Understanding Therapists' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study

U1504502

Nomsa Sandra Wayland

A thesis submitted in partial fulfilment of the requirements of the

University of East London for the degree of

Professional Doctorate in Counselling Psychology

September 2023

Wordcount: 33,000

Abstract

Studies indicate a link between experiences of racism and psychological distress and trauma. Most of these findings are based on correlational studies from the United States (US). There is a significant lack of research from the United Kingdom (UK), predominantly qualitative research, examining how these experiences are addressed within psychological services. This thesis attempts to honour the voices of therapists of clients who have endured Race-Based Traumatic Stress (RBTS) and seeks to make a modest contribution to the limited literature concerning UK therapists' experiences of working with racial trauma. This research adopted a relativist stance within a constructivist paradigm, drawing upon the principles of Critical Race Theory (CRT), intersectionality, and Cultural Humility (CH) as potential frameworks to explore and possibly illuminate the complex nature of racial phenomena within the UK context. Interpretive Phenomenological Analysis (IPA) was employed to explore the lived experiences of eight therapists working with Black clients presenting with RBTS. Participants were recruited via social media and participated in semi-structured virtual interviews.

Five Group Experiential Themes (GET) were identified: (1) Navigating the Uncharted: Recognition, Understanding, and Addressing Racial Trauma in Professional Practice; (2) Navigating Therapists' Intersections of Race, Personal Experiences, and Professional Practice in Therapy; (3) It's Not My Place to Bring it Up; (4) Inadequacy of the Systemic Response to Racial Trauma in Education and Mental Health Services; and (5) Navigating Racial Dynamics in Professional Spaces. These GETs detailed participants' lived experiences, recognising, addressing, and navigating often uncomfortable racial dynamics in therapy, as well as the gaps in the therapists' training, and finally managing the challenging intersection of the participants' racial identities, personal experiences and professional roles.

The study findings highlight a cycle wherein inadequate training for professional counsellors could contribute to cultural incompetency, often leading to the under-recognition, misdiagnosis, avoidance and/or minimisation of racial trauma. This dynamic may perpetuate the distress experienced by Black clients, highlighting the urgent need for systemic change in training and practice.

Acknowledgements

My most profound appreciation goes to my Research Supervisor, **Dr Fevronia Christodoulidi**, for her invaluable guidance, insights, constructive feedback, and unwavering support throughout this process. To all my participants, I sincerely appreciate your willingness to contribute and share, making this research more prosperous and comprehensive. I am equally indebted to my colleague, **Dr Lucia Berdondini**, for her belief in my abilities and continued support.

To my fellow CoP trainees and friends, **Christina, Elnaz, Sarah, Shireen,** and **Tahlia**, the motivation, support, laughter, knowledge, and camaraderie we shared have been sources of strength and inspiration. To my beautiful family, your love and encouragement have been the foundation for this doctoral work. My elder son, **Thabo**, your endless support was paramount; this journey would have been impossible without you. My two daughters, **Tyra** and **Tiana**, and my younger son, **Tayo**, your boundless love kept me going; you provided endless inspiration. My husband, **Paul,** your support and understanding have been invaluable.

I would be remiss not to acknowledge my sister, **Rejoice**, whose support and prayers have been unwavering. To my **parents**, words cannot express how grateful I am to God for keeping you alive. You remain a beacon of hope and inspiration in my life. Above all, I am profoundly grateful to God for the blessings and strength bestowed upon me throughout this journey.

Table of Contents

Glossary of Terms

Abbreviations

BAME: Black Asian and Minority Ethnic

BME: Black and Minority Ethnic

BLM: Black Lives Matter

IPA: Interpretative Phenomenological Analysis

CRED: Commission on Race and Ethnic Disparities

RCP: Royal College of Psychiatrists

POC: People Of Colour

UnRESTS: UConn Racial/Ethnic Stress & Trauma Survey

NHS: National Health Service

US: United States

UK: United Kingdom

Terminology

Complex PTSD: A condition where a person experiences long-term trauma that affects their emotional and mental stability beyond the symptoms of PTSD.

Post-Traumatic Stress Disorder (PTSD): A mental health condition triggered by experiencing or witnessing a terrifying event, characterised by severe anxiety, flashbacks, and uncontrollable thoughts about the event.

Countertransference: A situation in psychotherapy where a therapist projects their own feelings or issues onto the patient, often as a reaction to the patient's transference.

Critical Race Theory (CRT): An academic framework that examines society and culture as they relate to race, law, and power categorisations.

Cultural Competence Model (CCM): A framework that outlines the ability to understand,

communicate with, and effectively interact with people across cultures.

Cultural Humility (CH): A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases.

Intersectionality: A theoretical framework for understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege

BREXIT: Britain' and 'exit' refer to the United Kingdom's (UK) withdrawal process from the European Union (EU).

Diagnostic and Statistical Manual of Mental Disorders (DSM-5): The authoritative guide for diagnosing mental disorders, published by the American Psychiatric Association.

International Classification of Diseases, 11th Revision (ICD11): This guide provides a common language for health professionals, researchers, and policymakers to share and compare health information across hospitals, regions, and countries.

Race-Based Traumatic Stress (RBTS): refers to the psychological and emotional impact experienced by individuals due to encountering racial harassment, discrimination, or violence. This concept recognises that the stress and trauma associated with racial encounters can have profound and lasting effects on an individual's mental health, similar to other forms of traumatic stress.

Race-Based Traumatic Stress Symptom Scale (RBTSSS): A psychological assessment tool that measures the emotional and psychological reactions to perceived racial discrimination.

UnRESTS: A clinician-administered interview that assesses the impact of multiple experiences of racism throughout one's life (e.g. personal, vicarious, microaggressions, etc.).

Chapter One: Introduction

1.1 Introduction

In this introductory section, I share a glimpse of my background and motivations for pursuing this subject.

I was born and raised under apartheid in South Africa. This political and social system existed from 1948-1994, in which the nation's White minority ruled over the Black majority and other racial groups, systematically discriminating against them (Christopher, 1994; Hartshorne, 1992). My early experiences arguably prepared me to address racism more effectively and support those affected by racial trauma.

However, my relocation to the UK exposed me to the nuanced nature of contemporary racism, which was not fully covered by my personal experience. I found myself unprepared to effectively support clients impacted psychologically by their encounters with more *subtle* forms of racism, and their accounts often triggered memories of my own experiences. Yet despite my limitations, my previous encounters with racism enriched my capability to offer genuine, impactful support. These experiences became the foundation upon which I tried to develop appropriate interventions for my clients.

I subsequently became motivated to explore the experiences of other therapists working with Black clients who have experienced racial trauma. Therefore, drawing from my professional identity and personal experiences, I believe my positionality equipped me with a unique understanding of the topic. I aim to bring a greater awareness of this topic to the public arena for debate and discussion so that my findings may pave the way for further research, which may eventually inform professionals in psychology and improve mental healthcare services.

1.2 Structure of the Thesis

This thesis comprises five chapters. Continuing with Chapter One, I first state the identified problem and discuss the terminology. I then address relevant social aspects, Race-Based Traumatic Stress (RBTS) and the theoretical framework used for the study, followed by considering associated counselling issues. The chapter concludes by reviewing relevant literature and presenting the overall research question and objectives. The study methodology is explained in Chapter Two, with detailed findings presented in Chapter Three. In Chapter Four, I discuss my findings and their implications for practice, and the conclusion is presented in Chapter Five.

1.3 Statement of the Problem

This research explores therapists' experiences of working with Black clients presenting with RBTS in the UK. In psychological therapy, supporting individuals who have experienced any form of trauma is paramount (Carter, 2007; Comas-Díaz et al., 2019; Van der Kolk, 2014). However, the complexity of trauma tied to racial identity is less understood (Carter, 2007; Comas-Díaz, 2016). The challenge for counselling psychology is not just in recognising the existence of this type of trauma, but in understanding its nuances, its interplay with other forms of trauma, and in developing therapeutic interventions that are culturally sensitive and effective. Given the historical context of the British Empire and the ongoing racial disparities impacting the mental health of Black and minority communities (Fernando, 2012; Khan et al., 2003; Wallace et al., 2016) racial trauma, I believe, should be recognised as a public health issue in the UK. However, there is limited acknowledgement and understanding of racial trauma within the existing literature and clinical practices (Comas-Díaz et al., 2019; Menakem, 2021; Roberson & Carter, 2021).

Most UK research on the impact of racism covers the whole spectrum of ethnic

groups (Beck, 2019; Bhui et al., 2018; Hackett et al., 2020; Halvorsrud et al., 2019; Kinouani, 2020), although studying these groups together does not necessarily increase our understanding of the impact of racism on each minority culture. While all forms of racism are severe, historically, Black people have faced more significant levels of racial discrimination and racism than any other ethnic group (Bhui et al., 2018; Jones & Norwood, 2016), which may have contributed to their mental health problems. Yet, the literature has paid scant attention to the experiences of therapists dealing with the unique racial trauma of Black people.

Most literature on this topic is dominated by US-based studies, which may lack cultural relevance for the UK and focuses on *clients' experiences* of racism, not on *clinicians' experiences* of working with those impacted by racism. Consequently, there is little research on empirically supported practices for professionals working with these groups. Secondly, while there is extensive research on multicultural competency, racism, and Post-Traumatic Stress Disorder (PTSD), the literature on *trauma* induced by racist experiences is still in its infancy compared to the body of work dedicated to other forms of trauma, hence the significance of this study. Before discussing how this study is situated within a British social context, I will first document the relevant terminology.

1.4 Terminology

RBTS is a framework that helps clinicians working with ethnic minorities to understand racial trauma. It defines trauma as emotional, psychological, and physical reactions to racial experiences that cause pain (Carter, 2007; Evans et al., 2016). The term 'Black' historically differentiated individuals based on skin colour, distinct from Caucasians and other racial groups (Omi & Winant, 2014). Beyond colour, it embodies deep socio-political and cultural connotations rooted in Western history (Omi & Winant, 2014).

Therefore, in therapeutic contexts, recognising 'Black' may require understanding the systemic influences on Black communities over time. For many Black individuals, racial identity is central to their self-perception and therapeutic dialogue (Helms, 1995). I use 'Black people' (capitalised 'B') to denote individuals of African origin, encompassing African, Black British, African-Caribbean, or mixed heritage, central to this study. This acknowledges the shared historical, socio-political, and cultural experiences in societies with racial hierarchies. The capitalisation distinguishes between the colour and the socio-political identity, signifying respect for the collective experiences of Black individuals.

'Black, Asian and Minority Ethnic' (BAME) and 'Black and Minority Ethnic' (BME) are some of the terms used to refer to minority groups; 'People of Colour' (POC) is a US term for non-White individuals, encompassing ethnic and racial groups. This research uses these terms when referencing other researchers' literature, highlighting shared experiences of systemic racism. The thesis categorises counselling psychologists, counsellors, and psychotherapists as '*therapists'* and provides a rationale for this classification in the methodology chapter.

Literature Review

1.5 The Social Context for the Study - Racism and RBTS

1.5.1 Contemporary Racism in the UK

To understand racial trauma, one must first have a clear understanding of racism. One definition of racism is the belief that specific phenotypes or ethnic groups are inferior (Bryant-Davis & Ocampo, 2005; Hulteen & Wallis, 1992). Such attitudes may be motivated by bias or a desire to preserve privileged access to educational, economic, and social advantages (Horton & Sykes, 2001). Understanding contemporary racist attitudes in the UK requires a historical lens. The complexity of racism in the UK, shaped by its colonial legacy and post-colonial migration patterns, necessitates an exploration of anti-racist efforts that are deeply contextualised within this specific milieu. The conceptual contributions of Gilroy (1993), particularly his notions of cultural hybridity and the Black Atlantic, offer valuable lenses through which to examine the specificity of the UK's racial dynamics. These perspectives underscore the importance of considering the UK's colonial past in understanding and addressing racism today. Fernando (2010) also argues that to address racial inequalities effectively, it is crucial to consider the historical and cultural contexts shaping the mental health system in the UK. Since the 1970s, the UK has undergone significant socio-political changes, influenced by decolonisation and the evolving discourse on race and ethnicity. The Race Relations Act (1976) and the Equality Act (2010) could be considered pivotal moments in legislative efforts to combat discrimination, perhaps reflecting broader societal shifts towards recognising and addressing racial inequalities.

It is perhaps worth noting that, despite the implementation of various race discrimination legislations, scholars have pointed out the absence of a comprehensive anti-racist structure within the UK. Scholars such as Gillborn (2008), with his critical engagement

with critical race theory (CRT) in the UK, and Meer and Modood's (2012) analyses on multiculturalism, provide a foundational basis for understanding these dynamics. Eddo-Lodge (2017) in *Why I'm No Longer Talking to White People About Race* and Hirsch (2018) in *Brit(ish): On Race, Identity and Belonging* also provide compelling narratives that critique the UK's racial discourse and the limitations of its anti-racist structures. Their work suggests that while legislative efforts are crucial, they must be part of a broader, more holistic, action-oriented approach to dismantling systemic racism. There is a critical need to develop robust anti-racist structures that are informed by the unique historical, social, and cultural context of the UK.

Furthermore, the critique concerning the absence of a notable anti-racist structure in the UK raises significant questions about the nature and efficacy of existing frameworks. This observation invites a deeper investigation into how systemic and institutional racism is addressed within various sectors, including education, healthcare, and criminal justice. The work of organisations such as the Runnymede Trust (2020) and the study by McGregor-Smith (2017) offer critical insights into these areas, highlighting both progress and persistent challenges. These findings underscore the complex interplay between legislation, institutional practices, and lived experiences of racial minorities in the UK. Thus, it highlights the need for a more nuanced understanding and approach to tackling racial discrimination, one that transcends legislative measures to encompass structural and systemic interventions guided by the voices and the experiences of those most affected by racism.

The current issue of racism in the UK is complex and contentious, with racism arguably taking on new forms despite legislative advancements. Although there has been a decline in overt racist behaviour, subtler forms persist (Bhui et al., 2018; Memon et al., 2016). The UK has seen a rise in racial tensions and incidents of racism, exemplified by an increase in hate crimes, particularly against individuals from ethnic minority backgrounds,

post the Brexit referendum in 2016 (Allen, 2021; Burnett, 2017; Home Office, 2023). The Black Lives Matter movement, which gained momentum in the UK following George Floyd's murder in the US (Wadsworth, 2020), appears to have highlighted the systemic racism within UK institutions. This includes the criminal justice system, where individuals from Black and minority backgrounds are disproportionately represented (Home Office, 2023; Race Disparity Unit, 2023).

In the healthcare sector, individuals from BAME backgrounds are more likely to experience physical and mental health issues and less likely to receive appropriate care, although they may experience higher mental illness diagnoses (Bhui et al., 2018; DHSC, 2023; Hackett et al., 2020; Halvorsrud et al., 2019; Karlsen & Nazroo, 2014; Karlsen et al., 2005; Otu et al., 2020; Smith et al., 2020). Research by McKenzie and Bhui (2007) within the UK has shed light on the complex interplay between race, mental health, and societal inequities. Their findings reveal significant gaps in healthcare delivery and outcomes for the BME population, identifying socio-economic variables and institutional racism as key contributors to these inequities.

McKenzie and Bhui's (2007) research advocates for a holistic approach to mental health care that addresses the social determinants of health, emphasising the need for an anti-racist framework within the healthcare system to improve outcomes for BME communities. Fernando's (2010) contributions to understanding institutional racism further enrich the discourse on racism and healthcare. Fernando has critically examined how cultural biases and systemic practices within mental health services contribute to the marginalisation and misdiagnosis of ethnic minority patients. He argues for a transformation in the mental health care paradigm, one that integrates cultural competence and anti-racist practices to provide equitable and effective care for all individuals, irrespective of their racial or ethnic backgrounds.

In the education sector, students from BAME backgrounds are more likely to be excluded from school and less likely to achieve high grades (Department for Education, 2021; Joseph-Salisbury, 2020; Roberts & Bolton, 2020). This educational disparity seems to contribute to future socio-economic inequality and potentially limits opportunities for individuals from BAME backgrounds (Ashe & Nazroo, 2016; Bhui et al., 2018; Jones & Norwood, 2016). Such findings suggest that racism may be a significant public health issue in the UK requiring more research attention, although a recent report by the Commission on Race and Ethnic Disparities (2021) suggested that the UK is *not* institutionally racist and that factors such as socioeconomic background and family structure significantly impact life outcomes more than race. However, this report has been widely criticised (e.g., Iacobucci, 2021) for the inconsistent ethnicity data across different health conditions and the assertion that ethnic minority groups, despite facing higher deprivation, have better outcomes than the White population. The Royal College of Psychiatrists (2022) also criticised the report, stating that it implies individuals or families are to blame for the negative experiences and discrimination they face.

Whilst the UK has, however, progressed in addressing overt forms of racism, establishing legislative frameworks through the various Race Relations Acts to protect individuals from racial discrimination (Solomos, 2022), enforcing equal opportunity policies within the workplace **(**Noon, 2018), and increasing the representation of ethnic minorities in various sectors (Sobande, 2021), subtler forms of racism may persist. This requires nuanced approaches to tackle it effectively, including within the healthcare system. This may entail a multidisciplinary approach that encompasses policy reform, educational initiatives, practitioners and community engagement to combat systemic racism effectively.

1.5.2 The Impact of Racism on Mental Health

The association between racial trauma and mental illness has only recently been recognised in mainstream psychology and mental health care (American Medical Association, 2023; Hackett et al., 2020; Roberson & Carter, 2021). However, there is no specific understanding of how racism as a stressor can cause mental illness (Roberson & Carter, 2021). This lack of knowledge has made it challenging to establish assessment methods and intervention techniques for counselling BME individuals psychologically affected by racism (Carter et al., 2017). This is further supported by Bhugra and Poole (2011) and Bhugra and Gupta's (2011) analysis of cultural diversity and mental health, which has focused on the challenges and opportunities presented by cultural diversity in mental health care. Their study explored the complexities of diagnosing and treating mental illness in multicultural societies, advocating for a greater understanding of cultural factors that influence mental health and the patient-care provider dynamic. Their work emphasises the importance of cultural sensitivity and the need for mental health professionals to be educated in culturally appropriate practices and individualised care.

This is important because Carter (2007) and Roberson and Carter (2021) indicate people experience and react to racism differently according to how they make sense of it. Individual differences (e.g., age, gender) and the subjective nature of encounters may cause different reactions to the same racist incident (Carter et al., 2017), and it is believed that racial experiences do not need to be overt and direct to have a detrimental effect (Roberson & Carter, 2021; Sue et al., 2008; Wallace et al., 2016). Experiences may include slights referred to as microaggressions (Sue et al., 2007), such as annoyances like being followed in a shop (Bhugra & Becker, 2005; Bhugra & Bhui., 2001; Came & Griffith, 2018; Carlson et al., 2018; Slaughter-Acey et al., 2016). These seemingly innocuous, often unintentional, discriminatory actions, avoidance or comments (English et al., 2020; Helms et al., 2012) can

be just as harmful as overt acts of racism, leading to psychological distress such as anxiety (Soto et al., 2011), increased depressive symptoms (English et al., 2020; Helms et al., 2012; Wheaton et al., 2018) and racial trauma (Sue et al., 2007). Thus, people may adjust their behaviour to decrease the probability of being discriminated against, for instance, switching tone while speaking with someone regarded as significant to 'sound professional' (Bhui et al., 2018; Kinouani, 2020; McKenzie & Bhui, 2007; McKenzie-Mavinga, 2020).

Persons frequently targeted may lack the ability to explain their experience and articulate the emotional significance of racism adequately (Carter & Reynolds, 2011; Evans et al., 2016). Consequently, they may receive inadequate diagnoses for capturing the depth of the racist encounter(s) (Pieterse et al., 2012). Individuals enduring traumatic events for extended periods may normalise, internalise, and embrace abusers' statements as their own, making it difficult to trace back to racial origins (Bryant-Davis, 2007; Roberson & Carter, 2021). This is particularly relevant in therapy, where racial and cultural dynamics significantly influence the experiences and outcomes of Black and ethnic minority clients.

1.5.3 Race-Based Traumatic Stress (RBTS)

Race-Based Traumatic Stress (RBTS) has been defined as a complex and multifaceted psychological impact that results from experiencing, witnessing, or confronting events that perpetuate racial discrimination and prejudice (Carter, 2007; Carter et al., 2013). RBTS has been characterised by a range of emotional, cognitive, and behavioural responses similar to, yet distinct from, those associated with Post-Traumatic Stress Disorder (PTSD) (Carter, 2007; Roberson & Carter, 2021). Unlike PTSD, which is typically linked to a single or short-term traumatic event, RBTS encompasses the cumulative emotional and psychological wear and tear that individuals of racial minorities may endure over time due to ongoing racism and microaggressions (Roberson & Carter, 2021; Williams et al., 2018).

The RBTS model suggests that people are prone to RBTS when they perceive a racial encounter as uncontrollable, extremely negative, and unpredictable (Pieterse & Carter, 2010). Immediate effects of perceived stress from racism are associated with symptoms that are less severe and short-lived, such as fear, anger, sadness, low mood or anxiety or detachment, and, while distressing, they may not always reach the threshold for a formal mental health diagnosis (see, for example, Anderson, 2012; Paradies et al., 2015; Pieterse et al., 2023; Wallace et al., 2016).

In contrast, racial trauma is described as a more severe stress response that is of longer duration, significantly impairs daily functioning and involves multiple symptoms that coping or adaptation interventions cannot reduce (Pieterse et al., 2023; Roberson & Carter, 2021). These effects may have long-term consequences affecting one's identity, often resulting in low self-esteem, self-concept, and inability to cope, potentially leading to devaluation and prolonged durations of change, difficulties coping with grief, present with symptoms that align with the criteria for existing mental health disorders (like PTSD, anxiety disorders, or depression) (Helms et al., 2012; Roberson & Carter, 2021), avoidance, and hypervigilance. All of these can signify RBTS (Helms et al., 2012; Ikuenobe, 2013; Pieterse et al., 2012; Williams et al., 2018). Failure to cope or adapt may exacerbate reactions and contribute to the severity of the trauma (Roberson & Carter, 2021; Pieterse et al., 2023).

The RBTS framework itself is designed to help clinicians recognise and validate the unique experiences of minoritised individuals who have endured racial trauma (Carter, 2007; Carter & Pieterse, 2020). It acknowledges what is often seen as the reality of systemic racism and its psychological impacts, providing a language for individuals and professionals to articulate these experiences. This may empower Black clients, validating their experiences and providing a context for their symptoms. It may also provide a foundation for therapeutic interventions designed to address the unique needs of these individuals.

1.5.4 RBTS and Post-Traumatic Stress Disorder (PTSD)

The relevance of studying RBTS is underscored by literature linking it to diagnosable psychiatric symptoms that mirror those of PTSD (Polanco-Roman et al., 2019; Roberson & Carter, 2021), albeit with unique contributing factors, such as racial identity, the historical context of racism, and the ongoing nature of racial stressors. The key differentiator from PTSD appears to be the apparent *source* of the trauma. Racial trauma is linked with identity and is said to be experienced by people identifying as any race, people group or ethnicity (Williams et al., 2022).

The conceptualisation of RBTS as a psychological construct necessitates a discussion on its placement within traditional taxonomies of trauma and stress-related disorders. Traditional taxonomies, such as those found in the DSM-5, primarily conceptualise trauma and stressor-related disorders based on responses to events involving actual or threatened death, serious injury, or sexual violence (DSM-5, 2014). However, RBTS extends this paradigm by acknowledging that racial trauma can arise from systemic, cultural, and interpersonal racism that may not involve physical violence but still results in significant psychological harm (Williams et al., 2022).

Unlike PTSD, typically associated with a single, identifiable traumatic event, RBTS often results from a cumulative series of traumatic racial experiences (Carter, 2007; Carter et al., 2020; Ikuenobe, 2013; Roberson & Carter, 2021). Therefore, those affected by racism do not often fit the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2014) criteria for PTSD (Carter, 2007; Chae et al., 2011, 2015; Comas-Diaz et al., 2019; Pieterse & Carter, 2010); however, some experiences of racial trauma (e.g., physical assault in the context of hate crime) would meet the DSM-5's definition of trauma ('exposure to an actual or threatened death, serious injury, or sexual violence; APA, 2-13, p.271).

Other manifestations of racial trauma, such as chronic exposure to racial microaggressions and vicarious trauma through graphic media coverage of police brutality, may not match the aforementioned criterion despite being experienced as traumatic (Williams et al., 2022). This distinction between RBTS and traditional classifications is crucial for the development of appropriate therapeutic interventions. While PTSD treatments appear to be geared towards addressing the aftermath of acute and identifiable traumatic events, interventions for RBTS may also consider the ongoing and systemic nature of racial discrimination. This may include addressing issues related to identity, belonging, and self-esteem, as well as developing coping mechanisms for dealing with recurrent racial stressors.

Researchers such as Neville et al. (2008) argue that the criteria for diagnosing PTSD should be expanded to address the trauma of racism. However, using the criteria of PTSD as the basis for assessing race-based trauma appears to be problematic for several reasons; racial discrimination may be subtle and not always include direct physical threats, which are key for PTSD diagnosis in the DSM (Carter & Pieterse, 2020). Additionally, the symptoms of racial trauma, such as hyper-vigilance, flashbacks, and physical complaints, may vary significantly from those of PTSD, making tools such as the RBTSSS or UnRESTS (see page 9-10 for terminology), more relevant for assessing racial trauma (Carter & Pieterse, 2020; Comas-Díaz et al., 2019).

The argument for using RBTS in the US as a conceptual tool is that African Americans have higher levels of PTSD unexplained by a specific incident compared to Caucasians, and it is speculated that race may be a factor (Carter & Pieterse, 2020; Carter et al., 2019; Kirkinis et al., 2018). As such, although people with racial trauma are suffering psychologically, the source of the problem may not be within the person, but possibly rather the product of a dysfunctional society. Therefore, in this sense, RBTS can be viewed as a reactive experience, rather than a defined mental health condition. It is important to highlight

that White people may suffer from racial trauma as well. However, it should be noted that the impact of racial stress on White people may not be amplified by their chronic and systemic racial oppression (as it can be for Black people or minorities in the UK); therefore, it may be less likely to be experienced as traumatic. This is not to undermine the racial stress experiences of any other racial group but to highlight a particular type of trauma that appears to be largely unique to racial minorities. This underscores the potential need for interventions that acknowledge the impact of the socio-cultural context of the client's experiences (Sue, 2007). In the context of examining racism in the RBTS framework, the manifestation and acknowledgement of this issue differ between the UK and the US.

1.5.5 Adapting the Concept of RBTS from the US to the UK

Both the US and the UK have histories of racial oppression, though they manifest differently due to their unique historical, social, and political contexts. In the US, racial oppression arguably has its roots in the institution of slavery, followed by the Jim Crow laws that enforced racial segregation and disenfranchisement of African Americans (Pollak, 2021). These historical injustices may have evolved into systemic racism that affects African Americans and other racial minorities, such as Latino/Hispanic communities, Asian Americans, and Native Americans, all of whom can experience significant challenges as a result (Allen & Easley, 2006).

By contrast, the UK's racial oppression appears to be intertwined with its colonial past. Post-colonial migration patterns from former UK colonies have brought unique intergenerational experiences that appear to differ from those of African Americans in the US (Trovão, 2012); therefore, understandings of RBTS and subsequent assessment tools may not be easily transferable between the UK and the US.

In the UK, there is an increasing awareness of the mental health implications of

racism. Studies have indicated higher rates of psychosis in Britain's Black Caribbean populations in the UK (Bhui et al., 2018; Halvorsrud et al., 2019). Compared to the US, the UK has its own unique set of institutional structures that may perpetuate racism, such as the class system (McKenzie & Bhui, 2007). Class-based systems may contribute to the perpetuation of racism by upholding economic, educational, and social inequalities that disproportionately impact racial minorities (McKenzie & Bhui, 2007). These systems are seemingly interwoven, each reinforcing the other, which may present challenges in addressing racial disparities without simultaneously confronting class inequalities. This intersection of class with race can add layers of complexity to the trauma experienced by racial minorities in the UK, implying that it may not be entirely suitable to apply the RBTS framework to the UK without careful adaptation. Nevertheless, it offers a starting point for global conversations about racial trauma.

1.6 Theoretical Framework

Three critical theories that can be employed to evaluate and comprehend these influences within the context of RBTS are CRT, Cultural Humility (CH) and intersectionality. This section establishes the applicability of these theories to the current study and proposes a rationale for their use in this context.

1.6.1 Critical Race Theory (CRT)

Critical Race Theory (CRT) originated from legal studies in the mid-1970s and has since permeated various disciplines, including education, sociology, and psychology (Bell, 1992; Delgado & Stefancic, 2017). CRT challenges the conventional notions of race, racism, and power, focusing on the systemic and structural aspects of racism (Delgado & Stefancic, 2017). Therefore, CRT is foundational in the exploration of systemic racism and its psychological ramifications, which is particularly relevant to understanding RBTS. The key

tenets of CRT crucial to this study include:

Tenet 1: Race is a social construction. CRT argues that race is not a biological fact but a social construct that changes over time and across different contexts. It emphasises that the concept of race has no inherent biological significance but is created and given meaning through social processes to maintain and justify systems of power and privilege.

Tenet 2: Racism is not a person but a system of power and domination. Although individuals can indeed be racist, racism and its outcomes are perpetuated in society through social processes above and beyond individual actions, including through cultural norms, institutional rules, and laws and regulations. Rather than focus on racism as primarily being a problem of person-to-person racism, CRT elucidates how institutions, systems, and policies can be designed in ways that reinforce, codify, and perpetuate exposures, risks and opportunities that differ across socioeconomic and racial groups.

Tenet 3: Racism and racial discrimination have become a part of our society. The differential treatment of individuals based on their race is deeply rooted in our social systems and institutions, including public policy and law. As a result, racism has become a common occurrence. Understanding structural racism in our systems and policies related to education, income, housing, criminal justice, the environment, and healthcare is crucial in addressing population health inequities.

Tenet 4: Storytelling and Counter-Narrative. While racism is perpetuated at the structural/macro level in society, listening to and understanding the lived experiences of individuals is essential for understanding how racism works to create inequities in individual outcomes, including mental health.

CRT's relevance to the current study lies in its ability to illuminate the systemic

factors that might influence the therapeutic process, often manifesting in ways that are subtle and institutionalised, contributing to the psychological distress observed in racial trauma that parallels diagnostic criteria for trauma-related disorders (Carter 2007; Roberson & Carter 2021). Therefore, CRT can provide a theoretical basis for understanding the dynamics within the therapy room, as they may reflect broader socio-political dynamics of racial power and privilege and not merely individual experiences (Goodman et al., 2004; Hook & Watkins, 2015; Sue et al., 2007). CRT serves as a critical lens through which therapists can assess the extent to which systemic racism is embedded in their own professional development and practice settings. CRT's utility in this research further provides a lens through which therapists may consider systemic barriers that their Black clients might face and through which to examine their own positionality/biases and the systemic influences on therapeutic relationships.

Black clients often report feeling misunderstood or stereotyped in therapy, which can hinder the healing process from RBTS (Chin et al., 2023; Comas-Díaz, 2016). Therefore, applying CRT to the therapeutic context may provide a framework for analysing how racial trauma can be better understood, validated, and treated in therapy. Further, CRT emphasises the value of lived experiences and storytelling as valid sources of knowledge (Solórzano & Yosso, 2002). Therefore, adopting CRT aligns with the research goal in this study, and is anticipated to help validate and prioritise the experiences and voices of therapists and their Black clients, potentially offering a nuanced understanding of their experiences with RBTS (Solórzano & Yosso, 2002). While offering a crucial lens through which to view the structural and systemic (macro-level factors) underpinnings of racial trauma, CRT may not fully encapsulate the individual and interpersonal aspects of racial trauma experienced by clients. However, when paired with intersectionality, the framework expands to recognise the multifaceted nature of identities and how different aspects of identity (such as race, gender,

class, etc.) intersect to shape experiences of oppression and trauma (Ortiz & Jani, 2010). This combination appears to encourage therapists to consider both the broad societal factors and the specific, individualised experiences of their clients.

1.6.2 Cultural Humility

In exploring therapists' experiences of working with Black clients presenting with RBTS, the concept of 'cultural competence' frequently emerges as a framework for addressing the therapeutic needs of racially and culturally diverse clients. Cultural competence consists of three dimensions: (1) therapists' self-awareness of their own biases and stereotypes; (2) knowledge of the client's culture; and (3) skills to implement culturally appropriate interventions (Sue & Sue, 2016). Research indicates that culturally adapted interventions can significantly improve therapeutic outcomes among racial minority clients (Griner & Smith, 2006). Cultural Competence Model (CCM) calls for clinicians to critically reflect on any biases, stereotypes, and preconceptions that may influence their approach. Such self-awareness is suggested as the critical first step in providing culturally competent care, as it may facilitate professionals' dismantling of potential barriers to understanding and empathising with their clients (Isaacs & Benjamin, 1991).

In the context of RBTS, self-awareness is important, as therapists must be aware of how their cultural biases might impact their ability to recognise and validate their clients' experiences of racism and racial trauma (Carter & Scheuermann, 2019; Isaacs & Benjamin, 1991). This requires understanding how race and racism intersect with mental health and how these intersections manifest in the therapeutic setting (Carter, 2007). Therefore, such self-reflection seems vital in creating a therapeutic environment that acknowledges and mitigates the effects of systemic racism.

While CCM stresses the importance of therapists' ability to understand, appreciate, and adapt to cultural differences in the therapeutic process (Sue & Sue, 2012), the term

‘cultural competence’ itself has come under scrutiny. Critics argue that the concept implies a definitive level of knowledge or an endpoint at which one can be deemed competent in the cultures of others (Khan, 2023). This perspective is increasingly seen as problematic as it suggests that understanding and effective interaction across cultures can be fully achieved, neglecting the ongoing and dynamic nature of cultural learning and interaction. Furthermore, the concept of ‘cultural competence’ has been criticised for potentially reinforcing simplistic and stereotypical understandings of culture (Harrison & Turner, 2010). It can inadvertently suggest a checklist approach to culture, where knowledge of certain cultural facts or behaviours is seen as sufficient, thereby failing to capture the complexities, fluidities, and individual variations within any cultural group (Kirmayer, 2012). This critique suggests a need for models that emphasise Cultural Humility (CH) and an ongoing commitment to learning about and reflecting on one’s own cultural lenses and biases, as well as those of others, rather than asserting a state of competence.

Recognising these limitations, the concept of CH was adopted over CCM for the present research. In this study, CH is positioned as a guiding principle for therapists, emphasising an ongoing process of self-reflection and personal decolonisation, whereby the therapist does not see themselves as a fully competent ‘knower’ but rather as a committed learner in the context of their client’s cultural experiences (Danso, 2018). This approach is viewed as crucial for therapists in acknowledging their own biases and power dynamics within the therapeutic relationship and learning from clients about their experiences of racism and how these experiences affect their mental health (Tervalon & Murray-García, 1998). This ongoing process aligns with this study’s objective of contributing to the development of therapists’ knowledge, sensitivity to, and practical skills surrounding a client’s cultural identity and experiences. Thus, CH arguably involves recognising one’s limitations in terms of understanding the cultural experiences of others, particularly those from marginalised

racial groups. It seems to encourage therapists to approach each client without preconceived notions and remain open to how the client's cultural identity shapes their experience of the world, including the experience of racial trauma. This approach seems to be paramount when supporting Black clients presenting with racial trauma, as it emphasises the importance of ongoing learning and reflection in understanding clients' unique cultural backgrounds and the impact of racism on their mental health. This lifelong process could potentially contribute to developing more empathetic, effective, and culturally sensitive therapeutic practices and a more personalised approach to therapy, including for Black clients experiencing RBTS.

1.6.3 Intersectionality in RBTS

Kimberlé Crenshaw (1989) conceptualised intersectionality as a framework for understanding how people are located on a power-oppression spectrum. Similar to CRT, intersectionality is concerned with the structures and processes that perpetuate inequality and is committed to uncovering and dismantling these systems. The core tenets are as follows:

Tenet 1: Intersecting Identities. This posits that people's experiences of discrimination (degree of oppression) and privilege (power held) stem from the combination of various social categories, such as race, gender, class, and sexuality and all other identity characteristics, which intersect to create unique modes of oppression or privilege (Crenshaw, 2013).

Tenet 2: Matrix of Domination. Patricia Hill Collins (1991) expands on this concept, arguing that systems of oppression (e.g., racism, sexism, classism) are multifaceted and cannot be examined in isolation. This helps to locate and understand the person's social position and lived experience within systems and structures of inequality. The approach allows for all the multiple identity characteristics to be acknowledged within one person and how the multiple privileged and oppressed identities co-exist as well as reinforce one another

and their overall sense of self (Eddo-Lodge, 2017; Thomas, 2022).

Tenet 3: Relationality and Power. This reframes the power narrative to consider privilege and oppression as overlapping, affecting inter- and intra-group relations. It is imperative to remember that intersectionality (intersectional identities) recognises and acknowledges both a person's privileged (advantaged) identities *and* their oppressed (disadvantaged) identities (Eddo-Lodge, 2017; Thomas, 2022; Winter, 2021).

This framework is particularly relevant in this study, as it highlights that the multifaceted Black client's experience of racial trauma is not homogenous for all Black individuals; rather, multiple sources of oppression may influence experiences, including other aspects of the client's identity or factors such as political, representational, or structural intersectionality (Sue & Sue, 2016). Intersectionality is also significant to the research objective of examining how therapists' training has influenced their perceived ability to work with Black clients. It was therefore chosen as a theoretical framework to ensure that the research does not take a monolithic view of the Black experience but acknowledges the varied and layered forms of discrimination that can affect mental health outcomes.

Arguably, awareness of intersectionality is crucial in ensuring that therapists can engage with Black clients in a manner that is both culturally attuned (targeted therapeutic interventions) and responsive to the broader socio-political realities of racism that might lead to RBTS. It is, however, equally vital to recognise the shared experiences of racial trauma that unite Black individuals. This arguably aligns with research indicating that, despite varying intersecting identities, Black individuals commonly face racial microaggressions and systemic discrimination (Galán et al., 2022). These experiences may be deeply rooted in historical and ongoing racial injustices, shaping the collective trauma and resilience of the Black community (Mohatt et al., 2014).

Cole (2009) discusses the potential limitation of intersectionality in psychology, particularly its ability to overlook *commonalities* across different groups' experiences, challenging the conventional view of social categories as defining fundamentally different types of people. She suggests that identifying both differences and similarities is crucial, as focusing solely on differences may not provide full insight into the psychological experiences that can accompany each category, or the practices that create and maintain them. Instead, she encourages psychologists to conceptualise social categories as defining structural relations with implications for individual, social, and institutional practices, which necessitates attending to both differences and similarities. This suggests that, while intersectionality is critical for understanding the multiplicity of social identities and their impact, it is crucial researchers remain sensitive to common experiences that cross different social categories.

Therefore, incorporating intersectionality within the study of RBTS may allow therapists to gain a comprehensive understanding of both the shared and distinct aspects of the racial trauma experience. This includes recognising the themes and patterns of racial trauma while remaining attentive to the unique manifestations and impacts of these experiences. Intersectionality complements CRT in this study by allowing for an exploration of varied experiences of racial trauma from personal, societal, and systemic discrimination and intersectional perspectives.

1.6.4 A Summary of the Rationale for the Application of Theories

In this research, the aim was not only to identify and categorise experiences of racial trauma but also to understand how therapists may develop competencies to support Black clients effectively. The combined use of CH, CRT, and intersectionality provides a comprehensive framework for examining these competencies. The synergistic application

also addresses the limitations inherent in each theoretical framework when considered in isolation, while offering a robust scaffold for understanding the nuanced experiences of therapists working with Black clients who have endured RBTS. Furthermore, together, these theories seem to align with the imperative need to develop practical, empathetic, and socially just therapeutic practices that acknowledge and address the multifarious impacts of racism on mental health within the UK context. Thus, they are attempting to address the need for personal, professional, systemic, and institutional awareness and change, which may be crucial for effective therapy in cases of RBTS.

Participants in my study reported experiences that align with microaggression theory, detailing how microaggressions contribute to a sense of exclusion, rejection, and an ongoing experience of being an outsider. As defined by Sue et al. (2007), microaggression theory provides an essential framework for understanding the nuanced and pervasive nature of racial trauma experienced by Black individuals in the context of RBTS. This theory elucidates the everyday, subtle, and often unintentional interactions or behaviours that communicate hostile, derogatory, or negative racial slights and insults towards people of colour, which are critical to explore within the therapeutic setting for Black clients experiencing RBTS. Microaggression theory posits three primary tenets that contribute to the perpetuation of racial trauma: Microinsult, Micro assault, and Microinvalidation (Sue et al., 2007). Each of these tenets plays a significant role in the lived experiences of Black individuals, which may impact their mental health and well-being:

Microinsult: This tenet suggests the often unconscious behavioural or verbal remarks that convey rudeness or insensitivity, ultimately demeaning a person's racial heritage or identity, such as the framing of cultural expressions, values, and communication styles of Black individuals as deviant or problematic within the dominant culture. This misrepresentation could lead to feelings of alienation and misunderstanding within

therapeutic settings, emphasising the need for therapists to cultivate CH and an appreciation for the diversity of Black cultural expressions.

Micro assault: This tenet seems to reflect a societal tendency to unjustly perceive Black individuals as inherently suspicious or prone to criminal behaviours, which may lead to name-calling, avoidance or fear. This unjust perception can lead to experiences of racial profiling and increased encounters with law enforcement, contributing to heightened levels of anxiety, stress, and trauma among Black communities. Therapists' awareness and understanding of these experiences may be crucial for creating a therapeutic environment that acknowledges and validates the client's reality.

Microinvalidation: This may involve verbal comments or behaviours that inadvertently exclude, negate, or dismiss the psychological thoughts, feelings, or experiential reality of people of colour. This invalidation is suggested to often extend into therapeutic spaces, where, if not actively acknowledged and addressed, it may lead to the invalidation of the Black client's experiences, further exacerbating their trauma. Therefore, recognising microinvalidations appears to be critical in therapy to prevent the alienation of Black individuals and to ensure that their cultural expressions and values are understood and respected.

While incorporating microaggression theory within this broader framework would undoubtedly add value, the research question demands a wider lens. Thus, although microaggression theory is relevant and was considered integral to understanding the everyday experiences of subtle forms of racism in this study, it was not the central focus of the research framework. It is my belief that it does not encompass the full spectrum of RBTS, especially in the therapeutic context where the dynamics may be complex and multi-layered. Anchoring the study in CRT, CH, and intersectionality facilitated a more comprehensive exploration of racial trauma that aligns with the research objectives, enabling an in-depth exploration of the

knowledge, skills, and systemic influences that shape therapists' preparedness and efficacy in working with Black clients who have experienced RBTS. This approach was not to diminish the value of microaggression theory, but to prioritise theoretical frameworks that provide the most applicability and relevance for the specific aims of this study. Moreover, the research objectives extend beyond the individual experience of racism to include the broader socio-political context that appears to shape and inform these experiences. It was argued that microaggression theory may not adequately capture the complexity of RBTS, which is often embedded within the larger systemic structures that CRT addresses. While microaggressions may contribute to the individual's *experience* of racial trauma, they appear to be symptomatic of the broader systems of oppression; therefore, unpacking and dismantling these systems might work to reduce microaggressions in future.

Therefore, the theoretical blend adopted by the present study contextualises microaggressions within broader systemic and cultural narratives, which seem particularly pertinent to the UK context, whilst also emphasising the need for therapeutic practices responsive to the complexities of racialised experiences. This approach ensured that the study is equipped to explore the therapeutic interactions between therapists and their Black clients experiencing RBTS, providing a nuanced understanding that might support effective, culturally responsive therapeutic interventions.

1.7 The Prevalence of RBTS in Black Clients

The prevalence of RBTS symptoms among Black individuals is a concern highlighted in numerous studies (Carter et al., 2019; Fast & Collin-Vézina, 2020). Systematic literature reviews have found that racial discrimination is associated with many cases of trauma symptoms and negative mental health outcomes (for example, in Kirknis et al. (2018), it was present in 70% (28) of 44 studies; in Priest et al. (2012), it contributed to 76% of mental health outcomes for children and young people; in Pieterse et al. (2012), it was found

in 66 studies of Black adults; and in Paradies et al. (2015), it was present in 293 studies). This association extends beyond overt forms of racial discrimination to include more subtle forms, such as racial microaggressions. However, these findings compound the complexities of isolating racism from other forms of psychological distress, such as depression and anxiety (Paradies et al., 2015; Pieterse et al., 2012; Priest et al., 2013). The high prevalence of RBTS among Black individuals arguably underscores the systemic and pervasive nature of racism in society, reinforcing that RBTS should be recognised as a factor in PTSD that requires specific support (Carter et al., 2019).

1.7.1 The Role of Supervision

Given the emotionally demanding nature of working with clients who have experienced RBTS, supervision arguably provides a critical support system for therapists (Bernard & Goodyear, 2009). Studies indicate that the level of multicultural competence possessed by a supervisor has a significant impact on the supervisor-supervisee relationship (Green & Dekkers, 2010; Zhang et al., 2022). When supervisees perceive their supervisor to possess multicultural competence, they tend to express a higher level of satisfaction with supervision (Inman, 2006). Yet a substantial number of supervisors might not have engaged in thoughtful reflection of their conscious or unconscious biases regarding race (Constantine & Sue, 2007).

Constantine and Sue (2007) and Inman and DeBoer Kreider (2013) suggest that supervision can also play a paramount role in promoting CH. It offers a platform for reflective dialogue, case consultation, and feedback, helping therapists enrich their understanding and application of CH with their clients. However, many supervisors report a lack of preparedness to effectively address these issues, suggesting a need for more training in CH (Gatmon et al., 2001).

Working with racial trauma can result in exhaustion, cynicism, and a sense of ineffectiveness – common indicators of burnout (Maslach & Leiter, 2016) that supervision may help to forestall. Supervision can offer emotional support, validation, and self-care strategies, enabling therapists to maintain their performance over extended periods. However, research points to a need for better supervisor training in identifying and addressing supervisee burnout (Ladany et al., 2013), revealing yet another lacuna in current supervisory practices. Additionally, there is evidence that most supervisors are ill-equipped to navigate issues related to racial trauma-induced countertransference (Hook et al., 2016).

1.8 Literature Review of Therapists Working with Black Clients Presenting with RBTS

1.8.1 Focus of the Review

This review focuses on the experiences of therapists working with Black clients presenting with RBTS. Limitations in the existing literature are identified, as well as relevance to counselling psychology.

1.8.2 Methodology for Literature Search

The literature review involved a comprehensive search of academic databases, including PubMed, *EBSCO* PsycINFO, and Google Scholar, to obtain articles and e-books. The search was conducted using a combination of keywords: *"counsellors", "psychotherapists", "counselling psychologists", "race-based traumatic stress", "experiences",* and *"Black clients*." The inclusion criteria for the review were studies that focused specifically on the experiences of therapists working with racial trauma and clients from minority groups presenting with RBTS. This ensured that the findings were directly relevant to the research question. The timeframe for publications was set within the last 16 years, as it has been during this period that RBTS has become a recognised phenomenon,

particularly in the US. Selected studies were critically evaluated based on their methodology, findings, and contribution to the field.

Papers were excluded from the review if not available in English, as translation was not a viable proposition. A total of six studies met the inclusion criteria and were selected for the review (see Appendix N).

1.8.3 Therapists' Experiences of Working with RBTS

The search revealed very few studies focusing on therapists working with RBTS, yet some do exist. For example, Williams et al.'s (2018a) study serves as a guide for counselling clinicians, particularly trainees, on how to approach sensitive questions about race and racism for culturally informed assessment and treatment approach race and racism. The study reviewed the literature and existing measures for the assessment of racial trauma and introduced the UComRacial/Ethnic Stress & Trauma Survey (UnRESTS), a clinician-administered interview designed to aid in uncovering racial trauma. The study found that racial trauma is likely to be unrecognised by clinicians due to the lack of awareness and discomfort surrounding discussions about race in the therapeutic setting and the lack of validated methods for assessment (Williams et al., 2018a). Thus, it highlights a critical need for clinicians to understand the role of racial stressors as traumatic experiences and calls for research into effective treatments for individuals suffering from racial trauma.

While the UnRESTS was tested by psychological clinicians at various sites, including clinician workshops, student counselling clinics, outpatient clinics, a multisite PTSD treatment programme, and forensic settings, it is unclear how many professionals reviewed and tested this framework or how many clinicians worked with Black clients experiencing RBTS. The study was correlational and quantitative in nature and focused mainly on self-reported individual-level experiences, most of which included some measure

of frequency, utilising measuring tools such as the Likert Scale. Qualitative data was also incorporated, primarily to probe and demonstrate claims based on statistical inferences from quantitative results (Williams et al., 2018a).

The study thus arguably lacks an in-depth grasp of the experiences of counselling professionals working with Black clients who presented with RBTS. Furthermore, although the tool might help clinicians identify and address racial traumas in their practice and present as an essential step towards providing validation and culturally informed care for ethnic minority clients, it is not recognised in the UK. Significant adaptations may be required to apply the UnRESTS scale to a UK context given various cultural and societal differences between the UK and the US.

Another quantitative study was conducted by Hemmings and Evans (2018), who investigated 106 counsellors' experiences of identifying and treating race-based trauma and the relationship between training and treatment. A survey consisting of multiple-choice, multiple-response questions was used to collect data. They found that participants (70.8%) reported working with clients who had experienced RBTS. Sixty seven percent of counsellors stated they had not received adequate training on recognising RBTS, and 81.1% claimed they had not received training on treating racial trauma. The study also found a lack of professional policies that include interventions and recommendations (Hemmings & Evans, 2018). Additionally, therapists reported difficulties accessing models that address RBTS, with most of those in existence lacking strategies for coping with the interpersonal and emotional suffering of racism.

The study's limitation is that it mainly relied on quantitative methods to explain the personal emotions that individuals experience when faced with significant events, such as racial abuse. These emotions can be diverse and complex and cannot be fully captured through quantitative analysis alone. However, this study arguably illuminates a significant

gap in training for therapists regarding recognising and treating race-based trauma, highlighting the need for more professional policies and strategies to help therapists navigate these issues.

King's (2021) qualitative study (using thematic analysis) explored the experiences of 13 NHS-qualified psychologists in understanding and exploring racial trauma within their clinical work with service users from Black and Asian racialised communities. The study findings suggest that mental health services often underestimate the experiences of racial trauma among service users, leading to the omission of discussions related to the impact of racism on mental health. Participants expressed the need to adapt clinical practices to support individuals and communities affected by racial trauma effectively. King's study is arguably pivotal for its in-depth exploration of how racial trauma is navigated within the NHS. It provides valuable insights into the challenges and potential strategies for more inclusive and effective psychological support. One notable limitation of the study, however, is its approach to treating the experiences of Black and Asian communities as a collective phenomenon. While this approach allows for a broad examination of racial trauma within NHS psychological services, it might unintentionally gloss over the distinct and nuanced ways in which racism impacts different racial and ethnic groups. Racism is not a monolithic experience; its manifestations and the subsequent traumatic stress it induces may vary significantly between different communities due to a myriad of factors, including cultural context, historical backgrounds, and the specific stereotypes and prejudices faced by each group. Therefore, the combination of experiences from diverse racialised communities may lead to a generalised understanding of racial trauma that does not fully capture the unique challenges and specific therapeutic needs of Black clients, as compared to those from other minority backgrounds.

Carter et al.'s (2013) study offered the Race-Based Traumatic Stress Symptom Scale (RBTSSS) as a tool for therapists to assess the emotional reactions to racism and racial discrimination. Three hundred and eighty-one mental health professionals from diverse minorities in the US participated. The findings indicated that individuals who regarded memorable events of racism as emotionally distressing, characterised by suddenness and unexpectedness, scored higher than those who did not. The findings from Carter et al.'s (2013) study may help clinicians comprehend the broader consequences of racism and potentially offer a psychological assessment tool that can determine how an encounter with racism or racial discrimination may have caused psychological harm. However, the limitations of the measure include that it is mainly quantitative, self-reported and cannot be generalised to all minorities (e.g., in the UK as, similarly to the UnRESTS, the RBTSSS it is not recognised in the UK). Additionally, the study used a complicated scoring system to examine just one racial incident.

Malott and Schaefle (2015) provide a four-stage model for clinical practice to help therapists address and promote a client's exploration of racism and its effects. Although the model provides guidance in addressing racism with clients, less is known about its effectiveness or counsellors' experiences. The study lacks primary in-depth qualitative data, as the synthesised literature was based on quantitative findings.

Several cross-sectional design studies have been conducted in the US to examine therapists' multicultural competence. These studies have found that therapists avoid discussing racism-related topics during counselling sessions due to their unease and concern about saying something that might upset their clients (Bryant-Davis, 2007; Carter, 2007; Carter & Forsyth, 2010; Evans et al., 2016). Researchers further discovered that this avoidance occurs due to a lack of specific multicultural training and awareness of the significance of racism in clients' lives (Carter & Forsyth, 2010). These studies indicate a

paucity of training opportunities beyond academia and modalities for treating the effects of racism and RBTS. It is worth noting however that these studies mainly focused on therapists' competencies, including awareness of personal biases, knowledge of their clients' worldviews, and expertise to give culturally appropriate interventions, rather than their *experiences* of working with clients. Despite general acknowledgment of the importance of cultural competence, the definition and measurement of cultural competence remain contested, as to whether one can be fully culturally competent (Khan, 2023).

While all studies presented here provide valuable insight into therapists' experiences of working with ethnic minorities, the general reliance on quantitative approaches may not provide a comprehensive, in-depth understanding of the experiences of therapists working with Black clients who have RBTS. Additionally, most prior research has focused on clients' experiences, rather than exploring the challenges *professionals* face in supporting them. The paucity of appropriately targeted qualitative studies therefore arguably constitutes a significant gap in the literature.

1.9 The Study Research Question

The overall research question of the proposed study is: **How do therapists make sense of their experience of working with Black clients who have endured race-based traumatic stress?**

Particular areas of interest are:

- The knowledge and practical skills of therapists in supporting Black clients with RBTS.
- How therapists perceive and interpret their readiness and competence in working with Black clients who have RBTS.

- How their training has influenced their perceived ability to work with this particular population.
- Where therapists turn to for support related to RBTS if required.
- What recommendations therapists may have for improving support and provision for clinicians working with Black individuals who have experienced racism/RBTS.

Chapter Two: Methodology

2.1 Overview

This chapter outlines and provides a rationale for my epistemological position, methodology and methods, before addressing ethical issues.

2.2 Research Paradigm

The philosophical underpinnings of psychological research can be diverse. In all research, there are assumptions regarding the nature of reality (ontology), how knowledge is obtained (methodology), and the association between 'knower' and 'what is known' (epistemology) (Ponterotto, 2005).

In quantitative studies, researchers often seek objective truths (realist ontology) and prioritise measurable data (a positivist paradigm), while in qualitative studies, most researchers embrace the idea that truth is subjective (relativist ontology) and are more open to varied, subjective interpretations, such as through the lenses of critical realism or constructivism-interpretivism (Ponterotto, 2005). Within the context of a specific study, researchers are recommended to embrace a stance that reflects their beliefs about how knowledge is gained and the nature of reality (Denzin, 2000). Such a heightened consciousness of these paradigms not only cements the foundational integrity of an investigation but also significantly steers methodological choices (Morrow, 2007). Since the research on RBTS in the UK is in its infancy, a qualitative approach offers the flexibility to explore a problem that is ill-defined (Sekaran & Bougie, 2016) and capture additional nuances and complexities that might be missed in a quantitative study.

Given that RBTS is an internal psychological response to external stressors that are likely to manifest and be experienced differently in each individual based on background,

culture, upbringing, and several other factors (Roberson & Carter, 2021), including perhaps even the client-therapist interactions, a constructivist paradigm provides an appropriate lens to capture the multifaceted nature of such experiences (Zimmerman & Dickerson, 1996).

Constructivist epistemology asserts that our knowledge of the world is constructed through our experiences and interpretations (Zimmerman & Dickerson, 1996). In this context of my research, it is about understanding how therapists interpret the experiences of Black clients with RBTS. Hence, adopting a constructivist paradigm allowed me to embrace and acknowledge these varying perspectives in line with relativism, asserting that truth is subjective and varies between individuals and cultures (Willig, 2013). It is important to note that constructivism does not negate the existence or significance of external phenomena like racism or race-related trauma; instead, it emphasises understanding how individuals interpret these phenomena. Similarly, racist experiences vary in magnitude depending on how individuals make sense of their experiences (Carter et al., 2017; Roberson & Carter, 2021). Hence, I adopted a relativist stance within the paradigm of constructivism.

Since the study's objective was to explore the nuances of how professionals perceive, make sense of, and navigate RBTS, a qualitative design using Interpretive Phenomenological Analysis (IPA) (Willig, 2013) was an invaluable tool to unpack these layers of subjective experiences and the intricacies of navigating these issues within a therapeutic context.

2.3 Choosing Interpretative Phenomenological Analysis

Before settling on IPA, I considered Narrative Analysis (NA) (Reissman, 2008), Discourse Analysis (DA) (Coyle, 2007; Jorgensen & Phillips, 2002), and Thematic Analysis (TA) (Braun & Clarke, 2006) as potential methodologies. Whilst each approach has strengths, after careful consideration, IPA was deemed the most suitable approach for several

compelling reasons.

NA focuses on how individuals construct narratives to understand their experiences (Reissman, 2008). Yet the primary focus of this research was not on how therapists *tell* their stories but on how they *experience* working with RBTS and their emotions, thoughts and reflections; hence, NA might not delve as deeply as IPA could. Therefore, NA was deemed unsuitable for the study aims.

Conversely, DA is rooted in the constructivist paradigm, focusing on how language constructs social realities (Coyle, 2007). While it would have provided insights into how therapists *talked* or *constructed* discourse about and framed RBTS, it may not have delved deeply into their personal experiences and emotions. For these reasons, the research aims of the study are incompatible with DA because it does not facilitate detailed participant exploration of their stories. Moreover, RBTS would be conceptualised differently if less emphasis was placed on the individual and their meaning-making.

I considered TA due to its flexible approach, which allows for identifying themes across datasets (Braun & Clarke, 2006), similar to IPA. However, it may have lacked the depth and sensitivity required to explore the intricate layers of meaning within the experiences of RBTS. Therefore, IPA was deemed the more appropriate choice. While TA, NA, and DA each offer unique strengths and perspectives, the interpretative nature of IPA promised to facilitate a richer understanding (Larkin et al., 2006) of how therapists perceive, navigate, and assign meaning to encounters with RBTS. This could potentially better uncover the dilemmas and coping mechanisms therapists employ in their practice. Furthermore, IPA could consider the insider position of a researcher who has lived experience of the topic, hence providing a suitable methodology.

2.4 Overview and Rationale of IPA as a Chosen Methodology

IPA can encompass various contextual layers, including societal, linguistic, and cultural, all playing pivotal roles in constructing meaning (Smith & Fieldsend, 2021); hence, it was chosen for this study. IPA's strength lies in its inductive approach, with its data emerging primarily and naturally from semi-structured interviews with participants (Willig, 2017). This permits a richer, more nuanced insight into human experiences and associated interpretations (Smith, 2016; Willig, 2017). Thus, IPA was deemed well-suited for this exploratory research (Ricoeur, 1986). IPA is grounded in three core frameworks: phenomenology, hermeneutics, and idiography (Smith et al., 2009) as follows:

Phenomenology: IPA is rooted in the works of prominent phenomenological philosophers such as Husserl (1859-1938) and Heidegger (1962). Husserl focused on grasping the core aspects of personal experiences through 'bracketing' all prior existing assumptions and beliefs, focusing on the content of one's consciousness (Smith & Osborn, 2008). This approach aimed to provide a clear and unobstructed view of the phenomenon under investigation. Conversely, Heidegger placed significant emphasis on utilising interpretation as a means of accessing an individual's in-depth experience (Smith et al., 2009). This methodology positions the researcher at the heart of the study, facilitating meaning-making via the hermeneutic tradition (Smith et al., 2020).

Hermeneutics: Hermeneutic phenomenology emphasises that every event or contact entails an interpretation based on an individual's background and life experience (Smith & Osborn, 2008), including their social, cultural, and psychological contexts (Smith et al., 1995). IPA was chosen as it involves a double hermeneutic process, the reciprocal process of sense-making between participants and researchers (Smith et al., 2020). This means I, the researcher, attempt to understand the participants' meanings (second hermeneutic—the

interpretative aspect of IPA) as they make sense of their experiences (first hermeneutic—during the interview) (Smith et al., 2020). Therefore, language serves as a medium through which the double sense-making occurs (Smith et al., 2008; Smith & Osborn, 2008).

Idiographic Focus: IPA is inherently idiographic, meaning it focuses on a nuanced exploration of individual accounts (Pietkiewicz & Smith, 2014), which is crucial when exploring complex topics such as RBTS. This study aims to gain a deep understanding of unique experiences, challenges and coping mechanisms rather than identifying general themes.

Limitations: Some researchers have questioned whether IPA captures experiences and meanings rather than opinions (Brocki & Wearden, 2006; Larkin et al., 2006). These apprehensions stem from the complexities involved in distinguishing between an individual's direct experiences and the opinions or beliefs they may hold (Brocki & Wearden, 2006). In this context, an opinion is understood as a belief or judgement founded on grounds insufficient to produce complete certainty (Eatough & Smith, 2008). Conversely, an experience or meaning is a direct encounter with or undergoing an event or occurrence, which has a distinct subjective quality that the individual interprets (Larkin et al., 2021). The crux of the debate is whether IPA, through its interpretative lens, inadvertently blurs the line between these two concepts.

This concern has merit, considering that IPA, by definition, relies on the researcher's subjective perceptions (Smith et al., 1995). This risks clouding the differentiation between genuine lived experiences and individual opinions. A possible counter is to ensure a rigorous and reflexive process during data collection and analysis (Smith & Osborn, 2008; Tufford & Newman, 2010).

Additionally, IPA research aims to comprehend lived experiences but does not

attempt to explain *why* they occur (Smith et al., 2009), which may limit our understanding. However, Nizza et al. (2021) argue that IPA uses hermeneutic, idiographic, and contextual analysis to ascertain participants' cultural positions. Hence, in this study, I focused on understanding participants' orientation as therapists towards their clients with RBST.

2.5 Quality and Validity

This study aligns with Yardley's evaluative criteria (2000; 2008) designed to gauge the rigour and quality within an IPA methodology (Smith, 2009). As outlined by Yardley, these evaluative metrics are as follows: (1) sensitivity to Context, (2) Commitment and rigour, (3) Transparency and Coherence, and (4) Impact and Importance. While Yardley promotes these as guiding rather than stringent principles, my study seeks a balance between the principles and this study's unique demands and challenges. This research embraced reflexivity in alignment with the tenets of transparency and coherence; throughout the study, I made a conscious effort to critically assess my role as a researcher. This ensured I remained transparent and added depth and authenticity to the analysis. Such self-reflection is evident where I emphasise moments of personal reflexivity. Yardley's evaluative metrics will be elaborated on further in the discussion chapter.

2.6 Research Design

2.6.1 Sampling

In IPA, homogeneity is paramount (Creswell & Plano Clark, 2017); therefore, all participants had to have experienced working with Black clients who had encountered RBTS, as this issue was the main focus of the study. The study inclusion criteria were accordingly considered to facilitate participant accessibility, adhere to ethical standards, and ensure sample homogeneity (Creswell & Plano Clark, 2017). It should be noted that employing a

degree of flexibility is essential for attaining a homogenous sample, though the degree may differ across studies (Smith et al., 2009).

2.6.2 Inclusion and Exclusion Criteria

(1) All participants had to be UK-based therapists with at least three years of experience with diverse clients: this requirement was based on the premise that such duration allowed participants substantial professional experience and exposure to working within diversity, characteristics deemed crucial for understanding the subtle dynamics of RBTS and ensuring that the study captured informed perspectives.

(2) The requirement that participants must have had direct experience of working with the targeted group of clients suggested that they would ideally be familiar with RBTS in theoretical terms and through practical application. Such direct involvement was expected to enable therapists to share meaningful insights into various therapeutic strategies, the obstacles they faced, and the successes they achieved while addressing RBTS.

(3) Individuals professionally qualified as counsellors, counselling psychologists, and psychotherapists were eligible to join the study. The lines between the practices of psychotherapists, counsellors, counselling psychologists and similar therapists are often fluid, with professionals borrowing techniques and insights from each discipline. Therefore, a narrow definition of 'therapist' in the participant criteria could inadvertently overlook the nuanced differences in how these professionals perceive, approach, and navigate the complexities of RBTS.

(4) Participants were required to communicate effectively in English without any limitations related to psychological or expressive language barriers. This was to ensure that participants could articulate their thoughts and experiences clearly. Additionally, this criterion aimed to address ethical considerations, given that it was important for participants to fully understand the study's aims and the consent process and that their contributions

would be represented as accurately as possible in the research findings.

Exclusion criteria: To preserve homogeneity, participants were not eligible if they had not engaged in psychological work with clients during the past three years, either due to changing their professional occupation or other reasons. This criterion was set because of the increasing global focus on race-based/racial injustice issues (e.g., the Black Lives Matter movement and Covid-19 pandemic): people's awareness of the racial issues might accordingly have been affected by the wider social context.

2.6.3 Recruitment

The original intention was to use purposive sampling rather than opportunity sampling; however, in practical terms, it became apparent that a 'snowballing' sampling was possible. Therefore, I seized the opportunity to recruit participants who came forward via snowballing sampling to capitalise on accessible participant networks. Given that research of this nature is still in its infancy in the UK, it was postulated that this could breed reluctance to participate; hence, a flexible approach to participant recruitment was considered necessary. Opportunity sampling provided this flexibility, enabling the study to adapt to the availability and willingness of participants who are, to some extent, knowledgeable, experienced in this area, and emotionally prepared to discuss the nuances of racial trauma within therapeutic settings.

Additionally, the opportunity sampling, through snowballing, allowed for a quicker recruitment process of self-selecting professionals who were likely to be more engaged and reflective on the issues of racial trauma—a key aspect in generating rich, nuanced insights. The snowballing method appeared to have facilitated a level of trust as participants came through referrals from their trusted networks. It also increased the diversity of experiences and perspectives within the sample, which is critical in a qualitative study aiming to explore complex and varied personal (Willig, 2013) and professional experiences with racial trauma. Furthermore, the practicality of this approach, given the constraints of the study, such as time

and resources, further justified its use of opportunity sampling over the more traditional purposive sampling.

In principle, while purposive sampling remains a cornerstone of IPA for its targeted nature, the specific circumstances surrounding this study warranted adopting an opportunity sampling approach. It provided a pragmatic balance between methodological rigor and the practicalities of researching under-explored phenomena within constrained environments, thus supporting the overarching goal of the study to illuminate the therapeutic dynamics encountered by professionals when addressing RBT.

A study recruitment poster (Appendix A) was advertised on various social media platforms. I also requested colleagues, family, and friends to post my recruitment poster on their social media and share it in relevant work or group settings. Snowballing also resulted in recruitment, as some participants made contact with other therapists**.** The research poster provided concise details about the study, which included a clear delineation of eligibility criteria, the interview process, and the researcher's contact information.

The poster was circulated on Facebook, Instagram, the Black African Asian Therapy Network (BAATN), and LinkedIn. Social media mostly yielded a response from female therapists from minority groups, particularly those who identified as Black or Asian; no White individuals or males responded at first. A higher female response was anticipated, considering that the psychological field is predominantly female (APA, 2013; BPS, 2021). After highlighting this issue with my supervisor, I revised the poster to specify that White therapists and males were also invited. Furthermore, I joined various therapists' groups on Facebook, resulting in a greater response rate from potential participants, including White and male individuals.

Reflection on the Recruitment Strategy

The onset of the recruitment phase was marked by anticipation. I was aware RBTS was under-researched and the hesitancy this might cause among potential participants. My own experiences compounded my apprehensions. I wondered whether potential participants would be reluctant to share their experiences with someone who might be perceived as 'too close' to the subject. Would they fear judgement, misrepresentation, or misunderstanding? Straddling the dual roles of a researcher and an individual who has experienced racial trauma was like treading a tightrope.

Alternatively, my personal experience granted me an insider's perspective, allowing me to empathise deeply with potential participants and appreciate the gravity of their experiences. However, it also presented the challenge of ensuring that my own experience did not overshadow or influence the narratives of my participants. To navigate through these complexities, I maintained a reflexive journal throughout the process, where I could acknowledge my vulnerabilities and biases, ensuring they did not cloud the research outcomes.

2.6.4 Initial Screening

I received eight email responses from eligible potential participants wanting further information regarding the study. All participants responded to my subsequent email and were offered an online debriefing on the study and an opportunity to ask questions. During the initial screening meeting, participants and I discussed the study's aims, eligibility, and ethical guidelines (confidentiality, data storage, right to withdraw) in alignment with The Code of Human Research Ethics (BPS, 2021). All respondents were interested in participating in the study, so further information was sent, which included an information sheet (Appendix B), consent forms (Appendix C) and a demographic sheet (Appendix D). Upon receiving the

participants' consent, a mutually convenient date and time were arranged to conduct an online interview. A maximum of 90 minutes was agreed for the interviews via the Microsoft Teams platform (as per the UEL agreement). We agreed 90 minutes was sufficient to account for any technical issues. Conducting interviews online allowed for a broader range of participants to be reached from across the UK.

Reflection on the Initial Screening of Participants

During the initial screening, I was struck by participants' interest in the roots of my motivation for the study, with some sharing a longing to conduct such research, yet they had hesitated, given the topic's sensitivity. This gave me an idea of the anxieties surrounding discussions on race, trauma, and therapy in the UK. Interacting with each participant amplified my sense of responsibility to represent their voices with authenticity, respect, and integrity. Their interest in my motivations made me realise two things: first, the participants saw me not just as a detached researcher but as an individual with motivations, and second, they trusted me to tell their stories with the deserved respect and sensitivity.

2.6.5 Participant Demographics

Sample sizes in qualitative studies are often small (Langdridge, 2008). Reid et al. (2006) suggested that 6-10 participants was the ideal sample size for IPA. The recruitment process resulted in 8 eligible study participants (see Table 1 below). To maintain anonymity, I referred to each participant by number. Any identifying information in the transcripts (such as schools, universities, or online private practice names) was altered. The sample consisted of three males and four females (who identified as White, Black, Asian, and mixed heritage British) between the ages of 35 and 55. Three participants were also educators, either at college or university, teaching psychological courses, and five of eight were also clinical supervisors. Participants' shared experiences made the sample homogenous in relation to RBTS (Smith et al., 2009), yet the variability in demographics and other professional roles added richness and depth, allowing me to capture a broader range of perspectives within this shared experience.

Table 1: Summary of Participants' Demographic Information

Participant ID	Age	Years in practice	Gender	Occupation	Modality used	Ethnicity
P1	50+	20+	Male	Counselling Psychologist	Integrative	Black British
P2	35-44	10	Female	Counselling Psychologist	Integrative	Black British
P3	45-50	9	Male	Psychotherapist	Relational Psychodynamic	White British
P4	45-50	10	Female	Counsellor	ERT	White British
P5	35-44	5	Female	Counsellor	Person-Centred	Asian British
P6	50+	10	Female	EMDR and Art Therapist	Psychodynamic	Mixed Heritage (White-British and African-Caribbean
P7	45-50	12	Female	Psychotherapist	Integrative	White-British
P8	50+	29	Male	Psychotherapist	ERT (Gestalt)	White-British

EMDR=Eye Movement Desensitisation and Reprocessing
ERT= Embedded-Relational Therapy

2.7 Data Collection

A semi-structured interview method was used to collect data as it allowed me to guide the conversation and keep participants on topic whilst remaining flexible, enabling participants to discuss and share their experiences and perspectives (Smith & Osborn, 2008). The interview guide was developed from the literature review and similar research questions. Prompts and follow-ups encouraged participants to elaborate further (Smith, 2016).

2.7.1 Pilot Interview

The interview questions were piloted (Tashakkori & Teddlie, 2003) with one ProfDoc counselling psychology student to practise interviewing techniques and verify the clarity and relevance of the interview schedule. The pilot study revealed that some questions elicited similar responses, which led to their removal. The resulting interview schedule comprised 13 open-ended questions (see Appendix E).

2.7.2 Conducting the Interviews

Interviews took place between October 2022 and January 2023 due to participants' schedules and the Christmas holiday. Each interview lasted 50-90 minutes, was recorded using Microsoft Teams, and later transcribed verbatim (Braun & Clarke, 2006).

Before commencing each interview, I reminded all participants of their right to withdraw or take a break if they felt overwhelmed and emphasised the importance of asking questions about the study. Furthermore, I reminded each participant that the interview was designed to be informal. Given the sensitive topic, I wanted to ensure participants understood they were not obligated to answer questions they did not wish to.

I was mindful that my presence as an interviewer might make participants feel pressured, defensive, or uncomfortable about possibly revealing something that might

generate judgement from me. To counteract these potential reservations, I reassured participants that I was not looking for RBTS experts; instead, I was keen on understanding their lived experiences. Hence, there was no right or wrong answer. Notably, I observed that most, mainly White participants, were more forthcoming when I emphasised this point. They seemed more at ease discussing their anxieties about possibly saying something that might be deemed racist.

Therefore, throughout the interviews, I prioritised sensitivity, a non-judgemental stance, empathy, and patience and allowed space for silence (Pietkiewicz & Smith, 2014). These attributes are highlighted by Smith et al. (2009) as necessary for fostering rapport and gathering rich and detailed experiences. I monitored the emotional undertones of our conversations, noting any feelings or reactions that some questions might invoke. This attentiveness allowed me to be sensitive to the intensity of the interview and check if the participant felt comfortable continuing.

One challenge I faced was keeping the participants focused, particularly when sharing their personal or clients' racial traumatic experiences (instead of sharing their experience of working with the racial traumatic experiences). Balancing my role as a neutral yet emotionally supportive researcher without veering into a psychotherapist role was challenging. When narratives drifted, I responded reflexively using different techniques: (1) I first validated the participant's experience to maintain the established rapport and then redirected: for example, I would say something like: *"I appreciate you sharing that experience", "Could you tell me more about how you worked with your client in that situation?";* (2) I summarised what the participant had said and linked it back to the research question: an example would be: *"You mentioned your client's experience of X and Y, which relate to racial trauma. How did these experiences influence your professional approach?"*; (3) I also gently redirected the conversation to the main topic using probing questions and

prompts indicated on the interview schedule (Appendix E).

As we concluded, I asked if participants had any additional insights they felt had not been explored sufficiently. I then allocated 10 minutes for debriefing (Appendix H), followed by gathering feedback regarding the interview process. At the end of each interview, I emailed the debrief handout. I also reminded each participant of their right to withdraw from the study within a two-week post-interview window without questioning their decision. Lastly, I checked each participant's emotional state. Reassuringly, all participants confirmed they had access to personal therapy and would seek out their therapist if needed.

Reflection on Conducting the Interviews

Whilst enjoyable, I found each interview emotionally draining. My resonance with the stories shared by the participants and my personal and professional experiences (as a Black woman, working with Black clients who have endured RBTS) heightened this emotional exhaustion. The mirroring of these narratives presented both a challenge and an opportunity for introspection. Whilst it augmented the emotional labour as I navigated the dual role of being both the interviewer and someone deeply connected to the subject matter, on the other hand, it enriched my understanding and empathy, as I was not merely an external observer but someone who related to the phenomena discussed. I found myself lingering on certain narratives, even when with my family, and, at times, grappling with my reactions to them. This resonance and subsequent reflection revealed the complex intertwining of personal and professional identities and how they can influence and inform each other. Engaging in my reflection, journaling, and speaking to my friends and supervisor provided a space to unpack these emotions, reflect on them, and ensure that I was taking care of my well-being and maintaining the integrity and objectivity required by my research role.

2.7.3 Data Preparation

After each interview, a verbatim transcript was generated, as demographics and consent were securely stored online on UEL One drive. Two weeks after completing the interviews, transcripts were cross-checked against their original recording to ensure accuracy and to incorporate non-verbal cues, such as laughter, which are often instrumental in interpreting and understanding the nuances of participants' experiences and responses (Smith et al., 2009). Each participant was assigned a unique identifier (see Table 1, above) to ensure anonymity and, thus, ethical and methodological integrity.

2.8 Ethical Considerations

The study followed the British Psychological Society Code of Human Ethics (BPS, 2021), the Health and Care Professions Council's guidance on conduct and ethics for students (HCPC, 2015) and the UEL Code of Practice for Research Ethics (UEL, 2013). Before commencing, ethical approval was obtained from the School of Psychology Research Ethics Committee at the UEL to adhere to ethical guidelines (Appendix F). The Code of Human Research Ethics (BPS, 2021) emphasises that all individuals' dignity and worth must be appreciated and recognised in relation to their rights. I strove to protect individuals from physical and psychological harm while maintaining their dignity, privacy, and confidentiality (Appendix G) (BPS, 2021). This was achieved through informed consent (Appendix C), anonymising and data storage procedures with password protection and displaying a sign on the door during online Microsoft Teams interviews to limit distractions.

Physical data (i.e., transcripts) were locked away; only I could access and share with my supervisor, without identifying features. Participants were reminded of their unconditional withdrawal rights up to two weeks following the interview schedule. I further informed them that they could not withdraw their consent once the transcribed data and the

thesis were written and submitted. Due to the sensitivity of the research topic, I was attentive to any emotional cues evoked by our discussions to maintain a respectful conversation.

Before initiating the interviews, I conducted a pre-interview risk assessment to assess the implications of interviewing online. A few concerns were raised, such as potential compromises to privacy, participants being interrupted or fear of being overheard. In case of distractions, both parties agreed to reschedule the interview to a more conducive time. Post-research, all participants reported gaining profound awareness about RBTS and articulated a desire to instigate changes within their professional spheres (Appendix M). Additionally, the participants showed aspiration for further education in cultural awareness, demonstrating the study's impact on their professional outlook.

2.9 Data Analysis Procedure

The interview transcripts were analysed individually using a 5-step IPA method (Smith & Fieldsend, 2021), including reflexive commentary.

Stage One: Initial Exploratory Comments

The analysis began with immersion in data (Smith & Osborn, 2008), listening to and reading the transcripts repeatedly to understand the participants' stories better. Within each transcript, a three-column method captured exploratory comments documented on the right-hand margin categorised as descriptive (what participants said), linguistic (the use of language) and conceptual comments (the context and potential meanings of participants' experiences) (Smith et al., 2009). The exploratory notes formed the basis of experiential statements (Appendix I).

Reflection

The immersion stage was time-consuming and emotionally demanding; each

transcript was attended to a day apart to avoid mental fatigue. Repeatedly listening to the participants' stories invoked emotions akin to re-experiencing the interview process. I occasionally found myself entangled in narratives, posing a unique challenge. I often found myself entwined in self-analysis, struggling with whether I was interpreting participants' experiences or unintentionally superimposing my own experiences onto theirs. To navigate this, I consciously recalibrated my analytical stance and abstained from using the first-person, endeavouring to occupy the role of an impartial observer. This linguistic shift, although subtle, aimed at striking a balanced equilibrium between immersion and object analysis. Further, I journaled about my thoughts and feelings.

Stage Two*: *Formulating Experiential Statements (ES)

The second stage involved re-reading transcripts and exploratory notes. Exploratory comments were then scrutinised to identify statements or phrases that captured the essence of each participant's unique experiences, feelings, thoughts, and perceptions, which were annotated and highlighted (Smith et al., 2020). The identified significant statements were transformed into experiential statements (ES), ensuring ES remained faithful to the participant's original words and meaning (Smith et al., 2022). To maintain consistency, I took regular breaks and re-visited transcripts. ES were then listed on a Word document, ready for the next stage of examining, looking for patterns, similarities, and differences.

Reflection

I found myself mixing experiential statements with exploratory notes. To alleviate this confusion, I reverted to the previous terminology, labelling ES as 'emergent themes' within the transcript.

Stage Three*: *Looking for Associations through ES

ES that shared a common theme were clustered, and those lacking substantial evidence or prevalence were excluded. Once satisfied with the identified ES and their ability to provide an accurate and clear overview, they were grouped accordingly (Smith & Fieldsend, 2021). The categorisation of ES was a dynamic and iterative process that involved assigning and reassigning statements to appropriate categories (Smith et al., 2009).

Reflection

Stage 3 of the data analysis generated an internal conflict, as I recognised the value of all ES, including outliers, making it hard to eliminate some. I was challenged by the dilemma of whether these statements were reflective of my own experiences or those of the participants. To clarify this ambiguity, I referred back to my research question, ensuring that the selected clusters of ES resonated with the study's aims. This iterative process was exhaustive, necessitating repeated assessments, modifications, and reconsidering previously set aside statements until they accurately reflected the desired outcome.

Stage 4: Clustering ES into Personal Experiential Themes (PETs)

This stage began by revisiting all the ES identified from the data; those that conveyed similar sentiments or themes were grouped. For each group, an overarching theme that encapsulates the essence of those statements was identified (as a personal experiential theme, or PET), and the remaining ES became sub-themes. I then reviewed the PET in the context of the original data to ensure it remained within the participant's intended meaning. As I developed more PETs, I found that some overlapped; thus, I merged or refined them further to better capture the nuances. For each PET, the ES that contributed to its formation was documented to provide evidence for analysis. The identified PETs were discussed with my supervisor and colleagues (Appendix J)**.**

Reflection

I was reminded of the researchers' profound responsibility to represent participants' experiences authentically; this was not only about clustering statements or finding commonalities but also capturing the essence of human experience in its unfiltered form. As the statements were grouped, patterns emerged, giving a picture of the participant's world, akin to piecing together a jigsaw puzzle. The iterative process was a reminder of the fluidity of human experience. Themes evolved, merged, and sometimes diverged, reflecting the dynamic nature of perceptions and understandings. This stage was a reflective exercise, as I continuously returned to the data to ensure the themes were authentic.

Stage Five*: *Clustering PETs to Develop Group Experiential Themes (GETs)

Turning PETs into group experiential themes (GETs) aimed to capture the group's shared experiences while honouring each participant's nuances and individualities. However, ensuring that each GET represented the group's shared experiences was essential, so it was not dominated by a single participant's perspective (Smith et al., 2020). I started this stage by reviewing the PETs of each participant before listing all the PETs identified across all participants. PETs with similar content meaning or essence were grouped to form a higher-order theme or GET. I ensured the GETs represented the group's experiences as a whole.

Reflection

Devising each GET title allowed me to experiment with different ideas and concepts, arriving at titles that captured the essence of each sub-theme. I also incorporated relevant quotes from participants as titles. I found the data analysis process very reflective as I needed to constantly reference data to check my interpretations aligned with participants' narratives and were not influenced by prolonged exposure to a single transcript or my own experience.

However, I struggled with new IPA terminology. Mentally mapping familiar processes to new terms felt like relearning a language. However, this cognitive dissonance prompted deeper reflection on the essence of IPA and the importance of language in shaping our understanding of methodologies.

Chapter Three: Analysis

3.1 Overview

IPA analysis revealed five significant Group Experiential Themes (GETs) and nineteen sub-themes (Smith et al., 2022), which are introduced and presented below.

3.2 Introduction to the Themes

The subjective nature of seeking meaning implies the themes derived from this analysis may differ from another researcher's interpretation of the same data (Smith et al., 2020). Consequently, the identified themes are my perspective and may not fully encapsulate every aspect of participants' subjective multifaceted experiences working with RBTS. The intricacies of this interpretive endeavour are further compounded by what could be viewed as the triple hermeneutic process inherent in this study (three-stage interpretation process of understanding social phenomena) wherein my analysis as the researcher (third hermeneutic) interprets the therapists' reflections (second hermeneutic) on their clients' narratives (first hermeneutic). Each GET, and its sub-themes, are introduced with a summary of primary findings followed by verbatim accounts from participants. Every quote is tagged with the relevant participant, page number and timestamp in the transcribed interview.

3.3 GET 1: Navigating the Uncharted: Recognition, Understanding, and Addressing Racial Trauma in Professional Practice

3.3.1 Sub A: Definition and Operationalisation of Racial Trauma

3.3.2 Sub B: Unrecognised Racial Trauma: The Silent Struggle and the Elephant in

3.6.2 Sub B: Recommendations for Educators

3.6.3 Sub C: Mental Health Services Possibly Perpetuating Racial Trauma

3.7 GET 5: Navigating Racial Dynamics in Professional Spaces: The Interplay of Supervision, Self-Care, and Racial Trauma

3.7.1 Sub A: Supervision

3.7.2 Sub B: Self-Care and Coping Strategies

A table indicating how many participants contributed to each sub-theme is presented in Appendix K.

3.3 GET 1: Navigating the Uncharted: Recognition, Understanding, and Addressing Racial Trauma in Professional Practice

This overarching theme encapsulates the complexity of defining, recognising, understanding and addressing racial trauma within professional practice. It highlights that the psychology field is still trying to understand and navigate the concept and implications of racial trauma.

3.3.1 Sub A: Definition and Operationalisation of Racial Trauma

Participants' narratives depicted racial trauma as a multifaceted phenomenon, not always easily defined or identifiable, yet ingrained in individuals' experiences of race and racism, as expressed by Participant 3:

P3: *"…feeling like they are outsiders, having experienced rejection based on your colour… it is an ongoing sense of not being seen or heard or welcome and the*

impact that has on your sense of self, sense of identity, the impact of sense…." pg. 3 [00:02:00 -00:03:12]

This suggests a definition of racial trauma grounded in repeated experiences of marginalisation based on invisibility that undermines one's sense of belonging and self-esteem. The repeated emphasis on *"sense of self"* and *"sense of identity"* could signify a disrupted or fragmented self-concept. This may indicate a struggle with self-worth and an ongoing search for a stable identity.

The narrative further suggests a ripple effect: the immediate experience as an outsider leads to feelings of rejection, culminating in a compromised sense of identity. Arguably, this sequence demonstrates the cumulative weight of microaggressions and discrimination over time. This narrative resonates with Participant 2's description of racial trauma:

P2*: "…. it can be overt, but mostly, it's covert.... subversive… It's really difficult to name it, it is just more gaslighting and more punishing if you bring it up out loud" pg. 67 [00:06:01-00:17:14].*

The use of the term '*subversive*' suggests the behaviour is intended to undermine or harm the individual emotionally or psychologically. The challenge of '*naming*' this experience suggests the participant's struggle to verbalise what she is undergoing, perhaps because such experiences might not align with established definitions. Both participants' accounts point to a conceptualisation of racial trauma that underscores its complexity. Participant 5 reflects a more direct operationalisation of racial trauma as experiences that lead to mental health disorders rooted in racial discrimination:

P5*: "I see it as trauma that is synonymous with race …I have a client whom I*

see is being racially discriminated against at work, …as a result, they are depressed and anxious … experiencing the…, symptoms of post-traumatic stress disorder coming from a trauma-based cause" pg. 1 [00:00:49-00: 01:37]

She seems to link racial discrimination at work with resulting psychological distress, implying racial discrimination is not simply an isolated incident of unfair treatment; it has severe mental health implications. This narrative contrasts with the more abstract discussions of Participants 1 and 3, offering a tangible illustration of the possible psychological impact of racial trauma.

Participant 1 acknowledges the difficulty in defining racial trauma, highlighting it as a nuanced and complex concept. He argues that the accumulation of racial microaggressions can satisfy diagnostic criterion A (DSM5, ICD11). P1's perspective appears to challenge the conventional threshold for what constitutes trauma, advocating for a broader, more inclusive understanding that recognises the psychological impact of sustained racial stressors. This suggests a desire for systemic change in the mental health field to better address and support the experiences of individuals facing racial trauma.

P1: *"Racial trauma is complex because in a way you could argue, according to the DSM5 and ICD11 manuals, the criterion A is not as straightforward as somebody had an accident or they were in a bomb or, but actually what we are arguing is the accumulation of microaggressions leads to equating to criterion A …" pg. 2 [00:00:36-00:03:51]*

This indicates the challenge of applying traditional trauma criteria to racial trauma, where microaggressions can be seen as triggers for trauma instead of a single traumatic event. Participant 6 places racial trauma in a broader historical context, describing it as a transgenerational issue, stressing that the legacy of historical racial oppression continues to

inflict psychological harm.

P6: *"… if you have 336 years of torture and abuse and a system of slavery… that damage is continuous...It's transgenerational and can lead to racial trauma …" pg. 3 [00:01:41-00:03:16]*

This seems to offer a broader societal perspective, suggesting the effects of such historical trauma do not dissipate easily. This resonates with Participant 5's account of a client experiencing racial trauma due to *ongoing* racial discrimination at work, suggesting a shared understanding of racial trauma as a *continuous* experience that spans generations.

3.3.2 Sub B: Unrecognised Racial Trauma: The Silent Struggle and the 'Elephant in the Room'

The participants' narratives expose the unrecognised nature of racial trauma within their professional contexts, which can leave affected individuals in continuing distress as their experiences of racism are either misdiagnosed as depression or anxiety or, worse, ignored completely. Participants 2 and 8 echo this sense of silence and avoidance surrounding racial trauma:

P2: "*I've never even heard anybody consider ideas around racial trauma, and I've just experienced extreme discomfort from others when I bring it up..." pg.30 [00:54:57-00:55:35]*

This suggests that racial trauma is a largely unexplored, unspoken topic. Participant 8 reflects on the paradox of this avoidance; by trying to avoid discomfort, professionals may inadvertently amplify client discomfort:

P8: *"It's not named …., I think that's mainly to do with discomfort and the avoidance of discomfort" pg. 24 [00:37:57-00:38:50]*

This narrative points to challenges therapists and clients face in addressing racial trauma and the potential consequences of leaving it unacknowledged. Participants 4 and 5's narratives below imply that RBTS is a significant yet unspoken issue within psychotherapy. This is evident in Participant 4's narratives, who seems to struggle with articulating her feelings, indicating a sense of confusion or frustration:

> P4: *"…It is unspoken … it's like a sensitive subject... It's like… it is very much like there's an elephant in the room… It's like, it's obvious, but I don't know …" pg. 1 [00:01:05-00:03:51]*

Whilst Participant 5 shares a similar view to Participant 4, she suggests that the issue might be systemic, potentially ingrained in power structures:

> P5: *"…No, it's never talked about... the elephant in the room is coming from a higher place, higher people …" pg. 23 [00:27:07-00:28:09]*

The use of phrases such as '*higher place, higher people'* seems to imply that this silence is from an institutional unwillingness or inability to acknowledge and discuss racial trauma, reinforcing the perception of racial trauma as a '*silent struggle'* within therapy. Participant 5, who has also personally experienced racism, highlights the tendency of therapists to misattribute racial trauma as anxiety or depression:

> P5: "*I have experienced racism myself … I am able to help clients recognise racism as trauma; although experiencing racism is often not spoken about, so we as therapists say, oh, well, you are depressed, you're anxious… we're targeting anxiety and depression based on European psychology… model for psychotherapy when actually this is race-based. So how do we approach that from that perspective?" pg. 5 [00:05:15-00:07:21]*

Participant 5's account portrays a sense of dissonance between the experiences of racism, perceived as trauma, and how such experiences are identified and addressed within therapy. This discrepancy highlights the importance of understanding trauma in a broader, more culturally aware context. The question about how to approach trauma from a race-based perspective highlights a need for methodological advancements and other psychological models in treating racial trauma. While Participant 5 shows familiarity with RBTS, Participant 7 admits to being unfamiliar with the concept:

> P7: *"I've never heard that race-based traumatic stress exists. Sounds awful, doesn't it? It's just not part of the training; it is not recognised" pg. 17 [00:42:31-00:45:11]*

This signifies a sense of dismay and an openness to recognising RBTS as a valid issue.

3.3.3 Sub C: Factors that Contribute to Clients' Racial Trauma

This sub-theme reveals a complex interplay of internal and external factors contributing to the experience of racial trauma. The participants highlight the role of overt and covert forms of racism. Participant 8 describes subtle forms of racism as potentially more toxic due to their subtlety, unconscious nature and accumulation over time, making them harder to manage. Due to being less overt, they might not be addressed or even be dismissed by others, leading to further harm and invalidation.

> P8: "… *racist attacks, racial ignorance, … dismissal, microaggressions, both those ones which are clear and those ones which can slip under our conscious radar so that they're not seen. The accumulative effect of that is in a way more toxic because it's less visible, so we can't manage it seriously.*" *pg. 1 [00:01:03-00:01:57]*

The narrative appears to end with a sense of helplessness in managing these

experiences because they are '*less visible*', indicating a challenge in seeking support or redress. Participant 8's narrative aligns with Participant 5's account of daily microaggressions, such as being persistently questioned about one's origins, potentially serving as a constant reminder of one's perceived 'otherness':

> P5: *"...those questions that you get asked from people. Where are you from? I'm from England…but where are your parents from? ...that's a microaggression, and we experience it on a day-to-day basis…" pg. 2 [00:02:03-00:04:40]*

Alternately, Participants 3 and 1 discuss the internal factors contributing to racial trauma, though focus on different aspects. Participant 3 explains racial trauma can lead to:

> P3: "...*feeling like an outsider all the time and impact of sense, sense of self and self-esteem….". pg. 66 [00:02:00-00:03:12]*

His narrative emphasises the denial of one's identity, suggesting a lived experience where racial trauma leads to profound internal struggle, impacting an individual's sense of self and self-esteem. Participant 1 appears to suggest a dynamic, bi-directional relationship between personal experiences of racial trauma and the larger societal context.

> P1: *"Racial trauma should be seen within a context, so it's a symbiotic relationship rather than a one-way street... we've gotta be careful not to place the experience of racial trauma as residing within the individual, but to see it within a context... how you process your experience… how you are in the world... dependent on your upbringing and what your perceptions are, also dependent on how others' interpretation, social justice and so forth…" pg. 5 [00:09:01-00:09:50]*

This quote suggests personal experiences of racial trauma interact with broader societal conditions and are deeply interwoven with societal structures and prejudices. The

role of societal and environmental factors is also highlighted by Participant 7's reflection on racism not as an isolated experience but as an event often witnessed by others. This emphasises the importance of external validation when an individual is experiencing racism, suggesting how the lack of acknowledgement and support can exacerbate the trauma or even be perceived as complicity or denial of the discriminatory act, further contributing to the individual's distress:

> P7: … "*When people are experiencing racism, it's possibly in front of other people, verbal, or physical, so…..those people ignore what's being said, or ignore that it's happened, so the person who is facing that or dealing with it feels probably confused….*" *pg.1 [00:01:38-00:03:06]*

The participant also mentions '*feelings of confusion*', perhaps stemming from the cognitive dissonance arising from the mismatch between their internal experience (the hurt and humiliation from the act of racism) and external reactions (the silence of the bystanders). Participant 1 elaborates on the role of environmental factors in shaping an individual's experience of racism, noting individuals who cannot communicate effectively or blend in are more likely to experience racial abuse. The narrative suggests that language proficiency can be equated with integration and acceptance within a community. He also highlights the role of colourism and shadeism: this might imply a hierarchy of discrimination even within racial or ethnic groups, where skin shade can determine the degree of prejudice one might encounter:

> P1: *"…I think environmental factors, microaggressions, racist attacks, and social class…" pg. 2 [00:04:24-00:05:00]*

> "*… how do you communicate, and how do you respond to the abuse? Can you stand up for yourself? Can you blend in? … we know that somebody who can't*

speak English is likely to experience racial abuse because they can't communicate as opposed to somebody who can speak more fluently and eloquently and...if you're really dark-skinned like I am, you're likely to face more discrimination than perhaps if you are lighter-skinned… colourism and shadeism, you know..." pg. 4 [00:05:12-00:08:47]

The participant's reference to his own appearance might additionally indicate a self-awareness of personal identity formed by language ability and physical appearance. This self-recognition suggests an internalisation of societal values and potential accompanying biases. Overall, the participants' accounts imply that addressing racial trauma requires a comprehensive understanding of the internal and external factors contributing to it.

Table 2: Summary of The Discussed Factors

EXTERNAL FACTORS	INTERNAL FACTORS
• Societal e.g. Social class • Gaslighting • Ignored and dismissed by others • Language • Education Microaggressions: • Being stared at due to your colour • Being questioned about ones origins e.g. where are you from, Where are your parents from	• Feelings of being an outsider • Low self-esteem • Lack of confidence • Questioning ones self identity • Feelings of inadequacy

3.3.4 Sub D: The Black Lives Matter Movement (BLM) and The Impact of Covid-19 (C-19) Pandemic

The participants' narratives underscore the impact of the BLM movement and the

COVID-19 pandemic on the recognition and understanding of racial trauma. These global events have served as catalysts for increased awareness and dialogue around racial trauma within professional practice. Participant 8 noted:

> P8: "*C-19 and the BLM … brought awareness for me…. I think it just really increased awareness amongst White therapists to actually start thinking about racial trauma… a number of courses were made available to therapists like myself..*." *pg. 6 [00:05:53-00:09:55].*

This suggests a personal and professional shift in understanding and focus, ensuring that issues of race became more central in their work or activities, a sentiment echoed by Participant 3. The incident seems to have instigated a desire for action and change. Participant 3's use of phrases like '*what are we doing?*' might signify a questioning of one's role, position, and responsibility in the context of systemic racism.

> P3: *"… when George Floyd was killed, we really tried to educate ourselves about racism, trauma … and we started asking questions: what are we doing?...it certainly helped us to keep this issue of race at the forefront of our work … make us examine and change and do things differently..." pg. 21 [00:25:13-00:26:33.]*

Participant 6 offers a more critical perspective, conveying disappointment related to the short-lived nature of the impact of these events, suggesting the superficial engagement of some sectors with the issue.

> P6*: "…. People did lots of publicity on racial trauma, then within three months it dropped actually further, you know, CEOs got bored with it…*" *pg. [00:33:31-00:33:59].*

This indicates a discrepancy between the public response and the sustained

commitment required to address racial trauma. Participant 7 echoes this sentiment but adds another layer of critique, alluding to a sense of temporal significance associated with the BLM movement:

> P7: *"... I think people started having policies...they've got stuff on the website, but it clearly doesn't make any difference, it's not filtered down, people still don't talk about it..." pg. 12 [00:29:14-00:30:28].*

This suggests a lack of systemic changes, implying that the surface-level changes have not translated into substantial changes in everyday practice. Participant 5 describes a reactive response within their professional environment following the death of George Floyd, generating mixed feelings:

> *P5: "...when the George Floyd thing came, in my service, we started hearing about cultural competence training, diversity training for therapists... I didn't know what to make of it, why now, today… It was a sad reminder of our experience of racism, and so we created a space where people could come and talk about any experiences of racism how they felt in the therapeutic space. But before, then they were nothing… racism was not talked about..." pg. 40 [00:48:02-00:50:35]*

She appears to interpret the training initiatives in her service as reactions to current external events and societal pressure rather than genuine efforts to combat racism. The phrase '*I didn't know what to make of it, why now, today…*' indicates suspicion about the timing and motivation behind these initiatives. Perhaps she is wondering why it took such an incident for the service to recognise the importance of addressing racial biases and cultural insensitivities. However, she also acknowledges a new openness to discuss racism, indicating a positive shift in dialogue towards racial issues. Participant 2 shares a similar view of BLM serving as a positive catalyst, causing a shift in the professional environment. The quote below suggests a

more transformative change in their White colleagues' awareness and empathy levels, creating an honest space to discuss racism:

> P2: "*…Black Lives Matter was like a watershed moment...NHS Trust started talking about what they're doing to embed anti-racist practices; for us, it triggered painful reminders of painful memories and the reality of racial racism… and several of our White colleagues said I am actually really affected by this; they feel terrible saying ..they're taking up space, and... they shouldn't be crying about it, they were more able even to take some criticism...it just became a more honest space…" pg. 38 [01:08:11-01:11:33]*

However, Participant 2's narrative also touches on the raw emotions stirred by the movement; similar to Participant 5, she seems confused and scrutinises the appropriateness or authenticity of this current space created.

Summary

The theme unveiled racial trauma's multifaceted and complex nature as it presents itself in professional practice. The sub-themes discovered offer invaluable insights into how racial trauma is recognised, understood, and addressed, clarifying how this often-invisible phenomenon can significantly affect individuals, yet is often ignored.

3.4 GET 2: Navigating Therapists' Intersections of Race, Personal Experiences, and Professional Practice in Therapy

This theme captures the broad issues affecting participants' grappling with their racial identities, personal experiences, and any subsequent effects on their professional practice as therapists. This includes the dimension of '*race*' either through the advantages and disadvantages that participants perceive in their racial identity, their consciousness of

privilege, or their fears of being misunderstood or causing harm.

3.4.1 Sub A: Empathy Through Shared Experience

The narratives provided by the participants underscore the role of shared experiences in fostering empathy in their professional practice. Participant 5 discusses her approach to her clients through a lens of humility and emphasises the beneficial effects of shared experiences:

> P5: *"…I approach it with humility… I would be saying to the patient, I know what you feel… if you show humility and a willingness to learn, I always say to the patient, you are the one who's the expert on the problem." pg. 49 [59:32-1:00:35]*

This suggests a personal connection to the client's experiences, which may enhance therapists' ability to empathise and provide support. Similarly, Participant 1's narrative highlights the value of personal experience and the use of 'self' as a tool for building a safe and empathetic therapeutic space:

> P1: "*…I live in this skin as a Black man, and so I understand; I have experienced racism too, I sort of get their experiences…I try and provide therapeutic conditions for the client to talk about whatever they wanna talk about that has distressed them…" pg.13 [00:24:21-00:28:57]*

Participant 7 offers a contrasting perspective, drawing a parallel between her struggles as a childless woman facing societal discrimination and her clients' experiences of racial discrimination. While not directly related to racial discrimination, this shared sense of 'otherness' may deepen the therapeutic relationship's empathetic connection. This suggests a level of insight, understanding discrimination from a personal standpoint yet making a connection to broader forms of discrimination rooted in societal norms and expectations. However, there is an essential distinction to be made in the comparison of these experiences.

While personal adversities can provide a profound comprehension of exclusion, equating childlessness to the pervasive experience of systemic racism, it risks oversimplifying the complexities of racial trauma. It is then critical to acknowledge that although both experiences are forms of discrimination, they exist within vastly different socio-political contexts and carry distinct historical and cultural weights:

> P7: *"As a White, I can relate to discrimination ...I faced discrimination myself, I feel like if I hadn't faced it I don't think I would have learned about racism?...the discrimination is that women like me who can't have children... it feels as if as a woman I'm not important as mothers in society so reading about Black women and their struggles kind of really helped me." pg. 14 [00:34:09-00:35:27]*

Participants 6 and 2 share their personal experiences of racism with their clients to validate their clients' experiences and foster a sense of connection.

> P6: *"… I just said to her you are not alone it's real; I feel it too, I've seen it, I've experienced it… I'm not telling explicit stories about my experiences but validating their experiences…" pg. 55 [00:54:32-00:55:49]*

This statement shows empathy based on personal experiences and acknowledges a common background. Participant 5 shares:

> P5: *"They find me relatable because of the colour of my skin I mean, one particular patient often says to me, you must have gone through similar. I says, oh, yes... I sometimes mention a few of my experiences and say this is normal for people like us." pg. 15 [00:17:49-00:18:38]*

This comment by Participant 5's client suggests an assumption of shared experiences among individuals of similar racial or ethnic backgrounds, which others outside

of that group may misunderstand. Both Participants' statements (5 and 6, above) suggest that sharing personal experiences helps clients feel heard and understood, which could promote healing and growth.

3.4.2 Sub B: Empathy Despite Lack of Personal Experience

The theme highlights therapists' ability to empathise with and understand clients' experiences, including experiences of racial trauma, even those they do not share. Participant 4, for instance, shares a poignant account of witnessing a Black boy's struggle with mental health and racism. The phrase *"it broke me"* signifies deep empathy, trying to understand the boy's lived experience genuinely:

> P4: *"...Hearing this Black boy's experience with mental health service and with a schizophrenia diagnosis. I feel really quite upset talking about it; I remember just seeing him with his head in his hands; he was like...I just tried to imagine being in that situation; it broke me." pg.16 [00:29:10-00:32:41]*

The narratives demonstrate the participant's profound empathetic immersion and underscores how clients' experiences significantly affect therapists' emotional states. Participant 3 shares a similar reaction when confronted with an instance of direct racial abuse experienced by his client. The reaction highlights the depth of his empathetic resonance and personal investment in his client's well-being:

> P3: *"...I felt very sad, angry, ashamed when my client told me about being called N-word in the bar…I'm incredibly fond of him because there's a vulnerability to him. I was horrified that somebody would say something like that to his face in such a horrible way, and maybe I was carrying the anger that he couldn't express…" pg.6 [06:26-09:22] and pg. 8 [00:09:57-00:10:59]*

The narratives above further indicate the potential for emotional transference in the therapeutic relationship. Participant 8 brings a unique perspective, expressing an empathic response to the challenges faced by Black trainees:

> P8: *"…Something struck me … I really noticed that Black trainees are, have had to develop capacities to tolerate and the history and habit of White trainees of not being expected to sit with and tolerate the discomfort of addressing racism...it was hard to imagine what these Black trainees, must be going through…" pg. 9 [00:10:20-00:13:09].*

The participant acknowledges the privilege of being White and recognises the increased resilience these Black trainees have developed due to systemic racism, bringing attention to the systemic nature of these disparities.

3.4.3 Sub C: The Double-Edged Sword: The Complexity of Racial Identity

This sub-theme captures participants discussing their racial identities in the context of their professional practice and how this might positively and negatively impact their therapeutic relationships or understanding of their clients. Participant 1 communicates awareness of the double-edged sword of racial familiarity, acknowledging the challenge of balancing empathy with maintaining professional boundaries to avoid potential over-identification and projecting personal experiences onto the client:

> P1: *"…Being Black…makes it harder because you are experiencing what the patient is also experiencing, so there's a parallel process. So, you have to be very careful that you are not projecting your experience into the patient's experience…I have faced the same battle" pg. 16 [00:29:42-00:31:11] and pg. 17 [00:31:34-00:32:58]*

Participant 5's account echoes Participant 1's response, highlighting the challenging balance of being deeply connected to clients' experiences while still maintaining professional distance. The metaphor *'double-edged'* can be interpreted as unconscious bias being beneficial (possibly as a bridge for understanding and connection due to shared experiences) but also with potential downsides (perhaps leading to assumptions or over-identification with another's experience).

> P5: "… *we were talking about unconscious bias, it can be a double-edged sword…it's tricky because we are sharing similar experiences, but… it's easy to get lost in your own experiences. So doing my therapy work on my own experience is key..." pg. 15 [00:17:49-00:18:38]*

This highlights an awareness of the importance of ongoing personal therapeutic work to manage triggers that can arise from shared racial experiences, demonstrating the intricate intersection between personal and professional roles in therapy. Participant 2 explores the complexities of shared racial experiences from a dual-heritage perspective. The participant acknowledges that sharing similar experiences with a client, whether they are Black or White, can lead to emotional strain, but it could also lead to understanding the client's experiences, providing more tailored support:

> P2: "…*That's going to be very different for me as a Black practitioner working with a Black client, particularly, bringing racialised experiences… even if a White client brings racialised experience, that is also going to be triggering for me in different ways, especially me being mixed race as well… it can be hard when you share similar experiences but again, it helps because I'm more likely to understand, able to provide specific support" pg.1 [00:00:00-00:05:32].*

Furthermore, the participant identifies as a "*Black practitione*r" and "*mixed race*,"

indicating a conflict, perhaps feeling discrimination from different angles as she does not fit into one category, showcasing the intersectionality of racial identities.

3.4.4 Sub D: The Consciousness of Privilege

This sub-theme brings to light the White participants' awareness of the privilege associated with their ethnicity and its impact on their professional practice, interactions, and understanding of their client's experiences. Participant 8 acknowledges his White privilege, noting the effort required to understand the experiences of Black clients. He also reflects on his use of '*we'* when referring to Black clients, suggesting a conscious effort to connect and empathise with his clients' experiences, whilst acknowledging the limitations of his understanding:

> P8: *"I'm White, British, and I come from a rural white monoculture ...and so there's an awful lot of ground to cover, as it were…" "I'm just noticing I'm using the word 'we' referring to my Black clients, and I haven't suffered from racial trauma, so that's kind of intriguing." pg. 2 [00:02:11-00:03:55] and pg. 25 [00:38:57-00:41:13]*

Participant 4 similarly acknowledges the differential treatment she would receive from the police compared to her client:

> P4: *"…I said to the boy... if I do something bad, the police are gonna treat me slightly differently from you because of the colour of your skin... that was really difficult, I was at every stage of the conversation, trying to check his reaction…" pg. 7 [00:13:42-00:15:00]*

This quote suggests the participant was emotionally affected by the acknowledgement of such disparities. Participant 3's account further underscores conscious privilege, expressing shock at a client's experience compared to his own:

P3: *"… she said, I'm just sick of sitting in a room, being the only Black person there, and I thought, it is shocking to hear because I don't have to think about that I'm going, be the only White person there …. I think well, I'd probably be one of a few men..., but it's not the same, you know; men have power and privilege…" pg. 30 [00:35:25-00:36:37]*

This account highlights the surreptitious privileges associated with being part of the 'majority' race. His comparison with gender may further suggest an awareness of other pervasive power and privilege dynamics. Participant 7 also reflects on the privilege that comes with her race and seems to acknowledge that her personal experiences are vastly different from those of her Black clients:

P7*: "… I suppose things such as discrimination in a shop, which one of my Black client's experiences lots of times, I don't think about, if, when I go shopping…" pg. 5 [00:11:41-00:12:12]*

This suggests an awakening to the subtle forms of racial discrimination. Alternatively, it might imply some unintentional ignorance towards others' experiences, highlighting how certain experiences or challenges are not universal and can be overlooked when they do not directly affect someone.

Summary

Drawing from the rich narratives of therapists' experiences intersecting their race, personal experiences, and professional practice, highlighted the nuanced dynamics at play in therapeutic settings. Empathy emerged as a crucial aspect in fostering the therapeutic alliance, while therapists who experienced discrimination and racism seemed to bring a unique depth of understanding to their client relationships. However, sharing the same racial

identity with clients appeared to leave therapists facing the challenge of balancing empathy with maintaining professional boundaries and avoiding over-identification.

Conscious privilege was another significant theme, particularly among White therapists who acknowledged their privileged positions and the power-dynamics inherent in society and therapy. This awareness of privilege arguably provides therapists with the perspective to understand the systemic biases and power imbalances their clients might be facing.

3.5 GET 3: It's Not My Place to Bring it Up

This overarching theme emphasises the emotional and psychological aspects of handling discussions around racism, highlighting the internal conflict and unpreparedness in discussing/approaching sensitive topics such as racism in professional settings.

3.5.1 Sub A: Fear of Misunderstanding and Causing Harm

This sub-theme highlights some participants' apprehension and anxiety when discussing racial trauma. This appears to be rooted in the potential for misunderstanding and the possibility of causing harm to their clients or of being negatively perceived. Participant 7 acknowledges the (often unspoken) fear of being labelled as racist:

> P7: *"I think from a White person's point of view.... people are really afraid of being called racist... if I was called racist, I don't know how I'd feel… there are a lot of deep-rooted unspoken feelings" pg. 12 [00:30:28-00:33:09]*

Participant 7 seems to struggle with her position as a White individual in conversations about race, stemming from a lack of confidence in discussing sensitive topics. Participant 8 below shares a similar struggle:

P8: *"I was a bit frozen ...finding it difficult… I think I didn't have the confidence in myself around racism… this was deeply uncomfortable" pg. 8 [00:10:20-00:13:09]*

Participant 8's quote suggests a heightened sense of inadequacy and apprehension in broaching such subjects. The term "*frozen"* seems to convey immobility, implying an emotional or cognitive paralysis when confronted with a challenging situation or topic, indicative of intense emotions or internal conflicts.

Participant 3 further illustrates this fear:

P3: *"… I was worried about getting it wrong…I think there's a lot of guilt and fear on White people's part, but it's not talked about, and I think that's what makes it continue" pg.7 [00:06:26-00:09:22]*

The silence around fear and guilt seems to make these conversations even more challenging, possibly indicating collective struggle within the profession. Similarly, Participant 7 expresses a fear of causing harm:

P7: *"It is sensitive, isn't it? …it felt like it's not my place to bring it up, but then I thought, I've got to bring it up because it's here, and it felt like my client had faced a lot of racism, but the word was never being said" pg. 8 [00:18:32-00:22:24]*

The narrative conveys a sense of delicacy around discussing racism and a strong sense of responsibility in addressing it, despite the perceived risk.

3.5.2 Sub B: Unintentional Minimisation of Clients' Racial Experiences

This sub-theme reveals a complex dynamic in the therapeutic relationship. In their role as therapists, the participants appear to downplay or overlook the racial experiences of

their clients unintentionally.

P7: *"…And with my Black female client, she is a manager of a big company…I don't know if it's my resistance; she's got this great life. She's got loads of friends…I don't know, I felt, do I bring in this?..." pg. 5 [00:11:41-00:12:12]*

This illustrates an assumption that a successful career and social status can somehow shield an individual from racial trauma. This unintentional assumption appears to minimise the client's experiences with racism and could hinder a deeper exploration within the therapeutic context. Participant 3's reflection reveals similarities:

P3: "… I don't know if it was me not wanting to go there or if it was him not wanting to go there. He did tell me about one experience he had in a bar one night where somebody …called him the N-word to his face, and that was shocking to me, but he kind of dismissed it and said … it doesn't matter…, and we didn't get very far with that…but he's got a good life now" pg. 6 [00:06:26-00:09:22]

This quote demonstrates a missed opportunity to delve into a significant racial incident. The client's dismissal of the incident might have been a defensive mechanism or a sign of internalised racism, both of which warrant further exploration in therapy. Participant 8 also appears to struggle with a similar issue and displays a reluctance to bring up racial issues with their client, who seems more focused on her relationship and job:

P8: *"…She wanted to talk about her work… her boyfriend …not much about her racism incidents, … so maybe I told myself I don't have to do anything because she's not bringing it in, we can talk other things… she has a good job..." pg. 5 [00:05:53-00:09:55]*

This suggests a preconceived notion that success can diminish or shield one from the

impacts of racism, exemplifying how socioeconomic factors might overshadow the importance of discussing racial experiences in therapy, leading to unintentional minimisation.

3.5.3 Sub-C: Professional Self-Doubt and Personal Anxiety about Discussing Racism

The participants' narratives under this sub-theme reveal a palpable tension and uncertainty that they experience when addressing racial issues in their practice. The *'should I?' and 'what if*?' questions highlight the internal struggle about the potential negative impact of such conversations on their therapeutic relationships. This underlines the crucial role of therapist-client communication and how it may be affected by societal issues such as racism. Participant 7 states:

> P7: *"I was nervous about bringing it up…because I don't know; it is just that feeling of, what if I bring this up and she doesn't? …she was talking about her work experience…I remember thinking this is racist, this is racism and thinking, should I say? Should I point this out? Should I say this to her?" pg. 60 [00:12:30-00:15:09]*

Participant 3 deliberates:

> P3: *"… Should I be bringing racist experience here? Do I bring it in? Am I making it about race? …she's gonna get annoyed with me if I bring in aspects of race that she doesn't want to talk about…" pg. 6 [00:06:26-00:09:22]*

The narratives above highlight the fear of misinterpretation, or misinterpreting their clients' experiences of racism. Participant 3 seems to be trying to gauge what is expected or accepted in the situation. This anxiety is also echoed in Participant 8's narrative centring on the perceived inadequacy of his relevant skills and knowledge:

> P8: *"…if I imagine myself to be a Black client…my starting assumption*

would be that a White therapist wouldn't know what they were doing frankly, and so I would seek a therapist of colour. I felt I was not good enough to help Black clients; I was anxious with my first Black client" pg. 4 [00:04:21-00:05:46]

This quote arguably reveals a profound insecurity about this participant's sense of professional competence, exacerbated when dealing with clients of different racial backgrounds. Participant 3 brings another angle to this theme, introducing the concept of boundaries in discussing topics such as racism. The fear of '*crossing a line*' and causing discomfort to the client (ethical considerations) illustrates the balance needed in tackling such an issue:

P3: *"…There was something about, am I crossing a line and asking him to look at something he doesn't want to look at, something that he might be uncomfortable with… I didn't feel I had the right to press him on something he might feel not comfortable with" pg. 10 [00:13:04-00:14:05]*

This participant's reluctance to '*press him on'* implies the complicated interplay between respecting boundaries and addressing crucial, albeit challenging, issues. Lastly, Participant 5 reveals internalised inadequacy, rooted in race, in assuming a supervisory role despite having significant professional experience:

P5: *"… I feel so ashamed; I don't feel that my colleagues will see me as adequate enough to be a supervisor…I'm Black, and I'm not so sure that White supervisees would accept me as knowledgeable…they probably wouldn't feel I'm good enough to be their supervisor*" *pg. 53 [01:03:51-01:04:40]*

Her narrative, whilst not directly connected to her experiences of working with clients, conveys a profound sense of self-doubt, possibly arising from the larger societal issue

of racial biases and stereotyping infiltrating the professional sphere, which is likely to have affected individuals' confidence and professional development.

3.5.4 Sub D: Discomfort: Different Vessels Weathering the Same Tempest

In this theme, the participants and their clients demonstrate a tendency to downplay or dismiss incidents, creating discomfort and uncertainty. For example, Participant 7 recalls a hesitant conversation about racism, where she questioned whether certain experiences could be attributed to racism:

> P7: *"…I did say something like, could this be racism? and she said, yes, I suppose so... it was almost like she didn't want to bring it up or… we were both not sure…" pg. 6 [00:12:30-00:15:09]*

The participant's question, *'could this be racism?'* suggests discomfort in labelling the experience as such, indicating her struggle in addressing the issue. A similar scenario emerges from Participant 3's narrative, where his client dismisses his experiences of racism, seemingly to avoid a deeper conversation about it:

> P3: *"…When he was saying, oh, look, it happens all the time, could be anywhere in shops, you know, work, it doesn't matter, he kind of dismissed it… then I thought, am I making something of this… do I press him on this point if he doesn't want to talk about it…*" *pg. 10 [00:11:14-00:12:38] "…I don't know if it's me not wanting to go there or if it's him not wanting to go..." pg. 6 [00:06:26-00:09:22]*

Here, the participant appears to acknowledge the potential avoidance on both sides, indicating the shared discomfort, further perpetuating the cycle of racism as an unspoken issue. This statement may also suggest a fear of imposing interpretations or assumptions onto the client. Participant 8 below shares a similar experience where both participant and client

appear to dismiss the topic of racism:

> P8: "*…I don't know if it was her resistance or my resistance or I didn't know what to do with this, or she doesn't know what to do with it, but we didn't follow it up that much …because she says, it just happens, it's no big deal...*" *pg. 5 [00:05:53-00:09:55]*

The narratives reveal a mutual decision, perhaps unconscious, not to delve into the issue of racism. This shared dismissal elucidates the ambivalence experienced by both therapists and clients in handling such emotionally charged topics, probably perpetuating a culture of silence. Lastly, Participant 3 expresses concern about possibly enforcing his perspective on the client's experience and demonstrating an awareness of the underlying power dynamics at play:

> P3: *"So I thought, maybe he just doesn't want to talk about this…. maybe I'm behaving like I'm some kind of White saviour. I'm saying, no, we must talk about it, I, we need to talk about this, and it's a big issue for you and… I thought, is this my place to do this?" pg.12 [00:14:24-00:15:19]*

This captures the complexities and nuances of these discussions, highlighting the role of power dynamics and systemic influences that complicate addressing racism in therapy.

3.5.5 Sub E: The Role of Therapy in Unmasking Unconscious Racial Experiences

This sub-theme showcases how therapeutic conversations can help clients realise and articulate experiences with racism. These stories depict situations where clients initially fail to recognise incidents of racism, perceiving incidents simply as negative or unfortunate events. This could be understood as a protective mechanism or a simple lack of awareness

due to sociocultural factors.

P5: *"...what I have found is that clients don't admit to it straight away, they just see it as something bad happened to me...but when we talk about it further...she realised this thing called racism which she didn't recognise growing up*" *pg. 14 [00:16:05-00:17:32]*

This narrative could reflect the need for therapeutic conversations that delve beyond surface level, allowing clients to recognise the racial dynamics within their experiences and facilitating deeper understanding. Participant 2 shares a similar experience with a client who initially dismissed incidents of racism:

P2: "*…he woke up to the word 'nigger' carved on his dormitory door, he sees it was just boys being silly...he didn't see racism as a thing… like very dismissive, but through questioning, he came to realise it was racism...*" *pg. 12 [00:18:51-00:24:17]*

The narrative appears to emphasise the importance of dialogue and reflection in bringing self-awareness and a deeper understanding of systemic societal issues. Another instance from Participant 2 demonstrates the impact of therapy on a client's self-reflection. She again recounts a client who initially downplayed the racial implications of her neighbour's actions:

P2: *"...She was like, but why would you think about that I'm the only Black person in the room or neighbourhood? Because if I don't think about it, then it doesn't bother me... after challenging this client, she sees it" pg.7 [00:06:01-00:17:14]*

Through exploration and the therapist's gentle guidance, the client ultimately

realises the significance of the racial dynamics at play. This narrative showcases the therapeutic process as a catalyst for clients to examine their beliefs, challenge dismissive attitudes, and develop a deeper understanding of the impact of racism on their well-being.

3.5.6 Sub F: "Feel the Discomfort and Do it Anyway"

The narratives shared by the participants in this sub-theme illuminate a shared experience of a sense of discomfort when addressing racial trauma with clients whilst also highlighting the therapists' courage and resilience in confronting their feelings. Participant 7 shares her fears:

> P7: "*I was worried that she might prefer a Black therapist... I did it anyway, ...my supervisor really encouraged me to stay with her, and he said, it's the relationship that matters…*" *pg.10 [00:25:06-00:27:13]*

There appears to be a perceptible struggle with identity and representation, an anticipation of prejudice and an apprehension that race may become a barrier in the client-therapist relationship. However, she proceeded, driven by her supervisor's encouragement and understanding of the significance of the therapeutic relationship, highlighting the importance of supervision in containing therapists' anxieties. Participant 4 echoes this sentiment, acknowledging her discomfort when addressing racial trauma with a child.

> P4: "*I did speak to the child anyway, …. it was very, very discomforting, and it still is...but there's nothing wrong with that, you know when things are real, that's how they are…*" *pg. 6 [00:11:17-00:13:23]*

The phrase *'but there's nothing wrong with that'* might suggest a reconciliation of feelings; the participant seems to be coming to terms with the discomfort, suggesting an acceptance of reality. This can also be interpreted as displaying a mix of emotions:

discomfort on one side and acceptance on the other. This duality might indicate an internal struggle or tension between what the participant feels and what they believe or think they should feel.

Alternatively, the participant might be acknowledging discomfort as inherent to the therapeutic process. Despite unease, she chose to be open and transparent in her approach, recognising the authenticity of discomfort in such conversations. Participant 8 shares his experience of shame and dysregulation, revealing embracing discomfort has been a transformative journey for him:

> P8: "*There are times when I feel ashamed… and … dysregulated... but also being taught that it's not wrong to feel deeply uncomfortable....*" *pg. 13 [00:17:58-00:19:19]*

The use of *'ashamed'* suggests potential societal or internalised judgement about certain behaviours or feelings, possibly stemming from perceived societal standards or norms about what emotions are *'acceptable*' to express or experience. Accepting a degree of discomfort seems to challenge the initial feeling of shame and offer a more compassionate introspection. Participant 2 highlights an ethical dilemma that can arise in therapy. She acknowledges the need to respect her client's worldview, while recognising her duty to confront the potential influence of racism and gaslighting that her client experiences:

> P2: *"… it gets very murky here, ethically, because they don't want to go there…I have to respect my client's worldview…I don't wanna cause a re-traumatise, but when you can see how their worldview has been distorted by racism, oppression, and gaslighting, …you also have an ethical duty to name abuse, it's not your job to make it easier for them to stay abused…."* *pg. 8 [00:06:01-00:17:14]*

This narrative underscores the complexity of the therapeutic role, which sometimes involves challenging a client's perspective to facilitate healing, even when it could induce discomfort. Similarly, Participant 1's narrative conveys the uncomfortable yet necessary challenge of addressing racial dynamics within the therapeutic relationship as an ethical duty.

> P1: *"... I often name the elephant in the room ...I'm a Black therapist, and they're Black clients and we can't just ignore that..., it is not easy, but if we're to be blind to that or not pay attention to that is unethical..." pg. 13 [00:24:21-00:28:57]*

Summary

The overarching theme revealed significant tension in the participants' minds, fuelled by fear of saying the wrong thing. Unintentional minimisation of racism because of assumptions about clients' lifestyles emerged as a crucial aspect. This minimisation was also evident in narratives recounting how therapists and clients tend to downplay incidents of racism, perpetuating a cycle of avoidance. However, some participants' narratives suggest they are willing to confront their discomfort and 'do it anyway'. The observed disproportionality in sub-theme *Sub-C: Professional Self-Doubt and Personal Anxiety about Discussing Racism*, with a predominance of White participants, could be viewed as offering a window into the complexities faced by White therapists when engaging with racial trauma. This sub-theme composition appears to reflect a particularity in the White therapists' experience that is not as pronounced for therapists of other racial backgrounds.

One possible rationale for this could be that, as members of the racial majority, White therapists may be more likely to experience unease when addressing racism, due to a heightened awareness of their societal positioning and its implications within the therapeutic relationship. Their hesitation can stem from a fear of being seen as presumptuous or intrusive when addressing race, a topic that they may feel is not theirs to initiate or navigate within the

therapeutic context. They might fear their interventions being viewed as appropriative or reductive, further complicating the therapeutic alliance. Additionally, it is possible that these therapists may be more likely to question their capacity to empathise across racial lines, perhaps worrying about the adequacy of their skills and knowledge in such sensitive dialogues. This disproportionality may further indicate a lack of adequate training in addressing racial issues.

However, it is important to note that while White therapists may exhibit professional self-doubt and personal anxiety, this does not necessarily translate to a lack of effectiveness in addressing racial trauma. Instead, it may highlight the need for a supportive framework within which therapists can develop the skills and confidence to engage with these complex and sensitive issues.

3.6 GET 4: Inadequacy of the Systemic Response to Racial Trauma in Education and Mental Health Services

This overarching theme captures the essence of the participants' narratives on the lack of relevant training, recommendations for educators, and how mental health services possibly perpetuate racial trauma.

3.6.1 Sub A: Lack of Relevant Training

Under this sub-theme, participants echo the sentiment of a lack of sufficient and relevant training to handle racial trauma and related issues. For instance, Participant 8 commented:

> P8: "*I think there's a lack of training which supports practitioners to actually drop down and be able to tolerate the discomfort of addressing racism... my sense is that racial trauma is taught as an informational process rather than as a relational*

and embodied process...” pg. 23 [00:36:20-00:37:12]

This quote indicates a belief that confronting racism requires a certain depth of engagement and emotional resilience, suggesting clinicians might avoid deep engagement because of discomfort. The term ‘drop-down’ can be interpreted as a metaphor for the act of engaging with deeper, more intuitive levels of emotional and psychological experiences, possibly suggesting the need to shift from a purely cognitive understanding of racial trauma, to one that acknowledges a descent into more challenging emotional states, greater vulnerability, and an openness to sit with and process the difficult emotions that come with confronting racial trauma both in practitioners and their clients.

Moreover, the participant differentiates between two methods of teaching/learning, ‘*informational’* and *‘relational and embodied’*. Participant 8 seems to critique the depersonalised, abstract manner in which racial trauma is often taught, favouring a more personal, experiential, and holistic approach. Participant 7 reflects disappointedly on her own training experience at a reputable university, highlighting the absence of any mention of racial trauma:

P7: “*I don’t even remember racial trauma being mentioned at all in my training course...it wasn’t even addressed on any of the courses...I’ve never heard...about racial trauma...*” *pg. 17 [00:42:31-00:45:11]*

This view is shared by Participant 5, who critiques the predominately Eurocentric focus in psychology training, which fails to address or include alternative perspectives and experiences, particularly those about race:

P5: *“... we had one lecture on diversity, nothing about racism... training in the education sector is necessary, not just on the surface level of equality, diversity*

and inclusion. What we're doing is we're applying Eurocentric techniques to culturally diverse communities…" pg. 43 [00:51:07-00:52:06]

She also criticises the oversimplification of cultural experiences and labels it as a form of pathologising Black people, suggesting a lack of cultural understanding. She emphasises the need for training that recognises and respects cultural differences, enabling practitioners to avoid misinterpretations and stereotypes:

P5: *"…If training was up today...we wouldn't still be...over-pathologising Black people...if we understood the culture a little bit more... they wouldn't then assume that because I'm assertive, then I'm aggressive and equally, that doesn't mean I'm schizophrenic, I'm just expressing myself…" pg. 44 [00:52:09-00:52:39]*

The link made between assertiveness, perceived aggression, and schizophrenia suggests that there are broader societal misconceptions about the behaviours of certain groups, which may lead to misdiagnosis. Participant 2 also criticises the insufficient and perfunctory nature of diversity training, emphasising the need for a more comprehensive curriculum. The remark about having diversity training *'only two in two years'* might suggest that the 'tokenistic' efforts cannot bring about change; thus, a genuine understanding requires consistent, dedicated learning:

P2: *…I don't feel equipped … diversity training is a joke, I'm sitting there like…Why are we having two lectures on diversity and inclusion, only two in two years…It's fucking ridiculous… I brought this up and was told, shamelessly in front of the whole class, we don't focus on any one group" pg. 27 [00:48:30-00:49:55]*

This narrative appears to expose the shortcomings of current training, which seems to fail to provide the necessary foundation for understanding and addressing racial trauma.

Participants 3, 1, and 6 also highlight the minimal training they received on cultural and racial issues, with Participant 6 criticising the lack of global perspectives and the dominance of Eurocentric *'one-size-fits-all'* approaches in mental health training, suggesting a lack of cultural inclusivity in the curriculum and treatment approaches. Participant 1 also comments on the limited training on culture and the slow progression in improving training:

> P1: *"...we are so behind with our training... we've had a hundred years since Sigmund Freud to get our act together, and we still haven't done much, it's not good enough..." pg. 26 [00:47:15-00:47:31]*

3.6.2 Sub B: Recommendations for Educators

The participants' narratives provide valuable insights and constructive recommendations for educators to address racism and racial trauma within educational settings. Participant 7, for instance, proposes that the fear around discussions of racism should be explicitly addressed and emphasises the importance of raising awareness about racial issues. The suggestion of asking how individuals feel about discussing racism indicates introspective and reflective dialogues are necessary:

> P7: *"...We definitely need training... to raise awareness...they could put something about why people are frightened to talk about racism. And ask questions such as how do you feel about talking about racism?" pg. 17 [00:40:44- 00:42:11]*

This seems to highlight the desire for educational programmes that foster an open dialogue and allow trainees to confront their discomforts in discussing racism. Participant 5 proposes a grassroots approach to understanding Black people's experiences through embedding racial trauma within the educational programme, suggesting that without a foundational understanding of such experiences, one cannot truly comprehend Black individuals' cognitive and emotional circumstances:

P5: *"…I think that education and training need to go right back to grassroots and to talk about the experience of Black people and where they're coming from so that they can understand what's going on up here…" pg. 46 [00:55:21-00:57:30]*

Participant 2 stresses the need for training that enables therapists to engage in open conversations about race, navigate discomfort, and manage unexpected emotions:

P2*: "I think there needs to be a specific and explicit exploration of relationship, racism and race; I think that that's imperative, learning how to talk about it and how to say it out loud and how to cope with the unexpected emotions that will come up for people of colour and for white people to learn to deal with discomfort*" *pg.33 [00:58:59-1:01:25]*

This seems to suggest the discussions surrounding these topics should not be euphemistic but addressed clearly. This is likely rooted in the understanding that clarity and specificity are necessary for meaningful dialogue or change. Participants 8 and 3 below suggest adopting small-group settings for training, promoting an intimate environment that encourages candid discussions about racism. Participant 8 identifies the importance of noticing our reactions when discussing racism, suggesting he views confronting racism as a deeply emotional process requiring self-awareness and self-regulation:

P8: *"… I think training that allows thinking as a group of people who are really willing to go there, regulate our nervous systems, sit with a deep discomfort of our own racism and to really pay attention to what happens when we talk about these things, what happens when we get challenged" pg. 28 [00:42:00-00:43:33]*

This underlines the importance of creating a supportive learning environment where

participants can learn from one another's perspectives, confront their biases, and collectively work towards understanding and addressing racism. Participant 3 finds practical group exercises more beneficial than theoretical learning, emphasising experiential learning plays a crucial role in understanding and confronting racism:

> P3: *"I found specifically helpful is working with a small group of people through...actually doing the exercises… not just reading... that's been something that I would wish was part of every training" pg. 46 [00:59:25-1:00:10]*

3.6.3 Sub C: Mental Health Services Possibly Perpetuating Racial Trauma

This sub-theme highlights how mental health services, while intended to help, may inadvertently perpetuate racial trauma by dismissing or invalidating the experiences of marginalised individuals. Participant 2's narrative emphasises the possible re-traumatisation caused by the silence around racism in mental health services:

> P2: "*There is silence around racism and race in mental health services … is …a re-traumatization… it's a repetition of gaslighting… part of the conversation is being left out … I think that is harmful…*" *pg. 27 [00:45:51-00:48:16]*

This arguably indicates the need for mental health services to address racism explicitly. Her perspective resonates with Participant 4's, which highlights the misdiagnosis of young Black individuals:

> P4: *"…a lot of young Black guys…most of these boys fell out of school, and people supporting these boys found that they couldn't contain the boys' anger and, then that's when they got diagnosed with, schizophrenia, or that kind of similar diagnosis then stuck on this terrible cycle…" pg. 16 [00:29:10-00:32:41]*

Both participants shed light on the systemic issue of overlooking or dismissing the

experiences of marginalised communities within mental health services. Participant 6's narrative highlights the lack of representation and cultural sensitivity within mental health services. This could signify a psychological impact wherein Black individuals might feel like outsiders, leading to potential disengagement from services that are meant to support them and further alienate them from seeking help.

> P6: *"The mental health system doesn't reflect Black people's experience... and I think Black people think I'm not coming back, the advertising is for White people … it backs up your feeling of being othered or not considered or not being worthwhile…" pg. 44 [00:43:41-00:43:53]*

This narrative reflects the complex interplay of systemic issues, representation, identity, and perceived value, all of which can influence the mental health-seeking behaviours of Black individuals, emphasising the need for mental health services to demonstrate commitment to the well-being of marginalised communities. Participant 6's perspective aligns with Participant 2's narrative, addressing the overt racism within the NHS:

> P2: *"…my own experience with the NHS has been at times overtly racist… never in a single one of those contexts has the factor of race or racial trauma been mentioned...when I have brought it up, I have been met with, ranging from discomfort and surprise and not really knowing what to do to outright hostility to where I've had to leave...literally being told this is not the place for that, that is very traumatic…" pg.29 [00:50:18-00:52:15]*

The spectrum of reactions when Participant 2 tried to address the issue demonstrates discomfort or surprise, perhaps indicating a lack of preparedness or understanding of racial trauma. These responses might be damaging, arguably dismissing the participant's concerns and preventing them from seeking help. Participants 6 and 2 share experiences of feeling

unheard and invalidated within mental health settings, indicating a common theme of marginalisation and the need for inclusivity and cultural humility in mental health services.

Participant 3's narrative goes even further:

> P3: *"I think mental health services... contribute to racial trauma and maybe even make it worse… I suppose on two levels, the systems that are in place can be quite rigid, and if you don't fit nicely into some categories, then you are labelled... and then dismissed…" pg. 27 [00:32:24-00:34:29]*

This quote appears to emphasise the need for mental health services to move away from rigid categorisation and become more inclusive and individualised. Participant 3's perspective echoes Participant 5 and 1's narratives, pointing out the lack of cultural awareness in mental health services, noting that while some services cater to South Asian and Muslim communities, there seems to be a deficiency in addressing the needs of Black people. Participant 5 recounts a personal family history, highlighting stereotypes about Black women's strength and the resulting neglect of their mental health needs:

> *P5: "I think mental health services can…make it worse…the NHS seem to have this view that Black women are like strong and can withstand anything, my Nan experienced very poor mental health, and she did not speak English… She just needed HRT because she was going through menopause… she was treated like she was a crazy old Black lady…" pg. 37 [00:43:02-00:44:56]*

Participant 5's quote spotlights the intersectional experiences of racism, sexism and ageism that may further contribute to racial trauma within mental health services. She illustrates the need to address racial trauma and the unique experiences of different marginalised groups. Participant 1 indicates the potential pitfalls of an over-reliance on

formal procedures, like treatment plans, when they are used in a way that prioritises power dynamics over genuine engagement.

> *P1:"…If they deny the lived experience … (1) if there's a lack of support and relationship, (2) if we do not engage and encounter and we use processes such as the forms, such as treatment plans… in a way that is to do with power over rather than power with, that's problematic and perpetuates the trauma, if we do not understand what racial trauma is, how are we ever going to work with it… " pg. 24 [00:44:19-00:45:24]*

This view suggests such an approach might reinforce the trauma, especially if the individual feels they are another case or statistic. The emphasis on *'power over'* versus *'power with'* seems to advocate for a collaborative approach, where the therapist and the individual work together, instead of a hierarchical one. All participants under this theme highlight the limitations of current systems and call for a more nuanced understanding of racial trauma and its impact on individuals.

Summary

Participants' narratives revealed practitioners' lack of relevant training and preparation to address racism effectively. The training and educational programmes were characterised mainly as Eurocentric, with limited consideration of non-Western psychological approaches or intersectionality of racism and mental health.

Participants advocated for more inclusive education, incorporating open, honest dialogues, grassroots understanding of marginalised populations and the need to explore racism and race. These findings arguably expose the need for a more inclusive and informed approach to addressing systemic inadequacies.

3.7 GET 5: Navigating Racial Dynamics in Professional Spaces: The Interplay of Supervision, Self-care, and Racial Trauma

The overarching theme encompasses the experiences shared by the participants regarding their professional experience within supervision, their self-care and coping mechanisms.

3.7.1 Sub A: Supervision

The participants' narratives provide valuable insights into the lived experiences and interpretations of their supervisory relationships when addressing race-related issues. Participant 5 expresses inadequacy in the supervision received from her White supervisors, whom she feels unable to approach on issues concerning race due to potential discomfort:

> *P5: "… no disrespect to my supervisors; they are all fantastic… I guess I feel supported to a certain extent, but I do not feel fully supported...I don't think I've approached supervision around any race-based stuff…" pg. 51 [01:01:07-01:01:27]*

> *"…I don't talk about it because I don't wanna feel uncomfortable making them feel uncomfortable..." pg. 53 [01:02:35-01:03:37]*

Participant 5 highlights the presence of cultural disparity, resulting in partial supervision due to a lack of mutual cultural understanding. This discomfort also surfaces in Participant 7's account, who, despite acknowledging the understanding of racism by her Jewish supervisor, still *'tiptoes'* around discussions of race. This sense of partial support, or a void due to cultural differences, suggests a gap in supervisor-supervisee communication:

> P7: *"my supervisor … he's Jewish actually…he does understand racism... in a way, it feels as if, it's not that it's not important... I don't think we talk about racism, which is strange thinking about it, I suppose, to be honest… I still tiptoe*

around it a little, even with my supervisor…" pg. 20 [00:48:18-00:52:49]

This similarity in hesitation indicates a shared experience of caution when discussing race-related issues with supervisors.

In contrast, Participant 6 reports a positive experience, feeling fully supported due to her supervisor's experience with Black individuals. This highlights the influence a supervisor's CH can have on their supervisee's comfort and perceived effectiveness of supervision. The phrases *'exploring stuff'* and *'getting the support to explore'* implies the supervisory sessions might involve introspection and self-discovery, and potentially provide opportunities to address complex issues related to identity, race, and professional development:

> P6*: "…I've got two White supervisors… they have done lots of work with young Black men… I feel when I'm coming to those conversations in supervision, I'm exploring stuff, getting the support to explore a little bit more about what's going on for me, but I also think I'm actually bringing quite a lot of skills to that supervisory, relationship..." pg. 50 [00:49:49-00:50:45]*

Participants 3 and 2 also emphasise the comfort and understanding they receive from having a Black supervisor who understands experiences dealing with issues of race, allowing for open and honest discussions about race-related matters:

> P3: *"... It felt really important that we had a Black woman supervisor, we can really bring those things about race, she's really open about her own experiences of racism and classism. So, you know, she's really good at being able to help us to form conversations…" pg. 52 [01:06:11-01:07:53]*

Participant 3's mention of the supervisor being *'really open about her own*

experiences of racism and classism' suggests appreciation of a supervisor who understands these issues and is willing to address them. These qualities seem important, particularly in settings where conversations about race and class are challenging or potentially taboo. Participant 2 reports feeling seen, understood, and safe enough to be open about personal or potentially sensitive topics:

> P2: *"...I have a very good supervisor; we work through all kind of stuff, I have a Black supervisor that was very important to me, she understands these issues, I can be open…."* *pg. 5 [00:06:01- 00:17:14]*

The commonality of racial identity appears to foster open conversations about race and racism within a supportive supervisory relationship.

3.7.2 Sub B: Self-care and Coping Strategies

Participants' narratives under this theme provide insights into how they manage their professional and personal challenges in dealing with racial trauma. Participant 6 highlights the significance of taking breaks between clients:

> P6: *"I always do something between clients … kind of processing stuff through my materials... I try to really connect with the body systems… I'll go out and get some fresh air, ride my bike…" pg. 53 [00:52:51-00:53:56]*

This highlights the importance of engaging in activities that facilitate introspection, enabling therapists to connect with their own experiences and emotions while rejuvenating themselves. Similarly, Participant 7 recognises the essential value of personal therapy and professional external emotional support, reinforcing how therapists also need psychological support:

> P7: *"I do maintain weekly personal therapy in addition to my supervision…*

for me is necessary, with the level of work that I'm doing" pg. 20 [00:48:18 - 00:52:49]

Participant 2 advocates for personal growth and introspection in dealing with racial trauma, asserting that without self-work, one cannot safely work with such trauma:

P2: "…I think the most important is to do work ourselves, our own trauma, so racial trauma is no different …. If you haven't done the work yourself, you're not safe to work with this kind of trauma… I feel that quite strongly..." pg. 21 [00:36:47-00:39:37]

This perspective highlights the significance of therapists cultivating self-awareness, building a strong alliance with themselves and fostering a supportive community. Participant 1 underscores the importance of deep self-reflection and introspection:

P1: *"…search within yourself, doing that work, looking at what was that experience...? Looking at prejudices I have on others… to continue to peel those layers so that I don't, or I do my best not to, project on my clients. When I do so, I face it, in my own therapy…*" *pg. 16 [00:29:42-00:31:11]*

The narrative underlines the importance of continuous self-exploration to mitigate prejudice and provide adequate care.

Summary

The sub-themes of Supervision, Self-Care, and Coping Strategies highlight critical insights into the overarching theme of navigating racial dynamics in professional spaces, illustrating the interconnectedness of individual experiences and systemic influences. The narratives construct a mosaic of shared and unique experiences, highlighting supervisors' cultural understanding – or lack thereof – in shaping the supervisees' experiences. While all

participants were cognisant of racial dynamics at play, their strategies varied, either broaching the topic of racism carefully or not at all. This form of self-preservation allowed some participants to navigate their professional spaces with less discomfort. However, those who had supervisors who shared their racial identity or had a demonstrated understanding of race-based issues seemed more comfortable, suggesting a correlation between racial identity or awareness in supervisors and their supervisees' perceived safety and effectiveness. These narratives also underscore the need for ongoing self-work to address racial trauma safely.

Chapter Four: Discussion

4.1 Overview

This chapter synthesises the findings of the previous chapter, framing results in the context of existing literature presented in Chapter One. However, the discussion extends to include research unaddressed in the Literature Review, a consequence of the inductive nature of IPA, where interviewing and analysis pathways may lead the researcher to unexplored areas (Smith et al., 2009).

Subsequently, I critically evaluate my study, reflecting upon the methodology and inherent limitations within my approach. I propose implications of my findings for counselling psychology professionals, focusing on their role in supporting Black clients presenting with RBTS. Additionally, I suggest potential avenues for future research. Lastly, I reflect upon the research process, examining how this study has shaped my professional identity as a counselling psychologist.

4.2 Summary of the Research Findings

The five GETs offer distinct perspectives that intersect in critical ways to illuminate the multifaceted, complex landscape of racial trauma in the therapeutic setting. The participants' narratives spotlighted a persistent, ongoing cycle embedded in their professional practice. The cycle begins with the lack of relevant training provided to therapists and their supervisors, particularly in the context of Black clients enduring RBTS. This lack, in turn, fuels cultural incompetency within professional practice, contributing to a sense of under-preparedness among practitioners when navigating the unique challenges of racial trauma in therapy rooms or supervision, arguably leading to a failure to adequately address racial trauma or incorrectly attribute symptoms to other issues.

This cultural incompetency often leads to therapists' inadvertently minimising clients' experiences of racial trauma or avoiding discussions on racism due to fear of misunderstanding or causing further harm. The prevailing self-doubt and discomfort surrounding the topic of race, stemming from a lack of confidence and competence, further exacerbate this issue, making racial trauma an *'elephant in the room'*, potentially worsening the original trauma and marginalisation. Such cultural incompetency can risk re-traumatising clients within mental health services.

In turn, the mental health services perpetuating racial trauma could deter individuals from seeking help, reinforcing the cycle of '*silence', 'invisibility'*, and '*distress'.* This avoidance can feed into the systemic issues surrounding training, with educators, supervisors and mental health professionals continuing to overlook the need for culturally competent care and understanding.

Participants' recommendations highlighted the need for systemic changes in professional practice, education, and culturally competent training programmes.

Below is the presentation cycle:

Figure 1: Cycle Diagram Outlining Recurring Processes Related to The Challenges Clinicians Face When Dealing with Racial Trauma.

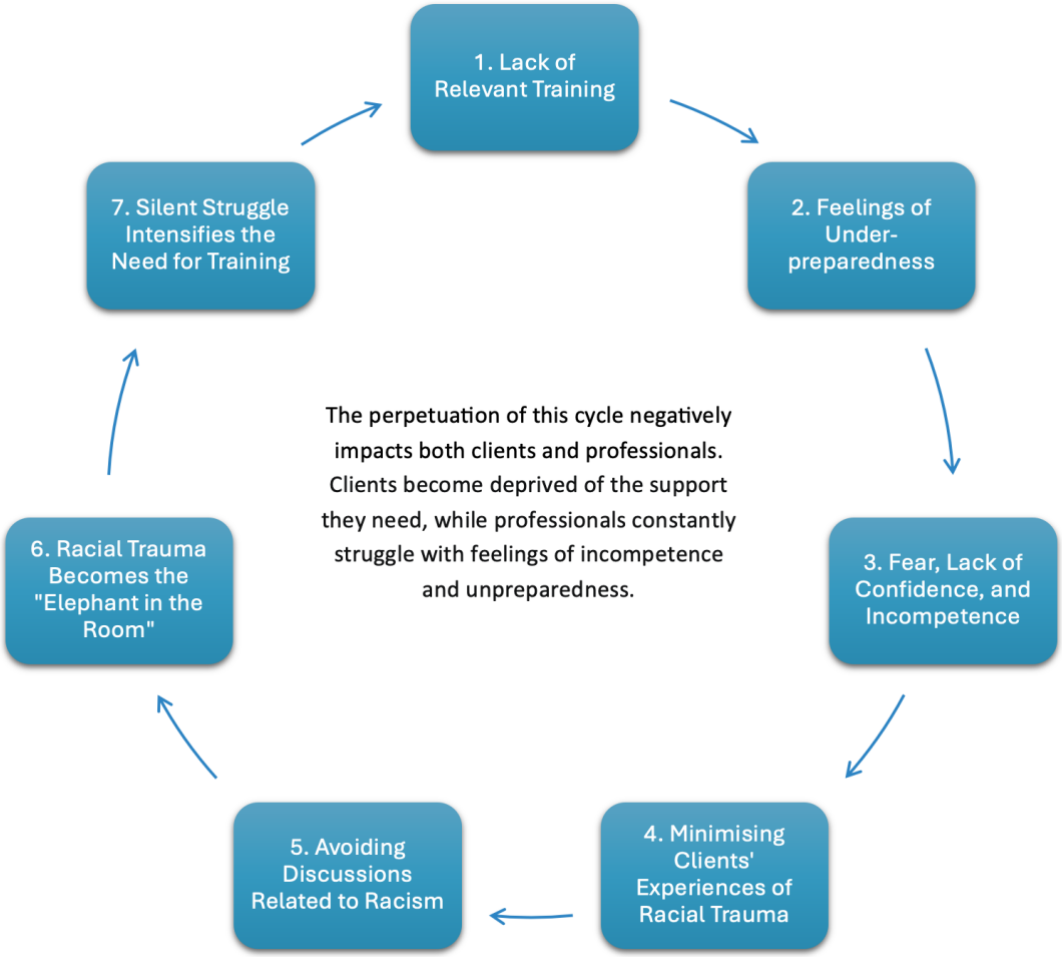


Table 3*: In-depth Explanation of Figure 1*

1. Lack of Relevant Training:

The cycle begins with professionals not receiving adequate training on racial trauma. Most curriculums and psychological programmes might not fully incorporate lessons on racial trauma, its manifestations, and ways to address it.

2. Under-preparedness:

Due to deficiency in training, professionals enter their practices under-prepared. This under-preparedness is not just about a lack of knowledge but also the lack of practical skills to navigate sensitive discussions on racial trauma.

3. Fear, Lack of Confidence, and Incompetence:

Given under-preparedness, these professionals often experience a fear of discussing topics related to race. This fear is twofold: first, the fear of causing further harm to their clients, and second, the fear of revealing their incompetence. This fear seems to reduce clinicians' confidence, and this lack of confidence becomes apparent in their professional interactions, reinforcing their perceived incompetence.

4. Minimising Clients' Experiences of Racial Trauma:

A consequence of this fear and lack of confidence is that professionals might unconsciously minimise the experiences of racial trauma shared by their clients – thus unintentionally invalidating their clients' lived realities.

5. Avoiding Discussions Related to Racism:

To avoid potential confrontations or perceived shortcomings, professionals might avoid discussions related to racism, depriving clients of a space to address and process their trauma.

6. Racial Trauma Becomes the "Elephant in the Room":

The avoidance creates an environment where racial trauma becomes an unspoken yet glaring issue – the proverbial "elephant in the room." The unaddressed trauma then compounds as clients feel isolated in their experiences, perpetuating the "silent struggle".

7. Silent Struggle Intensifies the Need for Training:

As racial trauma remains unaddressed, its manifestations become even more pronounced, amplifying the necessity for relevant training.

4. 3 Relating Findings to Existing RBTS Literature

4.3.1 GET 1: Navigating the Uncharted: Recognition, Understanding, and Addressing Racial Trauma in Professional Practice

The first overarching theme, *Navigating the Uncharted,* captures the essence of therapists' navigating the relatively unexplored domain of racial trauma. This presents various complexities, making it challenging for professionals seeking to recognise, understand, and effectively address RBTS. The findings from this theme resonate with existing literature, notably Carter (2007), Roberson and Carter (2021) and Williams et al. (2018). My interpretation of *'Uncharted'* reflects the lack of standardised definitions, classification criteria, and treatment approaches for racial trauma, as well as the emotional and cognitive dissonance professionals experience. Emotional dissonance happens when there is a discrepancy between what therapists are feeling and what they think they *should* be feeling (Abraham, 1998; Heuven & Bakker, 2003). For instance, most of my study's White participants expressed feelings of uncertainty when dealing with the topic of racial trauma, yet believed they should approach their interventions with confidence.

Contrastingly, cognitive dissonance may result from experiencing discomfort from holding two or more contradictory beliefs, thoughts, values, or attitudes simultaneously (Festinger, 1957; Gawronski & Branon, 2019). For example, some of the White participants' narratives indicated they prided themselves on being racially unbiased. However, when clients shared distressing experiences where they felt racially dehumanised, White clinicians shared stories that implied they might have unintentionally contributed to or overlooked racial trauma in their clients, creating significant discomfort. I viewed this as stemming from the conflict between their self-perception as culturally competent therapists and the conflicting idea that gaps in their understanding may have worked to unintentionally harm

clients.

This dissonance is evident in participants' narratives, highlighting an ongoing struggle to recognise and operationalise racial trauma, with most reporting that understanding RBTS is a complex process requiring significant professional and personal effort, arguably revealing blind spots within the system. The relevance of racial identity notably seemed to influence how therapists conceptualised and approached RBTS. Black therapists frequently highlighted the systemic nature of racial trauma, incorporating the collective history of racial oppression and broader societal contexts into their discussion about their experiences of working with Black clients. On the other hand, White therapists at times seemed to struggle to integrate the systemic dimensions of racial trauma.

This was evident in some narratives, indicating tension between understanding racial trauma as an individual experience and recognising it as a manifestation of societal structures. Additionally, most of the Black participants' descriptions highlight covert racism, often manifesting as microaggressions and gaslighting, suggesting societal issues influenced by external factors such as discrimination and social justice, aligning with findings from Crenshaw (1989) and Sue et al. (2007). Most Black participants also expressed their experience with the *'accumulation of microaggressions',* indicating a subtle process of racism, making it challenging to identify and acknowledge, leading to racial trauma, consistent with Williams et al.'s (2019) study. This also aligns with the ample evidence indicating that racism, in any form, can induce stress (Carlson et al., 2018; Carter, 2007; Roberson & Carter, 2021). This can occur when individuals perceive they are being mistreated or avoided due to race, which can lead to adverse outcomes and hinder recovery from trauma (Bhugra & Bhui, 2001; Came & Griffith, 2018; Carlson et al., 2018; Roberson & Carter, 2021; Slaughter-Acey et al., 2016).

Most participants described racial trauma as an ongoing experience of exclusion and rejection, which impacts one's sense of self and self-esteem and includes a chronic feeling of being an *outsider* and being powerless, as found by Sue et al. (2007) and Turner (2021). CRT posits that racism is a pervasive and normalised aspect of society, often manifesting in subtle and institutionalised ways (Delgado & Stefancic, 2017). The cumulative effect of these microaggressions can lead to profound psychological distress, as noted in the data, where parallels are drawn between racial trauma and the diagnostic criteria in DSM-5 and ICD-11.

This is supported by English et al. (2020), Helms et al. (2012), and Wheaton et al. (2018), who argue the accumulation of racial microaggressions, such as the use of prejudicial language and avoidance of individuals, can lead to an increase in depressive symptoms and anxiety (Soto et al., 2011). Furthermore, physical attacks due to racially based hostility can lead to symptoms akin to PTSD (Helms et al., 2012; Sibrava et al., 2019). This may further align with literature discussing the multifaceted nature of trauma and its effects, specifically race-based trauma, where therapists may fail to see the signs of racial trauma in their clients or incorrectly attribute symptoms to other issues (Carter, 2007).

This lack of recognition and understanding can lead to what participants termed a *'silent struggle'*, where racism, although significant, remains unspoken due to the reluctance or inability of professionals to address it. This seems to leave the affected individuals in a state of constant distress, as their experiences of racism may be either misdiagnosed as depression or anxiety or, worse, ignored entirely as suggested by participants' narratives. The data reflects the often-unspoken nature of racial trauma, which resonates with Comas-Díaz's (2016) work on the invisibility of racial trauma, suggesting a cyclical relationship between the inability to define racial trauma and its subsequent non-recognition. The silence surrounding racial trauma is not just about the lack of recognition; it is also about the discomfort and systemic barriers to addressing it, as supported in Williams et al.'s (2018)

study. Conversely, silence might shield professionals from the discomfort of confronting deeply ingrained biases. However, it also underscores the systemic challenges in bringing racial trauma to the forefront of therapeutic discourse.

Black participants also spoke about transgenerational trauma, passed down unintentionally in families of colour linked to slavery and colonialism, providing context in which contemporary experiences of racism are juxtaposed (Degruy-Leary, 2017). The data suggests this trauma's legacy continues to inflict psychological harm. This transgenerational perspective, supported by DeGruy (2005), is further enriched by intersectionality, leading to overlapping systems of discrimination or disadvantage (Crenshaw, 1989). Furthermore, participants frequently indicated an intersection of external oppressive systems, covert racist acts, and internalised oppression manifesting as racial trauma, underscoring its complex aetiology.

Some participants also highlighted the role of colourism and shadeism (Goldsmith et al., 2006; Reece, 2018; Russell et al., 2013), suggesting that darker-skinned individuals are more likely to face discrimination. Reece (2018) found that individuals with lighter skin tones are often granted certain privileges not readily accessible to individuals of darker complexions. The compounding effect of these experiences appears to erode an individual's sense of self and belonging when these experiences are dismissed or overlooked in therapeutic settings (Carter, 2007; Hemmings & Evans, 2018; Malott & Schaefle, 2015).

Hence, the data indicates that to acknowledge and address racial trauma effectively, it is essential to adopt a comprehensive approach that considers the various factors contributing to its formation, consistent with Williams et al. (2022). Employing a holistic approach might aid in developing appropriate interventions to address racial trauma. Recent events, such as the COVID-19 pandemic and the BLM Movement, suggest a noteworthy shift

in discussions about racial trauma and seem to have prompted mental health professionals to re-evaluate their understanding and approach to racial trauma, as evident in participants' narratives.

4.3.2 GET 2: Navigating Therapists' Intersections of Race, Personal Experiences, and Professional Practice in Therapy

The second theme demonstrates the power of empathy, allowing participants to connect with clients' experiences, feelings, and perspectives, even if they have no similar experiences. This is critical in therapy, where understanding a client's emotions and experiences helps to build trust and promote healing (Cooper, 2001; Rogers, 1957).

Empathy is a fundamental concept in psychology, often divided into affective empathy (sharing emotions with someone else) and cognitive empathy (the ability to understand and imagine someone else's feelings) (Gladstein, 1983; Goldstein & Michaels, 1985; Hoffman, 1977; Myers & Hodges, 2013; Strayer, 1987). Despite differing personal experiences, psychologists can and must cultivate empathy for their clients' experiences to provide effective therapy. This highlights the critical nature of the ability to step outside one's perspective to understand and validate the experiences of others (Rogers, 1957).

However, it is also important to note that while empathy is essential, it does not replace the lived experiences of individuals from marginalised communities. Empathy can provide understanding, but the nuances and complexities of lived experiences can be fully grasped only by those who have personally experienced them (Tervalon & Murray-García, 1998). It is apparent in the data that some Black therapists leveraged their personal experiences of racism to foster a connection with their Black clients on a deeply personal level (affective empathy).

Black therapists often incorporated language that reflected a lived understanding of racism's impacts and, at times, used more direct language, speaking to the systemic oppression and its impacts on mental health. Participants of mixed heritage frequently identified more with their Black side, reflecting in their narratives a closer alignment with the experiences and challenges faced by their Black clients. Both Black and mixed heritage participants' narratives were rich with references to cultural resilience, personal anecdotes that mirrored the racial traumas of their clients, community trauma, and the importance of culturally informed therapy, suggesting a deep, intrinsic understanding borne out of shared experiences.

Benthall and Haynes (2018) suggest that such connections are rooted in the broader socio-political landscape, where racial identity is both a personal attribute and a marker of systemic inequalities and historical legacies. Thus, the therapeutic space becomes a microcosm of these societal dynamics, where shared racial experiences can either be a tool for connection or a pitfall if not navigated with reflexivity.

In contrast, the narratives of White participants' regarding their experiences of working with Black clients appeared to describe a form of cognitive empathy, an intellectual understanding of their clients' racial traumas (Myers & Hodges, 2013), allowing them to provide adequate psychological support. Such empathy seems not to be rooted in shared experiences, but cultivated through active listening, genuine curiosity, and a commitment to understanding the client's world (Rogers, 1957). Baten et al. (2021) further illuminate this, suggesting that while racial identity is influential, it is not the sole determinant of empathetic connections and further aligns with intersectionality's tenets, suggesting that while individual identities might be multifaceted and complex, the core human experience transcends these divisions (Crenshaw, 1989).

As revealed in the narratives, the complexity of shared racial experiences in therapeutic contexts presented both opportunities and challenges. Central to this complexity seems to be the interplay between personal experiences and professional responsibilities. This was evident during the interview process, where my shared racial identity with Black participants appeared to have played a crucial role in the dynamics of information sharing. This dynamic required me to proceed carefully, ensuring that my identity did not skew the authenticity of the narratives shared.

An intriguing observation was that Black participants, perhaps seeing a reflection of their own experiences in my presence, appeared to approach the interviews with a sense of confidence and were often more willing to share openly, sometimes even assuming a shared understanding or common experience of racial trauma. This shared identity often led to deeper conversations that were not just professional but also personal, as a member of the Black community, although there was potential for blurred professional boundaries if not navigated with care. In this sense, participants' narratives suggested that therapists, especially those who share racial experiences or identities, find themselves navigating a delicate balance.

Firstly, their personal experiences with racial trauma or discrimination appeared to have offered a profound empathy toward their clients' struggles. This 'insider' perspective, rooted in lived experiences, seems to have provided deep understanding that might lead to nuanced therapeutic interventions, tailored advice, and a heightened sense of validation for the client. However, the possible reverse of this deep connection was the risk of over-identification, whereby professionals might find their own unresolved traumas triggered during sessions, potentially blurring the boundaries between personal experiences and those of clients. This situation may be counterproductive, potentially leading to misinterpretations or misguided therapeutic interventions (Hemmings & Evans, 2018; Malott & Schaefle, 2015).

Therefore, it is important for therapists to empathise with clients who have experienced racial trauma without internalising their trauma (Comas-Díaz, 2016; Helms, 2012).

For mixed heritage/multi-race therapists (e.g., Participant 2), the complexities appeared to be further magnified. Their own multiplicity can allow them to relate to a diverse range of clients; however, it can also introduce additional challenges. For instance, they might feel torn between different racial communities or face accusations of not being 'enough' of one race or the other. Furthermore, this multifaceted identity may also be a source of internal conflict, especially when racial identities have historically been at odds. For instance, a therapist of both Black and White heritage might grapple with understanding privileges associated with one part of their identity while also empathising with the struggles linked to the other. Therefore, while shared racial experiences can be a powerful tool in therapeutic practice, offering depth, empathy, and validation, they also introduce further complexities for therapists.

Additionally, besides over-identification, the therapeutic space might be considered a dynamic, evolving entity between the therapist and the client. In this space, shared racial experiences can be perceived as both a bridge to facilitate more profound understanding and connection, and a barrier, potentially leading to assumptions and generalisations. Consequently, it is the clinician's responsibility to ensure this space remains open, non-judgmental, and centred on the client's unique experiences.

This delicate equilibrium requires reflexivity, continued learning and adaptation in clinical practice (Oliveira, 2022). This involves being acutely aware of one's biases, engaging in continuous self-reflection and seeking supervision or personal therapy to process and understand these experiences (Christodoulidi, 2023; Fuertes & Williams, 2017; Kite et al., 2022). Such continued learning ensures therapists can harness the benefits of shared racial

experiences while mitigating potential challenges (Oliveira, 2022).

Contrastingly, the consciousness of privilege, especially among White participants, is a testament to the evolving understanding of racial dynamics in therapy. This is because recognising one's privilege, as the narratives suggest, is not merely an acknowledgement of societal advantages, but also an introspective journey into understanding systemic structures that perpetuate racial disparities, consistent with Dotollo and Kaschak's (2016) work. This aligns with CRT's foundational principles, which call for critical examination of systemic privileges and their implications (Delgado & Stefancic, 2017). Acknowledging the presence and impact of racial privilege is crucial in dismantling systemic racial hierarchies (Delgado & Stefancic, 2017) and challenging personal biases and assumptions (Sue et al., 2012).

However, recognising one's privilege requires therapists to confront uncomfortable truths about societal structures and their position within them (DiAngelo, 2018; Hook et al., 2016). As highlighted in the narratives, some White participants grappled with privilege, reflecting on the differential treatment they might receive in various situations compared to clients of colour. Such introspection can be interpreted as indicative of a deeper understanding of the systemic nature of racism and its pervasive impact on everyday experiences.

The acknowledgement of privilege by White therapists can also influence the dynamics of the therapeutic relationship (Baten et al., 2021). For instance, when a White therapist acknowledges the differential treatment a Black client might receive, it validates the client's experience and fosters trust, which is crucial for building a therapeutic alliance where the client feels seen, heard, and understood. Therefore, when therapists are conscious of privilege, they are more likely to be intentional in interactions with their clients, ensuring they are not perpetuating negative, harmful stereotypes or biases (Sue et al., 2022).

Furthermore, therapists' acknowledgement of their privilege may create a safe space for clients to share their experiences without fear of minimisation or invalidation.

However, it is essential to note that recognising privilege is just the starting point (DiAngelo, 2018). DiAngelo (2018) also argues that addressing this privilege using actionable steps is key to challenging systemic racism. This includes therapists continuously educating themselves, seeking supervision, and being receptive to feedback, especially from clients of minority backgrounds, as highlighted by participants. It also means advocating for systemic changes within the mental health field to ensure that therapy is accessible, inclusive, and culturally sensitive (Carter & Scheuermann, 2019).

4.3.3 GET 3: It's Not My Place to Bring It Up

The stories shared by therapists in this GET highlight internal conflict and feelings of unpreparedness from therapists when engaging with this topic; participants' narratives suggest current training is inadequate in this regard. While multicultural competency and CH has been a growing focus in psychology and therapy (Sue & Sue, 2012), the narratives seem to suggest that there is still a long journey ahead. Historically, discussions of race and racism have been largely absent or marginalised in therapeutic training (Comas-Díaz, 2016), possibly contributing to therapists' discomfort when addressing racial issues.

Conversely, therapists' anxieties around topics of race and racism can be interpreted as indicative of a therapeutic culture that has yet to confront its colonial and Eurocentric legacies. According to Hooks (2005), these legacies continue to cast a long shadow, affecting the fabric of therapeutic training, methodology, and practice and continue to influence the field and its practitioners. During the interview, White participants (compared to Black participants) often approached the topic of RBTS with caution (careful consideration of language and approach) and, at times, with hesitancy, desiring reassurance that the space was

non-judgemental, possibly reflecting a broader societal discomfort around discussing racism or indicating fear of overstepping or misunderstanding racialised experiences (perhaps influenced by the researcher's racial identity). Their narratives suggested that, although they are dedicated to their work with Black clients, they often encounter challenges/discomfort and felt unsure of the best ways to address and navigate complex issues surrounding racial trauma in their practice. The discomfort seems to deter even highly qualified professionals from engaging, perhaps due to fears of being perceived as racist, unintentionally causing harm or misinterpretation. These findings mirror Carter and Forsyth (2010), Carter and Scheuermann (2019), Evans et al. (2016), Ponterotto et al. (2019), Sue et al. (2019), and Williams et al. (2018), who found racism is likely not discussed in therapy rooms due to unease about saying something incorrect or upsetting.

The participants' anxieties seem to mirror the concept of 'White fragility', where White individuals may feel threatened and defensive when confronted with issues of race due to their limited racial consciousness (DiAngelo, 2018). This is echoed by Sue and Sue (2012), who suggest discomfort around the topic of racism can lead to avoidance, perpetuating the cycle of misrecognition and distress (Ghavami et al., 2011). Therefore, cultivating an environment that promotes open dialogue within therapeutic settings is of paramount importance. Some participants suggested that willingness to embrace discomfort and engage authentically with clients is essential for effective therapeutic outcomes, as found by Knox and Hill (2003). Furthermore, by bringing racial traumas to the forefront, therapists can indirectly challenge the systemic structures perpetuating racism (Carter & Scheuermann, 2019; Delgado & Stefancic, 2001). However, the fear of being labelled 'racist' appears to be intertwined with a broader societal context, wherein discussing racism is often stigmatised and fraught with potential negative consequences (Helms, 1995; Nadal, 2008).

Ironically, the lack of conversation may lead to the unintentional minimisation of

racial experiences, as noted in participants' narratives, further marginalising individuals who already feel marginalised in broader societal contexts (Atkinson et al., 1991; Pieterse et al., 2023). This minimisation seems to stem from various factors, such as preconceived notions about the client's life circumstances, such as a successful career, discomfort in addressing racial issues, and perhaps a lack of awareness or understanding of racial trauma's pervasive and nuanced nature. For example, phrases used by participants, such as *'she has got this great life'* and *'she has a good job'*, seem to assume success and social status can shield individuals from racial trauma. This might be viewed through the lens of the 'model minority' myth (Cheryan & Tsai, 2007), where certain racial groups are stereotypically viewed as more successful, overshadowing their experiences of racism.

Based on most participants' narratives, addressing racial trauma can be uncomfortable; however, true authenticity in therapy requires therapists to lean into this discomfort and recognise it as a genuine facet of the therapeutic process (Carter & Scheuermann, 2019; Rogers, 1961). Avoiding discussions on racial dynamics can inadvertently perpetuate racial trauma (Carter & Forsyth, 2010; Evans et al., 2016; Williams et al., 2018), suggesting that confronting these issues is not just best practice, but an ethical imperative. However, participants' narratives (mostly White) suggest addressing these issues is often laden with internal conflicts and dilemmas (highlighted in participants' statements such as the *'Should I?'* and *'What if?'*). This highlights the complexities of navigating uncertainty within clinical practice.

The data further revealed professionals are faced with a delicate balance between ethical responsibilities to address sensitive topics, and concerns about being perceived as a *'White saviour'* or unintentionally causing discomfort. This is also discussed in research on *'racial battle fatigue',* which describes the psychological and emotional toll experienced by individuals when dealing with racism-related stressors (Smith & Allen, 2007). This evokes

the principles laid out by the APA (2013), emphasising therapists' duty to prevent harm and promote clients' best interests. However, as participants indicate, recognising where these principles intersect and conflict, especially in the context of racial trauma, is challenging, revealing the thin line therapists tread between validation and confrontation.

In this sense, ethics in the therapy room seems to be more than just abiding by guidelines; it is also about navigating grey areas with sensitivity and competence (Wamser-Nanney et al., 2018). It is imperative for therapists to exercise caution to avoid missteps that can have serious negative consequences for the client's mental health (Carter & Pieterse, 2020; Comas-Díaz et al., 2019). Despite ethical complexities, participants emphasised that therapists bear the ethical responsibility to name and challenge distortions in clients' worldviews, a delicate balance that ensures the therapist neither invalidates the client's experiences nor shies away from addressing harmful influences of racism (Neville et al., 2013). This balance highlights the duality of therapists' roles as compassionate validators, providing emotional support and gentle confronters, aiming to make positive changes.

This balance appears crucial to the success of therapy and the clients' overall well-being, especially in cases where clients have difficulty identifying and articulating incidents of racism, internalised as just *'unfortunate events'* or normalised experiences. For example, Participant 5's client's initial dismissal of the racial implications behind the *'N word'* on his dormitory door as '*boys being silly'* offers compelling support for how normalised and omnipresent racial microaggressions have become (Carter & Reynolds, 2021; Evans et al., 2016). This resonates with Tatum's (1997) proposition that societal racism often operates like a *'smog'* that everyone inhales, but few recognise, emphasising the need for therapeutic spaces that allow reflection upon these realities.

The data also support Neblett et al.'s (2008) work, which revealed that many people

downplay racial implications as a protective mechanism for self-esteem. It also supports McKenzie and Bhui's (2007) work indicating people may adjust their behaviour to decrease the probability of being discriminated against. By choosing not to attribute negative events to racism, individuals are thought to protect their self-esteem (Kinouani, 2020).

However, as these narratives demonstrated, therapy can serve as a pivotal space for confronting and *'unmasking'* the unconscious and re-evaluating these protective beliefs. The transformative potential of therapy is depicted in the data (from Participants 2 and 5), showcasing the potential of therapeutic conversations in reshaping clients' understanding of their racial experiences. The findings hold implications for the therapeutic relationship itself. Some participants (e.g., Participant 7) shared their fear of a client preferring a therapist of their own race, suggesting deep-seated anxieties therapists may have about how the role of race plays out in therapeutic relationships.

This aligns with Williams et al. (2022), who posit that clients might feel better understood and validated by therapists who share their racial background, challenging the traditional view of therapy as a neutral space. This suggests therapy, like any other social interaction, is situated within the larger socio-political and cultural context, where the client and therapist's cultural backgrounds play a significant role in their therapeutic relationship. Sue and Zane (1987) suggested that effective therapy is not race-blind but rather race-informed, indicating therapists should be aware of cultural differences, actively engage with racial dynamics, and acknowledge them instead of skirting around them.

However, some argue that beyond shared racial experiences, it is the depth of understanding, empathy, and connection that ultimately drives therapeutic success (Bernard & Goodyear, 2009). This is also evidenced in the account provided by Participant 6, highlighting a positive experience whereby she felt supported by her supervisor despite racial

differences between them, highlighting the importance of therapeutic relationships.

4.3.4 GET 4: Inadequacy of the Systemic Response to Racial Trauma in Education and Mental Health Services

Most participants indicated that current education and training fail to capture racially diverse populations' lived experiences and cultural nuances, leaving them underprepared for real-world scenarios. These findings are consistent with studies by Carter and Forsyth (2010) and Hemmings and Evans (2018); in the latter, 67% of 106 counsellors reported not receiving adequate training on recognising RBTS, and 81.1% had not undergone training on treating racial trauma. Following graduation from university, several participants, particularly those who identified as Black clinicians, expressed a keen interest in obtaining additional education on racial trauma. This also indicates a common thread: a significant and concerning gap in the current system's understanding, acknowledgement, and addressing of racial trauma.

Participant narratives highlighted this shortfall is about more than lack of content; it also extends to the method and approach of training, advocating training that goes beyond the theoretical and offers skills to engage with racial trauma on a relational and embodied level. The absence of a consistent and comprehensive focus on racial trauma within the professional curriculum arguably creates a vacuum in understanding and addressing these issues, echoing the findings of Crosby et al. (2022), McAdoo et al. (2023) and Saleem et al. (2022).

This lack of appropriate training seems to have cascading effects. First, it might contribute to a significant deficiency in CH among therapists, who often struggle to understand the unique challenges Black clients face when dealing with racial trauma. For instance, clinicians might lack the knowledge to effectively incorporate clients' cultural backgrounds and experiences of racism into the therapeutic process. Also, clinicians may lack awareness of how their racial and cultural identities shape client interactions, leading to

mental health clinicians unintentionally causing harm or creating further barriers to treatment, as evident in the current findings.

In addition to the complexity and sensitivity of the topic of racism, highlighted in the data, therapists may feel uneasy discussing it. This discomfort was found to exacerbate the issue. This is supported in the literature (Carter, 2007; Carter & Forsyth, 2010; Evans et al., 2016). Most participants shared the observation that existing curricula have a Eurocentric bias and were viewed as failing to provide an adequate understanding of the diverse experiences of clients. Similar sentiments were unearthed in Haskins and Singh's (2015) work. This suggests an alarming neglect of non-European cultures, experiences, and perspectives, widening the gap between the training mental health professionals receive and the culturally diverse realities they encounter.

The findings support previous research that advocates for the decolonisation of mental health/illness by questioning the dominant Western models that may not be relevant to other groups (Awad et al., 2016; Charura & Lago, 2021; McKenzie-Mavinga, 2009; McKenzie-Mavinga, 2020). This arguably highlights the importance of adopting education and training with a more inclusive approach to mental health that acknowledges the cultural diversity and unique experiences of different groups. For example, participants suggested it is imperative to develop curricula that reflect an understanding of different racial experiences and provide trainees with the skills to recognise and effectively address racial trauma.

The narratives further revealed that the approach to training in racial trauma must not merely add content, but should encompass re-evaluating pedagogical strategies and changing the approach to mental health education. This reformed pedagogy, as suggested by participants, should be grounded in understanding the multi-layered nature of racial trauma, providing a nuanced understanding of racialised experiences, promoting empathy, including

intersectional perspectives, fostering multicultural competency, and grounding in social justice theories (Helms, 2007).

Christodoulidi (2023) and Gay (2010) champion culturally responsive teaching, while Sue et al. (2007) stress the importance of nuanced, empathetic education. Therefore, incorporating an understanding of societal structures that contribute to racial trauma seems to be key in training mental health professionals to assist in comprehending the lived experiences of individuals impacted. The participants' narratives further highlighted a deficiency in the depth and breadth of coverage of topics related to race and racial trauma, suggesting when these topics are touched upon, they are often inadequately explored. This deficit may impair the comprehension of race and racial trauma, resulting in a shallow understanding that fails to capture the intricacies of these concepts, thereby limiting the practical effectiveness of mental health professionals. Therefore, the coverage of topics related to race and racial trauma should be comprehensive and deep enough to facilitate a profound understanding of the psychological implications, nuances, and complexities of these issues for therapists to cultivate CH.

Participants who exhibited higher levels of CH appeared more likely to establish a strong therapeutic alliance with their clients, in line with Constantine's (2007) work. This is an essential collaborative bond between therapist and client, characterised by mutual trust, respect, and goal alignment. Furthermore, studies show that clients who perceived their therapists as culturally competent reported higher levels of satisfaction with the therapy sessions and the perceived outcomes and overall well-being improvements (Constantine, 2007).

Studies of misdiagnosis also suggest a lack of understanding or bias may stem from a failure to fully grasp the cultural context of the client's experiences (APA, 2003), in turn

indicating a lack of sensitive training in this area. This was echoed in participant narratives, which highlighted that people from minority backgrounds might be misdiagnosed, invalidated, or 'othered' within the mental health services.

The term 'othering' encapsulates instances where individuals from racially marginalised communities are made to feel alienated (Turner, 2021) or distinctly different, potentially leading to a sense of isolation and exacerbating feelings of distress. Some participants reported having negative experiences within the mental health services, and some witnessed family members being treated inappropriately. Therefore, invalidation of one's experiences in mental health may undermine the individual's subjective experiences and intensify trauma. This may happen due to a lack of CH or unconscious biases, and the place intended for healing can become a site of re-traumatisation (Helms et al., 2012).

Therefore, it is arguably imperative to foster a cultural shift within mental health institutions that acknowledges racial trauma, promotes open and empathetic dialogue about race, and implements comprehensive, culturally competent training. Addressing this *'elephant in the room'* both in the classroom and the therapy room might enhance therapy's efficacy for clients experiencing RBTS and contribute to more culturally sensitive, inclusive therapeutic practice. However, this is not just about admitting the existence of racial trauma; it also involves understanding its deep-seated roots and complex manifestations in individuals' mental health (Carter, 2007).

4.3.5 GET 5: Navigating Racial Dynamics in Professional Spaces: The Interplay of Supervision, Self-Care, and Racial Trauma

This overarching theme encapsulated the intertwining of personal and professional racial dynamics, highlighting the role of supervision and self-care strategies in fostering supportive environments and open dialogue about racial trauma. This illuminated how

therapists manage their personal experiences of racial trauma within their professional roles. The participants expressed a yearning for understanding and validation, especially around racial and cultural nuances, that sometimes seemed unfulfilled.

Supervision emerged as a critical element of professional practice, often shaping the effectiveness of the therapeutic or counselling process. This aligns with Bernard and Goodyear (2019) and Rose (2011), who indicate supervision provides a critical support system for therapists to delve into their emotional responses, understand their biases and assumptions, and devise effective coping strategies to handle these reactions.

Ethically speaking, supervisors' responsibilities extend beyond providing guidance on therapeutic techniques; they bear the moral duty to ensure that the care provided under their supervision is ethical, competent, and sensitive to clients' diverse needs (Mackenzie-Mavinga, 2020; Tribe & Morrissey, 2020). A supervisor's lack of CH might inadvertently perpetuate biases, misunderstandings, or even harm (Carter, 2007; Constantine & Sue, 2007). Consequently, this ethical imperative extends to upholding the integrity and trustworthiness of the therapeutic profession (Mackenzie-Mavinga, 2020; Pendry, 2012; Pieterse & Carter, 2010).

As suggested in the narratives, the dynamics of this supervisory relationship significantly impact how racial trauma is approached, understood, and ultimately addressed. For example, the presence or absence of cultural understanding appeared to significantly influence how comfortable the participants felt about discussing race-related issues within supervision, which therefore affected their ability to provide culturally sensitive therapy to their clients, echoing literature from Ababio (2023) and Chang and Berk (2009). This was particularly evident when participants shared their challenges of navigating professional spaces as Black therapists, emphasising the constant balancing act of remaining authentic

while managing potential biases and misunderstandings. This dual consciousness appeared less pronounced in the narratives of White therapists, who did not seem to face the same personal resonance with the issue.

Those participants with supervisors of the same race felt more open and supported discussing race and racial trauma, consistent with Inman's (2006) findings. These experiences demonstrate how shared racial identity could foster a more supportive supervisory relationship, fostering an environment conducive to professional and personal growth.

The complex interplay between professional growth, cultural background, and individual comfort levels in discussing race-related issues, reflects the layered nature of navigating racial dynamics in professional spaces (Ababio, 2023). Similarly, regardless of their race, the supervisors' understanding and openness to discuss racism seemed to influence the participants' experience. Participants who felt supported by culturally competent supervisors narrated a more enriched supervisory experience, as it elevated the supervisor's perceived ability to empathise, validate, and address RBTS. Such supervisors, as described by the participants, were not only aware of the challenges faced by Black clients, but were also equipped to provide guidance, resources, and emotional support to therapists navigating these challenges. This, in turn, enhanced the therapists' ability to form strong therapeutic alliances with their clients, leading to more effective outcomes.

Conversely, while some supervisors were viewed as well-versed in addressing racial biases, the narratives suggest they lacked the necessary understanding of the specific challenges faced by Black individuals, especially in the context of RBTS. This is because RBTS is not just a product of racial discrimination; other intersecting identities and experiences may also influence it (Carter, 2007; Roberson & Carter, 2021). Consequently, an

intersectional approach is required, whereby supervisors are trained to recognise and address the multiple, overlapping challenges their supervisees might face.

Furthermore, some participants observed a level of discomfort and self-censorship around race-based discussions that existed among participants with White or non-Black supervisors, hinting at the depth of racial and cultural barriers in supervision. This disparity is not merely a lack of knowledge or understanding; it is a gap that affects the dynamics of the supervisory relationship. Self-censorship due to discomfort could potentially lead to the need for Black therapists to engage in emotional labour (Ashforth & Humphrey, 1993; Hochschild, 2019). Emotional labour here refers to the effort required to manage and suppress one's emotions to maintain a harmonious professional relationship. The fact that a therapist feels the need to suppress discussions about race, especially in a supervisory setting designed for open dialogue and learning, indicates the systemic issues at play. This suggests the structures and norms within therapeutic professions might be reinforcing racial silences, making it challenging for individuals, especially those from marginalised backgrounds, to speak openly. This may hinder therapists' professional growth and ability to provide culturally competent care.

Therefore, participants' stories highlight the pivotal role of CH in the supervisory relationship. This finding aligns with Ababio's (2023) and Falender and Shafranske's (2017) assertion that supervisors are expected to possess cultural awareness; CH, however, is not only about understanding different cultures on a superficial level but about recognising the unique challenges, biases, and systemic barriers faced by individuals from marginalised backgrounds (Sue & Sue, 2003). It is also about creating a space where these issues can be discussed openly, without fear of judgement or discomfort (Sue & Sue, 2003).

These findings indicate a potential gap in CH in supervisory settings and highlight

the challenges therapists of under-represented ethnic groups mitigate in supervision. This lack of CH in supervisory settings is also highlighted by Gatmon et al. (2001) and Hook et al. (2016), who found most supervisors are ill-equipped and unprepared to navigate and address issues related to racial trauma-induced countertransference. Thus, CH is not just a theoretical concept, but a practical necessity that has profound implications.

All participants emphasised the importance of self-care and the cultivation of adaptive coping strategies to safeguard one's mental and emotional well-being when confronted with demanding subjects, such as racial trauma, irrespective of whether it pertains to themselves or their clients. Carter and Barnett (2014) posited that self-care entails one's ability to cultivate self-awareness and self-regulation as tools to achieve equilibrium between physical, psychological, and spiritual needs. Participants' narratives coincide with the perspectives of McLeod (2014) and Reeves (2018), highlighting the potential for traumatic experiences to arise in the course of therapeutic work, emphasising the critical importance of the need for practitioners prioritising self-care.

The recommendations projected by the participants suggest that self-care, in the context of RBTS, does not entail avoidance of related topics. Rather, it involves utilising self-examination and introspection to effectively manage racial trauma, developing comprehension of one's own racial trauma, cultivating self-awareness, and creating a supportive community that fosters a secure environment to promote the well-being of both therapists and clients. Such strategies were advocated as vital for psychological health and personal resilience and imperative for delivering efficacious therapy (Richard & Shea, 2011; Shapiro et al., 2007; Skovholt et al., 2001).

These coping strategies ranged from structured practices such as personal therapy to more spontaneous activities, including taking breaks between sessions to process experiences,

to somatic interventions, like physical exercise and cultivating a supportive community. Congruent with participants' narratives, Carter and Barnett (2014) and Barnett and Cooper (2009) posited that the practice of self-care encompasses a variety of strategies, including the cultivation of interpersonal boundaries, the taking of periodic breaks, and engaging in enjoyable activities.

Personal therapy was highlighted as an important space for participants to process their racial trauma, acknowledging the relevance of their experiences to their practice, aligning with Cooper (2001) and McLeod's (2013) views on the importance of personal therapy in processing emotions and memories tied to traumatic experiences. Most importantly, narratives suggested these professionals pursue personal growth and development, not just 'coping' with their challenges. They seem aware of personal experiences and biases and understand that they must continually address these to provide effective therapy. This ongoing work of self-awareness and improvement was viewed as vital to their ability to navigate the complexities of their roles within culturally diverse therapeutic contexts.

This attention to self-care and introspection reflects the understanding that personal experiences and traumas can inadvertently shape therapeutic encounters. This indicates reflexivity and self-awareness are critical tools for coping with the challenging situations they face, mitigating potential prejudice, and ultimately contributing to their growth and competence as therapists' (Barnett, 2014; Barnett & Cooper, 2009; Miller et al., 2019).

4.4 Adapting the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS) as a Potential Assessment Tool for Racial Trauma in the UK Context

In exploring the relevance of the UnRESTS within the UK psychological service context, it is important to consider the narratives provided by participants in this study as

indicative of a potentially beneficial tool, albeit with careful consideration for adaptation and application. The prospective benefits of integrating UnRESTS into the UK's therapeutic frameworks might be multifaceted: firstly, UnRESTS could provide a structured framework that might empower therapists to confidently address racial and ethnic stress and trauma with their clients, potentially alleviating some of the discomfort associated with initiating discussions on race. This might lead to a more open therapeutic environment where issues of racial trauma are recognised and validated, aligning with participant reflections on the need for a more explicit focus on racial dynamics within therapy. Moreover, incorporating UnRESTS into therapist training programmes in the UK could potentially address the identified training gap in current curricula, equipping future therapists with the skills to address racial trauma more effectively. Also, adapting and researching the efficacy of UnRESTS within the UK context could contribute to an evidence-based approach to managing racial and ethnic stress and trauma.

However, the direct application of UnRESTS from the US context into the UK may encounter significant challenges. Cultural and societal differences necessitate carefully adapting the tool to ensure it resonates with the UK's unique racial and ethnic dynamics. Additionally, without proper training and understanding, there is a risk that the tool could be misapplied, leading to inappropriate or ineffective use, which could further alienate clients. There is also the risk of overreliance on UnRESTS as a singular solution, which could oversimplify the intricate nature of racial trauma, neglecting other critical therapeutic factors such as personal rapport and therapist empathy.

Participants' narratives arguably reflect a need for systemic and individual competency in assessing and addressing racial trauma within therapeutic spaces. These narratives suggest that a tool like UnRESTS, properly adapted for the UK, could address several identified gaps by providing a structured means to explore and address racial trauma,

thus enhancing therapeutic efficacy.

Therefore, considering UnRESTS within the British context presents an opportunity to enhance the therapeutic approach to racial and ethnic stress and trauma. Nevertheless, its success would rely on careful adaptation to the UK's unique cultural dynamics, comprehensive therapist training, sustained research to ensure its relevance and effectiveness, and the broader systemic shifts required to support its implementation.

4.5 Reflexivity

I considered it significant to insert some entries from my reflexive diary throughout the thesis at points when my process and insights were heightened. Therefore, this section brings forth some 'final' reflections on my journey, highlighting the transformative experiences and pivotal moments that shaped my research trajectory.

IPA stresses the importance of researchers being reflexive and aware of their biases, perceptions and beliefs and how these might influence the interpretative process (Smith & Osborn, 2008). Reflexivity allows the researcher to stand outside the research process and critically reflect through continuous self-awareness (Finlay, 2002; Takeda, 2022). Guided by these authors' works, I was able to step outside the research process and reflect on my emotions and experience and the impact of my positionality on my study.

In my research journey, I faced two significant challenges. The first was managing the unpredictable aspect of encountering upsetting information while maintaining an appropriate distance to maintain a research-oriented rather than a personally-oriented perspective. While there is some discussion in the literature about the possibility of researchers encountering ongoing emotional challenges as they confront issues of social justice, inequality and powerlessness (Fenge et al., 2019; Pio & Singh, 2016), I was unable to find a protocol/supporting information for the unpredictable/unknown upsetting information,

making it difficult to manage or plan for the unknown. This struggle was present during the interviews and persisted into the analysis and discussion phase.

The second challenge I encountered was managing the participants' emotions during the interview process and ensuring their focus remained on the topic. There were moments during the interviews when my responses were more therapeutic rather than gathering information. This was partly to ground participants and validate their experiences whilst gently redirecting the conversation back on track.

Therefore, I experienced various emotions and feelings throughout. I interpreted these feelings as a possible indication of countertransference (Romanyshyn, 2020). Gemignani (2011) underscores the importance of acknowledging and reflecting on countertransference during qualitative interviews, particularly when conducting research that is sensitive or holds personal significance. Romanyshyn (2020) states that transference and countertransference dynamics can also manifest in research, which, if neglected, may negatively impact data quality. Romanyshyn (2020) further contends that researchers are not detached observers; they carry personal wounds that shape their inquiries. This was evident after some interviews when I struggled to detach from my emotions, feeling horrified and angry hearing client experiences; I was taken back to memories of my own experiences. Listening to my research participants felt like I was uncovering fragments of my life from their narratives, giving me a sense of belonging and sadness.

Reflecting on the countertransference during and after interviews proved a valuable analytical resource; I recognised my interconnectedness with participants and how my emotions resonated with them and their struggle to comprehend their clients' experiences. Sharing emotions in supervision was conducive, and my supervisor's advice to read Romanyshyn's (2020) work allowed me to recognise and work with my own wounds,

hopefully leading to more self-reflexive, deeper inquiry, instead of seeing my personal experience as a bias that needs to be eradicated.

Yet I still found it challenging, especially during the analysis process and writing the discussion, to manage the balance between making descriptive and interpretative comments that provided a rich account, while adhering to my participants' experiences. However, I felt my role as a qualified psychotherapist and counselling psychology trainee was helpful; I viewed descriptive comments in IPA as similar to content notes written in therapy and interpretative comments as similar to process notes. For example, descriptive comments in IPA focus on providing a detailed account of the participant's experience in their own words, which is similar to content notes in therapy sessions, where therapists write down key phrases, comments, or a summary of what the client discussed. Alternatively, interpretative comments in IPA focus on engaging in a deeper level of analysis, trying to understand the meaning behind participants' words and how they fit into broader themes or concepts. Process notes might contain a therapist's thoughts about underlying issues, patterns in the client's narrative, or the dynamic between therapist and client. Therefore, while IPA and therapy notes serve different primary functions, they both involve capturing, summarising, and interpreting human experiences. Framing this way enabled me to balance descriptive and interpretative comments during my analysis and discussion. Reflective diary entries acted as an outlet, helping me process my feelings and experiences and distinguishing whether my discussion was led by my emotions or participants' lived experiences.

Overall, the process of conducting this study has proven to be a valuable experience, both on a personal and academic level; I have significantly enhanced my knowledge and research skills.

4.5.1 Quality of Research

As indicated in Chapter Two, the quality and rigour of my research were assessed against the evaluative criteria proposed by Yardley (2008).

Sensitivity to Context: From the onset of my research, it was evident in participants' narratives the trauma experienced by their clients was not only deeply personal, but also intertwined with larger societal narratives**.** Hence, I ensured I incorporated and respected these larger societal contexts, placing them at the forefront of the analysis. This sensitivity was evident in my methodological approach and my chosen interpretative lenses. By adopting a relativist stance and the paradigm of constructivism, I endeavoured to acknowledge and respect the multifaceted nature of lived experiences, recognising an intricate interplay of sociocultural, historical, and personal contexts uniquely shape each therapist's encounter and the experiences of Black clients in the UK.

Commitment and Rigour: I conducted in-depth, semi-structured interviews to fully grasp the complexities of race-based trauma and the challenges faced by therapists, designed to provide rich data and be frequently revised to ensure they remained relevant and probing. Therefore, the iterative data collection and analysis process ensured that participants' experiences were captured and reflected upon. I maintained a reflective journal throughout to continually examine and challenge my assumptions and biases, ensuring the research's integrity.

Transparency and Coherence: I provided a transparent step-by-step breakdown of the research process, allowing for an open examination of my research processes and decisions. The arguments and conclusions were firmly rooted in data, ensuring coherence. Participants' verbatim excerpts were frequently utilised to anchor the interpretations and link the raw data and the conclusions.

Impact and Importance: The overarching ambition of my study was to illuminate an area of counselling that is under-researched and under-discussed. My research highlights the importance of CH in therapy by exploring the complex intersection of race, trauma, and counselling, underscoring the significance and impact of attending to these dynamics in the therapeutic space. In exploring the lived experiences of therapists working with Black clients presenting with RBTS, I aimed to contribute a nuanced understanding that may help influence policy, shape counselling practices, and provide a template for future research.

In conclusion, my research upheld the pillars of quality as delineated by Yardley's evaluative criteria (2008). Embedded in a robust methodological framework and marked by its sensitivity to context, commitment, transparency, and potential impact, I hope that this study will contribute in some way to the academic and psychology field in the UK and internationally.

4.6 Implications and Recommendations

The findings of this thesis provide valuable insights into the experiences of therapists working with Black clients who have experienced RBTS. These insights not only contribute towards deepening our understanding of the complexities involved in navigating racial trauma within therapeutic contexts; they also bring forth significant implications for a wide array of stakeholders, including policymakers, practitioners, educators, and the broader society, each playing a pivotal role in addressing the nuanced challenges of racial trauma within therapeutic contexts. The findings theoretically contribute to the existing literature by pivoting the focus towards the professionals' perspective on racial trauma, contrasting with the prevalent focus on client experiences. This shift unveils the multifaceted challenges that professionals encounter, arguably contributing to improving psychological practices and, by

extension, the mental health outcomes for clients experiencing RBTS. Below, I discuss the study's implications, offering targeted suggestions for stakeholders indicated above.

4.6.1 Implications for Practice and Suggestions for Practitioners

The findings suggest compelling evidence that practitioners need to embrace continuous professional development focused on racial trauma, CH, and the nuances of RBT. Engaging in ongoing self-reflection to identify and mitigate personal biases and ensuring therapy spaces are welcoming and safe for clients of all racial backgrounds could further enrich their therapeutic approach.

Furthermore, findings indicate that practices should strive to foster inclusivity at every level, from the physical environment to the therapeutic modalities employed. There appears to be a need for the thoughtful integration of culturally sensitive therapeutic models and tools into practice. This integration should consider clients' individual and cultural contexts, acknowledging the diversity of racial trauma experiences. This may entail moving beyond Eurocentric perspectives, perhaps incorporating African-centred psychological principles, particularly Ubuntu principles (Ewuoso & Hall, 2019), and engaging in open dialogues that challenge inherent biases, where conversations about racial trauma are encouraged, even in the face of discomfort. Ubuntu is a philosophical concept from Southern Africa that emphasises communal life, reciprocal respect, shared humanity, and interconnectedness, captured in the aphorism 'I am because we are' (Ewuoso & Hall, 2019). Ubuntu embodies the idea that an individual's well-being is intrinsically connected to the well-being of others; it speaks to the fact that our human existence is deeply tied to how we interact with those around us.

Ubuntu's principles advocate for seeing the other person truly, beyond superficial labels, acknowledging their humanity, strengths, and vulnerabilities. This perspective might be invaluable in therapeutic settings, encouraging therapists to engage with clients in a

manner that transcends mere transactional interactions to cultivate deep, empathetic connections. Ubuntu principles appear to prompt therapists to approach racial trauma not just as an individual burden, but as a shared societal ailment that affects the communal fabric, thus broadening the scope of therapeutic interventions to encompass societal healing and empowerment. This effort could be supported by training that equips clinicians with strategies to address their discomfort and uncertainties, thereby enhancing the inclusivity and supportiveness of the therapeutic environment. This might involve regular review and adaptation of practice policies to ensure they align with principles of equity and inclusion.

Furthermore**,** practice guidelines could be developed to encourage therapists to consider clients' racial and ethnic experiences as a standard component of therapeutic work, ensuring a culturally informed approach to therapy. Also, sharing best practices and case studies on successful interventions for RBTS could further enrich the pool of resources available to therapists. Practitioners may need to integrate culturally informed models and tools, such as an adapted version of the UnRESTS, into their practice. This integration should be done with sensitivity to the unique cultural and individual context of each client, recognising the diverse ways in which racial trauma can manifest.

Additionally, an enhanced focus on supervision practices is needed to ensure that therapists receive the support necessary to address racial trauma effectively. This includes ensuring supervisors are adequately equipped to promote self-care and resilience among therapists navigating these complex issues.

4.6.2 Implications for Policy

The inadequacy of systemic responses to racial trauma highlighted in the study, especially within education and mental health services, calls for comprehensive policy reforms. These reforms should aim at embedding an understanding of racial trauma across all

levels of mental health service provision, backed by clear, implementable strategies for addressing racial trauma sensitively and effectively.

Policymakers could work towards establishing mental health policies to advocate for a structured approach to therapist training that includes specific training on racial trauma within the curricula for all mental health professionals. The policies could also include developing standards and clear guidelines to ensure all mental health professionals receive comprehensive mandatory training modules on understanding the impact of racism, RBTS and its manifestations. The training recommendation could cover the theoretical underpinnings of RBTS and practical tools to identify, assess, and address RBTS, perhaps incorporating tools such as UnRESTS when suitably adapted for the UK context. Moreover, policies could mandate ongoing professional development in this area to accommodate evolving understandings of racial trauma.

The participants' narratives also highlight the delicate balance therapists strive to maintain when navigating clients' racial and ethnic experiences. Policies could, therefore, advocate for the adoption of culturally sensitive practice guidelines that respect and validate the individual experiences of racial trauma. Such guidelines could offer frameworks for engaging with clients on matters of race and ethnicity in an empathetic and constructive manner, promoting healing and understanding.

Furthermore, policymakers could consider establishing and allocating funding for research on racial trauma within the UK. Such funding could enable the development of new methodologies for addressing RBTS, the adaptation of new potential assessment tools (like UnRESTS) and the exploration of the efficacy of current therapeutic interventions in treating racial trauma. Encouraging innovation through research grants and partnerships between academic institutions and clinical practices may be more likely to foster the development of new, evidence-based methodologies and tools for addressing RBTS effectively.

4.6.3 Implications for Education, Training and Educators

These research findings serve as a call to action for educators and mental health trainers to prioritise comprehensive training that integrates discussions of race and racism into psychology curricula. The findings from participants highlighted the significant disconnect between the training practitioners receive and the requirement for addressing racial trauma. This discrepancy may exacerbate the problem and contribute to its persistence. The data suggests that education systems must re-evaluate curricula to ensure comprehensive coverage of racial trauma, CH, sensitivity, and related issues. This should ideally involve a shift from an informational perspective to a more interpersonal and embodied approach. Utilising case studies and narratives of lived experiences, alongside evidence-based practices focusing on racial trauma, could significantly augment students' readiness to work with racially diverse populations. Such measures seem imperative to promote more inclusive and equitable academic settings that foster student growth and learning, possibly equipping trainees with tools to navigate racial intersections adeptly. The narratives further highlight the importance of understanding the role of racial intersections within therapeutic contexts. Therefore, educators could emphasise the intersectionality framework, preparing future therapists to navigate the complexities and challenges presented by the intersections of race with other identity aspects. Furthermore, encouraging and facilitating opportunities for students to engage in community-based learning experiences may offer invaluable insights into the real-world implications of racial trauma, thereby enriching their academic and professional journey.

The experiences shared by participants indicate a potential need for revision in supervision models to incorporate considerations of racial trauma more explicitly. Therefore, supervisors should be trained in the nuances of RBTS and ensure they are equipped to support therapists in their work with racially and ethnically diverse clients. This might

involve the integration of CH into supervision standards and practices. The study also calls for further research on other explicit parts of cultural training that are necessary to equip professionals with the tools and understanding to address racial trauma effectively. These findings call for a paradigm shift in professional settings, emphasising the need for proactive strategies, training, and research to address racial trauma effectively.

4.6.4 Broader Social Implications and Recommendations

A potential broader societal implication of this research is the need for increased public awareness and education regarding the impact of racism on mental health. Campaigns and initiatives that highlight the realities of RBTS could contribute towards destigmatising discussions around race and mental health, promoting a more inclusive understanding of mental health challenges. Sustained commitment to long-term efforts to address racial trauma, beyond temporary spikes in attention, like those catalysed by the BLM movement, is crucial. Continuous education, policy changes, and efforts to challenge racial biases and discriminatory practices are arguably essential for societal healing and progress.

The narratives suggest that therapeutic practices could benefit significantly from a more profound engagement directly with the communities (e.g., community leaders for those most affected by RBTS) in the co-production of therapeutic services and interventions with members of racially and ethnically diverse communities. Such collaborative approaches could ensure services are more aligned with the needs and preferences of those they aim to support, potentially making therapeutic interventions more culturally sensitive, relevant, and effective. Advocating for policies that ensure equity in mental health care and address broader determinants of mental health and a transformative shift in how society at large perceives and engages with racial trauma—promoting a more inclusive, compassionate, and interconnected approach to healing—is a collective responsibility of all stakeholders involved.

In essence, the findings from this study call for a collaborative effort from practitioners, policymakers, educators, and wider society to address and mitigate the effects of RBTS. The experiences and challenges highlighted by therapists in this research serve as a catalyst for thoughtful consideration and gradual change in the way racial trauma is approached within the UK's mental health services. The findings suggest it is through collaborative and sustained efforts, underpinned by ongoing research and dialogue, that progress in addressing RBTS in the UK can be achieved, thereby moving towards more equitable and responsive mental health services.

4.7 Limitations

It is well established that no study, regardless of its depth or rigour, is without limitations. When reflecting on the gathered narratives and insights, several potential constraints emerged that may impact the generalisability or interpretative nuances of the findings. Hence, it is important to acknowledge these limitations to ensure a comprehensive understanding of the research and its implications.

4.7.1 Limitations of IPA Methodology and the Current Study

Firstly, the nature of IPA requires a deep exploration of individual experiences, yielding rich, multifaceted accounts. While this depth is valuable, it may limit the broader applicability of these findings to the wider population of therapists. However, the goal of IPA is not broad generalisability but rather a nuanced understanding of particular experiences (Smith et al., 2009).

Additionally, the self-selected nature of participants' involvement may introduce biases. Numerous factors, including personal history, workplace environment, and individual coping mechanisms, among others, could have influenced participants' experiences.

Therefore, while the narratives provide depth, they might not offer the breadth required to understand the experiences of all therapists' working with Black clients enduring RBTS. The exclusive focus on the experiences of therapists could result in an incomplete understanding of the therapeutic process.

Moreover, the IPA methodology used in this study is inherently subjective, influencing the analysis and interpretation of findings. The narratives, which often contain emotion and personal experience, are subject to the researcher's interpretations. Additionally, the over-representation of urban therapists in my sample might not capture the nuanced experiences of those practising in different settings.

The study did not explore the impact of researcher characteristics, such as race, ethnicity, and gender, on the participants' experiences. This omission limits further understanding of how these characteristics influenced the participants' responses. Further exploration of the impact of researcher characteristics could enhance understanding of the dynamics in participant responses.

4.7.2 Future Research

Future research could explore therapists' experiences from diverse racial backgrounds, including clinical psychologists, providing a more comprehensive understanding of the challenges and experiences faced by therapists from different racial and ethnic groups and other mental health professionals. For instance, future research could explore how Asian professionals or clinical psychologists perceive and navigate the dynamics of working with Black clients experiencing RBTS. Such exploration could uncover unique challenges or coping mechanisms that therapists from different racial backgrounds employ.

Additionally, the study could be expanded to include participants from varied professional settings, such as private practices, community health centres, refugee centres or

different institutions, such as the criminal justice system. Different settings might present unique challenges or support structures affecting therapists' experiences. An in-depth exploration into the experiences of therapists with dual-heritage or mixed-race backgrounds could provide valuable insights into their challenges and opportunities. Additionally, comparing the therapist's perspective with that of the clients could offer a holistic view of the therapeutic relationship in the context of racial intersections.

While the importance of cultural humility and broader competence is well-established, it is necessary to understand which training methodologies and programmes are most effective in enhancing supervisors' CH. This could involve evaluating existing training programmes, comparing different training methodologies, or developing and testing new training interventions. Such research may benefit supervisors and have broader implications for the entire therapeutic community, helping to ensure therapists receive the best supervision and support to provide culturally sensitive interventions and explore strategies for therapists to mitigate their fears and uncertainties. Additionally, it might be beneficial to explore the correlation between therapists' CH training and their comfort and efficacy in addressing racial trauma. Such research could shed light on ways of improving therapists' abilities to address and treat clients who have experienced racial trauma. As Sue et al. (1982) proposed, the cultural competence model emphasises the significance of therapists being equipped with knowledge, skills, and attitudes to cater to a culturally diverse clientele effectively. Researching this area could offer actionable insights into enhancing therapist training programmes.

The narratives uncovered revealed significant layers of therapists' experiences and highlighted the complexities and gaps that remain to be explored. For instance, while this research offers profound insights into therapists' encounters with racial trauma, there remains a need to understand how these experiences influence the actual therapeutic outcomes for

clients. Lastly, exploring the role of technology and online spaces, especially in the post-pandemic era, would be useful. How do therapists navigate the realm of racial trauma in virtual therapy sessions? How does the lack of physical presence influence the dynamics of addressing such sensitive topics? These questions merit further investigation in the field of mental health.

Chapter Five: Conclusion

This research offered a multi-layered understanding of racial trauma through the lens of IPA and the researcher's interpretations. The narratives shared by counselling participants provide valuable insight into the challenges they face when addressing RBTS. Based on participants' narratives, clinicians in the field of psychology appear to need to move beyond monolithic views of race and racism and develop a more nuanced understanding of racial intersections.

The findings align with the existing literature, underscoring the systemic nature of racism and the challenges individuals face in seeking validation for their experiences. This study calls for a paradigm shift in professional settings, emphasising the need for proactive strategies, training, and research to address racial trauma effectively. Reflecting society's increasing diversity, it seems essential to create a therapeutic space that resonates with the multi-faceted experiences of individuals. Such an environment may facilitate and foster a sense of belonging and healing within the therapeutic space. This research has laid the groundwork by exposing the complex emotions, challenges, and dilemmas therapists encounter when addressing racial trauma in therapeutic settings. The findings serve as a fundamental stepping stone, urging the research community to probe further, illuminating even more nuanced aspects of this critical therapeutic area. These findings serve as a clarion call for educators and mental health professionals to not only navigate the uncharted waters of racial trauma, but also to chart a course toward understanding, healing, and change.

References

Ababio, B. (Ed.). (2023). *Intercultural Supervision in Therapeutic Practice: Dialogues, Perspectives and Reflections.* Oxon: Routledge.

Abraham, R. (1998). Emotional dissonance in organizations: Antecedents, consequences, and moderators. *Genetic, social, and general psychology monographs,* 124(2), 229-246.

Allen, C. E., & Easley, C. E. (2006). Racial and ethnic minorities. In: Levy, B.S. & Sidel, V.W. (Eds.) *Social injustice and public health* (pp. 42-67). Oxford: Oxford University Press.

Allen, C. (2021). A Hate Crime Crisis? Investigating the function of Brexit, Terrorism, COVID-19 and Black Lives Matter on Levels of Hate Crimes in Today's United Kingdom. *The Police Review*, 2(142), 61-72.

American Medical Association. (2023). American Medical Association. Retrieved September 17, 2023 from https://www.ama-assn.org/

American Psychological Association. (2013*). Publication manual of the American Psychological Association (6th ed.).* American Psychological Association.

Anderson, K. F. (2012). Diagnosing discrimination: Stress from perceived racism and the mental and physical health effects. *Sociological Inquiry*, 83(1), 55–81.

Ashe, S., & Nazroo, J. (2016). Equality, Diversity and Racism in the Workplace: A Qualitative Analysis of the 2015 Race at Work Survey. University of Manchester & Business in The Community.

Ashforth, B. E., & Humphrey, R. H. (1993). Emotional labor in service roles: The influence of identity. *Academy of management review*, *18*(1), 88-115.

Atkinson, D. R., Morten, G., & Sue, D. W. (1979). *Counselling American minorities: A cross-cultural perspective*. Madison, WI, USA: Brown & Benchmark.

Awad, G. H., Patall, E. A., Rackley, K. R., & Reilly, E. D. (2016). Recommendations for

culturally sensitive research methods. *Journal of Educational and Psychological Consultation*, *26*(3), 283-303.

Barnett, J. E. (2014). Renewing one's self-care sensibilities: Distress, burnout, vicarious traumatization, and self-renewal. In: Wicks, R.J. & Maynard, E. (Eds.). Clinician's Guide to Self-Renewal: Essential Advice from the Field (pp. 25-43). New Jersey: John Wiley & Sons.

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice, 16*(1), 16–20.

Baten, R. A., Aslin, R. N., Ghoshal, G., & Hoque, E. (2021). Cues to gender and racial identity reduce creativity in diverse social networks. *Scientific reports*, *11*(1), 10261.

Beck, A. (2019). Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation, and treatment of mental health problems in cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, 12(8), 1-7. https://doi.org/10.1017/s1754470x18000223

Bell, C. (1992). *Ritual theory, ritual practice*. Oxford: Oxford University Press.

Benthall, S., & Haynes, B. D. (2019). *Racial categories in machine learning.* In*: Proceedings of the conference on fairness, accountability, and transparency* (pp. 289-298). FAT 2019, January 29–31, 2019, Atlanta, GA, USA. Retrieved May 4th 2024, from https://arxiv.org/pdf/1811.11668

Bernard, J.M. and Goodyear, R.K. (2009). Fundamentals of Clinical Supervision. 14th Edition. Boston, MA: Pearson.

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. World Psychiatry, 4(1), 18-24.

Bhugra, D., & Gupta, S. (2011). *Migration and mental health*. Cambridge: Cambridge University Press.

Bhugra, D., & Bhui, K. (2001). *Cross-cultural psychiatry*: a practical guide. London: Arnold.

Bhugra, D., & Poole, N. (2011). Culture and mental health. In: *Current themes in psychiatry in theory and practice* (pp. 3-17). London: Palgrave Macmillan UK.

Bhui, K., Halvorsrud, K., & Nazroo, J. (2018). Making a difference: Ethnic inequality and severe mental illness. *The British Journal of Psychiatry*, 213(4), 574–578.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology,* 3(2), 77-101.

British Psychological Society. Bps.org.uk. (2021). Retrieved 28 March 2023, from https://www.bps.org.uk/guideline/bps-code-human-research-ethics

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and health,* 21(1), 87-108.

Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic stress. *The Counseling Psychologist*, 35(1), 135-143.

Bryant-Davis, T., & Ocampo, C. (2005). Racist Incident–Based trauma. *The Counseling Psychologist*, 33(4), 479–500.

Burnett, J. (2017). Racial violence and the Brexit state. *Race & class*, 58(4), 85-97.

Caballero, C., Edwards, R., Goodyer, A., & Okitikpi, T. (2012). The diversity and complexity of the everyday lives of mixed racial and ethnic families: Implications for adoption and fostering practice and policy. *Adoption & Fostering*, 36(3-4), 9-24.

Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: enabling allies in anti-racism praxis. *Social Science & Medicine*, 199, 181-188.

Carlson, M., Endlsey, M., Motley, D., Shawahin, L. N., & Williams, M. T. (2018). Addressing the impact of racism on veterans of colour: A race-based stress and trauma intervention. *Psychology of violence*, 8(6), 748.

Carter, L. A., & Barnett, J. E. (2014). *Self-care for clinicians in training: A guide to psychological wellness for graduate students in psychology*. Oxford: Oxford University Press.

Carter, R. T. (2007). Racism and psychological and emotional injury. *The Counseling Psychologist*, 35(1), 13–105.

Carter, R. T., & Forsyth, J. (2010). Reactions to racial discrimination: Emotional stress and help-seeking behaviours. *Psychological Trauma: Theory, Research, Practice, and Policy*, 2(3), 183-191.

Carter, R. T., & Pieterse, A. L. (2020). *Measuring the effects of racism: Guidelines for the assessment and treatment of race-based traumatic stress injury*. Columbia: Columbia University Press.

Carter, R. T., & Reynolds, A. L. (2021). Race-related stress, racial identity status attitudes, and emotional reactions of Black Americans. *Cultural Diversity and Ethnic Minority Psychology,* 17(2), 156-162.

Carter, R. T., & Scheuermann, T. D. (2019). *Confronting racism: Integrating mental health research into legal strategies and reforms*. New York: Routledge.

Carter, R. T., Kirkinis, K., & Johnson, V. E. (2020). Relationships between trauma symptoms and race-based traumatic stress. *Traumatology*, 26(1), 11-18.

Carter, R. T., Lau, M. Y., Johnson, V., & Kirkinis, K. (2017). Racial discrimination and health outcomes among Racial/Ethnic minorities: A Meta-Analytic review. *Journal of Multicultural Counselling and Development*, 45(4), 232–259.

Carter, R. T., Mazzula, S., Victoria, R., Vazquez, R., Hall, S., Smith, S., & Williams, B. (2013). Initial development of the Race-Based Traumatic Stress Symptom Scale: Assessing the emotional impact of racism. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(1), 1-9.

Chae, D. H., Clouston, S., Hatzenbuehler, M. L., Kramer, M. R., Cooper, H. L. F., Wilson, S. M., Stephens-Davidowitz, S. I., Gold, R. S., & Link, B. G. (2015). Association between an Internet-Based Measure of Area Racism and Black Mortality. *PLOS ONE*, 10(4), e0122963.

Chae, D. H., Lincoln, K. D., & Jackson, J. S. (2011). Discrimination, attribution, and racial group identification: Implications for psychological distress among Black Americans in the National Survey of American Life (2001–2003). *American Journal of Orthopsychiatry*, 81(4), 498–506.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, 56(4), 521-536.

Charura, D., & Lago, C. (2021). *Black identities white therapies: Race, respect, diversity.* York St. John, UK: PCCS Books.

Cheryan, S., & Tsai, J. L. (2007). Ethnic identity. In: Chang, E.C. & Downey, C.A. (Eds.) *Handbook of Asian American psychology* (pp. 125-139). New York: Springer.

Chin, D., Smith-Clapham, A. M., & Wyatt, G. E. (2023). Race-based trauma and post-traumatic growth through identity transformation. *Frontiers in Psychology*, *14*, 1031602.

Christodoulidi, F. (2023). A pedagogy of vulnerability: Its relevance to diversity teaching and 'humanising' higher education. *Equity in Education & Society,* 27526461231185834.

Christopher, A. J. (1994). *The atlas of apartheid*. New York: Routledge.

Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In: Alvarez, A. N., Liang, C. T. H. & Neville, H. A. (Eds.), The Cost of Racism for People of Colour: Contextualizing Experiences of Discrimination. (pp.

249–272). New York: APA. https://doi.org/10.1037/14852-012

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, 74(1), 1-5.

Commission on Race and Ethnic Disparities. The report. Mar 2021. Retrieved 4th March from:https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology,* 54(1), 1-16.

Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among black supervisees in cross-racial dyads. *Journal of Counseling Psychology,* 54(2), 142-153.

Cooper, M. (2001). *Embodied empathy.* In: S. Haugh & T. Merry (Eds.), *Empathy* (pp. 218-229). Ross-on-Wye: PCCS Books.

Coyle, A. (2007) Discourse analysis. In: Lyons, E. & Coyle, B. (Eds.) *Analysing qualitative data in psychology.* London: Sage Publications Ltd.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum,* 1989(1), 139-167.

Crenshaw, K. (2013). *Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics.* In *Feminist legal theories* (pp. 23-51). New York: Routledge.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications.

Crosby, S. D., Kniffley, S. D., Jr., Mitchell, B., Jones, K. V., Middleton, J., Caine, A., &

Vides, B. (2022). “Decolonizing mental health”: Exploring insights from clinicians trained in Kniffley Racial Trauma Therapy. *Practice Innovations, 7*(3), 280–29.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs M.R. (1989). Towards a culturally competent system of care a Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. *CASSP*. Retrieved 4th May from https://spu.edu/-/media/academics/school-of-education/Cultural-Diversity/Towards-a-Culturally-Competent-System-of-Care-Abridged.ashx

Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*, 18(4), 410-430.

Degruy-Leary, J. (2017). *Post-traumatic slave syndrome: America’s legacy of enduring injury.* Portland, OR: Joy DeGruy Publications Inc.

DeGruy, J. (2005). *Post traumatic slave syndrome. America’s legacy of enduring injury and healing.* Portland, OR: Joy DeGruy Publications Inc.

Delgado, R., & Stefancic, J. (2001). *An introduction to critical race theory*. New York: NYU Press.

Delgado, R., & Stefancic, J. (2017). *Chapter I. Introduction.* In: Delgado, R., & Stefancic, J. *Critical Race Theory* (Eds.) (pp. 1-18). New York: NYU Press.

Denzin, N. K. (2000). Aesthetics and the practices of qualitative inquiry. *Qualitative inquiry,* 6(2), 256-265.

Department for Education. (2021). Ethnicity facts and figures: Students getting 3 A grades or better at A level. Retrieved 5th January, 2024 from https://www.ethnicity-facts-figures.service.gov.uk/education-skillsand-training/a-levels-apprenticeships-further-education/students-aged-16-to-18-achieving-3-a-grades-or-better-at-a-level/latest#by-ethnicity

Department of Health and Social Care. (2023). Retrieved 28 August 2023, from

https://www.gov.uk/government/organisations/department-of-health-and-social-care

Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (5th edition). (2014). *Reference Reviews*, *28*(3), 36–37.

DiAngelo, R. (2018). *White fragility: Why it's so hard for white people to talk about racism*. Boston: Beacon Press.

Dottolo, A. L., & Kaschak, E. (Eds.). (2018). *Whiteness and White privilege in psychotherapy*. New York: Routledge.

Eatough, V., Smith, J. A., & Shaw, R. (2008). Women, anger, and aggression: An interpretative phenomenological analysis. *Journal of interpersonal violence,* 23(12), 1767-1799.

Eddo-Lodge, R. (2017). *Why I'm no longer talking to white people about race.* London, UK: Bloomsbury Publishing.

English, D., Lambert, S. F., Tynes, B. M., Bowleg, L., Zea, M. C., & Howard, L. C. (2020). Daily multidimensional racial discrimination among Black US American adolescents. *Journal of Applied Developmental Psychology,* 66, 101068.

Evans, A. M., Hemmings, C., Burkhalter, C., & Lacy, V. (2016). Responding to race related trauma: Counselling and research recommendations to promote post-traumatic growth when counselling African American males. *The Journal of Counsellor Preparation and Supervision*, 8(1), 1-26.

Ewuoso, C., & Hall, S. (2019). Core aspects of ubuntu: A systematic review. *South African Journal of Bioethics and Law,* 12(2), 93-103.

Falender, C. A., & Shafranske, E. P. (2017). *Supervision essentials for culturally responsive supervision*. American Psychological Association. Retrieved 4th May from: https://psycnet.apa.org/fulltext/2016-21196-000-BKM.pdf

Fast, E., & Collin-Vézina, D. (2020). Historical trauma, race-based trauma and resilience of

indigenous peoples: A literature review. *First Peoples Child & Family Review*, 5(1), 126-136.

Fenge, L. A., Oakley, L., Taylor, B., & Beer, S. (2019). The impact of sensitive research on the researcher: Preparedness and positionality. *International Journal of Qualitative Methods*, 18(8), 1-8.

Fernando, S. (2010). Mental health, race and culture. London, UK: Bloomsbury Publishing.

Fernando, S. (2012). Internal racism: A psychoanalytic approach to race and difference. *British Journal of Psychiatry*, 200(5), 436-437.

Festinger, L. (1957). 17. *A theory of cognitive dissonance*. Stanford: Stanford University Press.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative health research*, *12*(4), 531-545.

Fuertes, J. N., & Nutt Williams, E. (2017). Client-focused psychotherapy research. *Journal of Counseling Psychology*, 64(4), 369-375.

Galán, C. A., Auguste, E. E., Smith, N. A., & Meza, J. I. (2022). An intersectional-contextual approach to racial trauma exposure risk and coping among black youth. *Journal of Research on Adolescence*, 32(2), 583-595.

Garcia, G. A., & Johnston-Guerrero, M. P. (2015). Challenging the utility of a racial microaggressions framework through a systematic review of racially biased incidents on campus. *Journal of Critical Scholarship on Higher Education and Student Affairs,* 2(1), 48–66.

Gatmon, D., Jackson, D., Koshkarian, L., Martos-Perry, N., Molina, A., Patel, N., & Rodolfa, E. (2001). Exploring ethnic, gender, and sexual orientation variables in supervision: Do they really matter? *Journal of Multicultural Counseling and Development,* 29(2), 102-113.

Gawronski, B., & Brannon, S. M. (2019). *What is cognitive consistency, and why does it matter?*. In: E. Harmon-Jones (Ed.), *Cognitive dissonance: Reexamining a pivotal theory in psychology* (2nd ed., pp. 91–116). American Psychological Association. https://doi.org/10.1037/0000135-005

Gay, G. (2018). Culturally responsive teaching: Theory, research, and practice. New York: *Teachers College Press.*

Gemignani, M. (2011). Between researcher and researched: An introduction to countertransference in qualitative inquiry. *Qualitative Inquiry,* 17(8), 701-708.

Ghavami, N., Fingerhut, A., Peplau, L. A., Grant, S. K., & Wittig, M. A. (2011). Testing a model of minority identity achievement, identity affirmation, and psychological well-being among ethnic minority and sexual minority individuals. *Cultural Diversity and Ethnic Minority Psychology,* 17(1), 79-88.

Gillborn, D. (2008). *Racism and education: Coincidence or conspiracy?* London: Routledge

Gilroy, P. (1993). The black Atlantic: Modernity and double consciousness. Harvard: Harvard University Press.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. *Journal of Counseling Psychology,* 30(4), 467-482.

Goldsmith, A. H., Hamilton, D., & Darity Jr, W. (2006). Shades of discrimination: Skin tone and wages. *American Economic Review,* 96(2), 242-245.

Goldstein, A. P., & Michaels, G. Y. (1985). *Empathy: Development, training, and consequences.* New York: Routledge.

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The counseling psychologist*, 32(6), 793-836.

Green, M. S., & Dekkers, T. D. (2010). Attending to power and diversity in supervision: An

exploration of supervisee learning outcomes and satisfaction with supervision. *Journal of Feminist Family Therapy*, 22(4), 293-312.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: *Theory, research, practice, training*, 43(4), 531-548.

Hackett, R. A., Ronaldson, A., Bhui, K., Steptoe, A., & Jackson, S. E. (2020). Racial discrimination and health: A prospective study of ethnic minorities in the United Kingdom. *BMC Public Health*, 20(1), 1658.

Hall, R. E. (2008). *Racism in the 21st Century: An Introduction*. New York: Springer.

Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E., & Bhui, K. (2019). Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Social psychiatry and psychiatric epidemiology*, 54, 1311-1323.

Harrison, G., & Turner, R. (2010). Being a 'culturally competent'social worker: Making sense of a murky concept in practice. *The British Journal of Social Work*, 41(2), 333-350.

Hartmann, W. E., Wendt, D. C., Burrage, R. L., Pomerville, A., & Gone, J. P. (2019). American Indian historical trauma: Anticolonial prescriptions for healing, resilience, and survivance. *American Psychologist,* 74(1), 6-19.

Hartshorne, K. (1992). Crisis and challenge: Black education 1910-1990. Cape Town: Oxford University Press.

Haskins, N. H., & Singh, A. (2015). Critical race theory and counsellor education pedagogy: Creating equitable training. *Counsellor Education and Supervision,* 54(4), 288-301.

Health and Care Professionals Council. (2015). Practitioner psychologists. HCPC. Retrieved 6 September 2023, from https://www.hcpc-uk.org/standards/standards-of-

proficiency/practitioner-psychologists/

Heidegger, M. (1962). *Being and time.* New York: Harper & Row.

Helms, J. E. (1995). *An update of Helm's White and people of colour racial identity models. In Versions were presented at the Psychology and Societal Transformation Conference*, U Western Cape, South Africa, Jan 1994, and at a workshop entitled "*Helm's Racial Identity Theory*," Annual Multicultural Winter Roundtable, Teachers Coll–Columbia U, New York, Feb 1994. Thousand Oaks, CA: Sage Publications, Inc.

Helms, J. E., Nicolas, G., & Green, C. E. (2012). Racism and ethnoviolence as trauma: Enhancing professional and research training. *Traumatology*, 18(1), 65-74.

Hemmings, C., & Evans, A. M. (2018). Identifying and treating race-based trauma in counselling. *Journal of Multicultural Counselling and Development,* 46(1), 20-39.

Heuven, E., & Bakker, A. (2003). Emotional dissonance and burnout among cabin attendants. *European Journal of Work and Organizational Psychology,* 12(1), 81-100.

Hirsch, S. (2018). Brit(ish): On Race, Identity and Belonging. *Immigrants & Minorities*, 36(3), 293-295.

Hochschild, A. R. (2019). *The managed heart: Commercialization of human feeling*. California: University of California Press.

Hoffman, M. L. (1977). *Empathy, its development and prosocial implications. In Nebraska symposium on motivation.* Nebraska: University of Nebraska Press.

Home Office. (2023). Retrieved 28 August 2023, from https://www.gov.uk/government/organisations/home-office

Hook, D. (2005). The racial stereotype, colonial discourse, fetishism, and racism. *The Psychoanalytic Review*, 92(5), 701-734.

Hook, J. N., & Watkins Jr, C. E. (2015). Cultural humility: The cornerstone of positive contact with culturally different individuals and groups?. *American Psychologist,* 70(7), 661–662.

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology,* 63(3), 269-277.

Horton, H. D., & Sykes, L. L. (2001). Reconsidering wealth, status, and power: Critical Demography and the measurement of racism. *Race and Society*, 4(2), 207–217.

Hulteen, B., & Wallis, J. (1992). America's original sin: A study guide on white racism. Washington: *Sojourners Resource Centre*.

Iacobucci, G. (2021). Healthcare leaders reject "damaging" denial that institutional racism exists. *British Medical Journal*, 373, n911.

Ikuenobe, P. (2013). Conceptualizing and Theorizing About the Idea of a "Post-Racial" Era. *Journal for the Theory of Social Behaviour,* 43(4), 446-468.

Inman, A. G. (2006). Supervisor multicultural competence and its relation to supervisory process and outcome. *Journal of Marital and Family Therapy,* 32(1), 73–85.

Inman, A. G., & DeBoer Kreider, E. (2013). Multicultural competence: Psychotherapy practice and supervision. *Psychotherapy,* 50(3), 346-350.

Isaacs, M. R., & Benjamin, M. P. (1991). *Towards a Culturally Competent System of Care. Volume II: Programs Which Utilize Culturally Competent Principles*. Washington: CASSP.

Jones, T., & Norwood, K. J. (2016). Aggressive encounters & white fragility: Deconstructing the trope of the angry black woman. *Iowa Law Review*, 102, 2017-2069.

Jorgensen, M. W., & Phillips, L. J. (2002). *Discourse analysis as theory and method*. Thousand Oaks, CA: Sage.

Joseph-Salisbury, R. (2020). Race and racism in English secondary schools. *Runnymede Perspectives.* Retrieved May 4th 2024 from https://www.runnymedetrust.org/publications/race-and-racism-in-secondary-schools

Karlsen, S., & Nazroo, J. Y. (2014). *Ethnic and religious variations in the reporting of racist victimization in Britain: 2000 and 2008/2009. Patterns of Prejudice,* 48(4), 370-397. https://doi.org/10.1080/0031322X.2014.951160

Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K., & Weich, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological medicine*, 35(12), 1795-1803.

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural psychiatry*, 49(2), 149-164.

Khan, K. S., Kunz, R., Kleijnen, J., & Antes, G. (2003). Five steps to conducting a systematic review. *Journal of the Royal Society of Medicine*, 96(3), 118–121.

Khan, M. (2023). *Working Within Diversity: A Reflective Guide to Anti-oppressive Practice in Counselling and Therapy.* New York: Jessica Kingsley Publishers.

King, S. O. (2021). Experiences of NHS Psychologists exploring racial trauma with service users from Black and Asian racialised communities (Doctoral dissertation, University of Essex).

Kinouani, G. (2020). Silencing, power, and racial trauma in groups. *Group Analysis,* 53(2), 145–161.

Kirkinis, K., Pieterse, A. L., Martin, C., Agiliga, A., & Brownell, A. (2018). Racism, racial discrimination, and trauma: *A systematic review of the social science literature*, 26 (3), 392–412.

Kite, M. E., Whitley Jr, B. E., & Wagner, L. S. (2022). Psychology of prejudice and discrimination. New York: Taylor & Francis.

Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, 59(5), 529-539.

Ladany, N., Mori, Y., & Mehr, K. E. (2013). Effective and ineffective supervision. *The Counseling Psychologist,* 41(1), 28-47.

Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education?. *International journal of qualitative studies in education*, 11(1), 7-24.

Langdridge, D., & Hagger-Johnson, G. (2013). Phenomenological research methods. Introduction to Research Methods and Data Analysis in Psychology. Harlow: Pearson Education Ltd.

Larkin, M., Flowers, P., & Smith, J. A. (2021). Interpretative phenomenological analysis: Theory, method and research. Thousand Oaks, CA: Sage Publications.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology,* 3(2), 102-120.

Levin, A. P., Kleinman, S. B., & Adler, J. S. (2014). DSM-5 and posttraumatic stress disorder. *Journal of the American Academy of Psychiatry and the Law Online,* 42(2), 146-158.

Malott, K. M., & Schaefle, S. (2015). Addressing clients' experiences of racism: A model for clinical practice. *Journal of Counseling & Development,* 93(3), 361-369.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry,* 15(2), 103-111.

McAdoo, G., Williams, K., & Howard, T. C. (2023). Racially Just, Trauma-Informed Care for Black Students. *Urban Education*, 00420859231175668.

McGregor-Smith, R. (2017). Race in the workplace: the McGregor-Smith review. London: Department for Business. Energy and Industrial Strategy.

McKenzie-Mavinga, I. (2009). *Black issues in the therapeutic process*. London: Bloomsbury Publishing.

McKenzie-Mavinga, I. (2020). The challenge of racism in therapeutic practice: Engaging with oppression in practice and supervision. London: Bloomsbury Publishing.

McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health care. *British Medical Journal,* 334(7595), 649-650.

McLeod, J. (2013). *An introduction to counselling*. London: McGraw-hill Education.

Meer, N., & Modood, T. (2012). How does interculturalism contrast with multiculturalism?. *Journal of intercultural studies*, 33(2), 175-196.

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open,* 6(11), e012337.

Menakem, R. (2021). *My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies*. London: Penguin UK.

Miller, J., Lee, J., Niu, C., Grise-Owens, E., & Bode, M. (2019). Self-compassion as a predictor of self-care: A study of social work clinicians. *Clinical Social Work Journal*, 47, 321-331.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social science & medicine*, 106, 128-136.

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The counseling psychologist,* 35(2), 209-235.

Myers, M. W., & Hodges, S. D. (2013). Empathy: Perspective taking and prosocial behavior: Caring for others like we care for the self. In: J. J. Froh & A. C. Parks

(Eds.), *Activities for teaching positive psychology: A guide for instructors* (pp. 77–83). American Psychological Association. https://doi.org/10.1037/14042-013

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The Impact of Racial Microaggressions on Mental Health: Counseling implications for clients of color. *Journal of Counseling & Development,* 92(1), 57–66.

Neblett Jr, E. W., White, R. L., Ford, K. R., Philip, C. L., Nguyen, H. X., & Sellers, R. M. (2008). Patterns of racial socialization and psychological adjustment: Can parental communications about race reduce the impact of racial discrimination?. *Journal of Research on Adolescence*, 18(3), 477-515.

Neville, H. A., Awad, G. H., Brooks, J. E., Flores, M. P., & Bluemel, J. (2013). Color-blind racial ideology: Theory, training, and measurement implications in psychology. *American Psychologist*, 68(6), 455.

Neville, H. A., Tynes, B. M., & Utsey, S. O. (Eds.). (2008). *Handbook of African American psychology*. Thousand Oaks, CA: Sage Publications.

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology,* 18(3), 369-386.

Noon, M. (2018). Pointless diversity training: Unconscious bias, new racism and agency. *Work, employment and society*, 32(1), 198-209.

Oliveira, J. T. (2022). *Cultural reflexivity in counselor professional identity development of international doctoral students* (Doctoral dissertation, Texas A&M University-Commerce).

Omi, M., & Winant, H. (2014). *Racial formation in the United States*. New York: Routledge.

Ortiz, L., Jani, J., (2010). Critical race theory: a transformational model for teaching diversity. *Journal of Social Work Education*, 46(2), 175–93.

Otu, A., Ahinkorah, B. O., Ameyaw, E. K., Seidu, A. A., & Yaya, S. (2020). One country, two crises: what Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?. *International Journal for Equity in Health*, 19, 1-6.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., & Gee, G. (2015). Racism as a determinant of health: a systematic review and meta-analysis. *PloS one,* 10(9), e0138511.

Pendry, N. (2012). Race, racism and systemic supervision. *Journal of Family Therapy,* 34(4), 403-418.

Pieterse, A. L., & Carter, R. T. (2007). An examination of the relationship between general life stress, racism-related stress, and psychological health among black men. *Journal of Counseling Psychology,* 54(1), 101-109.

Pieterse, A. L., & Carter, R. T. (2010). The role of racial identity in perceived racism and psychological stress among Black American adults: Exploring traditional and alternative approaches. *Journal of Applied Social Psychology,* 40(5), 1028-1053.

Pieterse, A. L., Carter, R. T., Evans, S. A., & Walter, R. A. (2010). An exploratory examination of the associations among racial and ethnic discrimination, racial climate, and trauma-related symptoms in a college student population. *Journal of Counseling Psychology,* 57(3), 255-263.

Pieterse, A. L., Roberson, K. L., Garcia, R., & Carter, R. T. (2023). Racial discrimination and trauma symptoms: Further support for the Race-Based Traumatic Stress Symptom Scale. *Cultural diversity and ethnic minority psychology*, 29(3), 332-388.

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: a meta-analytic review. *Journal of counseling psychology,* 59(1), 1-9.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal,* 20(1), 7-14.

Pio, E., & Singh, S. (2016). Vulnerability and resilience: critical reflexivity in gendered violence research. *Third World Quarterly*, 37(2), 227-244.

Pollock, A. (2021). *Sickening: Anti-Black racism and health disparities in the United States*. Minnesota: University of Minnesota Press.

Polanco-Roman, L., Anglin, D. M., Miranda, R., & Jeglic, E. L. (2019). Racial/ethnic discrimination and suicidal ideation in emerging adults: The role of traumatic stress and depressive symptoms varies by gender not race/ethnicity. *Journal of Youth and Adolescence,* 48, 2023-2037.

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology,* 52(2), 126-136.

Priest, N., Paradies, Y., Trenerry, B., Truong, M., Karlsen, S., & Kelly, Y. (2013). A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social science & medicine*, *95*, 115–127.

Race Disparity Unit. (2023). Retrieved 28 August 2023, from https://www.gov.uk/government/organisations/race-disparity-unit

RCPsych response to the report of the Commission on Race and Ethnic Disparities. (2021). *Www.rcpsych.ac.uk.* https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/04/01/rcpsych-response-to-the-report-of-the-commission-on-race-and-ethnic-disparities

Reece, R. L. (2018). Genesis of US colourism and skin tone stratification: Slavery, freedom,

and mulatto-Black occupational inequality in the late 19th century. *The Review of Black Political Economy,* 45(1), 3-21.

Reeves, A. (2018). An introduction to counselling and psychotherapy: From theory to practice. *An Introduction to Counselling and Psychotherapy*. Thousand Oaks, CA: Sage Publications.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist,* 18(1), 20-23.

Richard, A. A., & Shea, K. (2011). Delineation of self-care and associated concepts. *Journal of nursing scholarship*, *43*(3), 255-264.

Ricoeur, P. (1986). Life: A story in search of a narrator. In Doeser, M.C. & Kraay, J.N. (Eds.) *Facts and values: Philosophical reflections from western and non-western perspectives* (pp. 121-132). Dordrecht: Springer Netherlands.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications.

Roberson, K., & Carter, R. T. (2021). The relationship between race-based traumatic stress and the trauma symptom checklist: Does racial trauma differ in symptom presentation? *Traumatology*, 28(1), 120-128. https://doi.org/10.1037/trm0000306

Roberts, N., & Bolton, P. (2020). Educational outcomes of Black pupils and students. House of Commons Library: Briefing Paper Number, 9023.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology,* 21(2), 95-103.

Rogers, C. R. (1961). The process equation of psychotherapy. *American Journal of Psychotherapy,* 15(1), 27-45.

Romanyshyn, R. D. (2020). *The wounded researcher: Research with soul in mind*. New York: Routledge.

Rose, C. (2011). *Self-awareness and personal development: Resources for psychotherapists and counsellors.* London: Bloomsbury Publishing.

Russell, K., Wilson, M., & Hall, R. (2013). *The colour complex (revised): The politics of skin colour in a new millennium*. New York: Anchor.

Runnymede (2020). State of the Nation: Race and Racism in England, Scotland, Wales and Northern Ireland. *Runnymede Trust.* Retrieved May 4th 2024 from https://www.runnymedetrust.org/publications/race-and-racism-in-secondary-schools

Saleem, F. T., Howard, T. C., & Langley, A. K. (2022). Understanding and addressing racial stress and trauma in schools: A pathway toward resistance and healing. *Psychology in the Schools*, 59(12), 2506-2521.

Sekaran, U., & Bougie, R. (2016). *Research methods for business: A skill building approach*. West Sussex: John Wiley & Sons.

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and education in professional psychology,* 1(2), 105-115.

Sibrava, N. J., Bjornsson, A. S., Pérez Benítez, A. C. I., Moitra, E., Weisberg, R. B., & Keller, M. B. (2019). Posttraumatic stress disorder in African American and Latinx adults: Clinical course and the role of racial and ethnic discrimination. *American Psychologist,* 74(1), 101-116.

Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counseling for longevity: Self-care and burnout prevention strategies for counselor resilience. *Journal of Career Development*, 27, 167-176.

Slaughter-Acey, J. C., Sealy-Jefferson, S., Helmkamp, L., Caldwell, C. H., Osypuk, T. L., Platt, R. W., & Misra, D. P. (2016). Racism in the form of micro aggressions and the risk of preterm birth among black women. *Annals of epidemiology*, 26(1), 7-13.

Smith, J. A. (1995). Semi structured interviewing and qualitative analysis. In: Smith, J.A., Harre, R. & Van Langenhove, L. (eds.) *Rethinking Methods in Psychology* (pp. 9-26). Thousand Oaks, CA*:* Sage Publications.

Smith, J. A. (2016). *Interpretative phenomenological analysis in sport and exercise: Getting at experience*. In: Smith, B. & Sparkes, A.C. (Eds.) *Routledge handbook of qualitative research in sport and exercise* (pp. 241-251). London: Routledge.

Smith, J. A. & Osborn, M, (2008). The fearfulness of chronic pain and the centrality of the therapeutic relationship in containing it: An interpretative phenomenological analysis. *Qualitative Research in Psychology,* 5(4), 276-288.

Smith, J. A., & Fieldsend, M. (2021). Interpretative phenomenological analysis. In: Camic, P.M. (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (2nd ed., pp. 147–166). American Psychological Association. https://doi.org/10.1037/0000252-008

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications.

Smith, J. A., Harré, R., & Van Langenhove, L. (Eds.). (1995). *Rethinking psychology* (Vol. 3). Thousand Oaks, CA: Sage.

Smith, K., Bhui, K., & Cipriani, A. (2020). COVID-19, mental health and ethnic minorities. *BMJ Ment Health*, 23(3), 89-90.

Smith, W. A., Allen, W. R., & Danley, L. L. (2007). "Assume the position... you fit the description" psychosocial experiences and racial battle fatigue among African American male college students. *American Behavioral Scientist,* 51(4), 551-578.

Sobande, F. (2021). Spectacularized and branded digital (re) presentations of black people and blackness. *Television & New Media*, 22(2), 131-146.

Solomos, J. (2022). *Race and racism in Britain*. Switzerland AG: Springer Nature.

Solórzano, D. G., & Yosso, T. J. (2002). Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qualitative inquiry*, 8(1), 23-44.

Soto, J. A., Dawson-Andoh, N. A., & BeLue, R. (2011). The relationship between perceived discrimination and generalized anxiety disorder among African Americans, Afro Caribbeans, and non-Hispanic Whites. *Journal of anxiety disorders*, 25(2), 258-265.

Strayer, J. (1987). *Affective and cognitive perspectives on empathy*. In: N. Eisenberg & J. Strayer (Eds.), *Empathy and its development* (pp. 218–244). Cambridge: Cambridge University Press.

Sue, D. W., & Sue, D. (2012). *Counselling the Culturally Diverse: Theory and Practice (6th ed.)*. New York: John Wiley & Sons.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. The Counseling Psychologist, 10(2), 45-52.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*, 62(4), 271.

Sue, D. W., Nadal, K. L., Capodilupo, C. M., Lin, A. I., Torino, G. C., & Rivera, D. P. (2008). Racial microaggressions against Black Americans: Implications for counseling. *Journal of Counseling & Development*, 86(3), 330-338.

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2022). *Counseling the culturally diverse: Theory and practice.* New York: John Wiley & Sons.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist,* 42(1), 37-45.

Takeda, A. (2022). Uncovering ethical concerns through reflexivity—ethics in practice in fieldwork. *International Journal of Social Research Methodology*, 25(3), 419-424.

Tashakkori, A., & Teddlie, C. (2003). Issues and dilemmas in teaching research methods courses in social and behavioural sciences: *US perspective. International journal of social research methodology*, 6(1), 61-77.

Tatum, B. D. (1997). *Why are all the black kids sitting together in the cafeteria?* New York: Basic Books/Hachette Book Group.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, 9(2), 117-125.

Tribe, R., & Morrissey, J. (Eds.). (2020). *The handbook of professional ethical and research practice for psychologists, counsellors, psychotherapists and psychiatrists.* London: Routledge.

Trovão, S. (2012). Comparing postcolonial identity formations: Legacies of Portuguese and British colonialisms in East Africa. *Social Identities*, 18(3), 261-280.

Tufford, L., & Newman, P. (2010). Bracketing in qualitative social work. *Qualitative Social Work,* 11(1), 80-96.

Turner, D. (2021). *Intersections of privilege and otherness in counselling and psychotherapy*: Mockingbird. London: Routledge.

University of East London. (2013). Code of Practice for Postgraduate Research Degrees. Www.Uel.Ac.Uk. Retrieved 6 September 2023, from https://www.uel.ac.uk/sites/default/files/5751.pdf

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma.* London: Penguin UK.

Wadsworth, A. (2020). *How the United States' Black Lives Matter movement became transatlantic*. The Dahrendorf Forum. Retrieved 4th May 2024 from: https://www.dahrendorf-forum.eu/how-the-united-states-black-lives-matter-

movement-became-transatlantic/

Wallace, S., Nazroo, J., & Becares, L. (2016). Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom. *American Journal of Public Health*, 106(7), 1294-1300.

Wamser-Nanney, R., Howell, K. H., Schwartz, L. E., & Hasselle, A. J. (2018). The moderating role of trauma type on the relationship between event centrality of the traumatic experience and mental health outcomes. *Psychological trauma: theory, research, practice, and policy,* 10(5), 499-507.

Wheaton, F. V., Thomas, C. S., Roman, C., & Abdou, C. M. (2018). Discrimination and depressive symptoms among African American men across the adult lifecourse. *The Journals of Gerontology*, 73(2), 208-218.

Williams, M. T., Holmes, S., Zare, M., Haeny, A., & Faber, S. (2022). An evidence-based approach for treating stress and trauma due to racism. *Cognitive and Behavioral Practice*, 30(4), 565-588.

Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018a). Assessing racial trauma within a DSM–5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations*, 3(4), 242.

Williams, M. T., Printz, D. M. B., & DeLapp, R. C. T. (2018b). Assessing racial trauma with the Trauma Symptoms of Discrimination Scale. *Psychology of Violence, 8*(6), 735–747.

Willig, C. (2013). *Introducing qualitative research in psychology*. London: McGraw-hill Education.

Willig, C. (2017). *Interpretation in qualitative research.* In: Western, C. &b. Stainton Rogers, W. (Eds.) *The SAGE handbook of qualitative research in psychology* (pp. 274-288). Thousand Oaks, CA: Sage Publications.

Yardley, A. (2008). Piecing together—A methodological bricolage. In: *Forum: Qualitative Social Research* 9(2), Article 31.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health*, 15(2), 215-228.

Zhang, H., Watkins Jr, C. E., Hook, J. N., Hodge, A. S., Davis, C. W., Norton, J., & Owen, J. (2022). Cultural humility in psychotherapy and clinical supervision: A research review. *Counselling and Psychotherapy Research*, 22(3), 548-557.

Zimmerman, J. L., & Dickerson, V. C. (1996). *If problems talked: Narrative therapy in action*. Guilford: Guilford Press.

Appendices

Appendix A: Recruitment poster

Calling Practitioner Counsellors, Psychotherapists, and Counselling Psychologists

For research on Race-Based Traumatic Stress

What is the study about?

My research aim is to: understand Counselling Professionals' experiences of working with Black clients that have endured Race Based Traumatic Stress (RBTS).

Who can Take part?

I am looking to recruit professional counsellors, including counselling psychologists, psychotherapists, and counsellors from all backgrounds from the age of 21+ (white therapists included who are willing to discuss this phenomenon), with three years of experience working with diverse clients. All participants must have worked with Black clients (in their caseload) who have **experienced** or described the **phenomena associated** with Race-Based Trauma.

What will I have to do?

You will be invited to an online interview lasting approximately 50-60 minutes. We will engage in a conversation where there will be questions that invite your reflections about your experience working with black clients presenting with RBTS.

By participating in this research, you will make a valuable contribution towards:

- Gaining an understanding around perceptions of RBTS
- Identifying the kind of knowledge and skills required when supporting clients with RBTS
- Producing recommendations for improving support and provision for clinicians working with Black individuals who have experienced racism/RBTS

Please contact me for further information on the research and how to volunteer, please email Nomsa Sandra Wayland: u1504502@uel.ac.uk [redacted]

Appendix B: Participant information sheet

PARTICIPANT INFORMATION SHEET

Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study

Nomsa Sandra Wayland

U1504502@uel.ac.uk

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

Who am I?

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

What is the purpose of the research?

I am conducting research into how therapists' make sense of their experience of working with Black clients that have endured race-based traumatic stress (RBTS). I am particularly interested in understanding/exploring:

- The knowledge and practical skills of therapists' in supporting Black clients with RBTS.
- How far do therapists' feel equipped to work with and support Black clients with RBTS?
- Where therapists' feel they can turn to for support if they require it.
- What recommendations do therapists' have for improving support and provision for clinicians working with Black individuals who may have experienced racism/RBTS?

The study findings are anticipated to have significant relevance to counselling psychology, the mental health care sector, and the psychology field. For example, the study will provide a deeper understanding of the current experience of therapists' dealing with and supporting clients with RBTS, thus potentially increasing awareness of RBTS among therapists'. Furthermore, the findings could reduce instances of therapists' pathologising common everyday experiences of Black clients and instead provide effective, culturally appropriate therapeutic practices and interventions that address the complexity of race, racism and RBTS in the future. Using race-specific and psychologically based models will aid in the effort to reduce mental health disparities and encourage Black clients to seek therapy.

Why have I been invited to take part?

You have been invited to participate in the research as someone who fits the criteria, I am looking for help to explore the research topic. I am searching for therapists' from the

ages of 21+ living in the UK with at least three years of practical counselling experience (after qualifying) that have worked with Black clients who have endured/described the phenomena associated with RBTS to take part in my research. It is entirely up to you whether you take part or not, participation is voluntary.

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

If you agree to participate you will be asked to take part in 50-60 minutes recorded face to face, semi-structured interview, either via Teams or on site at the University of East London will be conducted. The interview will be conducted as an informal chat where I will try to create a friendly environment for you to engage with. Interviews will be audio recorded to facilitate the transcription and analysis of the information collected. I will not be able to pay you for participating in the research, but your participation would be very valuable in helping to develop knowledge and understanding of the research topic.

Can I change my mind?

Yes, if you would like to withdraw from the study, you can do so up to two weeks following the interview, with no obligation to provide a reason. If you decide to withdraw within the two weeks following the interview, your data will not be used as part of the research and all your contact details will be destroyed. You will be unable to withdraw your consent after the data has been transcribed and the thesis has been written and submitted.

Are there any disadvantages to taking part?

No risks are anticipated. This study will not have any intervention that appears to impact you directly, however, phenomenological research can promote sensitive and deep answers which may provoke certain emotions in participants. Therefore, I will be watching

out for any signs of distress during the interview and offer termination if needed. You will be advised that during the interview process you can decline to answer the question you are not comfortable with. In case of distress brought up by the interview and feel that you need further support please contact any of these free services offering counselling i.e. giveusashout.

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

Audio/video recordings and interview notes will be stored electronically using encryption software and password protection. To protect anonymity of participants pseudonyms or ID numbers will be used when typing transcripts in a password protected folder. The data you provide will not be linked to your name, identificatory references and contact details in anyway. Physical data will be locked away where only I will have access and only share data with my supervisor via password protected secure email via UEL with no identifying features and interview transcripts may be included and be read by the examiners. Data will be kept up to five years after the study for further analysis towards a published research article/chapter or a future research project and then all data will be destroyed.

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

personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians) through journal articles, conference presentations, talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any identifying information will either be removed or replaced. You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lucy Poxon for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

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

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

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

Nomsa Sandra Wayland

u1504502@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lucy Poxon School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: l.poxon@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix C: Consent form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study

Nomsa Sandra Wayland

u1504502@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated XX/XX/XXXX (version X) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 2 weeks from the date of the interview to withdraw my data from the study.	

I understand that the interview will be recorded using video screen recording on Microsoft Teams and voice recording if by face to face at UEL.	
I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……

……

Participant's Signature

……

……

Researcher's Name (BLOCK CAPITALS)

……

……

Researcher's Signature

……………………………………………………………………………………………

……………………………………………

Date

……………………..……………………………………………………………………

……………………………………………

Appendix D: Participant demographics sheet

PARTICIPANT DEMOGRAPHICS SHEET

Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study

Nomsa Wayland

Trainee Counselling Psychologist

U1504502@uel.ac.uk

Please do not write your name on this form. It will be stored separately from any other information that you provide during the study (e.g., the consent form and audio recording) and will not be linked with your responses.

For the following items, please tick the most appropriate box/ write your response on the line provided.

How would you currently describe your gender identity?:

Please specify: ..... I prefer not to answer ☐

18-24☐ 25-34☐ 35-44 ☐ 45-50 ☐ 50 and over ☐

Ethnicity

White

☐ British/ English/ Welsh/ Scottish/ Northern Irish /Irish

☐ Gypsy/ Irish Traveller

☐ Other

Black

☐ Black British

☐ African

☐ Caribbean

☐ Any Other Black/ African/ Caribbean background

Asian

☐ Asian British

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Any other Asian background

Mixed

☐ Multiple ethnic groups

☐ White and Black African

☐ White and Black Caribbean

☐ White and Asian

☐ Any other Mixed/Multiple ethnic backgrounds

☐ Other ethnic groups, such as Arab ☐ Any other ethnic group

Occupation:…….. Modality used: ……..

Appendix E: Interview Schedule

Interview Schedule

Topic Guide for Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study

Interview Questions

Perceptions of Race-based Traumatic Stress

1. How do you interpret or understand the concept of "race-based traumatic stress"?

- ***Prompts***: what experiences comes to mind if any when considering this term?
- ***Prompts:*** *how might this differ from other types of traumas or stress you are familiar with*
- ***Prompts:*** can you think of any societal or personal implication stemming from RBTS

2. In your opinion, what factors do you think might lead to someone experiencing race-based traumatic stress?
3. In your interactions with your clients, how do you perceive the impact of race-based traumatic stress on them?

Implications for assessment and treatment/ intervention

4. How have your experiences been when working with clients from Black Minority backgrounds?

- ***Prompts****: can you share some insights about the diversity within your caseload?*
- ***Prompts****: what challenges and opportunities/ insights have you encountered*
- ***Prompts****: how have these experiences influenced your professional approach*

5. Can you describe any experiences where you or work colleagues encountered a client sharing incidents of racism? While ensuring client confidentiality, can you describe this incident?

- ***Prompts****: what emotions did the client convey during the conversation?*
- ***Prompts****: what was your initial reaction or response to their sharing?*
- ***Prompts****: Were there particular challenges you encountered while addressing this issue? If yes, what were they?*
- ***Prompts****: Were there any factors or resources that assisted you in handling the*

situation?

- ***Prompts:*** *In what way did you support or assist the client after they shared their experiences?*
- ***Prompts****: Reflecting on your response, how do you evaluate your handling of the situation? Would there be aspects you'd consider changing in the future?*

6. Which factors would you identify as significant during the assessment/formulation process for clients who have experienced racial trauma?

7. When approaching the treatment/intervention process, what considerations do you deem essential?

8. In your perspective, how might mental health services influence the experience of racial trauma, either positively or negatively?

Implications for Service Provision and Proposals for Change

9. To what extent do you believe mental health services successfully acknowledge the interplay between racism and trauma?

10. Can you describe your level of confident are you in working with and assisting Black clients who experience race-based traumatic stress (RBTS)?
Prompts: are there any specific resources or methodologies you rely

- ***Prompts:*** *In what areas do you believe you might benefit from further support to address experiences of race-based trauma adequately? What would that support entail?*
- ***Prompts:*** *how do you approach the unique needs of Black clients presenting with RBTS*
- ***Prompts:*** *What modifications or improvements would you suggest for the current approach?*

Training and Academic Background

11. What kind of training or academic exposure have you had related to RBTS? (It could be from your career or previous academic studies?)

Prompt*: what training have shaped your understanding of RBTS*

- ***Prompt****: How would you evaluate the effectiveness of this training in preparing you to support clients with RBTS*
- ***Prompt:*** *If you feel there are gaps, what additional training would benefit those working with clients experiencing RBTS?*

12. Does your professional practice incorporate any assessment tools or policies specifically for RBTS?

- ***Prompt:*** *How do these tools or policies guide your approach?*
- ***Prompt****: how did you choose these tools*
- ***Prompt****: what advantages or challenges of using these specific tools or policies*

13. Can you share your experiences and feelings about discussing your work with black clients who have experienced RBTS during clinical supervision sessions.

- ***Prompt****: If you feel a gap in support, what recommendations would you offer to trainers and clinical supervisors to address it?*
- ***Prompt****: Are there any recommendations you would make to enhance the support trainers and clinical supervisors provide in this area?*

Concluding questions

- Is there anything else we have not discussed that would be useful to share?
- What else do you think should be asked in this type of interview?
- Do you have any reflections you would like to share about speaking about this topic?

Thank you for your participation

Appendix F: Ethical approval form UEL

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;

MSc/MA RESEARCH;

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING &

EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).

1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for

	completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details		
2.1	**Your name:**	Nomsa Sandra Wayland
2.2	**Your supervisor's name:**	Lucy Poxon
2.3	**Name(s) of additional UEL supervisors:**	Jeeda Alhakim
2.4	**Title of your programme:**	PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY
2.5	**UEL assignment submission date:**	**28/08/2023**

		Re-sit date (if applicable)

Section 3 – Project Details		
Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study.
3.2	**Summary of study background and aims (using lay language):**	The proposed research will explore therapists'' experiences of working with Black clients experiencing Race-Based Traumatic Stress (RBTS) in the United Kingdom (UK). Although there is growing quantitative literature on the relationship between racism and trauma (Carter et al., 2019; Carter & Pieterse, 2020; Kirkinis et al., 2021; Pieterse et al., 2012), there is limited literature exploring clinicians' experiences addressing race-based trauma. RBTS may not be formally recognised in counselling psychology; however, there is evidence that Black people experience more RBTS than other ethnic groups, resulting in more emotional and psychological stress (Kinouani, 2020; Roberson

		& Carter, 2021). There is a lack of in-depth qualitative research in the UK addressing the unique experience of therapists' working with this group. This proposed research aims to explore this topic in-depth by conducting a qualitative study. The findings are anticipated to have significant relevance by raising awareness among therapists' and potentially influencing the future development of new racially sensitive and suitable assessment measures.
3.3	**Research question(s):**	How do therapists' make sense of their experience of working with Black clients that have endured race-based traumatic stress?
3.4	**Research design:**	The proposed qualitative project will take a phenomenological approach to answering the research question. The qualitative approach entails the collection, analysis, and interpretation of non-numerical data, such as language, subjective beliefs, and opinions (Smith, 2016; Willig, 2007), which is appropriate for the proposed study because it is concerned with the quality and texture of experience than with establishing cause-effect relationships. Interpretative Phenomenological Analysis (IPA) is concerned with comprehending how people construct meanings, how they make sense of their world and experiences within it, with the objective of gathering

		and generating phenomenological knowledge about participants' subjective experiences (Smith, 2016; Willig, 2017). IPA is consistent with the present research, necessitating subjective inquiry and critical analysis (Ponterotto, 2005).
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Eight participants (any ethnicity and gender) will be recruited for face-to-face online interviews. Participants' ages will be 21 and above to allow for sufficient counselling experience. All participants must have worked with Black clients who have experienced or described the phenomena associated with Race-Based Traumatic Stress. All participants must be therapists' living in the UK with at least three years of practical counselling experience (after qualifying) working with clients with RBTS. I chose not to limit the participants to a specific profession, (i.e., counselling psychologists) as the experiences of all therapists' working with Black clients with RBTS are perceived to be essential to answering the research question. Furthermore, this research topic is under-researched; many people might not possess sufficient knowledge regarding RBTS or may be reluctant to participate, leading to potential recruitment challenges if inclusion criteria are too specific. Participants must articulate themselves in

		English without psychological or expressive language limitations. This ensures that participants express themselves without their experiences being interpreted by others.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	A purposive sample will be utilised to recruit 8 participants via contacting organisations for Therapists'. Google will be utilised to narrow down organisations for Therapists', such as The Black African, Asian Therapy Network (BAATN) and the British Association for Counselling and Psychotherapy (BACP) and the Psychology Today directory. These organisations will be contacted for permission to recruit and distribute email invitations to potential participants. In addition, online platforms such as LinkedIn, Facebook, and posters (Appendix F) will be displayed at the University of East London, advertising the study. All participants will be screened for inclusion criteria. Given the topic's sensitivity, practising professionals may hesitate to participate if they feel ill-equipped. This can be overcome by contacting even more therapist bodies, charity organisations offering counselling/therapy, and Universities with counselling/psychotherapy programmes to recruit suitable participants.
3.7	**Measures, materials or equipment:**	For the purposes of data collection, a semi-structured

	Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	interview (Appendix E) schedule will be used. The researcher will use Microsoft teams voice recorder during the interview. Copyrighted or pre-validated questionnaires, tests or other stimuli that I do not write, or design will not be used.
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Interested participants will be sent an information sheet (Appendix A), and consent form (Appendix B) as part of a briefing about the research's aim, purpose, and methods. A definition of Race Based Traumatic Stress will be provided, and participants will then be given a chance to ask questions about the study, their involvement, including the meaning of their consent (Appendix C). Once the participants are fully aware of the study and informed about the process, they will be asked to sign a consent form (Appendix B) prior to participating in the study. Face to face semi-structured online interviews will be used when conducting the interview **(**Appendix E). All participants will be asked the same questions. A semi-structured interview method was selected as it allows the researcher to guide the conversation and keep participants on topic, whilst remaining flexible, enabling participants to discuss issues that are important to their experience and understanding of the

		research topic (Osborn & Smith, 2008). The interview guide will be developed from the existing literature review and the research questions (Appendix E). Prompts will be used to encourage participants to elaborate further, and follow-up questions will be asked based on the participants' responses. The interview schedule will last around 50-60 mins, and data will be transcribed verbatim (Appendix A). The questions will be piloted with one ProfDoc counselling psychology student to practise interview techniques and verify the clarity and relevance of the interview schedule. Interviews will be conducted and recorded via online platforms (Microsoft Teams). Participants will be reminded of their withdrawal rights up to two weeks following the interview schedule, with no obligation to provide a reason. Participants will also be informed that they will be unable to withdraw their consent after the data has been transcribed and the thesis has been written and submitted.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and	If you selected yes, please provide more information here	

	how/when will you inform them about its real nature?		
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers	
3.11	**Data analysis:**	The interview transcripts will be analysed individually following these five steps, using an IPA method (Osborn & Smith, 2008). **Stage one** - immersion in the data: This will involve listening to each recording several times to get a deeper understanding of the participants' stories. **Stage two**- involves initial coding, where transcripts will be scrutinised for significance. Data will be annotated and highlighted for any noticeable descriptions. **Stage three** - developing potential themes: this stage will focus on capturing themes with important meaning to the research participant. **Stage four** - examining the association within developing themes. **Stage five** - writing up: writing themes into a narrative that contains detailed extracts and illustrative quotations from the individual's	

		transcript.

Section 4 – Confidentiality, Security and Data Retention			
It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations. If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.			
4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** x	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	For each transcript, an altered, unique participant name or ID number will be used. Data will be kept confidential by changing all names and identifying references (e.g., a name of a place, name of a service) in the transcriptions of the interviews.	
4.3	**How will you ensure participant details will be kept confidential?**	Names and contact details of participants will be kept in a safe password protected folder on UEL One	

		Drive that only the researcher will have access to, and they are going to be destroyed after the end of the research project.	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	Physical data will be locked away where only I will have access and only share data with my supervisors with no identifying features. Data will be stored and backed up on UEL One Drive. A password protected zip folder will be used when sharing data with supervisors without any identifying features.	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	All data will be accessed by the researcher only and shared with above mentioned supervisors if requested. This will be in the form of password protected zip folder via UEL email.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	After the end of the research project, anonymised data (interview transcripts) and consent forms may be kept by the researcher in a secure password protected folder in UEL One Drive that only I have access to, in order to be used for further analysis towards a publication of a research article/chapter or a future research project (For a period of 5 years).	
4.7	**What is the long-term retention plan for this data?**	For further analysis towards a published research article/chapter or a future research project (For approximately two years). In any other case, they will be destroyed	
4.8	**Will anonymised data be made**	**YES**	**NO**

	available for use in future research by other researchers?	☐	☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment			
If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.			
5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will	Minimal risks are anticipated as I will be interviewing	

	they be minimised?	professional counsellors. This study will not have any intervention that appears to impact participants directly, however, phenomenological research can promote sensitive and deep answers which may provoke certain emotions in participants (Appendix D). Therefore, the researchers will be watching out for any signs of distress during the interview and offer breaks or termination if needed. Participants will be advised that during the interview process they can decline to answer the question they are not comfortable with. Furthermore, participants will be provided with a relevant list of free services (i.e., giveusashout) that may be accessed for support in case the interview process has brought up any distressing feelings and they feel that they need further support to process them.	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	There is a potential of triggering distress during the interview process (As detailed above). The researcher will seek support from their supervisory team and personal therapy to minimise any distress.	
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to**	**YES**	

	complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:	☐		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	Participant interviews will be conducted via MS Teams.		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard).	**YES** ☐		

	Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor).	

	▪ 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.

Section 6 – Disclosure and Barring Service (DBS) Clearance			
6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		

6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☐	**NO** x
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☐	**NO** x
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**001716728002**	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions			
7.1	**Does the research involve other organisations (e.g., a school,**	**YES**	**NO**

	charity, workplace, local authority, care home, etc.)?	☐	☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☐	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.		

University of East London

Section 8 – Declarations		
8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Nomsa Sandra Wayland**
8.3	**Student's number:**	**U1504502**
8.4	**Date:**	**10/05/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

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

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

Details	
Reviewer:	**Helen Murphy**
Supervisor:	**Lucy Poxon**
Student:	**Nomsa Wayland**
Course:	**Prof Doc Counselling**
Title of proposed study:	Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress

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

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

Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the

	PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	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. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments
Please clearly detail the amendments the student is required to make
It would have been useful to see the finalised research interview schedule. **Dr Poxon to approve before data collection commences.**

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If	☐

	unsure, please refer to the Chair of Ethics.	
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**D**r Helen Murphy
Date:	**15/07/2022**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology 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	

Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**Nomsa Sandra Wayland**
Student number:	**U1504502**
Date:	**08/09/2022**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Research Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

Required documents	
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Nomsa Sandra Wayland**
Programme of study:	Professional Doctorate in Counselling Psychology
Title of research:	**Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress.**
Name of supervisor:	**Dr Fevronia Christodoulidi**

Proposed title change	
Briefly outline the nature of your proposed title change in the boxes below	
Old title:	Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress.
New title:	Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study.
Rationale:	I realised that I did not include "A qualitative study" at the end of my title. I just need this added to the title.

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐

Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature) Nomsa Sandra Wayland	**Nomsa Sandra Wayland**
Date:	**19/09/2023**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title is more specific than the original one. It will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**19/09/2023**	

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Research Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Nomsa Sandra Wayland**
Programme of study:	Professional Doctorate in Counselling Psychology
Title of research:	Understanding Counselling Professionals' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study
Name of supervisor:	**Dr Fevronia Christodoulidi**

Proposed title change	
Briefly outline the nature of your proposed title change in the boxes below	
Old title:	Understanding Counselling Professionals' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study
New title:	Understanding Therapists' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study.
Rationale:	Examiners asked me to change the tittle from "Counselling Professionals" to Therapists.

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature) Nomsa Sandra Wayland	**Nomsa Sandra Wayland**
Date:	**28/01/2024**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The title change was suggested by the examiners.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**30/01/2024**	

Appendix: G: General Risk Assessment Form template

University of East London Pioneering Futures Since 1898	UEL Risk Assessment Form		
Name of Assessor:	Nomsa Sandra Wayland	**Date of Assessment:**	12/05/2022
Activity title:	Semi-structured interview	**Location of activity:**	Microsoft Teams, UEL Stratford
Signed off by Supervisor: (Print Name)	Dr Lucy Poxon	**Date and time: (if applicable)**	12/05/2022
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:			
Semi structured interviews (up to one hour) over Microsoft Teams with up to 8 participants.			
Overview of FIELD TRIP or EVENT:			
N/A			

Guide to risk ratings:

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

		Hazards attached to the activity					
Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**

Psychological distress to the participants	Participant	All participants will be practicing professional counsellors who have their own therapist and supervisor. Phenomenological research can promote sensitive and deep answers which may provoke certain emotions in participants.	1	1	1	The researchers will be watching out for any signs of distress during the interview and offer termination if needed. Participants will be advised that during the interview process they can decline to answer the question they are not comfortable with. Furthermore, participants will be provided with a relevant list of free services for support if needed.	1
Psychological distress to the researcher.	Researcher	No physical risk to the researcher is anticipated, however, the participants responses may evoke emotional distress in me	1	1	1	I will notify my supervisor the date when conducting the interviews in case I need support. Furthermore, I will utilise personal therapy if needed and journal my emotions evoked by interviewing participants.	1

Appendix H: Participants debrief sheet

PARTICIPANT DEBRIEF SHEET

Understanding Therapists'' Experiences of Working with Black Clients Presenting with Race-Based Traumatic Stress: A Qualitative Study.

Thank you for participating in my research study on understanding therapists'' experiences of working with black clients presenting with Race-Based Traumatic Stress. This document offers information that may be relevant in light of you having now taken part.

The aim of the proposed project is to explore therapists'' experiences of working with Black clients experiencing Race-Based Traumatic Stress (RBTS) in the United Kingdom (UK). Although there is growing quantitative literature on the relationship between racism and trauma, there is limited literature exploring clinicians' experiences addressing race-based trauma. RBTS may not be formally recognised in counselling psychology; however, there is evidence that Black people experience more RBTS than other ethnic groups, resulting in more emotional and psychological stress (Kinouani, 2020; Roberson & Carter, 2021). Therapists' (and their clients) need to understand the impact of RBTS, how its effects manifest, and how to manage the emotional and psychological effects it may have on their clients. There is a lack of in-depth qualitative research in the UK addressing the unique experience of therapists' working with this group. This proposed research aims to explore this

topic in-depth by conducting a qualitative study. The findings are anticipated to have significant relevance by raising awareness among therapists' and potentially influencing the future development of new racially sensitive and suitable assessment measures.

How Raced Based Traumatic Stress is defined

Race based traumatic stress is defined as The RBTS framework helps clinicians working with ethnic minorities to understand racial trauma. It defines trauma as emotional, psychological, and physical reactions to racial experiences that cause pain (Carter, 2007; Evans et al., 2016). Stress reactions produced by racial experiences are usually associated with less severe symptoms that are short-lived, such as depression or anxiety (Pieterse & Carter, 2010). In contrast, RBTS produces longer-lasting stress responses involving multiple symptoms that cannot be eased through coping or adaptation; in fact, failure to cope exacerbates and adds to the trauma (Roberson & Carter, 2021).

How will my data be managed?

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

What will happen to the results of the research?

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

In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you. Any identifying information will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by the researcher and supervisor (Dr Lucy Poxon) for a maximum of 5 years, following which all data will be deleted.

What if I been adversely affected by taking part?

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

Text "SHOUT" to 85258 to contact the Shout Crisis Text Line

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

University of East London

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

Nomsa Sandra Wayland

U1504502@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lucy Poxon. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: Email: l.poxon@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix I: Example transcript

Experiential Themes	Transcript	Exploratory Notes
multi-faceted experience of racism. Ambiguity of Microaggressions feelings of vulnerability, invisibility, and invalidation experienced by the participant. Factors that Contribute to Clients' Racial Trauma. Silent factors that contribute to the client's race-based trauma The accumulative effect of racism. Microaggression, the silent killer	[00:00:42] Interviewer: I'm gonna start really broad asking you questions just to hear about your understanding of the term race based traumatic stress. [00:01:03] Interviewee: . I suppose I, would see it as the kind of cumulative effect on people's nervous system of, um kind of constant or often incidence of, um, racist attacks, racial ignoring, um, racist dismissal, um, microaggressions, both, both of those ones which are clear and those ones which are also, um, kind of can slip under our conscious radar so that they're not, seen, but they impact the nervous system and that, and that. The accumulative effect of that is, umm I think, I wanna say in a way more toxic because it's less visible, so we can't manage it seriously. That's happening. [00:01:57] Interviewer: in your own understanding, what factors do you think may contribute to an individual experiencing racial trauma? [00:02:11] Interviewee: the factors that contribute to racial trauma? Okay well, I suppose I would say it's a broad areas. one is kind of	**Descriptive comments** incidents is not just immediate but accumulates over time. continual exposure to microaggressions or overt racism can have long-term psychological and physiological consequences. the use of terms like "attacks", "ignoring", and "dismissal" can indicate feelings of vulnerability, invisibility, and invalidation experienced by the participant. Describes subtle forms of racism as potentially more toxic due to their invisibility. linguistic comments "toxic" highlights the danger of subtle and unrecognised racial acts conceptual comments sense of helplessness due to challenges of managing less visible microaggression

Internal factors that allow clients to cope with racial trauma. Internal and external factors that contribute to racial trauma. the internal resilience external that contribute to racial trauma eg racial attacks The Consciousness of Privilege and of the use of language. inherent strengths or coping strategies. internal resources assist in identifying ("see spot") and responding to challenges ("defend, refuse, take care, discharge").	the internal resilience, if you like, and, um, our own resources. Um, but I think, um, most of the factors are, are to do with, um, external stuff. whether we're experiencing racism, , whether racial attacks are happening, um, how much, um, support consciousness and understanding there is within the communities that, that, that we live in. Um, Um, I'm just, I'm just noticing what I'm using the word 'we' and I haven't suffered from racial trauma, so that's kind of intriguing. I'm not quite sure what to make of that, but, um, uh, so yeah, so how much support, how much, uh, racist, attacks of all kinds are happening, whether, whether they're, whether they're opportunities to kind of spot them into, to have the opportunities to process them and then internally, um, , what resources perhaps do we have from our own upbringing, our own childhoods that enable us to, to see spot and defend, refuse, um, take care, discharge. Yeah So, so those are the two kind of broad things. So things from kind of really broad culture like things you happen, to hear on the radio that that may or may not catch your attention, but they land inside right through to the kind of very	**Descriptive comments** The external factors include experiencing racism, racial attacks, support within communities, opportunities for processing, and cultural context. conceptual comments reflecting on his use of the word 'we' when referring to black clients he is supporting, despite not personally suffering from racial trauma. Wondering why he used 'we', feelings of not entitled **conceptual comments** The internal factors acknowledge the role of a persons' own resources and upbringing in coping with racial trauma. a contemplation on the adequacy and availability of resources or allies. reflecting on the moments when they can identify, confront, and process these racist attacks **conceptual comments** Subtle racism that might slip under the radar is hard

Invisible wounds that continue to bleed Lack of exposure to diverse caseload Professional Identity and Presentation. introspection about the responsibilities Ambiguity	clear, obvious kind of racist attacks that happen. Mm-hmm. [00:03:55] Interviewer:. Tell me about your general experience of working with client from, uh, Black minority background I just want understanding how diverse is your caseload now, or in the past or, and if, you think it's a reflection of your geographical composition in which you operate? [00:04:21] Interviewee: So, so my caseload, I wanna say is very monocultural. Mm-hm,Um, so the, the clients I work with as a individual therapist are mostly white and kind of always have been and I've been wondering about that, I mean, I do live in, in, in a very monocultural area where, where, where there, there, there's a very, very little diversity as always So there's that I'm aware of that, but I also, I guess there's another couple of things. One is, um, how much do I flag that I'm interested in working with racial trauma, Do I need to have another look at what I'm saying in terms of what I'm putting out there to say that this is something I 'm wanting to work with or I'm interested in working with and have some, capacity to work with, so there's that and then there's something	dictate while leaving some interna wounds. Acknowledges having a monocultural caseload consisting of white clients. Reflecting on his caseload 's lack of diversity, narrative portrays a professional's introspective journey regarding how to authentically and ethically present themselves in a field as sensitive as racial trauma. actively engaged in meaning-making about his positionality and how it may be perceived by others.

Clients seeking therapists within familiar faces and background. Professional Self-Doubt and Personal Anxiety about Discussing Racism Lack of diversity within training Racism within the training institutions	about how, if I imagine myself to be a black client I would imagine that my starting assumption would be that a white therapist wouldn't know what they were doing frankly and so I would, I would seek a therapist of colour. I have worked with, trainees and, uh, trainees and supervisees who are of colour and yeah and I felt that I was not , not good enough not, not capable to helping the Black clients, I was anxious with my first black client. [00:05:46] Interviewer: And how are you experiencing working with trainees of colour now compared to before?, [00:05:53] Interviewee: that's a big story so I think, , when I think back, I was working in, in this room, running a training with a colleague and we had a trainee of colour who had, uh, brought up the issue of racism within the group. There wasn't a specific incident, but they wanted flag that they were the only person of colour in, in a, white group, racism was bound to be functioning and they brought it back later in the training and, um, and a white trainee said something in response. It was quite dismissive, and I didn't take	assumptions of black clients seeking therapists of colour. Lack of confidence in the self, might be due to lack of skill conceptual comments He expresses self-doubt, seem to be rooted in the perceived inadequacy of his skills and knowledge to address racial trauma effectively. brings attention to the systemic nature of these disparities, possibly suggesting a pattern that has persisted over time

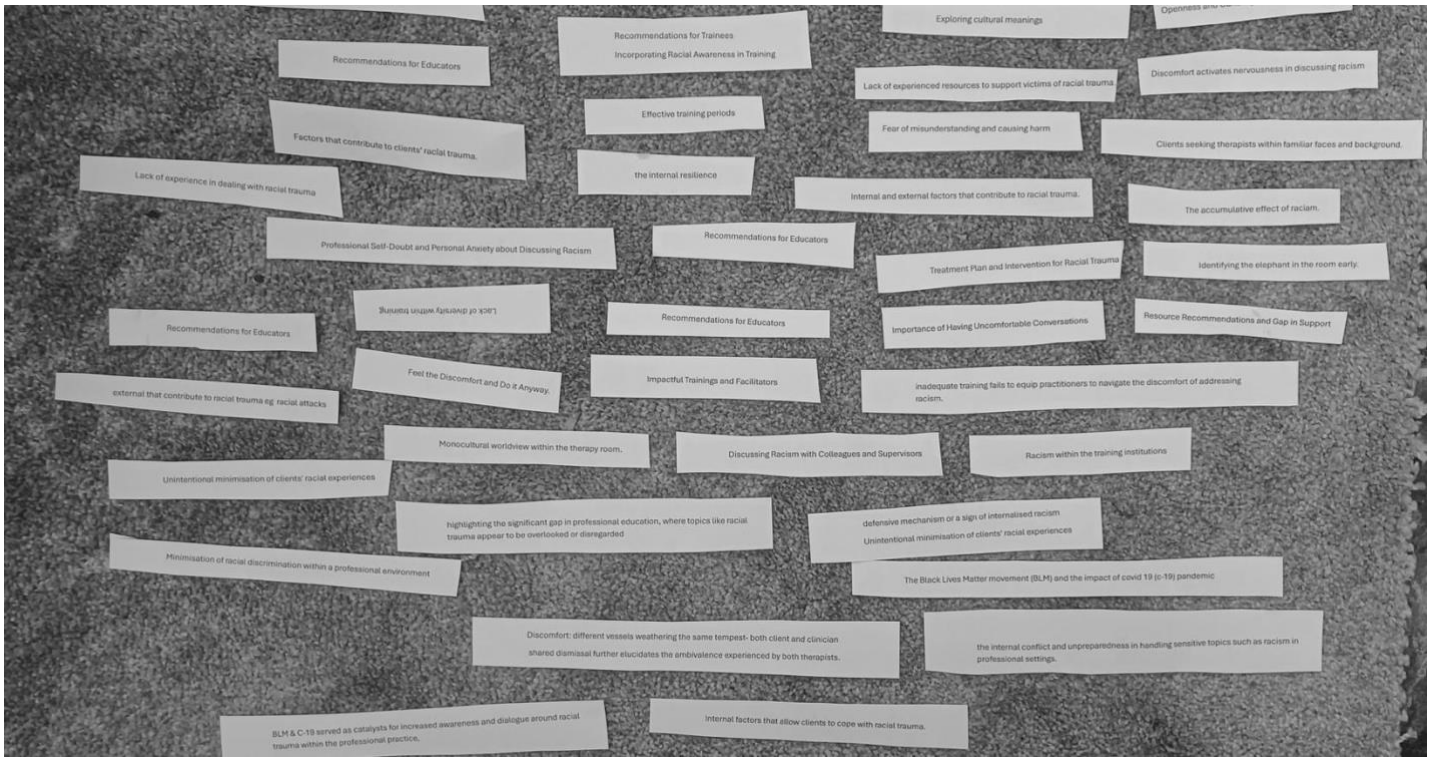
Minimisation of racial discrimination within a professional environment Unintentional Minimisation of Clients' Racial Experiences Discomfort: different vessels weathering the same tempest- both client and clinician. Shared dismissal further elucidates the ambivalence experienced by both therapists. defensive mechanism or a sign of internalised racism Unintentional minimisation of clients' racial experiences	action and that was really for me, very, galvanizing. I think I would say it really got me to kind of say to kind of start to really notice, hey, my practice is not my, my work is not fit for practice. I need to do something about this So that was my first experience, really I felt noticing, my, my failure. I, they would've, there would've been times earlier when I wouldn't have been, uh, successful in supporting the colour and, and it's interesting when I think back to before then I remember with this client , not sure what to do I don't know if it was her resistance or my resistance or I didn't know what to do with this, or she doesn't know what to do with it, but we didn't follow it up that much because she says, it just happens, it's no big deal talking her what I see now it um racism experience, , so we both dismissed the topic. She wanted to talk about her work; She wants to talk about her boyfriend not much about um, her racism incidents, on both cases I remember thinking, so maybe I told myself I don't have to do anything because she's not bringing it in, we can talk other things she had a good job. Again then I don't remember uh, issues of race and racism being brought and that's possibly, partly because the	the term "galvanising" seems to suggest a strong emotional reaction. What are the underlying emotions and feelings tied to this event? The participant's decision not to take action becomes a focal point for reflection. The participant appears to have experienced some inner conflict or emotional stirrings ("very galvanising") as a result of their inaction. This could be a manifestation of regret, self-evaluation, or a pivotal moment of realisation about their own behaviour or the dynamics of the situation. Appears to be awakened to the fact that his practice may not be fit for purposes and needs to be more inclusive. expresses self-doubt from both client and clinician Shares experience where he and the client appear to dismiss the topic of racism, considering it as something that "just happens". Expresses self-doubt seem to be rooted in the perceived inadequacy of his skills and knowledge to address racial trauma effectively. preconceived notion that success and being in relations can diminish or shield one from the impacts of racism

inadequate training fails to equip practitioners to navigate the discomfort of addressing racism.	trainings were very monocultural, but also I think because, I wouldn't have had sufficient safety and consciousness for that to be brought in a safe way So, uh, so that was back in, that event happened back in, uh, when was it, 2018? and it, and it got me reading and it got me starting to	reflecting The previous on the training that wouldn't have facilitated a safe space to talk about race. Monocultural worldview within the therapy room.
highlighting the significant gap in professional education, where topics like racial trauma appear to be overlooked or disregarded	look for trainings and courses and uh, ways that I'm about to learn how , to, to offer work of sufficient, good enough quality and, uh, being, being, being in Devon, being a long way from everywhere, it's a challenge. Um, you know, getting to London for, for things uh, and then two things happened, which made it much easier.	Motivated to seek knowledge and training on Racial trauma
The Black Lives Matter movement (BLM) and the impact of covid 19 (c-19) pandemic BLM & C-19 served as catalysts for increased awareness and dialogue around racial trauma within the professional practice,	One, one was, COVID 19, which meant that a lot of things went online and, , and the other was the Black Lives Matter movement, which made, made things more, I dunno, I think, I think it just, I think it just really increased the amount of, awareness for me and also confidence within black professionals, black training organizations, uh, and also the interest, uh, also amongst most white therapists to actually start thinking about racial trauma, start doing things, So that made the amount of courses and things more available ,to, for therapist like myself. So, so, so I've done a fair bit of training	The narratives underscore the significant impact of the BLM movement and the C-19 pandemic on the recognition and understanding of racial trauma.

heightened sense of inadequacy and apprehension in broaching such sensitive subjects.	but to come back to your question the other thing that happens is I found Barton (laughter) so enormously helpful, helpful Um, let's come to your question I then had an experience just over a year ago Yeah. Where, um, essentially, we, we did, had have some slightly unclear, but nevertheless, I want to label as racist. Things happen within a training residential and, and, and I, I. Uh, what happened? It's like, I, I, I, I wasn't able to find a way to kind of step in and kind of say, hey, hang on a minute, this is what this is we need to support people and we need to address this and there were various reasons why the, uh, why the why the whole training group was not well placed to have an sufficient holding and so that was frankly a disaster. It was a disaster for, for particularly for the, the trainees of colour Yeah I could say lots more about this, but I, I probably wanna be guided by questions. Just say to get a sense of what's interesting for you. [00:09:55] **Interviewer:** I'm quite interesting in hearing what happen next ? [00:10:20] I**nterviewee**: I mean, um, so specifically, I remember thinking, I was going through this loop, I need to step in, I need to do	. to express a struggle to grapple with his position, having the internal conflict

the internal conflict and unpreparedness in handling sensitive topics such as racism in professional settings. Racism the uncomfortable 'elephant in the room' Fear of misunderstanding and causing harm	something here but the structure of what we're doing right now is not a process, it's just a check-in and therefore, if I'm stepping outta that, then is that okay? That's what, that's my top line rationale What's going underneath on underneath much more was a sense of, um, I was a bit frozen I, I, I was sort of trying to move uh, and finding it difficult, and I think I didn't have the confidence in myself Yeah. , um, to, to, to do what was needed to be done. what else was going on there? and also hadn't done sufficient work with my own nervous system around racism So, so at that point, I wasn't, I hadn't had the experiences, which resourced me to kind of go, okay, so this is deeply uncomfortable. This is what needs to be done. I'm the trainer, I'm gonna do it and that feels very different now so, so, and I I think also, well, what something else that's really shifted is at, at that time our contracting, before the training started, which had been years earlier because of Covid hadn't included, we are gonna be looking at racism. and that's, and that's something that was a real learning and certainly, um, more recently it's, it's a clear part of our contracting, our, our	**Conceptual comment** :This fear seems to stem from a lack of confidence in discussing sensitive topics such as racism. suggesting a heightened sense of inadequacy. Conceptual comment: He is reflecting on the need to address racism within their training. Recognising racism and the need to address it within the training program

Experiential Statements



Appendix J: PETs for the transcript

Unintentional minimisation of clients' racial experiences	**Clustering**
self-doubt rooted in the perceived inadequacy of skills and knowledge to address racial trauma effectively.	*She wants to talk about her boyfriend not much about um, her racism incidents, on both cases I remember thinking, so maybe I told myself I don't have to do anything because she's not bringing it in, we can talk other things she had a good job. [00:05:53]* *I remember thinking, so maybe I told myself I don't have to do anything because she's not bringing it in, we can talk other things she had a good job. Again then I don't remember uh, issues of race and racism being brought and that's possibly, partly because the trainings were very monocultural [00:05:53]* *I was going through this loop, I need to step in, I need to do something here but the structure of what we're doing right now is not a process, it's just a check-in and therefore, if I'm stepping outta that, then is that okay? [00:10:20]* *I was a bit frozen I, I, I was sort of trying to move uh, and finding it difficult, and I think I didn't have the confidence in myself Yeah, , um, to, to, to do what was needed to be done. what else was going on there? and also hadn't done sufficient work with my own nervous system around racism [00:10:20]*
Professional Self-Doubt and Personal Anxiety about Discussing Racism	*I imagine myself to be a black client I would imagine that my starting assumption would be that a white therapist wouldn't know what they were doing frankly and so I would, I would seek a therapist of colour. [00:03:55]* *I have worked with, trainees and, uh, trainees and supervisees who are of colour and I felt that I was not, not good enough not, not capable to helping the Black clients, I was anxious with my first black client. [00:04:21]* *I remember with this client , not sure what to do I don't know if it was her resistance or my resistance or I didn't know what to do with this, or she doesn't know what to do with it, but we didn't follow it up that much because she says, it just happens, it's no big deal talking her what I see now it um racism experience, , so we both dismissed the topic. [00:05:53]* *It was quite dismissive, and I didn't take action and that was really for me, very, galvanizing. I think I would say it really got me to kind of say to kind of start to really notice, hey, my practice is not my, my work is not fit for practice. I need to do something about this So that was my first experience, really I felt noticing, my, my failure. [00:05:53]*
Racial trauma is taught as an informational process rather than as a relational and embodied process	
Lack of training that supports practitioners	*I think there's a lack of training which supports practitioners to actually drop down and be able to tolerate the discomfort of addressing racism. I think my sense is that, is that, is that, um, racial trauma is taught as, as an informational process rather than as a relational and embodied process [00:36:20]*
	I noticed is that some of the trainings that were most impactful, that have most changed my practice weren't ones that necessarily took up more time. There were trainings where it was a small group mm-hmm. where we were expected to, we were given some tools to regulate and other systems, and we were then expected to sit with a deep discomfort of our own racism and of the impact of that on black people and people of color and those, those have been the most effective trainings. Some of the trainings that have been more informational, um, they're useful, but they, they haven't changed my practice as much So that's the thing that really helps. and it's, and also add in there is where the trainers have been confident and, and willing to name the racism in the room. That's been really important. [00:42:00] *So those I think training that allows thinking as kind of, those kind of training experiences have been really helpful to be in small groups of people who are really willing to go there regulate our nervous systems and to, to, to really pay attention to what happens when we talk about these things sit with a deep discomfort of our own racism and to really pay attention to what happens when we talk um, about these these, things, what happens when we get challenged. [00:42:00]*

Appendix K: PETs clustering across all transcripts to develop GETs

	P1	P2	P3	P4	P5	P6	P7	P8
PETs	**Definition and Operationalisation of Racial Trauma**	**Profound impact of explicit racial hostility,**	**Racial discrimination could lead to feelings like an outsider especially when one is the only person of colour.**	**Racial discrimination based on colour**	**Definition and Operationalisation of Racial Trauma**	**Definition and operationalisation of racial trauma**	**Description of the experience of racism as a form of gaslighting, and experiences of being ignored or dismissed by others.**	**Microaggression , the silent killer**
Sub Themes	**Complex and multifaceted understanding of racial trauma.**	**The long-term impacts of racial encounter**	**Factors contributing to racial trauma**	**Discrimination/Stereotyping Based on Appearance**	**Experiencing racial discrimination can lead to severe mental health issues, including depression and anxiety.**	**Continuous Impact of Historical Trauma**	**Factors that contribute to clients' racial trauma**	**Silent factors that contribute to the client's race-based trauma**
	So for me, racial trauma, Is complex because in a way you could argue to, according to the DSM5 and ICD11, um, manuals, the criterion A is not as straightforward as somebody had an accident or they were in a bomb or, but actually what we are arguing is the micro aggression Um, accumulation of microaggressions leads to equating to criterion A. [00:00:36]	here in uk it is, you know, it can be its overt, it's more, um, but mostly, it's covert, um, subversive yeah um,It's really difficult to name it, Um, and it's more gaslighting. Yeah, that's it. It's just more gaslighting and more punishing if you bring it, if you bring it up out loud [00:06:01]	Well, I suppose the, um, maybe all weeks having to, um, try to fit in, in a way to not being allowed to maybe be themselves, to honour parts of their heritage, parts of their culture, part of an identity that is not allowed to be expressed, or the feeling. that it wouldn't be welcome. feeling like they are outsiders, having experienced rejection based on your colour it is an ongoing sense of not being seen or heard or welcome [00:02:00]	I said if we, if, if we do some, if I do something, uh, the, you know, bad, the police are gonna treat me differently from, from you because of the colour of your skin. It, you know, it shouldn't be that [00:13:42]	So any, anything that, um, somebody who has experienced trauma, that, and race has been the actual reason why they've experienced that trauma. So, for example, I have a client whom I see now who is being racially discriminated against at work and as a result, they are depressed and anxious. Um, and that, and they're traumatized, have been traumatized because they are experiencing the, the, um, symptoms of post-traumatic stress disorder, Um, but it's coming from a trauma-based, um, cause. [00:00:49]	336 years of torture and abuse and a system of slave that's like no other in the world now that damage is continuous and it's also, it is, uh, through colonialism in the same experience and it's transgenerational. So, it's genetic. [00:01:41]	So when people are experiencing racism, and then it's possibly in front of other people, so other people are around, and those people ignore, choose to ignore what's being said or what's been, you know, they ignore that it's happened. [00:01:38]	I suppose I, would see it as the kind of cumulative effect on people's nervous system of, um kind of constant or often incidence of, um, racist attacks, racial ignoring, um, racist dismissal, um, microaggressions. [00:01:03]
	I think environmental factors un, microaggressions, racist attacks, and social class. [00:04:24]	It isolated you, it made you, um, feel unwanted and afraid that's what you just said to me and you lost a lot, you lost your whole first year because of this one incident and he kind of didn't say much and he came back the next session. [00:18:51]	I suppose, my understanding is that the sort of ongoing, um, experience of having to, um, to try to fit in or be part of something, of a society that maybe makes people feel like they are outsiders and that their parents and their parents before them have experienced rejection and lack of welcome because of the colour of their skin. (00:00:39)	I work, and she was like, oh no, because you are, um, and she kind of stumbled around the words, and then it eventually came out cause of the colour of your skin, and I was like, oh wow no, I'm not, especially not in this situation we are trying to work for you. [00:01:05]	Microaggressions, um, you know, those questions that you get asked from people. Um, where are you from? I'm from England. Where are you? But where are your parents from? You know, that's a microaggression and you know, we experience it on a day-to-day basis. Um, experiences of walking into a space where people stare at you and you know, they're not staring at you because of what you're wearing. They're staring at you	Well, I think the, um, education system, the health system. So, at any point you interact with any sort of institutional system, I think it's just kind of, it backs up your feeling of being othered or otherness or not included, or not considered or not being important or	Colour is obviously, the colour of the person's skin, the accent, the way they speak um, maybe the size of a person, hair maybe hmm. clothes, if people dress, say, uh, in their own, you know, uh, country of origins, that sort of style if, if they become emotional. [00:04:05]	both, both of those ones which are clear and those ones which are also, um, kind of can slip under our conscious radar so that they're not, seen, but they impact the nervous system and that, and that. The accumulative effect of that is, umm I think, I wanna say in a way more toxic because it's less visible, so we can't

					because of your colour. [00:02:03]	worthwhile. [00:03:31]		manage it seriously. That's happening. [00:01:03]
	I think social class is a lot to do with it so how do you communicate and how do you respond? Can you stand up for yourself? Can you somewhat blend in? So we know that somebody who can't speak English, for example, is likely to experience racial abused because they can't communicate and they stand out as opposed to somebody who can speak more fluently and eloquently. [00:05:12]	what contributes to them experiencing racial trauma? Yeah. Mm. Not being white, there's literally, there's not a single client that has not experienced racial trauma. That's, that's, yeah. I, that does, I've had many tell me that they never have, but that ends up to never, ever be true. Yeah [00:18:51]	. he's also gay, and I think he is trying to fit into a community, so it's almost like, you know, um, it's, it's another thing almost that he has to deal with on a daily basis, So racism, homophobia, you know, um, and it felt, yeah, maybe I just, I didn't feel I had the right to press him on something he might feel not comfortable with. [00:13:04]	I said if we, if, if we do some, if I do something, uh, the, you know, bad, the police are gonna treat me differently from, from you because of the colour of your skin. It, you know, it shouldn't be that way, but that is something that I feel I need to say and we had a conversation about that. [00:13:42]	But it is about colour. Yeah. So, you know the micro Yeah. The microaggressions. The unconscious bias. Unconscious bias one is, um, an example that I have is when I was training to be a psychotherapist, I remember when we were finishing our training, they decided to do, um, or it might have been Christmas time mm-hmm,, but they were, they were, they thought, oh, we'll do some games and things. So we had to bring in our baby pictures and put them on this board and everyone had to guess who was the baby. Yeah. Which student was the baby?. Well, I was the only black student in the cohort, so I'm putting my picture up there thinking I'm already at a, a disadvantage because I'm the only black face there. So I just thought that is so, such an example of unconscious bias, you know? It wasn't done. [00:02:030]	then is currently facing a race-based trauma due to the way he's being treated at work by, um, raising an issue about being other than being treated differently as a black man. [00:05:01]	Yeah that's what it felt like and it felt like this white student attacked her really, um, for being angry, but it was obviously race-based. It was obviously because she was a black woman, and I don't think she'd have done that to a white tutor white female. [00:06:00]	it's tricky working with racism because it's likely that it's still happening [00:30:01

Five GETs with quotations selected for analysis

Illustrative quotes and sub- themes –

Group Experiential Themes (GET)	**Sub theme**	**Evidence from transcripts**	**Participant**
Navigating the uncharted: recognition, understanding, and addressing racial trauma in professional practice	**Sub A: Definition and operationalisation of racial trauma**	"…feeling like they are outsiders, having experienced rejection based on your colour… it is an ongoing sense of not being seen or heard or welcome and the impact that has on your sense of self, sense of identity, the impact of sense, um, and self-esteem." pg. 3 [00:02:00 - 00:03:12]	P3
		"…. it can be overt, but mostly, it's covert..... subversive… It's really difficult to name it, It's just more gaslighting and more punishing if you bring it up out loud" pg. 67 [00:06:01-00:17:14]	P2
		"…I see it as trauma that is synonymous with race …I have a client whom I see now who is being racially discriminated against at work, and as a result, they are depressed and anxious … experiencing the…, symptoms of post-traumatic stress	P5

		disorder coming from a trauma-based cause" pg. 1 [00:00:49-00: 01:37]	
		"Racial trauma is complex because in a way you could argue, according to the DSM5 and ICD11 manuals, the criterion A is not as straightforward as somebody had an accident or they were in a bomb or, but actually what we are arguing is the accumulation of microaggressions leads to equating to criterion A …" pg. 2 [00:00:36-00:03:51]	P1
		"… if you have 336 years of torture and abuse and a system of slavery, that's like no other in the world now, that damage is continuous...It's transgenerational and can lead to racial trauma" ... pg. 3 [00:01:41-00:03:16]	P6
	Sub b: Unrecognised racial trauma: the silent struggle and the 'elephant in	"…I've never even heard anybody consider ideas around racial trauma, and I've just experienced extreme discomfort from others when I bring it up..." pg.30 [00:54:57-00:55:35]	P2
		"It's not named …., I think that's mainly to do with discomfort and the avoidance	P8

	the room'	of discomfort," pg. 24 [00:37:57-00:38:50]	
		"…It is the unspoken It's almost like... I don't know, it's like a sensitive subject... and but I don't know It's like… it is very much like there's an elephant in the room… It's like, it's obvious but, but I don't know It's like" pg. 1 [00:01:05-00:03:51]	P4
		"…No, it's never talked about. It's never talked about. ... the elephant in the room is coming from a higher place, higher people ...."pg.23 [00:27:07-00:28:09]	P5
		"I've never heard that Race-based traumatic stress exists. Sounds awful, doesn't it? It's just not part of the training, it is not recognised" pg. 17 [00:42:31-00:45:11]	P7
	Sub C: Factors that contribute to clients' racial trauma.	"… racist attacks, racial ignorance, racist dismissal, microaggressions, both of those ones which are clear and those ones which can slip under our conscious radar so that they're not, seen. The accumulative effect of that is in a way	P8

		more toxic because it's less visible, so we can't manage it seriously." pg.1 [00:01:03-00:01:57]	
		"...those questions that you get asked from people. Where are you from? I'm from England…but where are your parents from? ...that's a microaggression, and we experience it on a day-to-day basis… experiences of walking into a space where people stare at you…, they're not staring at you because of what you're wearing. They're staring at you because of your colour…" pg. 2 [00:02:03-00:04:40]	P5
		"…within a context, so it's a symbiotic relationship rather than a one-way street... we've gotta be careful not to place the experience of racial trauma as residing within the individual, but to see it within a context... how you process your experience… how you are in the world,...dependent on your upbringing and what your perceptions, also dependent on how others we interpret social justice and so on and so	P1

		forth…"pg. 5 [00:09:01-00:09:50]	
		… "when people are experiencing racism, it's possibly in front of other people, verbal, or physical, so…..those people ignore, what's being said, or ignore that it's happened, so the person who is facing that or dealing with it feels probably confused…." pg.1 [00:01:38-00:03:06]	P7
		"…I think environmental factors, microaggressions, racist attacks, and social class…" pg. 2 [00:04:24-00:05:00] "… how do you communicate, and how do you respond to the abuse? Can you stand up for yourself? Can you blend in? … we know that somebody who can't speak English, for example, is likely to experience racial abuse because they can't communicate as opposed to somebody who can speak more fluently and eloquently and...if you're really dark-	P1

		skinned like I am, you're likely to face more discrimination than perhaps if you are lighter-skinned… colourism and shadeism, you know..." pg. 4 [00:05:12-00:08:47]	
	Sub D: The Black Lives Matter movement (BLM) and the impact of covid 19 (c-19) pandemic	"…C-19 and the BLM … brought awareness for me…. I think it just really increased awareness amongst White therapists to actually start thinking about racial trauma umm, start doing things, number of courses made available to therapists like myself…." pg. 6 [00:05:53-00:09:55]	P8
		"… when George Floyd was killed, we really tried to educate ourselves about racism, trauma ….and we started asking questions What are we doing?... Are we trying to be good white people...it certainly helped us to keep this issue of race and race-based trauma at the forefront of our work ... make us examine and change and do things differently..." pg. 21 [00:25:13-00:26:33] P3	P3
		"…within three months, it dropped	P6

		further, you know, CEOs got bored with it…" pg. 34 [00:33:31-00:33:59]	
		"…. People did lots of publicity on racial trauma, then within three months it dropped actually further, you know, CEOs got bored with it…" pg. [00:33:31-00:33:59]	P6
		"… I think people started having policies...they've got stuff on the website, but it clearly doesn't make any difference, it's not filtered down, people still don't talk about it..." pg. 12 [00:29:14-00:30:28]	P7
		"In our trust, when the George Floyd thing came, in my service, we started hearing about cultural competence training, diversity training for therapists..., I didn't know what make of it, why now, today… it was a sad reminder of our experience of racism, and so we created a space, people could come and talk about any experiences of racism, how they felt in the therapeutic space.	P5

		But before, then they were nothing, racism was not talked about." pg. 40 [00:48:02-00:50:35]	
		"…Black Lives Matter was like a watershed moment, and it's very important, NHS Trust started talking about what they're doing to embed anti-racist practices, for us, for me, it triggered painful reminders of painful memories and the reality of racial racism.., and several of our white colleagues said I am actually really affected by this; they feel terrible saying that because they're taking up space, and they feel like they shouldn't be crying about it, they were more able to actually even take some criticism...it just became a more honest space…"	P2

Illustrative quotes and sub- themes – GET

Group Experiential Themes (GET)	**Sub theme**	**Evidence from transcripts**	**Participant**
Navigating therapists' intersections of race, personal experiences, and professional practice in therapy	**Sub A: Empathy through shared experience**	"…I have experienced racism myself…" pg. 6 [00:05:15-00:07:21] "…I approach it with humility… Go there with humility, and I would be saying to the patient, I'm, know what you feel…, if you show humility and a willingness to learn, I always say to the patient, you are the one who's the expert on the problem." pg. 49 [59:32-1:00:35]	P5
		"…I have experienced racism myself…" pg. 6 [00:05:15-00:07:21] "…I approach it with humility… Go there with humility, and I would be saying to the patient, I'm, know what you feel…, if you show humility and a willingness to learn, I always say to the patient, you are the one	P1

		who's the expert on the problem." pg. 49 [59:32-1:00:35]	
		"As a white I can relate with discrimination, I faced discrimination myself, I feel like if I hadn't faced it I don't think I would I have learned about racism?,….my husband and I couldn't have children we wanted children and, , , the discrimination is that women like me who can't have children...it's a real grieving process, not spoken about… not recognised.. it feels as if as a woman I'm not important as mothers in society so reading about black women and their struggles kind of really helped me." pg. 14 [00:34:09-00:35:27]	P7
		"… I just said to her you are not alone It's real; I feel it too, I've seen it, I've experienced it… I'm not telling explicit stories about my experiences but validating their experiences…" pg. 55 [00:54:32-00:55:49]	P6

		"…They find me relatable because of the colour of my skin I mean, one particular patient often says to me, you must have gone through similar. I says, oh, yes and I will sometimes mention a few of my experiences and say this is normal for people like us…" pg. 15 [00:17:49-00:18:38]	P5
	Sub B: Empathy despite lack of personal experience	"…Hearing this black boy's experience with mental health service and with a schizophrenia diagnosis. I feel really quite upset talking about it, I remember just seeing him with his head in his hands; he was like, I just couldn't break out of ....(I) just tried to imagine being in that situation, it broke me." pg.16 [00:29:10-00:32:41]	P4
		"…I felt very sad, angry, ashamed when my client told me about being called N-word in the bar, I felt very angry that he'd been picked on…" pg. 6 [06:26-09:22] "…I'm incredibly fond of him because there's a vulnerability to him, I was just sort of… horrified that somebody would say something to his face in such a horrible	P3

		way, and maybe I was carrying the anger that he couldn't express…" pg. 8 [00:09:57-00:10:59]	
		"…I felt very sad, angry, ashamed when my client told me about being called N-word in the bar, I felt very angry that he'd been picked on…" pg. 6 [06:26-09:22] "…I'm incredibly fond of him because there's a vulnerability to him, I was just sort of… horrified that somebody would say something to his face in such a horrible way, and maybe I was carrying the anger that he couldn't express…" pg. 8 [00:09:57-00:10:59]	P8
	Sub C: The double-edged sword: the complexity of racial identity	"…Being black does not mean it makes it easier If anything, it makes it harder because you are experiencing what the patient is also experiencing, so there's a parallel process. So, you have to be very careful that you are not projecting, your experience into the patient's experience…" pg. 16 [00:29:42-00:31:11]	P1

		"… that If you're black, there are certain things that you are aware ... I having faced the same battle …" pg. 17 [00:31:34-00:32:58]	
		"..I had one patient today, and we were talking about unconscious bias, it can be a double-edged sword….it's tricky because we are sharing similar experiences, and its easy to get lost in your own experiences. So doing my therapy work on my own experience is key..." pg. 15 [00:17:49-00:18:38]	P5
		"…That's going to be very different for me as a black practitioner working with a black client, particularly, bringing racialised experiences. Still, even if a white client brings racialised experience, that is also going to be triggering for me in different ways, especially me being mixed race as well… it can be hard when you share similar experiences but again, it helps because I'm more likely to understand, able to provide specific support" pg.1 [00:00:00-00:05:32]	P2

	Sub-D: The consciousness of privilege	"I'm white, British, and I come from a rural white monoculture ...and so there's an awful lot of ground to cover, as it were…"pg. 25 [00:38:57-00:41:13] "I'm just noticing I'm using the word 'we' referring to my black clients, and I haven't suffered from racial trauma, so that's kind of intriguing." pg. 2 [00:02:11-00:03:55]	P8
		"I'm white, British, and I come from a rural white monoculture ...and so there's an awful lot of ground to cover, as it were…"pg. 25 [00:38:57-00:41:13] "I'm just noticing I'm using the word 'we' referring to my black clients, and I haven't suffered from racial trauma, so that's kind of intriguing." pg. 2 [00:02:11-00:03:55]	P4
		"… she said, I'm just sick of sitting in a room, being the only black person there, and I thought,, it is shocking to hear because I don't have to think about that I going, be the only white person there …. i	P3

		think well, I'd probably be one of a few men... It'll be mostly women, but it's not the same, you know; men have power and privilege…" pg. 30 [00:35:25-00:36:37]	
		"… she said, I'm just sick of sitting in a room, being the only black person there, and I thought,, it is shocking to hear because I don't have to think about that I going, be the only white person there …. i think well, I'd probably be one of a few men... It'll be mostly women, but it's not the same, you know; men have power and privilege…" pg. 30 [00:35:25-00:36:37]	P7

Illustrative quotes and sub- themes –

Group Experiential Themes (GET)	**Sub theme**	**Evidence from transcripts**	**Participant**
It's not my place to bring it up	**Sub A: Fear of misunderstanding and causing harm**	"I think from a white person's point of view.... people are really afraid of being called racist... if I was called racist don't know how I'd feel… there are a lot of deep-rooted unspoken feelings" pg. 12 [00:30:28-00:33:09]	P7
		"I was a bit frozen ...finding it difficult, and I think I didn't have the confidence in myself around racism… this was deeply uncomfortable" pg. 8 [00:10:20-00:13:09]	P8
		"… I was worried about getting it wrong…I think there's a lot of guilt and fear on white people's part, but it's not talked about, and I think that's what makes it continue, really" pg.7 [00:06:26-00:09:22]	P3
		"it is sensitive, isn't it? …it felt like it's not my place to bring it up, but then I thought,	P7

		I've got to bring it up because it's here and it felt like my client had faced a lot of racism, but the word was never being said" pg. 8 [00:18:32-00:22:24]	
	Sub B: Unintentional minimisation of clients' racial experiences	"…And with my black female client, she is a manager of a big company….I don't know if it's my resistance, she's got this great life. She's got loads of friends,…I don't know, I felt, do I bring in this?..." pg. 5 [00:11:41-00:12:12]	P7
		:"… I don't know if it's me not wanting to go there or if it's him not wanting to go there, he did tell me about one experience he had in a bar one night where somebody …called him the N-word to his face, and that was shocking to me, but he kind of dismissed it and said, oh, well, it doesn't matter…, and we didn't get very far with that…, but he's got a good life now" pg. 6 [00:06:26-00:09:22]	P3

		"…She wanted to talk about her work; She wants to talk about her boyfriend not much about her racism incidents, on both cases… so maybe I told myself I don't have to do anything because she's not bringing it in, we can talk other things.. she has a good job...," pg. 5 [00:05:53-00:09:55]	P8
	Sub C: Professional self-doubt and personal anxiety about discussing racism	"I was nervous about bringing it up, actually, because I don't know; it is just that feeling of? What if I bring this up and she doesn't? …she was talking about her work experience, and I remember thinking this is racist, this is racism and thinking, should I say? Should I point this out? Should I say this to her?" pg. 60 [00:12:30-00:15:09]	P7
		"I was nervous about bringing it up, actually, because I don't know; it is just that feeling of? What if I bring this up and she doesn't? …she was talking about her work experience, and I remember thinking this is racist, this is racism and thinking,	P3

		should I say? Should I point this out? Should I say this to her?" pg. 60 [00:12:30-00:15:09]	
		"…if I imagine myself to be a black client, I would imagine that my starting assumption would be that a white therapist wouldn't know what they were doing frankly, and so I would seek a therapist of colour. I felt I was not good enough capable to helping the Black clients, I was anxious with my first black client". pg4, [00:04:21-00:05:46]	P8
		"…There was something about am I crossing a line and asking him to look at something he doesn't want to look at, something that he might be uncomfortable with… I didn't feel I had the right to press him on something he might feel not comfortable with" pg. 10 [00:13:04-00:14:05]	P3

		"…There was something about am I crossing a line and asking him to look at something he doesn't want to look at, something that he might be uncomfortable with… I didn't feel I had the right to press him on something he might feel not comfortable with" pg. 10 [00:13:04-00:14:05]	P5
	Sub D: Discomfort: different vessels weathering the same tempest	"…I did say something like, could this be racism? and she said, yes, I suppose so, I think so; yes, it is.. it was almost like she didn't want to bring it up or don't know either, almost like we were both not sure…" pg. 6 [00:12:30-00:15:09]	P7
		"…When he was saying, oh, look, it happens all the time, could be anywhere in shops, you know, work, it doesn't matter, he kind of dismissed it and said it doesn't matter and then I thought, am I making something of this… do I press him on this point if he doesn't want to talk about it…" pg. 10 [00:11:14-00:12:38]	P3

		"…I don't know if its me not wanting to go there or if it's him not wanting to go..." pg. 6 [00:06:26-00:09:22]	
		"…I don't know if it was her resistance or my resistance or I didn't know what to do with this, or she doesn't know what to do with it, but we didn't follow it up that much …because she says, it just happens, it's no big deal, so we both dismissed the topic..." pg. 5 [00:05:53-00:09:55]	P8
		"so I thought, maybe he just doesn't want to talk about this…. maybe I'm behaving like I'm some kind of white saviour. I'm saying, no, we must talk about it, I, we need to talk about this, and it's a big issue for you and, … I thought, is this my place? to do this?" pg.12 [00:14:24-00:15:19]	P3
	Sub E: The role of therapy in unmasking the	"…what I have found is that clients don't admit to it straight away, they just see it as something bad happened to me...but when we talk about it further...she realised this thing called racism which she didn't	P5

	unconscious racial experiences	recognise growing up as a child." pg. 14 [00:16:05-00:17:32]	
		"…he woke up to the word 'nigger' carved on his dormitory door, he sees it was just boys being silly...he didn't see racism as a thing…, like very dismissive, but through questioning, he came to realise it was racism..." pg. 12 [00:18:51-00:24:17]	P2
		"…She would like, but why would you think about that I'm the only black person in the room or neighbourhood? because if I don't think about it, then it doesn't bother me..." pg.7 [00:06:01-00:17:14]	P2
	Sub F: Feel the discomfort and do it anyway	"…I was worried that she might prefer a black therapist... I did it anyway, …my supervisor really encouraged me to stay with her, and he said, it's the relationship…" pg.10 [00:25:06-00:27:13]	P7
		"…I felt a lot of discomforts, but I mean, I did speak to the child anyway, …. it was very, very discomforting, and it still is...but	P4

		there's nothing wrong with that, you know when things are real, that's how they are…." pg. 6 [00:11:17-00:13:23]	
		"…There are times when I feel ashamed…, and there are times I feel dysregulated...being taught that it's not wrong to feel deeply uncomfortable...." pg. 13 [00:17:58-00:19:19]	P8
		"… it gets very murky here, ethically because they don't want to go there, I don't have to go there, …I have to respect on my client's worldview, I don't wanna cause a re-traumatise, but when you can see how their worldview has been distorted by racism and oppression, gaslighting, even though you want to take on their view, you also have an ethical duty to name abuse, it's not your job to make it easier for them to stay abused…." pg. 8 [00:06:01-00:17:14] "…Most clients don't want to	P2

		acknowledge their racism experience, so it's also become a situation where it's difficult and uncomfortable for me to even fully put myself in their position…" pg. 9 [00:06:01-00:17:14]	
		"… I'm not necessarily saying that it was easy for me,… I often name the elephant in the room ...I'm a black therapist and they're black clients and we can't just ignore that cuz that's, that's before us, it not easy, but if we're to be blind that or not pay attention to that is unethical…" pg. 13 [00:24:21-00:28:57]	P1

Illustrative quotes and sub- themes –

Group Experiential Themes (GET)	**Sub theme**	**Evidence from transcripts**	**Participant**
Inadequacy of the systemic response to racial trauma in education and mental health services	**Sub A : Lack of relevant training**	…"I think there's a lack of training which supports practitioners to actually drop down and be able to tolerate the discomfort of addressing racism... my sense is that racial trauma is taught as an informational process rather than as a relational and embodied process...practitioners and systems of the NHS are not in a position to come close..." pg. 23 [00:36:20-00:37:12]	P8
		"...I don't even remember racial trauma being mentioned at all in my training course...it wasn't even addressed on any of the courses...I've never heard...about racial trauma..." pg. 17 [00:42:31-00:45:11]	P7
		"… we had one lecture of diversity, nothing about racism... training in the education sector is necessary, not just on the surface level of Equality, diversity and inclusion. What we're doing is we're	P5

		applying euro-centric techniques to culturally diverse communities…" pg. 43 [00:51:07-00:52:06]	
		"…If training was up today...we wouldn't still be...over-pathologising black people...if we understood the culture a little bit more... they wouldn't then assume that because I'm assertive, then I'm aggressive and equally, that doesn't mean I'm schizophrenic, I'm just expressing myself…." pg. 44 [00:52:09-00:52:39]	P5
		… "Certainly not the university training I got; …I don't feel equipped … diversity training is a joke I'm sitting there like…Why are we having two lectures on diversity and inclusion, only two in two years…It's fucking ridiculous…, I brought this up, and I was told, shamelessly in front of the whole class, we don't focus on any one group" pg. 27 [00:48:30-00:49:55]	P2
		"…No other global perspectives in training taken into consideration or even other different ways that people are developing, like, you know, this Afrocentric in terms of	P6

		psychology, there are all sorts of disciplines that are … completely not referred to at all in training, its only one size fit only …very Eurocentric of mental health training programs…" pg. 49 [00:48:25-00:48:47]	
		"I…t was pretty limited on training … in my university training, we did a little module on, uh, cultural differences and religious differences …, nothing on racism…" pg. 44 [00:57:34-00:58:25]	P3
		"I…t was pretty limited on training … in my university training, we did a little module on, uh, cultural differences and religious differences …, nothing on racism…" pg. 44 [00:57:34-00:58:25]	P1
	Sub B: Recommendations for educators	"…We definitely need training… to raise awareness, training that could put something about, why people are frightened to talk about racism? And ask questions such as How do you feel about talking about racism?" pg. 17 [00:40:44-00:42:11]	P7
		"…I think what education and training	P5

		need to go right back to grassroots and to talk about the experience of black people and where they're coming from so that they can understand what's going on up here… needs more than just one hour of lecture…" pg. 46 [00:55:21-00:57:30]	
		"I think there needs to be a specific and explicit exploration of relationship, racism and race, I think that that's imperative, learning how to talk about it and how to say it out loud and how to cope with the unexpected emotions that will come up for people of colour and for white people to learn to deal with discomfort" pg.33 [00:58:59-1:01:25]	P2
		"… I think training that allows thinking as a group of people who are really willing to go there, regulate our nervous systems, sit with a deep discomfort of our own racism and to really pay attention to what happens when we talk about these things, what happens when we get challenged"pg. 28 [00:42:00-00:43:33]	P8

		"…I found specifically helpful is working with a small group of people through...actually doing the exercises… not just reading... that's been something that I would wish was part of every training" pg. 46 [00:59:25-1:00:10]	P3
	Sub C: Mental health services possibly perpetuating racial trauma	"…there is silence around racism and race in mental health services … is Just a, a re-traumatization… It's a repetition of gaslighting… part of the conversation is being left out ... I think that is harmful…" pg. 27 [00:45:51-00:48:16]	P2
		"…a lot of young black guys…, most these boys fell out of school, and people supporting these boys found that they couldn't contain the boys' anger and, then that's when they got diagnosed with, schizophrenia, or that kind of similar diagnosis and then stuck on this terrible cycle…" pg. 16 [00:29:10-00:32:41]	P4

		"… The mental health system doesn't reflect black people's experience... and I think black people think I'm not coming back, the advertising is for white people ...it's not for me… it backs up your feeling of being othered or not considered or not being worthwhile …"pg. 44 [00:43:41-00:43:53] "…I don't think they've got the tools or the equipment or the knowledge to kindly even ask those questions, How do we make sure that real black minds matter?..." pg. 34 [00:33:31-00:33:59]	P6
		"…my own experience with the NHS has been at times overtly racist… never in a single one of those contexts has the factor of race or racial trauma been mentioned...when I have brought it up, I have been met with, ranging from discomfort and surprise and not really knowing what to do to outright hostility to where I've had to leave...literally being told this is not the place for that, that is very traumatic…"pg.29 [00:50:18-	P2

		00:52:15]	
		"…my own experience with the NHS has been at times overtly racist… never in a single one of those contexts has the factor of race or racial trauma been mentioned...when I have brought it up, I have been met with, ranging from discomfort and surprise and not really knowing what to do to outright hostility to where I've had to leave...literally being told this is not the place for that, that is very traumatic…"pg.29 [00:50:18-00:52:15]	P3
		"I think mental health services can …make it worse, … the NHS seem to have this view that Black women are like strong and can withstand anything, my nan experienced very poor mental health, and she did not speak English… She just needed HRT because she was going through menopause; we can see that now;	P5

		she was treated like she was a crazy old black lady…" pg. 37 [00:43:02-00:44:56]	
		"…Sometimes they're not moving with the lived experience of the time of the clients…" pg. 19 [00:34:08-00:37:02] " …If they deny the lived experience of one, (1) if there's a lack of support and relationship (2) if we do not engage and encounter and we use processes such as the forms, such as treatment plans, such as care plans in a way that is to do with power over rather than power with, that's problematic and perpetuates the trauma, If we do not understand what racial trauma is, how are we ever going to work with it… " pg. 24 [00:44:19-00:45:24]	P1

Illustrative quotes and sub- themes –

Group Experiential themes (GET)	**Sub theme**	**Evidence from transcripts**	**Participant**
Navigating racial dynamics in professional spaces: the interplay of supervision, self-care, and racial trauma	**Sub A: Supervision**	"… no disrespect to my supervisors; they are all fantastic, and they're all white. I guess I feel supported to a certain extent, but I do not feel fully supported...I don't think I've approached supervision around any race-based stuff…" pg. 51 [01:01:07-01:01:27] "…I don't talk about it because I don't wanna feel uncomfortable making them feel uncomfortable..., I sort of have an external Black supervisor…" pg. 53 [01:02:35-01:03:37]	P5
		"…my supervisor … he's Jewish actually…he does understand racism... in a way, it feels as if, it's not that it's not important... I don't think we talk about racism, which is strange thinking about it, I suppose, to be honest… I still tiptoe	P7

		around it a little, even with my supervisor…" pg. 20 [00:48:18-00:52:49]	
		"…I've got two white supervisors;… they have done lots of work with young black men, … I feel when I'm coming to those conversations in supervision, I'm exploring stuff, getting the support to explore a little bit more about what's going on for me, but I also think I'm actually bringing quite a lot of skills to that supervisory, relationship..." pg. 50 [00:49:49-00:50:45]	P6
		"… It felt really important that we had a black woman supervisor, we can really bring those things about race, she's really open about her own experiences of racism and classism. So, you know, she's really good at being able to help us to form conversations…" pg. 52 [01:06:11-01:07:53]	P3
		" ...I have a very good supervisor we work through all kind of stuff, I have a black	P2

		supervisor that was very important to me, she understands these issues, I can be open….” pg. 5 [00:06:01- 00:17:14]	
	Sub B: Self-care and coping strategies	“…I always do something between clients … I just go back to kind of processing stuff through my materials... I try to really connect with the body systems… I’ll go out and get some fresh air, ride my bike…" pg. 53 [00:52:51-00:53:56]	P6
		“I do maintain weekly personal therapy in addition to my supervision,… for me is necessary, with the level of work that I’m doing” pg. 20 [00:48:18 -00:52:49]	P7
		“…I think the most important is to do work ourselves, our own trauma, so racial trauma is no different …. If you haven’t done the work yourself, you’re not safe to work with this kind of trauma. and I feel that quite strongly, ... I’ve built a strong community…” pg. 21 [00:36:47-00:39:37]	P2

		"…search within yourself, doing that work, looking at what was that experience...? looking at prejudices I have on others,…work is to continue to peel those layers so that I don't, or I do my best not to project on my clients when I do so, I face it, in my own therapy…" pg. 16 [00:29:42-00:31:11]	

Part of Appendix K: Table of group experiential themes and frequency

Master table of Group Experiential Themes and Frequency

Sub Themes / Participants	P1	P2	P3	P4	P5	P6	P7	P8
GET 1: Navigating the Uncharted: Recognition, Understanding, and Addressing Racial Trauma in Professional Practice								
***Sub A*:** Definition and Operationalisation of Racial Trauma	✓	✓	✓		✓	✓		
***Sub B*:** Unrecognised Racial Trauma: The Silent Struggle and the Elephant in the Room		✓		✓	✓	✓	✓	
***Sub C*:** Factors that Contribute to Clients' racial trauma.	✓		✓		✓	✓	✓	
***Sub D*:** The Black Lives Matter movement (BLM) and covid 19 (C-19)		✓			✓	✓	✓	✓
GET 2: Navigating therapists' Intersections of Race, Personal Experiences, and Professional Practice in Therapy								
***Sub A*:** Empathy Through Shared Experience	✓	✓			✓	✓	✓	
***Sub B*:** Empathy Despite Lack of Personal Experience			✓	✓				✓
***Sub C*:** The Double-Edged Sword: The Complexity of Racial Identity	✓	✓			✓	✓		
***Sub-D*:** The consciousness of Privilege			✓	✓			✓	✓
GET 3: It's not my place to bring it up								
***Sub A*:** Fear of Misunderstanding and Causing Harm			✓	✓			✓	✓
***Sub B*:** Unintentional minimisation of clients' racial experiences			✓				✓	✓
***Sub C*:** Professional self-doubt and Personal anxiety about discussing racism		✓	✓				✓	✓
***Sub D*:** Discomfort: Different vessels weathering the same tempest		✓	✓				✓	✓
***Sub E*:** The Role of Therapy in Unmasking the unconscious racial experiences		✓			✓			
***Sub F*:** Feel the Discomfort and Do it Anyway	✓	✓	✓	✓			✓	✓
GET 4: Inadequacy of the Systemic Response to Racial Trauma in Education and Mental Health Services								
***Sub A*:** Lack of Relevant Training	✓	✓	✓		✓	✓	✓	✓
***Sub B*:** Recommendations for educators		✓	✓		✓		✓	✓
***Sub C*:** Mental health services possibly perpetuating racial trauma	✓	✓	✓	✓	✓	✓		
GET 5: Navigating Racial Dynamics in Professional Spaces: The Interplay of Supervision, Self-Care, and Racial Trauma								
***Sub A*:** Supervision		✓	✓		✓	✓	✓	
***Sub B*:** Self-Care and Coping Strategies	✓	✓				✓	✓	

Appendix L: journal extract

Journal Extract:

Today, I had an unsettling and intriguing thought whilst listening to my research participants' interviews: I wondered if I am a wounded researcher (Romanyshyn, 2021) As I explore my research topic of Race-Based Traumatic Stress, I cannot help but feel like I am uncovering fragments of my own life story and those of my participants. The more I delve into this topic, the more I find echoes of my experiences within its pages. Although the emotional weight is heavy, I find a sense of authenticity and strength.

I have experienced racism in subtle ways and countless manifestations of prejudice. Sadly, this is a harsh reality of my experience coming from a historically disadvantaged background. I can see how prevalent these experiences are as I examine the data. This raises the question: Does my personal experience with the subject negatively taint my analysis or make it more valuable?

As a researcher, I understand that I am expected to maintain some level of impartiality, yet, I cannot disregard the wounds I carry from my own experiences and the impact that racism has had on my research and, to some extent, my worldview. However, I also recognise the value that arises from being a wounded researcher. My journey grants me a unique lens through which I perceive my topic.

In my vulnerability lies a resilient strength, an intensity that stems from my ability to connect and empathise with the research participants. Drawing from my racist encounters enables me to comprehend better and contextualise the experiences of others, making my research more meaningful. Through this connection, I feel compelled to shed light on my participants and clients' experiences, advocate for change and challenge the status quo by raising awareness about Race-Based Traumatic Stress.

Upon reflection, I realise that being a wounded researcher is not indicative of weakness but rather a testament to the resilience that can arise from personal experience. This perspective allows me to empathise more profoundly with my participants, see the world through their unique perspectives, connect with the data more deeply, and present it meaningfully and impactfully. Despite the emotionally challenging journey, I can see a glimmer of hope. The wounds that once held me back have now become my strengths. What I initially regarded as a liability has emerged as a source of strength. I now understand that my research project encompasses more than an academic pursuit – it embarks upon a personal journey towards healing. Today proved to be emotionally demanding but also a day of self-discovery.

Appendix M: Emails from participants

Hi Nomsa,

I just wanted to thank you for yesterday's conversation. it raised so many useful and interesting aspects of working with racial trauma, I will be sharing what we discussed with my local team; our discussion made me realise I need to be more culturally aware. I await your findings with anticipation!

Thank you for making me self-reflect.
XXXX

Hello Nomsa››
"Thank you for allowing me to be part of your research project… I didn't actually think I would have much to say.
I realised afterwards that I should have said I grew up in an openly racist family, and this was something I explored extensively in therapy for this reason, I know that racism is rooted in my thinking and being and have no problem with raising my awareness. I also make mistakes around racism in my counselling and in life and will admit this openly, although I see this as a general approach and not specific to racism. I can easily forget things or misread someone's facial expression, too.
The training I have done (cultural humility) (white privilege circles).
I hope your research and writing up goes well."

Hi Nomsa
"I just wanted to let you know our conversation gave me the confidence to discuss the topic of race frankly with my client. It was an emotional and very important conversation for my client. She seemed shocked but shared quite a lot, I had not realised all this time what it meant for her. It has made me realise it is a much-ignored topic because of the fear of not knowing what to say. I will bring up these issues more in supervision and with peers.
Please share your research once completed".
Thank you
XXXX

Appendix N: Table of Selected Studies

Author(s)	Year of Publication	Title	Study Design	Key Findings	Relevance to Research Question
Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C.	2018	Assessing racial trauma within a DSM–5 framework: The UConn Racial/Ethnic Stress & Trauma Survey.	Correlational	The introduces the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS), a clinician-administered interview designed to assist clinicians in asking clients sensitive questions about race and racism for culturally informed assessment and treatment.	The survey is highly relevant to investigating therapists' experiences with Black clients dealing with race-based traumatic stress. It offers a foundational framework for understanding racial trauma which is crucial for therapists aiming to recognise and treat such trauma.
Hemmings & Evans'	2018	Identifying and treating race-based trauma in counseling	Quantitative	The study involved 106 counseling professionals who completed the Race-Based Trauma Survey for Counselors. Key findings highlighted that although a significant proportion of participants reported working with clients experiencing symptoms associated with race-based trauma, many lacked formal training in identifying and treating such trauma among individuals of colour	This study is relevant to my research question as it sheds light on the experiences of therapists when working with Black clients who present with race-based traumatic stress. The findings emphasise the challenges therapists face, including a lack of adequate training and the need for improved competencies in addressing race-based trauma.
King, S. O.	2021	Experiences of NHS	Qualitative	The findings revealed that	King's study provides a contextually rich

		Psychologists exploring racial trauma with service users from Black and Asian racialised communities.		mental health services often underestimate the experience of racial trauma, leading to its impact on mental health being frequently overlooked or omitted from discussions with service users and among colleagues.	background that aligns with my research study.
Carter, R. T., Mazzula, S., Victoria, R., Vazquez, R., Hall, S., Smith, S. & Williams, B.	2013	Initial Development of the Race-Based Traumatic Stress Symptom Scale: Assessing the Emotional Impact of Racism	Quantitative (self-reported)	Developed and evaluated a new scale designed to assess psychological and emotional stress reactions to racism and racial discrimination.	The findings align with symptom clusters associated with race-based traumatic stress, adding a significant tool for counseling assessment to gauge emotional reactions to racism and racial discrimination, and discussing implications for counseling and future research.
Malott & Schaefle	2015	Addressing Clients' Experiences of Racism: A Model for Clinical Practice	synthesized literature was based on quantitative findings	Developed a four-stage model designed to guide clinicians in effectively addressing their clients' experiences with racism.	This study provides a structured model for therapists on addressing racism in clinical practice. This model enhances understanding of how therapists can navigate discussions on race-based traumatic stress with Black clients, integrating considerations of racial and ethnic identity into therapy. It offers practical insights into the therapeutic process, focusing on culturally sensitive interventions and coping strategies, which are essential for therapists working with

					clients affected by race-based trauma.
Carter, R. T.	2007	Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress	Conceptual research	Highlights the psychological and emotional injuries caused by racism, advocating for the integration of models from psychology research on racism, stress, and trauma. It emphasizes recognizing and assessing race-based traumatic stress and underscores the importance of developing specific assessment tools for clinical practice to address the unique impacts of racism.	It provides a foundational understanding of the emotional and psychological effects of racism, which is crucial for therapists aiming to provide effective, empathetic, and culturally competent care to clients dealing with race-based traumatic stress.