and potential experiences of discrimination.

3.3. Professional structures, discourses and practices as sites of power

3.3.1. The dominance of Whiteness and Eurocentricity

The day-to-day experiences of supervisors reflected theoretical and practice-based claims in the literature that Western models of psychology were often limiting and culturally irrelevant (e.g. Patel, 2010). Casper suggests that this is increasingly an issue, which might be linked to the decreasing number of people identifying as White British in the UK (Office for National Statistics, 2011):

...there's people [...] well, fewer and fewer [laugh], where you kind of present the model in the way it's taught, and it kind of holds them there, and off they go. And there's other people where, Western psychology is quite a strange kind of cultural thing...

(Hannah) ...it's such an incredibly personal, value-informed, culturally-informed thing to be a parent [...] you come with what you come with as a professional, and if you are, don't talk about the meaning around what you come with, when you're having conversations with parents, then you're really being abusive of your, with your power, and also less likely to be, to effectively understand and work with, work around parenting [...] people who develop parenting models were also parented in a particular way in a particular place [...]. It's not that we can't use models, but it's, everything should be at least acknowledged and talked about and reflected on.

Hannah's reflections suggest that the personal-professional interplay is relevant not only in clinical psychology practice, but also in theory development and research. Although making the origins of clinical psychology theory explicit may

reduce *some* power imbalances by acknowledging the possibility of other viewpoints, this may not be enough to prevent secondary colonisation in mainstream services, where these alternative viewpoints can rarely be adequately explored or translated into practice (Patel & Fatimilehin, 1999):

(Sophia) ...we do need to discuss it more, and we probably need to be reflecting on some of the values that are inherent, implicit in our psychology [...] we can forget that it's very Eurocentric and individualistic and that it just represents one kind of paradigm, or one way of seeing the world, or one way of thinking. [...] On some of the training courses people are sometimes taught models of psychology that might not fit with their own personal experience, for example attachment theory [...] and they might sort of feel that their personal experience is pathologised [...] sort of being just a bit curious about that, and sort of saying 'what are you learning from psychology, and how does that, or does it not fit in with your personal experience and where do you want to take that, and how do you want to develop as a psychologist' really. So just kind of having those discussions as well, and just kind of raising that, [sigh] sometimes we are taught a one-size-fit-all model of psychology, and that actually trainees might have very valid thoughts, feelings and reflections on that, and that it's OK to kind of bring that up in supervision.

(Brian) As a profession we are far too dominated by internal things [...] for someone who's, you know, who's Black, and brought up in a dominant White culture, that is without doubt going to affect them. Now, it may not be horrendously bad, but it's going to be a little bit affecting [...] you're going to suffer, unless you're extremely lucky, quite a bit of discrimination, whether that's subtle or blatant. [...] How do we not think about that?

Sophia suggests that someone with majority-world heritage may be excluded by mainstream psychology models, while Brian reflects on the dominance of "internal things" in the profession, which is a particular consequence of

Eurocentric theory (Patel *et al.* 2000). Therefore, for psychologists experiencing exclusion or disadvantage, this discrimination is also likely to be individualised and internalised rather than contextualised (Miller & McClelland, 2006), leaving them *doubly* disadvantaged. This echoes Pethe-Kulkarni's (2017) recent findings and Bernal, Trimble, Burlew and Leong's (2002) assertion that Eurocentric theories do not leave room for aspects like cultural values, racial discrimination or ethnic identity.

Structural issues, particularly the Whiteness of the profession, were also mentioned by several participants (Wood & Patel, 2017):

(Hannah) I've spoken to trainees about what a psychologist looks like, and feeling that they don't look like what a psychologist looks like, because it's not what you're surrounded by [...]. And when you're a trainee and your whole, your sort of job is to sort of think about what sort of psychologist you want to be, [...] when there isn't an image that seems like it's relevant, then that's very hard.

The suggestion that trainees could benefit from relatable role models could be extended to more experienced supervisees and supervisors, highlighting the advantages not only of a more heterogeneous profession, but more heterogeneity at senior levels. Although Hannah is specifically discussing a lack of racial heterogeneity in the profession, a similar argument may apply to, for example, class, ability, or other areas of inequality in clinical psychology (e.g. Goodbody, 2012; Twena, 2008). However, it should be noted that heterogeneity in itself might not lead to an equal distribution of power, and may therefore only represent a partial solution. As a more experienced clinician, Fariha found her own way to resist the profession's demands:

(Fariha) My way of dealing with that has been I've gone to those places wearing more of [...] my other style of clothing [...] perhaps seeing more images like that will help people, you know, cut down those barriers and not see me as different, to be able to see me as an equal professional.

For Fariha, equality seemed to be a privilege, difference negative and within her, and embracing her embodied cultural or racial presence was a form of

resistance. However, her colleague's observation in section 3.1 would suggest that this came at a cost, as she was viewed as less professional than her White counterparts as a result.

Interestingly, no participants explicitly suggested the profession's Eurocentricity or reluctance to discuss race was a cause of its skewed demographics (Patel, 2010). This could be due to the proliferation of discourses around the profession needing to educate underrepresented groups about its value preventing clinical psychology from looking inwards, as *these* discourses *were* referenced. Sophia does, however suggest that clinical psychology might look to other professions:

I've actually had some colleagues come up to me and [...] have these little in-jokes about 'well, got another sort of long-haired blond trainee coming along who's very well-spoken [...] has been brought up very well, whatever, I don't know, [laugh] has just had a very sort of privileged upbringing?' And I think like because nursing, and because medicine is more diverse, they're just more on it than we are [...] there's something not quite right in our profession [laugh], they've actually noticed it, and commented on it and joked about it, it's that obvious.

Daniel points out that centring issues of power may be to the profession's advantage in terms of how it is seen by some communities:

...actually I think it would strengthen the profession to do more things around addressing issues of power, [...] by doing that, you actually gain lots of people in the communities, who actually will speak- you know, value what you're doing, and see that this is a profession that makes a difference [...] not just doing what you have to do, but actually putting it at the centre of your practice, around issues of power I'd say essentially...

This may be one way of breaking the cycle of White middle-class female applicants to clinical psychology courses (Kinouani *et al.*, 2016).

3.3.2. Incorporating race and culture

In line with the systemic literature discussed in subsection 1.7.2, participants had strategies for harnessing professional structures, discourses and practices:

(Cyrus) ...looking at the make-up of the family, and within that people do mention things like, you know, 'my parents were Irish', and we'll ask them questions like, 'did that have an effect on your upbringing?' And people will say, 'well, we came over from Kenya'. We'll go, OK fine, 'what was life like in Kenya, and what was the difference coming over here?' People will say things like the adjustments, the difficulties, the differences, the advantages. [...] What people do is they drop in the culture, race issues into that. And if they spend a great deal of time on that, it's important. We need to ask more questions [...] a bit like asking risk questions, don't fluff your words, ask the question.

Cyrus' comparison of raising these issues to asking questions around risk echoed the construction of these topics as 'risky', found elsewhere in the transcripts and in the literature (e.g. McLeod, 2009). His observation that people "drop" race and culture issues into conversation suggested that people who access services might also perceive a 'risk', sometimes preventing them from focusing on these issues directly until they are granted permission to do so. In contrast, Sophia's strategies moved away from traditional assessment or intervention models. Instead she looked to other disciplines:

One of the reasons that he'd been bullied at school, this particular client, was because he was Black [...] I was sort of talking to the trainee about drawing on sort of Black history, [...] we don't use history enough as a therapeutic intervention actually. I think it can be really empowering for people sometimes, to make those connections [...] and kind of looked at some recent stuff that was in the media that I thought could be really helpful in terms of kind of helping this man find a more positive identity.

Books, articles and films were also mentioned regularly, suggesting that Sophia's observation regarding the profession's neglect of history could be extended to most other disciplines including literature and the arts. A critical stance might also acknowledge the complicity of the profession in disconnecting people from their histories of colonisation, for example by failing to recognise

the impact of intergenerational racial trauma¹⁵.

Systemic techniques, narrative and liberation psychology approaches were frequently cited as useful influences perhaps due to their explicit attention to social inequalities as part of a professional culture (e.g. Ayo, 2010). This contrasts with the relative privileging of the internal world by other models, which were notably absent. Adopting a 'not knowing' position was mentioned several times:

(Casper) There's always new things to discover, and certainly, with trainees, that relationship, can actually, and that's one of the reasons I do it, it's actually quite a good way of learning about one's own practice [...] how we position people with language, [...] who's got the control, the power, and how's that moving around, to keep, try and keep an eye on all of that stuff, and as well as trying to make space for not knowing [...] we need that space too, particularly in this area, because we, almost by definition, cannot see the whole picture.

Daniel described drawing on (narrative) supervisee story development ideas:

I remember one supervisee kind of talking about [...] something they were kind of getting from the work in this placement and through supervision was I guess conversations [...] not feeling like 'oh, now I'm doing therapy', that this is so different, there being a kind of natural feel to the way of working and kind of asked if they could think of a metaphor that, you know, that that related to. It felt like almost from a kind of narrative point of view, this could be a kind of useful kind of story development for them as a supervisor and they talked about the kind of a certain type of tree, they found some images of it in [country], the kind of idea of, kind of sitting under the tree, where you kind of resolve, kind of issues are resolved, rather than kind of going in such a

¹⁵ Intergenerational racial trauma is race-based trauma affecting whole groups of people which has been transmitted from earlier generations or ancestors. An example of intergenerational racial trauma might be the trauma resulting from slavery continuing to be experienced by the descendants of slaves, decades, and even centuries, after its abolition. Kinouani (2018) suggests that this concept, and the empirical evidence for it (e.g. Kellermann, 2013), challenges Eurocentric notions of individualism.

kind of professionalised context.

Indeed, Daniel's use of supervisee-led story development ideas itself was in sharp contrast to a trainer-led competency model, the latter of which can lead to particular difficulties as described in subsection 3.3.3.

Several participants noted the power of conversation in prioritising these issues, whether research interviews such as this one, or supervision discussions:

(Zoya) Regardless of if you were Asia- you know Asian, White, you know, any race, I think if you'd come at it, because you're interested in this, that to me allow-, gives me permission to speak openly, whereas, you know, if it was a, just a conversation that came up randomly I wouldn't know if you were interested in it or not. So you've [...] already given this topic and this discussion importance, which I think has an impact on my ability to sort of engage with you.

Zoya's reflections suggest an absence of permission to speak openly about these topics, which were a part of her everyday experience, as the default, resonating with previous studies (e.g. Rajan & Shaw, 2008).

3.3.3. Whose responsibility?

All participants acknowledged their power or responsibilities as psychologists, and some reflected on a duty to bring these issues up 'at the start'. This was in relation to supervisory relationships, trainings, and even the lifespan, and was seen as a responsibility shared between supervisors, training courses, professional bodies, the NHS and external institutions. Some participants also had dilemmas around being led by supervisees versus actively advocating for these issues to be addressed, which led back to the issue of permission-giving, as is discussed in the literature (Patel, 2004). Sophia suggests the need for a *repeated* permission-giving, which again suggests that the default is an absence of permission to raise issues of racism on placements:

One thing I do always say at the beginning of placement, is if anyone experiences any racism then to, or any experiences that make them feel uncomfortable, to kind of talk to me and not to be afraid to bring that up, whether that's from another member

of staff or whether it's from a service-user, yeah. So I try to kind of make sure that people feel comfortable to bring that up [...] but I'm not sure I keep repeating that or reminding people of that message.

Gary cites alternative reasons for why supervisees may or may be able to bring up issues of race or culture themselves:

I think these issues are more likely to be brought up by the trainee if they're from a different ethnic or cultural background. [...] You will get some trainees who are very interested in, so will themselves bring up, but then you will also get trainees who are kind of a bit more oblivious to these issues...

Gary's observation suggests trainees are not currently seeing these issues as standard aspect of their work, as they are typically brought up due to a personal salience or interest. In contrast, Daniel refers to his responsibilities as a psychologist:

One of the things I see is my role as a psychologist is to kind of keep asking questions or being curious about those elements.

Here, Daniel implicitly refers to multi-disciplinary working, suggesting he sees his role as psychologist in raising issues of race and culture as wider than conversations in the therapy (or supervision) room. Bobby extends this responsibility to outside organisations, which seems to be a way to address the "obliviousness" noted above:

...if we think about this stuff right from the beginning, right from when people are young. If we talk about what racism is, like not just racism, oh you say bad thing to person, person feels bad about themselves based on their skin colour whatever, but racism in terms of power and access to resources. [...] even in schools, even things like Black history month. [...] Black history month is really interesting now, because it's more about, is it about culture? But it's more about oh, let's make some stuff, let's have some food, let's do this. Whereas I feel like it should be more about actually, let's think about what difference is, let's

think about how we talk about difference, let's think about how we really acknowledge it...

Bobby's remarks suggest that talking about cultural aspects of racial or ethnic background may be more comfortable than talking about race or ethnicity directly. He notes that some may view these as "heavy conversations for young kids", which is interesting in light of findings regarding the regular and explicit conversations about racism and inequality reported within Black families (Hughes & Chen, 1997; Phinney & Chavira, 1995). Indeed, Copenhaver-Johnson (2006) suggests that some of the reluctance to talk to school children about race may be a projection of White adults' discomfort. Putting any such discomfort in perspective, Casper felt that holding in mind the responsibility conferred by being in a dominant group gave him the confidence to bring up these issues, as even if he did get it wrong, he knew that relatively speaking, he would be comfortable due to his Whiteness (however much he did not cherish this inequality):

I suppose I have a confidence that I'm OK because I'm White. That's not the same thing as confidence in delivering whatever it is that cultural competence imagines itself to be. So, I'm happy, to address this stuff and if it runs into trouble, to me that's, here's an opportunity to learn.

Casper's explanation of his confidence suggested that what he felt might be akin to bravery stemming from a sense of responsibility and desire to learn. However, other participants also noted the complexity of their various responsibilities towards clients, supervisees and courses, the conflicting demands on supervisees, and a lack of guidance about this, echoing previous literature (e.g. Patel, 2004; Dennis & Aitken, 2004):

(Bobby) The anxiety of being an imposter, not a good enough clinical psychologist, not a good enough assistant. I think maybe that ties in as well with not really talking honestly about race, and being like actually, this guy really scares me, why does he scare you, because he's huge, and he's a Black guy, and I'm just really scared.

(Daniel) The ultimate responsibility for a supervisor is that

somebody is performing at a level where they can provide the necessary service. And obviously, if, it is a cultural factor [...] is a challenge in that, then that is one thing, but if it's just that the person's not able to do certain tasks...

Bobby's example of what talking honestly about race might look like involved admitting to racial bias, which some have termed unconscious racism (Quillian, 2008). He was suggesting that these open conversations were helpful or even necessary, in contrast to the fears of being accused of racism described in subsection 3.2.1. Further illustrating the complexity of competing responsibilities and power dynamics in a supervision context, Daniel's distinction raises questions about who gets to decide whether cultural factors are relevant, particularly in the case of multiple power imbalances within White supervisor–supervisee of colour dyads, as is typically the case with such conflicts. In contrast to Bobby's and Daniel's concerns, Chiara suggests the exploiting of personal and professional development competencies to prompt regular discussions around these issues as standard, given supervisors' role as both mentors and assessors:

When tutors come in, I've, I often get asked [...] how's the trainee generally doing with issues of, you know, ethical practice, culture, diversity, and it's kind of like a catch-all [...] we end up going yes, very good, no concerns. [...] If a tutor who follows a trainee for three years could say, do you know, this has come up for this trainee, I wonder whether you could support them in exploring it within [service context]. [...] because you are assessing the person anyway as part of their placement, whether that's an opportunity to open up those conversations a bit more, and actually ask the trainee where they're at with their thinking about this [...] rather than necessarily feeling like I need to have all this wisdom...

Chiara's concern that she needed to have "all this wisdom" acknowledges the difficulties of the obligation on supervisors to attend to these issues when they themselves may not have reflected on them much, perhaps due to their own training course or generation (Burkard et al., 2006; Inman et al., 2014). Combining issues of culture, diversity and ethical practice is interesting as it

suggests links between race, culture and ethics. However, Chiara refers to this as a “catch-all”, which allows for an easy dismissal, perhaps suggesting trainers’ prioritisation of skills and knowledge over ‘messier’ and more uncomfortable aspects of professional practice such as ethics and inequalities. This may be linked to the profession’s individualisation (or family-isation) of distress, which obscures professionals’ roles in contributing to it. Considering ‘the profession’ as a whole, some participants expressed disappointment in professional bodies with regards to issues of race and culture:

(Brian) Have we ever had a non-White chair of [professional body]? I don’t believe we ever have.

(Cyrus) Of course, [professional body] has the race and culture division, so yes, it’s there. [Interviewer: Not any more I don’t think]. No? Urgh, God, you see, this is, this, this, this is the kind of thing that makes you lose heart. It’s there, but it always has had the feeling that it’s been on the periphery of, rather than central to the workings of...

Cyrus reference to a “race and culture division” speaks to the difficulties with positioning these issues. Having a “division” positions them as the responsibility of that division, implicitly conferring a reduced responsibility on those outside it. However, the absence of such a division might suggest a lack of commitment to reducing racial inequality and effectively addressing issues of culture, and risk a situation similar to Kline and colleagues’ (2014) findings of a “deep confusion” about who is responsible for racial equality in the NHS.

3.3.4. Barriers

Many participants cited ideological or structural barriers to conversation and action, as well as more indefinable feelings of ‘stuckness’ or needing to keep quiet at times:

(Hannah) Sometimes I get a sort of sense that, not that there isn’t time, but that, [sigh] I’m sort of talking about it in a problematic way and that isn’t always received as a helpful thing. Or I’m talking about it as, because I find something problematic, and again I think maybe conversations get a bit stuck...

Just as there seemed to be a circularity between the welcoming of difference and conversations being rewarding, there may be a circularity between seeing these issues as problematic and conversations becoming 'stuck' (Goodbody, 2012).

One discourse which several participants cited as being particularly unhelpful was that which positioned these issues as a 'special interest', somehow 'separate' from the rest of our work. Bobby compared the value placed on our competency in particular modalities such cognitive behavioural therapy, which in itself may only be relevant for some clients, to cultural competency, which in the broadest sense should be applicable to all clients and colleagues (e.g. Division of Clinical Psychology, 2011):

It would be nice if that was just interwoven into everything [...] I wish there was a way that it was just kind of one of the foundations. You know how they're like oh yes, to become a clinical psychologist you must have competence in CBT and one other thing, it would be nice if they were like, oh, and cultural competence [...] the [Community Development Worker] was a Muslim lady, and her role was just so painful, like the team just really rejected her, because it was like she was just a reminder of like the team failing basically in thinking about race, and difference, and ethnicity, and all that sort of stuff, or even if they did think about her it was very easy for them to almost be like OK well that's what so and so does, [...] I think people split that kind of stuff off all the time.

Indeed, the second part of Bobby's extract sounded very much like othering and scapegoating and suggested the potential relevance of psychoanalytic group processes, as well as clinical psychologists' potential position in being able to draw upon these concepts (e.g. Hook, 2004). Other participants also shared worrying accounts of exclusion and discrimination:

(Cyrus) I was invited to teach somewhere, and then I got a phone call to say that if someone else could come in my place. Because what they were asking for, was a British national [...]

When I did point out that I am a British national, that I hold a British passport, it got very uncomfortable.

Cyrus goes on to describe his decision not to challenge their refusal to let him do the teaching, as he knew he had little power in that situation, despite seemingly explicit discrimination, echoing the concerns of other participants. He also suggests an additional tension between senior managers having the power to effect change and not responding well to feedback regarding the need for it:

You could easily get excluded, and I've seen that. That's what I mean by the subtle ways in which organisations shut up shop, yeah? You got to be incredibly careful [...] you'll just find you won't be there for too long, and then you've got to backtrack and go 'what the hell just happened here?' [...] Especially the more senior managers, they're not in the business of being told 'you need to shift'.

Cyrus' was a very conscious, calculated awareness of possible risks which seem to include victimisation (Equality Act, 2010). This caution and awareness of barriers when discussing these issues in personal and professional contexts contrasted with discussions around race and culture in clinical contexts, which were typically discourses in terms of either 'necessity' or 'falling off the radar'.

3.3.5. The role of training

Participants had a range of experiences with regards to the helpfulness of their clinical psychology training in discussing these topics with supervisees. A minority (all-White) found it helpful, but many were clear the training had a long way to go. This seemed to be the case across courses, in line with other findings (Patel, 2010):

(Sophia) I think some of my colleagues also found it difficult to start conversations [...] because that hadn't necessarily been addressed on the training course, so maybe they felt that they came out ill-equipped to kind of tackle issues of culture within their own clinical work, let alone within supervision.

In line with the literature, Sophia's observations suggest that specialist attention need to be given to issues of culture on training courses, and ideally on issues

of culture *in relation to supervision* as part of supervisor training, rather than relying upon generic skills (Wong, 2000). Cyrus noted that in contrast to his own training, his trainees were receiving *some* teaching on race and culture:

Another little thing I noticed with one [course] trainee, was that every time they had a lecture [laughs] then suddenly the supervisee was interested in that particular feature.

Although Bobby felt that his training had not been particularly helpful, he reflected on how it had at least put words to his experiences, echoing Paulraj's (2016) findings:

Actually what was useful was training helped me to put names to things that I'd been feeling and observing for such a long time... [...] ...that hunch that I had about that time, maybe it was about race... [...] Having allies is useful [...] you're like oh my god I'm glad it's not just me, and that can take the edge off, but again, that doesn't do anything about like the wider systemic issues, but I guess on an individual level, it helps you to kind of keep going and to feel like actually this is a valid thing to do, like, this is a sensible thing to do, I'm not being out of order or disruptive, like I'm just being curious, and I'm trying to kind of like, you know, educate people along the way as well actually.

Bobby's account suggests that the average supervisee or person accessing services, without the same exposure to the language or ways of thinking, may experience ongoing confusion, internalisation and invalidation of any racialised events, hindering their ability to challenge the status quo. Bobby's consideration of wider systemic issues limiting the power of professional structures and practices was shared by other participants, who, for example, referenced the impact of Brexit, Prevent training and limited resources (Virdee & McGeever, 2018; Goldberg, Jadhav & Younis, 2017; Bulman, 2018).

As with previous literature (e.g. Patel, 2004), all but one participant noted an absence of useful guidance on issues of race, culture and ethnicity in their supervisor training:

(Gary) It's a really important topic. But, and I also think it's a

difficult one, it's not a kind of straightforward thing to be doing. [...] I don't feel like we get a lot of training or guidance on being a supervisor, and we certainly don't get anything specific around this area...

(Bobby) Even the supervisory trainings that I've done, I think people allude to difference, we talk about difference with broad brushstrokes, but I don't think anybody actually is like 'and this is what you might do, this is what you might say, this is how you might handle it'. Oftentimes I think it's because people don't really know...

Bobby alludes to the benefit of concrete suggestions in a complex area, however, he suggests that these may not be available to trainers of supervisors, perhaps reflecting generational gaps and a profession-wide need for awareness raising, as suggested by Sophia below. Like other participants, she also offered suggestions for what a good training might look like:

The further away from your own training you get, it's amazing what you kind of lose on the way [...] we need more awareness raising and more training, for supervisors in our profession, to be honest with you, we really do, so I think that's still [...] a gap that needs to kind of be met [...] you probably need on the training like a safe space for supervisors who can do some role plays or can look at vignettes or [...] be curious and to stumble around, and maybe ask things in the wrong way. [...] It's just good that you're doing the research, and I think if you can, yeah, definitely get it written up and get it published, because I think the more discussion around this issue the better I think, and wouldn't it be wonderful, if this kind of feedback and this kind of, research could morph into something like a really kind of robust and helpful training programme that maybe supervisors can go on, and kind of have, equip them with the confidence and the skills to kind of bring these issues up in supervision, and make them more alive, and make it a safe place for trainees to talk about those things if they want to. So I think it would be great if there was also like practical outcome from the research as well,

because it's very much needed I think [...] and helpful also maybe for trainees to kind of share it with future generations of trainees and, so that they know that they're not alone on some of the issues that maybe they're left to be grappling with on their own, you know, so yeah. Good luck with it.

3.4. Survey results

Due to the large number of survey questions, qualitative results were used to guide the selection of particular questions for further analysis. Questions 1, 2, 4 and 5 were excluded as comfort and confidence in themselves were too closely and subtly influenced by situation and background for a quantitative approach to be particularly enriching. Wilcoxon Signed-Ranks tests were conducted comparing medians against a criterion value of the midpoint on the remaining questions due to concerns regarding normality (see Appendix Q). A Bonferroni correction for seven tests was applied before reporting p values and the effect size was calculated as $d=Z/\sqrt{N}$ (Pallant, 2007).

Participants reported being more comfortable and confident discussing clinical issues than personal and professional development issues, with a medium effect size, $Mdn(\text{comfortable})=2$, $z=-3.95$, $p<0.001$, $d=0.66$ and $Mdn(\text{confident})=2$, $z=-3.95$, $p<0.001$, $d=0.66$. This is consistent with interview data which suggested that conversations around personal and professional development issues, but not clinical issues, often felt like secret conversations between psychologists of colour. It was also consistent with interview participants' reports that they were sometimes afraid of causing offense by 'getting it wrong', or being accused of racism by supervisees, and that this felt like less of a risk when discussing clinical issues.

There was no significant difference in survey respondents' comfort or confidence between discussing these and other issues of difference and inequality, $Mdn(\text{comfortable})=3$, $z=1.886$, $p=0.347$, $d=0.32$ and $Mdn(\text{confident})=3$, $z=1.21$, $p=0.832$, $d=0.21$.

Further trainings were seen as helpful $Mdn=2$, $z=-2.89$, $p=0.028$, $d=0.58$. Where participants had rated this question higher than the midpoint, any specific trainings named were typically systemic or narrative, which is again consistent with interview data. There were no significant results when testing for the helpfulness of clinical psychology or supervisor trainings, $Mdn(\text{clinical psychology})=4$, $z=0.03$, $p>0.999$, $d=0.01$ and $Mdn(\text{supervisor})=4$, $z=1.958$, $p=0.302$, $d=0.33$.

Although a formal analysis was beyond the scope of this project, free text responses held strikingly similar themes and perspectives to the interview transcripts, with the exception of one participant who felt there was “too much focus on race/skin colour/religious differences and not enough focus on difference, diversity and cultural background in all [its] forms”. This discrepancy may be due to this being a view that might be hard to express to a trainee-researcher of colour, and psychologists with similar views perhaps being less likely to volunteer to be interviewed about race, culture and ethnicity (Gunaratnam, 2003). The view itself may be a more explicit expression of some interview participants’ interpretation of culture in the broader sense and privileging of this over issues of race and discrimination when interviewed. This may be linked to issues of “difference, diversity and cultural background” being more palatable or easier to talk about than those of racism or discrimination, and reflects many clinical psychology policy documents as discussed in subsection 1.6.4.

See Appendix R for breakdowns and free text responses.

4. CHAPTER FOUR - FURTHER DISCUSSION, EVALUATION AND IMPLICATIONS

This chapter summarises my findings in relation to my research questions, and evaluates the study considering limitations and my influence as a researcher. I end with recommendations for the profession.

4.1. Summary of discussion of themes and research questions

4.1.1. What are the experiences of supervisors discussing issues of race, culture and ethnicity with supervisees?

In some cases, (dis)comfort and (lack of) confidence seemed to be linked to the experiences of discussing these issues with supervisees (discussed in subsection 4.1.2). In addition, supervisors of colour's discussions with supervisees often centred on experiences of racism and racial inequality within the profession (see theme *The blue whale in the room*), resonating strongly with the literature reviewed in subsection 1.6.3. (e.g. Odusanya's, 2016, p.74 subthemes "difference: the elephant in the room" and "working hard to interpret the unspoken"). This was typically accompanied by feelings of distress for one or both parties and a need for these conversations to be kept 'secret' (see subtheme *Risk and avoidance*). This adds to literature suggesting that supervisees often faced resistance or even hostility in raising issues related to their race and culture, as repeated negative experiences or an awareness of colleagues having had these are likely to preclude open conversations in future, whether as a supervisee or supervisor (e.g. Paulraj, 2016; Shah, 2010, Odusanya, 2016).

This may in part explain why these issues were strikingly absent from White supervisors' discussions with supervisees, although this finding may also result from the comparative ease with which White supervisors could avoid thinking or talking about these issues in conjunction with the risk of rupture or distress for one or both parties (see subthemes *(In)escapability*, *Risk and avoidance*, and *Distress and discomfort*). Supervisors across backgrounds experienced discussions of race, culture and ethnicity as focusing on issues of difference, and to a slightly lesser extent, power and inequality (see subtheme *Difference*

and power), which reflects the profession-wide discourses discussed in subsection 1.6.4.

Some conversations with supervisees around issues of race and culture were experienced positively, either for their supportive function or for the rewarding and interesting nature of the subject matter (see subthemes *Supporting supervisees* and *Enrichment*). This is consistent with Patel et al's (2000, p.19) highlighting of the importance of confidential support structures for BME trainees, and their suggestion that the process of supporting others' learning around issues of race and culture could be one "of immense learning and discovery". Finally, many supervisors described practical strategies or theoretical concepts which they used to scaffold these discussions (see subtheme *Incorporating race and culture*). This resonates with the systemic literature reviewed in subsection 1.7.2, and these tools may have acted as scaffolds for both supervisor and supervisee.

4.1.2. How comfortable and confident do supervisors feel during these discussions?

Comfort and confidence meant different things to different supervisors at different times, but were useful constructs to probe supervisors' experiences and facilitate self-reflection.

Many participants described a reasonable degree of confidence and little discomfort (see subtheme *Distress, (dis)comfort and confidence*). For some, their confidence had grown from practising discussing issues of race, culture and ethnicity. For others, discomfort or a lack of confidence led them to avoid raising these issues (see subtheme *Risk and avoidance*). This accords with literature suggesting that people tend to avoid tasks which they believe exceed their capabilities and engage with those which they believe fall within them, (Bandura, 1977), which may lead to circularity between failure to address issues of race and culture and loss of confidence in talking about them for some supervisors. However, for other supervisors, it became more about bravery than as both these conversations, and developing one's confidence in having them, was constructed as 'mandatory', (see subtheme *(In)escapability*), thus moving beyond the literature on confidence and capability.

Where participants described a lack of confidence, they typically linked it to a lack of training (see subtheme *The role of training*), fear of 'getting it wrong' (see subtheme *Risk and avoidance*), and uncertainty about whether to bring it up first or wait for their supervisee to do so (see subtheme *Whose responsibility?*). Although dilemmas around raising issues of race and culture are acknowledged in the literature as they can indeed both strengthen and worsen supervisory relationships (e.g. Cardemil & Battle, 2003; McLeod, 2009), it is generally argued that responsibility lies with the supervisor as the person with more power (e.g. Patel, 2004; Adetimole, Afuape & Vara, 2005).

There were additional implicit indications of discomfort during interviews. Supervisors sometimes experienced these issues as elephants (or whales) in the room, itself suggesting discomfort. Laughter was also a common feature of the interviews, which could be seen as a defence mechanism, as it particularly marked painful or awkward realisations. However, I wondered whether the use of humour to diffuse tension offered a helpful alternative to situations of unengaging equalities trainings, uncontained/unmanageably emotive group dynamics or unsafe supervision discussions. Indeed, Cushway and Knibbs' (2004) study found humour to be a helpful aspect of supervision and the authors noted that its use may be linked with experience in supervising.

Survey results suggested that lack of comfort or confidence were less of an issue. However, this must be taken in the context of a cruder method of data gathering which was unable to probe subtler manifestations of discomfort or lack of confidence, or allow for less comfortable experiences to be brought to mind and expressed as an interview might. Furthermore, 87.5% of survey respondents were White, which was a much closer reflection of the profession's demographics due to less scope for more active recruitment of supervisors of colour outside the region in which I was training. Therefore, the particular discomforts experienced by supervisors of colour would have been less widely captured in the results. Despite this, survey results did suggest less comfort and confidence in discussing issues of personal and professional development rather than clinical issues of race, culture and ethnicity with supervisees, and less comfort and confidence discussing these issues of difference and inequality compared with others

4.1.3. What are the systemic factors influencing these experiences?

The obvious systemic factor running through the interviews was that of wider societal power imbalances, differences and inequalities, as would be expected from social inequalities theory (Miller & McClelland, 2006). These wider inequalities were woven through their personal accounts of talking or thinking about these issues, and as with previous research (e.g. Goodbody & Burns, 2011), it was clear that the personal was often the professional when it came to these issues, particularly for those supervisors who were personally impacted by racism. Supervisors of colour drew on their experiences in wider society or their families, while White participants drew on their experience of cultural difference, learnings from mixed-race relationships or (family) stories of opposing inequality. Participants often cited the diversity of their locality as a particular reason for attending to issues of race and culture, but also referenced the relevance of these issues to *all* people accessing services, and some participants additionally referenced the relevance to *all* supervisees.

Beyond this, participants felt the influence of their particular teams, NHS, professional bodies and other organisational structures, resonating with Rajan and Shaw's (2008, p.15) idea of "institutional thinking" and other literature highlighting the role of the organisation in these discussions (e.g. Patel, 2004; Messent, 2016) (see theme *Professional structures, discourses and practices as sites of power*). Supervisors described powerful systemic barriers including lack of role models, expertise or commitment in the system, fear of exclusion and group processes, and a sense of resignation to these.

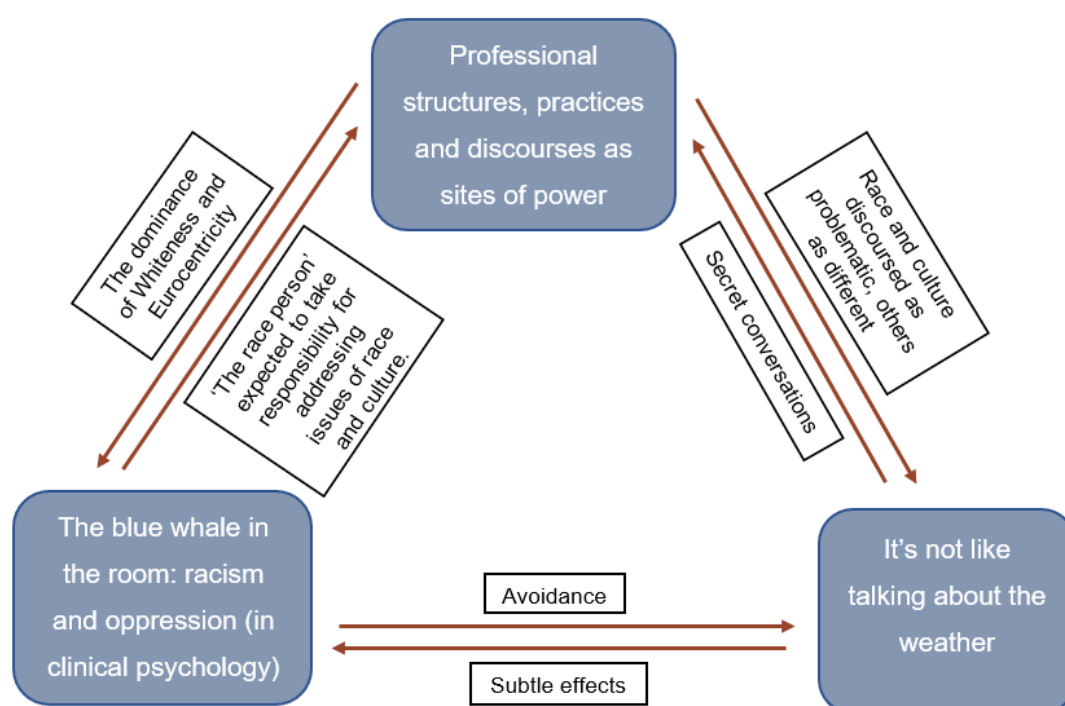
While the disproportionately negative impact of austerity policies on people of colour accessing services has been documented in terms of statistics and cuts to services (e.g. Griffiths, 2018), the current study also highlighted some of the subtler effects such as lack of time for 'thinking space' in teams, which in turn might reduce the frequency with which issues of race and culture are raised in supervision, impacting both supervisees and clients of colour. Like previous studies (e.g. Rajan & Shaw, 2008), participants noted the dominance of Whiteness, Eurocentricity and individualising discourses in clinical psychology, and the role of training courses in reinforcing these (see subtheme *The dominance of Whiteness and Eurocentricity*).

The lack of training was a strong finding and was supported by the survey results. This is consistent with Patel's (2004) observation almost 15 years ago that there is little guidance on incorporating issues of race, culture and power into supervision, and that training supervisors on these issues seems to be option rather than an ethical obligation. This study extends Patel's observations and findings from studies such as Paulraj's (2016) that the support provided for trainees of colour is insufficient and suggests that clinical psychology and supervisor trainings are also unsatisfactory in developing the skills and understanding required to attend to these issues.

4.1.4. Connecting themes

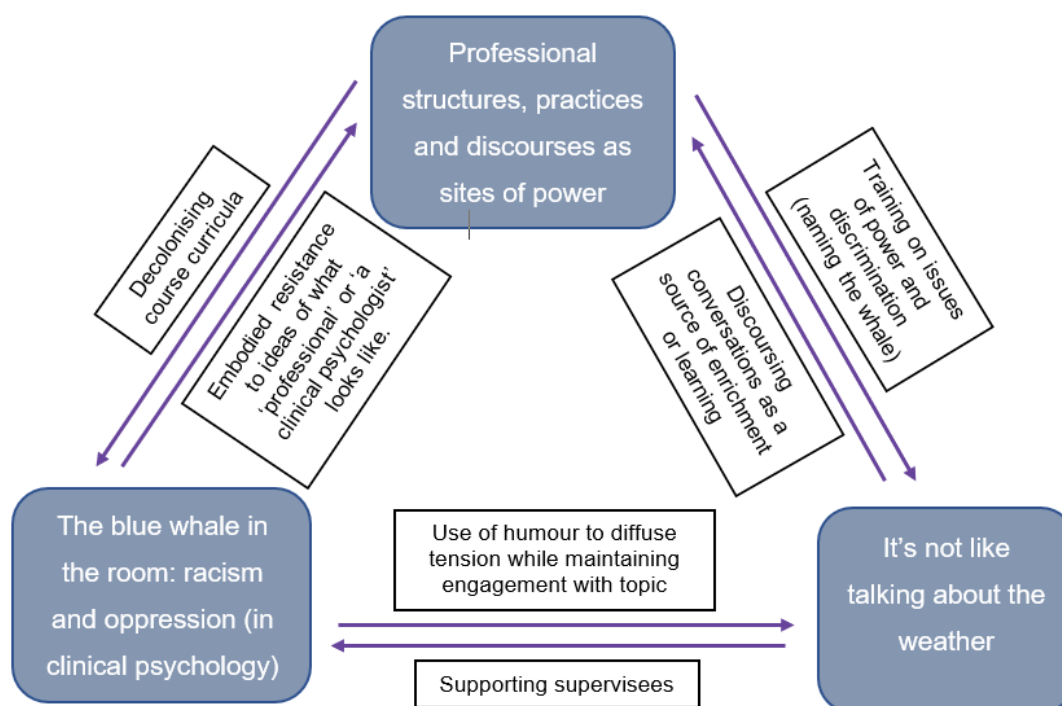
The three themes discussed in the previous chapter were inextricably linked, often as part of maintenance cycles (see Figure 1). For example, the dominance of Whiteness and Eurocentricity in the profession fed into the discrimination experienced by some psychologists, and the discouraging of issues of race and culture as problematic and difference residing in 'others' contributed to the risks and discomfort of race talk. The risky nature of these discussions sometimes led to their being avoided and their often being restricted to secret conversations. The nature of the discrimination experienced by psychologists of colour also resulted in their being left with the responsibility to address it, and was particularly subtle, making it harder to raise.

Figure 1. *Connecting themes in maintenance cycles*



However, sources of resistance could also be found within these connections (see Figure 2) as reported in other literature (e.g. Paulraj, 2016; Shah, 2010). For example, supervisors of colour responded to experiences of discrimination with a sense of pride in or gratitude for their difference in relation to the profession's 'norm' and used their experiences to support supervisees. Supervisors of all backgrounds also retained their sense of humour and contributed to discourses of discussions around race and culture being enriching. Despite sometimes experiencing the profession as oppressive in relation to race and culture, supervisors identified opportunities for harnessing professional structures, for example, by course teams decolonising their curricula¹⁶, and introducing more robust training for supervisors and supervisees on issues of power and discrimination.

Figure 2. *Connecting themes in resistance cycles.*



¹⁶ Examples of 'decolonising curricula' would be the inclusion of Black, African, Latin American and Asian psychologies alongside Eurocentric models and thinkers, and the introduction of critical perspectives which provide students with the tools to contextualise all the models, thinkers and theories which they are exposed to. Paulraj (2016, p.90) adds that these critical perspectives and more geographically diverse psychologies should not be "marginalised as 'alternative perspectives' but positioned as of equal value to 'mainstream' psychology" as part of the decolonisation process.

4.2. Reflexivity

4.2.1. Identities

I am a British Asian woman, as many interview and survey participants might have guessed. My family (who, in line with my collectivist upbringing, I view as my primary attachment figure) has spent several generations living in East Africa, and is predominantly of Indian origin, although we now comprise many nationalities, ethnicities, races and religions.

My supervisor is a White woman of Spanish descent with multicultural heritage, with whom I share some experiences of sitting outside the White British clinical psychology norm, and compared to whom I have had some different racialised experiences in the profession. From our first supervision meeting we have discussed our similar and different identities and acknowledged the potential ways in which our different lenses might lead to both clashes of opinion and a richer perspective on this research.

4.2.2. Spoken and unspoken

My participants were qualified psychologists, all were older than me and half identified as a different gender. These and other areas of difference are likely to have interacted in unique ways for each interviewer-interviewee dyad.

For example, the demands of hegemonic masculinity or discourses around supervisor as 'experts' or 'containers' may have prevented participants from acknowledging discomfort or a lack of confidence (Dennis & Aitken, 2004; Beinart, 2004). My racial 'otherness' could have led to discomfort and fears of being labelled racist or not thinking, talking or feeling the 'right' way about race and culture, which could have inhibited open conversation for some participants (Nolte, 2007). Several participants of different ethnic backgrounds reflected that they felt at ease and all denied my identities having restricted what they felt able to say. However, I was mindful that they may not have been able to say otherwise, and that the impact of my racial background may not be in their conscious awareness. For example, I noticed that all the 'challenging' clinical or professional dilemmas mentioned involved supervisees, clients or colleagues of African or Caribbean backgrounds. This might have reflected the fact that I am in a relatively privileged racial group in the hierarchy of those impacted by racism in clinical psychology, or my participants' fears of offending me.

The 'secret' conversations discussed in the first theme often seemed to be enacted during interviews, sometimes after I had stopped recording, as has been reported in previous studies (Gunaratnam, 2003). Many participants highlighting problems within the profession expressed worries about identifiability, which in turn caused me to consider my position as someone who was soon to be qualified and job-hunting. One participant was notably keen to confirm and re-confirm their anonymity during recruitment, which surprised me due to their seniority and familiarity with research procedures. These experiences further illustrated the power of clinical psychology's resistance to 'naming the whale'.

For my part, I was keen to be viewed by participants as more than a 'scary' or 'angry' woman of colour, and hoped that my personal experience could be helpful in steering interviews in relevant and interesting directions (Gunaratnam, 2003). Contrary to the more politicised stance which I took in the write-up, I tried to follow participants' use of language, reassure them when they appeared to hesitate over terminology, and swallow any discomfort arising from particular opinions or anecdotes, although this discomfort may have been communicated in more subtle ways which were unknown to me. I was aware that when prioritising White participants' comfort levels in particular, I was enacting a societal and profession-wide inequality in how people of different races are expected to tackle issues of racism for the sake of meeting my research aims. Some participants similarly reflected that they would have preferred to share their perspectives with me in a context where I could have more of a voice, and that that in itself was a source of discomfort for them.

4.2.3. Reflexivity during recruitment

I additionally wondered whether racialised and gendered dynamics had been significant during recruitment. White male potential participants were quicker to come forward and schedule in for interviews, perhaps reflecting increased confidence and availability. Psychologists of colour were much harder to recruit, and childcare responsibilities impacted on interviews with half my female participants; one was rescheduled, the start of a second was delayed, and demographic information was collected via email for the third to ensure her child was collected in time. Although my sample was small, these examples were striking enough to make me question whether they reflected a need for

psychologists of colour and women to worker harder and juggle more in practical terms on top of any additional affective labour (Dennis & Aitken, 2004; Cottingham, Johnson & Erickson, 2018).

Despite a surplus of potential participants, I also chose to include some participants with whom I had a pre-existing relationship after attending a presentation by a psychologist who had interviewed members of their own close-knit ethnoreligious community and even family as part of a research project. The profession's often unquestioning adherence to Anglocentric notions of boundaries was discussed in the presentation, and I realised the potential power of prior relationships in facilitating honest research interviews. I had pre-existing professional relationships with three interview participants, but had not worked closely with any of them for at least one year at the time of interviewing, nor would I have described my relationship with them as very close. The remaining nine participants I had never met. Prior relationships did not lead to noticeable differences in themes, subthemes or the quality of interviews, in opposition to my initial hypothesis regarding their potential benefit. Similarly, comparison with the themes in the free text survey responses does not suggests that the fact that my participants were identifiable to myself had a marked impact on their responses.

I personally was also very keen to ensure a balance of ethnic backgrounds in my interview participants. On one hand, I was concerned about White perspectives 'dominating' and being considered the 'norm', while psychologists of colour were seen as in need of 'special' supervisor training or guidance, or none (as they must already be experts on these issues) (Seward, 2007). On the other hand, I was also afraid that the domination of perspectives of colour would lead to their being accused of being bitter or too emotional (Dennis & Aitken, 2004). Therefore, I was transparent mid-way through recruitment that I had already recruited several White (and particularly male) clinical psychologists, and was now particularly seeking out psychologists from "Black, Asian, Hispanic or Dual heritage backgrounds¹⁷". I hoped this would highlight these as identities

¹⁷ I struggled with this language myself, for example, later wondering whether I had assumed the absence of psychologists with Native American or Aboriginal heritages in this country, and then worrying about being perceived as 'too politically correct' for having even considered this.

in their own right, rather than comparisons to a White norm, and reinforce the idea that this topic was important for psychologists from all backgrounds.

4.2.4. Research as praxis

I have found clinical psychology supervision very positive, quite discriminatory, and everything in between with regards to issues of race, racism and culture. Experiencing the impact of myself and others bringing up these issues in the professional context within and outside of supervision has been both fascinating and frustrating. It is this range of experiences that prompted me to explore and contextualise the differences between them, coupled with general interests in the process of supervision and critical pedagogy. As a trainee, I was particularly wary of replicating my experiences of unhelpful conversations, and keen to draw on helpful ones in any future discussions that I may have with clients, supervisees, other colleagues, friends and family. What I had not anticipated was the extent to which the research process itself may serve as a form of actioning some of my theorising about awareness raising (see Appendix S for a further exploration of this in my research journal).

4.3. Critical review

The main arm of the study was evaluated against Northcote's (2012) criteria for high quality qualitative research:

- Contributory
- Rigorous (in conduct)
- Defensible (in design)
- Credible (in claim)
- Affective (in nature)

Additional strengths and limitations were also considered, including those of the survey arm.

4.3.1. Contributory

The ways in which this study has furthered our understanding of clinical psychology supervisors' perspectives on how issues of race, culture and ethnicity are addressed in supervision discussions are discussed in the Analysis chapter and section 4.1. Implications for clinical practice, research, training and

wider policy are discussed in section 4.4. Benefits to participants, and even their colleagues and clients, are described in my research journal (Appendix S). These contributions accorded with my pragmatist epistemological stance which prioritised a broad aim of reducing social inequalities over a particular relationship to truth or knowledge.

4.3.2. Rigorous

Data collection and analysis was systematic and transparent, with a close adherence to Braun and Clarke's (2006) six phases of Thematic Analysis, example material presented as appendices, and multiple illustrative extracts provided for each subtheme.

4.3.3. Defensible

The ways in which the study design followed from the research questions was clearly explained in the Methodology chapter, while section 4.1 summarises the success of the design in answering these questions.

4.3.4. Credible

The claims made in this study are grounded in data extracts and supported by psychological theory and relevant research studies, as well as survey data.

4.3.5. Affective

The nuances of participant affect and emotional involvement were described in the Analysis chapter. Researcher affect was particularly attended to in section 4.2. I hope that a passion for the project has been conveyed throughout.

4.3.6. Additional strengths

The research was primarily qualitative and aiming for a richer understanding of the key issues from a set of supervisor perspectives. However, it was also useful to consider its generalisability in line with its pragmatic aims.

Participants represented a wide range of personal and professional backgrounds and all worked within the North Thames region. This assisted the practicalities of interviewing and provided a varied source of clinical and professional examples, but it may not fully reflect the experiences of supervisors in other parts of the country. Survey data suggested similar themes nationally, however, local demographics cannot be deduced from the broad regions in

which supervisors worked. Nonetheless, one would hypothesise that supervisors in London might be more accustomed to dealing with these issues in their personal and professional lives than those in less multicultural regions. Therefore, the implications and recommendations deriving from the research are likely to be helpful and applicable in other parts of the country; if anything, the need for awareness raising may be greater.

All participants cited an interest in the area as a motivation for participating. Both study arms would have been more likely to attract participants who were interested in the topic, had strong opinions or desired change. Again, this would not necessarily preclude the generalisability of findings as supervisors with less of an interest might be less likely to seek discussion and reading in this area and, therefore, would particularly benefit from awareness raising.

Additional methodological strengths included the reaching of coding saturation while employing an interview schedule which two participants spontaneously described as “comprehensive”. The flexibility afforded by the epistemology, methodology and method facilitated a rich analysis and allowed me to attend to and connect broader themes such as racism with details such as laughter, as I had hoped.

4.3.7. Limitations

Survey data was limited by a small, predominantly White sample despite the pool of potential participants being much greater than was the case for recruitment to the interview arm of the study. This may be suggestive of a view among psychologists interested in the area that issues of race, culture and ethnicity benefit from more detailed, perhaps dialogical, exploration than might be afforded by an online survey, or due to less personal recruitment strategies.

Despite my pragmatic aims, Thematic Analysis was at times also limited in its ability to utilise the many excellent concrete or practical suggestions made by interviewees. Sometimes these naturally appeared in quoted extracts. However, I often had to resist the urge to compile lists of these to share with the reader, and accept that others may be ‘lost’ in the analysis due to its focus on themes rather than domains (Braun & Clarke, 2018). Despite a contextualist approach, the focus on shared themes and concerns about identifiability related to the

topic area sometimes additionally obscured between-participant differences such as ethnic background and its visibility, sexual orientation, age and class.

4.4. Implications and Recommendations

4.4.1. Research

Future studies might use other analytic methods with a similar dataset, for example Narrative Analysis or Foucauldian Discourse Analysis to investigate in more detail supervisors' individual accounts or the power implications of how race, culture and ethnicity are talked about by supervisors respectively (Emerson & Frosh, 2004; Willig, 2013).

Participants also highlighted the role of training courses in perpetuating a lack of skills and awareness around issues of race and culture, yet the experiences and systemic contexts of course tutors and lecturers discussing these issues with trainees, supervisors and fellow trainers remain unresearched, which should be rectified (Paulraj, 2016). Small scale projects could also evaluate the effectiveness of clinical psychology and supervisor/trainer trainings in preparing attendees to discuss these issues with clients and colleagues to support their ongoing improvement.

Many participants were concerned about the Whiteness of the profession. Therefore, pre-training aspiring clinical psychologists of colour could also be interviewed on their experiences, which may provide an insight into how professional discourses and practices impact their journey into (or move away from) clinical psychology (Patel, 2010). No doubt linked to clinical psychology's Whiteness, study participants shared concerns about the 'special interest' status of issues of race, culture and ethnicity, while the study itself challenged this by exploring White psychologists' views on them. This resistance could continue by investigating White psychologists' perspectives on these issues in contexts other than supervision discussions.

Finally, class was often part of the wider context of participants' racialised or cultural experiences of the profession. Yet the perspectives of psychologists from working class families on being in a largely middle-class profession or of psychologists of any class background on attending to these issues has been minimally researched (although see Goodbody, 2012 for an exception to this).

Future studies could usefully focus on intersectional experiences of race and class, or on class alone.

4.4.2. Therapeutic work and supervision

The importance of attending to issues of race, culture and ethnicity in therapeutic work is clear. This attention may helpfully be operationalised using systemic, narrative and liberation psychology approaches and techniques and should always include consideration of one's own race, culture and ethnicity. More individualising modalities or Eurocentric theories should neither be implemented across the board, nor dismissed altogether, rather their cultural relevance and ethical implications should be carefully considered on a case-by-case basis.

Due to the sometimes-challenging nature of discussing issues of race and culture, the supervision of psychologists with regards to these therapeutic conversations requires a nurturing approach. Supervisors needs to remain aware of the dynamic movement of power between all members of the supervisory triad, name the blue whale in the room where necessary, and remain open to external consultation. As well as clinical work, personal and professional development should be an integral part of supervision, and attention to race, culture and ethnicity an integral part of personal and professional development. See Part 3 of Patel *et al.*'s (2000) Clinical Psychology, 'Race' and Culture for several chapters' worth of comprehensive discussion and suggestions around attending to issues of race and culture in therapeutic work. These can be adapted from the trainer-trainee to supervisor-supervisee context.

4.4.3. Public health and policy

If their full interventive potential is to be realised, these conversations need to go beyond the therapy and supervision rooms into the spheres of public policy and campaigning. Due to their frontline experience, clinical psychologists are well-placed to advocate for the implementation of a cohesive, long-term, well-resourced national mental health race equality strategy and a much-needed resourcing and prioritisation of the more culturally relevant user-led support often found in the voluntary sector (Griffiths, 2018).

Bobby's suggestion of starting race talk early is also compelling and timely with the current focus on mental health provision in schools (DoHaSC & Department for Education, 2017), commentary that the lack of attention on inequalities in the government's proposed approach is likely to limit its effectiveness (Head & Bond, 2018), and highlighting of the profession's need to increase its focus on public health and preventative approaches (Harper, 2016).

Clinical psychologists may be reasonably well positioned to teach children about the links between inequality, discrimination and distress. However, this role may more effectively be taken on by schools to encourage ongoing conversation, integration with current curricula across a wide range of subjects, and emphasis during events such as Black History Month. Psychologists may, nonetheless, be able to prompt and consult to schools on the social, emotional and educational consequences of inattention to racism and cultural insensitivity, and on the containment of the heavier aspects of these conversations.

4.4.4. Learning, development and awareness raising

The average clinical psychologist consulting to a school on children's well-being is only likely to attend to issues of race and culture themselves if their essential, necessarily messy and rewarding nature is emphasised by the profession, rather than their being viewed as 'sticky', avoidable, and the preserve of marginalised groups. This needs to bear out in discourse and practice across course curricula, supervision discussions, professional journals, conferences, and representation at senior levels of the profession.

An ethical approach to addressing issues of racial and cultural discrimination must begin within the profession as part of our duty of care towards trainees and supervisees, especially when there is such a strong case for the significant benefit to people accessing services. Therefore, the implementation of good quality supervisor and trainer trainings, decolonisation of course curricula, and other awareness-raising programmes should precede other initiatives to diversify the profession.

A formal widespread reverse-mentoring¹⁸ programme including those at the very top of the profession accords with an educator-learner ethos and may allow more senior psychologists to adopt a 'not knowing' position around this topic without the complication of competing supervisory responsibilities. However, this would bring its own power dynamics and risks of exploitation to navigate, so requires careful thought and clear benefit to the junior psychologist of colour. Trainings led by supervisees of colour or people of colour accessing services may similarly harness the knowledge of junior psychologists and those with lived experience of the mental health system (Hitchen, Gurney-Smith & King, 1997).

More space for issues of race, culture and ethnicity, with particular foci on personal and professional development, and raising these issues, is needed on supervisor and clinical psychology trainings. The appropriate use of humour or even satire might combat some of the dryness often associated with mandatory equality and diversity trainings and allow learners to feel that they can 'get it wrong' without undermining the seriousness of the topic. The valuing of conversations around race, culture and ethnicity by participants in the present study, and the unvoiced nature of many psychologists of colours' experiences in the profession, suggests that dialogical approaches may also need privileging relative to competency-based frameworks. The use of role plays, vignettes and reading lists may additionally be helpful.

Supervisors, tutors and psychologists in management positions may be able to facilitate the translation of trainings into practice by encouraging those whose learning they are supporting to identify specific areas of development with regards to these issues during placement reviews, appraisals or other points of reflection and review such as team away days (BPS, 2010).

¹⁸ Reverse-mentoring initiatives involve the pairing of senior members of a profession or organisation with junior colleagues who may be able to mentor them on an area of expertise, such as 'What it is like to be a trainee clinical psychologist of colour'.

4.5. Conclusion

The findings from this study would suggest that racial inequalities continue to be perpetuated by, and a problem for, the profession, despite the wealth of creative thinking, documented and undocumented, around ways of addressing this.

Turpin and Coleman's (2010) sense of *déjà vu* seems to pervade not only clinical psychology training statistics, but also the experiences of trainee and qualified psychologists, and clinical psychology theory, practice, and discourse. Despite this, the collective rage, sadness and frustration expressed by clinical psychologists and trainees of colour, and people of colour who access services, seems to remain largely unheard. As such, it may be seen to sit, sometimes uncomfortably, and largely invisibly, in supervisory relationships and the profession as a whole.

Nonetheless, the experiences of discrimination and marginalisation described in this study and related literature urge clinical psychologists, supervisors, trainers and the professional systems around them to develop the skillsets to address these issues. This is likely to require a combination of training, supervision, individual reflection, dialogue, wider public engagement and informal everyday awareness raising. A strong case can be made for this being likely to lead to improved care for all people accessing services, regardless of background.

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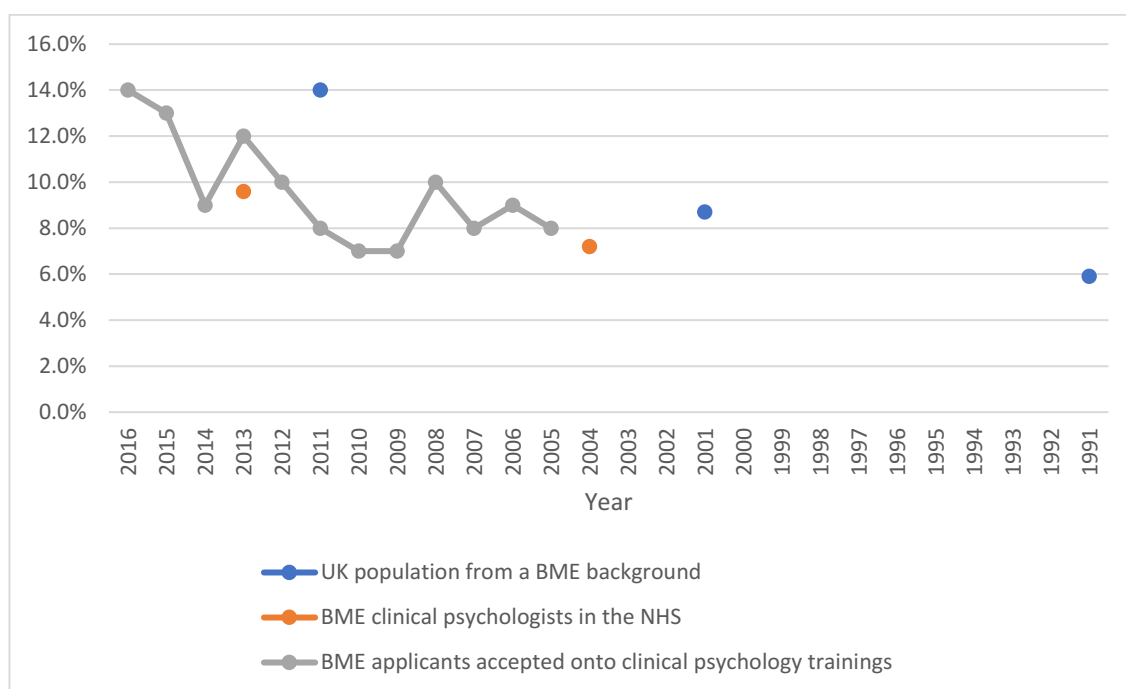
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APPENDICES

Appendix A: Comparing clinical psychology demographics with the UK population

Figure A.1. Comparing proportions of those from a BME background from the total UK population, applicants accepted onto clinical psychology training courses, and number of qualified clinical psychologists working in the NHS



(NHS Digital, 2013; Office for National Statistics, 2011; Office for National Statistics, 2001; Office for National Statistics, 1991; The Clearing House for Postgraduate Courses in Clinical Psychology, 2018)

Appendix B: Key clinical psychology policy documents

Table A.1. *Key policy documents*

Author (Year)	Policy document	Relevance to supervision
Division of Clinical Psychology (1998)	Briefing paper no. 16. Services for Black and Minority Ethnic People: A guide for commissioners of Clinical Psychology services (by the Race and Culture Faculty, which the DCP closed down in 2004)	<ul style="list-style-type: none"> • Acknowledged the inequalities experienced by BME people accessing services and provided a guide for the commissioners of clinical psychology services on addressing them. • Recommended a range of common-sense strategies for reducing racism and discrimination towards certain ethnic groups in service design and delivery (from the level of direct individual work right through to institutional practices). • Although supervision was not directly mentioned in this briefing, one would assume that it would be a key means of supporting the change the authors acknowledged as necessary.
BPS (2004)	A report into widening access within undergraduate psychology education and implications for professional psychology	<ul style="list-style-type: none"> • Echoes the need for psychology to be able to explain human behaviour “across a wide range of cultural groups other than the traditional white euro-centric approach with which it has been traditionally associated” (ibid, p.7). • Recommends that effective supports are provided for trainees from other cultures or ethnic backgrounds. • Recommends that culture and racism awareness training feature in all programmes.
Division of Clinical Psychology (2010, p.4)	The core purpose and philosophy of the profession	<ul style="list-style-type: none"> • States that “Clinical Psychologists also recognise and value the cultural, racial and community influences within individuals, groups and society. The DCP [...] actively promotes

		continuous training for the profession in this important area.”
Division of Clinical Psychology (2011, p.18)	Good practice guidelines on the use of psychological formulation	<ul style="list-style-type: none"> • Emphasises the importance of considering cultural issues “with every service user”, due to the continuous evolution of cultural frameworks (Anderson & Fenichel, 1989). • The guidelines note several aspects of Western models of psychology, and the formulations based on them, which may not be universally relevant; these include their tendency to privilege ideas of independence and self-actualisation over spirituality and communality (Webster, 2002), which may lead to conflicting ideas about causation and intervention. • Also note that the concept of formulation itself is culturally-based and that a great deal of work remains to be done with regards to the development of culturally appropriate forms of formulation and intervention.
Division of Clinical Psychology (2014)	DCP policy on supervision	<ul style="list-style-type: none"> • Defines supervision within clinical psychology as “the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused and which manages, supports, develops and evaluates the work of [junior colleagues]” (Milne, 2007, p.439). • Considers sociocultural aspects potentially relevant to the task of building a safe and trusting supervisory relationship. • Includes an impact assessment of various aspects of difference, including culture, which it suggests may result in “[d]ifferences in experience, values, knowledge and understanding and [c]onflicting belief systems” (Division of Clinical Psychology, 2014, p.11). • “Possible reallocation of supervisor or supervisee without prejudice” is

		<p>recommended when these differences cannot be worked through.</p> <ul style="list-style-type: none"> • Interestingly, there is no mention of race or ethnicity in the impact assessment, despite age, disability, religion, culture, pregnancy and maternity, marriage and civil partnerships, sexual orientation, gender and gender reassignment each having their own sections.
BPS (2017)	Standards of proficiency – Professional psychologists	<ul style="list-style-type: none"> • Reiterate the importance of attending to culture. • No mention of race or ethnicity. • Supervision is highlighted as a means of promoting reflective practice, including around social, cultural and ethical aspects of the work.
HCPC (2015)	Standards for the accreditation of Doctoral programmes in clinical psychology	
BPS (2017)	Practice Guidelines (Third edition)	<ul style="list-style-type: none"> • Psychologists are expected to understand the nature and history of racism, including the dangers of maintaining a colour-blind approach, and the discrimination inherent in cultural pathology¹⁹ and micro-aggressions. • Psychologists are encouraged to go beyond understanding when operating in an organisational context and aim to influence others in their thinking and practice around equalities for clients and staff.

¹⁹ The problematising of disadvantaged groups by seeing them as having ‘special needs’, rather than seeing the playing field as needing to be levelled, can be seen as cultural pathology.

Appendix C: Supervision models and therapy approaches

Table A.2. *The relevance of race, culture and ethnicity to different supervision models and therapy approaches*

Supervision model or therapy approach	Particular relevance and integration ²⁰
Cognitive behavioural therapy (Ricketts & Donohoe, 2000)	Cognitive behavioural therapy (Ricketts & Donohoe, 2000) and developmental (Beinart, 2004) models of supervision, with their emphasis on modelling, would support the need for supervisors to begin conversations around the complexities of race, culture, ethnicity and distress so that supervisees may learn how this may be done safely and sensitively with clients.
Developmental models of supervision (Beinart, 2004)	
Seven mode model of supervision (Hawkins & Shohet, 2006)	Ryde (2009) recommends attending to Whiteness in supervision even if none of the supervisor-supervisee-client supervisory triad are White, as the work is likely to be viewed through the White gaze in some way. She demonstrates how 'Whiteness' may be brought into Hawkins and Shohet's (2006) seven mode model of supervision.
Psychodynamic supervision models (Sarnat, 2016)	The need to attend to the impact of race, culture and ethnicity on parallel processes applies to psychodynamic supervision models with their focus on transference/counter-transference reactions.
Systemic approaches to supervision (Barnes,	Systemic models advocate deconstructing problems, comparing cultural scripts (including those of supervisor and supervisee), introducing difference, and

²⁰ These should not be seen as prescriptive, but as examples of areas where issues of race, culture and ethnicity may naturally be integrated into, or emphasised during, supervision discussions when a particular model is being drawn upon. In practice, ideas such as 'modelling' open and sensitive discussion, Ryde's caution regarding the ubiquity of the 'White gaze', and narrative thinking around privileging client and supervisee experiences and knowledges are likely to be useful regardless of model or approach.

Down & McCann, 2000)	forefronting context, all of which necessitate a reflexive exploration of the nuanced links between distress, race, culture and ethnicity. They also acknowledge potential isomorphism between the supervisor-supervisee and supervisee-client dyads.
Narrative approaches (White, 1997)	Narrative approaches to supervision aim to privilege the experience and knowledges of supervisees, which will inevitably be influenced by their racial, cultural and ethnic backgrounds (Carlson & Erickson, 2001).
Social inequalities approaches (Kagan, Burton, Duckett, Lawthom, & Siddique, 2011; Miller & McClelland, 2006)	Social inequalities approaches perhaps make the strongest case for due attention to issues of race in supervision owing to their inherent focus on racial inequality and the processes by which it impacts not only supervisor, supervisee and client, but also the relationship between them. It emphasises the inherent power imbalance in supervisory relationships, often compounded by racial inequalities. This confers a responsibility on supervisors which necessitates reflexivity and a commitment to an ongoing learning process, particularly in responding ethically to complex power dynamics (Patel, 2004).

Appendix D: Interview participants

Table A.3. *Interview participants' demographics.*

Demographic	Occurrence
<i>Racial, ethnic or cultural background</i>	
Asian ²¹	2
Black	3
Mixed	2
White-British	4
White-Other	2
<i>Gender</i>	
Female	6
Male	6
<i>Age in years</i>	
30-39	5
40-49	5
50-59	2
<i>Years since qualifying</i>	
0-5	2
5-10	4
10-15	2
15-20	4
<i>Service context</i>	
Integrated social care/clinical services	2
NHS ²²	10
<i>Client group</i>	
Adult ²³	6
Child	2
Child and Adult ²⁴	2
Learning Disability ²⁵	2

²¹ More specific identity descriptors such as 'Indian' were collapsed into broader categories to preserve anonymity. Interview participants' permission was granted for this. Two interview participants commented that being able to place one's ethnic background in a single category felt reductive, but were very obliging given my intention to contextualise my results as best I could without identifying them.

²² This included primary, secondary and tertiary services

²³ This included inpatient and early intervention in psychosis services

²⁴ This included clinical health psychology services

²⁵ This included adult and child services

<i>Number of qualified clinical psychologists supervised</i>	
0	2
1-5	7
6-10	0
11-15	0
16-20	2
21+	1
<i>Number of trainee clinical psychologists supervised</i>	
0	1
1-5	4
6-10	2
11-15	2
16-20	1
21+	2
<i>Number of assistant psychologists/equivalent supervised</i>	
0	0
1-5	9
6-10	1
11-15	0
16-20	0
21+	2

Appendix E: Survey participants

Table A.4. *Survey participants' demographics.*

Demographic	Occurrence (n=32). No information for 6 additional participants.
<i>Racial, ethnic or cultural background</i>	
British Asian	2
Black British	1
Mixed	1
White-British	21
White-Other	7
<i>Age in years</i>	
20-29	2
30-39	15
40-49	12
50-59	2
60-69	1
<i>Years since qualifying</i>	
0-5	11
5-10	6
10-15	8
15-20	3
21-25	3
25-30	0
30-35	1
<i>Service context</i>	
Local authority	3
NHS	25
NHS and non-statutory	1
Private	1
Not stated	2
<i>Client group</i>	
Adult	9
Adult and older people	1
Child	7
Early intervention in psychosis	2
Health	3
Learning disability	4

Learning disability and health	1
Older people	4
Training course	1
Service location	
East Midlands	1
East of England	2
London	17
North East	2
North West	1
Northern Ireland	0
Scotland	3
South East	4
South West	0
Wales	1
West Midlands	1
<i>Number of qualified clinical psychologists supervised</i>	
0	8
1-5	15
6-10	6
11-15	0
16-20	0
21+	3
<i>Number of trainee clinical psychologists supervised</i>	
0	2
1-5	13
6-10	7
11-15	3
16-20	6
21+	1
<i>Number of assistant psychologists/equivalent supervised</i>	
0	3
1-5	22
6-10	6
11-15	1
16-20	0
21+	0

Appendix F: Interview schedule

(Example questions to indicate topic area, bullet points indicate prompts)

Remind interviewee that we do not have consent for them to disclose identifying material about supervisees (for example, there are very few Black male trainee clinical psychologists), and we are more interested in the interviewee's experience. Ask if they have any questions.

1. How did you come to hear about the study?
 - Reasons for participating?
 - Thoughts around the topic area?
2. Can you tell me a bit about your approach to supervision generally?
 - Do issues of race, culture and ethnicity come up often within this?
 - In what contexts? (E.g. therapeutic approach, access, recent political events)
3. Do these issues get discussed much in your team or service?
 - Comfortable speaking to own supervisor re particularly complex clinical or professional situation where race etc is relevant?
 - What about taking it to the team?
 - Wider professional networks?
 - Reading? Conferences?
 - How much importance do you feel the system gives these issues?
 - How much support is there around grappling with them?
 - How does this relate to your particular client group or service context?
 - What could the service, etc be doing differently?
 - What would you like to change?
4. Can you give me an example of a time when you have discussed issues of race, culture and/or ethnicity with a supervisee in depth?
 - What was this like?
 - Who brought up the issue?
 - Felt adequately prepared?
 - Easy to talk about?
 - Impact of your and your supervisee's identities?

- Impact of this experience on your confidence in discussing these issues?
5. How well do you feel any training has prepared you for discussing these issues with supervisees?
- Clinical psychology training?
 - Supervisor training?
 - Any other trainings?
 - What made it helpful?
 - Any particular content that was helpful?
 - Any particular learning styles that were helpful?
 - How do your feelings of confidence/preparedness/competence in discussing these issues compare with your feelings of confidence/preparedness/competence in other areas of supervision?
 - What does cultural competence mean to you as a supervisor?
6. Some people find these issues difficult to talk about and report feelings of guilt, frustration, or anxiety about 'getting it wrong'. How comfortable does discussing these issues with supervisees feel for you?
- Who most often brings up these issues - you or the supervisee?
 - More comfortable when supervisor or supervisee brings them up?
 - How does this compare to other issues of 'difference'?
 - Clinical issues vs personal and professional development issues – does this affect comfort?
 - Impact of service context on comfort levels?
 - Reason for any discomfort?
 - Who or what helps overcome this?
 - What would help in the future?
7. How confident do you feel discussing and responding to these issues?
- Impact of who brings them up on comfort/confidence?
 - Clinical issues vs personal and professional development issues – does this affect confidence?
 - Reason for any lack of confidence?
 - Who or what helps or would help increase confidence?

8. How does your comfort/confidence in discussing these issues compare to your comfort/confidence in discussing other issues of difference and diversity?
 - How does comfort/confidence compare to when you might discuss issues of race/culture/ethnicity with family, friends or other colleagues?
9. Are there any aspects of your own identity which you feel have impacted on your comfort and confidence in discussing these issues with supervisees?
 - Impact of supervisees' identities?
 - Other personal contexts, such as upbringing?
10. What has it been like being interviewed by a trainee and/or specifically a BME trainee/Asian trainee/trainee of colour/trainee who isn't White?
11. Is there anything I haven't directly asked about which you would like to add?

Demographic information

- How old are you?
- In which year did you complete your clinical psychology training?
- How many clinical psychologists have you supervised? **(0; 1-5; 6-10; 11-15; 16-20; 21+)**
- How many trainee clinical psychologists have you supervised? **(0; 1-5; 6-10; 11-15; 16-20; 21+)**
- How many pre-training aspiring clinical psychologists (e.g. assistant psychologists) have you supervised? **(0; 1-5; 6-10; 11-15; 16-20; 21+)**
- How would you describe your racial/ethnic/cultural identity?
- How would you describe your service context with regards to client group, main treatment modality if applicable, primary/secondary/tertiary care and whether it is an NHS service or not? (E.g. "NHS LD service", "Social enterprise for young asylum seekers") **(Free text)**
- In which geographical region are you currently working? **(East Midlands; East of England; London; North East; North West; Northern Ireland; Scotland; South East; South West; Wales; West Midlands)**

Appendix G: Online questionnaire

Thank you for participating.

There are 11 multiple choice questions in total, followed by a free text question where you will be able to say anything you like. This will be followed by some very brief demographic questions, after which you will have reached the end of the survey.

The first three questions concern how **comfortable** it feels discussing issues of 'race', culture and ethnicity with supervisees. This may be during formal supervision meetings or more informal discussions with your supervisee(s). If you haven't supervised a clinical psychologist or pre-qualified aspiring clinical psychologist (e.g. trainee clinical psychologist, assistant psychologist) during the last six months, think about your most recent experiences as a clinical psychology supervisor.

1. Over the past six months, I have felt comfortable *bringing up* issues of 'race', culture and ethnicity with supervisees.
(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)
2. Over the past six months, I have felt comfortable *discussing and responding to* issues of 'race', culture and ethnicity with supervisees.
(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)
3. Does this change according to whether you are discussing clinical issues or issues of personal and professional development?
(Much more comfortable discussing clinical issues; slightly more comfortable discussing clinical issues; equally comfortable discussing clinical and person and professional development issues; slightly more comfortable discussing personal and professional development issues; much more comfortable discussing personal and professional development issues)

The next three questions concern how **confident** you feel as a supervisor when discussing issues of 'race', culture and ethnicity with supervisees. This may be during formal supervision meetings or more informal discussions with your supervisee(s). If you haven't supervised a clinical psychologist or pre-qualified aspiring clinical psychologist (e.g. trainee clinical psychologist, assistant

psychologist) during the last six months, think about your most recent experiences as a clinical psychology supervisor.

4. Over the past six months, I have felt confident *bringing up* issues of 'race', culture and ethnicity with supervisees.
(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)
5. Over the past six months, I have felt confident *discussing and responding to* issues of 'race', culture and ethnicity with supervisees.
(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)
6. Does this change according to whether you are discussing clinical issues or issues of personal and professional development?
(Much more confident discussing clinical issues; slightly more confident discussing clinical issues; equally confident discussing clinical and person and professional development issues; slightly more confident discussing personal and professional development issues; much more confident discussing personal and professional development issues)

The next three questions concern how well any training you have done has prepared you for discussing issues of 'race', culture and ethnicity with supervisees.

7. *Clinical psychology training* prepared me well for discussing issues of 'race', culture and ethnicity with supervisees.
(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)
8. *Supervisor training* prepared me well for discussing issues of 'race', culture and ethnicity with supervisees.
(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)
9. Further trainings other than my clinical psychology training and supervisor training prepared me well for discussing issues of 'race',

culture and ethnicity with supervisees. (Feel free to move on to the next question without selecting an answer if no other trainings apply).

(Strongly agree; agree; somewhat agree; neither agree nor disagree; somewhat disagree; disagree; strongly disagree)

Please specify which training(s) you are referring to.

(Free text)

The final three questions are more general questions about how it feels to discuss issues of 'race', culture and ethnicity with supervisees.

10. How does your comfort in discussing issues of 'race', culture and ethnicity compare to your comfort in discussing other issues of difference or inequality with supervisees?

(Much more comfortable discussing these issues; slightly more comfortable discussing these issues; equally comfortable discussing these issues and other issues; slightly more comfortable discussing other issues; much more comfortable discussing other issues)

11. How does your confidence in discussing issues of 'race', culture and ethnicity compare to your confidence in discussing other issues of difference or inequality with supervisees?

(Much more confident discussing these issues; slightly more confident discussing these issues; equally confident discussing these issues and other issues; slightly more confident discussing other issues; much more confident discussing other issues)

12. Is there anything else you would like to say?

Feel free to comment on:

- what you think is behind any discomfort or lack of confidence
- any other thoughts or feelings which you notice when discussing these issues
- what has helped or would help
- how discussing these issues relates to your general approach to supervision
- the impact of service context
- the impact of the wider context
- the impact of your own identities

- the impact of your supervisee's identities
- any of the multiple-choice questions in more detail
- anything else which you feel is relevant
(Free Text)

Demographic information

- How old are you? **(Drop down, numbers 24-100)**
- In which year did you complete your clinical psychology training?
(Drop down, years 1970 - 2018)
- How many clinical psychologists have you supervised? **(Drop down: 0; 1-5; 6-10; 11-15; 16-20; 21+)**
- How many trainee clinical psychologists have you supervised?
(Drop down: 0; 1-5; 6-10; 11-15; 16-20; 21+)
- How many pre-training aspiring clinical psychologists (e.g. assistant psychologists) have you supervised? **(Drop down: 0; 1-5; 6-10; 11-15; 16-20; 21+)**
- How would you describe your racial/ethnic/cultural identity? **(Free text)**
- How would you describe your service context with regards to client group, main treatment modality if applicable, primary/secondary/tertiary care and whether it is an NHS service or not? (E.g. "NHS LD service", "Social enterprise for young asylum seekers") **(Free text)**
- In which geographical region are you currently working? **(Drop down: East Midlands; East of England; London; North East; North West; Northern Ireland; Scotland; South East; South West; Wales; West Midlands)**

Appendix H: Transcription and quotation conventions

Interviews were transcribed in line with Braun and Clarke's (2006) minimum orthographic transcription requirements, that is the verbatim reproduction of verbal utterances as well as significant non-verbal utterances. This included false starts, cut-offs in speech (e.g. discrimin-), coughs, laughter (indicated by [laugh]), long pauses (indicated by [pause]) and strong emphasis (indicated by underscore, e.g. really). Hesitations (e.g. umm) and repetitions were removed for readability.

Pseudonyms are used for quotations to facilitate a more personalised account of the findings. Assumptions about ethnic background should not be made from pseudonyms. The convention [...] indicates an edit for brevity of quotation.

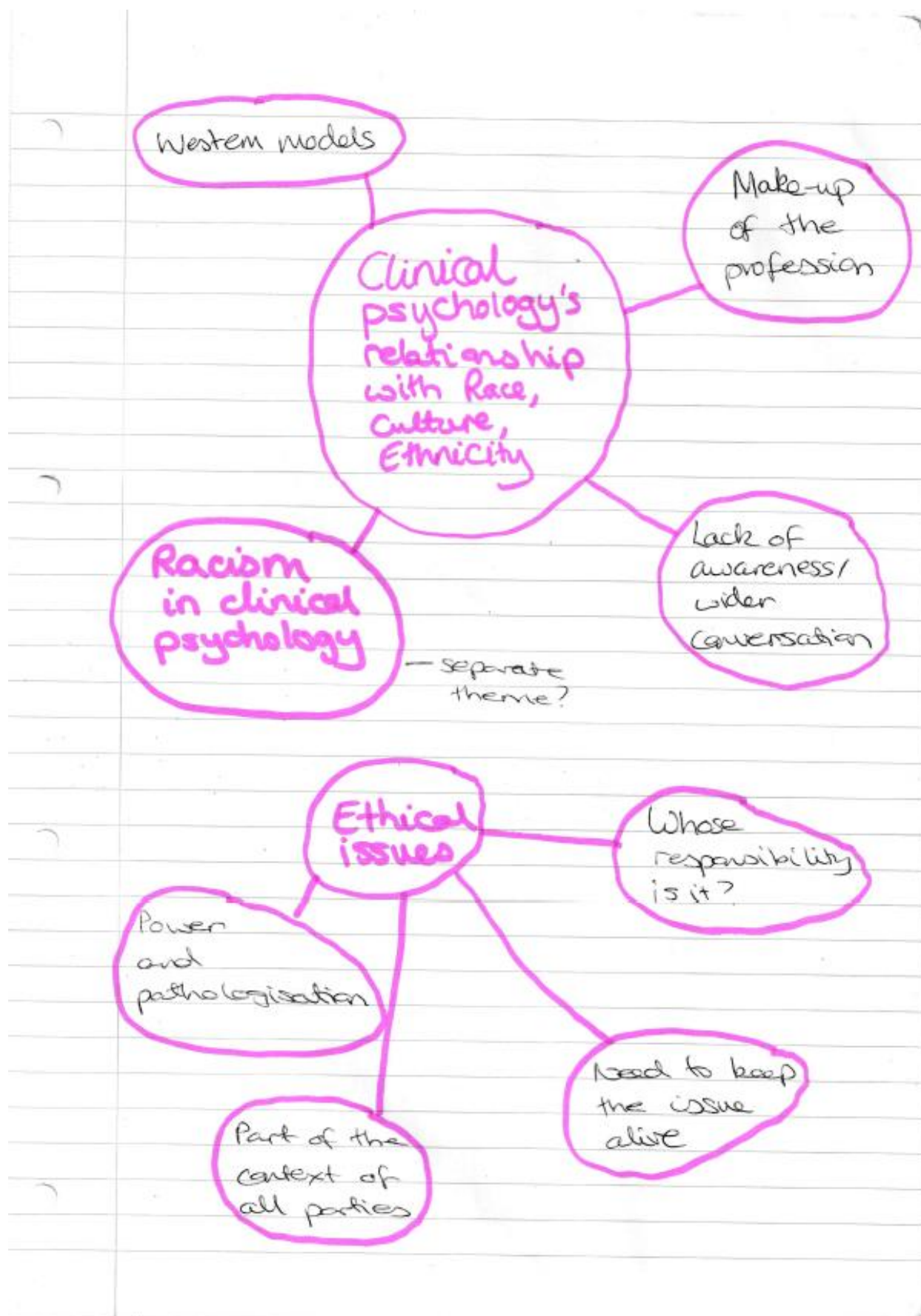
Very occasionally, particular extracts could not be included in the write-up to illustrate points as there were no relevant, but unidentifiable, sections of the extract. These extracts fell into two groups. One was extracts describing the intersectional impacts of very specific multiple identities where two or more of the identities are held by a small minority of the profession. The other was extracts describing particular events that supervisees had shared with supervisors where I had some doubts about identifiability. Following supervision discussions, I chose to err on the side of caution in the absence of permission from supervisees themselves.

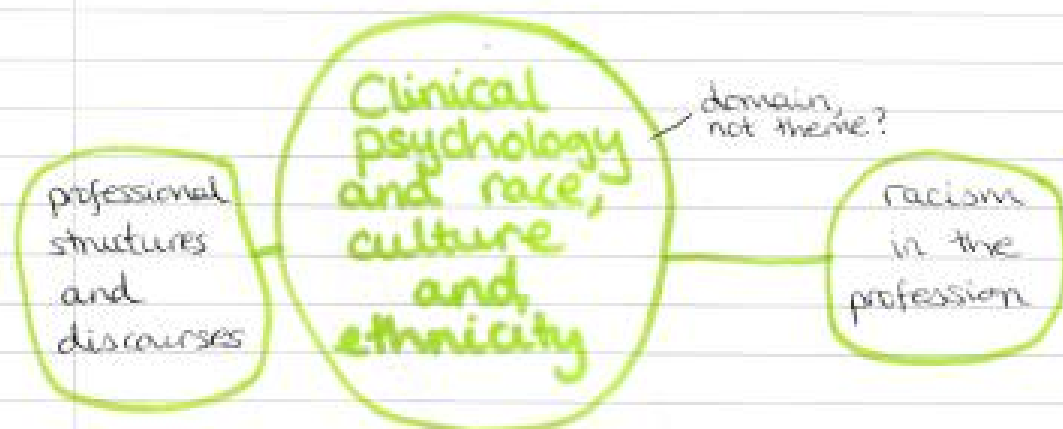
Appendix I: Initial list of codes

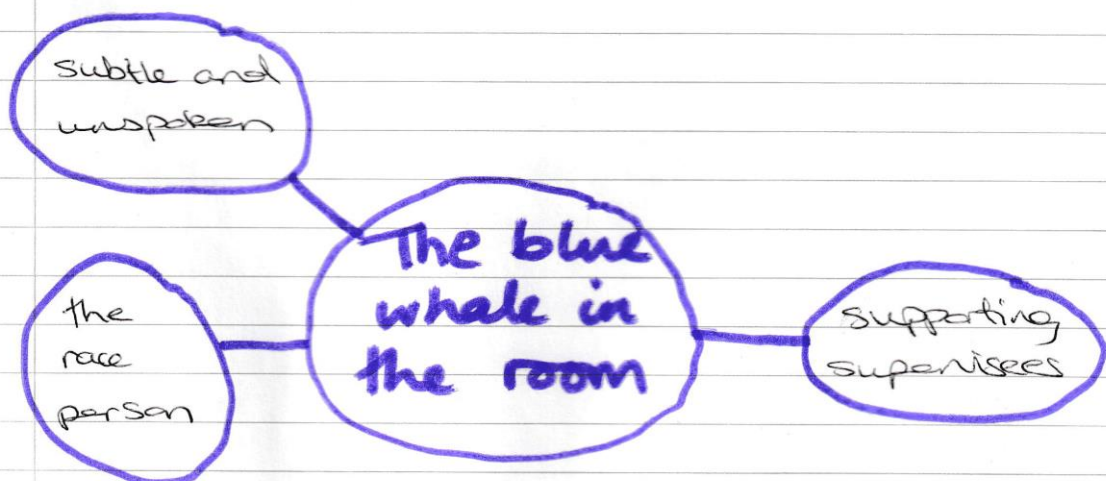
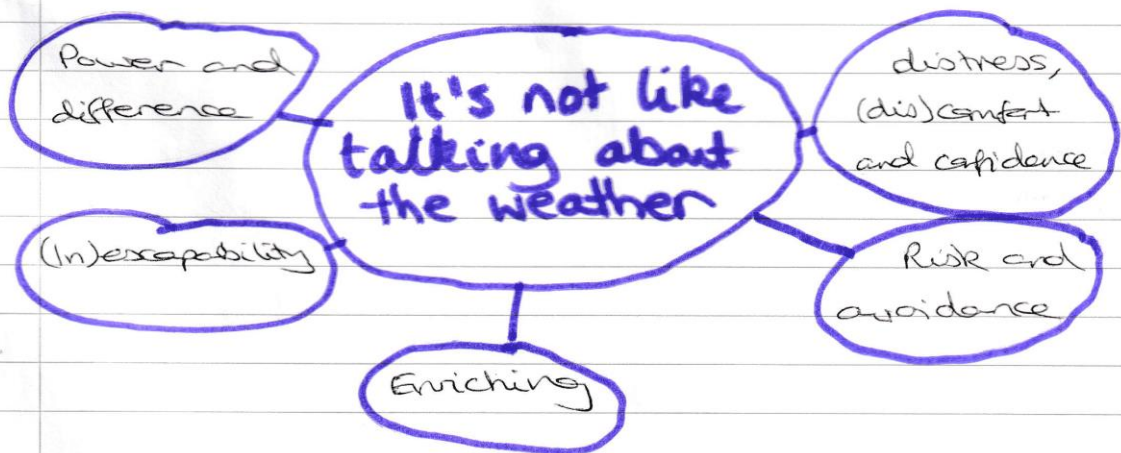
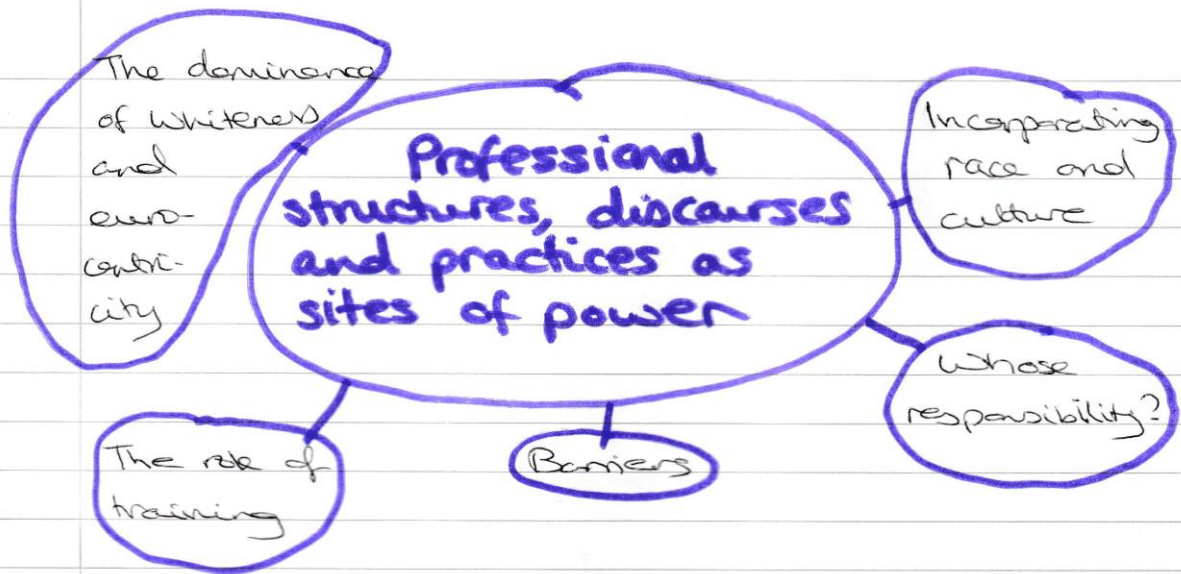
1. Risky topic
2. Getting it wrong (concerns about)
3. Variable experiences
4. Difficult conversations
5. Focus on difference
6. (In)escapable
7. Discomfort
8. Raising these issues
9. Interest in topic
10. Language (concerns about)
11. Emotive/personal
12. Wider/historical context
13. Case discussion
14. Practical strategies
15. Third position
16. Conversation as performative
17. Safety important
18. Relational qualities important
19. Beyond difference/a deeper connection
20. More talking about these issues necessary
21. Talked about from the start
22. Care for others drives attention to these issues
23. Space for conversation needed
24. Lived experience useful
25. Systemic thinking helpful
26. More awareness/promotion of these issues necessary
27. Honest, open conversation as valued
28. Time and experience helpful
29. Learning position
30. Literature helpful
31. These issues affect everyone
32. Westernised models in psychology
33. Relevant to client group

34. Flexibility necessary
35. Risk of complacency
36. Workplace influences
37. Conversations as narrow, shut down, absent
38. Relevant/necessary/important topic
39. External pressures (e.g. on time) unhelpful
40. Whose responsibility?
41. Role of training
42. Personal professional development (links with)
43. Role of supervisor
44. Competence – links to
45. Demographics of profession
46. Part of a psychologist's remit
47. Standard topic of conversation
48. Tokenistic
49. Role of policy
50. Pathologisation
51. Power
52. Resistance
53. Shock, trauma, distress
54. Replicating dynamics
55. Intersectionality
56. 'The race person'
57. Sanitised
58. Racism (experiences of)
59. (In)visible
60. Racism outside the profession
61. Asset to supervisee/team/client
62. Identity as related

Appendix J: Thematic map examples







Appendix K: Ethical approval

UNIVERSITY OF EAST LONDON School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to:

<http://www.uel.ac.uk/gradschool/ethics/>

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.

Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.

Among other things this site will tell you about UEL sponsorship

Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website

http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015)

<http://www.uel.ac.uk/gradschool/ethics/>

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.
2. Type your name in the 'student's signature' section (5.1).
3. Include copies of all necessary attachments in the **ONE DOCUMENT SAVED AS .doc** (See page 2)
4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identify its content. Your supervisor will then look over your application.
5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.
6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are NOT to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- ☐ A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.
- ☐ Example of the kinds of interview questions you intend to ask participants.
- ☐ Copies of the visual material(s) you intend showing participants.
- ☐ A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- ☐ **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES**

VULNERABLE PARTICIPANTS: A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

1. Your name:

Meera Desai

2. Your supervisor's name:

Dr David Harper

3. Title of your programme: (e.g. BSc Psychology)

Professional Doctorate in Clinical Psychology

4. Title of your proposed research: (This can be a working title)

Exploring supervisor responses to issues of 'race', culture and ethnicity in clinical psychology supervision, and the systemic factors influencing this.

5. Submission date for your BSc/MSc/MA research:

14th May 2018

6. Please tick if your application includes a copy of a DBS certificate

N/A

7. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)

N/A

8. Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics (See links on page 1)



2. About the research

9. The aim(s) of your research:

1. To explore the experiences of supervisors discussing issues of 'race', culture and ethnicity with supervisees in clinical psychology.
2. To explore how comfortable and confident supervisors feel discussing these issues with supervisees.
3. To explore the systemic factors influencing supervisors' experiences, comfort and confidence.

10. Likely duration of the data collection from intended starting to finishing date:

7th December 2017 – 31st August 2018

Methods

11. Design of the research:

(Type of design, variables etc. If the research is qualitative what approach will be used?)

The research uses a mixed-methods design comprising semi-structured interviews to gather qualitative data and an online survey to gather quantitative data via a questionnaire. The qualitative data will be the main focus of the study, and the quantitative data is intended to enrich it.

Qualitative data will be analysed using Thematic Analysis and transcribed using transcription conventions suitable for this approach. Quantitative data will be reported as Descriptive Statistics. If there are sufficient numbers of respondents, and the qualitative data indicates that this is a useful avenue of exploration, Mann-Whitney U tests may be used to compare responses to different items on the online questionnaire. Qualitative data from the final free text box in the questionnaire will be subjected to a thematic analysis separately to the interview data, but discussed in conjunction with it.

12. The sample/participants:

(Proposed number of participants, method of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research)

No maximum or minimum limits will be placed on the number of participants in the online survey. Eight to twelve participants will be recruited for the interviews.

Recruitment will take place via word-of-mouth and online clinical psychology forums. Personal contacts of the researcher and/or the supervisor will facilitate recruitment.

Participants for both the survey and interview components of the study will be qualified clinical psychologists who have provided clinical supervision for at least one clinical psychologist or pre-qualification aspiring clinical psychologist (e.g. trainee clinical psychologist, assistant psychologist). This will need to have been in their role as a qualified clinical psychologist and should have been over a period of at least six months.

Current supervisors of the researcher will be excluded. If participants with whom the researcher has a prior relationship are recruited, the implications of this will subsequently be attended to in the analysis.

13. Measures, materials or equipment:

(Give details about what will be used during the course of the research. For example, equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application)

A questionnaire will be designed and published online using Qualtrics® software to collect data for the online survey. An interview schedule will be used to guide the semi-structured interviews. A digital voice recorder will be used to record interviews before immediate transfer of the data to a password protected file on a password protected computer. See attachments for further details on both the online questionnaire and interview schedule.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you

have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES / NO / NA

15. Outline the data collection procedure involved in your research:

(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

Participants in the survey component of the study will be required to complete an online questionnaire. They will be able to do this at a time and location of their choosing, which the researcher will not need to be informed of. The survey will be optimised for use on a computer, tablet or mobile device. It is anticipated that the questionnaire will take approximately ten minutes to complete.

Participants in the interview component of the study will be required to take part in a face-to-face audio-recorded interview with the researcher. It is anticipated that the interview will take approximately 45 minutes to complete. The interview will take place in a quiet, comfortable room which is convenient for and accessible by the participant. The time and location of the interview will be negotiated between the researcher and the participant and should not compromise the health or safety of either.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if

necessary): Would the participant information letter be written in a style appropriate for children and young people, if necessary?

Potential participants will be given an information sheet about the research. They will be given the option to contact the researcher and/or their supervisor prior to consenting via contact details provided on the information sheet. Interview participants will be given an additional opportunity to ask the researcher questions in person before the interview commences.

17. Obtaining fully informed consent from participants (and from parents/guardians if

necessary): Would the consent form be written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians?

Online survey participants will be required to indicate their consent by clicking on a 'Yes' button at the end of the online consent form prior to commencing the survey.

Interview participants will be required to sign a consent form prior to being interviewed. The consent form will be counter-signed by the researcher.

18. Engaging in deception, if relevant:

(What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.)

There will be no deception or withholding of information about the nature of the research.

19. Right of withdrawal:

(In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve deciding not to participate in your research and the opportunity to have the data they have supplied destroyed on request. This can be up to a specified time, i.e. not after you have begun your analysis. Speak to your supervisor if necessary.)

Online survey participants are free to withdraw from the study at any time without giving a reason by closing the online survey. If they choose to do this, their responses will be deleted. However, if they complete the questionnaire and submit their responses, the researcher will be unable to delete their responses as, due to the anonymous nature of the data collection, they will not be able to link them to the data the participant provided.

Interview participants are free to withdraw from the study at any time up until 1st January 2018, when data analysis will begin. Should they choose to withdraw from the study they may do so without disadvantage to themselves and without any obligation to give a reason.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?

(i.e. this is where you will not know the names and contact details of your participants? In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)

YES / NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? Make this clear in this section and in your participant invitation letter also.)

Participant names and other identifying information will be stored securely and separately from their audio-recordings and the subsequent data analysis. Consent forms will be stored in a locked drawer, and any data will be stored in password-protected files on password-protected computers. The supervisor and examiners of the study will not be given participant names. If participants have any additional concerns at any stage of the interview, every effort will be taken to agree with them what they wish to be anonymised. The researcher will carry out all the transcription and any identifying information will be altered in transcripts, thesis extracts and any resulting publications. The transcripts will not be accessible to anyone other than the supervisor and examiners of the study. The audio recordings will be erased when the researcher no longer needs them for university approval. The anonymised transcripts will be stored securely for five years to allow the researcher to publish the results. All remaining data will be destroyed or deleted after five years.

All information collected about participants will be kept strictly confidential. However, if a participant shares information which leads to serious concern about their safety or the safety of others, it may be necessary to involve a third party and this will be done in consultation with the supervisor unless there is an immediate concern. In the very unlikely event that this happens, the researcher will discuss this with the participant first where possible.

Interview participants will be reminded at the start of their interview that, in line with their

supervisory contract and/or local policy, they should refrain from sharing identifying information about supervisees. They will be encouraged to be mindful of the fact that, for example, reference to a “Black male trainee clinical psychologist” may make them identifiable due to the small number of trainees sharing this identity within a region. This will be explained in the context of the researcher’s wish to understand the supervisor’s experience.

22. Protection of participants:

(Are there any potential hazards to participants or any risk of accident or injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?)

N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.

Participants will not be exposed to potential hazards or risks of injury or accident. Completing the online questionnaire or taking part in the interview may cause some discomfort, but it is not anticipated that this will be higher than that which might normally be expected or required in their day-to-day role as a clinical psychology supervisor. However, sources of support will be provided during the survey, and survey participants will have the option of contacting the researcher and/or their supervisor if they wish to. Similarly, if interview participants find any of the questions particularly upsetting they will be reminded that, as per the information sheet, they do not have to answer them. They will also be reminded that they can ask to stop, take breaks, reschedule the interview or withdraw from the study at any time. There will be a space for de-brief at the end of the interview and they will be offered information on relevant sources of support.

23. Protection of the researcher:

(Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant’s house?)

The researcher will not be knowingly exposed to any potential hazards or risks of injury or accident. The supervisor will be provided with details of the times and locations of interviews and the researcher will contact the supervisor immediately after each interview to confirm that the interview has been completed safely. A risk assessment will be conducted prior to the commencement of the interviews.

24. Debriefing participants:

(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? Please attach to this application your debrief sheet thanking participants for their participation, reminding them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

There will be a space for de-brief at the end of the interview, which will include an opportunity to ask questions and/or raise concerns, as well as be reminded about what will happen to their data. See attached debrief sheet for further information.

25. Will participants be paid?

YES / NO

If YES how much will participants be paid and in what form (e.g. cash or vouchers?)
Why is payment being made and why this amount?

26. Other:

(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)
N/A

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

~~YES~~ / NO

28. Is ethical clearance required from any other ethics committee?

~~YES~~ / NO

29. Will your research involve working with children or vulnerable adults?*

~~YES~~ / NO

30. Will you be collecting data overseas?

~~YES~~ / NO

This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Meera Desai

Student's number: u1524904

Date: 17/09/17

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name:

Date: 18/09/17

YOU MUST ATTACH THESE ATTACHMENTS:

1. PARTICIPANT INVITATION LETTER(S)

See pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This can be adapted for your own use and must be adapted for use with parents/guardians and children if they are to be involved in your study.

Care should be taken when drafting a participant invitation letter. It is important that your participant invitation letter fully informs potential participants about what you are asking them to do and what participation in your study will involve – what data will be collected, how, where? What will happen to the data after the study is over? Will anonymised data be used in write ups of the study, or conferences etc.? Tell participants about how you will protect their anonymity and confidentiality and about their withdrawal rights.

Make sure that what you tell potential participants in this invitation letter matches up with what you have said in the application

2. CONSENT FORM(S)

Use the pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This should be adapted for use with parents/guardians and children.

3. PARTICIPANT DEBRIEF SHEET

OTHER ATTACHMENTS YOU MAY NEED TO INCLUDE:

See notes on page 2 about what other attachments you may need to include – your debrief document for participants? Example interview questions? A questionnaire you have written yourself? Visual stimuli? Ethical clearance or permission from another institution or organisation?)

SCANNED COPY OF CURRENT DBS CERTIFICATE

(If one is required. See notes on page 3)

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

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

REVIEWER: Claire Marshall

SUPERVISOR: David Harper

STUDENT: Meera Desai

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Exploring supervisor responses to issues of 'race', culture and ethnicity in clinical psychology supervision, and the systemic factors influencing this.

DECISION OPTIONS:

1. **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/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but 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 the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): 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.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but 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 the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

Minor amendments required (for reviewer):

One amendment required –

p.5. 12 “If participants with whom the researcher has a prior relationship are recruited, the implications of this will subsequently be attended to in the analysis.”

On p.12 of the BPS Code of Human Research Ethics it states that: “A difference in power inevitably exists between researchers and participants, even if researchers seek to minimise it.” http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Therefore, the researcher should consider the implications of a prior relationship with the participant not only on the research (i.e. by attending to it in the analysis) but also on the participant. Implications should be thought about in respect to power (particularly pertinent as issues of ‘race’, culture and ethnicity implicitly hold implications of power) as well as how able the participant might feel to communicate if they feel discomfort/ distress when responding to the questions. One way of addressing this might be to add more in the information sheet that addresses this.

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

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

Student's name (*Typed name to act as signature*): Meera Desai

Student number: u1524904

Date: 17.01.18

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

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

Has an adequate risk assessment been offered in the application form?

YES / ~~NO~~

Please request resubmission with an adequate risk assessment

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

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

N/A

Reviewer (Typed name to act as signature): Dr Claire Marshall

Date: 12.01.18

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 UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix L: Participant information sheet (interviews)

PARTICIPANT INFORMATION SHEET

Supervisors' experiences of discussing issues of 'race', culture and ethnicity



I would like to invite you to take part in a research study. The study is part of my Professional Doctorate in Clinical Psychology at the University of East London. Before you make a decision, you need to understand why the research is being conducted and what it would involve. Please read through the following information carefully before deciding whether or not you would like to take part in the research. If you have any unanswered questions please do not hesitate to contact me using the contact details at the end of this information page.

What are the aims of the study?

The links between distress and issues of 'race', culture and ethnicity have been well documented with regards to both clients and supervisees. The supervisory relationship is an important space through which the complexities of these links can be explored and impacted upon. This may be in relation to specific clinical cases or more broadly as part of personal and professional development. This is in line with the growing emphases on personal and professional development and cultural competence within the profession (BPS, 2016, *Standards for Doctoral Programmes in Clinical Psychology*; HCPC, 2015, *Practitioner Psychologists: Standards of Proficiency*).

This study aims to better understand supervisors' experiences in responding to these issues, and the systemic factors which may affect this. It is hoped that the findings from this research project will help shape future support, training and guidance for supervisors in discussing these issues. It is hoped that this will in turn benefit their supervisees and their clients.

Why do you want me to take part?

We are inviting qualified clinical psychologists to take part in an interview. To take part, you should have provided clinical supervision for at least one clinical psychologist or pre-qualification aspiring clinical psychologist (e.g. trainee clinical psychologist, assistant psychologist). This will need to have been in your role as a qualified clinical psychologist and should have been over a period of at least six months.

What will I be asked to do?

If you decide to participate, you will be asked to take part in an audio-recorded face-to-face interview lasting about 45 minutes. This will involve talking to me about your experiences of discussing issues of 'race', culture and ethnicity with supervisees. If you consent, you may be contacted at a later date to ask if you would like to hear about and comment on the research analysis. You can decline this offer without giving a reason.

Are there benefits to taking part?

By taking part, you will have the opportunity to reflect on your experiences of discussing issues of 'race', culture and ethnicity with supervisees and the systemic factors that impact this. You may find this useful as part of your ongoing personal and professional development.

Are there any disadvantages or risks to taking part?

Completing the survey may make you aware of aspects of your identity or role as supervisor that you may not typically focus on, which may cause some discomfort. It is not anticipated that this discomfort will be higher than that which might normally be expected or required in your day-to-day role as a clinical psychology supervisor. However, if you find any of the questions particularly upsetting you do not have to answer them. You will be reminded that you can ask to stop, take breaks, reschedule the interview or withdraw from the study at any time. There will be a space for de-brief at the end of the interview and you

will also be offered information on relevant sources of support. It is OK to take part if you have a personal or professional relationship with the researcher, but please take some time to think about whether this is likely to cause you significant discomfort or distress, or whether it would affect your ability to communicate any distress during or after the interview.

Will my taking part in the study be kept confidential?

All information collected about you will be kept strictly confidential, including the content of your interview. However, if you share information which leads to serious concern about your safety or the safety of others, it may be necessary to involve a third party and this will be done in consultation with my research supervisor unless there is an immediate concern. In the very unlikely event that this happens, I will discuss this with you first where possible.

To protect your anonymity, your name and other identifying information will be kept securely and separately from your audio-recording and the subsequent data analysis. My supervisor and the examiners of the study will not need to see your name. If you have any additional concerns at any stage of the interview, every effort will be taken to agree with you what you wish to be anonymised. I will carry out all the transcription and any identifying information will be altered in transcripts, thesis extracts and any resulting publications. The transcripts will not be accessible to anyone other than my supervisor and examiners of this study. The audio recordings will be erased when I no longer need them for university approval. I will store the anonymised transcripts securely for five years, as I may wish to publish the results.

Where and when will I take part?

If you decide to take part in this study, we will negotiate a convenient time and location for the interview (for example, a private room at University of East London).

Do I have to take part?

You are not obliged to take part in this study and you should not feel coerced. You are free to withdraw at any time up until the point at which data analysis begins. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

What will happen to the results?

The results of the study will be written up as a doctoral thesis and may be submitted to a research journal or used in conference presentations.

Has the study been reviewed?

The details of the study have been reviewed by an ethics committee at the University of East London.

Who can I contact about the study?

If you have any questions about the study please contact me using the following contact details:

Meera Desai, Trainee Clinical Psychologist, University of East London, Water Lane, London E15 4LZ. (Email: u1524904@uel.ac.uk)

If you have any concerns about how the study is being conducted you can contact my supervisor or the chair of the research ethics committee using the details below:

Dr Maria Castro Romero, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4422. Email: m.castro@uel.ac.uk)

Chair of the School of Psychology Research Ethics Sub-committee:

Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Appendix M: Participant information sheet (survey)

PARTICIPANT INFORMATION SHEET

Supervisors' experiences of discussing issues of 'race', culture and ethnicity

I would like to invite you to take part in a research study. The study is part of my Professional Doctorate in Clinical Psychology at the University of East London. Before you make a decision, you need to understand why the research is being conducted and what it would involve. Please read through the following information carefully before deciding whether or not you would like to take part in the research. If you have any unanswered questions please do not hesitate to contact me using the contact details at the end of this information page.

What are the aims of the study?

The links between distress and issues of 'race', culture and ethnicity have been well documented with regards to both clients and supervisees. The supervisory relationship provides an important space in which these issues can be discussed. This may be in relation to specific clinical cases or more broadly as part of personal and professional development. This study aims to better understand supervisors' experiences in responding to these issues, and the systemic factors which may affect this. It is hoped that the findings from this research project will help shape future support, training and guidance for supervisors in discussing these issues. It is hoped that this will in turn benefit their supervisees and their clients.

Why do you want me to take part?

We are inviting qualified clinical psychologists to complete a brief online survey. To take part in the study, you should have provided clinical supervision for at least one clinical psychologist or pre-qualification aspiring clinical psychologist (e.g. trainee clinical psychologist, assistant psychologist). This will need to have been in your role as a qualified clinical psychologist and should have been over a period of at least six months.

Do I have to take part?

Taking part is entirely your choice. If you do decide to take part you can withdraw from the study at any time without giving a reason by closing the online survey. If you choose to withdraw during the study, your responses will be deleted. However, if you complete the survey and submit your responses, we will be unable to delete your responses, as we will be unable to link you to the data you provided.

What would taking part involve?

If you decide to take part, you will be asked to answer some multiple-choice questions via a secure online survey. You will be given the opportunity at the end to expand on your answers and provide further context in a free text box at the end should you wish. It is estimated that it will take approximately 10 minutes to complete the survey.

Are there any disadvantages or risks to taking part?

Completing the survey may make you aware of aspects of your identity or role as supervisor that you may not typically focus on, which may cause some discomfort. It is not anticipated that this discomfort will be higher than that which might normally be expected or required in your day-to-day role as a clinical psychology supervisor. However, sources of support will be provided during the study and you have the option of contacting the researcher and/or their supervisor if you wish to.

Are there benefits to taking part?

By taking part, you will have the opportunity to reflect on your experiences of discussing issues of 'race', culture and ethnicity with supervisees and the systemic factors that impact this. You may find this useful as part of your ongoing personal and professional development.

What if I have concerns or a complaint about the study?

If you have any concerns about the study you can talk to the researcher or their supervisor. If this does not resolve the problem, you can make a formal complaint through the University of East London ethics committee. Further details about this can be obtained from Dr Mary Spiller (chair of the Research Ethics sub-committee) whose details are contained at the end of this information page.

Will my information remain confidential?

All of the information you provide will be confidential and will only be shared with my supervisor and I. We will not be collecting personal details such as your name or contact information, and you will be assigned an identification number, so your responses cannot be linked to you. This number will be used in the database where your responses will be recorded. The database will be stored on a password-protected computer file, which only my supervisor and I will have access to. Hard copies of information collected will be stored in a locked filing cabinet.

What will happen to the results?

The results of the study will be written up as a doctoral thesis and may be submitted to a research journal or used in conference presentations. All of the information you provide will remain

anonymous. All of the data belonging to the study will be destroyed after 5 years.

Has the study been reviewed?

The details of the study have been reviewed by an ethics committee at the University of East London.

Who can I contact about the study?

If you have any questions about the study please contact me using the following contact details:

Meera Desai, Trainee Clinical Psychologist, University of East London, Water Lane, London E15 4LZ. (Email: u1524904@uel.ac.uk)

If you have any concerns about how the study is being conducted you can contact my supervisor or the chair of the research ethics committee using the details below:

Dr Maria Castro Romero, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4422. Email: m.castro@uel.ac.uk)

Chair of the School of Psychology Research Ethics Sub-committee: **Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)**

Appendix N: Consent form (interviews)

Consent to participate in a research study

Research study: Exploring supervisors' experiences of discussing issues of 'race', culture and ethnicity.



Name of researcher: Meera Desai

- ☐ I confirm I have read and understood the information page.
- ☐ I have been given the opportunity to ask questions about the study and have received satisfactory answers.
- ☐ I understand that my involvement in the study is voluntary.
- ☐ I understand that I am able to withdraw before data analysis starts.
- ☐ I understand that anonymised quotes may be used from the transcript of my interview for publications and/or conference materials.
- ☐ I understand that the researcher and their supervisor will keep the information I share confidential.
- ☐ I understand that all information about the study will be destroyed after 5 years.

I hereby freely and fully consent to participate in the study, which has been fully explained to me.

Participant's Signature..... Researcher's Signature.....

Participant's Name..... Researcher's Name.....

Date..... Date.....

Appendix O: Consent form (survey)

Consent to participate in a research study

Research study: Exploring supervisors' experiences of discussing issues of 'race', culture and ethnicity.

Name of researcher: Meera Desai

- I confirm I have read and understood the information page.
- I have been given the opportunity to ask questions about the study and have received satisfactory answers.
- I understand that my involvement in the study is voluntary.
- I understand that I can withdraw from the study at any point up until I submit my responses without giving a reason.
- I understand that if I withdraw during the study all of the information I provided will be deleted.
- I understand that I will be unable to withdraw my responses once they have been submitted, as the data will be collected in an anonymous way.
- I understand that the researcher and their supervisor will keep the information I share confidential.
- I understand that all information about the study will be destroyed after 5 years.

I hereby freely and fully consent to participate in the study, which has been fully explained to me.

Please indicate your consent by clicking 'YES' below

YES

Supervisors' experiences of discussing issues of 'race', culture and ethnicity

Thank you very much for taking part in this study. It is hoped that the findings will help shape future support, training and guidance for supervisors in discussing these issues. It is hoped that this will in turn benefit their supervisees and their clients.

If you have any questions or concerns at all after taking part, feel free to contact the researcher and/or their supervisor via the contact details below. You may also wish to refer to your participant information sheet for more information on confidentiality, complaints and your right to withdrawal. If you have misplaced your information sheet, the researcher will be happy to give you another one.

What will happen to my data?

The results of the study will be written up as a doctoral thesis and may be submitted to a research journal or used in conference presentations. All of the information you provide will remain anonymous. Identifying information will be altered in any publications or disseminations. All of the data belonging to the study will be destroyed after 5 years.

What should I do if I experience any distress or concern as a result of participating?

The researcher and/or their supervisor will be available to provide further debrief if necessary via the contact details below.

You may also choose to consult your own supervisor if you would find this helpful.

You may find the following resource helpful to further reflect on these issues as part of your ongoing personal and professional development:

- Patel, N. (2012). Difference and power in supervision: The case of culture and racism. In I. Fleming & L. Steen (Eds.), *Supervision and Clinical Psychology Theory, Practice and Perspectives*. (Free via Google Books at time of writing)

Should you wish to speak to someone about your distress, you can contact the Samaritans on 116 123 (free 24-hour helpline) or, of course, your GP.

Who can I contact about the study?

If you have any questions about the study please contact me using the following contact details:

Meera Desai, Trainee Clinical Psychologist, University of East London, Water Lane, London E15 4LZ. (Email: u1524904@uel.ac.uk)

If you have any concerns about how the study is being conducted you can contact my supervisor or the chair of the research ethics committee using the details below:

Dr Maria Castro Romero, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4422. Email: m.castro@uel.ac.uk)

Chair of the School of Psychology Research Ethics Sub-committee: **Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.**

(Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Appendix Q: Testing for normality

One-sample Kolmogorov-Smirnov tests suggested that the data was likely to be non-normally distributed (Table A.5).

Table A.5. *Kolmogorov-Smirnov test summary*

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Does this change according to whether you are discussing clinical issues or issues of personal and professional development? is normal with mean 2 and standard deviation 0.688.	One-Sample Kolmogorov-Smirnov Test	.000 ¹	Reject the null hypothesis.
2	The distribution of Does this change according to whether you are discussing clinical issues or issues of personal and professional development? is normal with mean 2 and standard deviation 0.688.	One-Sample Kolmogorov-Smirnov Test	.000 ¹	Reject the null hypothesis.
3	The distribution of Clinical psychology training prepared me well for discussing issues of 'race', culture and ethnicity with supervisees. is normal with mean 4 and standard deviation 1.797.	One-Sample Kolmogorov-Smirnov Test	.005 ¹	Reject the null hypothesis.
4	The distribution of Supervisor training prepared me well for discussing issues of 'race', culture and ethnicity with supervisees. is normal with mean 4 and standard deviation 1.404.	One-Sample Kolmogorov-Smirnov Test	.001 ¹	Reject the null hypothesis.
5	The distribution of Further trainings other than my clinical psychology training and supervisor training prepared me well for discussing issues of 'race', culture and ethnicity with supervisees. (Feel free to move on to the next question without selecting an answer if no other trainings apply). is normal with mean 3 and standard deviation 1.472.	One-Sample Kolmogorov-Smirnov Test	.000 ¹	Reject the null hypothesis.
6	The distribution of How does your comfort in discussing issues of 'race', culture and ethnicity compare to your comfort in discussing other issues of difference or inequality with supervisees? is normal with mean 3 and standard deviation 0.699.	One-Sample Kolmogorov-Smirnov Test	.000 ¹	Reject the null hypothesis.
7	The distribution of How does your confidence in discussing issues of 'race', culture and ethnicity compare to your confidence in discussing other issues of difference or inequality with supervisees? is normal with mean 3 and standard deviation 0.702.	One-Sample Kolmogorov-Smirnov Test	.000 ¹	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

¹ Lilliefors Corrected

Due to the decreased power of non-parametric tests in the context of a small sample size, the results of the equivalent parametric tests are included in Table A.6 for reference.

Two-tailed one-sample t -tests were conducted comparing means against a criterion value of the midpoint and a Bonferroni correction for seven tests was applied before reporting p values. Parametric testing showed the same questions to have a significant difference between the mean/median and midpoint value, supporting the robustness of the analysis reported in section 3.4.

Table A.6. *Results of parametric statistical testing*

	M	SD	T	p	d
Q.3	2.39	0.69	$t(35)=-5.33$	<0.000	0.89
Q.6	2.39	0.69	$t(35)=-5.33$	<0.000	0.89
Q.7	3.97	1.80	$t(35)=-5.33$	>0.999	0.02
Q.8	4.47	1.40	$t(35)=-5.33$	0.31	0.34
Q.9	3.00	1.47	$t(24)=-0.09$	0.012	0.70
Q.10	3.24	0.70	$t(33) = 1.96$	0.342	0.34
Q.11	3.15	0.70	$t(33) = 1.22$	0.841	0.21

Appendix R: Survey results (full breakdown)

Table A.7. *Breakdown of responses to questions 1-11*

Question	Occurrence (n=38)
<i>1. Over the past six months, I have felt comfortable bringing up issues of 'race', culture and ethnicity with supervisees</i>	
Strongly agree	7
Agree	16
Somewhat agree	9
Neither agree nor disagree	1
Somewhat disagree	4
Disagree	0
Strongly disagree	1
Missing data	0
<i>2. Over the past six months, I have felt comfortable discussing and responding to issues of 'race', culture and ethnicity with supervisees</i>	
Strongly agree	8
Agree	19
Somewhat agree	6
Neither agree nor disagree	3
Somewhat disagree	2
Disagree	0
Strongly disagree	0
Missing data	0
<i>3. Does this change according to whether you are discussing clinical issues or issues of personal and professional development?</i>	
Much more comfortable discussing clinical issues	3
Slightly more comfortable discussing clinical issues	15
Equally comfortable discussing clinical or PPD issues	19
Slightly more comfortable discussing PPD issues	0
Much more comfortable discussing PPD issues	0
Missing data	1
<i>4. Over the past six months, I have felt confident bringing up issues of 'race', culture and ethnicity with supervisees.</i>	
Strongly agree	6
Agree	12

Somewhat agree	13
Neither agree nor disagree	0
Somewhat disagree	3
Disagree	0
Strongly disagree	0
Missing data	4
<i>5. Over the past six months, I have felt confident discussing and responding to issues of 'race', culture and ethnicity with supervisees</i>	
Strongly agree	7
Agree	16
Somewhat agree	10
Neither agree nor disagree	0
Somewhat disagree	2
Disagree	0
Strongly disagree	0
Missing data	3
<i>6. Does this change according to whether you are discussing clinical issues or issues of personal and professional development?</i>	
Much more confident discussing clinical issues	3
Slightly more confident discussing clinical issues	14
Equally confident discussing clinical or PPD issues	18
Slightly more confident discussing PPD issues	0
Much more confident discussing PPD issues	0
Missing data	3
<i>7. Clinical psychology training prepared me well for discussing issues of 'race', culture and ethnicity with supervisees.</i>	
Strongly agree	2
Agree	7
Somewhat agree	8
Neither agree nor disagree	5
Somewhat disagree	3
Disagree	7
Strongly disagree	3
Missing data	3
<i>8. Supervisor training prepared me well for discussing issues of 'race', culture and ethnicity with supervisees.</i>	
Strongly agree	2
Agree	1

Somewhat agree	3
Neither agree nor disagree	12
Somewhat disagree	9
Disagree	6
Strongly disagree	2
Missing data	3
<i>9. Further trainings other than my clinical psychology training and supervisor training prepared me well for discussing issues of 'race', culture and ethnicity with supervisees.</i>	
Strongly agree	2
Agree	11
Somewhat agree	4
Neither agree nor disagree	3
Somewhat disagree	3
Disagree	2
Strongly disagree	0
Missing data	13
<i>10. How does your comfort in discussing issues of 'race', culture and ethnicity compare to your comfort in discussing other issues of difference or inequality with supervisees?</i>	
Much more comfortable discussing these issues	0
Slightly more comfortable discussing these issues	4
Equally comfortable discussing these or other issues	18
Slightly more comfortable discussing other issues	10
Much more comfortable discussing other issues	1
Missing data	5
<i>11. How does your confidence in discussing issues of 'race', culture and ethnicity compare to your confidence in discussing other issues of difference or inequality with supervisees?</i>	
Much more confident discussing these issues	0
Slightly more confident discussing these issues	5
Equally confident discussing these or other issues	19
Slightly more confident discussing other issues	8
Much more confident discussing other issues	1
Missing data	5

Table A.8. *Further trainings specified in response to question 9*

Further training specified	Linked response (question 9).
1 year of Systemic/Family therapy Training	Agree
Systemic training	Agree
Specialist Supervisor training in Scotland	Somewhat disagree
General workshops / CPD	Somewhat agree
Not training perse but research interest in intersectionality and social graces	Agree
I joined the Trust's BME committee to facilitate this	Agree
Conferences, workshops and seminars, including [specific set of events at specific institution]	Agree
systemic/narrative	Agree
Foundation and Intermediate systemic training	Agree
Group dynamic training at [Institution]	Agree
Psychotherapy	Somewhat agree
Clinical practice in diverse areas	Agree
[NHS Trust] newly qualified CPD - systemic modules 1-2 with [systemic practitioner] and [systemic practitioner]	Strongly agree
my own self reading and research	Disagree
Workshops from non statutory agencies on specific ethnic minorities and their response to mental health issues.	Agree

Table A.9. *Free text responses to question 12*

12. <i>Is there anything else you would like to say?</i>
It is mentioned when we complete trainee evaluations in terms of how we rate their understanding of equality and diversity but I can't remember any supervisor training referring to it
I think it can sometimes feel a little uncomfortable because of the power differential in the supervisory relationship. As a supervisor of a trainee or assistant it may be difficult for the trainee/ assistant to state if they are unhappy with the discussion especially where the supervisor is of a different race or culture. In my experience these discussions are more fruitful if this power differential is also openly explored. I think a space for reflection of our own identities as clinical psychologists (qualified and in training) and the values and experiences we bring from our lives is an absolutely critical element of supervision & this has always made me feel more confident to discuss issues of diversity.
I am from a BME background which affects how I have answered and I also studied at [course] which has made me more confident and comfortable with these issues. I also live in a very ethnically diverse area.
Not wanting to offend
It has always been a salient topic for me. Being a white male psychologist, issues of intersectionality have always been in the forefront. This has been through reflecting on own experiences of marginalisation compared to my partners (of [specific region of the world] origin). Salient areas being my ethnicity, gender and social class. Reflections on privileges and disadvantages aide in how approach clinical practice and research interests. Something which I aim to model for trainees/supervisees in clinical/research supervision.
Also depends on trainees comfort and ease of discussing such issues.
I think that in Clinical Psychology training, and discussions more generally about this subject, there is too much focus on race / skin colour / religious differences and not enough focus on difference, diversity and cultural background in all it's forms. What helps me to feel confident and comfortable is an understanding that no two people are ever the same no matter what their race, life experiences, cultural background is. The absolute paramount thing is to be curious, to focus on understanding the person or the issue that is in the room and how it connects with the person and issues in the wider social context. It is vital not to make assumptions (or to understand that you might make incorrect assumptions and so be willing to check them out). I definitely think that this has got easier with experience of working with diverse populations in multiple cities around the UK. Cognitive Analytic Therapy training was very helpful in increasing my confidence and comfort with both noticing and raising issues with both the people I work with and my supervisees.
I am a BME clinical psychologist and am mindful that I'm still in the minority so often my views aren't always the dominant discourse and get side lined for more mainstream e.g. NICE etc.
I trained in [city] where the vast majority of placement supervisors were white middle class, which matched my own race/social class. This seemed to inhibit discussions about these factors which means this was rarely modelled. This has been in contrast to working in a multicultural setting ([city]) and supervising assistants from a variety of backgrounds. Therefore I feel more comfortable discussing race particularly when brought up by the assistant. There is a slight fear maybe of making too much of an assumption race plays a part, and that I might be imposing my view in that way.

However, discussions of culture, particularly parenting cultures is much more widely discussed in supervision as it is highly relevant to the work and therefore somewhat easier to bring in to discussions.

supervisee race makes a difference as does my perception of comfort/knowledge with this

Acknowledging diversity and power is fundamental to the role of a clinical psychologist as is acknowledging and addressing challenging and emotive topics. It is incumbent on supervisors to model this and to have the skills and ethical courage to make space for these discussions. That is not to suggest that I haven't worried about being sensitive or knowledgeable enough but curiosity and openness to learning should provide a safe enough space.

These conversations may be easier once a supervisory relationship has been formed but initially, e.g. especially at the beginning of the clinical placement, it can be difficult to bring up such issues without knowing much about the trainee/their background/their views etc; there is also so much to set up at the start of a clinical placement that it's often focused on what previous work experience/DClin placements the trainee has had and what the placement work will entail which does not leave much space for discussion regarding wider things. Then once something comes up, there haven't perhaps been enough of the "getting to know" you conversations that are so helpful at the start of a supervisory relationship. It can be easier to discuss these issues more "organically", i.e. as and when they come up through the clinical work, though I have rarely had trainees specifically bring such an issue to supervision or specifically asked me about it. I have also rarely had trainees bring a more personal issue of this nature to supervision. What would help - at the start of the placement, for me to "give permission" to trainees to bring up these issues/their thoughts and beliefs etc. so that the groundwork is done to then support with clinical discussions and/or discussion about the personal/professional etc.

I worked transculturally overseas including training counsellors and learned a lot re the impact of culture on presentation and learning. I find awareness of cultural difference can be beneficial as opening the opportunity for naïve questions which help clients and supervisees to reflect on the norms in their culture and why things may not be working or what would be the usual ways in their culture of resolving a difficulty. Discussion with interpreters often helps me to understand what may be cultural and what is more individual. I encourage trainees to inform themselves re the cultural/political background of the country of origin for refugee clients as key dates, references etc are often important and their significance can be overlooked if not know or the therapist can seem more removed if they do not know these basic reference points.

I think it may be a positive quality in a supervisor to be somewhat 'confidently uncomfortable' about discussing 'race' and cultural difference. I wonder if, if you think you are comfortable discussing difference you may well not be in touch with the actual negotiation of difference between people (which is inherently challenging and involves being genuinely self-reflexive, curious and prepared to notice your own failures in this(!)) but relying on stereotyped or 'safe' topics when approaching it. I think what 'helps' talking about difference (of any kind but especially charged subjects like 'race'/ethnicity/culture) is an acceptance that it's an ongoing process and dialogue (both with yourself and listening to others), not something you can ever really 'tick off' like a competency. It's a really active process that you have to keep at and invest in.

I'd say that fits into the way I supervise, encouraging reflection on how our personal

histories and experiences can intersect with our professional work and making it clear to supervisees that supervision is a space to consider any issues affecting the work and our relationship with one another - also in some ways to learn from one another, I certainly feel I've broadened my thoughts about all kinds of difference through supervising other psychologists.

Reflecting now I realise I've spoken about difference/cultural difference a lot more with trainees in which there were visible differences between us (also including gender) and I wonder how much of that has come from possibly the supervisee feeling it important to bring this up - I can think of incidences both in which I have named it or the supervisee has. Something I also feel is very relevant and which I am aware can be a blindspot in my supervisory relationships is the impact that my assumptions of social class have on my perception of cultural difference. Specifically that sometimes visible aspects of a supervisee's professional, education and SES status have made me blind to visible differences between us culturally. On occasion I've noted inward surprise when a trainee has shared something affecting them from their personal history which (I realise at that point) I had blindly assumed wouldn't have affected them. I think unconscious/ implicit attitudes around social class aren't acknowledged enough in conversations about cultural difference.

I think the supervisory relationship is key to comfort and confidence. To be able to discuss any issues of culture, race or any other area of diversity needs to be considered from a respectfully curious position and comfort is likely to significantly drop if this approach is not by both supervisor and supervisee. In an older adult population in a diverse area this is key to clinical issues I face in my work and is needed and regularly discussed as part of learning needs of trainees. I also teach on DClinPsy courses about cultural context so something I am comfortable with and trainees are aware of my interests in.

I would feel uncomfortable bringing it up if the supervisee was uncomfortable. I also have some white guilt. I find it upsetting to hear other people be racist which makes me hesitant too. I think I would feel uncomfortable with white and non-white supervisees for different reasons. With a non-white supervisee I would worry they wouldn't feel fully comfortable with me discussing these issues and it would add to the power issues. Despite this overall I talk about the subject a lot outside of supervision as I feel it is important.

The visible difference in ethnicity between people I supervise and me is something I find easier to address.

Doing cultural genograms together in supervision sessions from the beginning or supervisory relationship gives permission to explore the impact of race and ethnicity on how we relate.

Using social graces regularly to address difference in supervisory conversations.

Ironically, I think less and less about issues of race and culture although I work in a diverse workforce with a diverse range of clients. First and foremost, I see people as people and have become less aware of how culture may shape the development and expression of distress.

I also think about issues of ethnicity and culture less and less as my institutionalisation has increased. An overly-medicalised approach to mental health within the NHS does not really create a space for dialogue about the importance of culture.

Over time, I have lost not only the awareness but also the language to discuss these issues in a thoughtful way, particularly in supervision. So you might say I am out of

practise and there is not enough training to help you develop these skills of cultural competency.

One thing that might help in supervision, would be in the initial setting up of the contract in which each gives the other permission to make mistakes when discussing these issues.

I think it would help to have cultural competency training within the Trust I work in to keep the issues of culture, ethnicity and spirituality alive in our clinical work.

But as with increasing cuts impacting on the day to day demands of my day, I have less and less time to think thoughtfully about issues of race and culture, which is a great shame.

We do have a BME access psychology service, which has been really helpful for addressing these issues. In some ways it makes it too easy compartmentalise these issues. But still the emphasis needs to be on what we can learn from other cultures about improving mental health.

What has helped me to feel more confident and comfortable discussing these issues:

1. Having a particular supervisee (qualified) who is confident in putting these issues on the agenda for discussion, who is passionate and articulate when talking about these issues, suggesting articles, books, films, programmes etc which I might find helpful and then discussing together what we have read.
2. Getting feedback from supervisees.
3. Reflecting on my own identity and privilege
3. Experience of working with service users over many years - always offering them opportunities to discuss the impact of race, culture, ethnicity, class, difference and power on their lives, their contact with mental health services and our relationship. Learning from service users about incredibly important these issues are and how they need to be named and talked about.

I feel comfortable talking to trainees about the relevance of my own ethnic identity to mental health issues and I feel comfortable asking them what they know or think about the relevance of their ethnic identity to mental health issues. It is more difficult to think about a client from another ethnic group, not mine or the trainee's, about which we have limited information. This can changed when someone, possibly from a local non-statutory agency, has given us information on this topic. Alternatively it is useful, if possible, to talk to a colleague from a relevant background.

Appendix S: Research journal

Research as praxis

Following our interview, Chiara was curious about my experiences of discussing issues of race, culture and ethnicity with supervisors and asked me what I had found helpful. I appreciated her interest and was surprised by the number of concrete things that I either recalled supervisors having done in relation to issues of race and culture, or thought they could have usefully done, which Chiara reported to be valuable suggestions. I continued to think of these on the drive home and emailed her a final suggestion along with the debrief sheet which included further reading. Chiara replied saying that this had furthered her thinking and prompted a discussion with her team:

Email from Chiara, included with her kind permission.

Hi Meera,

Thank you very much for the debrief sheet. It was very interesting to discuss this topic with you and it prompted a lot of thoughts. I was able to find that chapter and have since also spoken to my team about this - thanks again, very interesting.

All the very best with wrapping up your recruitment and thesis.

Best Wishes,

Chiara

Similarly, I crossed paths with Hannah a few months after interviewing her. She told me that she had changed her mind as a result of the interview, realising that she needed to increase her awareness of these issues and shared with me areas of her clinical work in which she felt they required particular attention.

Several participants thanked me for the opportunity to talk and think about these issues, with Daniel describing it as a “privilege”. This highlighted to me how little space is created to talk about race, culture and ethnicity in clinical psychologists’ day-to-day jobs. However, it also gave me hope regarding the potential impact of brief, focused awareness raising. And challenged my scepticism about the potential for this research to have any effect beyond the ‘echo-chamber’ of those who are already dissatisfied with how these issues are attended to by the profession. Even if only one supervisor had been positively influenced, that felt like a good outcome.

Research as praxis – supervisors and colleagues

Supervisors and colleagues have responded with interest on hearing about my thesis topic, although they mostly construct the problem as laying elsewhere, in *other* supervisory relationships, and *other* teams. In contrast to this, one of my supervisors emphatically told me that they were as “racist and bigoted” as anyone, and proceeded to share with me some of the explicitly racist thoughts they had had upon moving to a more ethnically diverse area than that which they had grown up in. I immediately experienced an odd mixture of relief and disbelief on hearing this, both of which were heightened by it being our first supervision meeting. Relief as my experiences of racism, and those of colleagues in the profession, were not being denied. Disbelief as this felt so unlike the awkwardness and tendency to displace, avoid, sanitise and doubt that I was habituated to in clinical psychology. It felt like one of the most radically honest conversations about racism I had been able to have with a psychologist who had not themselves experienced it. We also talked about ways in which this supervisor’s committed anti-racist position informed their practice and relationship to clinical psychology theory, which influenced some of my thinking. Indeed, ‘naming the whale’ did not seem to legitimise it. Instead it made space for discussions about my experiences within the profession and indicated that I would be able to openly and constructively reflect on my own racist biases in supervision if necessary.

It also had an unexpected ripple effect; telling this story to trainee friends seemed to provide an alternative model for ‘talking about race’ in the

profession, which allowed us to maintain our critical stance and turn it on ourselves. Being able to confront and label racism did not seem to trivialise it or engender bad feeling either; these conversations were still tentative and careful to prioritise the voices of those who had experienced racism. They allowed us to begin sharing thoughts and strategies for addressing them. Many wished for innovative trainings for supervisors or trainees were dreamt up in these spaces. Which is not to say that I was not also swiftly and regularly brought back to the reality of the profession following these conversations...