White Clinical Psychologists, Race and Racism.

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Abstract

Racism within the UK remains structurally embedded in the fabric of society. The history of colonisation and race science, and current socio-political climate, influence how Clinical Psychologists are trained, how mental health services are structured, and how racialised individuals are 'treated' when accessing therapy. It is well known that racism is a contributing factor to distress and mental health difficulties yet there is very little research examining how racism is talked about in therapy. Whiteness enables power and privilege to dominate, to the detriment of racialised individuals, and exists as an invisible norm. With this in mind, the researcher was interested in the experiences of white clinical psychologists talking about race and racism in therapy.

This study interviewed fifteen self-identified white clinical psychologists about their experiences of talking about race and racism within therapy. Interviews probed participants on what hindered and facilitated these experiences.

Thematic analysis from a critical realist perspective identified three overarching themes, each with their own subthemes: 'I'm not a racist, even when I get it wrong' ('managing feelings of unease', 'certainty in audience', 'what my whiteness does') 'Proximity to racism' ('easier to do nothing' 'integral to clinical psychologist's role') and 'Commitment: *"anti-racism is a lifelong journey"* ' ('holding the power for change', 'stuckness: don't stop there'). Experiences were influenced by supervisory relationships, team dynamics, participant's DClinPsy training, and personal values and upbringing.

The findings were linked to previous research on whiteness, power and talking about race within other therapy professionals and discussed in relation to Ryde's White Awareness Model (2009). Recommendations for training, clinical practice and policy were made, and the researcher concluded by signposting to anti-racism resources and a call to action for clinical psychologists.

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LIST OF ABBREVIATIONS

Below is a list of common abbreviations used in the research.

BPS – British Psychological Society
CBT - Cognitive Behaviour Therapy
CFT- Compassion Focussed Therapy
DClinPsy - Doctorate in Clinical Psychology
DCP- Division of Psychology
IAPT - improving access to psychological therapies
NHS - National Health Service
NICE - National Institute of Clinical and Heath Excellence
ONS – Office for National Statistics

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“Race doesn't really exist for you because it has never been a barrier. Black folks don't have that choice.”

(Adichie, 2013, p. 346)

1 INTRODUCTION

This chapter will begin by introducing the constructs of interest and how they will be used for the purpose of this research. A summary of the historical context of these constructs both within the United Kingdom (UK) and Clinical Psychology will be presented, alongside how these constructs operate within present day mental health (MH) services. This will be followed by a review of the literature, which will provide a rationale for the proposed study. The chapter will close with an overview of the research aims and questions.

1.1 Outlining Constructs and Terminology

The constructs of race, racism and whiteness will be explored alongside a critique of particular terminology used in relation to these constructs. This will orient the reader to the ontological and epistemological position of this research and provide context for specific language choice. The researcher is aware of how personal experience of these constructs may impact readers differently and has written from their own racialised perspective (see chapter 2).

1.1.1 Race

Race is defined in numerous ways, influenced by individual’s ideology, and is associated with a long history of violence stemming from a colonial past. Race was conceptualised by white Europeans looking for means to understand the ‘other’, influence science and gain access to power (Ryde, 2019). It has long been understood that the term ‘race’ has no biological basis but operates within a social-political context (Helms, 1995; Ifekwunigwe et al., 2017; Smedley & Smedley, 2005). However, there are physical characteristics, for

example, hair and skin colour, which are used to categorise people into different racial groups.

Both within the literature, and society, race and ethnicity are often inappropriately used interchangeably. Whilst there are cultural associations linked to a person's ethnicity, race has been used within society to categorise people to enable racial inequality and racism (Cardemil & Battle, 2003). Ethnicity can be considered value-laden and used to describe groups that are culturally outside the dominate culture (Fernando, 2017). The researcher is interested in the construct of race, and subsequently racism, rather than ethnicity or culture.

1.1.2 Racism

Racism is a direct consequence of the development of the race construct, and it is imperative to understand that racism operates across multiple levels; direct overt acts to an individual, institutionally and structurally, as well as through microaggressions (Booth & Mohdin, 2018). It is argued that *"racism antecedes the notion of race…it generates the races"* (Kovel, 1988, p. xii).

The common understanding of racism is the direct and overt nature where an individual is treated negatively or spoken to in a derogatory manner, due to their race. Whereas institutional and structural racism, recognised as impacting structures in the 'Western world'[1] (Eddo-Lodge, 2017), relate to society operating in a way that constantly maximises the benefits to white people (Assari, 2018). It is linked to both colonial history and a perpetuating ideology that those who are not white are inferior. Microaggressions are defined as comments and behaviours which express a prejudiced attitude toward a member of a marginalised group (Lilienfeld, 2017). However, microaggressions due to their subtle nature are more frequent and therefore, harder to name and address (D. Sue, 2010).

[1] The western world is an outdated term which remains part of everyday vernacular to describe countries who considered themselves western when travelling eastwards for trade or colonisation of Asian countries (Kurth, 2003).

Racism of any sort is heinous. Whilst racism is illegal under the *Equality Act 2010 section 9,* some argued that it is a "ubiquitous part of Western culture and no individual is unaffected by it*"* (Lowe, 2014, p. 17). Race in the UK is closely bound up with class, status and social position (Akala, 2019), and the ideological myth of white superiority and black inferiority has become deep rooted in society and in consciousness for generations (Eddo-Lodge, 2017).

The researcher acknowledges that, due to structural racism, some individuals unintentionally behave in ways that perpetuate racism which has unintended consequences. This is still racism and is still unacceptable. Furthermore, it is crucial to acknowledge intersectional socio-political identities (of race, gender, ability, class etc.), and the complex and cumulative way the effects of different forms of discrimination can have (Crenshaw, 1989).

1.1.3 Whiteness

Race and racism cannot be researched without an understanding of the pervasive influence of whiteness. Whiteness is conceptualised as the production and reproduction of dominance and privileges of people who are racialised as white (Green et al., 2007), including those with lighter skin-tone who may not self-identify as white. It is argued that whiteness is caused by the enduring racial inequality, injustice and power differentials that exist within society (Neely & Samura, 2011). Through this understanding, whiteness is seen as the norm (Guess, 2006) and therefore remains somewhat invisible or ignored (Lindner, 2018). N. Patel & Keval (2018) describe the impact of whiteness below:

> Explanations for the data on racial inequality in health, education, criminal justice systems, employment etc. and on racial violence and race hate violence, are explained with a White privilege lens, where blame is located in genes, cultural 'habits', cultural and religious beliefs, 'Black culture', poor cultural values, poor parenting, poor MH etc. – but not on structural and institutional racism. (p. 2)

Whiteness enables power and privilege to dominate, to the detriment of racialised individuals, despite the view that race and culture are constructs that exist within the 'other' (Baima & Sude, 2020). Whilst racism is by no means a phenomena only white individuals enact and perpetuate; the influence of whiteness, and its effects on power relations, is pivotal to research examining racism.

1.1.4 Terminology

The language used within the literature to describe people's race often implicitly others and perpetuates whiteness. Terminology varies depending on where the research is conducted, for example, country. As a UK based research study, the terminology may differ from research conducted in other countries.

Throughout this report, the term 'racialised' will be used to refer to people who are not white and therefore experience the social consequences of race. For accuracy, the specific race will be used when known within the literature or detailed by participants. Racialised individuals are often inappropriately grouped and referred to as 'minorities'. 'Black, Asian and Minority Ethnic' (BAME, sometimes BME) conflates experiences as synonymous rather than examining the differences and nuances across different racialised experiences. The notion that BAME is considered a 'neutral' term is criticised heavily by those labelled with it (Fakim & Macaulay, 2020), and has been called redundant and unhelpful (Mohdin & Walker, 2021). It is important to note that, whilst the ONS (2011) show Black and Asian individuals within the minority category of race within UK population contexts, the racial category of white is globally the minority. Grouping people into 'BAME' others and subverts the message that white is the norm and any deviation from this is abnormal, feeding into whiteness, and the dominance of power within white individuals.

1.2 Race and Racism in UK

The way in which race and racism is discussed in society can take on a number of forms; frequently creating debate and divide. There is a long and complex history within the UK linking the way race has impacted on society, playing a crucial role in the way that race and racism is understood and discussed today. Often compared to the United States of America (USA), there is a common perception that racism in the UK is a historical issue of a colonial past. However, the global events of the last year have shone a spotlight on how institutional and systematic racism pervades in this country and impacts on the physical and MH of its citizens (see section 1.3).

1.2.1 Colonial context

Race and racism cannot be discussed without discussing the impact that colonisation, imperialism and slavery have played within society in present day. Colonialism, understood as a conscious and deliberate systematic destruction of a group's cultural values by another (Adebisi, 2016), has impacted the entire fabric of UK society and continues to enable cultural appropriation and oppression of racialised individuals (Kiefer, 2020). Imperialism and the legacy of colonialism has created a 'white washing' of historical events whereby the strengths and achievements of racialised individuals are minimised and ignored, in favour of white historical accolades. For example, the UK celebrates the successes of the world wars, with little mention or celebration of the contribution of armed forces from Africa, India or the West Indies (Gilroy, 1993).

Eurocentrism, the centring of European cultures and the marginalisation of 'other' cultural values (Sesanti, 2019), is another example of structural racism. The legacy of the slave trade is ever present, with buildings, streets and statues across the UK as a reminder of the way racism killed so many lives throughout the 16th-19th century. The UK's complicity in the slave trade is not addressed in mainstream education and is often minimised in museums and other historical events. The British Empire is taught in mainstream education

as something to be celebrated and does little to address the genocide and systematic oppression of nations around the globe. The UK lives in a state where the 'west is best' rhetoric is dominant in both the unconscious bias and popular discourse of society (Sewpaul, 2016). The shaping of these narratives results in white ignorance of the true violence of the history between white and racialised individuals in the UK that need to be understood when researching race and racism.

1.2.2 Race science

Scientists were instrumental in creating racial divisions within society from 18th century, which has heavily influenced the theories and practices of many professions (including clinical psychology) to date. Colonial ideas and scientific developments were bi-directional in their influence and resulted in perpetuating the exploitation of African people in particular and sustaining white supremacy, in the west, which then had a global influence (McNeil, 2010). For example, scientists falsifying results linking 'intelligence' to skull size to preference white Europeans (Mitchell, 2018), and the pathologising of black slaves who escaped their owners with a disorder 'drapetomania' (White, 2002), legitimised the slave-trade and paved the way for future science to continue the focus on racial divisions that influence society today.

Linking race to an individual's character and intellect has been implicitly and explicitly embedded into society, creating the racial prejudice seen today. Historically, language, religion and culture were seen as the dividing lines between groups of people. However, skin colour and other physical features has since become the place for prejudice (Mills, 2014; Snowdon, 1970). There are numerous other acts within history that, whilst now unthinkable in today's society, laid the foundation for the normalisation of racism within the Western world and the subsequent attitudes towards immigration and a multi-cultural society within the UK. Eugenics ideas heavily influenced the development of psychological theories and practices, and the use of human zoos embedded the racial hierarchy that engrained subhuman attitudes towards black

individuals in particular, with labels of ‘primitive’ and ‘savage’ being used up until the 1930s (Gander, 2016).

1.2.3 Post war context

The post-war mass migration to Britain, along with the ‘fall’ of the British Empire, benefitted Britain’s economic recovery, whilst shaping the coming decades of race relations between white British and black and Asian migrants. For many from Commonwealth countries who saw Britain as a place of wealth and freedom, the reality of overt racial abuse and invalidation of their citizenship was dehumanising and shattered the illusion of white superiority (Akala, 2019).

Alongside numerous other violent racist attacks, the 1993 murder of Stephen Lawrence, and the subsequent inquiry into how the police dealt with the perpetrators gripped the nation (MacPhearson, 1999). It was influential in the way race relations were considered in government and hoped to influence subsequent police training. Over twenty years on, it has become apparent that the police, along with many other organisations are still institutionally racist (Joseph-Salisbury, 2021; Kline, 2015).

Throughout the 1990’s a notion of ‘colour-blindness’ was adopted by the liberal white as a way to eradicate racism (Bonilla-Silva, 2006; D. Sue, 2010) and a ‘politically correct’ way of integrating the multicultural society within urbanised areas. This enabled a naïve and wilful ignorance in the white majority across the UK of a ‘post-racial society’ where terminology of ‘diversity and inclusion’ was used, and the dominance of ‘BME’ and ‘BAME’ in the common vernacular. This language serves to obscure and delegitimise the lived experience of racism, minimising the visceral reaction that occurs for racialised individuals (N. Patel & Keval, 2018).

1.2.4 Current socio-political context

A brief overview of more current socio-political events will provide a context and need for this research. This context will have influenced the researcher

and participants of this study. In recent years, language around race and racism has shifted within dominant discourse. At the point of writing this research engagement in discussions about anti-racism is becoming more common place. Kendi describes this in detail within his book “How to be an anti-racist’ as “*one who is supporting an antiracist policy through their actions or expressing an antiracist idea”,* also describing how an individual can be racist one minute and antiracist the next (2019, p. 25).

The political climate of the past 10 years has influenced racial dynamics significantly. From 2011 to 2019, under a Conservative government, reported hate crimes linked to race have doubled to almost 80 thousand in England and Wales (ONS, 2019). This can be understood by the way immigration and asylum seekers were positioned in the lead up to the EU Referendum, creating false scapegoating and increased hostility, resulting in a sharp increase in overt acts of racism by 41%, following the Brexit vote (BBC, 2016). The Hostile Environment has created a systematic invalidation of right to remain for many who have been in the UK for decades, most notably those individuals impacted by the Windrush Scandal (Freedom From Torture, 2010; Global Justice Now, 2018). Racism has been shown to exist in education, communities and workplaces (Ashe et al., 2019), notably important to this research, within the structures of the NHS (Kline, 2015).

Within 2020, the violent murder of George Floyd in the USA sparked global protests aligned with the Black Lives Matter (BLM) movement and highlighted in British consciousness how extensively racism remains pervasive within society, most significantly at a structural and institutional level. Within the context of the Covid-19 pandemic, the disproportionate death rate for ‘BAME’ populations in the UK further highlighted the social and health inequalities that have existed for a long time for racialised communities (Public Health England, 2020; Rao et al., 2020). Subsequent anti-Asian attitudes have led to a 300% increase of racism towards East and South Asian communities following the blaming of China at the beginning of the pandemic (Khan, 2021). The Capitol Hill riots of 2021 saw acts of violence and vandalism by white individuals, and the police response, confirm how the language around and

treatment of white terrorists is placated and downplayed in comparison to the protesting of racialised individuals, a prime example of white supremacy.

This historical understanding, alongside the current socio-political context, provides a picture of how pervasive and problematic racism in the UK is. The invisibility of whiteness enables white individuals to benefit from a society that oppresses and marginalises racialised communities. Experiencing racial violence will have effects on the physical, psychological and spiritual self, and many will be finding ways to reduce this suffering. Understanding the oppressive context will shape how solutions may be sought.

1.3 Racism and Mental Health

Racism, at every level, is the oppression and invalidation of an individual's worth, and at times, existence. For individuals and communities experiencing this invalidation, a negative impact on MH and wellbeing is perhaps unsurprising. This section will explore specifically racism in MH as well as the potential psychological impact of experiencing overt & covert racism and microaggressions.

Dependent on how an individual views and theorises distress, there will be certain models and therapies developed and utilised to reduce this distress. A sociogenic model sees distress as a result of a person's social location, events in the world, and in their relationships with others (Cromby et al., 2013). However, a psychogenic or somatogenic model would look more at the individual causes, locating the problem within the person. Racism can be viewed as a valid and integral contributing factor to distress or could be marginalised over genetic or biological causes. The researcher favours the former, however will explore the literature that examines the link between racism and MH difficulties.

1.3.1 Racism and psychological theory

Some academics argue that the ideology of psychology is built on racist ideologies, from the perspective of white men, that were dominant in society during the development of theories and practices of the profession (Bhui, 2002; Howitt & Owusu-Bempah, 1994). As previously mentioned, theories of biology and genetics were used to explain differences in race, and therefore intellect. Racist ideologies were absolute at the time due to colonialism, and therefore influenced the way that psychologists have conceptualised distress (Fernando, 2010; 2017).

The role that 'psy'-professions have played in racist practices is extensive. Graham Richards offers a comprehensive account of how psychology has overtly contributed to racist practices (2011), and the subsequent development of clinical psychology that is practiced today. For example, race science and intellectual superiority influenced the development of IQ and the subsequent IQ testing compounded racist ideology of the time (Gregory, 2004;) . Current tests and understanding of cognitive ability favour Eurocentric education and ways of relating that need to be challenged (Kwate, 2001; Nisbett & Miyamoto, 2005; Sternberg, 2013).

Broadly, psychology is rooted in learning of and about the 'other', which is considered separate and different from the 'self', with the language of 'abnormal' being common within the development of numerous theories related to distress (often referred to as 'mental ill health', Bhui, 2002). The 'science' of clinical psychology is shaped through an 'evidence-base' which disproportionately represents WEIRD (Western, Educated, Industrialized, Rich, Democratic; Henrich et al., 2010) populations, that accounts for 5% of the global population (Arnett, 2008). This WEIRD research informs therapy models, NICE guidelines for recommended psychological therapies, how services are designed and how professionals are trained.

1.3.2 Psychological impact of racism

There is strong evidence suggesting that racism is a contributing factor to MH problems within the UK, and has a cumulative effect (Carter & Forsyth, 2010; Okazaki, 2009; Wallace et al., 2016). Furthermore, it is well documented that social inequalities of income, gender and race within the UK are contributors to 'mental ill-health' (Wilkinson & Pickett, 2011). UK statistics have acknowledged that discrimination through education, legal and health systems are enacted upon disproportionately for 'non-white' groups, particularly black individuals (Cabinet Office, 2017). Structural racism, including the over policing of racialised communities (e.g., stop and search; Flacks, 2018), increased likelihood of school exclusion, and reported workplace discrimination all increase the likelihood that the intersection of race and class result in more racialised individuals also living in lower socio-economic conditions (Joseph-Salisbury, 2021).

It has been argued that the conflation of 'rurality' with notions of 'Englishness'/ 'Britishness' and whiteness, and the reluctance of services to acknowledge the specific needs of racialised groups, serves to reinforce marginalisation of racialised individuals living in rural areas (Chakroborti & Garland, 2006; Garland & Chakroborti, 2006). The variation in 'ethnic density' across the UK is vast, resulting in some counties' population being over 95% white (e.g., North Devon) in comparison to less than 5% in some London boroughs (e.g., Ealing; ONS, 2011). Ethnic density has been shown to be a protective factor for the impact of racism on MH (Bécares et al., 2009; Das-Munshi et al., 2010; Shaw et al., 2021), indicating that individuals in rural areas may be impacted more by experiences of racism.

One pertinent example of the link between racism and MH that is ignored within dominant narratives is the global differences in diagnostic rates of 'schizophrenia' in black individuals. Its biological and genetic causation has never been proven scientifically yet remains common practice for this assumption to be made by psychologists and psychiatrists (Cromby, et al., 2013; Fernando, 2010). However, the social consequences of race may lead an individual to behave in ways in line with this diagnosis e.g., paranoia or

thoughts that people are out to get you, this would be considered normal reactions (Oduola et al., 2021). Research comparing black populations to those in Jamaica and Barbados found significantly lower rates of psychosis compared to the UK (Hickling & Rodgers-Johnson, 1995; Mahy et al., 1999), challenging this biological discourse and emphasising the need to view the relationship between racism and distress.

Direct experiences of racism have been linked to physical and psychological responses akin to a trauma response including anxiety, guilt, hypervigilance (Carter & Forsyth, 2010), increased blood pressure (Harrell et al., 2003) and higher cortisol levels (Matheson et al., 2021). Racism is a source of stress which the body and mind responds in a similar way to any other source of stress (Carter & Pieterse, 2020; Paradies, 2006). The emergence of racial 'trauma' (or race-based traumatic stress; Carter, 2007) provides a framework for understanding how threatening racist encounters can be experienced, and their potential long-lasting impacts (Carter & Pieterse, 2020). Furthermore, the traumatic effects of slavery and colonialism can be understood through intergenerational trauma of internalised racism (McKenzie-Mavinga, 2016) which requires exploration that cannot be given justice in this report[2]. An acknowledgement of physiological and psychological impact of racism validates these experiences and paves the way for professionals and services to create structures of support for them.

1.3.3 Racism and Accessing MH Services

Given that race is often inappropriately considered synonymous with ethnicity and 'culture' (Ballard, 2002), the structures of whiteness within services enable blame to be located in factors such as 'cultural beliefs' and language barriers. Whilst these both contribute to the complex interplay between racialised communities and MH services, it is crucial to not allow institutional racism and whiteness to be ignored. The dominant culture regulates what

[2] Internalised racism: the values and beliefs of the oppressor are absorbed, causing people within the same community to view eachother as distrustful and seeking to be 'White'. This is passed down through generations, following trauma of slavery. Other forms of intergenerational trauma are understood as the collective trauma from events impacting specific racialised groups e.g., world war two on Jewish communities

sorts of problems are recognised and what kinds of cultural or social differences are viewed as worthy of attention (Kirmayer, 2012). Ignoring cultural understandings of distress, and imposing Western norms, results in a racist and oppressive approach to therapy (Waldegrave et al., 2003).

The medicalisation of distress has dominated in popular understanding and fuelled the rise in the use of psychopharmacology across the Western world for decades (Reid et al., 2019). The IAPT initiative has transformed the way MH services are commissioned (within England and Wales) and promoted the increased use of individualistic therapies such as CBT (Clarke, 2011). These Eurocentric models of therapy do not reflect the realities of race or cultural practices that racialised communities may experience, given they largely represent the worldviews of their authors (white European men) who have never experienced oppression based on their racial identity (N. Patel, 2010). It is a political notion that social problems can be treated through individual behaviour change (Afuape, 2016), creating 'symptoms' which could alternatively be understood as a normal reaction to an adverse experience (Boyle & Johnstone, 2014).

Understanding the complex relationship between racialised communities and MH services highlights how institutional racism and whiteness impact individuals during their help-seeking journey. Black men are more likely to access MH services through the criminal justice system or involuntary admission (Bhui et al., 2003; Edbrooke-Childs & Patalay, 2019) and have longer admissions (McKenzie & Bhui, 2007), more likely to experience restraint and medication (Jones et al., 2020; Keating, 2004; McKenzie et al., 2017), more likely to die by suicide (Bhui et al., 2012) and less likely to be offered talking therapies (Das-Munshi et al., 2018; Raleigh et al., 2007) than their white counterparts. Rates of common MH diagnoses (including depression, anxiety and phobias) have been found to be highest in the black British and South Asian populations and lowest in the White Other population (Manus et al., 2016), and black men are up to nine times more likely to be diagnosed with schizophrenia than their white counterparts (Pinto et al., 2008; Lawrence et al., 2021), yet they receive poorer 'treatment' (Karlsen, 2007).

Higher rates of inpatient admissions have been explained through increased prevalence of psychosis (Lawrence et al., 2021), increased perceived risk of violence, increased police contact and mistrust of GPs (Barnett et al., 2019). It is unsurprising that increased contact with police and increased perceived risk of violence are the given explanations, without considering the way that institutional racism leads to increase police contact for black communities in particular (Joseph-Salisbury, 2021). Keating et al (2002), provided a comprehensive understanding for how perceptions of black communities by professionals and vice versa results in more oppressive behaviour and treatment, creating the vicious cycle of fear.

Services and policies often focus on problematising the racialised individual as ‘hard to reach’ when there is a lack of engagement with MH services, rather than considering how the Eurocentric focus of services is ‘hard to access’ for racialised communities. The individual and institutional racism experienced is likely to further reduce the trust racialised individuals have in services, created by the governments and organisations that perpetuate this racism. There has been a call for Clinical Psychologists (CP; among other MH professionals) to consider the provision of services of ‘BAME’ populations for decades (Loewenthal et al., 2012; Naz et al., 2019; Williams et al., 2006), leading to ‘adapted’ therapeutic models that are ‘culturally appropriate’ (Beck, 2016; Rathod et al., 2010; Soto, 2010). This ‘adaptation’ implicitly locates the problem within the racialised person, rather than in the Eurocentric models and therapies that are offered. Furthermore, approaching distress from an individualistic perspective as a ‘problem’ to ‘fix’ is a damaging approach for those impacted by the psychological damage of racism. More appropriate approaches to increasing engagement and providing MH support has been through community psychology strengths-based initiatives (Byrne et al., 2011; Byrne et al., 2017; Vahnaninia et al., 2020).

Talking about emotions and problems is a western ideology that is not always shared across other cultures (Bhui, 2002). Problem saturated narratives about racialised communities and their MH creates further distrust for services.

South Asian women have shared making a conscious decision to exclude their culture and religion from their therapy, despite having a good therapeutic relationship with their therapist (Yasmin-Qureshi & Ledwith 2021) and black individuals have directly attributed their MH difficulties to social problems linked with material and social deprivation, racism and the subsequent inappropriate responses by MH services to respond to their needs (Rabiee & Smith, 2014). Many have recommended for services to adapt (Beck et al., 2019; Memon et al., 2016), yet the experiences and perspectives of racialised services users are continually ignored (Bowl, 2007).

It can be understood that racism exists across society in the UK to uphold whiteness and power in dominate groups. MH services have been constructed within this racist society in ways that further marginalise certain groups within society. A racialised individual may have experienced various institutionally racist practices, as well as direct racist experiences, that impact what they want to discuss in therapy. CPs have an ethical, moral and legislative duty to acknowledge racism and the context it arises, in order to reduce its impact for their clients (Nadirshaw, 1992).

1.4 Clinical Psychology as a Profession

Outlining Clinical Psychology in relation to its development, demographics, training and racism within the profession contextualises why this population may need examining. The profession is undoubtedly shaped by racism within society and is complicit in enacting whiteness within MH services.

1.4.1 Development and Influence of Psychology

Clinical Psychology does not sit within a vacuum, but within the social, economic and political structures of society in which it was developed and continues to exist within. *Clinical Psychology in Britain: Historical Perspectives* (Hall et al., 2015) outlines very little in relation to how the profession has played into institutional and structural racism, yet taking a critical perspective

on ‘science’ and the development of psychology provides evidence that there is a clear whitewashing within the theories and therapies developed.

The development of clinical psychology is linked with and heavily influenced by psychiatry. In order to be legitimate alongside psychiatry, prominent psychologists were firm in their perspectives related to the separation of social needs, in the move to develop the profession as a ‘science’ (Eysenck, 1949). Therapy was seen inferior to the skills of cognitive and psychometric testing until the 1970s, and many training courses remain steeped in this ideology. Over several decades, behavioural therapy, followed by cognitive behavioural and systemic therapy were introduced into the discipline as integral parts of the training. Whilst the profession is now broad in the skills and approaches that are offered, the influence of race science and imperialism remain ever present within the conscious and unconscious of many psychologists (N. Patel, 2010). The ideological myth that distress can be seen objectively, with no influence from cultural and social factors, leads to the eradication of racism as an influencing factor in this distress. The profession attempts to de-politicise and individualise distress, however therapists have a moral, ethical and legislative duty to be attuned to racism, and its insidious consequences.

1.4.2 Whiteness in Clinical Psychology

The historical context of the profession means that whiteness has become the normative and unchallenged position within the profession as much as within wider society (Odusanya, 2017). The demographic make-up influences the theories, therapies and narratives that are privileged within training and services. Clinical psychology is considered a career path exclusive to, or at least disproportionately made up of white, heterosexual, able-bodied, cis-gendered and middle-class females (Ahsan, 2020; Mcneil, 2010). Available statistics show 'BAME’ CPs represent 9.6 per cent of the workforce in England and Wales in contrast to 13 per cent of the population (DCP, 2015; ONS, 2018). Structural barriers into the profession have been criticised for decades and continue to disproportionately affect those from ‘minority ethnic’ groups (Bawa et al., 2019; Scior et al., 2007). White colleagues being offered more

opportunities for career progression compounds these barriers and demonstrates whiteness in action (Rennalls et al., 2019). An increase in racialised trainees in recent years has not eradicated whiteness or racism in the profession (Wood & N. Patel, 2017), as these voices are often silenced or marginalised (see 1.4.3).

As already outlined, structural racism influences MH distress and therapeutic outcomes for racialised individuals. Whiteness influences the way white CPs conceptualise race within their work at every level (Ahsan, 2020); it is an 'invisible norm' (Wallis & Singh, 2014) and many white therapists consider themselves 'culture free' (Nolte, 2007). Even within teaching on oppression and marginalisation, whiteness is often ignored or minimised within the narratives (Mazzula & Nadal, 2016). White privilege allows individuals to remain complicit in structures that uphold whiteness, and it has been highlighted that white middle-class female CPs are particularly guilty of this (Ahsan, 2020). This invisibility has been raised as problematic within clinical psychology (Baima & Sude, 2020; N. Patel, 2010), needing ongoing work within DClinPsy programmes (Kennedy & Young, 2019).

1.4.2.1 DClinPsy training

UK DClinPsy training currently stipulates that CPs need to demonstrate clinical competence in CBT and one other therapeutic model (BPS, 2019). There is no current specific guidance for working with race and racism, however the BPS (2019) states:

> ". . . clinical psychologists will be aware of the importance of diversity, the social and cultural context of their work. . . and have the skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives"
>
> (p. 14).

This broad statement implies but does not emphasise that racism may be a key issue that clients may bring to the therapy room. BPS practice guidelines (2017) stipulate that psychologists are expected to understand the nature and history of racism and the dangers of maintaining a 'colour-blind' approach but offer no guidelines for how this can be achieved.

A lack of clear and consistent guidance on training CPs to work with 'diversity' and 'difference' enables broad and poorly constructed interpretations that perpetuates whiteness and racial hierarchies. Systemic ideas of working with invisible and visible differences between psychologist and client (Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation, Spirituality; GGRRAAACCEEESSS) has provided a useful framework when thinking about contextual variables in which people feel marginalised by virtue of feeling different (Burnham, 1993). Alternatively, teaching from an intersectional perspective focuses instead on the oppression and marginalisation of individuals with subjugated identities (Crenshaw, 1984), which creates a space for racism and whiteness to be spoken about (N. Patel et al., 2000; Wood & N. Patel, 2017).

'Cultural competence' has been constructed to support (predominantly white) professionals to work effectively in cross-cultural situations (Bhui, 2002; McGoldrick et al., 1996). Similar to the controversial Prevent training[3] (Thomas, 2020) and criticisms about implicit bias training (Pan, 2020), some cultural competency education negatively reinforces stereotypes and fails to increase therapists' confidence (Dogra et al., 2007). Whilst Bassey & Melluish (2013) outline specific and helpful areas for counselling psychologists to address 'cultural competence', there is no current operationalisation within clinical psychology. It remains highly contested within the profession due to the dichotomous implications of incompetence (Shankar, 2009), and many are shifting language and frameworks towards 'cultural humility' (Mosher et al.,

[3] Part of the government counterterrorism strategy that aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism (NHS England, 2017).

2017). Moreover, a shift from ‘race and diversity’ (under ‘cultural competence’) to whiteness, racism and de-colonising, provides a more powerful and impactful focus for trainee CPs to develop their professional skills and identity (Kieth, 2018; Mintah et al., 2019).

The centring of whiteness results in vague notions of ‘working with diversity’, that is interpreted and demonstrated inconsistently across the various training courses (Shankar, 2009). Values underpinning DClinPsy training and varying interpretations of causes of distress lead to a variation in how theories are taught, utilised and how therapies are practiced. This is compounded by those who work on courses, and the geographical location of the programme and placements that trainees work at. As previously stated, ‘ethnic density’ influences the impact of racism on an individual’s MH and is vastly different across the UK. Furthermore, political beliefs and funding of local services and universities compound these differences. Courses and services within white-dominated regions may perpetuate whiteness and problematic ideologies more than ‘diverse’ areas.

1.4.3 Overt Racism within Clinical Psychology

The separation of whiteness in clinical psychology and racism in clinical psychology has not been an easy choice, given their interlinked nature (Wood & N. Patel, 2017). Both exist within the profession and have been a pervasive issue for decades. It is hardly surprising that the racism that exists within British society is present within a predominately white profession, however it is important to understand how it manifests itself and how this may influence CPs in the therapy room.

Within the past two years alone, the profession made national news following the depiction of a slave auction as ‘entertainment’ at the Group of Trainers in Clinical Psychology (GTiCP) Annual Conference in 2019, and the subsequent DCP Annual conference in 2020 saw racist vandalism on one delegate’s poster. Following the GTiCP Conference, there was public debate on the role of social justice and political ideologies within the profession, with the

invalidation of racialised individuals' experiences in favour of pathologising them as 'cognitive distortions' and 'biases', rather than the lived experience of oppression, discrimination and its impact on an individual's MH (Sutton, 2020). Many psychologists have called for individual and collective change, for the interrogation of whiteness within the profession (N. Patel et al. 2019, Rahim & Haye, 2020) and to understand how racism may be minimised by white psychologists in other spaces (Mintah et al., 2020). The BPS recently acknowledged the racism that exists within the profession, and how it will take a long time to address the issues at all levels (Bajwa, 2020).

Racialised trainees have shared experiences of supervisors, course tutors, and peers being directly racist and perpetuating racism (Adetimole et al., 2015; Paulraj, 2016; Tong et al., 2019). Experiences of microagressions, marginalisation of experiences, and challenges with white supervisors have been highlighted by black British and British Asian trainee and qualified CPs (Desai, 2018; McNeil, 2010; Odusanya et al., 2018, Shah, 2010,). These voices within the profession are being increasingly amplified through doctoral research, 'special issue' pieces, and other online spaces, however there is a paucity of peer-reviewed research exploring racism within the profession.

Although racial inequalities in MH care are apparent (e.g., access, treatment and outcomes), the majority of contributions to this literature are from psychiatry and public health research. Despite the relative absence of the CPs' voice(s), their contribution to service design and conversations about these inequalities has influence. The profession has been continually criticised for the dominance of Eurocentric values that marginalise the experience of racialised CPs (Berg et al., 2019; N. Patel & Fatimilehin, 2005; N. Patel et al., 2019; Wood & N. Patel, 2017), with few shifts to address this nationally.

Following significant social pressures during the BLM protests in 2020, systemic changes have increased in momentum, including changes to DClinPsy training courses. Increases in funding, and support around 'widening access' into the profession, as well as efforts to 'decolonise' the curriculum have begun at a national level despite years of campaigning for

this change. As already outlined, there will be variabilities across courses dependent on their own ideological position in relation to race. It is argued that CPs have an intellectual appreciation of the salience of race (Cardemil & Battle, 2003), yet little is known about how this translates into the 'work' (e.g., discussions within team meetings, supervision, therapy room). Acknowledging this professional context serves to demonstrate how racialised individuals may be understood or responded to by white CPs.

1.5 Impacts of Racism on White Individuals

As outlined above, there is a dominance of white individuals working as CPs, and a disproportionate amount of racialised individuals experiencing MH difficulties, who may want to talk about the influences of racism. It is therefore necessary to understand white individuals' position to racism (Poston, 1990). to ensure that whiteness is not essentialist (Eichstedt, 2001; Storrs, 1999).

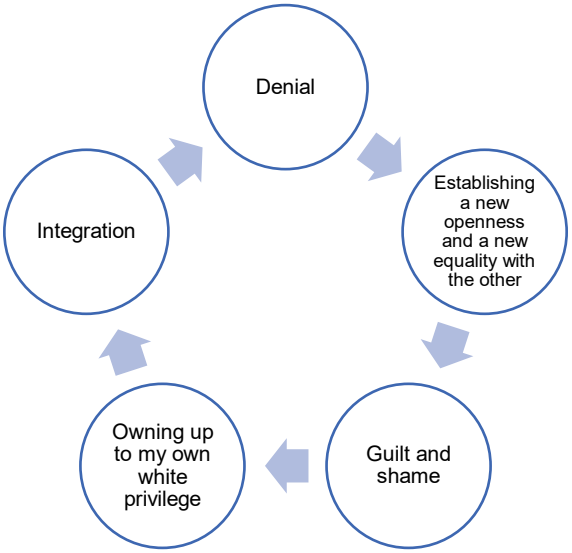
1.5.1 White Awareness Model

The White Awareness Model (WAM; Ryde 2009) provides a conceptual framework to understand the various stages white people experience in relation to racism and their whiteness. Ryde developed this model, building on Helms' White Identity model (1990) and van Weedenburgh's Intercultural Sensitivity model (1996). Ryde's framework adds guilt and shame as they viewed this as necessary to effect real change. Viewing 'white as the norm' is condemned as problematic when white individuals are confronting their complicity in oppressive systems.

This model can be used to understand how white individuals identify their level of awareness within race dyads. A cyclical model demonstrates how individuals can revert to a previous stage at any point, and how the learning deepens through every turn of the cycle. Racial identity and consciousness models have been developing since the 1980s but are not commonplace within clinical psychology in the UK.

Figure 1

The White Awareness Model



Note: Adapted from *White Privilege Unmasked: How to be Part of the Solution* (p. 122) Ryde, J., 2019, Jessica Kingsley Publishers. Copyright 2019 by Judy Ryde.

1. Denial - Ryde describes five varying degrees of denial dependant on the awareness of white privilege (see Appendix A).
2. Establishing a new openness and new equality with one another- This stage involves immersing oneself in reading and watching about the effects of racism and discussing with peers.
3. Guilt and shame - This stage links to individuals' understanding their own complicity within the structures of racial inequality in the UK. Ryde argues that *"guilt is not really a feeling"* (2019, p. 199), but something that arises from acknowledging being involved, which leads to feelings of shame.
4. Owning up to my own white privilege- This arises when individuals fully focus on their role within racism (examining colonial history and own racist thoughts/behaviours), rather than seeing as a problem for the 'other'.

5. Integration- An individual understands the depths and implications of their whiteness without denying their feelings and can relate to racialised individuals in a more authentic way.

The painful feelings that arise within each stage can lead to reverting to a previous position. Ryde also argues that individuals may want to hide from their complicity and viewing themselves as racist, benefitting from the system that perpetuates racism, leading back to denial.

1.5.2 Talking about race and racism

Frankenberg described three definitions of how race is discussed in public discourse; scientific racism implying inferiority, the 'colour blind' approach, or a race-cognisant way of acknowledging both historical and current abuses of power in relation to race in ways that are explicit and empowering (1993, p. 30). These align with the WAM and other racial identity models (Helms, 1995), and the current social discourse surrounding the BLM protests and subsequent 'All Lives Matter' approach (Halstead, 2017). A boom in mainstream literature by both white and racialised authors suggests there is acknowledgement for change in understanding and talking about race (Akala, 2019; DiAngelo, 2018; Eddo-Lodge, 2017).

Academics and therapists alike have been examining the psychological processes at play for white individuals when race or racism are naming in conversation. D. Sue (2015) provided a psychological understanding of 'race talk' which has been used to understand the various conscious and unconscious processes that are at play. Talking about race in the context of privilege and oppression brings up uncomfortable emotions which are naturally defended against (Bhui, 2012). It is thought that internal racism is a normal part of the processes of the mind, but it is defended against and out of consciousness (Davids, 2011; Lowe, 2014).

DiAngelo coined 'white fragility', to account for the defensiveness that arises in white individuals at the mention of racism (2011; 2018). They argue that the mainstream definition of racism leads to defensive reactions of anger, fear,

silence and guilt. Akala (2019) contributes to this by describing the good-bad dichotomy, where acts of racism are attributed to bad people, and therefore those who see themselves as 'good' believe they are not accountable. This minimises the role that all individuals play in perpetuating the structures which enable racism and creates little accountability for the need to talk about the existence of racism at all (Eddo-Lodge, 2017). Terms of 'white guilt' and 'white saviour' can be experienced as blaming or can close down the conversation when race is discussed within the context of race-dyads. It is important to understand that as individuals, existing within a society which perpetuates racial inequality, talking about race and racism will be ongoing.

1.5.3 Talking about race and racism in therapy

Given the challenges of talking about race and racism above, there is little wonder it may also be a challenge within therapy. Lago and Thompson (2002) argue that therapists need to address issues of racism during training to be able to work within the multicultural society that exists today, however individuals often overshadow and do not provide space for talking about race, in favour of talking about culture, preventing racism from becoming central to the discussion (Desai, 2018). Nolte (2007) calls for white therapists to reflect on themselves within the dominant culture, and engage with the multidimensional aspects of this, in order to prevent disengagement from the guilt and shame that arises and move towards conversations about power and oppression in cross-cultural therapy. Due to racism, there is an asymmetrical power relationship between black and white individuals which saturates all aspects of society, which can help therapists to understand why racial differences may affect the therapeutic relationship and outcomes (Cabral & Smith, 2011).

Lowe outlines how discussions about race and racism arouse strong feelings of guilt, shame, anger and anxiety when discussed in groups of psychotherapists, and are therefore strongly defended against (2014). A psychodynamic perspective creates an understanding of unconscious processes that arise and cause challenges such as projection and avoidance

(Bhui, 2012; Davids, 2011). McKenzie-Mavinga (2014) provides a comprehensive account of the complexity of 'intercultural' therapy within psychotherapy and provides practical guidelines for therapists on how to understand their own relationship to race, and work alongside clients in a way that allows exploration of racism within therapy.

Clinical psychologists have written about the dynamics of race and racism within systemic family therapy and systemic supervision (Erskine 2002; Pendry, 2012). Conscious and unconscious processes influence the way they respond to clients and their supervisors, regardless of race. There has been a call for therapists to 'do' self-reflection work to understand their own relationship to racism, gain a sense of their own culture and ethnicity, and experientially explore the way in which some voices become dominant and privileged, and others silenced and subjugated. Systemic training provides frameworks such as the cultural genogram (Hardy & Laszloffy, 2008) and social GGRRAAACCEEESSS exercises (Burnham, 1993; 2013; Totsuka, 2014) to begin addressing these conversations in a structured way.

It is argued that the person in the position of power should initiate conversations about racism (Hardy, 2008; Pendry, 2012). Microaggressions and prejudicial treatment are increasingly being exposed within the profession, particularly within supervisory relationships towards racialised psychologists (Constantine & D. Sue, 2007; Desai, 2018; Tong et al., 2019). The supervisory relationship is a crucial space to explore racism, as it directly impacts the competence and confidence of therapists with their clients (Pendry, 2012).

Research in USA found white therapists responding in a range of ways in cross-race dyads. Race discussions in therapy have been described by white therapists as uncomfortable (Knox et al., 2003), a threat (Utsey et al. 2005) and difficult to initiate (Cardemill & Battle, 2003; Knox et al., 2003). 'White racial identity' and 'white racial consciousness' have been used to understand these perspectives, and how therapists are able (or not able) to engage fully in these discussions (Gushe & Constantine, 2007; Utsey et al., 2005). The

overt and structural racism within the USA and the privatised structures of healthcare result in a context for therapy that is not comparable to the UK. This research does however provide some insight into how therapists relate and respond in ‘race-dyads’.

1.6 Researcher’s motivation to research topic

Alongside the literature, the researcher’s own experiences are important to outline to provide transparency around the motivation to research this topic. As a racialised trainee CP, talking about race and race differences has been central to conversations about the therapeutic relationship within therapy. Furthermore, the researcher became aware during their first year as a trainee CP of the language around and focus of ‘cultural difference’ and ‘cultural adaptations’ within placement. During this year, the researcher conducted a service audit whilst working in a London IAPT service. This audit examined the differences between black and white clients accessing services, receiving ‘treatment’ (CBT), and reaching ‘recovering’ (measured by scores on routine outcome measures, ROMs). The results found that black clients were more likely to be referred into the service with higher clinical scores on ROMs, were more likely to be referred onwards to secondary mental health services, more likely to drop out of therapy and less likely to reach ‘recovery’ than their white counterparts. The researcher made recommendations for qualitative explorations into understanding why these differences occurred and contributed to changes in how the service worked differently with black clients. During this project, the researcher also found research examining the experience of black and other racialised clients accessing IAPT services and talked informally with colleagues about how often they talked about racism within the therapy. This began shaping ideas of a research project linked to the experiences of talking about race and racism in therapy.

Furthermore, the researcher noticed a difference between white colleagues and racialised colleagues willing and ability to discuss racism and the impact on mental health and wellbeing, both at university and on placement. These experiences, alongside the researcher’s own experience of talking about

racism with a white therapist, drew the researcher to exploring the literature in relation to talking about race and racism within therapy, on how racism impacts mental health, and institutional racism within health services. Alongside discussions with the research supervisor, the motivation for this research topic grew and a review of literature was made.

1.7 Scoping Review

The majority of literature linked to race and clinical psychology in UK focuses on adapting therapeutic models, increasing access to services, and racism within the profession (Beck et al., 2019; Memon et al., 2016; Wood & N. Patel, 2017). As previously outlined, there is a growing body of literature about 'BAME' trainee and qualified CP's experience of racism within therapy and within the profession in general (Desai, 2018; McNeil, 2010; Shah, 2010). What appears unclear is the perspective of the white CP when race and racism is discussed within their role. How white CP's experience talking about race and racism will influence how they interact with their clients, within supervision and within teams.

A scoping review was conducted between September and December 2020 in order to understand what already exists within the literature. In order to identify and analyse gaps and examine how research is conducted on this particular topic a scoping review was considered more appropriate than a systemic literature review.

To identify relevant literature, four databases were searched: PSYCHINFO, PsychArticles, SCOPUS and Science Direct, in addition to Google Scholar and reference lists. The search strategy including terms, inclusion criteria and a flowchart demonstrating how the literature was reviewed is shown below. The following search terms of key words were used; (therapist or counsellor or psychotherapist or psychologist or clinician) AND experience AND white AND (race or racism or racial discrimination or racial or racist) AND (UK or United Kingdom or Britain or England or Wales or Scotland or Northern Ireland).

Limiters included:

- English language only
- UK study only
- Title, Abstract and Keyword only
- Adult only (>18yrs)
- Published between 2000-2020

Exclusion Criteria:

- If therapist's perspective was not main focus
- If therapist is considered racialised/minority
- If therapist is a trainee
- Not related to therapy
- Not related to race and racism

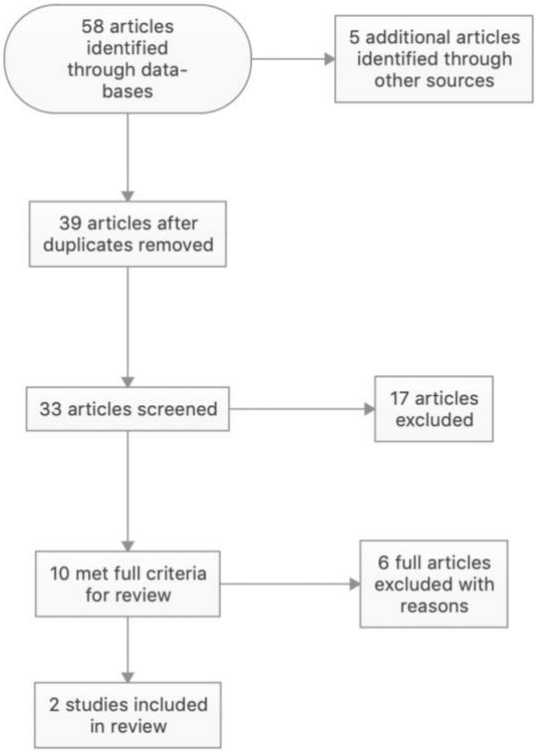
Initial search terms were expanded from 'CP' to include other professionals (counselling psychology, psychotherapist, therapist) when the initial search showed one study (Wood & N. Patel, 2017). Racial discrimination was included as a further definition of racism that is included within the literature. Whiteness was not included in the search terms to focus on the aspect of racism, although papers discussing whiteness did emerge. The review included doctoral theses which link to the topic in question, in addition to books and peer-reviewed articles.

From the review, 33 results were obtained and organised within Mendeley (version 1.19.8). Titles and abstracts were reviewed against the inclusion criteria and excluded as appropriate. Two studies were found to meet the criteria for this review and were read in full[4]. The guiding question in this literature search was: how have white therapists' perspectives of discussing race and racism in therapy been examined in the literature?

[4] One thesis identified was not accessible to the researcher (Buckley, 2003).

Figure 2.

Flowchart from Scoping Review



1.7.1 Dos Santos + Dallos (2012)

Dos Santos + Dallos (2012) interviewed three British African-Caribbean psychotherapy clients and their white British therapists to understand how they discussed race within 'cross-cultural dyads'. Open discussions of race and culture were found to be pertinent to the therapeutic relationship but did not often occur. The themes emerging from the white therapists and British African-Caribbean clients noted both a 'distancing from racial identity' in the discussions, and 'dilemmas in identifying with client groups'.

Political correctness was important for therapists, as there was a fear around saying the wrong thing, which often led to silence. This was seen to influence clients who felt that it was the therapist's responsibility to raise the topic, resulting in 'no race talk in therapy'. All participants appeared to have internalised Eurocentric sanitised views of therapy, as separate from socio-political aspects of identity, to focus on a symptom-reduction approach to

intervention. Clients shared the view that therapists, within the relative position of power, should be the person to raise the topic. The white therapists all shared own minority identity e.g., Jewish heritage, that interacted with their relationship to discrimination, and awareness of naming racism with caution. The impact on therapist's relationship to whiteness was shaped by their own cultural heritage.

The therapists had 10-15 years therapeutic experience which should be factored into the interpretation of these findings. Given that confidence in therapy may grow with experience, it may influence the confidence related to discussing issues of race. The authors expressed concern that both parties were waiting for the other to open up a conversation about race, thus hampering the therapeutic process. They conclude that the process of therapy was successful, despite feeling somewhat distant in the therapeutic relationship. This paper recommended therapists gain an awareness for the processes that limit discussions of race and culture in order to develop the skills necessary for 'cross-cultural' therapy. The barriers to naming race indicate that therapists had then not felt able to talk about client's potential experiences with racism.

1.7.2 M. Patel (2014)

M. Patel (2014) interviewed six white counselling psychologists about their experiences of working with 'ethnic difference' in 'multicultural' counselling. Through interpretive phenomenological analysis (IPA), these experiences were explored to identify the internal world of counselling psychologists within these dynamics and how they navigated these experiences. The results indicate that white counselling psychologists view racialised clients as having 'different world views' to themselves, which impacted on the development of the therapeutic relationship.

M. Patel noted the tendency for participants to talk about ethnicity theoretically rather than sharing their personal experiences, suggesting a separation between thinking about ethnic difference and connecting with the experience

of being in the room and working with ethnic difference. This research provided a good insight into the internal experiences of white counsellors, but explicitly did not explore contexts of counsellors addressing or talking about race within the therapeutic dynamic. The emotions raised by ethnic difference indicate how white individuals respond, through avoidance and defences.

Similar to this researcher, M. Patel acknowledges that psychology research often focuses on racialised individuals, rather than on the white therapist's experience. This study calls for white counsellors to develop the skills, and not view working with racialised individuals only the role of racialised therapists. M. Patel recommended clear and definitive guidelines to be created for 'multicultural counselling competencies' and training should be developed to engage counsellors in discourse around multicultural practice. They also suggest further research explores therapists experience of discussing client's racist experiences.

1.7.3 Summary of findings

Some promising conclusions can be drawn from the data; however, it is limited and does not directly examine CPs, rather homogenising the experiences with other therapists who are trained very differently. With a total of nine white therapists across the two studies, it is difficult to draw broad conclusions from the findings and experiences. Both studies noted avoidance of, or anxiety related to, 'difference' being raised within cross-race dynamics, indicating that white individuals find it challenging to talk about race, and therefore cope through silence or avoidance. These two studies have explored the experiences of 'ethnic difference' but not explored the perspectives of white therapists talking about racism. Following the recommendations from both studies, exploring the perspective of white therapists talking about racism is a next important step in research.

1.8 Rationale and Aims

In reviewing the current literature and considering the current socio-political context of racism, its impacts on MH, and the influence clinical psychology has, the researcher argues that it is imperative for racialised clients to be able to talk about their experiences of racism within therapy. Therapeutic professionals are aware of the importance and challenges of talking about racism in therapeutic practice (Fernando, 2017; McKenzie-Mavinga, 2016; Nolte, 2017), yet there remains little application of this within Clinical Psychology. Given the disproportionate rates of MH difficulties in racialised individuals (linked to the impact of structural racism), it is imperative that the workforce reflects the people who may access the services of CPs. Whilst barriers to accessing the profession still exist, the whole profession needs to be skilled and equipped to work with racialised individuals who may want to talk about the racism they've experienced in their lives.

There is a gap in understanding the experiences of white CPs talking about racism with their clients. These experiences will be shaped by other aspects of their role e.g., supervision, training, team dynamics. Other factors may also contribute to how white individuals experience these discussions. The experiences may be understood in relation to how Ryde conceptualises white individual's relationship to racism and whiteness; WAM (2009).

The results of this research aim to inform future training within the professional doctorate and post-qualification training, to move the profession away from the Eurocentric, white dominant positioning that exists today, and benefit racialised client's experiences of therapy with white CPs.

1.9 Research questions

To address the study aims, the following research questions will be explored:

1. What are white clinical psychologists' experiences of discussing race and racism in therapy?
2. What hinders and facilitates discussions of race and racism in therapy?

2 METHOD

2.1 Overview

This chapter outlines the philosophical assumptions within this research and discusses the ethical considerations. The research design, procedure and step by step account of analytic approach will be presented to enable replicability. The chapter will conclude with personal reflexivity to examine the relationship between the research and the researcher.

2.2 Philosophical Assumptions

2.2.1 Epistemology

Within the literature, authors predominantly argue that race is a social construct. However, it is important to understand that the perception of racism within this epistemological position (social constructionism) can invalidate an individual's lived experience (i.e., that racism is part of person a's social construct but not person b's social construct, therefore they (person a) have not experienced racism towards them). Conversely, through a critical realist approach, this research assumes that, as stated in 1.1, people are assigned to different race categories based on physical characteristics, and consequently, can experience discrimination due to this race category (racism). This research is interested in the experience of white individual's reality, which is shaped differently to racialised individuals, by cultural, language and political contexts of race categories and racism (Bhaskar, 2013; Willig, 2016). The participant's experience of discussing race and racism is taken as true within their reality e.g., a client experienced racism and is talking about the impact of this in therapy with their white CP (the participant), and they (the white CP) describe this experience as an anxiety provoking conversation. This lens (of white CP) is true and lived reality due to their context as a white individual growing up in the UK where their whiteness has provided privileges to them and talking about race and racism is not

commonplace. By adopting a critical realist approach, the aim is to understand how white CPs describe their experiences of discussing race and racism such as the example above.

Within this epistemological position, it is acknowledged that participants are affected by social processes, such as social desirability, in their responses (Bergen & Labonté, 2020). However, unlike social constructionism, through a critical realist epistemology, these statements can be argued to contain information about the 'real world' as seen through the view lens of the participant. Whilst the 'knowledge' created will be influenced by both the participant and the researcher's perspective and meaning making (Braun & Clarke, 2006), the basis of this knowledge remains grounded in reality, and is therefore not relativist (Willig, 2016).

2.2.2 Ontology

Based on the assumption of distinct racial categories, and therefore the experience and existence of racism, this research is grounded in ontological realism (Willig, 2016). Realism provides a basis for change to occur in the relationships and environments that the participants exist within. This realist ontology makes the assumption that material and social structures have an objective reality that exist independently of the awareness and beliefs of it (Willig, 2016). There are multiple dimensions of reality, including that of the researcher and participant. The reality of participants' experiences may be influenced by the researcher and is important to remain aware of throughout the research process (Willig, 2016). Talking about race and racism is experienced differently by each person within the interaction, with both influenced through a historical, political and social context. The experience of the participants (as white CPs), talking with their client about the client's experience of race and racism, is the reality that is being explored within this research.

2.3 Design

2.3.1 Qualitative Approach

Given the paucity of literature, it was crucial that the research was exploratory and sought to obtain broad and rich data. The aim of the study was to explore the experiences of white CPs discussing race and racism in therapy, and other aspects of their job role (e.g., supervision, meetings etc.). Individual semi-structured interviews were chosen because the researcher was interested in capturing the individual nature of the experiences. The researcher aimed to understand experiences and processes (Barker et al., 2015), which could be explored through open questioning and prompting.

The choice to conduct interviews was considered amongst other options, such as survey data and focus groups. Following initial searches about, and personal experience of, discussing race and racism within group contexts (Lowe, 2014), it was considered whether a focus group would provide challenges in understanding the participants' internal experiences at the level that was desired for the research. Focus groups provide a perspective of meaning as co-created through discussion (Breen, 2006, Smithson, 2008), therefore would not appropriately answer the research questions related to individual's experiences. Furthermore, it was felt that as a racialised researcher, facilitating focus groups could create unbalanced power dynamics, which could be more appropriately managed through 1:1 interviews. Therefore, individual interviews would address the researcher question related to 'experience' that could be explored in an open and curious manner. Semi-structured interviews enable flexibility to the conversation and allow the researcher to explore interesting or significant issues that are brought up during the interview (Smith et al., 2009).

The study aimed to recruit 8-10 participants during the recruitment period, which was considered an appropriate number necessary for conducting qualitative analysis and providing sufficient data to develop meaningful points of similarity and difference between the participants (Smith et al., 2009).

2.4 Ethical considerations

2.4.1 Ethical Approval

Ethical considerations were guided by the professional code of human research ethics (British Psychological Society, 2014). Ethical approval for all elements of the study were sought and received from the University of East London (UEL) prior to the collection of data (see appendix B).

2.4.2 Informed Consent and Confidentiality

Potential participants were given a study information sheet and consent form (see appendix C and D respectively) and the opportunity to contact the researcher or research supervisor with questions prior to consenting and partaking. The information sheet outlined what to expect from participating, benefits of taking part, ability to withdraw without consequence or explanation, confidentiality and data protection. Participants were given additional opportunities to ask questions before and during the interview. Consent forms were electronically signed and sent to the researcher prior to interview. This was reviewed before starting the interview and participants were reminded, at the start and end, of their right to withdraw without reason at any point up, until three weeks after the interview.

To ensure confidentiality; participant names, contact details and consent forms were stored securely and separately from video-recordings and transcriptions. Signed consent forms were emailed to the researcher, which were saved and then deleted from the researcher's email account. Video-recordings were stored on Microsoft Stream through a password-protected account and deleted once transcriptions were finalised. Transcriptions were auto created and reviewed by the researcher who removed all identifiable information (e.g., names of places/people). Anonymised transcriptions were accessible to the researcher, supervisor and examiners only. Transcriptions were imported onto NVivo (12) Software for analysis. Transcriptions, and other anonymised data which may be required for publication/dissemination,

will be stored securely by the research supervisor for three years, after which they will be deleted. A full data management plan was developed and approved by the Research Data Management Officer within UEL (see appendix E).

2.4.3 Remuneration

Participants were informed that they would be entered into a prize draw to win a £20 voucher. The research aimed to positively impact the training of the profession and therefore it was considered unnecessary for each participant to be remunerated for their time.

2.4.4 Possible Distress and Debrief

Given the outlined literature around the emotional responses to discussing race and racism, it was considered plausible that the interview process could be distressing for participants. The participants' experienced reality of distress is seen in the socio-political context of whiteness. Participants were recalling their own experiences as white individuals in the context of a racialised others' experiences of racism. Within the interview, reflexive questions were asked to gauge how the participant was experiencing the process. It was not necessary to stop any interview due to reported or visible distress; informal debrief at the end of the interview allowed for further discussion of any negative emotions the participant experienced within the conversation. A debrief sheet (see appendix F), detailing sources of support, the researcher's and research supervisor's contact details, was emailed to participants immediately after the interview. No subsequent contact was made to the researcher or research supervisor by the participants, indicating there was no complaints or other feedback related to the content of the interviews. It is possible that participants experienced distress and used the signposting information from the debrief sheet, however the researcher and research supervisor were not aware of any participant distress.

2.5 Participants

2.5.1 Inclusion criteria

Individuals who were:

- Qualified as a CP
- Working clinically in UK settings
- Self-identified as white
- English speaking

2.5.2 Recruitment

The research study was advertised through a number of social media platforms (e.g., Twitter and Facebook, see appendix G). Participants were recruited through convenience sampling and a snowballing approach, with no procedure in place to actively recruit from particular UK geographical locations. Given the context of the Covid-19 pandemic resulting in no face-to-face contact, there were also no restrictions placed in location of participants for conducting interviews.

2.6 Procedure

2.6.1 Interview schedule and pilot interviews

The interview schedule was designed to openly explore participants' experiences across various aspects of their job role (in therapy, supervision, and within teams). A draft interview schedule was piloted with two CPs who self-identified as 'white' and 'white other' to establish whether the interview questions were clear and appropriate. Some minor changes were made to the interview schedule, specifically related to the prompting questions, but was deemed generally appropriate. The feedback from these interviews, alongside discussion in supervision, informed the final interview structure. The final interview schedule followed a semi-structured format with probing and follow up questions to allow for further clarification of points or exploration of the participants' experiences (see appendix H).

2.6.2 Recruitment

As above, participants were recruited through convenience and snowball sampling. Recruitment was open for four months.

2.6.3 Demographic information

Demographic information was taken before the start of the interview, including a question about where and when participants completed their DClinPsy training (see appendix I).

2.6.4 Interviews

Due to Covid-19 social distance measures and lockdown restrictions, all interviews were conducted and recorded through video conferencing utilising Microsoft Teams. As above, the information sheet and consent form were reviewed at the beginning of the interview and participants were offered a chance to ask questions. At the end, participants were again offered the opportunity to ask questions before the researcher gave a verbal debrief. The debrief form was emailed to the participants immediately after the interview. All interviews lasted between 40 and 80 minutes.

2.6.5 Transcription

Microsoft Teams auto transcribed the audio from each video recording, which was downloaded into a Word document. The researcher reviewed and formatted this using conventions in line with recommendations by Bannister et al. (2011). Transcripts were punctuated for readability and pauses of more than one second were transcribed in ( ). Identifying details such as geographical locations or service names were replaced with words within [ ].

2.7 Analytic Approach

2.7.1 Thematic Analysis Justification

Thematic Analysis (TA) is a method that allows flexibility and openness to the analysis, as it can be applied to a range of theoretical and epistemological

approaches. The researcher was interested in understanding broad themes that were seen in the experiences of the participants rather than focusing in on the lived experiences of each individual, therefore TA was chosen over IPA (Braun & Clarke, 2006). A larger data set was preferred, in order to understand the experiences across and identify patterns across a range of different participants.

This approach to data analysis fits with the critical realist epistemology. Given that interviews are 'conversation with a purpose' (Burgess, 2002), supervision discussions and researcher journal were important elements of the process of data collection and interpretation. The researcher made interpretations that consider the socio-cultural contexts and processes that shape each participant's account of their experiences, whilst being aware of their own lens (Willig, 2016).

Braun and Clarke's six-phase approach (2006) was used to analyse interview transcripts. NVivo was used to develop initial codes. TA was then conducted manually by the researcher, alongside support from the research supervisor. This was an iterative and reflexive process linked to the six phases but for ease will be presented in a linear format outlined below.

2.7.2 Analytic Strategy

1) Familiarisation with the data: The researcher reviewed the initial auto-transcriptions and edited for accuracy during the first re-watch of the video recordings. These were re-watched, and transcriptions re-read whilst the researcher noted any initial analytic observations.

2) Initial code generation: Codes were created at a primarily semantic level of analysis (see appendix J). Some latent codes were generated, and the research journal enabled researcher reflexivity at the latent level to inform the analysis process and discussion. Due to the

exploratory nature of the research questions, analysis was both theory (deductive) and data-driven (inductive).

3) Searching for Themes: Initial codes were clustered into themes and subthemes based on unifying features. Visual mind maps and tables were used to capture the most salient patterns in the data.

4) Reviewing themes: The researcher and supervisor reviewed themes alongside the original data to assess their coherence and accuracy of reflection. Extracts under the themes and subthemes were reviewed for consistency, and rearranged where necessary, forming initial thematic maps (see appendix K). At this stage, the researcher re-read the transcripts to ensure the themes represented the data and thematic map as a whole. To decrease repetition, initial themes were merged, split or combined with other subthemes, leading to the final thematic map (see chapter three).

5) Defining and Naming Themes: This phase involved defining and refining themes to ensure the 'essence' of each theme was clear. Final naming of themes with the research supervisor ensured these were concise and sufficiently reflected data.

6) Producing the Report: The final report was written to indicate a clear and coherent story of the data. Participants have been referred to by interview number in the presentation of data extracts.

2.8 Researcher Reflexivity

Reflexivity can be understood as the researcher's consideration for the influence they have on the research process and the 'knowledge' produced (Nightingale & Cromby, 1999; Willig, 2013). It involves an ongoing process of mutual shaping between the researcher and the research therefore the researcher's position had been continually considered (Attia & Edge, 2017).

Qualitative research is particularly influenced by the researcher, through the interpretation of the data and development of themes. It is important to reflect on and make explicit the researcher's assumptions about the research topic, the researcher's values and life experiences, and how they might shape the interpretation of the data (Braun & Clarke, 2006).

Writing from the position of being a second-generation Chinese-Irish female, this project is important to the researcher from a dual perspective. Having personally experienced racism, the researcher recognises the personal challenge of exploring this within therapy, particularly with a white therapist. As a psychologist, the researcher is also invested in ensuring the profession is informed about the complexities of how white CPs are discussing race and racism in therapy and the wider contexts of their jobs.

The racial difference was important to consider as the interviews had the potential to be a difficult experience for the researcher. For racialised individuals, listening to white people discuss what they find more or less challenging about discussing race and racism, it is difficult to not feel a personal reaction to their sense making. Keeping a research journal and discussing experiences within supervision benefitted personal, epistemological and linguistic reflexivity, which will be explored in chapter four.

3 RESULTS

3.1 Overview

This chapter presents the themes from the data analysis of the individual participant interviews. Demographic information will be presented to locate the sample and contextualise the results. TA was used to explore the research questions, and a thematic map is presented to show a visual overview of the themes and their subthemes which will be explored, with extracts from the transcripts used to support the researcher's interpretations of the data.

3.2 Sample demographics

Sixteen CPs were interviewed between July-October 2020. One participant verbally consented but did not return written consent, therefore was excluded from the data set. The final sample of 15 participants included 13 females and two males. Participants had qualified from a range of clinical training programmes (M qualification period = 10.1yrs, range = 2-22yrs). Three participants no longer worked for the NHS but worked privately in a clinical capacity (M years working in NHS as qualified CP = 8.1yrs, range = 1-20yrs). In order to prevent participants being identified by presenting their individual demographic data, the figures below group self-identified ethnicity, age, location of training course, and current geographical working location. Twelve participants self-identified as white British, with others describing themselves as White Irish, White Mediterranean and White Other (figure 3). Participants' ages ranged from 28-50yrs (figure 4). The current geographical location of participants was evenly distributed between working in a city, working in the home counties and working rurally (figure 5). Over half of participants had trained at DClinPsy courses within UK cities, with two participants qualifying in South Africa and completing statement of equivalence to work in the UK (figure 6). Participant's course location was considered to be linked to the urbanicity or rurality of placement locations during training. The sample size

was larger than the typical sample size for a professional doctorate project using TA, maximising the range of perspectives informing the analysis (Clarke et al. 2015).

Figure 3

Participant self-identified ethnicity

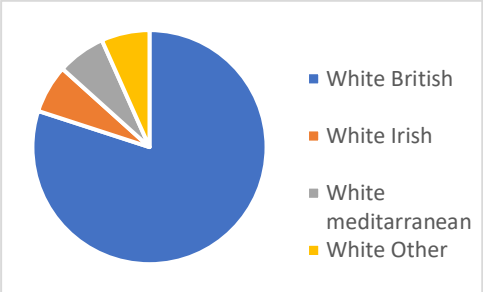


Figure 4

Age ranges of participants

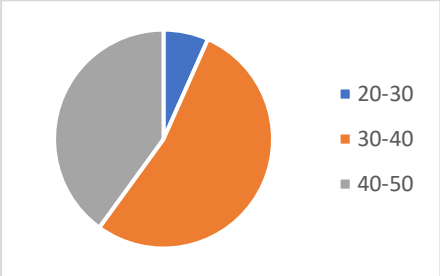


Figure 5

Participant current working geographical location

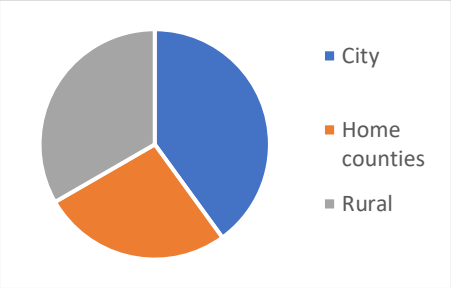
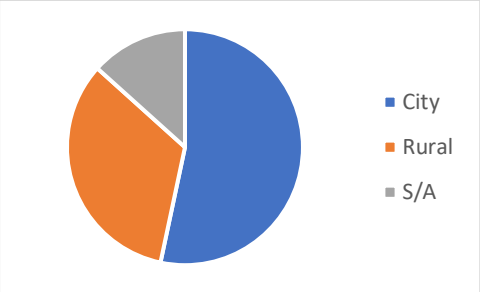


Figure 6

Location of DClinPsy training courses

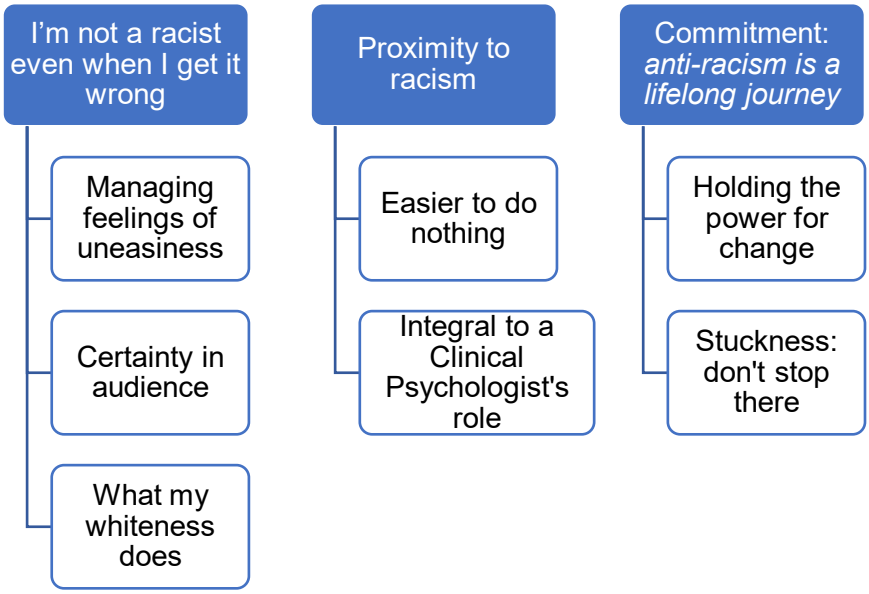


3.3 Thematic Map

Using TA, initial codes were categorized into an initial large thematic map (see appendix K). Themes were refined and collapsed to create three main themes: 'I'm not a racist even when I get it wrong'; 'Proximity to racism'; and 'Commitment: "*anti-racism is a lifelong journey*"', each with sub-themes (see figure 7).

Figure 7

Final Thematic Map



3.4 Theme 1: I'm Not a Racist Even When I Get it Wrong

The first theme captured participants' experience of their own understanding of themselves and their behaviour in contexts where race and racism are discussed. Participants shared their emotions and thought processes during various interactions with a shared sense that participants felt the impact of an implicit message within society of a good: bad dichotomy, demonstrated by participant 8:

> *"not wanting to be labelled as a bad person, and I think a lot of the time we kind of all associate being 'racist' with being a bad person and none of us want to be seen as a 'bad person'."*
>
> (P8, line 74)

Perception of self, and how clients and colleagues viewed them was described as important to all participants. 'Managing feelings of uneasiness' explores internal experiences for participants and how that links to them thinking 'I'm not a racist'. 'Certainty in audience' describes the relational risks

participants felt they were taking when talking about racism. Dependent on the individual and how 'safe' they felt that they would not be judged as 'a racist', impacted what they did and said. 'What my whiteness does' emerged as participants talked about them becoming aware of the impacts of their whiteness and beginning to own their complicity.

3.4.1 Managing Feelings of Uneasiness

Participants' internal experiences were described in various different ways. "*Anxiety"*, "*shame*", "*fear"*, and "*discomfort"* were all explored. Overall, the internal experience could be understood as 'uneasiness' at having to talk about racism, or in how participants anticipated others' perceptions of them when talking about race and racism.

> *"I had an extra layer of anxiety about, is, is my decision going to be attributed as if I'm being racist when I tried so hard to make it in affirmative action"*
>
> (P4, line 220)

Awareness that talking about race and racism as a white CP could result in saying the wrong thing, offending the other or being seen as racist led to this varying levels of uneasiness. Physical manifestations such as *"feeling it in my gut"* (P10) and *"I notice that I go hot"* (P8) showed a visceral level of uneasiness for participants during interactions with clients. When participants bring race and racism into the conversation, rather than the client naming it, they talked about *"my focus is a lot more internal…noticing that attention is on yourself"* (P8). There was a sense of inexperience in being the person to name race; white privilege has benefitted participants to rarely talk (or even think) about race.

A conflicting "*fear of getting it wrong"* (P2, P5, P7, P9) in knowing what to say, and in how they viewed themselves as *"not a do gooder"* (P7), implied that participants' self-perception in race-dyads were at the forefront of their minds. Discomfort seemed to act as a motivator to reflect on and change future

behaviour. Descriptions of internal experiences where participants had been perceived as racist or had witnessed racism give a further understanding to how visceral these conversations can be.

> *"It didn't feel quite right because …my internal experiences that I was… something quite complicated was going on here and so I felt quite clear that something had happened where I was somehow implicated*"
>
> (P5, line 217)

When perceived as racist, participant's sense of self is challenged. The uneasy feeling tells the participant that someone may think they are racist, which is not how they see themselves. Becoming consciously aware of potential ways participants have perpetuated racist structures was noted in all interviews. This conscious awareness linked to stronger emotions of *"shame"* and *"guilt"* at being faced with the reality of their white privilege; something that was not integrated within their identity. The complexity of conscious and unconscious processes was described by clients as causing feelings of unease, especially when they felt they were not acting in line with their values.

> *"silencing myself around it, that feels more uncomfortable*"
>
> (P3, line 140)

Choosing to be silent is further example of white privilege. Participants have the opportunity to manage their feelings through silence in a way that racialised colleagues may not. Participants expanded on their silence and rationalising this behaviour in team contexts:

> *"made me just feel awful because I'd always said I'm not going to be the person who sits there and lets comments kind of happen, but I had to become that person and part of that was that kind of fear not wanting to rock the boat and it was, you know, it was easier to sit there and to not challenge it"*
>
> (P7, line 285)

This ‘not wanting to rock the boat’ resulted in discomfort at what had not been done. Despite this, some shared “*trying to own that and start kind of leaning into*” (P8), and it was ok to feel “*that sense of this isn't right and I am being complicit in”* (P7) with an acknowledgment that talking about racism and the accompanying feeling was both necessary and acceptable. This indicates awareness of their whiteness, and a desire to be different in their behaviours.

> *“that a little bit of anxiety thinking about my white fragility, not wanting to be labelled as a bad person”*
>
> (P8, line 28)

For some who had talked about racism and racial inequality within their personal and professional lives a lot, there was an implication of desensitisation to hearing about client’s experiences:

> *“I don't think I personally found that hard to hear. I mean compared to hearing about you know some of the other horrible things that often happen to patients, including you know, being abused, being attacked, having to do horrible things to fuel their drug habits or whatever you know those things were often harder to hear.”*
>
> (P15, line 161)

Overall, participants shared a range of experiences relating to discomfort and unease. These internal experiences should be acceptable as part of the dynamic that occurs when discussing race and racism, without the judgement that they (the participant) are racist.

3.4.2 Certainty in audience

Participants described how contexts and relationships impacted on their experiences of discussing race and racism. How participants related to the other impacted how able they felt to speak openly. A dichotomy of experiences was described with clients, supervisors, supervisees and within teams. The way participants anticipated ‘the audience’ to respond or perceive

them provided a level of certainty or uncertainty about whether they would be perceived as a racist (or not) in what they did or said. This certainty then allowed participants to take (what they viewed as) a risk in talking about race and racism.

The therapeutic relationship as *'safe'* (P1), for participants is a context that is not usually considered. Participants talked about needing safety from their client or supervisor, implying an emotional risk is being taken when talking about race and racism. For some this risk stemmed from an awareness and cautiousness around the topic of racism being difficult for the client.

> *"being cognisant of the fact that it's a trauma and traumatised people are going to react in a range of ways"*
>
> (P10, line 170)

Awareness of how racialised individuals experience talking about race and racism impacted participant's approach to these conversations. The trauma that can be present for clients and colleagues is crucial for CPs to recognise and respond to through the skills they are trained in. Some participants expanded on this by naming relational dynamics through their psychological understanding and ways of managing this.

> *"there's been a lot of like transference and some kind of quite strong things in general, so I think it's a skill I've had to kind of learn to be able to give myself that little bit of a breather to reflect on whose this is, is it mine or theirs and where is it coming from and how do I use it rather than just going with it"*
>
> (P12, line 346)

From here, the supervisory relationship was discussed by all participants. Some described supervision as *"supportive"* (P5, P7, P11) and *"a trusting and safe space"* (P7, P8, P9, P12). This provided a level of certainty for participants that they could talk about race and racism with their supervisor *"without fear of being judged"* (P7, P12), regardless of the supervisor's race. A

space that enabled reflection on "*what kind of a particular client might be bringing up"* (P12), is the proponent for good supervision. However, the anxiety that racism raised for white individuals perhaps resulted in participants feeling the need for more reassurance and certainty within the supervisory relationship.

A strong supervisory relationship impacted participants' confidence in talking about racism. However, some described times where the relationship did not feel certain. *"Both being white"* (P3, P9, P8) sometimes felt like the conversation was *"colour blind"* (P8). Where participants felt that supervisors *"don't seem to get it"* (P1), they did not discuss clients' experiences of racism or issues of structural racism within the profession in supervision. Certainty in the supervisor directly impacted participant's certainty in their clients preventing meaningful conversations from occurring within both dynamics. The mirroring between the therapeutic and supervisory relationship highlights the importance of supervisor's willingness and engagement in talking about race and racism.

For participants who shared experiences with racialised supervisees, salient interactions linked to navigating a rupture in the relationship. Having been accused of being racist, or being complicit, raised most direct discomfort from racialised supervisees. Being positioned within the position of relative power did not seem to facilitate all participants to feel certainty from their supervisees. Team contexts had further relational complexities to them. In the wake of the BLM protests, participants shared experiences of teams discussing institutional racism and ways they could make changes. For some, raising issues of institutional racism within services was shut down or dismissed:

> *"I can't understand why other people aren't sharing my ideas about the importance of this right now that I find that very difficult if I'm honest to then be in the sort of service with people who perhaps aren't sharing those views"*
>
> (P11, line 282)

The working environment, and other team members, creates a context for fostering or stifling the energy and creativity of anti-racist practice, implying the 'risk' to speak up did not pay off. Some mentioned racialised team members, and how there was a want to be an "ally" *(P4, P15),* without this being performative or overstepping their place.

Participant 7 recalled their experiences of challenging racism within a white multidisciplinary team, and how having power and authority as a newly appointed team leader had impacted her feeling able to speak up.

> *"moving to the position of team leader has made it a lot easier for me to feel like I can be able to challenge those, and I guess that's my power dynamic. I've got more power in those situations now"*
>
> *(*P7, line 292)

The certainty (and power) that their new role provided enabled change at a level that had previously not felt accessible to them. Overall, once participants felt they had 'certainty in audience', they felt able to then open up the conversation about race and racism. This certainty allowed them to risk talking about this as a white person without a fear of being viewed as racist.

3.4.3 What my whiteness does

This subtheme emerged through naming and acknowledgement of participants' own white privilege, and complicity in perpetuating whiteness within their professional lives. Participants described a process of understanding themselves in relationship to whiteness, and how this led (or was leading) them through a process of realising 'what my whiteness does'. As well as describing the discomfort experienced when talking about race and racism, whiteness became apparent as part of the dynamics. Some named this, whereas others talked about their experiences in the context of power and privilege. The emotions described by participants related to how

whiteness had benefitted them and how racial difference in interactions was experienced by the (white) participant. Some shared being aware of their whiteness, and others reflected on times where their whiteness had impacted in ways they had not realised at the time.

> *"I started to get really agitated and angry and I felt attacked. Which (2) I know that's what I read in the white fragility book by Robin DiAngelo, I was like s*** like this is what happened to me"*
>
> (P5, line 190)

The interviews provided a space for participants to reflect on the changes that had occurred for them through reading and reflection, that enabled them to become more aware of the impact white privilege has and begin to realise the influence of biases. Participants 15 shared the difficult feelings that arose:

> *"showing that I have this unconscious negative bias and it really shocked me, you know, like it actually upset me… I was quite emotional about it because you know, I would have vociferously argued my sort of non-racial position. You know that there was no way I was a racist but it got me thinking… maybe you can't just rely on your conscious intent... you could still be making racist decisions that you know that you're not really even aware of what you're doing"*
>
> (P15, line 378)

Many shared similar experiences of single or multiple events that had stayed in their memory as a difficult interaction or realisation, leading them to seeking out change within themselves and their clinical practice. Participant 4 (line 424) described, *"you are blind to what you're blind to aren't you"* which highlighted the awareness, or lack of, for white CP's and impacts on the ways they relate within their roles. The invisibility of whiteness was described in numerous ways. When this became unveiled, there was a process that participants described they had gone through to accept and own this.

Whiteness is present in the room for the client, regardless of whether the white CP is aware of it at the time. Some noted this, whilst others did not. There was an implication that participants knew their clients would be reluctant to name race differences, demonstrating the power that comes from white privilege and from being in the position of therapist. As previously noted, there was a variation in whether participants named race or waited for the client to raise it. Awareness of the power of their whiteness enabled participants to be the one to name it.

> *"I am aware of that as a white therapist sometimes they might not think that I'd be interested in in talking about race."*
>
> (P1, line 168)

As participants moved to talking about team dynamics, the presence of racialised staff within conversations heightened participants awareness of their whiteness and led to a silencing or censoring of speech. Within this context, this silence was related to wanting to allow other (racialised) individuals to be heard within the service.

> *"I think I'm very aware…it's not my voice that needs to be escalated"*
>
> (P1, line 240)

Owning their whiteness was linked to upbringing and how their values system positions race. For some, the reality of racial inequality and the cognitive process related to this, as a white individual were part of theirs and their families' ways of relating in the world.

> *"I certainly have from a young age been aware of my own conscious and unconscious biases you know…around for me I guess for long time in terms of dealing with the reality of and the discomfort of that"*
>
> (P3, line 232)

Several participants talked about growing up, or family who had grown up, in South Africa, and how this had influenced their understanding of racism *"as*

insidious" (P15). The history of apartheid and the consciousness of white power impacted on participants relationship to their privilege and complicity. Similarly, participants own personal minority identities of ethnicity, gender etc. enabled a connection for participants to relate to the experience of racism.

> *"the rage, if you like that you feel when …to have that challenged and this wasn't, it wasn't his intent to kind of gaslight me in my understanding of what happened, but I hold in mind I don't want to be <Yeah>, not all men, are you sure? white person equivalent in these conversations, yeah so that has, I think that has made me want to engage <Yeah>, because you know that I know the discontent <Yeah>, when men didn't gauge or dismiss you"*
>
> *(P2, line 145)*

3.5 Theme Two: Proximity to Racism

Theme two emerged as participants shared the frequency of working with racialised clients, (not) living in multicultural areas, and then how race and racism was (or was not) talked about within their work. The polarisation of experiences across participants was understood further through the demographic information collected. Some talked about "*how few clients I can think of*" (P12) and attributed this to living in *"rural"* (P2) areas where "*ethnic minority groups were really under-represented"* (P3), whereas others talk about *"really diverse areas"* (P1) where "*many of them you know had been victims, often quite violent victims of you know of racism"* (P15).

Proximity to racialised clients, and colleagues, influenced the way racism was talked about by participants and their confidence in these contexts. Participants also shared the influence of their upbringing, training experiences and friends in how integral thinking about race and racism was within their lives. Some participants' accounts suggest that *"lack of practice at the idea of doing so"* (P2) or opportunity has a significant impact on their ability to discuss these issues more broadly across the team and to see it as an important part of their role. The subtheme 'easier to do nothing' demonstrated how

participants avoided talking about racism and their negative reactions through language choice and intellectualising. 'Integral to Clinical Psychologist's role' explores how participants DClinPsy training and their positioning of values influenced whether they prioritised talking about racism within their job.

3.5.1 Easier to do nothing

Participants shared accounts of doing nothing in situations when race and racism were discussed or could be discussed. The culture of services enabled an 'avoidance' of speaking up and challenging structurally racist practices.

> *"I think I have been guilty of staying silent about things when I should have said …I wanted to talk about race in relation to this"*
>
> (P9, line 202)

Despite participants working with racialised clients and their experiences of racism (being in proximity to racism), many shared how they were able to avoid or ignore aspects of the conversation. Language use can have a significant impact on both participant and their client. The language of *"diversity"* (all participants)*, "social GGRRAAACCEEESSS"* (P8, P10, P14) and *"cultural difference"* (P1, P2, P6, P7) were seen as avoidance and minimising of racist experiences. Engaging in conversations about '*difference'* appear somewhat less threatening to participants and diluted both the conversation and the experience (of unease for the participant).

> *"Maybe on a couple of occasions, it hasn't been named as such as race or racism. It's probably been thought of more in terms of cultural background, family history and sort of discussed in that sort of guise rather than be named as race and racism potentially."*
>
> (P13, line 383)

> "*as a professional I think we're OK at talking about power imbalances and thinking about the power differences between therapist and*

clients…we haven't developed a good way of thinking about that in regards to race"

(P2, line 107)

The power behind language within therapy is crucial. To be able to sit with the emotions that arise from naming oppressive and marginalising structures of racism and direct acts of racism, is a skill that many of the participants could not tolerate. Those that could were transparent about the challenge of this but named other ways that they were guilty of avoiding or 'doing nothing'. As conversations moved towards talking about institutional and structural racism, participants described an internal level of avoidance. Many shared an increase in conversations about changing structural inequalities, for clients, racialised colleagues and more widely in society. For all, this was following the increase in public conversations in the wake of George Floyd's murder. Through these conversations there was an implication of feeling helpless.

"Feeling like too much 'work', like too much effort like it makes me feel uncomfortable so it's really hard, I think kind of feeling overwhelmed sometimes and not knowing how to cope with it"

(P8, line 398)

For many participants, remaining aware of structural racism, and the deathly impacts it has for racialised communities, appears to be effortful and challenging, rather than a lived reality. Engaging with talking about inequalities, and the guilt and shame that arise, seemed too difficult. Placating these emotions or doing nothing is prioritised over the need for social justice and equality. Participants have found ways to rationalise that they cannot change the systems they are in, so they continue to do nothing. Participant 7 acknowledged how problematic this is:

"I keep saying, oh, it's really difficult. It's really difficult, and that's an excuse as well because it isn't that difficult. I could have done it, but I've not. So even when I'm talking about it, I'm kind of explaining it

away and giving excuses rather than say I made that choice, I know it's a choice I could have done something differently, but I didn't"

(P7, line 261).

Participants feel threatened by interactions about and even by thinking about inequality. This would lead to "*kind of pushing away response…a sort of shutting down"* (P6). When faced with the reality of inequality within the world, there was *"kind of paralysed, almost attacked kind of defensive place…so it's best to just do nothing"* (P12, line 180).

Participants were able to talk about their relationship to the racialised client and their experience in a way that disconnected from their lived reality:

"some intellectualisation that's happening, isn't there…in an academic way, maybe with the social GGRRAAACCEEESSS or systemic or in a psychodynamic way he might think in terms of the location of disturbance, so I think it creates more of a distance between you as a human"

(P10, line 75)

Separation from racism allowed participants to decrease the negative feelings of *"guilt"* and *"shame"* that arose when they 'did nothing' about racial inequality within their service. This was *"rationalised"* (P6, P7), through the idea of compassion (see theme three). A final element of 'easier to do nothing' can be understood by the pressure of services and "*not having time"* (P9) and being seen as "*perceived to be harder*" (P6) to work with, especially if it is not seen as the primary reason they came to therapy.

> *"I don't think there's an emotional reason why that wouldn't happen I if I'm honest. I think most of the time when I was in was doing therapy. The thing I wanted most was obviously for people to make progress, but often the thing I wanted you know, which was the pressure of the place was you know people I needed to have shorter therapies...I would you know, be happy to have those discussions. But…I was always thinking. The main issues here are, you know you've got emotional difficulties that we need to work on because we don't work on your emotional difficulties, won't get to your drinking or drug use"*
>
> (P15, line 122)

Whilst clients may not name race or racism, participants are implying a lack of awareness that this could be contributing to the reason they have come to therapy. The lack of awareness, or even ignorance, is somewhat justified by service pressures and other contextual factors. Whilst some participants had shared a level of acceptance of the emotional response of avoidance, many talked about how they could have acted differently in the past, implying recognition and regret at doing nothing.

3.5.2 Integral to Clinical Psychologist's role

This subtheme emerged as some participants talked about how it was *"part of my job"* (P11) and "*my responsibility"* (P1, P8) to talk about race and racism, as a white person and as a CP. This sense of responsibility was understood as integral to participant's way of working and linked heavily to participants DClinPsy training.

> *"It's my duty as a clinical psychologist to address power and think about differences within the relationship, whatever it might be, race, sexuality and so, well gender, lots of different things"*
>
> (P8, line 29)

Talking about all aspects of identity, in the context of power and privilege felt like a genuine way that some participants could work therapeutically. "Social

GGRRAAACCEEESSS" were again talked about in how race was named within the therapeutic relationship, not as an avoidance strategy, but as an invitation to the client. Their approach of forming relationships to manage the power dynamics had an impact on subsequently then being able to talk about race with their clients.

> *"I don't tend to adopt an expert position...I'm quite human as a therapist, like kind of connect more as a human rather than as a therapist client, sort of interaction."*
>
> (P12, line 463)

Once race difference was named with the client, moving towards talking about racism was dependent on how they viewed this as part of the therapeutic work. For some, racism was seen as *"abuse and oppression as any other"* (P11) which is something that participants spoke about being part of their work.

DClinPsy training was considered hugely influential in how participants view their professional identity. Some responses indicated that they had received minimal training on how to talk about racism, whereas others identified this as being integral to their DClinPsy training. Preferred therapeutic modalities, conceptualisation of distress, and how they viewed their role influenced their professional identity, and what they viewed as part of their job. The integration of socio-political influences and human rights approaches prioritised discourses around oppression and marginalisation as causes of distress for racialised individuals. Others noted language related to race and culture as being sanitised, contextualised by the time that they trained.

> *"like a colour-blind kind of conversation rather than, you know any language around oppression or injustice… I think that in the early 2000s that was the way that people talked"*
>
> (P5, line 381)

For many, "*race was kind of clumped in together with ideas of difference" (P3)* and talked about in the context of *"social GGRRAAACCEEESSS"* within training. This approach, whilst helpful to consider for the therapeutic relationship, would not address the structural and invisible nature of racism within the UK. Removing an individual's identity from the context of oppressive structures and experiences and framing it as a 'difference' to a CP, is an example of how whiteness impacts DClinPsy in the conceptualisation of distress.

Participants who had trained at particular courses appeared to have similar perspectives about the integration of teaching related to power, oppression and the structures that uphold racism.

> *"how can you train a clinical psychologist and not have that module where you spend three years looking at all those aspects of identity and intersectionality you have to, it's so important and it's you know such a huge part of everyone's life and such an important contextual factor behind a lot of people's problems"*
>
> (P14, line 340)

For those who did talk about racism on training, many felt the *"intellectualisation"* (P10) of these concepts had been somewhat helpful but had done little to prepare them for the emotions they would feel when they were in the room with a racialised client. *"Thinking about power"* (P2, P8, P11) and *"cultural awareness"* (P2) informed them that working with racialised clients was part of their role, but many described this as insufficient to take into practice. The separation from the emotional reality of racism on training indicates an othering of this phenomena, suggesting it doesn't exist within the profession. This was brought into sharper focus for participants who trained with racialised colleagues. Many spoke about *"one or two non-white trainees"* (P4, P5), across their course, but as participant 8 said *"I think hearing from people of colour about their experiences… that probably was more powerful than the lecture".*

Whilst the content of DClinPsy training could have changed since these participants qualified, this influenced how much they considered race and racism as part of their role. The experiential learning and personal development of some participants provided an understanding for how this had been integrated throughout their training.

> *"dismantle any defensiveness before you are in the room...I think there wasn't enough conversation about how to do it so that we felt comfortable enough. <Yeah> to sit in the discomfort and that be alright or to contain that discomfort"*
>
> (P2, line 250)

This discomfort of the client needs to be tolerated, which is integral to a CP's role when working with any other experience of abuse or oppression. A social inequality framework was explored by some participants.

> *"But would that have been overstepping my remit? Did I have permission from the family to do that? I wasn't in that family as a political consciousness raising campaigner."*
>
> (P13 line 411)

> *"I can't change a racist society…I do wonder whether we could do more about you know, activating our clients to be a bit more kind of politically aware and a bit more politically savvy, I don't know."*
>
> (P15, line 129)

This uncertainty about whether CPs should bring the socio-political context into their role is a contested topic within the profession. The notion that racism should be discussed in therapy, and whether participants should be encouraging their clients to think about racism in the context of social inequality are two separate issues which appear to be a dilemma for participants.

This subtheme provided a less dichotomous experience; participants talked about how they had previously not known whether racism should be addressed in therapy, but the impact of BLM protests had influenced how they now viewed this as integral for them. The proximity of racism in the months prior to the interviews, in the news and within personal and profession discussions, resulted in an inability to deny inequalities that needed to be addressed within their role as a CP. Participants shared some positive experiences on training, but acknowledged how it was an on-going process, and needed continual work from them as a white person.

3.6 Theme three: Commitment: *"anti-racism is a lifelong journey"*

As stated by participant 11, the final theme captures the ways participants talked about their process of change and learning in relation to working through an anti-racist lens. Participants felt that *"action needs to happen"* (P5) in relation to creating more inclusive teams and services and challenging institutional racism. Others described their own internal process of learning how to work therapeutically with someone who has experienced racism. The process of anti-racism was described as important but difficult for many, with descriptions of the structural inequalities within their workplace as the biggest challenge.

> *"It was more of a talking rather than a doing, and I think they're right, it's not better, but I think that's often when we get stuck. Psychologists we're quite good at talking and reflecting, but I don't think it's a good action"*
>
> (P7, line 194)

> *"I'm more interested in what are the tangible actions,"*
>
> (P10, line 532)

The notion of reflection without action reminded the researcher of the work of liberation psychologist Paulo Friere who said *"when a word is deprived of its*

dimension of action, reflection automatically suffers as well" (Friere, 2018, p.87).

'Holding the power for change' details how participants consider the changes they can make, internal and external, to engage in an anti-racist approach, influenced by the power from their whiteness. 'Stuckness: don't stop there' demonstrate how participants have used reflection, compassion and values to overcome the sense of 'stuckness' within their work.

3.6.1 Holding the power for change

Power is salient in any research where discrimination and oppression are discussed. The power that operates within the therapeutic dynamic was discussed throughout the interviews. The ability and power to create change within teams and services was then acknowledged.

> *"We need to acknowledge and accept our position of privilege and power and use it to try and make things better in the future…so trying to always acknowledge my privilege to recognise it and use it. So the fact that I've been able to become a clinical psychologist, I would, wherever I can, try to make things equitable in the provision of services in the NHS, to you know, to not stand for racism to tackle inequality and racism wherever I see it"*
>
> (P14, line 265).

There was a shift from participants sharing how they found it difficult to address race and racism within therapy, to acknowledging the power and agency they held as white individuals. Conversely, participant 8 talked about "*feeling a bit powerless like how can I make a change like being in a white team?"*. Years of experience, and role within a team were contextual factors to the power participants felt they had. For example, participant 7 shared changes that were possible due to being a team manager:

> *"To reflect on that and trying to build on that so I know within the service where I am now. I'm trying to make some more positive changes and trying to change that, but it is, there's a sense of I guess a discomfort that comes with any change so it's easier to often stay with things as they are, and maybe we need to be braver to push against that discomfort a little bit"*
>
> (P7, line 200)

Power shifts were noted as participants talked about their role within the varying systems they operate; directly with clients, within supervision, directly with a colleague and wider within teams. 'Holding the power for change' felt possible in direct interactions with clients for those who reflected on and owned their whiteness. This shifted within broader contexts, particularly within teams, where participants described moving towards power-less positions. Whilst there was power in their whiteness, the hierarchy within their services limited the power they felt in relation to this. Linked to 'certainty in audience', if service managers and teams were not prioritising this issue, participants felt power-less to change. On the other hand, those who had moved into senior positions within the NHS talked about feeling more able to implement change in inclusive hiring and shifting team narratives.

As part of the anti-racism journey, power for change from "*internal reflection*" (P1) and *"educating myself"* (P5, P8, P11) was important for participants to acknowledge and commit to. The researcher was aware of the ways that participants describe the different ways they were engaging in anti-racism development and wondered about the influence of social desirability in the interview process (Bergen & Labonté, 2020). This power for change from within was supported through relational learning with others such as anti-racism book groups (P5, P8, P9), reflective practice with psychology friends, and with racialised friends. There was an element of accountability being developed with other white CPs, and through the support of peers, participants felt they had more power collectively than individually.

All participants noted awareness of power in the relational dynamic between them and racialised other (client or colleague). How participants create a

therapeutic relationship felt pertinent to creating a space for racism to be discussed safely for clients. Participants described *"trying to even out that power balance"* (P7) and *"don't tend to adopt an expert position"* (P12) which contributed to facilitating a more open dialogue. The feelings (described in theme one) have the power to influence participants desire for change:

> *"when you sat with these difficult, ugly feelings and experiences and really thinking about how you're complicit in this. I also do get like a fire, like a motivation or fight. I don't know if it's like a hopefulness that you're turning rather than just sitting with guilt you're turning it into action to try to do something differently"*
>
> (P9, line 346)

> *"it just made me feel uncomfortable…. I'm aware of kind of where it's all coming from…. the feeling tells me something, so is telling me a bit about the power dynamics"*
>
> (P11, line 51)

There was somewhat of a stuck-ness amongst some participants in recognising and acting on their power within teams. The movement from reflection to action was seemingly difficult to enable systemic changes that participant wanted, and therefore the power to change felt to be more manageable within smaller changes.

> *"I'm still trying to do stuff. I think you know, I'm little bit frustrated with just talking about stuff I'm a bit like. I think talking's fine. I'm not opposed to talking, but you really gotta do some stuff now".*
>
> (P15, line 398)

Participants expressed that talking was necessary within teams, but this didn't always lead to meaningful change. The notion of change within teams and systems is a slower and more complex issue. This complexity was playing out within participants' stuck-ness.

> *“it's wanting to feel like we can do something, resolve something and it's not something that can just be resolved and fixed, and so it does have to stay at the forefront of your mind and that can be quite exhausting to hold anything with mindful of something”*
>
> (P8, line 410)

Participant 8 shares a desire to change and ‘fix’ the inequalities that exist within society. This social justice position was salient throughout many participants’ experiences in how they discussed their work and working with clients who had experienced racism and racial inequality. The power to change was acknowledged on multiple levels, mirroring the way racial inequality change is needed across society.

The increase in anti-racism conversations following the BLM protests gave further ideas of how participants saw their power to change their approach to working. Many participants had discussed the protests with racialised clients (P1, P8, P11), which had opened up a space for racism to be part of the therapeutic work. Participants acknowledged that they had the power to talk about structural racism with both clients and colleagues but had previously chosen not to.

> *It's a lot to process and to having you at the front of your mind constantly more so than usual for people from Black or Brown backgrounds”*
>
> (P1, line 179)

The implication that participants were now more willing to change their way of working, and attempt to change the systems they worked in, gave hope that the commitment to anti-racism was there within these participants in a way it might not have been prior to George Floyd’s murder.

3.6.2 Stuckness: don't stop there

This subtheme emerged through understanding how participants sustained themselves in engaging in anti-racist work and talking about racism. Despite their whiteness and uneasy physical reactions, participants acknowledged they had changed and shifted their position to allow their anti-racism process to be sustainable. Reflective spaces, compassion and reconnecting with values were all linked to moving beyond stuckness.

"*Compassion to self*" (P6, P12) was described through a Compassion Focused Therapy (CFT) approach. This idea of using psychological theory to self-formulate in supervision is common practice, and a kindness and compassion to themselves was the most salient way of finding a way to move forward from their guilt and shame. CFT gave participants a language to name their experiences within the comfort of a psychological framework. They could talk about *"how my threat system was activated"* (P5) and "*look back on that and not get stuck in the shame"* (P12). The way participants describe how they sustain themselves brought compassion and humanity into the conversation.

> *"if you start to notice that you're being defensive and you probably feel threatened in some way, so I'm sort of thinking that's not wrong cause I'm a human being, so I'm not going to beat myself up for that".*
>
> (P6, line 149)

> *"I feel that there's a humility in knowing that you can't know it all I guess."*
>
> (P10, line 264)

The ability for participants to step back and see themselves as humans who make mistakes, at the same time as being part of a system which perpetuates racism, demonstrates a deeper engagement in their awareness and anti-racism.

“we kind of avoid it like all humans, do we avoid things that feel uncomfortable”

(P8, line 79)

The researcher could see the nuance and complexity to this for each participant, whilst holding an awareness that this behaviour (of avoidance or inaction) may have been post-hoc rationalised. Participants described not wanting to be seen *“as a racist”* and needing to move beyond this. Those who had taken actions towards anti-racism within their practice had been able to move away from this stuck-ness.

“I think about what could have done differently, what I should have done differently, but then I also kind of just OK it was. It is also in the past”

(P5, line 367)

“remembering why you have those conversations and then that it might ruffle some feathers and people might not always appreciate or like we were saying but trying to kind of remain compassionate, but not being preachy, but being curious about why they might hold certain views, I'm finding that kind of useful”

(P9, line 270)

Compassion linked closely with the values described as influencing their professional identity. The values that came from family and growing up around ‘difference’ helped to integrate into participants thinking around how they related to those from other racialised backgrounds.

“I think it's just a bit of a personal value…otherwise it's just all in the head”

(P10, line 155)

The process of reflection and learning, within their anti-racism journey, gave participants more “*confidence”* (P2). Moving beyond stuckness was influenced

by acceptance. Participants relayed how they had shifted their perspective of racism broadly, and their complicity within racist structures.

> *"that kind of acceptance of difference in being, just be prepared to be different. This is kind of OK."*
>
> (P13, line 515)

There was an understanding that collectively a lot of white individuals were now moving more towards anti-racism, due to the social consciousness raising during the current context of the protests. Permission to progress and act differently had been given, and many felt this was a benefit to re-connecting them with their values and holding them accountable as CPs and as individuals.

4 DISCUSSION

4.1 Overview

This chapter will summarise the results of the research in relation to the research questions and context of the literature. The study's quality and limitations will be considered, before the researcher outlines the implications for clinical practice, future research and training. This report will conclude with reflections from the researcher and a summary of the project.

4.2 Summary of research findings

The first research question sought to explore white CPs' experiences of talking about race and racism. In this study, talking about race and racism was experienced as uneasy but necessary, context specific and easy to ignore. Participants contextualised their experiences and relayed changes in perspective around their own whiteness following a particularly difficult interaction or the personal impact of the BLM movement.

The second research question focused on understanding what hinders and facilitates these experiences. Participants described personal values, supportive peers and training as key facilitators. The certainty provided in the context of their audience both hindered and facilitated how open participants felt, particularly within supervision. The environment where they were trained, lived and worked were again both hindering and facilitative.

These findings suggest that experiences of white CPs are varied and situationally dependant. However, where challenges were discussed, others shared positive experiences which could be taken as good practice. The findings offer suggestions for best practice that can be used for trainee and qualified CPs (see section 4.4).

4.2 Contextualising the research findings

4.2.1 What are the experiences of white clinical psychologists when talking about race and racism in therapy?

Descriptions of participants' experiences covered emotional, physical and relation aspects. Talking about race and racism was explored in numerous contexts: with clients, in supervision and within teams. The three themes, 'I'm not a racist even when I get it wrong', 'Proximity to racism' and 'Commitment: "*anti-racism is a lifelong journey*"', encapsulate experiences of talking about racism as a white CP as difficult, necessary and an ongoing process, respectively.

Theme one 'I'm not a racist, even when I get it wrong' demonstrated participants' desire to not be perceived in a certain way, and the emotions this generates. Participants sense of personal and professional identity appeared to be challenged by the anxiety, guilt, shame and anger evoked from talking about racism. M. Patel (2014) also found psychologists shared feeling anxious about getting it wrong or offending the client and therefore damaging the therapeutic relationship. Participants in this study shared this concern, compounded with anxiety about being perceived as a *"bad person"* or *"racist".* This indicates how the nuances of power, oppression and complicity have not been integrated into participants' understanding of themselves as a CP.

The subtheme 'managing feeling of unease' explored both conscious and unconscious processes at play for participants. Anxiety and defensiveness arose when racism was raised by the client, more so than when race was discussed. This further supports M. Patel's findings (2014); talking about ethnicity and culture induced anxiety for therapists, which exacerbated when clients started talking about racism. Anxiety was also reported when participants raised race or racism, yet they described ways they managed this through language and timing (explored below).

Ryde (2019) emphasises the importance of the right amount of anxiety and discomfort to position an individual in the 'learning zone', and to prevent

feeling overwhelmed (white fragility). The experiences of anxiety and discomfort ranged across participants, with an overall sense that each participant had experienced this fragility within at least one therapeutic interaction. Participants explained the ways they managed this through various processes (see 4.2.2) but they did not want to be perceived as a racist person, and the experiences of these negative feelings were difficult to sit with in the moment. The subtheme ‘certainty in audience’ reminded the researcher of Barry Mason’s ‘Safe Uncertainty’ (1993), and the idea that certainty is a natural reaction, sought by all humans. Mason argues that in seeking certainty, curiosity and creativity are stifled.

Feelings of complicity in institutional racism raised the most difficult emotions. This supports Ahsan’s research on whiteness within CP (2020). D. Sue (2015) talks about the conspiracy of silence, and how those faced with the topic of race choose to remain silent. Within a team context, participants described how they had chosen silence, and therefore complicity, when others acted racist or spoke about racism and how change could occur within services. The researcher wondered about the interplay of sexism for female participants who may feel silenced within these team contexts (Swim et al., 2010). Silence enabled participants to ‘manage feelings of uneasiness’ however, some talked about how they were trying to find ways to move beyond silence and speak more in team contexts (theme three: ‘commitment: *“antiracism is a lifelong journey”*’).

The subtheme “easier to do nothing” from theme two demonstrated avoidance of engaging at service level because the emotions were considered too challenging, or the solutions felt too difficult. Psychodynamic understandings of defences (denial and splitting; Ahsan, 2020; David, 2011) were seen in how participants responded to clients and colleagues, to avoid being perceived as a racist. Participants in this study shared that their curiosity about a person was shut down somewhat by their anxiety and the defensiveness they experienced. Bhui (2012) theorised that transference reactions between client and therapist can lead to therapists feeling defensive. Whereas Goldsmith found that transference can provide useful insight into racialised client’s

difficulties (2002). It could be argued that in this study participants' experiences were both unconscious defences and transference responses.

Theme two 'Proximity to racism' shows how participants' varied experiences of talking (or not talking) about race and racism were influenced by the frequency they had done it, and how they positioned themselves during these conversations. Silence is one way that white individuals are known to manage the feelings that arise when race and racism are discussed (Eddo-Lodge, 2017; D. Sue, 2015). Similar to Knox et al., (2003), some participants in this study reported not always addressing race unless the client discussed it. The subtheme 'easier to do nothing' captured how participants used avoidance to manage the experiences of anxiety that the topic of racism raised. This has been shown within other therapeutic professions (Cardemill & Battle, 2003; Dos Santos & Dallos, 2012; Leary, 1997), which led to the discussion of race differences becoming 'forbidden talk'. Farooq (2015) argued that racism had become 'forbidden talk' within the profession through the conceptualisation of distress, dominance of individualistic approaches and the language of 'diversity', which was considered to be true with some participants.

For some, avoidance of the talking about race and racism was not an option. The subtheme 'integral to a CP's role' captured how some participants viewed talking about race and racism, and would therefore name this with their clients, supervisors and in teams. The power dynamic between therapist (white) and client (racialised) influences the ability to name race differences and talk about race (Dos Santos & Dallos, 2012; Hardy, 2008). In this study, participants recognise their responsibility as a white CP in raising the topic of race and racism. Some waited for clients to raise the topic of race in the past or had a sense of relief when clients had named race or racism, but prefaced this with knowing it was problematic, and still viewed it as part of their professional responsibility.

When a client or colleague raised racism, and it became inevitable for participants to talk about it, language choice was a way that they could avoid talking about racism. Furthermore, the language of participants varied across

the interviews, which gave insight into how confident they felt in talking about race and racism when they had to (see 4.2.2). The lack of naming racism but using language of *"cultural difference"* or *"diversity*" has been noted throughout the literature as a way for white therapists to avoid facing their own emotional reactions to the structures that enable and perpetuate race divisions (Utsey et al., 2005). Whilst Utsey et al. (2005) found therapists often struggled to name themselves as white, and to name clients as black, participants in this study described naming race differences, and naming their whiteness (and other 'social GGRRAAACCEEESSS'), as a way to introduce the topic and open up the conversation, in the hope to talk about racism later in therapy. Overall, talking about race differences was seen as relevant and positive for the therapeutic relationship, supporting previous literature (D.W. Sue & D. Sue, 2002; Knox et al., 2003).

The timing of this study resulted in many participants talking about the current socio-political shifts in talking about race and racial inequality. Various participants shared how they had talked about the BLM protests with racialised clients in recent months, however there were participants who shared how prior to this, there were times when they could have spoken about race and then racism with clients or in teams but chose not to. Similar to Gushe & Constantine (2007) participants demonstrated awareness of racism within society, whilst also reflecting on times when they had been less aware, and historically avoided talking about it with clients and colleagues.

Theme three 'Commitment: "*anti-racism as a lifelong journey*"' encapsulates the experiences of participants outside of therapy, within their supervision, own self-reflection and within teams. Taken from participant 11's interview, this quote has also been stated within the literature (Case, 2012; Saad, 2020), and they acknowledged having understood this from their own anti-racism reading and research. Unlike Erskine (2002), where therapists are encouraged to self-reflect on their own relationship to racism, the findings show that it is understanding the relationship to and impacts of whiteness, that are more meaningful for the white CPs in this study. The exploration of whiteness, and commitment to anti-racism provides a deeper level of

reflection. Self-reflection was used to explore uncomfortable emotions, like Erskine (2002), and taken further by linking this to the impact of their whiteness. 'What my whiteness does', explored more in 4.2.2, captured how participants demonstrated an awareness of their whiteness and ensuing privileges, and were navigating ways to understand and own this more.

4.2.2 What hinders and facilitates these experiences?

Participant's accounts varied vastly and provided a dichotomy of situations that either hindered or facilitated their experiences. Some contexts and dynamics that facilitated participants were also considered a hindrance to others. The results demonstrated that some white CPs had navigated through their experiences to secure ways to facilitate and build up their confidence.

All participants talked about how supervision influenced their ability to talk about race and racism. The way supervision facilitated these experiences is explored through subthemes 'certainty in audience', 'integral to a CP's role' and 'holding the power for change'. Supervision is considered a place to explore assumptions and biases (BPS, 2017) and *"enhance the quality and competence of practice offered to all clients"* (BPS, 2014, p. 15). Ryde (2009) also argues that attending to one's own whiteness in supervision, rather than focusing on the experience of the racialised client, could be useful for professional development.

The non-judgemental and open supervisor was described within 'certainty in audience' as a facilitating factor for participants to talk about racism in relation to their client and unpick the relational dynamics that were influencing the therapeutic relationship. The idea of *'safety'* (and lack of) in talking about racism is well documented and considered for racialised CPs (Desai, 2018; McNeil, 2010; Shah, 2010). In defining white fragility, DiAngelo states that *"whites often confuse comfort with safety and state they don't feel safe"* (2011, p. 61). Participants talked about "safety", and "white fragility" in numerous dynamics, particularly supervision but some recognised this need for "safety" as problematic in cross-racial dyads. The emotional and relational risk taking

that is perceived by white participants indicates a lack of experience connecting with discomfort of racism. Therefore, it is important to acknowledge that white CPs seek to feel contained and supported within their supervision space, however the researcher warns against the conflation of containment and safety, due to the need to ensure racialised individual's safety is protected.

The supervisory dynamic was also explored as a hindrance. Lack of *"safety"* or 'certainty in audience' impacted whether participants used supervision to reflect on their racialised clients and the emotions evoked in them. Equally, team discussions about systemic racism were impacted by participants' supervisors valuing the conversation (or not). Participants noted *"both being white"* or supervisors "*not getting it"* as a barrier to meaningful reflections. Supervision is a space for 'white-centric' and 'cultural' assumptions to be wondered about and challenged in a useful way (Ryde, 2019), whilst attending to power dynamics, for both supervisor and supervisee (N. Patel, 2013).

Perceptions of supervisor as 'expert' (Desai, 2018; Pendry, 2012), impact how individuals view their supervisors' ability to talk about race and racism. Participants with racialised supervisees shared discomfort of holding dual power as supervisor and white in the dynamic. The fear of being perceived as racist within this dynamic felt more challenging, given this position of power. The (un)certainty in this audience, and ideas for change, have been explored in more depth by Desai (2018).

Dilemmas of raising (issues of) race are acknowledged as both strengthening and worsening supervisory relationships (Cardemil & Battle, 2003; McLeod, 2009), and it is argued that the supervisor, as the person with more power holds more responsibility to then name race and racism (Adetimole et al., 2005; N. Patel, 2013). Supervisors have an ethical responsibility to be creating a space to talk about race and racism (Desai, 2018), which is shown through subthemes; 'integral to clinical psychologist's role' and 'holding the power for change'. The results indicate how, irrespective of race, the power

within the supervisor to facilitate conversations about race and racism is invaluable.

The results, along with previous research (Dos Santos & Dallos, 2012; Pendry, 2012), call for supervisors to be engaging in conversations about race and racism, and be willing and able to hold the emotions that are evoked within the supervisee. White supervisor's stage of white awareness was seen as a hindrance for participants, which supports previous findings in counselling (Imig, 2018; M. Patel, 2014) and clinical psychology (Desai, 2018). Supervisors need to set up a space to facilitate supervisees to feel able to talk openly about race and racism, without fear of being judged as a bad person, lacking knowledge or as a racist.

All participants acknowledged their whiteness as problematic within race-dyads. The subtheme ‘what my whiteness does’ seeks to demonstrate how participants understood the invisibility of whiteness and their complicity. As already discussed, whiteness enables silence within the therapy room and within team discussions. The researcher was pleased with the lack of silence within the interview. The retrospective account allowed participants to talk from an intellectual position of ‘what my whiteness does’ (reflection), yet not all participants described being able to act on this within the interaction with a racialised individual (action; lack of praxis). Some had named a desire to develop praxis (Friere, 2018), whereas others had achieved this.

Theme two ‘proximity to racism’ provided a range of understandings to answer this question. The geographical context of participants’ training and working environments impacted on how frequently they worked with racialised individuals. Previous studies have not addressed the geographical location of therapists, which provides a new layer of information to the results of this research. There were marked differences in participants’ experiences of talking about race and racism for those working in rural vs urban areas. For white CPs working in rural areas, they described rarely encountering racialised individuals, and reported working in (almost) all white teams, so it was ‘easier to do nothing’; whereas those working in urban areas talked about

working with racialised individuals frequently and being able to talk about racism as ‘integral to a CPs role’. As previously noted, regions of the UK have large variations in the numbers of racialised individuals living in particular areas. No area in the UK is immune from the effects of racism; growing up as one of few racialised individuals, as the researcher did, there is a spotlight on a person’s ‘difference’, and their racial identity, whereas growing up in ‘multicultural’ areas, social inequality and structural racism are particularly problematic. Whilst ‘ethnic density’ is considered a protective factor for the impact of racism on MH (Shaw et al., 2012), there is a need to be able to work with this within therapy. Irrespective of where you are living, a white CP should view this as ‘integral to Clinical Psychologist’s role’.

The subtheme ‘easier to do nothing’ represented the lack of action and in the language used, explored below respectively. Service pressures and lack of time contributed to an avoidance of addressing race and racism as part of the therapeutic work. Working in NHS services with targets, waitlists and large caseloads was used as a reason for people not talking about racism when it could have been important for the client. Equally, it was named as a further reason for teams not exploring racism at a structural level. Whilst it could be argued that this is an understandable reason – you are working therapeutically with someone for a specific reason (e.g., their drug addiction), it could also be considered ignorant to ignore the role racism may play in a person’s distress.

This externalising of responsibility for talking about race and racism both within therapy, and within teams was a hindrance, however it could be understood that this is how participants are rationalising their behaviour (or lack of). White CPs who are not supported within their teams, by supervisors and managers, may continue avoiding talking about racism, as they follow the behaviour of those in authority (with more power). Equally, supervisors and service managers who do not prioritise this, create an environment which feels non-inclusive and “unsafe” for participants to talk in ways they would like. Team context and working culture have not been explored within literature talking about race and racism, however the understanding of the

NHS as institutionally racist (Kline, 2015; Mitchell, 2021) indicates why participants may not feel able to address this within their teams. Alongside the ethical and legal duty of CPs, this study highlights the importance of anti-racist team environments to create space for white CPs to talk about racism within their role.

Language variation provided an insight into how participants positioned, or hoped to position themselves in relation to race, racism and anti-racism. The researcher noted increased fluidity in anti-racist language and literature in those who had trained more recently. Conceptualising racism as the oppressive and dehumanising act that it is moved these participants beyond a place of avoidance, allowing them to own their whiteness and manage the discomfort that it raised. Naming racism, oppression, discrimination and injustice in relation to a client's experience provided the vocabulary that facilitated participants to talk at both an emotional and intellectual level. This is linked to how authors describe a need to consider whiteness and its invisible influence when racism is discussed (Ahsan, 2020; Wood & N. Patel, 2017).

In contrast, language of *"difference"* and *"diversity"* felt the most appropriate way for some to approach talking about racism. The conflation of race with other intersecting identities prevents the critical perspective on whiteness. In the same way that examining sexism and ableism is steeped in patriarchal structures, addressing racism for what it is, an ideology of white superiority, can helpfully position a conversation about racism away from invalidating. Whilst previously discussed in 4.2.1, language around social GGRRAAACCEEESSS was described by some as an opening for a conversation about race (facilitator), whereas others talked about feeling that the homogenising of difference on DClinPsy training was problematic for their learning (hindrance).

The subtheme 'integral to Clinical Psychologist's role' encapsulated the way participants conceptualised their professional obligation to engaging with this topic. Training, supervision and services were all environments that

inconsistently reinforced this notion. As Dogra et al. (2007) found that ‘cultural competence’ can reinforce negative stereotypes, the way CPs are trained to think about race, culture, and ‘diversity’ had somewhat negatively shaped participants language and thinking about racism. Vera & Speight (2003) called for ‘multicultural competence’ to be grounded in commitment to social justice. These findings support the idea that the interlinking values of social justice and antiracism (and talking about racism) are all integral.

Similar to M. Patel (2014), the notion of ‘competence’ in talking about race and racism is not as simple as other clinical competencies that are required for clinical psychologists. ‘Cultural competence’ has been part of the agenda for DClinPsy training for decades, but the interpretation of this into practice has some clear gaps and challenges (Tribe, 2014; Wood & N. Patel, 2017). Within this study, the process of anti-racist praxis was suggested as a preferred ongoing point of development. This life-long journey acknowledged in this research highlights that ‘competence’ is not the construct CPs should aim for. An iterative, anti-racist cycle, that builds on Ryde’s WAM is necessary within individual’s personal and professional development (see 4.2.3).

Furthermore, the distancing and intellectualisation of racism by white therapists is well documented in the literature (Ahsan, 2020; Cardemill & Battle, 2003; M. Patel, 2014). Some participants described this as facilitative throughout their career, whereas others described reflecting on their emotions in a connected and embodied way as more powerful. Theoretical frameworks to understand the impact of power and oppression should provide an intellectual foundation for then working with the embodiment of emotions that may arise. Many participants acknowledged that this foundation had been laid on DClinPsy training, but the experiential learning had been lacking. The results show that it is insufficient to sanitise the emotional impact of racism, of the client, and the subsequent reactions of the white CP, in order to authentically work with the emotion in the therapy room. The integration of intellectualisation and embodiment should be integral to the training and practice of CPs.

Following the influences of DClinPsy training, participants described the impact of their upbringing on their relationship to whiteness, racism and their professional identity. Dos Santos and Dallos (2012) argued that dominant cultural discourses minimise or prevent race conversations within therapy. However, participants talked about their own experiences of minority identities (of gender and class) or living in countries outside the UK as facilitators for engaging in conversations about race. The values of humanity, equality, social justice was mentioned by numerous participants as 'integral to Clinical Psychologist's role', which in turn influenced the way they related to others and 'managed feelings of unease'.

Theme three 'Commitment: "*anti-racism is a lifelong journey"*' outlined participants account of various facilitating factors for them engaging in talking about race and racism and thinking about wider systemic ways to change racism within the services. Participants talked about reflection being more commonplace than action. As explored in liberation psychology (Friere, 2018), a lack of praxis is detrimental to the reflections themselves. Participants valued the reflective spaces they had to talk about race, racism and racial inequality, as already discussed, yet this was insufficient for many to not see the structures of their working environment change. Participants articulated their relationship to the profession, and how they viewed the need to move beyond reflection into action. The mixture of experiences across the sample demonstrated to the researcher how inconsistent the profession is within the 'anti-racism journey'.

Social discourses related to the BLM protests heavily influenced how participants felt they were 'holding the power for change'. Participants referenced books such as *White Supremacy and Me* (Saad, 2020), *White Fragility* (DiAngelo, 2018) and *Why I'm No Longer Talking to White People About Race* (Eddo-Lodge, 2017), which provided a framework for how they talked about understanding their whiteness. Some shared how they had previously wilfully remained ignorant and avoided stepping forward for systemic change within their roles, which on reflection raised negative emotions of guilt and shame as described in theme one. Some participant's

sense of political activism had been (re)engaged through the recent global events, and they were working through ways of integrating this into their work. Participants all noted the power dynamic present between themselves and the racialised other, as discussed above, the power as a white individual needs to be recognised and acted on (Pendry, 2012). Power within teams was not always a facilitator. The complexity of the unconscious processes within team dynamics (Stokes, 2019) was clearly being played out, as participants experienced the challenges of trying to change or influence systemic inequalities.

The subtheme 'stuckness: don't stop there' highlighted a facilitating factor for participants in their experiences. Compassion was described as a process during reflection or within supervision, that enabled participants to understand their responses differently, and to develop their future practice. Compassionate leadership is an NHS priority (de Zulueta, 2015; West et al., 2017), and the results show that participants who were supervised with and facilitated to work with compassion benefitted in their anti-racist practice. There is evidence of 'feeling under attack' and the psychological 'defences' that occur for white individuals in conversations about race and racism (Cardemill & Battle, 2003; DiAngelo, 2018; Kendi, 2019), which link to participants use of CFT model and the threat system. Use of a psychological framework is an example of intellectualising, rather than embodiment of experiences, which has been critiqued within this discussion. However, given that this psychological framework, and the human quality of compassion, was seen as facilitative for participants, it is important to consider.

4.2.3 Ryde's White Awareness Model (2009)

Ryde's model provides a helpful starting point for CPs to consider their whiteness, and the impact they have within race-dyads. The iterative nature of participants' experiences maps onto the cycle that Ryde describes. Given the self-selected nature of participants, denial of racism and whiteness would be unexpected. However, Ryde outlines nuances of denial that can be seen (see appendix A). Ryde describes individuals being 'well-intentioned but don't get

it'. The final two levels of denial within this model ('colour-blind' and 'liberal angst') could be seen within these results. Participants reflected on experiences when they had behaved from a colour-blind perspective or been guilty of holding 'white guilt' indicating that denial within the profession should be taken seriously, even with those who view themselves as anti-racist.

Across the themes, there are several processes described by participants that indicate they might be moving between the stages of Ryde's WAM. Guilt and shame were named in relation to talking about the impacts of structural racism with clients and colleagues. Reflective spaces and appropriate supervision facilitated the exploration of their whiteness and engaging with educating themselves to accept their complicity. Some shared how they had or were beginning to integrate their white privilege and it's impacts into their identity, both personally and professionally.

This model provides a helpful starting point for white CPs to understand the processes of experiences. This model could more helpfully engage CPs with the integration of psychological theory such as CFT or psychodynamic ideas. Building on a language that is familiar to the profession will integrate the (preferred) intellectualising with the embodied experiences. The integration of compassionate antiracist praxis could helpfully prevent individuals from reverting to stage one (denial). Practical and sustainable ideas for personal development, within supervision, group spaces and personal time, are needed to hold individuals to account and keeping whiteness at the forefront of their minds.

4.3 Process-Based Aspect of the Interviews

At the end of the interview, some participants shared that this was the first opportunity they had been given to reflect on what influences their experiences in relation to talking about race and racism within their role. Unlike M. Patel (2014), where the researcher explicitly focused on working with ethnic difference and purposefully did not focus on clients talking about

racism, participants in this study were able to reflect on this throughout the interview. Participants shared that it was helpful to reflect on their values and think about their anti-racism journey.

4.3.1 Staying connected to personal experiences and responsibility

Whilst the results provide rich data related to the experiences of talking about race and racism within therapy directly with clients, the majority of the interviews were spent talking about team dynamics, systemic issues and personal relationship to social justice. The unconscious desire to focus on the 'other' and reject the emotions raised when thinking about an individual's own role (and complicity) in racism is understood within psychodynamic literature (Lowe, 2014). These unconscious processes need to be acknowledged and validated within Clinical Psychology, in order for individuals to engage with and resist against accordingly.

4.3.2 Participant reflexivity

Reflexive questioning at the end of the interview provided further understanding of how participants had experienced the interview process. The researcher was particularly interested to explore how it felt to be interviewed by a racialised researcher. The researcher was curious about whether there was a mirroring of experiences through the interview dynamic, and whether this process impacted on the content of the data. Participants noted they *"would be less worried if you were white"* and "*it's not an easy topic to always kind of say everything that you think and feel because you have to be careful about not hurting or upsetting people"*. Hearing these accounts impacted the interpretation of the data somewhat, as the researcher questioned how honestly participants felt able to share their experiences.

Participants reported how the interview had been framed in a way that they did not feel they would be judged and wanted their experiences to be helpful. The certainty the researcher provided to participants that they would not be judged matched with the subtheme 'certainty in audience'. However, it was noted that participants felt they *"had to think harder"* and they were *"aware of*

getting it right". Many noted that their uncertainty of the researcher's race had been on their mind and felt the conversation would have been even harder if the researcher was black given the context of talking about BLM, and their experiences working with black clients. Overall participants reported feeling *"uncomfortable…maybe some of that is a healthy discomfort"*. It is unsurprising that the experiences participants described in their therapeutic work was similar to the experiences they were describing within the interview, given the racial dyad created. This was held in mind during the interpretation of the data.

4.4 Implications

The research findings suggest that white CPs have and can talk about race and racism within their role, despite the experiences they have being somewhat aversive. Exploring the hindering and facilitative factors related to these experiences have implications for future research and recommendations for clinical practice, training and policy.

4.4.1 Research

To the researcher's knowledge, this is the first UK study to explore the experiences of white CPs talking about race and racism. The study findings add to studies exploring whiteness in the profession (Ahsan, 2020; Wallis & Singh, 2014). Alongside research examining the experiences of racialised psychologists in the profession (McNeil, 2010; Odusanya et al., 2018; Shah, 2010), there is a consistent message of the need for further research and training into the whiteness of the profession and ways to enable talk of race and racism.

Based on the results generated, a number of studies could be conducted. A study comparing the differences in white CP's experiences (of talking about race and racism) by DClinPsy training or geographical working location. The socio-economic and political context of these locations will influence participants' experiences; this data can be further influential in deconstructing

the origins of individual's experiences, and support more targeted recommendations for specific courses or regions. It may also be worthwhile to examine white CP's experiences through Conversational Analysis, or Foucauldian Discourse Analysis to examine individual accounts in more detail or the power implications of how race and racism are talked about by white CPs respectively (Bloor & Wood, 2006; Willig, 2013).

The researcher's racial identity and experiences of racism impacted the researcher's interpretations of the data to provide one perspective of white CP's experiences as discussed in section 4.5. The injustice felt at hearing how racism had been invalidated or not given the space it needed during therapeutic work evoked strong feelings for the researcher. Researchers have an ethical duty to capture the richness/breadth of white CPs' experiences and ideas to promote change, whilst also protecting themselves from the emotional impact of the data. Research by other racialised or by white researchers could add to and further these findings, to move the conversation forward.

4.4.2 Recommendations

There is a wealth of resources frequently signposted to facilitate anti-racist practice, some of which have been mentioned throughout this report. The researcher has benefitted from other individuals' signposting lists (see appendix M) and directs the readers to McKenzie-Mavinga's book (2016): *The Challenge of Racism in Therapeutic Practice: Engaging with Oppression in Practice and Supervision* as a starting point.

A multi-prong approach is necessary for effective systemic change. Commitment from all stakeholders; qualified and trainee CPs, supervisors, service managers, commissioners, DClinPsy course tutors, and professional bodies is vital in anti-racist practice. Committing to anti-racism and becoming confident in talking about race and racism requires both embodiment and intellectualisation to succeed. The recommendations for training can also be taken into clinical spaces.

4.4.2.1 Training

The separation and integration of ‘diversity’ training within the curriculum have both been criticised. De-colonising the curriculum to integrate non-western healing approaches and skills, awareness of the history and politics underpinning psychological imperialism, and critical evaluation of the underlying assumptions, implications and relevance of dominant psychological approaches will engage the intellectual capacity of trainees, to enable them to work with racialised clients who hold different world views and experiences to white trainees (Wood & N. Patel, 2017). However, it is insufficient for training to simply focus on intellectual frameworks and theoretical underpinnings of race and racism, as this distances trainees from the emotional impact of being in the room with a client, and the transference that may be experienced (Bhui, 2012).

Sanitising the pain of racism is a privilege afforded only to white individuals. Emotional connectivity to and embodiment of whiteness, and the influence white CPs have within the therapeutic dynamic, needs to be experienced through structured facilitated spaces. The complex nature of power and its operations within training results in trainees often feeling powerless to change within the systems they exist. Spaces and support to examine and change their internal relationship to racism, as well as finding ways to change clinical practice to be anti-racist can begin. The power to change once qualified is a message that needs to remain at the forefront of individuals’ minds.

For trainees to be able to develop these skills, course tutors and placement supervisors must see this as integral to their role as educators within the profession. They too must embark on the journey of anti-racism and understand their own emotional defences and reactions to talking about race and racism within their jobs. Again, this requires spaces that engage in the embodied, emotional relationship to whiteness and racism, and a commitment to change within themselves.

4.4.2.2 Clinical practice

Creating a space for people to feel ‘safe’ in getting it wrong, will help develop the confidence described by participants who talked about race and racism within their role regularly. Individual (supervisory) and group spaces that enable an embodied experience of confronting whiteness; sitting with the internal experiences as a place that enables change.

The need to commit to anti-racism and see this as integral to the role of CP has implications for the way service managers and supervisors develop their workforce. Supervision training which focuses on operations of power and oppression within the profession can facilitate supervisors integrating these conversations and approaches in their practice, and with their supervisees. Values based recruitment, that examines how individuals view their whiteness, and their ability to develop anti-racist practice is essential. Equality and social justice are crucial and must be seen as integral to a CP’s professional identity. Compassion as a proponent of anti-racist practice can be developed through theoretical understanding of psychological models of compassion and embedding compassionate leadership within psychology services (West et al., 2017). The integration of training and reflective spaces within job plans, and line managers who facilitate and protect time to support the development of these skill are essential in creating sustainable change.

Theme two highlighted the proximal positioning of white CPs to racism within their professional role and their personal identity. Irrespective of geography, racialised clients deserve to be offered ethical therapy where their CP is willing and able to talk about their experiences of racism. White CPs, and trainees, who work in rural, predominantly white areas of the UK, must recognise, value and prioritise these recommendations as much as those working in urban areas.

4.4.2.3 Policy

Structural change must be taken by professional bodies. The researcher calls for the BPS Diversity and Inclusion Taskforce (BPS, n.d.), and the DCP

Equality, Diversity, Inclusion and Anti-racism Task and Finish Group (BPS, n.d.), to take these recommendations and create explicit practice guidelines and training spaces for white CPs. A revision to the BPS practice guidelines (2017), which goes beyond stating that psychologists are expected to understand the nature and history of racism, and provides explicit guidance on how to do this, with signposting to reading, resources and training that would benefit its members.

4.5 Critical Review

This research was assessed using Yardley's (2000; 2011) principles, given they are theoretically flexible and broadly cover domains identified within a systemic review of published criteria (Cohen & Crabtree, 2008). Key strengths and limitations will then be outlined.

4.5.1 Sensitivity to Context

This study was grounded in the current socio-cultural setting and relevant theoretical literature outlined in chapter one. Additionally, the researcher continually interrogated their position in relation to the literature and participants, to consider the social context and influence of this on different stages of the study through supervision and journaling. The Covid-19 pandemic and BLM protests had real consequences on participants at the time of the interviews. This influenced their responses and awareness of the sensitivity of the conversations. Aspects of the researcher's identity and relationship to the research topic were considered in chapter two.

4.5.2 Commitment and rigour

A conscious attempt was made to represent and understand the complexity and variation observed within participants accounts based on in-depth engagement with the data, alongside longstanding engagement with the topic. The researcher immersed themselves in literature about racism, it's impacts on MH, and how white individuals talk about racism, attended webinars and co-authored literature related to racism within clinical psychology (Mintah et

al., 2020; Rao et al., 2020). This enabled the researcher to connect with and thoroughly understand the professional dilemma that led to this research study. Throughout the process, the researcher consulted with supervisors, white CPs and racialised peers. This was particularly important in the beginning to inform the language and content used within the recruitment materials and interviews to maintain some neutrality.

Supervision was integral to ensuring rigour in the design and implementation of this research. To ensure methodological competence, the researcher immersed themselves in the data through an iterative process of reading and re-reading the data and linking codes and themes back to quotations during the analysis over a three-month period.

4.5.3 Coherence and Transparency

TA was chosen in order to gain a broad understanding of the experiences of CPs, whilst producing rich qualitative data and aligning with the epistemological stance of the research. Transparency was maintained through clear documentation of the research process in chapter two and interview extracts in chapter three to account to the analytic procedure.

The research made a conscious effort to stay alive to the effect of their actions and status as a racialised trainee CP, with their own experiences of talking about racism in therapy and used a reflective journal to facilitate this throughout. Suffice to say, the researcher's prior understanding of talking to white CPs about racism was challenged throughout this process, often in unexpected yet also positive ways. Reflexivity (section 4.5) further outlined the impact of the researcher's assumptions, intentions and actions on the research process and findings.

4.5.4 Impact and importance

This study hoped to shine a light on previously unheard experiences in conversation about race and racism within Clinical Psychology. The dominant white voice is understandably side-lined in order to raise up the voices of

marginalised stories. The results offer valuable avenues for progressing the profession towards anti-racist practice (see 4.6).

4.5.5 Strengths and limitations

4.5.5.1 Timing: socio-political context

The timing of data collection is important to acknowledge. The research was advertised from July-October 2020, in the weeks that followed the global BLM protests and social race discourses. The researcher was acutely aware of the impact this could have had on participant self-selection and the content of the interviews.

A prompting question was used when participants did not raise it organically (see appendix I), with participants naming the protests shaping participants' current relationship to racism and influencing their conversations with clients and teams. Some participants had very few experiences in their career of talking about race and racism in therapy. The researcher considered that partaking in the research was motivated by a social and personal pressure to be engaging in anti-racist practise following the protests. These interviews were interesting to explore the barriers to this, and unpick how this may have occurred, but provided less data for the research question 1. Had the data collection occurred prior to this, the participants and data may have been very different.

This research also occurred during the Covid-19 pandemic. The disproportionate deaths of racialised individuals were acknowledged by some and led to participants talking further about structural racism in the context of health inequalities. However, this is somewhat limited within the themes. The practical impact of the Covid-19 pandemic on the research process was limited. There was an added benefit of use of remote interviews as this resulted in a wider range of participants from across England and Wales. The ability to connect remotely with other trainees researching similar topics was a further strength to the project. In line with the critical realist epistemology, the results of this research need to be read within the context of these global

events, in how they influenced the participants and researcher throughout, and in the knowledge that was produced.

4.5.5.2 Sample: characteristics and size

Participation was voluntary. As mentioned, the sample of participants will have been influenced by the impact of global events at the time of recruitment. Remote interviewing facilitated the recruitment, resulting in a larger sample size than expected. This was a benefit in gathering a range of experiences.

Towards the end of the recruitment period, the researcher and research supervisor reflected together that all participants were female. Discussion considered whether there were differences in experiences of talking about race and racism that could be understood across gender/sex. A tentative hypothesis was explored about the gender differences in who values this research topic, who is doing this in their work and who is willing to talk about it even though it may be challenging and exposing. Two males participated towards the end, and whilst this sample may not fully represent the views and experiences of the profession of clinical psychology, the ratio of male to female participants mirrors the demographic of the profession (DCP, 2015).

The decision to interview self-identified white CPs allowed an open interpretation for participants in defining their ethnicity. The broad inclusion criteria resulted in individuals who had experiences of marginalisation through their ethnicity and culture e.g., white Irish, Jewish, South African. The researcher was aware of inadvertently homogenising participants similar to the way that racialised individuals critique services and policies. The results demonstrate the nuances of experiences in a way that should accurately represent the heterogeneity within the sample.

4.6 Reflexivity

Reflexivity is a key aspect in conducting ethical research (Attia & Edge, 2017) which can be considered in three forms: personal, epistemological and critical language awareness (Willig, 2013). Discussions held in supervision, alongside a reflective journal, facilitated conscious decision-making and an evolving awareness of the choices taken in relation to the research. This reflexivity is an interaction that is context dependent and context renewing (Attia & Edge, 2017); however, the researcher was also aware that not all decision-making is conscious (Ross, 2017).

4.6.1 Personal reflexivity

During the research process the researcher was pushed and challenged in numerous ways. From the onset, the researcher's relationship to racism was shaped by socio-political and personal events of the last two years. Many events, including the GTiCP conference and BLM protests, influenced the interpretations made in the analysis and how the researcher has presented the information throughout this report. The researcher noticed a focus on inequalities for black individuals over other racialised groups during their literature searching. There is no one time point that remains immune to structural racism, however, the involvement in this research, during a global pandemic, brought these issues into sharper light for the researcher.

The researcher was aware that participants may fear saying the 'wrong thing' with a racialised researcher, which could impact the richness of the data. The researcher attempted to manage this in how the interviews were set up and the aims of the research explained. As a trainee CP, the researcher was also aware of attempting to make the participant feel comfortable, in a similar way to therapeutic settings, and limit the distress experienced by the researcher-participant interaction. This led to a hesitance to probe about participants' experiences that they regretted or were associated with feelings of shame, therefore impacting the type of data collected. Reflexive questioning explored this with participants (see 4.3.2). The researcher and research supervisor

reflected on the influence of their racialised identities within Clinical Psychology and personal experiences impacting their assumptions about white CPs' experiences. The analysis of the data and the results may have been different if the research supervisor was white.

Furthermore, as a British-born and educated second-generation immigrant, the researcher holds some Western ideologies about MH and talking therapies. Whilst taking a critical perspective to examine the literature and data, it was important to reflect on blind-spots in their own world view that could perpetuate racist/Eurocentric ideas. The researcher is aware of the social and educational privilege they hold (Savage, 2015), and how this could inadvertently marginalise other voices.

The researcher had emotional, cognitive and visceral reactions to what participants said within the interviews, both at the time and whilst transcribing. Listening to participants describe the racism their clients had experienced, as well as hearing how participants thought and responded to these was emotive. This influenced the direction of coding and initial themes, for example, increased coding of participants describing their own behaviours of explicit acts of racism. The researcher noted a reluctance to then include quotes that may highlight participants working in unethical or racist ways. This could have been due to an unconscious defence of the researcher to not engage with this part of the data, as well as the researcher's reluctance to potentially offend participants through the write-up of the results. This was discussed in supervision, and the researcher reviewed the analysis further. During analysis, the researcher also noted a reluctance to develop a subtheme of whiteness. The researcher felt this would be centring white issues and permitting white privilege within the dialogue about racism (Wallis & Singh, 2014), rather than labelling it as problematic. This was discussed in supervision and the subtheme was shaped accordingly.

It is evident through this research, and through engaging more widely within the profession, that talking about race and racism for white CPs is both sensitive and challenging. This research process has made the researcher, as

a racialised psychologist, more determined to work ethically and professionally with topics of race and racism, and utilise the knowledge generated within their own practice.

4.6.2 Epistemological Reflexivity

It is important to acknowledge the limits of the knowledge produced. The critical realist epistemology resulted in both semantic and latent interpretations of the data. Whilst what participants said was taken as a reflection of their own thoughts and experiences, considerations for the influence of the socio-political and cultural contexts they live in were crucial. Race is not considered to be a definitive, objective construct with biological bases; however, the consequences of race dynamics in the UK have shown to have an impact on how whiteness has influenced participants' experiences. The researcher remained aware of the challenges of interpreting what the participants said in a way they may not have been consciously aware of, for example, the impact of their whiteness (Willig & Stainton-Rogers, 2007). The researcher was also cautious of imposing judgements on participants in the retelling of their accounts. The researcher's own moral and political positions and experiences (of racism, for example) rather than epistemology and ontology (Nightingale & Cromby, 1999) has heavily influenced the formation of themes and overall analysis.

4.6.3 Critical Language Awareness

This domain of reflexivity requires consideration for how the use of language may have affected participant's responses. Awareness of linguistic constructions has been essential to this research. The researcher and research supervisor were aware of carefully considering the constructs used within the research questions, however, there were times during the interviews where prompting or follow-up questions may have inadvertently implied the researcher's interpretation of what had been said (see appendix L). The researcher was mindful of using the participants' language for follow-up questions to ensure the constructed meaning was utilised, however, at times the researcher noted a reluctance to use terms they find problematic

(e.g., ‘BAME’ or ‘diversity’), as previously discussed. With this in mind, the creation of themes through the researcher’s language may have removed an element of the participants meaning, however, the use of quotations was aimed to bridge this gap.

4.7 Conclusion

This study explored white CPs’ experiences of discussing race and racism in therapy, and what may influence these experiences. Three themes were identified using TA; ‘I’m not a racist, even when I get it wrong’, ‘Proximity to racism’, and ‘Commitment: *“anti-racism is a lifelong journey”*. These themes provide a novel account of white CPs’ experiences, building on the research base and link to Ryde’s White Awareness Model (2009).

The participants of this research gave honest and authentic accounts of their experiences, and how they hoped to develop going forward. The results suggest ways white CPs could approach their work differently. Regardless of values and ideology, the results highlight a need for CPs to prioritise and become more confident in addressing race and racism as integral to their role. This study has shown that white CPs can move beyond their whiteness and get started with talking about race and racism in therapy.

Throughout the research process, the researcher was struck by the dominance and persistence of white supremacy, both within the profession and across society. Despite feelings of exhaustion, the researcher is committed to continue talking about race and racism in the presence of white people, particularly CPs, and strive to make this common place within the skills and values of this profession. It is likely to be an uphill battle, but overall, the results highlight that despite challenges experienced by the participants, conversations about race and racism are necessary. The hope is that this project has encouraged the reader to see their own agency for change in their clinical practice. The researcher urges CPs, supervisors, trainers and professional bodies to address these issues. This will require a combination of

training, supervision, individual reflection, wider public engagement and informal everyday awareness raising.

It is important to acknowledge that this study did not want to appropriate or invalidate the pain of radicalised individuals through only focusing on white individual's experiences (Anderson, 2003). There is a hope that by shining a light on the specific areas that hinder white CPs, they can take this knowledge forward to *"put our own house in order"* (Rao et al., 2020, p.3) and better meet the needs of racialised clients.

In the words of retired clinical tutor, Dr Nick Wood, who showed this researcher that it is possible for CPs to sit with the emotions and experiences of talking about race and racism as a white individual:

> Unless we can find a way to fully engage the dominant White membership of the society with a genuine and deep-seated commitment to not only want 'diversity', but to examine (and challenge) their own (and others) positions within privileged White structures, attempts to make headway will be nothing more than saying the right words (performative whiteness). (2020, p. 4)

Take this research and move beyond performative whiteness and commit fully to anti-racist practice.

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6 APPENDICES

Appendix A: Extract from Rydes' White Awareness Model

Appendix B University of East London Ethical Approval and Ethics form

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: Julia Papworth
SUPERVISOR: **Trishna Patel**
STUDENT: Leanna Ong

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: White Clinical Psychologists, race and racism

DECISION OPTIONS:

7 **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.

8 **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.

9 **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 with Minor amendments

Minor amendments required *(for reviewer)*:

3.3 – What methodology are you using?
3.4 – How will participants define themselves as white? What method are you using?
3.5 – Will participants have the opportunity to discuss the study after the information sheet?
In the **invitation letter**

a clearer boundary is required about their right to withdraw their data –after interview this vague. Also in the consent form. It is unclear when participants can withdraw – this is however made clear in the Interview debrief sheet. Please update all aspects to read the same.

And what happens to the audio recordings? After they have been transcribed?

4.6 – what will happen to any non-digital printouts of scripts ?

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):* Leanna Ong
Student number:

Date: 18.05.2020

(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

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).

Reviewer *(Typed name to act as signature)*: Julia Papworth

Date: 5 /05 / 2020

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

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

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

Completing the application

9.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood the codes: [X]

9.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

9.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. It is the responsibility of students to check this has been done.

9.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

9.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

10 The participant invitation letter [X]

11 The participant consent form [X]

12 The participant debrief letter [X]

12.1 The following attachments should be included if appropriate:

13 Risk assessment forms (see section 6 and appendix A)
14 A Disclosure and Barring Service (DBS) certificate (see section 7)
15 Ethical clearance or permission from an external organisation (see section 8)
16 Original and/or pre-existing questionnaire(s) and test(s) you intend to use
17 Interview protocol for qualitative studies
18 Visual material(s) you intend showing participants.

Your details

Your name: Leanna Ong

Your supervisor's name: Trishna Patel

Title of your programme: Professional Doctorate in Clinical Psychology

UEL assignment submission date (stating both the initial date and the resit date): May 2021

Your research

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

The title of your study: White Clinical Psychologists, race and racism

Your research question:

19 What are White Clinical Psychologists' experiences of discussing race and racism in therapy?
20 What hinders and facilitates discussions of race and racism in therapy?

Design of the research: Qualitative: individual semi-structured interviews

Methodology – thematic analysis of interview transcripts

Participants: Clinical Psychologists who identify as White working in the UK will be recruited. Between 8 and 12 participants will be recruited for individual interview. It is the participants who self-identity as White, there is no stipulation on this – a brief demographic sheet (see 3.6/appendix E) will provide an opportunity for participants to disclose their ethnicity

Recruitment: The research will be advertised on social media (e.g. twitter, Facebook) and via. relevant organisations related to Clinical Psychology (e.g. British Psychological Society, see appendix B). Interested participants will be provided with a participant information sheet outlining the nature and purpose of the research and their rights as participants (e.g. anonymity and withdrawal). There will be opportunity to discuss the study further with the lead researcher and for any queries to be addressed either via email, phone, MS Teams or in person (depending on changes in the current Covid-19 situation). Those interested in being interviewed will be asked to sign a written consent form – electronic copies will be provided for an e-signature.

Measures, materials or equipment:

A demographic information sheet
An interview schedule of potential questions / topics for discussion is attached to this application. The interview schedule will be piloted and refined before recruitment begins (please see, Appendix E).
A digital recording device will be used to record the interviews.
Access to secure UEL servers for data transfer and storage.
Access to MS Teams for online interviews.
Access to NVivo software.

Data collection:

Participants will be invited to an individual interview with the lead researcher for 40-60 minutes. In the first instance via MS Teams or in person (face-to-face at UEL if the current situation with Covid-19 changes) and video or audio recorded (for MS Teams and face-to-face interviews respectively). MS Teams will auto transcribe the interview and be stored as a written transcription in MS Stream, which will then be reviewed and anonymised by the researcher. Anonymised transcripts will be retained for a maximum of three years for dissemination purposes.
Face-to-face interviews will be transcribed and anonymised by the researcher.

Data analysis: Interview data will be analysed using thematic analysis.

Confidentiality and security

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

Will participants data be gathered anonymously?
No

If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

In reviewing the transcribed interview on MS teams, all personal identifiable information will be removed and pseudonyms will be used. Personally identifiable information (names, job location, contact details) will not be linked to the interview material in any way. In any disseminated material only short quotes will be used, no personal information and only broad demographic information, to ensure that it is not possible to identify participants.

How will you ensure participants details will be kept confidential?

Personally identifying information such as names and contact details for participants will be stored in a password-protected file on a password-protected computer only accessible to the lead researcher. Signed paper consent forms (if face-to-face interviews are conducted) will be scanned and shredded via confidential waste. Scanned consent forms and electronic signed consent forms will be stored in a password protected file on a password protected computer only accessible to the lead researcher. These will be deleted following completion of the study (i.e., write up and successful oral examination). E-mails will be sent from the researcher's UEL email account and deleted following the end of the study. Personally identifiable information will not be linked to the interview material in any way. The audio recording will be transferred to a password protected encrypted file on a password protected computer only accessible to the lead researcher. During reviewing the transcription of the audio recording, all identifiable information such as names of people, places etc. will be removed and replaced (e.g., pseudonyms will be used). Anonymised transcripts will be used in the analysis. Identifying references to participants will be removed from any material used in the write-up of the study. Only short unidentifiable quotes will be used in disseminated material (e.g., publications, conference presentations etc.). Anonymised transcripts will be kept for a maximum of three years in a password protected file on a password protected computer only accessible to the lead researcher all other information collected during the study will be destroyed upon completion of the study (i.e., write-up and successful oral examination).

How will the data be securely stored?
All personal and research data will be stored in password protected files on a secure server (UEL OneDrive for business) or password protected login on UEL H:drive. No personal or research data will be stored on personal portable electronic devices. Participant identifiable information will be kept separate to anonymised data. No one outside the research team (lead research and research supervisor) will have access to the research data. Examiners may request to see anonymised transcripts. Upon completion of the study anonymised transcripts will be stored on the research supervisor's UEL OneDrive for a maximum of three years.

Who will have access to the data?
The trainee (lead researcher) and research supervisor will have access to the interview and participant data. No one outside the research team will be able to access the data. Examiners may request to see anonymised transcripts as part of the examination process.

How long will data be retained for?
Anonymised transcripts will be stored securely for three years and then deleted. Audio-recordings and MS Teams video recordings will be deleted after the end of the study (i.e., write-up and successful oral examination).
Where transcripts have been printed out for analysis purposes, these will be shredded following the analysis process.

Informing participants

Please confirm that your information letter includes the following details:

Your research title: [X]

Your research question: [ ]

Knowledge of the research questions may impact the ability to have open and honest discussions within the interview- therefore these will not be included in the information sheet but information about the importance of the research will be outlined, alongside the aims of the study.

The purpose of the research: [X]

The exact nature of their participation. This includes location, duration, and the tasks etc. involve d: [X]

That participation is strictly voluntary: [X]

What are the potential risks to taking part: [X]

What are the potential advantages to taking part: [X]

Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): [X]

Their right to withdraw data (usually within a three-week window from the time of their participation): [X]

How long their data will be retained for: [X]

How their information will be kept confidential: [X]

How their data will be securely stored: [X]

What will happen to the results/analysis: [X]

Your UEL contact details: [X]

The UEL contact details of your supervisor: [X]

Please also confirm whether:

Are you engaging in deception?
No, participants will be fully informed as to the purpose of the study and what participation will involve before they decide to take part in the study.

Will the data be gathered anonymously?

No, data will be anonymised during transcription. This will be made clear to participants in the participant information sheet. However, data will be securely and sensitively managed to ensure that personally identifying information is not linked to interview material during analysis and dissemination.

Will participants be paid or reimbursed?

Participants will be given the option of being entered into a prize draw to win £20 amazon voucher. Travel expenses will be reimbursed for participants who travel to UEL for interviews (if the Covid-19 situation changes).

Risk Assessment

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

Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

27 Due to the sensitive nature of some of the concepts explored in the research, it is possible that participants may experience some negative emotions in thinking about and responding to questions asked in the interview – this will be explicitly outlined in the participant information sheet and the debrief letter and participants will be directed to supporting agencies in both the participant information sheet and debrief letter should they wish to seek support following their participation. However, it is worth noting that the participants recruited will be qualified clinical psychologists who will be used to thinking about themselves in relation to their work in a range of domains and about difficult topic areas.

28 Given the current world pandemic – there could be concerns about physical risks related to the virus Covid-19 through face-to-face interviews. Therefore, the first option for recruitment will be online individual interviews via Microsoft Teams. Face-to-face will be offered if the current situation changes and face-to-face contact does not pose any risks to researcher and participant.

Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

29 Due to the sensitive nature of some of the concepts explored, there could be psychological impacts upon the researcher during interviews or transcription/analysis. The researcher will regularly seek support and guidance through supervision.

In terms of physical risk, if face-to-face interviews are conducted they will be conducted at UEL during working hours and the research supervisor will be informed of the date and time of interviews. The research supervisor will also be notified when the interview ends. Interviews at UEL will not be conducted if a

staff member is not in the building and aware that the interview is taking place. There are no risks attached to conducting interviews via Microsoft Teams. The researcher will not use any personal contact details during the study.
If face-to-face interviews are conducted following a change in current government guidance, the appropriate recommendations at that point in time will be followed to ensure researcher safety.

30 See end for full risk assessment

Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant? Yes

Does the research take place outside the UEL campus? No

If so, a 'general risk assessment form' must be completed. This is included below as appendix 4. Note: if the research is on campus, or is online only, this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed: NA

Does the research take place outside the UK? If so, where? No

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. If that applies here, please tick to confirm that this has been included: NA

However, please also note:

31 For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.

32 For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).

33 For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low

risk, it must be signed by the Head of School (or potentially the Vice Chancellor).

34 Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Disclosure and Barring Service (DBS) certificates

Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)? NO

If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: NA

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: NA

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: NA

If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: NA

If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this NA

35 You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice

system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

Other permissions

Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS. NO

Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

YES

If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

N/A

Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? NO

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☐

Please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is

still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

Declarations

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

Student's name (typed name acts as a signature): LEANNA ONG

Student's number: Date: 06.04.2020

Supervisor's declaration of support is given upon their electronic submission of the application.

Risk-assessment form

UEL Risk Assessment Form			
Name of Assessor:	**Leanna Ong**	**Date of Assessment**	**15/01/2020**
Activity title:	**Interview for thesis project**	**Location of activity:**	**University of East London, Water lane campus**
Signed off by Manager (Print Name)		**Date and time (if applicable)**	
Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc) If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:			
Interviews for thesis project – firstly taking place via Microsoft TEAMS (video call), or if unavailable through face to face interviews. Minimum 8 people will be interviews for approximately 40-60 minutes. Face to face interviews will only occur if government guidelines related to covid-19 lockdown are changed to allow this.			
Overview of FIELD TRIP or EVENT:			

Guide to risk ratings:

36 Likelihood of Risk	**37 Hazard Severity**	**38Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity							
Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**
Participants becoming distressed or angry within the interview. **Any health and safety hazards within the interview room on UEL campus**	Participant Researcher	Signposting to appropriate services, use of clinical skills to manage and contain distress Follow all relevant health & safety guidelines – UEL	2 2	1 1	2 2	Ensure other people are aware of interviews occurring – within building or nearby. Interviews to take place during working hours (9-5) Supervisor aware of time/place of interviews	1 1
Contamination of Covid-19 virus through face to face interviews	Participant Researcher General public	Following government guidelines, public health England and UEL policy Avoid physical contact with participant Tissues, antibacterial gel and handwashing facilities available in interview room/nearby				Ensure contact with participants if researcher comes into contact with virus. **Review Date**	

Appendix C: Participant Information Sheet

Participant Information Sheet

White Clinical Psychologists, Race and Racism

Researcher: Leanna Ong
Email: U1826622@uel.ac.uk

Who am I?

I am a Trainee Clinical Psychologist studying at the University of East London (UEL). I am conducting this study as part of my Doctorate in Clinical Psychology. Before you make a decision as to whether you wish to take part, it is important for you to know the purpose of the research and what to expect. Please read through the following information and if you have any questions or concerns, you can contact me on the above email address.

What is the purpose of the study?

This research aims to qualitatively explore the concepts of race and racism within Clinical Psychologists' clinical work. Race is understood as a concept used to categorise people based on their skin colour. Racism is related to prejudice, discrimination or antagonism directed against other people because they are of a different race or ethnicity -the belief in the superiority of one race over another. Within Psychology as a Profession, there is an acknowledgment that individuals (clinicians, trainees, trainers, supervisors etc.) may feel challenged by discussing race and racism, and this can at times cause paralysis in how to act or what to say in the moment. As a profession, it is important to be able to have open and non-judgemental conversations to enable individuals to discuss these issues as part of their clinical work (e.g., clients, carers, supervisors, other professionals etc.). The longer-term goal is that study findings will inform training recommendations and/or guidelines.

Who can take part?

If you are a Clinical Psychologist who identifies as White and are interested in talking about race and racism in your clinical work, you are eligible to take part. The aim of the research is to openly discuss your experiences related to the above issues. I am not looking for 'experts' on the topic and you can be at any point in your own journey of thinking and talking about race and racism.

Do I have to take part?

No. Participation is completely voluntary, and you are free to withdraw without explanation, disadvantage or consequence at any time.

What will I be asked to do if I agree to take part?
You will be invited to an interview with myself, which will be via Microsoft Teams (secure online platform) or if the COVID-19 situation changes, face-to-face at UEL at a time and date convenient for you. The interview will last approximately 40-60 minutes and will be audio recorded (MS teams or face to face interviews respectively). You are free to stop the interview at any point, take breaks or reschedule. The interview will involve a conversation about your experiences of working as a Clinical Psychologist in the context of discussing race and racism in your clinical work. You do not have to answer any questions that you do not wish to and can stop the interview without providing a reason for doing so.

Can I withdraw at any time?
Yes.
During the interview: If you withdraw during the interview (for example, if you communicate that you wish to stop the interview), all the information provided by you will be erased.
After the interview: If you complete the interview, you have three weeks from the date of the interview to withdraw your interview data. If you would like to withdraw your interview data, you can do so by contacting me on the email address provided.

Are there any disadvantages or risks to taking part?
No. However, during the interview you may find yourself talking about difficult experiences with clients, colleagues etc., which you may find upsetting. If you feel too upset to continue, you are free to stop the interview, take a break or reschedule.

Will the information I provide remain confidential?
Yes. You will be given a pseudonym (a fake name) and potential identifiers (e.g. name of services/training courses) will be changed. Only myself and my research supervisor will have access to the anonymised interview data and this will stored in a password protected file on a password protected computer. Your interview data will not be linked to your personal information in any way. In all written documents resulting from this study, your identity will remain anonymous. Only short extracts from the interview will be used, so that it will not be possible to identify you personally. Transcripts produced by MS Teams will be anonymised by the researcher and these anonymised transcripts will be securely stored for three years, all other data collected during the study will be deleted upon completion of this study.

Will I be compensated?
As a thank you for taking time to participate in the study, all participants will be given the option of being entered into a prize draw to win a £20 Amazon voucher. Travel expenses for face-to-face interviews will be reimbursed.

Who has reviewed the research?

This research study has been reviewed and approved by the School of Psychology Research Ethics Committee. This means that the research follows the standard of research ethics set by the British Psychological Society.

What will happen to the results of the research study?
The results of the research project will be written up as a doctoral thesis and submitted for publication in psychological journals and presented at conferences. The longer-term goal is for study findings to be disseminated across the profession of Clinical Psychology to influence training both at Doctorate level and within services for qualified staff.
If you are interested in the results of the research, a summary will be available for participants following the write-up of the research. Within the consent form, there is an option to indicate whether you would like to receive a summary of the results.

What if I wish to complain?
If you have any concerns, you can contact me, Leanna Ong, or the project supervisor, Dr Trishna Patel and we will do our best to address your queries. Our details are at the bottom of the page. If you would like to make a formal complaint, please contact Dr Tim Lomas, Chair of the School of Psychology Research Ethic Sub-committee (t.lomas@uel.ac.uk)

Who can I contact following the study if I have any questions?
The researcher, Leanna, can be contacted at:
School of Psychology
University of East London, Stratford Campus, Water Lane
London E15 4LZ
Email: u1826622@uel.ac.uk

The research supervisor, Dr Trishna Patel, can be contacted at:
School of Psychology
University of East London, Stratford Campus, Water Lane
London E15 4LZ
Email: t.patel@uel.ac.uk

Relevant support services

This research may evoke difficult emotions. It is important to seek the appropriate support if you are impacted by the information above, or by the involvement in this research.
In2gr8mentalhealth - aims to destigmatise the experience of mental ill health in mental health professionals, through public talks and developing peer group support where needed. The web forum here provides a space for members to explore their personal and professional identity, and consider the systems they work in.

https://www.in2gr8mentalhealth.com/

Mindful Employer - is an NHS initiative designed to help employers and employees access information and local support for difficulties with stress, depression, anxiety and other mental health problems. Their website includes helpful information about how to look after yourself as an employee and a number of useful publications.
https://www.dpt.nhs.uk/mindful-employer

Mind- We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding. We won't give up until everyone experiencing a mental health problem gets support and respect.
https://www.mind.org.uk/information-support/

If you're worried about racism – find out information about equality and human rights here https://www.equalityhumanrights.com/sites/default/files/what-to-do-if-youre-worried-about-racism-eu-referendum-factsheet.pdf

If you're interested in reading from other Clinical Psychologist about their views/experience of Racism in the profession -
https://shop.bps.org.uk/publications/publication-by-series/clinical-psychology-forum/clinical-psychology-forum-no-323-november-2019.html

Appendix D: Interview Consent form

Interview Consent Form

White Clinical Psychologists, race and racism

Researcher: Leanna Ong
Email: U1826622@uel.ac.uk

Please sign initials next to the statements you agree with.

I have the read the information sheet relating to the above research study. The nature and purposes of the research have been explained to me.	
I have had the opportunity to discuss the details and ask questions about this information with the researcher to which I have received satisfactory answers.	
I understand what is being proposed and the procedures I will be involved in have been explained to me.	
I understand that my involvement in this study, and data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data.	
The information sheet has explained to me what will happen to my data once the research study has been completed and I understand this.	
I understand that I have **three weeks** from the interview date to withdraw my data from this study.	
I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.	
I now freely and fully consent to participate in the study, which has been fully explained to me.	
I would like to be contacted with the results of the research. Below are my contact details to which a summary of the results should be sent:	

Participant Name _____
Participant Signature _____ Date _____

Researcher Name _____
Researcher Signature _____ Date _____

Appendix E: Data management plan

UEL Data Management Plan: Full
For review and feedback please send to: researchdata@uel.ac.uk
If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

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

Administrative Data	
PI/Researcher	Leanna Ong
PI/Researcher ID (e.g. ORCiD)	0000-0003-3732-2700
PI/Researcher email	u1826622@uel.ac.uk
Research Title	White Clinical Psychologists, Race and Racism?
Project ID	NA
Research Duration	May 2020 – October 2021
Research Description	Race and racism are concepts which continue to remain problematic within the UK. They are linked to psychological distress and need to be addressed in the work of Clinical Psychologists who work with effected individuals. The issue of whiteness in the UK is pertinent in Clinical Psychology and may impact how race and racism are discussed in therapy. Little is known about how White Clinical Psychologists experience discussions about these concepts. In understanding this experience, how to support and change this could be explored for the profession. This research will explore how these concepts are experienced by White Clinical Psychologists. Individual semi-structured interviews will be conducted and analysed through thematic analysis. Attention to process will be considered as the experience of talking about experiences can be relevant in this context. This research may inform training, supervision and policy related to race and racism within Clinical Psychology.
Funder	N/A – part of professional doctorate
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	17.01.2020
Date of last update (of DMP)	04/04/2021
Related Policies	39 BPS Practice Guidelines Third Edition 2017 40 NHS England response to the specific equality duties of the Equality Act 2010 41 Research Data Management Policy 42 UEL Data Backup Policy

Does this research follow on from previous research? If so, provide details	N/A
Data Collection	
What data will you collect or create?	8-12 White Clinical Psychologists will be interviewed by the researcher. Individual semi- structured interviews will be conducted. Interviews will be approximately 40 – 60 minutes in length. All interviews will be audio or video recorded and transcribed by the researcher. Transcription will be created and saved as Word documents (.doc file formats). The transcripts will be organised and analysed by the researcher. Each participant will be given a participant number (in interview chronological order) and all identifiable information (e.g. names, job location, identifiable scenarios) anonymised in the transcripts. Personal data will be collected on consent forms (names) and prior to the interview (email address and/or telephone number for purposes of arranging the interview, via the researcher's UEL email address). No sensitive data will be collected. No further data will be created in the process of analysing the transcripts.
How will the data be collected or created?	Due to Covid19, interviews will be conducted via Microsoft Teams as the default. If the situation changes, face-to-face interviews will be conducted in UEL research laboratories. Interviews will be recorded on Microsoft Teams and will be auto-transcribed. The auto-transcriptions will be reviewed and edited by the researcher. Each participant will be given a participant number (in interview chronological order) and all identifiable information (e.g. names, job location, identifiable scenarios) anonymised in the transcripts. Personal data will be collected on consent forms (names) and prior to the interview (email address and/or telephone number).
Documentation and Metadata	
What documentation and metadata will accompany the data?	Participant information sheets, consent forms, list of guide interview questions and debrief sheet. Participant contact information and anonymisation process of data (transcripts)
Ethics and Intellectual Property	
How will you manage any ethical issues?	UEL Ethics approval will be sought before recruitment can take place. During recruitment, information sheets will be given to potential participants and given again prior to interviews. Written consent will be gained, and participants will be de briefed post interview. All participants have the right to withdraw from research prior to data analysis, this date will be given to participants throughout all information given. Interviews will be recorded on encrypted audio files and stored on password protected secure servers (UEL OneDrive for business). These will be transcribed by

	the interviewer/researcher and will only be accessible to the researcher and supervisor. All data will be anonymised. Any distress occurring during the interview will be managed in the same way the researcher would manage distress in clinical work. The supervisor will always be aware of where and when interviews are occurring. All participants will be signpost to relevant support services post interview.
How will you manage copyright and Intellectual Property Rights issues?	N/A
Storage and Backup	
How will the data be stored and backed up during the research?	Due to Covid19, all data will be stored on UEL OneDrive for business cloud. Audio/video files and transcripts will be stored on separate password protected folders only accessible by the researcher on a UEL OneDrive for business. Transcripts will be stored on both the researchers and supervisors secure accounts (so there is a backup) Contact details and other identifiable information will be stored in a folder separate from the audio/video files and transcripts. Hard copies of consent forms will be scanned and electronically stored on the UEL OneDrive for Business. Hard copies will then be shredded.
How will you manage access and security?	Video recordings from Microsoft teams will be auto-transcribed and stored on Microsoft stream. The researcher will review and edit this transcription (removing identifiable information in the process) before downloading into a word doc. This transcription will then be stored in a password protected file on both the researcher and supervisor's secure accounts. Only the researcher, supervisor and examiners will have access to anonymised transcripts. Due to Covid19, it is unlikely that face to face interviews will take place. Any face to face interviews will be recorded on an encrypted Dictaphone. Recordings from the encrypted Dictaphone will be uploaded onto the UEL OneDrive for Business prior to transcription, immediately after the interview has ended. Recordings will then be deleted from the device. Audio and video files will be saved in the UEL OneDrive for Business titled: 'Participant number, participant initials: Date of interview'. Consent forms will be scanned and stored in UEL OneDrive for Business. Hard copies will be shredded.

	Transcriptions will be typed or copied into a Word document and saved separate to the above information (on UEL OneDrive for business account). Encrypt files containing personal identifying data
Data Sharing	
How will you share the data?	Anonymised transcripts will be shared with the research supervisor via secure UEL email. File names will be participant numbers e.g. Participant 1. Short extracts of transcripts will be provided in the final write-up of the research and any subsequent publications. The final write-up will be uploaded onto UEL repository. Identifiable information will not be included in these extracts. Anonymised transcripts will not be deposited via the UEL repository due to issues with confidentiality and seeking further consent.
Are any restrictions on data sharing required?	Only researcher and supervisor will have access to data (i.e., no one outside the research team will be able to access the data)
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Electronic copies of consent forms will be kept until the thesis has been examined and passed. They will then be erased from the secure server. Audio and video files will be deleted as soon as they have been transcribed
What is the long-term preservation plan for the data?	Transcripts will be kept for three years on UEL's OneDrive for business by the research supervisor, after which point they will be deleted. These are kept securely within UEL servers but may be needed for further publication following the thesis examination.
Responsibilities and Resources	
Who will be responsible for data management?	Leanna Ong
What resources will you require to deliver your plan?	Laptop, audio-recorder, access to UEL's OneDrive for Business.
Review	
This DMP has been reviewed by:	
Date: 03/042021	Signature: Penny Jackson *Research Data Management Officer*

Appendix F: Interview Debrief Sheet

Interview Debrief Sheet

White Clinical Psychologists, race and racism

Researcher: Leanna Ong
Email: U1826622@uel.ac.uk

Thank you for participating in this research. It is a topic area that many of us still struggle to talk about. My contact details are below if you would like to contact me following your participation in the study.

I would like to remind you that:

43 All the information provided by you will be anonymised and there will be no way of connecting your interview material to you. You will be given a pseudonym (fake name) when the interview is written-up and any identifying information (e.g., names of people, services etc.) will be changed.

44 The results will be reported in a doctoral thesis and might be published in psychological journals, presented at conferences etc.

45 The results will be shared with different organisations that might benefit from the outcomes (e.g., British Psychological Society or Association of Clinical Psychologists UK).

46 You can withdraw your interview data three weeks after the interview takes place. After this, the data will have been analysed and it will not be possible to remove your data from the analysis.

I know it may be difficult to think and talk about the experiences that we discussed and there is information about different services which can support you at the end of this page. You can also contact me if you have any concerns about anything in this interview. Thank you again for taking part!
Best wishes,

Leanna Ong
School of Psychology
University of East London Stratford Campus Water Lane
London E15 4LZ
Email: u1826622@uel.ac.uk

Relevant support services

This research may evoke difficult emotions. It is important to seek the appropriate support if you are impacted by the involvement in this research.

In2gr8mentalhealth - aims to destigmatise the experience of mental ill health in mental health professionals, through public talks and developing peer group support where needed. The web forum here provides a space for members to explore their personal and professional identity, and consider the systems they work in.
https://www.in2gr8mentalhealth.com/

Mindful Employer - is an NHS initiative designed to help employers and employees access information and local support for difficulties with stress, depression, anxiety and other mental health problems. Their website includes helpful information about how to look after yourself as an employee and a number of useful publications.
https://www.dpt.nhs.uk/mindful-employer

Mind- We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding. We won't give up until everyone experiencing a mental health problem gets support and respect.
https://www.mind.org.uk/information-support/
If you're worried about racism – find out information about equality and human rights here https://www.equalityhumanrights.com/sites/default/files/what-to-do-if-youre-worried-about-racism-eu-referendum-factsheet.pdf
If you're interested in reading from other Clinical Psychologist about their views/experience of Racism in the profession
- https://shop.bps.org.uk/publications/publication-by-series/clinical-psychology-forum/clinical-psychology-forum-no-323-november-2019.html

Appendix G: Advert

Participants Needed!

White Clinical Psychologists, Race and Racism

Researcher: Leanna Ong
Email: U1826622@uel.ac.uk

If you are a Clinical Psychologist who identifies as White and are interested in talking about race and racism in your clinical work, you are eligible to take part.

What does the research involve?
Duration: One 40-60-minute interview
Location: Online, using Microsoft Teams

A chance to win a £20 Amazon Voucher for your participation.

Please contact me on the email above if you would like to be involved or would like some more information

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Appendix H: Interview Schedule

[Before turning on the recorder] Sign consent for recording - or confirm consent form has been sent (if online) and check participant still agrees with consent. Go over areas to cover and explain there is no wrong answer

[Turn on the recorder] "Thank you for agreeing to take part in my research, as you know this interview will be focused on asking about your experience as a Clinical Psychologist. There is no judgement based on the answers you give, but I hope this interview can generate some open discussions about your experiences." **Let me start by asking you broadly…**

47 Can you tell me about a time when race was discussed in your clinical work?

1. What was this like for you?
2. What does this mean for you? Who initiated this discussion/conversation?

48 (If not already discussed in previous) What is your experience of racism being discussed within your clinical work?

1. Can you tell me about other contexts outside of therapeutic work - what allows you to engage in these discussions/conversations? What holds you back? What has helped you move past these challenges? Are there some contexts where it is easier, which ones, why?

49 What is your experience of racism being discussed in the wider context of your job?

50 Within your wider professional networks. Within supervision? With trainees?

51 What do you notice about how you respond when race and racism are being discussed?

1 Did you notice that at the time, or just on reflection? How do you manage those responses? Have they changed over time?

1. What do you find makes it a challenge to have these discussions in your work?

1 How does it feel to discuss this now? What has helped with some of these challenges or what might help? Did you notice that at the time, or just on reflection?

Transition to next:

2 What might help you in these discussions in your work? (if not mentioned already)

2. Is there anything else that you think is important that we haven't talked about?

3. Before the interview, I asked about where you did your training. Do you think there were aspects of your training that have helped you think more about these topics? If yes, what were these?
4. Given the recent global discussions about the Black Lives Matter movement, and structural racism, has this impacted your experiences in anyway?
    1. Prompt: within therapy and more broadly

Prompts: Tell me more. What do you mean? What was that like?? Can you give me an example? Can you describe that? How does it feel to discuss this now? Did you notice that at the time, or just on reflection?

Debriefing: How do you feel about our conversation today? Is there anything that bothered you? Do you have any questions?

This is the end of the interview – please read through the debrief form and let me know if you have any questions. Thank you for your participation.

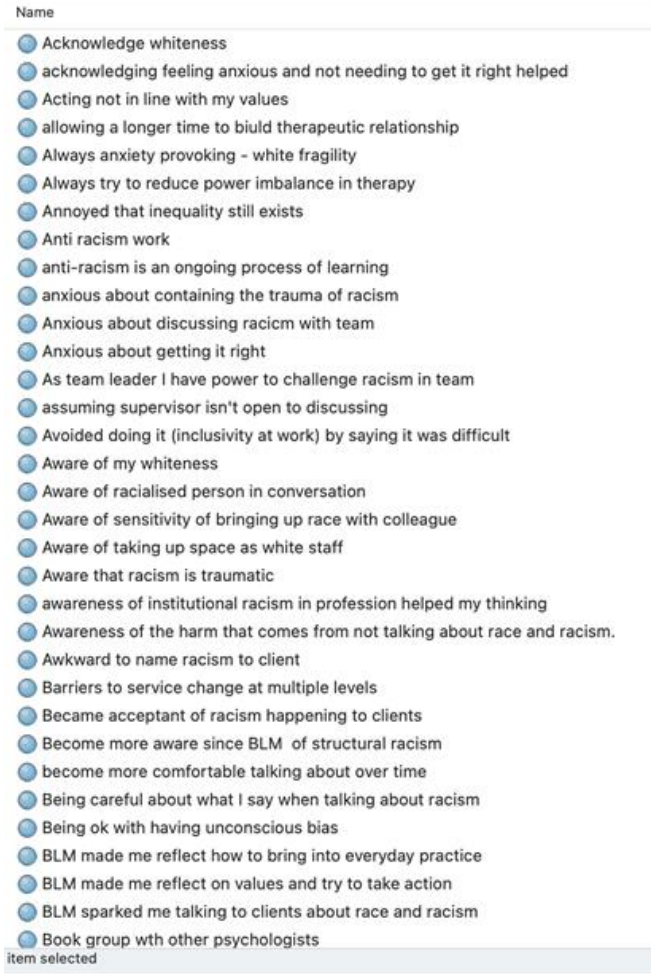
Appendix I: Demographic information

Demographic sheet

To be sent with information sheet or asked before the start of the interview?

How would you describe your ethnicity?
How would you describe your gender?
What is your age?
How long have you worked in the NHS?
Where and when did you do your DClinPsych Training?
Where (broad geographical region) do you currently work?

Appendix J: Example coding and annotated transcript



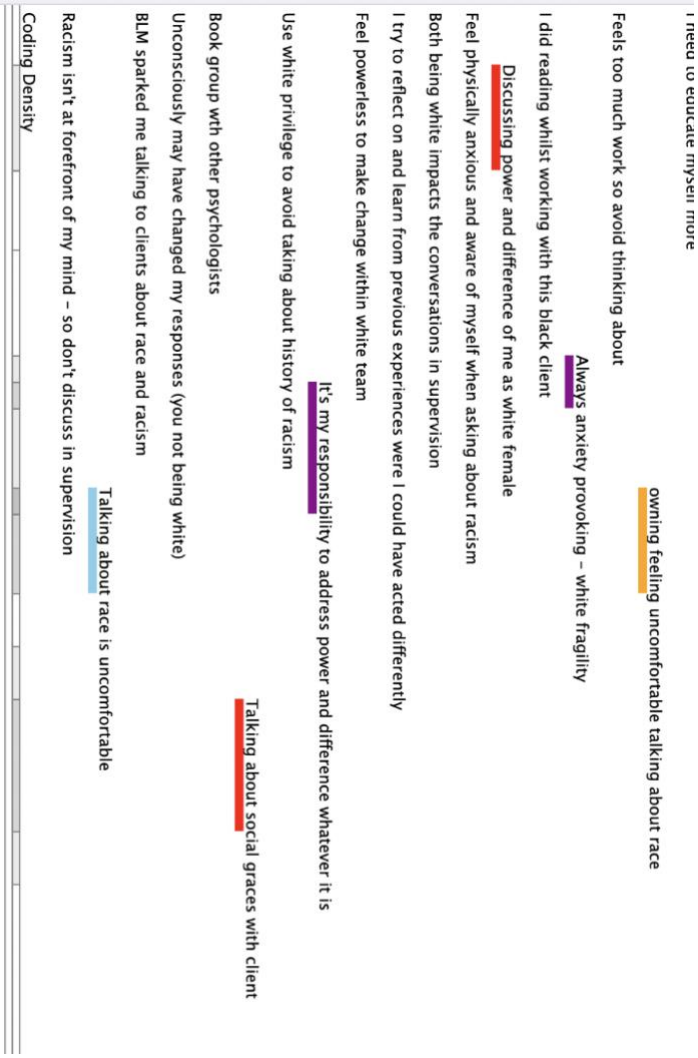
about in terms of like racial trauma that she seemed to be experiencing having quite a lot of nightmares at that point and then just discussing about how it was kind of in lots of different channels for her and really was on her mind, Um, so we kind of discussed about it and discussed back in terms of our work and our differences, me being a white female, thinking about kind of in terms of power and how, um, coping with that and kind of yeah talk about like relational kind of things between us too. But also talking about her symptoms of kind of racial trauma and coping with that, and that she was feeling quite overwhelmed by friends wanting to talk about it a lot and we were just talking about kind of boundaries and how to manage that a little bit. So that's probably like one of the more recent experiences I've had

R: and what was that like for you having that discussion?

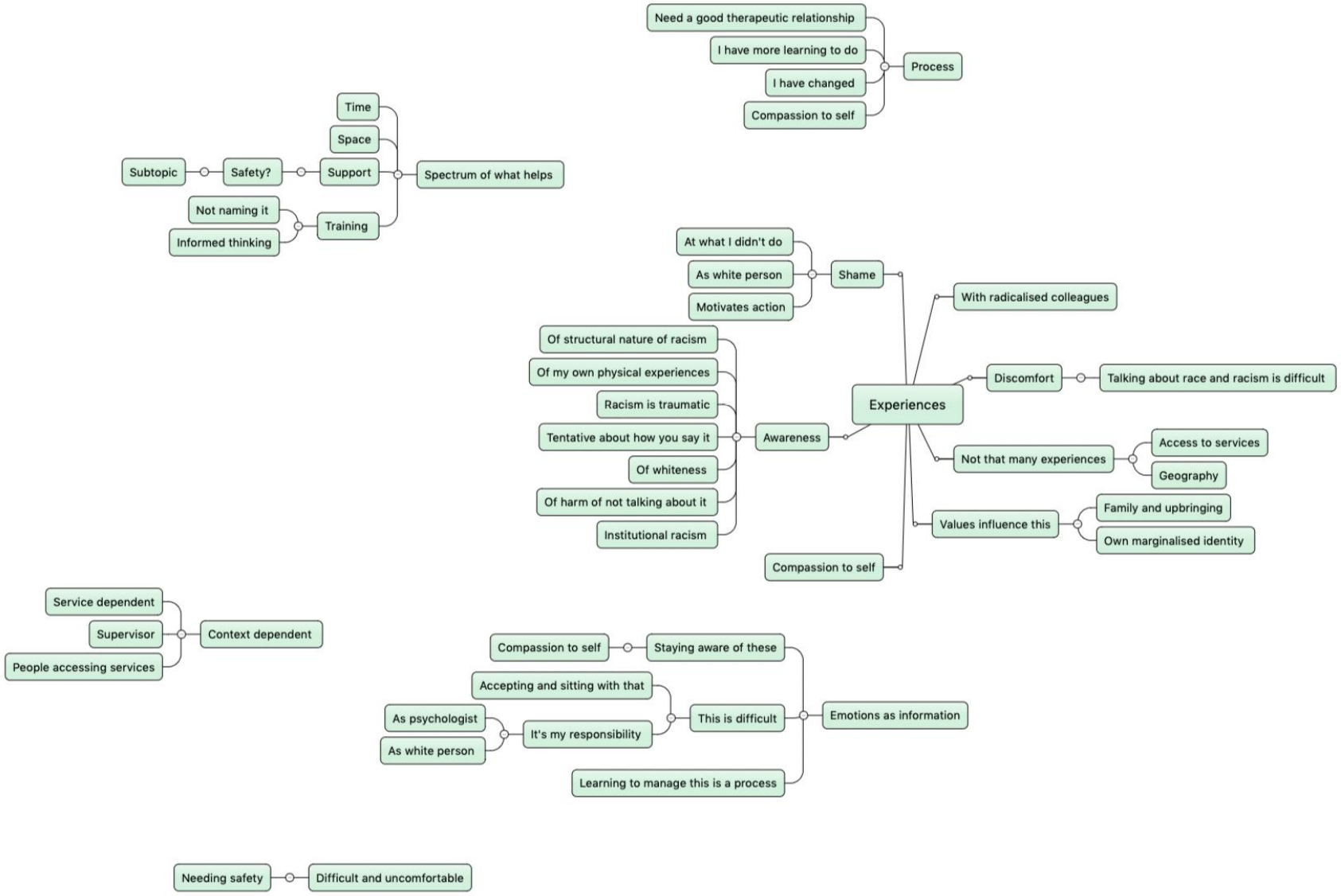
P9: Yeah, like I think it is always anxiety provoking, I think because of my white fragility I've been kind of that's my initial response, but I've become a lot more more comfortable than more I've done it and I think it is important and so kind of feeling (2) that it's my duty as a clinical psychologist to address power and think about differences within the relationship, whatever it might be, race, sexuality and so, well gender, Lots of different things, and so I think it is, It does make me feel more uncomfortable, but I'm sorry I'm trying to own that and start to kind of leaning into exploring why I'm feeling that uncomfortableness and then kind of then asking it just in an invitation kind of open way because I'm also aware that for some clients, they you know don't want to discuss it or they don't want to start it, particularly with me for example, so just trying to kind of open that conversation up and I felt pleased that I had and I am doing this more, especially I think it was important, especially around George Floyd to talk about but then I was going to reflect if had George Floyd not come up would I have not had this discussion especially with that client I had that discussion before we were doing like a social graces exercise and we were talking about how understanding HIV in terms of different parts of her identity and we spoke about the differences of her and I and some similarities between both being young ish and female so yeah, I was kind of some reflection of, I do bring this up in some conversations, but whereas when with the George Floyd thing I was discussing it a lot more and actively doing that and thinking about how I now take that forwards and it just comes into my everyday practice

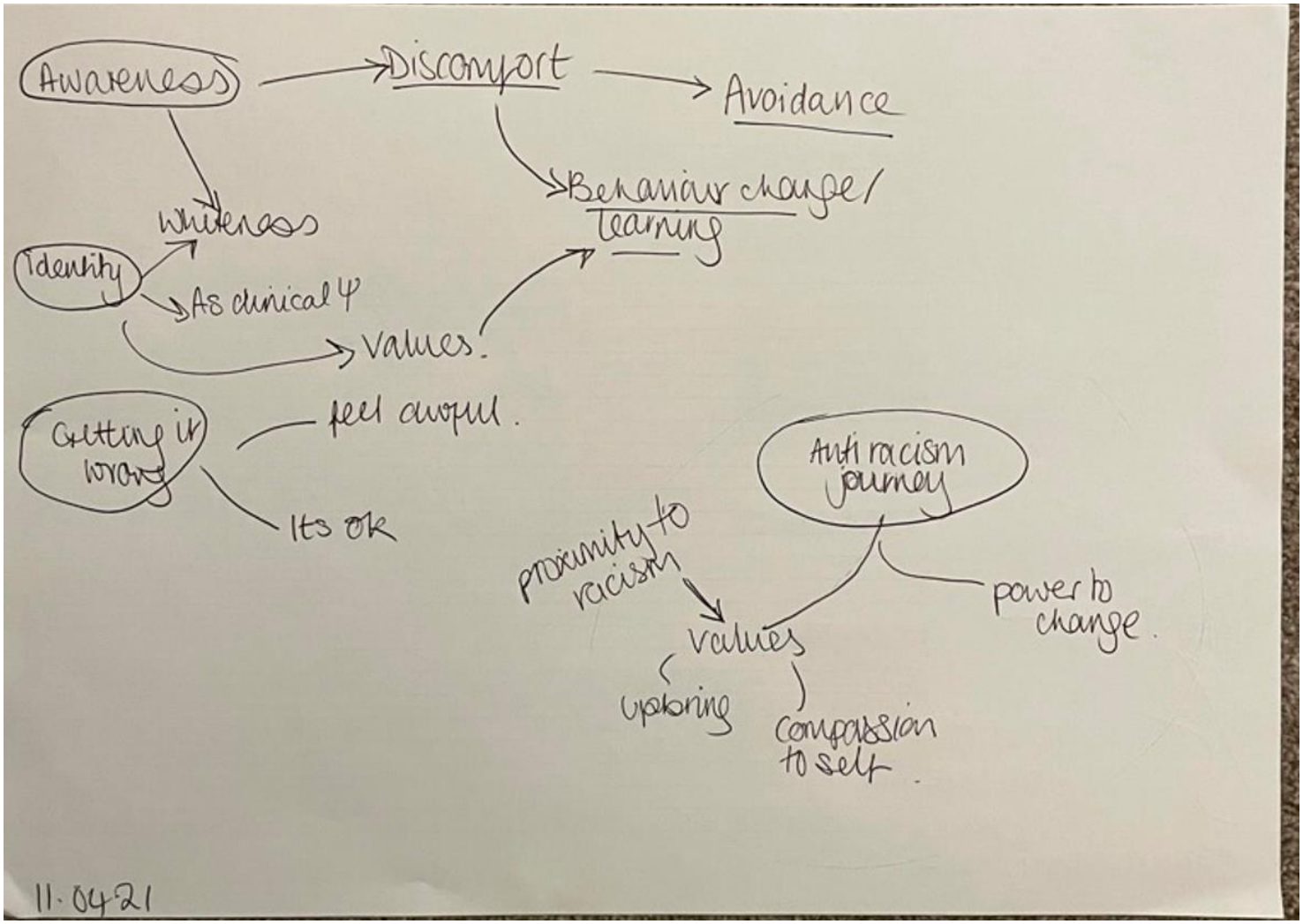
R: Yeah and with that that client and when you said you were discussing it before the George Floyd who initiated those first discussions?

P9: And that was myself and through the in terms of thinking about the social graces, exercise and so I was talking about. I'm right now. I was like obviously we have



Appendix K: Initial Maps




Awareness
Discomfort
Avoidance
Behaviour change/ learning
Whiteness
Identity
As clinical Y
Values.
Getting it wrong
feel awful.
Its ok
Anti racism journey
proximity to racism
power to change.
values
Curiosity
Compassion to self.
11.04.21

Appendix L – Extracts from transcripts re Critical Language Awareness

R: Yeah, and do you think that that's like problematic? To name it more as like culture and family?

P14: Um (long pause) I don't know actually it's a good question (3) I think it felt right. I mean, I'm thinking of one family in particular. I think it felt right for that family at that time (2) I think that's where the family were at. (2) If I think of. If I think specifically for that family for that situation, I think that was right for them. If I take a step further back and kind of think from a more

Appendix M: Anti-racism resources

Three main signposting resources used by the researcher. These lists will be overlapping and may also be incomplete.

Anti-racism for beginner: http://antiracismforbeginners.com/

Collective for Asian Psychological Therapists Anti-racism self-education guide: https://mailchi.mp/7ea5f2e87230/capt-anti-racism-self-education-guide

Social GRACES+ Library (developed by Trainee Clinical Psychologists Navya Anand and Holly Summers) : https://docs.google.com/spreadsheets/d/1EtTTQ4AKNhQl-L0ERwD9O9jgJU1ca9aFzjL83InEV5A/edit#gid=1890058709