Experiences of NHS Psychologists exploring racial trauma with service users from Black and Asian racialised communities

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A thesis submitted for the degree of Doctorate in Clinical Psychology

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June 2021

Acknowledgements

As always, my greatest thanks and praise goes to God. “I can do all things through Christ who gives me strength”- Philippians 4:13.

To the psychologists who so generously gave up their time to participate in this study, during a global pandemic no less. Thank you for your honesty, bravery, and perseverance to stay with such a difficult but essential conversation. I hope I have done justice to your experiences and hopes for change.

To my supervisors Dr Lisa Wood and Dr Mary Kennedy. Thank you for helping me to bring my calling in this profession to life and for encouraging me to immerse myself unapologetically in this research. My passion for research lives on because of you both.

I would also like to thank my colleagues in the 2018 cohort, including those who have become friends for life. To the future Dr Lola Olukotun, Dr Emma Harlow, and Dr Megan Kerr- we did it!

With special thanks to Dr Colin King, Dr Rhiannon Quann, and Dr Anne Coxon, who provided consultation during the design and analysis stages of the study. Thank you also to my mentor Dr Drusilla Joseph and to all my clinical supervisors across training, for providing a safe space for me to reflect and make sense of my own experiences throughout this process.

To my dear friends and family, thank you for seeing me through another degree. Your belief in me has never faltered and I am indebted to you all. Thank you for ensuring I took some downtime when I needed to. To my phenomenal sisters Hannah, Simi, and Keisha, words will never be enough. This would not have been possible without your daily reminders of my strength and capability.

And to my sisters, the future Dr Nifemi Ajala, Dr Ruth Mintah, and Dr Kassmin Tong; we earned our seat at this table, and we are here to stay.

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“Change will not come if we wait for some other person or some other time. We are the ones we’ve been waiting for. We are the change that we seek”

– Barack Obama

Abstract

Background: Research indicates that the appraisal of racist experiences is related to psychological distress and trauma. These conclusions have largely been drawn from correlational quantitative data conducted in the US. There is a notable dearth of literature in the UK, including qualitative research into how these experiences are explored within psychological services.

Methodology: A critical realist qualitative research paradigm was used to explore the experiences of 13 qualified psychologists. Participants were all employed by North East London NHS Foundation Trust, working across psychological services in the 4 London boroughs of Barking and Dagenham, Havering, Redbridge, and Waltham Forest. Semi-structured interviews were conducted virtually via Zoom and analysed using reflexive thematic analysis.

Results: Findings suggest that mental health services underestimate the experience of racial trauma, and as a result the impact of racism on mental health is often omitted from discussions with service users and colleagues. The psychologists interviewed reflected upon how they might adapt their clinical skills to work with individuals and communities experiencing racial trauma and highlighted how important it is to identify and name racism within services and in wider society. This was considered good practice, in order to ensure service users know that their racialised experiences, many of which are often subtle and hard to detect and prove, are seen and heard. Participants recognised that British society is structured in ways which often disadvantage Black and Asian racialised communities, and that as psychologists they possess a level of power that can and should be used to advocate for better experiences and outcomes within mental health services.

Conclusion: This study interrogates the accountability of psychological practitioners, but more importantly moves beyond this to critically examine the institutional structures which maintain the oppression of racialised communities, thus perpetuating racial trauma on a generational scale.

Chapter One: Introduction

Chapter Overview

This chapter serves to orient the reader to the topic of the current research. Firstly, a rationale will be presented for the current research, including contextual setting of the phenomenon under investigation and how this presents in UK practice and policy. This is followed by a clear statement of the research question and aims. Next, a critical discussion of key racial terminology will be provided, embedded within historical, social, and political structures. This will lead onto an exploration of both historical and contemporary racism on a global and localised scale. The line of argument within this chapter will be supported by psychological theory and contextualised using contemporary literature, policy, and legislation.

Rationale for Current Research

Contemporary Racism in the UK

Recent conclusions from a highly anticipated government report failed to identify and condemn institutional racism within the UK (Commission on Race and Ethnic Disparities, 2021). However, there remains evidence of racialised subjugation which posits a question as to whether modern-day racism represents anything other than a progression of different forms of racism. Sue and colleagues introduced the term racial microaggressions to describe the *"brief and commonplace daily verbal, behaviour, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults"* experienced by individuals from racialised communities (Sue et al., 2007, p.271). Unlike more overt and legally criminalised acts of racism, microaggressions often go unnoticed by those they do not impact, and as such, are harder to obtain justice for (Sue et al., 2019; Sue, 2010). Statistics suggest that recorded racially aggravated hate crimes in the UK have previously been exacerbated during racially politicised events. Most recently, this includes the EU referendum in 2016, the terrorist attacks of 2017, and the amplification of the Black Lives Matter (BLM) movement in 2020 following the murder of George Floyd in the US (Allen et al., 2020; Home Office, 2020). Moreover, the “hostile environment” introduced by the Conservative government in 2012, designed to deter asylum seekers from obtaining the means to stay in the UK, has been described as a way of criminalising people, predominantly those from racialised communities, for the act of fleeing persecution and seeking safety (Bowling & Westenra, 2020).

Racial disparities consistently disadvantage racialised communities, evident across the life span and within prominent domains, such as physical healthcare (Hackett et al., 2020; Khan, 2021; Otu et al., 2020), mental healthcare (Department of Health & Social Care [DHSC], 2018, 2021b; Halvorsrud et al., 2019), education (Joseph-Salisbury, 2020; Roberts & Bolton, 2020; Department for Education, 2021a, 2021b), employment (Chartered Institute of Personnel and Development [CIPD], 2017; Office for National Statistics [ONS], 2020), housing (Ministry of Housing, Communities and Local Government, 2019, 2020), social care (Skills for Care, 2020; Smith, 2020), and the criminal justice system (Home Office, 2020; Ministry of Justice, 2017; Ministry of Justice & Race Disparity Unit, 2020; Race Disparity Unit, 2021a). The culmination of these findings suggests that racism remains a public health concern in the UK and warrants further research attention.

Racial Policy Development in the UK

Societal understandings of racism develop across time, reflected in advancements in legislation and political attention. The invitation from Britain to members of Commonwealth countries in 1948 to help rebuild the economy following the Second World War represented a turning point in British history, as a time when racial tensions became exacerbated (Korte &

Pirker, 2011; Taylor, 2018). The prohibition of racial discrimination first passed legislation in the UK, with the Race Relations Act 1965 banning *"hatred on the grounds of colour, race, or ethnic or national origin"* (chapter 73). This was revised in 1968 to include unlawful acts of discrimination within employment, housing, and advertising (Race Relations Act, 1968, chapter 71), further in 1976 to include indirect discrimination (Race Relations Act, 1976), and finally in 2000 to include a responsibility for public authorities, such as the Police, to promote racial equality (Race Relations Amendment Act, 2000). Finally, the Equality Act 2010 superseded the Act, favouring a singular legislative piece, which incorporated nine protected characteristics, including race. This evolution illustrates a shift from understanding racism strictly in direct interpersonal forms, to broader ideas of institutional, systemic, transgenerational, and internalised racism.

Attempts to address racial disparities and improve mental health care for Black and Asian racialised communities in the UK have frequented policy initiatives over the past two decades. Most notably, following the independent inquiry into the death of a Black man, David "Rocky" Bennett, during physical restraint by staff in a medium secure unit (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003). This was the first inquiry to suggest the presence of institutional racism in the National Health Service (NHS). Subsequent policies have endeavoured to eradicate racial inequalities in mental health care, for example, the Delivering Race Equality strategy (Department of Health [DoH], 2005), the Race Equality Action Plan: Five Year Review (DoH, 2010), the Five Year Forward View for Mental Health (Independent Mental Health Taskforce, 2016), and the NHS Long Term Plan (NHS, 2019).

Most recently, in response to Professor Sir Simon Wessely's independent review of the Mental Health Act 1983, the DHSC published a White paper in January 2021 outlining proposed reforms to the Act (DHSC, 2021b). The White Paper specifically sought to investigate further the disparities in the use of the Act against people from Black and Asian racialised backgrounds. These developments have contributed to what is being termed as *"the most ambitious programme to transform mental health care that England has ever known"* (DHSC, 2021b, p.4). Proposed reforms in the paper include: the development of culturally appropriate advocacy, funding for further research into racial disparities in mental health care, a more diverse and representative workforce, improving ambulance provision and reducing police involvement in mental health emergencies, decreasing the duration of detention under the Act, and the introduction of Patient and Carer Race Equality Framework (PCREF). The PCREF represents a new co-production initiative between NHS mental health trusts, local authorities, service users, carers, and the wider public, to shape and reform organisational competency frameworks in the NHS. At the time of writing this thesis, consultation and testing are currently being piloted across four NHS trusts in East London, South London, Birmingham, and Manchester, aiming for national rollout in 2022, subject to preliminary findings. The culmination of policy developments in the UK presents a unique and timely opportunity for mental health services to improve services for racialised communities.

Problem Statement

Working with trauma has long been at the core of the psychological profession. Clinical guidelines focus largely on diagnosis and are sub-categorised by facets of identity, such as age or cognitive ability. However, rarely is this holistically adapted to account for the nuanced experiences of individuals for whom trauma is compounded by their racial identity. When contextualised within the history of the British empire and the consistent overrepresentation of Black and Asian racialised communities in positions of adversity to the present day, racial trauma can and should be understood as a public health concern in the UK.

Researchers working at the forefront of the emerging evidence base for racial trauma in the US have called for advancements across wider contexts (Comas-Díaz et al., 2019), including specific calls for qualitative research to build upon the expanding quantitative literature base (Sibrava et al., 2019). Despite the fact that Black and Asian racialised groups are statistically diagnosed with trauma-related difficulties at a disproportionately higher rate than their White counterparts, their experiences and outcomes consistently fall below the standards of care upon which the NHS is founded. In order to strengthen the evidence base in the UK, it is necessary to understand how racial trauma is currently understood and addressed by those working at the forefront of psychological trauma. As Bignall et al. (2020) concluded in the recently published Race Equality Foundation paper, "*Black and ethnic minority people are over researched and under resourced"* (p.47). The current research seeks to critically examine the provision of psychological services, to explore how these disparities are currently addressed within psychological services and make recommendations for meaningful change.

Research Question & Aims

The current research aims to answer the following question:

- How do NHS psychologists understand the term racial trauma and explore this within their clinical work with service users from Black and Asian racialised communities?

The following aims will be addressed:

- To explore NHS psychologists' understanding of racial trauma.
- To explore the experiences of psychologists working with service users from Black and Asian racialised communities.
- To develop an understanding of the barriers and facilitators perceived by psychologists in exploring racial trauma with service users from Black and Asian racialised communities.

A Chronological History of Race

It is important to consult relevant theory and literature concerning biology, psychology, sociology, anthropology, and history, as fields where racial terminology has been comprehensively explored and debated. For the purpose of this thesis, the exploration of race is prioritised, as a construct which, largely owing to the physicality of differences in skin colour, has been prominent in the perpetuation of discrimination and oppression. The researcher acknowledges that ethnicity and culture are important in contextualising the literature and these terms will be referred to where necessary. Nevertheless, it is upon the foundations of race as a construct characterised by physical, prominent, and unchangeable features which is deemed to perpetuate inequalities related to the current research, as opposed to the dynamic nature of ethnicity and culture.

Table 1
Overview of race, culture, and ethnicity

Term	Characterised by	Perceived as	Assumed to be	In reality
Race	Physical appearance	Physical, permanent	Genetically determined	Socially constructed
Culture	Behaviour, attitudes, etc	Sociable, changeable	Passed down by parents/ parent substitutes	Variable and changeable, blueprint for living
Ethnicity	Sense of belonging	Psychosocial, partially changeable	How people see themselves in terms of background and parentage	Culture-race mixture

Adapted from (Fernando, 2010, p.8)- Mental health, race and culture

Conceptualisations of race have evolved across time and place since the 16th century and continue to adjust with that of social and political climates. To truly understand the complexities and intricacies of the term, it is necessary to draw upon multiple domains and theories, including that of positivism and social constructionism. These are contextualised by key historical developments which have shaped the ontological understandings of the modern day across time and place. Whilst beyond the scope of this thesis to become fully immersed in this historical debate, particular attention will be paid to the *"very real effects [of racism] politically, socially, and economically"* (Templeton, 2013, p.262), which facilitate an understanding of the active role of race in perpetuating societal inequalities. It is this that the current thesis is predominantly interested in.

Race as a Product of Colonialism

The first distinctions of race can be traced back to the beginnings of the transatlantic slave trade in the early 16th century. This began with the exploration of the "New World" by Christopher Columbus in 1498, and the Spanish and Portuguese invasions of America. These events were characterised by the command of resources for political and economic gain through the exploitation and torture of Indigenous populations (Deagan, 2003; Fieldhouse, 1965). Meanwhile, the rise of the British empire was pioneered by political leader Oliver Cromwell in the 1640s, founded upon the capitalisation of sugar plantations in the Caribbean (Pestana, 2017). These colonial institutions maintained the exploitation and oppression of these populations whilst also defining and debating their existence (Okuefuna, 2007). Such fixations were built upon and justified by religious dogma, which stipulated that by interpretation of Christianity and the Bible, benign imperialism was a natural mechanism of society. To that end, the subordination of humans for economic gain through enslavement was considered both necessary and inevitable (Topolski, 2018). In this way, a definition of race was conceptualised, which dehumanised, exploited, and oppressed Indigenous (namely Black and Asian) populations for the political and economic elevation of White populations (DuBois, 1915; Porter, 2010).

Race as a Scientific Paradigm

The identification of populations of people from the same geographical location in the Caribbean with visibly different skin colours led to the first biological theories of racial difference (Andreasen, 2000; Marks, 1996; Smedley, 1998; Smedley & Smedley, 2005). This later initiated the development of "polygenism", that is, the belief that humans from different races originated from other species (Keel, 2013). This was most notable with the assimilation of Black African populations with chimpanzees, and the subsequent ideology of the Black person as animalistic, hypersexual, violent, and uncivilised (Fanon, 1952). Gaining further traction through the introduction of Social Darwinism in the 19th century, this school of thought attempted to apply the original theory posited by Charles Darwin of natural selection in order to subordinate those who did not belong to the White race (Claeys, 2000; Darwin, 1964; Dennis, 1995; Weikart, 2013).

Darwinian theories were later intersected with other facets of identity, such as socioeconomic and disability status, to fuel the Eugenics movement of Francis Galton (Galton, 1904). This movement sought to increase the reproduction of the perceived intelligent and wealthy middle class, and disinhibit reproduction of the lower, criminalised classes (Challis, 2013; Gillham, 2001). Such theories were used to justify mass extermination of racial populations through genocide, famine, sterilisation, and poverty (Barta, 2005; Dimijian, 2010; Moses & Stone, 2013; Savage, 2007). Overall, the idea of racial categorisation as a scientific paradigm presents a means of justifying the dehumanisation of groups of people, an idea which is explored later in this chapter.

Race as a Social Construct

The Enlightenment era of liberty, equality, and personhood in the 18th century saw the rise in prominent philosophers such as Immanuel Kant, John Locke, Georg Hegel and David Hume (Carey & Festa, 2009). This period represented the dichotomisation of church and state, in that reason based on the foundations of law and science were considered to have higher value than on faith and religion alone. Whilst the abolishment of slavery in the 19th century legally prohibited racial degradation through enslavement, the Jim Crow era of the Southern states of America, the apartheid regime of South Africa, and British racial segregation laws, maintained racial segregation and subjugation (Phillips & Harrison, 2010; Shah & Smith, 2021; Tischauser, 2012). This served to perpetuate a deeply entrenched fear within society and provided justification for the brutal torture and murder of thousands of Black people, most notably by lynching (Cook et al., 2018). Simultaneously, the rise of Minstrelsy and Blackface within the media and film industries reinforced White superiority by ridiculing and labelling Black people as simple-minded, childlike savages, a mechanism designed to deny them human capacity (Marable, 2007; Ross & Ross, 2004). Thus, there has been a shift towards the conceptualisation of race as a social construct, which exists to maintain social, political, and structural distributions of power within society (Omi & Winant, 2014). By virtue of race as a non-tangible concept based on perception, racial classifications have been *"created, inhabited, transformed, and destroyed"* across societies (p.55).

Modern Racial Classifications in the UK

The development of race has influenced terminology used in modern-day British society. This section draws upon the origins of these terms to provide a critical appraisal of terms frequently used in UK policy and literature.

Ethnic Minority

The UK Government defines an ethnic minority as *"all ethnic groups except the White British group"* (Race Disparity Unit, 2021b). Here, minority refers to the racial composition of the UK, which is 87% White and 13% other ethnic groups (ONS, 2012). This definition is used to classify 18 ethnic groups, within five aggregated groups: "Asian", "Black", "Mixed", "White", and "Other" (ONS, 2012). In the 1991 UK Census, racial classifications were introduced, with the specific aim of identifying individuals who may be more likely to experience racial discrimination (Moore & Hickman, 2010). The composition of ethnicity in the UK has developed over the last 30 years, in response to an increase in ethnic density, for example, the addition of "Mixed" in the 2001 Census, "Gypsy or Irish Traveller" and "Arab" in the 2011 Census, and "Roma" in the 2021 Census (Laux, 2019). However, categorisation inevitably risks neglecting the nuances of a multi-racial society, which are hard to capture in distinct groups (Burton et al., 2010; Ladier-Fouladi et al., 2004; Platt & Nandi, 2020). Furthermore, the term ethnic minority centres Whiteness as the dominant and default experience, perpetuating the narrative of those who do not fit into this category as the "other" (Chawla, 2017). Whilst non-White communities may make up the minority in the West, 80% of the world's population is comprised of people Indigenous to the global south, predominantly of Black or Asian heritage, thus making them the global majority. Consequently, the term ethnic minority is invalid outside of Western geographical borders (Campbell-Stephens, 2020; Johnson & Campbell-Stephens, 2013). Thus, for the purpose of this thesis, ethnic minority will only be used in reference to cited literature that uses this term.

Data from the most recent UK Census conducted in March 2021 is not yet available. Therefore, it is very likely that demographics may have changed in the last 10 years; particularly in response to significant events, such as Brexit (Nash, 2019) and the COVID-19 pandemic (Briggs et al., 2021). Nevertheless, as the Census is considered the most robust method of population analysis in the UK, the data are still deemed to be useful in contextualising the current research.

Black and Minority Ethnic (BME)/ Black and Asian Minority Ethnic (BAME)

Other terms that have gained popularity in the UK are “BME” and “BAME.” These terms have become commonplace and are widely used to summarise all ethnic minority groups, although there is no consistent approach to using these terms across government (Race Disparity Unit, 2021b). Combining all groups within a monolithic acronym presents further challenges (Commission on Race and Ethnic Disparities, 2021), particularly regarding ethnic disparities, such as education. For example, students of Chinese ethnicity are 79.6% more likely than students from any other ethnic group to achieve a grade 5 or above at GCSE, compared with 34.8% of students of Black Caribbean ethnicity (Department for Education, 2021a). Thus, whilst individuals of Chinese and Black Caribbean ethnicity would both be classified as “BAME” or “BME”, there are evident differences in educational attainment which these acronyms do not account for. Therefore, for the purpose of this thesis these terms will only be used where cited literature makes use of them.

Racialised

Racialisation is a sociological term, initially developed within the context of racial formation theory to refer to an *“extension of racial meaning to a previously racially unclassified relationship, social practice, or group”* (Omi & Winant, 1986, p.111). This term is distinct from ethnic minority, BAME, and BME, in that it focuses on the semantics attached to racial categorisation, which is inherently born of social dominance and power. Racialised categories are thus placed upon groups by the majority group without consent and vary across time and place (Gonzalez-Sobrino & Goss, 2018; Omi & Winant, 2014). For the purpose of the current thesis, the researcher has chosen to use the term racialised when referring to groups belonging to Black and Asian communities. This aligns with the importance placed on understanding racial history in the conceptualisation of the research question and aims.

Intersectionality

Intersectionality refers to the margins at which multiple social identities (e.g. race, gender, and class) combine to present a holistic view of oppression and privilege (Crenshaw, 1989, 1991). First applied in the context of US law to understand the nuanced experiences of Black women within the criminal justice system, intersectionality is now widely applied to the domain of healthcare, including understandings of the assessment and treatment of mental health difficulties (Burnham, 2018; Tang & Pilgrim, 2017; Totsuka, 2014). For this thesis, the researcher acknowledges these intersecting factors in helping to contextualise the topic of race and racism.

Theories of Racism

Multiple theories and models exist to understand the perpetuation of racism. In the current research, the researcher has chosen to draw upon traditional psychological theories (social and psychoanalytic) and critical race theory. These schools of thought have been selected purposively in order to critically appraise the contributions of psychological theory and analyse ways in which critical theory may offer more nuanced understandings of racism, relevant to the socio-political climate of the UK.

Social Theory

Social psychologists present the formulation of social groups as a tool which individuals use to evaluate their identity in the world (Festinger, 1954; Tajfel et al., 1979; Tajfel, 1974). Developed to understand in-group vs out-group structures, Tajfel and colleagues proposed that when ascribing themselves to social groups, individuals tend to seek out membership of groups which they believe affirm positive appraisals of the self. The maintenance of groups is subsequently upheld by the process of social comparison, which favours the in-group and derogates the out-group (Tajfel et al., 1979; Turner et al., 1979). Intergroup conflict ensues when groups perceive themselves to be under threat and in direct competition with an out-group for resources, such as economic gain, power, or social status (LeVine & Campbell, 1972; Sherif, 1966, 2015). Social understandings of racism can be further understood through the concept of dehumanisation, that is, the appraisal of groups of people as sub-human or inhuman entirely (Haslam, 2006; Smith, 2016). Dehumanisation exacerbates intergroup conflict and justifies the colonisation and subjugation of whole communities, under the guise of the racialised other as barbaric, aggressive, lacking cognitive capacity, and capable of tolerating high levels of pain (Jahoda, 2018). Contemporarily, these polarised views of racialised communities in comparison to their White counterparts live on, albeit in increasingly covert ways. This is exemplified by conceptualisations of the "strong Black woman" stereotype impacting the high maternal mortality rates for Black and Asian women (Anekwe, 2020; Knight et al., 2020) and the overrepresentation of Black men in the prison population (Ministry of Justice, 2019b).

Psychoanalytic Theory

In his seminal text "Black Skin, White Masks", psychoanalyst Frantz Fanon theorised racism as a product of the *"juxtaposition of White and Black races in the context of* *colonisation"* (Fanon, 1952). Here, the racialised person is objectified as "phobogenic" (fear-causing), that is the racial scapegoat representing the punishable feelings of fear, guilt, and blame projected by the White majority (Hook, 2004). Moving beyond an understanding of the perpetration of racism itself, Fanon proposed that through the process of cultural assimilation, Black people seek to divorce themselves from the inferiority of their Blackness, that is the *"ugliness, sin, darkness, and immorality"* (Fanon, 1952, p.1952), and strive to achieve the economic, political, and material rights and wealth only afforded to those with White skin under colonial rule. Fanon names this desire the "neurosis" of Blackness (Fanon, 1952). Here, he draws upon Freud's initial use of the term to emphasise the inherent pathology of the impossible task of reconciling the aspiration of obtaining basic levels of humanity, with the racialisation of the Black body which prevents this from becoming a reality (Hook, 2004). Psychoanalytic schools of thinking provide an understanding of contemporary racism which positions racially minoritised groups as synonymous with danger, aggression, and criminality (Smiley & Fakunle, 2016). This is most prolific in the extensive history of police brutality, notably, the killing of Black men in the US (Graham et al., 2020) and the overrepresentation of Black individuals targeted by stop and search requests by the Police in the UK (Home Office, 2021).

Critical Theory

In order to situate the current research within the socio-political climate within which race, and racism, are embedded, it is also necessary to draw upon theories that sit outside of the traditional psychological sphere. Such theories seek to identify and challenge the role of systems in perpetuating colonial ideologies at a structural level.

Critical race theory (CRT) analyses the relationship between race, racism, and power (Stefancic & Delgado, 2000). Originating in the 1970s, the theory builds upon two important movements in the US, critical legal studies, and radical feminism. This was in response to a decline in advancements for individuals from non-White racialised communities following the civil rights era in the 1960s, and an inability to recognise racial power within the legal sector. Six main principles are proposed to explain the presence and perpetuation of racism: (1) ordinariness; racism is difficult to eradicate because it is not obvious or acknowledged, (2) interest convergence; racism is in the best interests of White people, thus the majority of society do not have sufficient motivation or power to work towards eradicating it, (3) a social construction; as race is a subjectively constructed form of identification, there is no evidence that it corresponds to biological realities or traits such as personality, intelligence, or moral behaviour, (4) different racialisation; society racialises minority groups at different times in response to shifting needs, (5) intersectionality; the convergence of overlapping identities (e.g. race, sex and class), used to understand multiple ways that individuals are oppressed, (6) storytelling; individuals from racialised communities are in a better position to communicate their experiences than their White counterparts.

Although originating within US law, since its inception CRT has been adapted and applied to many other disciplines, including psychology. (Brown, 2003, 2008) provides a useful analysis of how *"structured inequality influences the distribution of psychological health and illness"* (p.58). He proposes that CRT can be used to acknowledge and address shortcomings within mental health literature, most notably a disregard for narratives about how racism negatively impacts mental health. More recently, attempts have been made to apply CRT to a "critical race psychology", whereby psychologists are encouraged to address and reveal how *"institutions and practices in society at large, including such politically liberal and highly educated spaces as psychological science, both bear traces of and function to reproduce racial power"* (Salter & Adams, 2013, p.782). This concept is developed further in the next chapter, with specific considerations for how UK mental health systems and psychological services contribute to the perpetuation of racial inequality.

Summary

In summary, the existing literature presents a picture that robustly relates the experience of racism with psychological distress and trauma, and the relevance of this within a UK context. However, understandings of how these experiences are acknowledged and explored within mental health services remain fragmented. The next section will initially address this, through the systematic review of the qualitative literature concerning mental health professionals' experiences of discussing race within clinical practice. This is followed by a narrative review of the contemporary literature pertaining to the relationship between racism and psychological trauma, culminating in a working understanding of the concept of racial trauma for the purposes of the current research.

Chapter Two: Review of the Literature

Chapter Overview

This chapter provides a further in-depth exploration of the literature concerning race, racism, and racial trauma. This begins with a qualitative systematic review of the literature surrounding mental health professionals' experiences of discussing race within clinical practice. This is followed by a narrative literature review of the broader literature pertaining to conceptualisations of psychological trauma within mental health services, and more specifically of racial trauma. Together, these bodies of literature culminate in a working understanding of racial trauma for the purpose of the current research.

Systematic Literature Review: Experiences of mental health professionals discussing race within clinical practice

Overview

The experiences of staff have been explored both quantitatively and qualitatively, however, to date qualitative experiences of staff have not yet been synthesised into a systematic review. Thus, the aim of the present review was to provide a qualitative synthesis of the experiences of qualified mental health professionals discussing race within their clinical practice. The question under review was: "How do qualified mental health professionals experience discussing race within their clinical practice?" The review was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 12th January 2021 (registration number: CRD42021228294).

Methods

Design. The review used a qualitative design to explore the experiences of qualified mental health professionals. A qualitative methodology was considered to be most appropriate, with particular consideration for the concept of race as a social construct which holds nuanced meanings relative to historical, political, and economic contexts (Fernando, 2012; Omi & Winant, 2014). Whilst race, ethnicity, and culture are distinct concepts, they have been combined for the purpose of the search criteria for the current review, in acknowledgment of the interchangeability of these terms within the literature (Baer et al., 2012). The process of the review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement, as an evidence-based set of criteria for reporting systematic reviews (Moher et al., 2009).

Search Strategy. Prior to conducting the search, a scoping search of the key trial registries (including Prospero, the Journal of Systematic Reviews, and the Cochrane library) was conducted to ensure that a review of this nature did not already exist. The SPIDER search tool was used to generate search terms based on the review question, focusing on sample, phenomenon of interest, design, evaluation, and research type (Cooke et al., 2012) where relevant (see Appendices A and B). Truncation and Boolean operators (AND + OR) were used to refine the search. Searches were conducted in February 2021 using four databases: CINAHL Complete, PsycINFO, PsycARTICLES and MEDLINE (via EBSCOHost).

Inclusion and Exclusion Criteria. Studies which met the following inclusion criteria were included in the review: (a) qualitative studies, or mixed method studies where qualitative findings could be extracted, (b) focusing on the experiences of qualified mental health staff discussing race in their clinical practice, (c) studies recruiting qualified mental health professionals, or studies where the experiences of qualified professionals could be extracted (qualified refers to professional registration and the standards of competency stipulated in the country of origin), (d) peer-reviewed empirical studies; (e) published in English, (f) published in any time period, (g) published in any geographical area.

Studies were excluded if they focused on the experiences of (a) service users or (b) unqualified mental health professionals.

Screening. Initial results were filtered through EBSCOHost, excluding non-English language and non-peer-reviewed articles. Following this, search results were exported to Mendeley reference manager, and duplicates were removed. Results were first screened by title, then abstract, and finally full text. Following this, forward and backward citation chaining was used to identify potential articles listed in the reference lists of the included articles, and articles which had since cited the included articles via Google Scholar. Finally, author searches were conducted, culminating in the final articles included in the review.

Quality Appraisal. The final articles were assessed for methodological quality using the Critical Appraisal Skills Programme checklist (CASP, 2018), selected for its specific adaptation for appraising qualitative studies. Each article was assessed against 10 questions based on three criteria: (a) Are the results of the study valid? (b) What are the results? (c) Will the results help locally? Each question was answered either yes, no, or can't tell. The purpose of the appraisal was to support an in-depth analysis of the quality of the articles in relation to the review question, not to exclude articles at this stage.

Data Extraction. For the purpose of this review, "data" were determined to be any text labelled as "Results" or "Findings" within the articles (Thomas & Harden, 2008). In case of variation amongst the articles in terms of how and where key concepts were reported, a degree of flexibility was exercised at this stage to ensure inclusivity of all findings (Sandelowski & Barroso, 2002). Where articles included the experiences of mental health professionals and service users (Aggarwal et al., 2016; Yon et al., 2018), only findings related to professionals were extracted. The results sections of all articles were transcribed verbatim in preparation for the synthesis.

Synthesis. The synthesis of the articles was conducted using Thomas and Harden's (2008) method of thematic synthesis for systematically reviewing qualitative research. This method is informed by thematic analysis as developed by Braun and Clarke (2006). The three stages of thematic synthesis were followed: (1) line-by-line coding of findings from the primary studies, (2) organisation of codes to facilitate developing descriptive themes, and (3) generating analytical themes. Each article was coded line-by-line using both a deductive and inductive approach which initiated the process of translating concepts between articles. These initial codes were checked for consistency and collapsed where multiple codes were deemed to explain the same concept. Next, codes were organised into a hierarchical structure of descriptive themes, which remained close to the original findings from the studies. Finally, analytical themes were developed by going beyond the descriptive themes to synthesise and interpret the data in a way which provided answers to the review question.

Reflexivity. This qualitative synthesis aimed to explore the experiences of qualified mental health professionals discussing race in their clinical practice. The author of the review is a trainee clinical psychologist; thus, it should be considered that prior knowledge and assumptions are likely to be held about the clinical psychology profession, in comparison to other mental health professions. Furthermore, as a person of Black Caribbean heritage, the researcher has both personal and professional experience of discussing race and racism. This includes clinical practice with service users and colleagues (such as clinical supervisors and multi-disciplinary team members). This may have influenced how the data have been interpreted and presented within this review and should be held in mind when drawing conclusions.

Results

Search Results. Search results were screened using the PRISMA flow chart (Appendix C). A total of 921 articles were retrieved from the four databases, reduced to 556 once duplicates were removed. Once exported to Mendeley, articles were screened at title (excluding 269 articles) and abstract (excluding 214 articles). Finally, 73 articles were screened at full text, excluding a further 60 articles. Forward and backward citation chaining retrieved an additional three articles. A final author search retrieved a further two articles written by Alan Burkard, bringing the final number of articles included in the synthesis to 18.

Study Characteristics. Following the systematic database search, 18 articles satisfied the inclusion criteria and were included in the qualitative synthesis. Key study characteristics for all 18 articles are detailed in Appendix D. Experiences were gathered from 199 qualified mental health professionals, including, amongst others, psychiatrists, clinical psychologists, counselling psychologists, and social workers. Participants worked across multiple settings in the UK, USA, Canada, Finland, Singapore, and New Zealand. Study sample sizes ranged from 3-29 participants. Participants engaged in discussions about race across many contexts; 11 articles reported experiences of participants discussing race in therapy sessions with service users, three articles reported experiences in therapy sessions with service users and in training sessions, three articles reported experiences in therapy sessions, in training sessions, in supervision/mentoring sessions, and wider discussions within the multi-disciplinary team, and one article reported experiences in supervision sessions only. Settings included general hospitals, mental health inpatient units, prisons, universities, adult community mental health services, child and adolescent mental health services, private practice, and one mental health service designed specifically for South Asian women.

Quality Appraisal. Appendix E details the quality appraisal of the articles included in the thematic synthesis (CASP, 2018). Collectively, the final 18 articles represent a diverse body of literature of good methodological quality. Whilst this supports the ability of the studies to answer the review question, it should also be considered that the common aim of all studies was to explore the experiences of mental health professionals discussing race and culture within clinical practice. Thus, some level of bias may be present in that those recruited are likely to be clinicians who actively address race and culture in their practice. Consequently, there is potential for the findings to be skewed towards those who may feel somewhat comfortable incorporating race into their clinical practice.

All studies provided a clear statement of aims and used qualitative methodology appropriately, illustrated by the use of terms such as “perceptions”, “perspectives”, “views”, “experiences”, and “narratives”. All studies provided some level of justification for the research design used, for example, a phenomenological approach (Grimmer & Schwantes, 2018; Reddy, 2019), or a constructivist paradigm (Zaharopoulos & Chen, 2018). Reference was made by all study authors to the use of appropriate recruitment strategies and data collection methods. Purposive sampling was the most popular sampling method, also complimented by snowball sampling (Knox et al., 2003). Studies such as Aggarwal et al.'s (2016) also justified recruiting in areas of “hyperdiversity” to ensure a broad and representative sample of participants. In contrast, Atkins et al. (2017) justified exclusively recruiting White clinicians, noting the high prevalence of White middle-class individuals within the counselling profession in Canada.

Semi-structured interviews and focus groups were the dominant data collection methods, consistent with methods used in many qualitative healthcare studies (Liu et al., 2020; Matheson et al., 2016; Waugh et al., 2017). Many studies provided further details about the process of developing the topic guide, such as consulting previous literature (Aggarwal et al., 2016; Atkins et al., 2017; Burkard et al., 2006; Sunderani & Moodley, 2020; Verdinelli & Biever, 2013), consulting with mental health professionals with experience in the field (Bassey & Melluish, 2012; Zaharopoulos & Chen, 2018), or using pilot interviews (Burkard et al., 2014; Rosenfield, 2020; Zaharopoulos & Chen, 2018). Eleven study authors adequately considered the relationship between researchers and participants; however, only 10 study authors explicitly linked aspects of their own personal and professional identity in an attempt to bracket their biases (Atkins et, 2017; Burkard et al., 2006, 2014; Fuertes et al., 2002; Grimmer & Schwantes, 2018; Kang & Moran, 2020; Keselman & Awais, 2018; Knox et al., 2003; Reddy, 2019; Rosenfield, 2020).

Just eight studies demonstrated that sufficient ethical considerations had been made, for example, by indicating that approval was sought from an ethical committee or that the welfare of participants had been monitored throughout the research process. Nine different methods of qualitative data analysis were described across the studies, with Grounded Theory (Glaser & Strauss (1967) and Consensual Qualitative Research (Hill et al., 1997) being the two most popular methods. Most studies provided an in-depth description of the data analysis process, with one study failing to mention how the data were analysed (Taylor et al., 2006). All studies utilised direct participant quotations to support the interpretation of their findings. Further, all studies included a “Discussion” section where findings were critically explored in relation to the research question and discussed in relation to implications for practice, policy, and research.

Main Findings. This section will provide a summary of the key findings of the current review, including an identification of the gaps in knowledge which remain and would benefit from further investigation.

Heightened awareness of the diverse needs of racialised communities. Findings from the review suggest that mental health professionals are increasingly aware of the need to adapt and be responsive to the diverse needs of racialised communities. This takes many forms, including seeking out information about cultural norms, values, and how psychological distress is appraised differently cross-culturally. Maintaining curiosity about service users' racial and cultural background allows professionals to make adaptations to the way that mental health support is offered, to ensure that care is truly person-centred.

Professionals and service users share commonalities. The current review importantly highlights the contributions of both professionals and service users to furthering discussions about race. Whilst professionals bring their theoretical expertise and experience of navigating psychological distress, service users bring their expertise in their own racial identity and experiences. The current review suggests that by working collaboratively, professionals and service users can create a healthy climate within which to discuss race in the therapeutic domain. However, there remains a gap in knowledge concerning where the responsibility of this lies, and this is an important consideration given the emotional burden of leading discussions on race identified by professionals within the review.

Making mistakes and learning. A key finding from the current review surrounds the willingness of mental health professionals to practice humility and growth in their navigation of race in clinical practice. Most importantly, professionals recognised the need to be mindful of and interrogate their own implicit biases, and to recognise that as fallible humans it is both okay and expected that they will at times "get it wrong". The current review suggests that as long as professionals are open and honest about mistakes or omissions concerning race in the therapeutic domain, these discussions can be viewed as reflective of the continuous development of professionals and moves away from ideals of there being "experts" in this area. It could be argued however, that the current review neglects the process of repairing mistakes or ruptures concerning race and that this is an area that is still in need of further research.

Talking about race is not the same as talking racism. Whilst the aim of the current review was to explore mental health professionals' experiences of discussing race within clinical practice, the findings seem to assume synonymy between discussing race and discussing racism. Although related, it could be argued that the latter presents a distinct and nuanced requirement for professionals and systems to address both the associated psychological distress and the duty of care to preserve human rights. Thus, the current review leaves a gap in understanding how racism is discussed and addressed in mental health practice.

Thematic Synthesis. A thematic synthesis was conducted to analyse the main findings from the review, generating five themes and nine sub-themes (see Table 2). The prevalence of themes across the 18 studies is illustrated in Appendix F.

Table 2

Themes and sub-themes developed from the thematic synthesis

Themes	Sub-themes
1) Bias is in the eye of the beholder	-
2) The power of self-disclosure	Lived experience facilitates understanding Checking blind spots The risk of overfamiliarity
3) Navigating the relevance of race and culture in the therapeutic space is complex	Getting it wrong and sitting with discomfort Making cultural adaptations Race is not the only factor
4) Mental health services are a microcosm of a racialised society	Societal history The history of the helping professions
5) There is always a lesson to be learned	Formal vs informal education The emotional burden on people of colour Maintaining curiosity

Theme One: Bias is in the eye of the beholder. This theme relates to the process through which participants came to understand that embarking on a journey of exploring race within their clinical practice required them to identify and be mindful of racial biases, assumptions, and stereotypes. This was influenced by professionals' own cultural upbringing (Aggarwal et al., 2016; Verdinelli & Biever, 2013; Yon et al., 2018), as well as wider stereotypes and assumptions perpetuated within society (Atkins et al., 2017; Kang & Moran, 2020; Zaharopoulos & Chen, 2018). One participant in Kang and Moran's (2020) study shared this reflection when working with a Ghanaian service user on an inpatient ward in the UK, who believed that his presenting difficulties were the result of voodoo:

> *"They were quick to label what he was talking about as a mental disorder without exploring and not giving enough time in a clinical area to assess and put into perspective [...] In my opinion, it was a cultural difference. He said things they believe in spiritually, which I have experience with [...] it's frustrating".* (p.119)

Across the articles, professionals described realising that addressing race and culture within their clinical practice meant to look beyond the service users sat in front of them. When making sense of their own biases, many professionals spoke critically of the *"attitudes and beliefs that we come into this practice with that we have to check at the door"* (Aggarwal et al., 2016, p. 8) and a perceived need to "watch" their stereotypes (Bassey & Melluish, 2012). These ranged from ideas about what might be helpful based on preconceptions about the service user's culture (Keselman & Awais, 2018; Reddy, 2019), to a perceived fear of threat from service users based on racial stereotypes (Atkins et al., 2017). Participants in Reddy's (2019) study reflected on their own implicit biases in assuming that a shared racial identity would automatically facilitate a shared understanding of service users' difficulties:

> *"I had to remove this preconceived notion of what being South Asian meant and become aware that I was typecasting all these individuals into that setup. I thought they're going to fall into my understanding of being South Asian, so I already have something ready, but it was always different, everytime, always different".* (p.10)

Others acknowledged biases to be a natural part of their identity that contributed to how they understood the world; this facilitated curiosity to explore their own racial and cultural identity (Grimmer & Schwantes, 2018; Nelson et al., 2001; Yon et al., 2018). This self-realisation at times meant that professionals were met with a conflict between their own belief system and that of their service users (Reddy, 2019; Taylor et al., 2006; Verdinelli & Biever, 2013). One participant in Taylor et al.'s (2006) study exemplifies this:

> *"I always considered myself a culturally competent therapist, but I was taken aback at the living conditions of some of my clients. My feminist side wanted to intervene and ask why all the females were waiting on the males in the household [..] A collective culture came to mind. I felt great respect for their values and traditions from their culture of origin and the present culture"*. (p.439)

Ultimately, professionals came to a consensus that whilst this was a personal endeavour, this level of reflexivity was important, to model the level of vulnerability which they were expecting of their service users (Knox et al., 2003; Zaharopoulos & Chen, 2018), or supervisees (Burkard et al., 2006). Furthermore, this enabled professionals to reflect upon whether strong emotional responses they experienced came from their service users or from within themselves, allowing them to monitor this accordingly (Bassey & Melluish, 2012; Reddy, 2019; Taylor et al., 2006).

Theme Two: The power of self-disclosure. This theme encapsulates the complexity experienced by professionals surrounding disclosing personal information about themselves within their clinical practice. Three sub-themes were generated: *"lived experience facilitates understanding"*, *"checking blind spots",* and *"the risk of overfamiliarity"*.

Professionals often gravitated towards self-disclosure as a way of bridging the gap between themselves and their service users, particularly where they perceived there to be a shared identity, such as racial or cultural similarity (Taylor et al., 2006; Verdinelli & Biever, 2013), oppression (Fuertes et al., 2002), or lived experience of difficult life events (Reddy, 2019; Rosenfield, 2020; Sunderani & Moodley, 2020). In doing so, professionals hoped to convey empathy and understanding, by sharing that although they were mental health professionals, they were not immune to the experience of distress (Aggarwal et al., 2016; Atkins et al., 2017). One participant in Aggarwal et al.'s (2016) study reported the perceived benefits of sharing their own experiences of immigration:

> *"I'm an immigrant too. I can relate to them with my own experiences, with my kids and then I can share a little bit of [...] disclose my issues"*. (p.7)

While two studies recruited solely mental health professionals from diverse ethnic backgrounds (Reddy, 2019; Taylor et al., 2006), most studies included professionals who identified as being of White or European ethnic origin. In the absence of their own racially minoritised experiences, White professionals introduced self-disclosure by naming that which they could not understand but recognised the importance of. Burkard et al. (2006) and Atkins et al. (2017) capture the honesty with which professionals approached such self-disclosures, in validating the impact of racist events disclosed by service users, and recognising ways in which their own racial privilege contributed to structural racism. The following extract from Burkard et al.'s (2006) study illustrates this:

> *"Therapists also typically used self-disclosure to acknowledge the role of racism and oppression in clients' lives. For instance, one therapist felt that it was necessary for his client to see that he (therapist) was not going to whitewash the issue of racism and that he was willing to confront racism and say that it exists in this world"*. (p.20)

Such disclosures were also valued in supervisory relationships, where European American supervisors invited supervisees within cross-racial supervisory dyads to *"be open to processing through those struggles"* (Burkard et al., 2014, p.325). Finally, professionals recognised the potential limitations of identifying shared racial characteristics or experiences with service users or colleagues. This included a risk of *"boxing people in"* (Nelson et al., 2001, p.367), or homogenising the experiences of minoritised people as being the same (Atkins et al., 2017). Indeed, family therapists in Yon et al.'s (2018) study alluded to this, identifying the *"naivety and ignorance"* of the therapist who did not share the same cultural background as the family (p.193). Ultimately, self-disclosure was experienced as a useful tool in facilitating a meaningful relationship across the studies.

Theme Three: Navigating the relevance of race and culture in the therapeutic space is complex. This theme relates to the analysis undertaken by mental health professionals in navigating race within clinical spaces. This theme is divided into three sub-themes: *"getting it wrong and sitting with discomfort"*, *"making cultural adaptations",* and *"race is not the only factor"*.

Professionals expressed concerns over appearing rude (Yon et al., 2018), being labelled as racist (Burkard et al., 2014; Rosenfield, 2020; Sunderani & Moodley, 2020), feeling uncomfortable (Kang & Moran, 2020), the risk of a *"culture clash",* (Taylor et al., 2006, p.438), the fear of getting it wrong (Reddy, 2019; Verdinelli & Biever, 2013), and the pressure to get it right (Grimmer & Schwantes, 2018). Most professionals experienced race as the *"elephant in the room"*, constantly present and in need of addressing (Fuertes et al., 2002, p.775; Knox et al., 2003, p.18). One participant in Atkins et al.'s (2017) study describes this period of sitting with discomfort:

> *"Some people close to me helped me in that they didn't pull me out of it. They didn't save me [..] they let me sit in it. It helps because they don't let you get away with it or take the pain away. You have to sit with it until you make your way out of the pain by realising there's something about my pain now compared to what certain cultural groups have had to endure".* (p.681)

Linked to this was the acknowledgement that traditional theories for the assessment and treatment of psychological distress often neglect cultural differences and assume that Westernised explanatory models are applicable cross-culturally. Many professionals reported making adaptations to evidence-based treatments to account for such differences, including accommodating religious events (Kang & Moran, 2020), observing cultural differences in non-verbal communication (Aggarwal et al., 2016), speaking the language (Sunderani & Moodley, 2020; Verdinelli & Biever, 2013), incorporating alternative treatment methods

(Taylor et al., 2006), and community outreach (Reddy, 2019). One participant in Taylor et al.'s (2006) study described their adaptation of traditional Westernised theories:

> *"The notion of enmeshment cannot be used with this population that has a strong sense of family connectedness as cultural pride [...] I use a narrative approach with my Latino clients instead of the traditional stage models. It broadens the exchange of one's family, friends, institutions, and socio-cultural considerations. It also values emotional experiences and relationships"*. (p.441)

In contrast, some professionals described a period of assessment where they attempted to establish whether race was relevant to the presenting issue in question at all (Knox et al., 2003; Nelson et al., 2001; Rosenfield, 2020). Others preferred to use an intersectional lens to combine race with other factors, such as gender and social class, to incorporate a broader understanding of the person before them (Fuertes et al., 2002; Sunderani & Moodley, 2020; Taylor et al., 2006). The following extract from Knox et al. (2003) highlights this internal assessment:

> *"These therapists typically did not address race if they deemed it not an issue in therapy. For example, one participant stated that she does not address race systematically or automatically with a client of a different race, because race can be irrelevant to the client's concern [...] One therapist stated that if she believed discussing race would be an impediment to therapy (e.g., heighten a client's defensiveness), she would not engage in such a discussion"*. (p.19)

Theme Four: Mental health services are a microcosm of a racialised society. This theme pays homage to historical racial events as significant factors in the experience of vicarious and generational racial distress. Professionals recognised parallels with the racialisation of society within the mental health domain. Two sub-themes address this: *"societal history"* and *"the history of the helping professions"*.

Some professionals made reference to the *"segregated South"* (Knox et al., 2003, p.14), racialised riots during the Civil Rights Movement (Fuertes et al., 2002; Knox et al., 2003), the transatlantic slave trade, and Jim Crow laws (Fuertes et al., 2002). Others spoke of the systemic inequalities which continue to oppress those from minoritised backgrounds and inevitably present themselves in mental health services, and through the immigration (Verdinelli & Biever, 2013), criminal justice, and social care systems (Rosenfield, 2020). Participants in Fuertes et al.'s (2002) study acknowledged the understandable mistrust African American service users displayed:

> *"I think what's really important is to convey a sense of openness and acceptance of the historic effects of racism and the healthy mistrust that an African American client would bring to a counselling relationship with a White counsellor"*. (p.772)

While some professionals seemed to hold these inequalities in mind at the periphery of their practice, others delved deeper into inequalities within the theoretical paradigms that underpinned their own disciplines. Professionals were critical of mental health interventions which seemed to predominantly favour the dominant Eurocentric demographic. Examples of this included the perceived inadequacy of Bowen's family systems theory when considering the difference between individualist and collectivist cultures (Taylor et al., 2006), and the *"overly Western orientation"* of the cognitive behavioural therapy (CBT) model (Bassey & Melluish, 2012, p.229). This was also considered from a supervisory perspective. Participants in Burkard et al.'s (2014) study described the challenge of balancing basic counselling skills, which typically favour White cultural values, with allowing supervisees to practice from their own cultural perspectives:

> *"I had a hard time drawing the line between a supervisee who was practising from a certain cultural perspective and if there are basic counselling skills a supervisee should have. I wondered if my feedback on counselling skills to the supervisee [of colour] may have been based more on White cultural values"*. (p.328)

Theme Five: There is always a lesson to be learned. This theme relates to professionals' desire to seek out education to develop their clinical skills concerning race and culture. Three sub-themes were identified*: "formal vs informal education"*, *"the emotional burden on people of colour",* and *"maintaining curiosity"*.

Professionals across all 18 studies shared a desire to fill identified gaps in their knowledge and acknowledged that the process of learning was ongoing. Sources of informal education ranged from asking for *"clarification and meaning"* from service users (Nelson et al., 2001; Taylor et al., 2006, p.437) or family members (Kang & Moran, 2020)*, "exploring solutions and overcoming shared challenges"* through peer support from colleagues (Reddy, 2019, p.9; Verdinelli & Biever, 2013), to seeking information from community led grassroots organisations (Bassey & Melluish, 2012). Other professionals felt they needed formal education to enable them to address race and culture in their clinical work, valuing opportunities to attend diversity and cultural competence training (Fuertes et al., 2002; Rosenfield, 2020). Others commented that those they supervised had undertaken such training (Burkard et al., 2014). One participant in Rosenfield's (2020) study commented on the usefulness of diversity training in helping to widen their perspectives:

> *"I feel like some kind of diversity training had to [...] have gotten me somewhere to be able to imagine all these stressors [...] or risk factors"*. (p.69)

Many professionals attempted to collaborate with their service users by encouraging them to assume an expert by experience position in educating about their race and culture

(Zaharopoulos & Chen, 2018). One participant described her service user as an *"excellent teacher"* (Keselman & Awais, 2018, p.82). Joint working with colleagues who could identify with the ethnic backgrounds of service users was also identified as a way to learn (Aggarwal et al., 2016; Knox et al., 2003; Yon et al., 2018):

> *"It helps because Therapist 1 brings that knowledge from within, and I bring that naivety, ignorance, and knowledge from the White dominant".* (Yon et al., 2018, p.192)

Whilst this was generally considered a useful tool for clinicians, Reddy (2019) drew attention to the risk of distress and *"trauma overload"* for such individuals, for whom their own historical or current experiences may be activated (p.9). Moreover, one participant in Knox et al.'s (2003) study described feeling as though she was *"representing all Black women to her White supervisors"* (pg. 16). A participant in Sunderani and Moodley's (2020) study also alluded to the role reversal when a service user feels the need to come to the rescue of the therapist:

> *"If it's painful for me, then if I disclose 'oh I have the same problems', the client will feel guilt and may want to help me, and then you switch the roles".* (p.749)

Overall, curiosity consistently arose as an important skill in maintaining the learning process (Burkard et al., 2014; Grimmer & Schwantes, 2018; Keselman & Awais, 2018; Yon et al., 2018).

Discussion

This thematic synthesis reviewed the experiences of qualified mental health professionals discussing race within their clinical practice, with service users, and in supervision, consultation, and training. This process generated five analytical themes, reflecting experiences from mental health professionals across a diversity of countries. Professionals were employed in various settings, including inpatient and community settings, and reported working with individuals, groups, and families, as well as supervising junior members of staff.

The current review supports several findings when appraised in relation to the existing literature pertaining to mental health professionals and race. The review identified a consensus across all studies that discussions about race are an important part of clinical practice in mental health services (Carter, 2007; Hemmings & Evans, 2018). This reflects cultural competency standards of proficiency stipulated by key governing bodies, such as the British Psychological Society [BPS] (2017b), the American Psychological Association [APAb], 2019), the Royal College of Psychiatrists (2021), and the Health and Care Professions Council [HCPC], 2015), as well as key review papers (Cardemil & Battle, 2003; Murray-García et al., 2014; Sue, 2011). Secondly, this review further fuels the ongoing dialogue within the literature surrounding the rollout of formal training programmes of cultural competency (Bhui et al., 2007; López et al., 2020; Whaley & Davis, 2007), as well as more informal consultation type models (Owiti et al., 2014). Finally, this review aligns with research concerning service users (Berger & Sarnyai, 2015; Polanco-Roman et al., 2016), as well as professionals in training (Constantine & Sue, 2007; Utsey et al., 2005), in supporting the evidence base for the importance of race in understanding psychological distress.

Ultimately, this review suggests similar narratives for both service providers and service users of mental health care with respect for the importance of involving race in clinical practice. At present, a breadth of literature exists to support the link between racism and poor mental health, which has been evidenced systematically (Ben et al., 2017; Carter et al., 2019; Kirkinis et al., 2018; Paradies et al., 2015; Pieterse et al., 2012). This review magnifies a comparatively poor research effort regarding the experiences of professionals in responding to such experiences. Future research endeavours should aim to explore the experiences of mental health professionals working with racism to further contribute to understandings of why outcomes for care are significantly poorer for those from racially minoritised backgrounds.

Study Strengths and Limitations. Findings from the current review successfully communicate the complexity of bringing race into the therapeutic dome. Specifically, the review challenges the usefulness of racially similar therapeutic and supervisory dyads and encourages against homogenising racial groups and cultures. Further still, the current review highlights an important issue with placing the onus on individuals from racially minoritised backgrounds to educate White individuals about race and racism. Whilst this finding has been present in previous literature (Constantine & Sue, 2007; Eddo-Lodge, 2017), this review further interrogates this and points specifically to the potential for re-traumatisation for both service users and professionals from racially minoritised backgrounds when positioned to lead this work (Sweeney et al., 2016). This is a particular strength given the increase in trauma-informed care within mental health services in many Western countries (Becker-Blease, 2017; Reeves, 2015; Sweeney et al., 2018; Wilson et al., 2017). Finally, the current review supports the concept of implicit bias and the importance of not simply acknowledging this, but also working to address the impact of such biases within spaces where race is explored (Murray-García et al., 2014; Sue, 2013).

The broad nature of the current review across countries and professions, whilst necessary to yield a satisfactory number of studies, risks homogenising the exploration of race across different disciplines. The review further highlights a lack of operationalism of key terms such as race, ethnicity, and culture, as these are used interchangeably across the studies, despite describing different components of identity (Baer et al., 2012). Finally, whilst some studies touched upon experiences of addressing racism within their clinical practice, this was not the primary focus of any of the studies. Thus, this review identifies a critical gap and absence of qualitative literature examining how racism presents itself within presentations of psychological distress, and how this is discussed in clinical practice when working with service users from racialised communities.

Methodological Strengths and Limitations. The current review is believed to be the first to explore the experiences of qualified mental health professionals discussing race within their clinical practice. In this way, it provides a culmination of the existing literature and identifies areas of continuing research concern. The systematic process undertaken suggests that the review demonstrates a high quality of methodological rigour (Liberati et al., 2009; Munn et al., 2018). The dates of the articles ranged from 2001-2020, representing 19 years of racialised social and political climates across predominantly Western areas of the globe. This presents challenges regarding how generalisable the results are considered to be, particularly as racial climates vary across time and place. It is also expected that the racialised context of COVID-19 and the amplification of the BLM movement in 2020 will become topical areas of interest for researchers within this field, which at the time of writing this review cannot capture. Furthermore, mental health services are not provisioned universally. Thus, there are significant differences in how qualifications are awarded and how services are commissioned, ultimately impacting how mental health is addressed.

Whilst the inclusion of studies globally was intentional, due to the lack of UK based studies, these considerations should be held in mind when making interpretations about the usability of the findings. This review was conducted by a single researcher, who is currently a mental health professional in training with prior knowledge of this topic. As such, the possibility of researcher bias is increased. Finally, whilst it was beyond the scope of this review to include grey literature, it is acknowledged that the included studies represent a subset of the knowledge of this topic and that publication bias may have prevented the inclusion of wider findings.

Narrative Literature Review

Race and Racism in the Mental Health System

The NHS operates with the function of *"providing a comprehensive service, available to all, irrespective of race"* (amongst other protected characteristics), *"promoting equality and paying particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population"* (DHSC, 2021a, p.3). Despite this, profound disparities suggest that this does not necessarily translate into practice. There are significant racial differences in access, experiences, and outcomes for individuals from ethnic minority backgrounds within mental health services (Bignall et al., 2020).

Pathways to accessing mental health care are more likely to involve the Police (Bradley Report, 2009; London Assembly Health Committee, 2017) and occur at a point of crisis rather than of an individual's own accord, for example, through a General Practitioner (GP) referral (Cooper et al., 2013; Memon et al., 2016). Indeed, most recent statistics illustrate that between 2019-2020, Black people were four times more likely than White people to be detained under the Mental Health Act 1983, and a staggering 10 times more likely to be subject to the conditions of a community treatment order (CTO) (NHS Digital, 2020). Members of Black and Asian racialised communities are also more likely to be diagnosed with schizophrenia (Fernando, 2017). Furthermore, they are more likely to be treated with medication (Bignall et al., 2020), including that which is administered coercively, for example, rapid tranquilisation using physical restraint (NHS Digital, 2021). Both Fanon's (1952) conceptualisation of Black people as the "phobogenic" (fear-causing) object and dehumanisation theory (Haslam, 2006; Smith, 2016) provide a useful lens through which to view the limits in choice and exertion of control threaded throughout these experiences. The Discovering Community Psychology Collective (2021) suggests that these acts can be conceptualised as examples of by-standing coloniality, by perpetuating the disposability of racialised people through the removal of their rights to liberty and autonomy, and the criminalisation of their experiences of psychological distress.

Race and Racism in Psychological Services

The colonial history of Britain can be further understood within psychology as a predominantly White, middle class, and female profession (Baker & Nash, 2013; Longwill, 2015; Turpin & Coleman, 2010; Williams et al., 2006). This replicates the "snowy white peaks" of the NHS more broadly (Kline, 2014). Psychologists working in the NHS are required to hold professional registration with the HCPC. Standards of proficiency set out by the organisation require that clinicians "be aware of the impact of culture, equality, and diversity on practice" (HCPC, 2015, p.8). Psychologists are expected to understand the impact of differences, such as ethnicity and culture, on psychological wellbeing and behaviour, and adapt their practice to meet the needs of different groups (HCPC, 2015). Despite this, service users from racialised communities are less frequently referred to psychological services compared with their White counterparts (Bignall et al., 2020; Das-Munshi et al., 2018; Fernando, 2017). This remains the case even when psychological therapy is considered frontline treatment, for example, CBT for psychosis (Morris et al., 2020).

Research suggests that people from racialised communities are more likely to drop out before the agreed end of psychological therapy (de Haan et al., 2018; Zeber et al., 2017). These disparities are often considered the inevitable product of beliefs that racialised communities are less likely to disclose mental health difficulties due to cultural stigma

(Bracke et al., 2019; Park et al., 2018; Salami et al., 2019), are less likely to trust professionals (Brooks & Hopkins, 2017; Carlisle & Murray, 2020; Taylor et al., 2019) and are more likely to prefer informal community-led avenues of support (Brown et al., 2014; Chase & Sapkota, 2017; Weng & Spaulding-Givens, 2017). Whilst evidence exists to support these hypotheses, there is arguably a more nuanced explanation of this issue, for example, surrounding the representation of psychological services in the NHS as an institution of power and authority (Memon et al., 2016). Although it is widely acknowledged in the psychological profession that a one size fits all approach is inappropriate at best and harmful at worst for the diverse representation it serves (Cloitre, 2015), the evidence base detailed in the next section is yet to truly reflect these issues.

Race and Psychological Trauma

Exploration thus far within this thesis positions racism as a human rights issue (Mollica & Fernando, 2020), which is a pervasive and persistent experience for people from racialised communities. The current research now turns to the psychological impacts of such experiences, beginning with an overview of how trauma is traditionally conceptualised, before appraising frameworks to understand the psychological impacts of racism. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) defines post-traumatic stress disorder (PTSD) as *"actual or threatened death, serious injury, or sexual violence"* (American Psychiatric Association [APAa], 2013, p.271). Emotional responses to traumatic events manifest in variable ways and can occur immediately following the event or over a longer period of time. Commonly experienced symptoms of PTSD are grouped into four categories: (1) intrusions; involuntary memories, nightmares, and flashbacks of the event, which often feel vivid or real, (2) avoidance; of people, places, objects, or dialogues which are reminders of the event, (3) alterations in cognition and mood; including low mood, anxiety, difficulties integrating contextual memories with emotional memories of the event, and distorted thoughts about the cause or consequences of the event, and (4) alterations in arousal and reactivity; including hypervigilance, irritability, and difficulties concentrating and sleeping (APA, 2013; National Instutute for Health & Care Excellence [NICE], 2018).

Psychological understandings of trauma have developed significantly in recent decades. The emphasis on a singular event in the diagnosis of PTSD has been criticised for neglecting the impact of prolonged and repeated incidences of trauma, often originating in childhood and interpersonal in nature, for example, childhood sexual abuse, neglect, or torture. Herman (1992) proposed complex post-traumatic stress disorder (C-PTSD) as a clinical syndrome to incorporate such experiences. This has gained momentum in the contemporary literature, most prominently to challenge highly debated diagnoses, such as psychosis (Mayo et al., 2017; Misiak et al., 2017; Vallath et al., 2020) and emotionally unstable personality disorder (Darongkamas et al., 2020; Morris et al., 2021).

Research indicates that members of Black and Asian racialised communities experience higher rates of PTSD than their White counterparts, evident in the extensive US literature (Alegría et al., 2013; Comas-Díaz et al., 2019; Roberts et al., 2011; Sibrava et al., 2019). This is echoed in UK statistics, where, according to the Adult Psychiatric Morbidity Survey, last conducted in 2014, 8.3% of those belonging to the “Black British” and 5.8% of both the “Asian British” and “Mixed/Other” ethnic groups screened positive for PTSD. This was compared with 4.2% of those belonging to the “White British” and 2.2% of the “White Other” ethnic group (McManus et al., 2016). Here, screening positive refers to individuals who obtained a score of 50 or more on the PTSD Checklist- Civilian (PCL-C) and met DSM-V criteria for PTSD. As such, this does not confirm a diagnosis of PTSD, but rather that further investigation, for example, through a clinical interview, may be beneficial. These figures should be interpreted with caution, however, as they represent a very small subset of the British population (7,500 people), and the survey included both clinical and non-clinical samples. Furthermore, the survey represents data from seven years ago and is due to be repeated this year (2021). Thus, it is likely that these figures may have changed, particularly in light of the aforementioned growth in the trauma literature. Nevertheless, this disparity warrants further investigation into the potential influencing factors.

It is suggested that racial disparities in rates of PTSD reflect wider inequalities in society, such as socioeconomic status (Assari, 2020; Brewin et al., 2000; Mock & Arai, 2011). However, it is argued that these disparities cannot wholly account for racial differences. Sibrava and colleagues conducted a recent five-year longitudinal study examining the relationship between perceived racial discrimination and the presence of clinically diagnosed PTSD in a large sample of 166 African American and 132 Latinx individuals (Sibrava et al., 2019). Logistic regression analyses suggested that experiences of discrimination significantly predicted a PTSD diagnosis but did not predict any other type of anxiety disorder (such as generalised anxiety disorder or panic disorder), accounting for 24.8% to 37.9% of the variance in PTSD diagnostic status. Significant predictors of PTSD in the African American group included: being called names and/or insulted, threats or harassment, and witnessing friends being mistreated because of racial or ethnic group. Being treated as though one has a lower educational status because of race was identified as a predictor of PTSD in the Latinx group. Five-year remission rates of 0.38 were identified in the African American sample and 0.10 in the Latinx sample, respectively, further evidencing the chronicity of PTSD in this sample. Sibrava and colleagues suggest that these findings point to the potential implication that for individuals from racially marginalised backgrounds, racial discrimination may itself be a traumatic experience, rather than a by-product of PTSD (Sibrava et al., 2019). This line of inquiry, of racism as a traumatic experience in and of itself, is the focus of this thesis and will be introduced in the following sections.

Eurocentric Approaches to Psychological Trauma

Clinical guidelines recommend individual trauma-focused CBT interventions for the treatment of PTSD, including cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy (NET), prolonged exposure therapy, and eye movement desensitisation and reprocessing (EMDR) (NICE, 2018). Translating evidence-based treatments from Westernised countries in response to ongoing diversification is complicated by the balance between successfully adapting approaches whilst staying close to the protocols upon which the evidence is based (Bernal et al., 2009). Recent systematic reviews report positive outcomes, yet significant heterogeneity across studies compounds the generalisability of these findings (Ennis et al., 2020; Thompson et al., 2018; Wright et al., 2020). This is particularly the case for EMDR, for which the evidence base is promising but less extensive (Naseh et al., 2019; ter Heide et al., 2014; Wilson et al., 2018). A review of the EMDR and NET evidence base between 1990 and 2016 by Afuape (2020) raised concerns regarding the decontextualisation of trauma involved in these approaches. Afuape (2020) noted that these approaches risked compartmentalising ethnicity, culture, and language from understandings of the experience of trauma, and assuming the universality of PTSD. Furthermore, the dominance of WEIRD (Western, Educated, Industrialised, Rich, and Democratic) populations in those both undertaking and participating in the research literature maintains a focus on individualism in the aetiology and treatment of psychological distress (Arnett, 2016; Henrich et al., 2010). This presents challenges for the current psychological evidence base in providing holistic and racially sensitive care for the diverse populations across the UK.

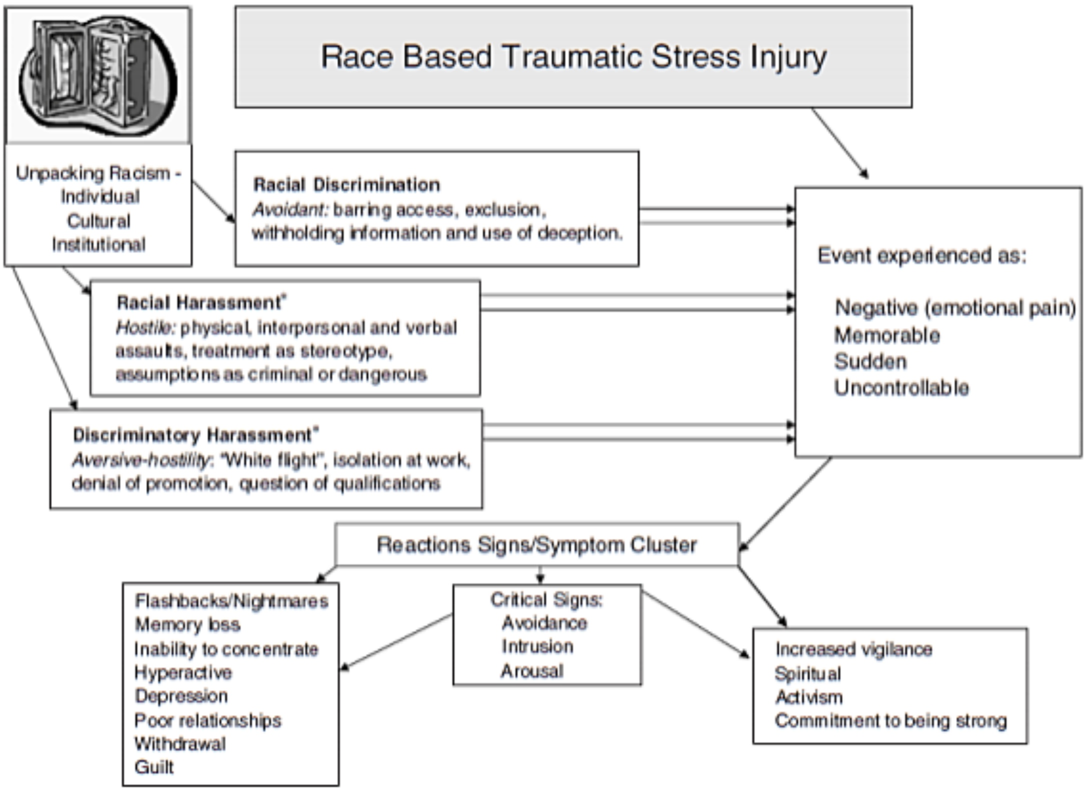
Conceptualising Racial Trauma

American psychologist Carter (2007) introduced the concept of racial trauma, or race-based traumatic stress, in his seminal paper. Drawing upon historical literature concerning psychological trauma, Carter noticed that stressful life events and racial discrimination did not appear to marry together to explore the direct impact of racism on mental distress, or the possibility of trauma as a response to racism (Clark et al., 1999; Norris, 1992). Noting that where researchers had attempted to link racism and trauma, they had done so using the criteria for PTSD outlined by the APA, Carter argued that this neglected the complexities in how individuals appraise traumatic events and in their own relationship with their racial identity (Bryant-Davis & Ocampo, 2005; Williams & Williams-Morris, 2000). Notably, Carter was interested in the emotional and psychological harm resulting from racism, which clinical guidelines did not account for, due to the focus on actual or threatened physical harm (APA, 2013). This can be viewed as an example of Eurocentric standards of psychological distress failing to meet the needs of racialised communities, as racist experiences do not always pose an actual or immediate threat to life (Carter & Pieterse, 2020; Carter et al., 2013).

Carter (2007) proposed the race-based traumatic stress injury model to understand the psychological impacts of racism (see Figure 1). The theory postulates that racism occurs at multiple levels (individual, cultural, and institutional), and in various forms. These include: (1) racial discrimination; this often involves avoidance of racialised communities, by barring access to opportunities, (2) racial harassment; this involves hostile treatment, for example, through physical, interpersonal, and verbal assaults, or assigning stereotypes which portray racialised communities as dangerous or criminalised, and (3) discriminatory harassment; this incorporates racial microaggressions, such as the denial of promotions, and questioning the intelligence of members of racialised communities. These events are experienced as sudden, out of one’s control, and emotionally painful, and give rise to stress responses, such as flashbacks, nightmares, depression, withdrawal, avoidance, intrusion, and increased vigilance. Whilst many of these responses are parallel to those understood in the dominant discourse of psychological trauma, an important distinction of Carter's (2007) model is that the emotional response is dependent upon the appraisal of the individual, rather than a predetermined set of criteria, as is the case for PTSD (APA, 2013). This is a key strength of the model, as it acknowledges the chronicity of racial trauma, as an experience that is often the product of an accumulation of racial events across an individual's life instead of one singular event (Williams et al., 2018a). Interestingly, this echoes the premise of C-PTSD; however, racial trauma remains absent from the literature pertaining to this. Carter's (2007) definition has influenced an emergence of research and clinical interest in racial trauma, primarily in the US, which will now be explored in relation to contemporary literature.

Figure 1

Carter's (2007) race-based traumatic stress injury model



Contemporary Racial Trauma Literature

The relationship between racism and mental health is prolifically reported within the literature and supported by robust systematic review findings. Pieterse et al. (2012) conducted a meta-analytic review of 66 studies of Black American adults analysing mental health indicators associated with perceived racism. They concluded that there was a significant positive correlation between perceived racism and psychological distress. Similarly, Paradies et al. (2015) reported that racism was associated with poor mental health in a systematic review and meta-analysis of 293 studies. Most recently, Kirkinis et al. (2018) systematically reviewed 28 studies pertaining to the relationship between racism and trauma, determining moderate to strong associations between racial discrimination and trauma. The results highlighted that 70% of the trauma symptomology outcomes were statistically significantly associated with racial discrimination. These findings are further supported by Priest et al.'s (2013) review of the literature concerning children and young people, with statistically significant associations with racial discrimination found in 76% of outcomes concerning mental health. However, these findings compound the complexities of isolating racism from other forms of psychological distress, such as depression and anxiety, as is the case in the reviews of Paradies et al. (2015), Pieterse et al. (2012), and Priest et al. (2013). Furthermore, Kirkinis et al.'s (2018) review did not control for non-race related trauma. None of these reviews incorporated secondary forms of racism, such as vicarious, collective, or intergenerational (Santiago et al., 2016). These novel forms are arguably of increased interest in the current climate, where access to video footage of traumatic events is readily accessible via social media and news broadcasting. Finally, no qualitative systematic reviews exploring the relationship between racism and trauma currently exist to the researcher’s knowledge, indicating a substantial gap in the literature.

Limitations in the literature correlating racism and trauma has implications for the acknowledgement of and attention paid to racial trauma within therapeutic domains. Hemmings and Evans (2018) conducted a survey of US counsellors' experience of exploring racial trauma, concluding that whilst 70.8% of participants had worked with service users who had disclosed experiences of racial trauma, 67% reported that they had not received sufficient training to identify racial trauma at assessment. Furthermore, 81.1% had not received training on the treatment of racial trauma. This is further complicated by disparities within the literature with regards to whether racial trauma should be conceptualised as a clinical diagnosis, defined by symptomology which can be assessed and treated as such (Bryant-Davis & Ocampo, 2005), or as a critical discourse, which focuses on the social and political structures perpetuating racial injustice (Comas-Díaz, 2016; Hartmann et al., 2019). The former has been explored in the development of specific psychometric assessment tools which provide information about the symptomology of racial trauma (Carter et al., 2013; Torres-Harding et al., 2012; Williams et al., 2018a; Williams et al., 2018b). However, the latter would represent a significant shift in how psychological services operate, which the literature to date has yet to explore.

Chapter Three: Method

Chapter Overview

The current research used an exploratory qualitative paradigm, embedded within a critical realist framework, to explore UK psychologists' understanding of racial trauma, and their experiences of exploring this with clients from Black and Asian backgrounds. This chapter overviews the research process through a critical realist lens, providing justification for the qualitative paradigm and methodology adopted. This will give rise to a rationale for the appropriate methods of data collection and analysis, informed by consultation with an expert by experience in the topic area of racial trauma. The research process will then be detailed, placed in the context of the mental health services from which participants were recruited. Ethical considerations relative to both participant and researcher safety and wellbeing, as well as wider societal ethical considerations, will be discussed. Finally, preliminary plans for dissemination will be discussed, with a view to assessing which avenues would be best placed to share the findings of the research widely. The reporting of this research process was guided by the consolidated criteria for reporting qualitative research (COREQ), which details a 32-item checklist based on three domains: research team and reflexivity, study design, and analysis and findings (Tong et al., 2007).

Philosophical Paradigm

At the cornerstone of any research process is the philosophical paradigm upon which it is grounded. This paradigm critically analyses what is considered to be reality, and the ways in which knowledge is acquired about this reality. This process ensures that the researcher's subjective understanding of the phenomenon of interest is embedded within the relevant context (Kuhn, 1962). Research philosophy is most often positioned within the theories of ontology and epistemology, which broadly refer to the nature of reality or being, and the nature of knowledge, respectively (Grix, 2019). Identifying ontological and epistemological positions is an essential step in maintaining consistency throughout the research process, employing appropriate methods which align with this positioning, and in situating the researcher as an active component within this process (Coolican, 2018). In taking ownership of positionality, the researcher is able to demonstrate transparency, strengthening the rigour of the research (Jacobson & Mustafa, 2019; Willig, 2013). The following sections will provide details of the various ontological, epistemological, and methodological frameworks, to set the scene for why a critical realist position was adopted for the purpose of this research.

Ontology

Ontology relates to the philosophical study of being in relation to the world around us (Effingham, 2013; Grix, 2019; Guba & Lincoln, 1989). That is, how do we know that something exists? Positioning oneself along the ontological continuum encourages the researcher to make sense of whether they believe that reality exists external to human understanding or perspective (realism), or whether in order for a concept to be real it must be interpreted (relativism) (Braun & Clarke, 2013).

The realist position assumes that there is one objective truth, which exists outside the realm of human interpretation (Coolican, 2018). Researchers who adopt a realist position hold the belief that through the application of objective measurement, it is possible to discover the true reality of a phenomenon (Denzin & Lincoln, 2017). At the other end of the ontological continuum, the relativist position acknowledges the existence of multiple truths, which are believed to be imperative in understanding a phenomenon (Coolican, 2018). Researchers who adopt a relativist position demonstrate fluidity by incorporating contextual information, in order to analyse and reformulate their understanding of the world as and when new information arises (Denzin & Lincoln, 2017).

Between the realist and relativist positions sits the critical realist position. Researchers who adopt this position combine the belief that there exists a pre-social reality, which must be recognised in order to produce research grounded in knowledge to make worthwhile change (Bhaskar, 2016; Pilgrim, 2019). This is combined with the acknowledgement that there are limits to the accessibility of this reality. These limitations are representative of the social lens through which researchers inevitably view the world, which consequently shape the way in which knowledge is interpreted.

Epistemology

Once an ontological position has been established, epistemology helps us to understand how we acquire, conceptualise, and communicate knowledge, in a way which makes sense in relation to our world view of what reality is (Grix, 2019; Scott & Usher, 2010). That is, what is considered to be valid, trustworthy knowledge and what determines whether we trust this knowledge or not? Epistemology relates to the philosophical study of the origin of knowledge and how we investigate the world around us (Audi, 2010). The epistemological continuum broadly places researchers in relation to whether they believe that reality is discovered through the research process (positivism), or whether it is created through the research process (constructivism) (Braun & Clarke, 2013, p.29). This contributes to researchers' understanding of how best to acquire knowledge about the world and its reality.

The positivist position draws upon empiricism to use objective, unbiased methods of data collection to discover the single truth, consistent and independent of human perception (Denzin & Lincoln, 2017). Research which adopts the positivist position is considered to be "value-free", in using scientific methods (e.g., experiments) to control variables and thus eliminate the influence of confounding variables (Coolican, 2018). As such, positivist researchers believe in the impartiality or detachment of the researcher, in maintaining an observational role and avoiding influencing the research with their own beliefs and ideas (Pilgrim, 2019). Alongside positivism also sits post-positivism, a position which maintains the quest for the single truth, whilst also acknowledging the inevitable influence of the researcher's context (Creswell & Creswell, 2018; Phillips et al., 2000).

At the opposite end of the epistemological continuum lies the constructivist position, which locates the production of knowledge within the social world in which individuals exist (Berger & Luckmann, 1967; Lincoln & Guba, 1985). The notion of one singular truth or foundation of knowledge is rejected, and instead constructivist researchers seek dynamic understandings of the world, informed by social, cultural, moral, ideological, and political contexts (Braun & Clarke, 2013, p. 30). Knowledge is believed to be the result of the process by which we come to understand it, through our views of the self, others, and the world (Creswell & Creswell, 2018; Crotty, 1998). Thus, constructivism both accepts and values the active presence of the researcher in the research process, and the process by which knowledge is acquired is collaborative and everchanging (Creswell & Creswell, 2018).

Methodology

Collectively, ontology and epistemology are used to identify the most appropriate methodological framework to answer the research question through the theoretical lens adopted by the researcher (Braun & Clarke, 2013). Research methodology outlines theoretical assumptions relative to the philosophical approach adopted by the researcher. This provides direction as to which methods are best placed to answer the research question, how best to identify participants, collect data, analyse data, and position the researcher (Braun & Clarke, 2013). Methodology is traditionally viewed in terms of two dichotomous approaches, quantitative and qualitative (Coolican, 2018). Drawing upon realist and positivist paradigms, quantitative methods use numerical data to identify relationships between variables, with the aim of making predictions and deductively testing them (Braun & Clarke, 2013; Tolich & Davidson, 2003). Data collected in this way are often used to make generalisations to the wider population, to seek consensus, and to make correlational patterns (Martin & Bridgmon, 2012). Quantitative methods require a level of objectivity and impartiality from the researcher and emphasise the importance of reducing the impact of confounding variables, such as the personal involvement of the researcher (Coolican, 2018). Examples of the use of quantitative methods include the statistical data collected to evidence ethnic inequalities in mental healthcare (Bhui et al., 2003; Halvorsrud et al., 2018; Moore et al., 2019).

Conversely, qualitative methods adopt the principles of relativism and constructivism, using discourse to explore, understand, and interpret meaning (Maxwell, 2012). Such methods are not usually used to make generalisations, but rather provide further understanding of quantitative findings and a voice to those participating (Coolican, 2018). Qualitative methods value subjectivity and reflexivity throughout the research process and it is argued that the researcher and participants cannot be separated from the data (Denzin & Lincoln, 2017).

Research Paradigm

The research paradigm combines the beliefs, assumptions, and values underpinned by the ontological, epistemological, and methodological position of the researcher into a qualitative framework (Braun & Clarke, 2013). These are then used to select specific qualitative data collection and analysis techniques to answer the research question (Kidder & Fine, 1987). The current research adopts a critical realist approach, bridging together realist ontology and constructivist epistemology (Willig, 1999). Realist ontology is applicable to racism within British society as a reality for people from Black and Asian racialised backgrounds, demonstrated by consistent disproportionate rates of inequality. The positioning of racism as a reality is especially important given the subtle and insidious nature of microaggressions, the impacts of which are often overlooked, ignored, or poorly understood (Sue et al., 2007, 2019).

Constructivist epistemology is applicable to the individual experience and interpretation of racial trauma as being subjective. Qualitative methodology lends itself well to studying this phenomenon, as it focuses on understanding the nuanced accounts of individuals (Schneider, 2010), giving a deeper insight into the *"co-constructions of meaning, lived experiences, cultural rituals, and oppressive practices"* (Atkinson, 2017, p.65). The current lack of qualitative research into racial trauma in the UK also highlights a gap in knowledge, which could be used to help further understand the well-established racial inequalities in mental health care.

Researcher Positionality

By recognising and using the researcher as an active agent in the research process, that is, the sculptor, who makes choices about the ways in data are interpreted, the rigor and trustworthiness of the research can be strengthened (Braun & Clarke, 2013; Leibing & McLean, 2007). This allows the reader to make sense of the findings within the social context of the researcher's identity (Finlay, 2002). This section will be written in the first person, to represent the researcher's active presence within the research, and the impact of this on how the research was conducted (Webb, 1992).

At the time of submitting this research, I identify as a 27-year-old Black British female of third-generation Jamaican heritage. I am a final year trainee clinical psychologist at the University of Essex, employed by Essex Partnership University NHS Foundation Trust. I have a BSc Honours degree in Psychology and have previous experience of conducting qualitative research on the topic of race and mental health, using thematic analysis. I have experiences of working as an assistant psychologist and research assistant pre-training, and more recently as a trainee clinical psychologist, with service users from Black and Asian backgrounds in diverse areas of East London and Bedfordshire. At the time of writing this thesis I am on a year-long clinical placement within a specialist refugee service. This has enriched my understanding of the intersectional forms of oppression faced by individuals leaving their country of origin to seek asylum in the UK, and the ongoing psychological impact of these experiences. My experiences have all involved working closely with and receiving supervision from qualified clinical, counselling, forensic, and health psychologists.

The following account is underpinned by the process of social identity mapping, a reflexive tool designed to provide a starting point for qualitative researchers to position themselves in relation to their research (Jacobson & Mustafa, 2019). Key questions for consideration were: *"How do these facets of my identity (in combination with other facets) impact the way I approach, interact with, and interpret my research? How do these facets impact the way I understand and interact with my participants?"* (Jacobson & Mustafa, 2019, p.4). Whilst reflecting on positionality is in practice an iterative process that evolves as the research develops, for the purpose of this thesis a linear account, from the point of design, data collection, data analysis, and interpretation of findings, is provided. A visual representation of my own social identity map can be found in Appendix G, depicting the parts of myself which I believe most came alive and influenced the research. The next sections are written using headings adopted by Jacobson & Mustafa (2019), representing my presence and influence across the entire research process.

Approach to Research (Design). As a Black woman first and foremost, I acknowledge that I bring to this research both a personal and collective history of racist experiences within the Black community. As such, I am acutely aware of the strong sense of injustice which contributes to the way I view and make sense of the world. These experiences have been motivating factors in my commitment to social justice, and from the early stages of my career in clinical psychology I have been aware and increasingly vigilant of the racist foundations upon which the profession rests.

In the early stages of designing the current research, concerns were raised about the emotional impact of this topic area, and the ability for me to maintain sufficient analytic distance to approach the study from a research-oriented, rather than personal, standpoint. Whilst important to consider, I maintained that had a researcher from a different racial background conducted this research, there may not have been the same level of cultural sensitivity or knowledge of the topic required to contribute to the level of systemic change I hope to achieve. In an effort to both take care of myself and take steps to produce a high-quality piece of research, I made use of a reflective log, regular supervision, personal therapy, and peer reflective spaces throughout the research process.

Interaction with Participants (Data Collection). Qualitative research studies often report on the presence of power within the researcher-participant relationship, most notably of the power held by researchers as those who have the most control over and ultimately benefit the most from the research interaction (Durkin et al., 2020). As a trainee, interviewing qualified psychologists presented power dynamics on both manifest and latent levels. Participants represented both the position I aspire to assume once I complete the doctorate, and the position of those who are complicit members of the NHS as an institutionally racist system. This is a concept continually supported by statistics concerning the experiences of staff in the NHS (Workforce Race Equality Standard [WRES], 2021). Furthermore, my previous experience of engaging in dialogues around racism in professional spaces has been challenging, and I acknowledge that this will have influenced my frame of reference when anticipating participants' responses. I am aware that the topic of racism is difficult to discuss, and is often met with silence (Lee et al., 2018; Premkumar et al., 2018; Sue, 2016), denial, and defensiveness (Carter & Murphy, 2015; Greenhill & Marshall, 2016).

I began conducting interviews in July 2020; the context behind this time period is of great significance to this research. On 25th May 2020, a Black man, George Floyd was murdered by a White police officer in Minneapolis, USA. Subsequently, the BLM movement was amplified on a global scale. During the time of my interviews, protests were happening across the world, and news and social media coverage of current events was inescapable. This climate of racial tension may have, both consciously and unconsciously, influenced my feelings towards participants, and my hypotheses about their motivations to participate. Indeed, the events of 2020 have been conceptualised as a societal "racial awakening" (Cordy, 2021). This manifested within the power dynamics between myself and the participants in the different experiences I had when interviewing White psychologists and Black psychologists. I experienced a level of familiarity and comfort when interviewing Black psychologists which was not present with other participants. I believe this facilitated a shared colloquial understanding of issues faced uniquely by Black psychologists. In comparison, I noted my own anxiety, discomfort, and at times anger when interviewing White psychologists, a common experience reported by people of colour who are often burdened with the task of naming racism (Eddo-Lodge, 2017). Interestingly, I experienced some similarities when interviewing Asian psychologists, perhaps related to a shared experience of being racially minoritised. I recall the apprehension I felt before each interview, almost an unease about how having repeated discussions about racism and racial trauma would impact me. This manifested in different ways during the interviews; at times I felt like I brought high energy, asking multiple probing questions, seeking to dig deeper into the reasons why participants had responded in the ways they had when exploring racial trauma. During other interviews, I was taken by surprise at the level of detail participants shared with me when describing case examples of racism experienced by service users they had worked with. I vividly remember pausing during many interviews, caught off guard at the powerful emotions erupting within me, the deep-seated sense of injustice almost taking my breath away. These emotional responses were supported through extra research supervision sessions, as well as my own personal therapy space.

Interpretation of Findings (Data Analysis and Write Up). Given the breadth of this topic, there were many ways in which I could have approached analysis of the data. I am acutely aware that due to my desire to educate myself about my own racial history, in the absence of this in the British education system, it was not possible for me to disregard this information when analysing participants' accounts. The process of researching and educating myself about Britain's role in the colonisation of many nations, including those of my ancestors, was an intensely emotional experience. I recall feeling paralysed with anger and pain on many occasions during the process of writing up this thesis. At times I genuinely wondered if I could complete this work, whether those who had questioned my proximity to the research in the initial design stages of the project were right to express concerns. I now recognise this as part of my own experiences of racial trauma, which have been exacerbated throughout my clinical psychology training. Whilst I could not have anticipated that I would be conducting this research in the midst of such heightened racial unrest across the world, in hindsight I believe that at times I gave so much, perhaps even too much, to this process, at the expense of my own self-care and wellbeing. I draw stark comparisons here with Chen and Gorski's (2015) conceptualisation of "activism burnout", that is the cycle of exhaustion, stress, social isolation, and selflessness, which can ultimately result in the inability to continue the work. In all honesty, the past three years were never going to be enough to fully convey this topic with the justice that I so strongly believe that it deserves, whilst balancing my professional development as a clinical psychologist, and my personal healing as a Black woman.

The interpretative stance I chose to adopt was one which went beyond the semantic level of simply describing how participants experienced addressing racial trauma with service users from Black and Asian racialised communities. I instead sought to situate these experiences within the systems participants sat as members of the NHS, a complicit institution in the racial subjugation of minoritised groups. This shaped my interpretations at the latent level, thinking beyond the therapeutic dyad and more widely to consider the responsibility of psychologists as advocates for the promotion of racial equality within mental health services. Thus, I acknowledge that my interpretations are embedded within my own self-proclaimed identity as a racial activist and will have influenced the specific attention that I paid to the colonial history of Britain, and the links between this and the perpetuation of racial trauma within psychological services.

Research Design

Consultation

The inclusion of expert opinions from key stakeholders, such as service users, carers, communities, academics, and professionals, is increasingly common practice in qualitative research (Ferraz, 2018). Seeking views from those directly affected by the topic helps to situate the research in a way which gives voice to those for whom the implications hold the most relevance (Groot et al., 2020). This is a key motivator of participatory health research (PHR), which aims to consider the inherent power dynamics within healthcare and subsequently in healthcare research (Groot & Abma, 2018). This is especially important for research concerning minoritised and marginalised communities, for whom structural forms of power historically operate against (Bell & Pahl, 2018; Burns et al., 2014). Whilst beyond the scope of this doctoral thesis to conduct research entirely in collaboration with experts by experience, the researcher acknowledges that for the research to fully embody the values of anti-racist research, co-production at every stage of the process with individuals with lived experience of racial trauma would be ideal. The following paragraphs describe the process of consultation at the point of design and analysis, in collaboration with individuals who hold positions of expert by experience, mental health professional, and researcher.

The researcher sought consultation from Dr Colin King, a mental health survivor, practitioner, author, and researcher, during the design and analysis stages of the current research (King, 2007). Dr King suggested consistency in referring to racial trauma throughout the research and made recommendations for further reading to enrich the literature review in chapters one and two. The researcher also sought consultation from Dr Rhiannon Quann (clinical psychologist) and Dr Anne Coxon (health psychologist), who knew the researcher within the capacity of providing clinical supervision for the purpose of the Doctorate in Clinical Psychology programme. Dr Quann and Dr Coxon took part in pilot interview style discussions with the researcher, in order to feedback how they might respond to the questions asked. Both Dr Quann and Dr Coxon are of White British heritage, which the researcher identified as significant in providing a space to explore the concept of Whiteness, as it pertains to defensiveness, guilt, shame, and denial. This generated rich and meaningful discussions, within which Dr Quann and Dr Coxon commented on the importance of the research outweighing any discomfort they may have experienced.

The researcher also consulted with Tracey Johns, Public Involvement Lead for the Essex hub of the National Institute for Health Research (NIHR) East of England Research Design Service. Ms Johns engaged with the researcher in a reflective space surrounding the terminology used to define race throughout the thesis. To complement the design of the current research, the researcher also attended conferences and webinars on the topic of racism and mental health, which provided opportunities to network with other researchers in the field.

Data Collection Method

Of utmost importance is the selection of a method which aligns with the researcher's philosophical and theoretical frameworks and has the ability to answer the research question well (Coolican, 2018). After consideration of various primary and secondary methods of qualitative data collection, semi-structured interviews were considered best suited to the current research.

Semi-Structured Interviews. Interviews are one of the most common and familiar data collection methods available to qualitative researchers (Coolican, 2018; Jamshed, 2014), including those conducting healthcare research (DeJonckheere & Vaughn, 2019). The process of a qualitative interview traditionally involves questions asked by the researcher and answered by the participant, with the aim of learning about the participant's experiences and perspectives in relation to the researcher's predetermined topic (Kvale, 2007; Rubin & Rubin, 2011). Types of interviews can be divided into structured, semi-structured, and unstructured. The semi-structured interview, or interview guide approach (Patton, 2002), is most dominant in qualitative research. This approach provides a balance between the strict predetermined nature of the structured interview, and the free participant-led nature of the unstructured interview (Smith, 1995). Semi-structured interviews allow for the exploration of topics in a way which balances the benefits of having the structure of a topic guide to refer to for guidance and adherence to the research question, with the freedom of participants to explore areas of the phenomenon which resonate and hold the most importance to them (Smith, 1995). In this way, the researcher is able to deviate from the topic guide where necessary, to capture perspectives and experiences which may not have been anticipated in the initial development of the interview questions, but hold resonance for the individual participant, and subsequently change the trajectory of the interview (Charmaz, 2002). Within the critical realist paradigm of the current research, semi-structured interviews were considered the most appropriate method of data collection, in line with the reality of racism as a psychologically distressing experience, which can be understood using multiple interpretations.

Data Analysis Method

The process of qualitative data analysis serves different functions, dependent upon the research paradigm adopted by the researcher. Descriptive analysis provides a platform for participants to share their experiences, whereas interpretative analysis moves beyond the descriptive level to generate ideas about how and why participants have recounted their experiences in this way (Braun & Clarke, 2013). For the purpose of the current research, thematic analysis was identified as the most appropriate method of data analysis, and justification for this is detailed in the following sections.

Thematic Analysis (TA). TA is broadly defined as an overarching term for methods of *"identifying, analysing and reporting patterns (themes) within data"* (Braun & Clarke, 2006, p.79). In the early days of its conception, Braun and Clarke (2006) noted that the approach was *"a poorly demarcated, and rarely acknowledged, yet widely used qualitative analytic method"* (p.77). This places the onus on the researcher to actively present the ontological, epistemological, and methodological positions from which they approach the analysis (Braun et al., 2019). Braun and Clarke (2020) propose that common misconceptions largely originate from the assumption of TA as one singular approach (Firmin, 2008).

Conversely, Braun and Clarke (2019) separate TA into three typologies, each possessing different assumptions and ascribing to different theoretical frameworks: coding reliability, codebook, and reflexive. Reflexive thematic analysis, that is, a complete qualitative approach combining qualitative data collection techniques with a qualitative paradigm (Braun & Clarke, 2019), was deemed to be most aligned with the current research.

Reflexive Thematic Analysis (TA). Also known as a "Big Q" approach (Braun & Clarke, 2019; Kidder & Fine, 1987), reflexive TA most commonly uses an inductive (data-driven) approach to generate themes, whilst maintaining theoretical alliance with the researcher's philosophical values and assumptions (Braun & Clarke, 2013). Unlike in coding reliability TA, coding in reflexive TA is viewed as a subjective process, which does not require validation from other researchers (Braun & Clarke, 2019). In line with the critical realist approach of the current research, reflexive TA was considered to be the most appropriate method of data analysis, in allowing for nuanced understandings of racial trauma to be developed between the participant and researcher.

Research Materials

Demographics Sheet. In order to situate the study sample, a demographics sheet requesting the following information from participants was disseminated prior to each interview: gender, age, ethnicity, occupation, current job role, name of current service, London borough of current service, length of time working in current service, and length of time qualified (See Appendix H). This information aided the researcher's interaction with each participant and the interpretation of each interview, within the context of the participants' personal and professional identities.

Interview Topic Guide. The use of a topic guide is a useful material in qualitative research. The guide provides consistency and direction for the researcher in setting the parameters for areas of exploration necessary to answer the research question (Patton, 2002; Smith, 1995), within the methodological approach adopted (Laksov et al., 2017). The use of a guide as opposed to a set agenda allowed for the trajectory of the interviews to be influenced by lines of inquiry that the participants raised. In this way, the interviews could be tailored to the areas of importance as determined by each individual participant, whilst still allowing for the data to be combined to allow for patterns and themes to be interpreted (Charmaz, 2002; Kallio et al., 2016). The use of probes and follow up questions also facilitated a rich in-depth interview process (Lingard & Kennedy, 2010).

The topic guide was developed in collaboration with Dr Colin King, Dr Rhiannon Quann and Dr Anne Coxon. Dr Quann and Dr Coxon recommended using terminology that participants, as psychologists, could easily make sense of, such as assessment, formulation, and intervention. Dr King recommended separating questions into sub-headings relative to the research question. The topic guide was piloted with Dr Quann and Dr Coxon, who suggested that including the word “psychological” when referring to racial trauma may aid in orienting participants to the topic. These suggestions are reflected in the final topic guide (see Appendix I).

Service Context

The current research was conducted with psychologists working in acute and community mental health services in North East London. The topic area of racial trauma required the research to be set in a context within which the ethnicity data indicated a diverse population. This section begins with a general overview of the wider population in North East

London from which the study is situated, before considering levels of representation of mental health services in this area, in order to situate the sample recruited into the study.

Overview of Ethnic Diversity within North East London

North East London is made up of four boroughs: Barking & Dagenham, Havering, Redbridge, and Waltham Forest. Of these areas, two boroughs were identified to be in the top 10 most diverse local authorities in England and Wales in the 2011 UK Census; Redbridge was 4th in the ranking with a 42.5% White population, whilst Waltham Forest was 10th in the ranking, with a 52.2% White population (ONS, 2018).

Table 3 details the breakdown of ethnicity demographics for each borough, compiled from the most recent UK Census data in 2011 by the ONS (2018). This has been categorised into five main ethnic categories according to terminology used by the ONS. However, it is acknowledged that this data risk homogenising distinct groups of people and could be further sub-categorised to reflect such distinctions (Thompson, 2015). It is important to situate the level of representation of individuals from Black and Asian racialised communities in each area, as this may have influenced the diversity of the services from which the current research recruited, and subsequently how participants interpreted and answered the interview questions.

Table 3

Ethnicity demographic information for the four boroughs of North East London

Ethnic Group	Barking & Dagenham	Havering	Redbridge	Waltham Forest
White	58.3%	87.66%	42.53%	52.2%
Black	19.98%	4.84%	8.91%	17.34%
Asian	15.92%	4.87%	41.76%	21.06%
Mixed	4.24%	2.08%	4.11%	5.33%
Other	1.57%	0.56%	2.7%	4.07%

Extracted from the 2011 UK Census data (ONS, 2018)

Mental Health Services in North East London

Mental health services across North East London are commissioned by Clinical Commissioning Groups across the four boroughs and provided free at the point of access by North East London NHS Foundation Trust (NELFT). NELFT provides both acute and community services for individuals across the life span residing in the area.

Participants

Inclusion & Exclusion Criteria. Participants were invited to take part in the current research if they met the following criteria. Firstly, participants were required to be qualified psychologists (e.g., clinical, counselling, health, or forensic psychologists), working in acute or community mental health services across the four London boroughs of NELFT. Qualified status was determined by confirming that participants held professional registration with the HCPC. Secondly, participants needed to have experience of working clinically with service users who identified as being from Black and Asian backgrounds. Clinical work here is inclusive of direct work with service users (e.g., assessment, formulation, and treatment), as well as indirect work (e.g., consultations and multi-disciplinary team meetings). Thirdly, participants were required to have worked in their current service for a minimum of six months, so as to increase the likelihood that they would be familiar with the local area within which they worked. Participants were excluded from participation in the current research if they were non-qualified members of staff or if they were employed through the NELFT bank or by an external agency. This was carefully considered, as discussing the psychological impact of racism would likely require trust and a consistent therapeutic relationship, which could be more difficult to establish for those who hold temporary contracts, or those for whom limited training may impact on the ability and appropriateness of providing such a space.

Sampling Method. Purposive sampling was used to select participants for recruitment into the study, a method concerned with recruiting groups of people who share distinct experiences or characteristics (Creswell & Poth, 2016; Suzuki et al., 2007). This was necessary for the current study, as the researcher was interested in participants who collectively have the experience of working in acute and community mental health services, and with service users from Black and Asian racialised backgrounds. A snowball sampling method was also used to strengthen the sampling process, whereby existing participants in the study were asked to refer eligible colleagues to take part in the research. Snowball sampling has been identified as a particularly effective sampling method in research studies where the topic is emotive and challenging to discuss, as a trusted source can provide encouragement to others in the population of interest (Boehnke et al., 2011; Noy, 2008; Penrod et al., 2003).

Braun and Clarke (2013) recommend between 10-20 participants for the purpose of a UK professional doctorate undertaken using reflexive TA, later revised to a more specific recommendation of 6-15 (Terry et al., 2017). This was considered in conjunction with other factors, such as the possibility of withdrawal from the study, and the restrictions imposed by the time-consuming nature of transcribing interviews within the specified timeframe, balanced with other doctoral commitments. With these factors in mind, and the knowledge that the purpose of qualitative research is to amplify specific voices as opposed to make generalisable conclusions, a target of 15 participants was decided upon.

Research Procedure

Recruitment

The Lead Collaborator initially sent email invitations via NELFT psychology email circulation lists, inviting potential participants to contact the researcher directly via email to express interest in taking part. This invitation email also included an attachment of a brief PowerPoint presentation created as a visual aid of the study (see Appendix J). The researcher was also invited to present at a virtual psychology business meeting with the NELFT Early Intervention in Psychosis services via Zoom in August 2020 to encourage recruitment. The voluntary nature of the study was clearly communicated to potential participants, making sure staff were aware that it was not a requirement of their employment with NELFT to participate in the study.

Those who expressed interest in taking part were screened by the researcher to ensure that they met the inclusion criteria for the study and given the opportunity to ask any questions. Once this was satisfied, the researcher sent a follow up email detailing the Zoom link and password for the interview, scheduled at a suitable date and time for both the participant and the researcher.

Conducting Interviews

All interviews took place via Zoom. The researcher took notes during interviews, to account for details which could not be captured via the audio recorder (e.g., facial expressions and body language). Both Zoom and an encrypted Dictaphone were used to audio record each interview and consent was obtained from participants for this. The audio recording was started after initial introductions during the Zoom call and stopped after the final question had been answered. Participants were given the opportunity to debrief about their experiences of taking part immediately after the interview. Participants were verbally thanked for their time. Interviews lasted between 31-78 minutes, with a mean time of 54.56 and a standard deviation of 14.65.

Transcribing Interviews

Interviews were transferred from Zoom and the Dictaphone to a personal computer, where they were saved as encrypted files. Interviews were then transcribed using an orthographic style, focusing on spoken words and non-semantic sounds (Braun & Clarke, 2013). Where relevant, paralinguistic features deemed significant, such as laughter, pauses or emphasising words, were also highlighted during the transcription process. A transcription notation system developed by Jefferson (2004) and later adapted by Braun and Clarke (2013) was used to ensure consistency across transcription of all interviews. In order to mediate the potential for sentence structure errors (Poland, 2002), the researcher chose to limit the punctuation used in the transcription process. This was important in avoiding altering the interpretation of the raw data by placing punctuation in places which could change the meaning of participants' words (Braun & Clarke, 2013).

Interviews were anonymised using participant numbers and assigned pseudonyms. Any information which could potentially compromise anonymity, such as names of people or geographical places more specific than London borough, was redacted. Transcripts were checked for accuracy by the researcher and sent to the academic supervisors for secondary clarity. Transcripts were also sent to each participant via email, to invite any feedback or discrepancies before the final transcripts were confirmed. This was not a mandatory exercise for participants, and they were informed of this and given two weeks to respond if they wished to comment. This process resulted in amendments requested by two participants; one amendment was a request to further redact potentially identifiable information and the second request was to amend a grammatical error. Once these amendments had been made, the interview transcripts were approved and deemed ready for analysis.

Data Analysis

Data analysis involved analysing verbatim responses from the interview transcripts, using contextual information from the demographic sheets, and incorporating the researcher's active presence. The process of data analysis was supported by the use of NVivo qualitative data software (Mac version 1.4) to store and organise codes and themes (QSR International, 2021).

Reflexive Thematic Analysis (TA). Using a critical realist lens, the current research adopted Braun and Clarke's (2006) reflexive approach to TA, combining qualitative values and philosophies with qualitative techniques (Kidder & Fine, 1987). The analysis used both a deductive (theory-driven) and an inductive (data-driven) approach, aiming to combine themes and concepts identified from the literature with interpretations generated directly from the interviews (Braun & Clarke, 2013).

The six stages of TA were followed: (1) familiarisation and writing familiarisation notes, (2) systematic data coding, (3) generating initial themes from coded and collated data, (4) developing and reviewing themes, (5) refining, defining, and naming themes, and (6) writing up the final report (Braun & Clarke, 2006, 2020). Reflexive TA involves familiarity at the level of full immersion with the data, thus the researcher listened back to the audio recordings and read through the transcripts several times, making notes, before proceeding. A complete coding approach was then used to generate subjective codes at the semantic (descriptive) and latent (implicit) level, using the researcher's own conceptual frameworks to interpret implicit meanings (Braun & Clarke, 2013). This process identified 483 initial codes. Interview coding was completed in a random order to reduce order effects, and a second coding sweep of the data was conducted to incorporate any changes to the way the researcher related to the data during the coding process (Braun & Clarke, 2013). See Appendix K for a worked example of a coded transcript.

At this point, codes were gradually collapsed into 37 categories, grouped by central organising concept (the essence or core point of each theme), and a further three categories of codes which related to understanding racial trauma, exploring racial trauma, and making change. Once collated, codes were then used to generate candidate themes, capturing the most salient patterns across the dataset in relation to the research question (see Appendix L for a table detailing which codes fell under which themes). The process of translating codes into themes was influenced by the researcher's own identity as a Black woman, for whom personal and professional experiences of racism have shaped a strong interest in structural forms of oppression related to the exploration of racial trauma in psychological services. As such, the researcher engaged in an in-depth analysis of how participants' responses related to the wider structures of psychology, the NHS, and British society. Candidate themes were then reviewed by revisiting the transcripts, the coded data, and the whole dataset, to ensure that the themes were reflective of the data, captured meaningful patterns, and incorporated central organising concepts which answered the research question (Braun & Clarke, 2013). Candidate themes were then further reviewed by the research supervisors and sent to all participants who had expressed interest in member checking, as well as Dr King. A full description of the member checking process is detailed in the following section on quality assurance. Finally, themes were refined, defined, and named, and written up into the final thesis. Whilst these stages were used as a guideline, reflexive TA is an iterative process, and stages were revisited by the researcher and discussed with the academic supervisors throughout (Braun & Clarke, 2013).

Quality Assurance

Evaluating the quality of research is imperative to assessing the extent to which rigorous criteria have been appropriately maintained to generate trustworthy findings, which can ultimately be used to operationalise clinical, research, and policy change (Braun & Clarke, 2013). Unlike quantitative research, there is no formal criteria for assessing the quality of qualitative research (Reicher, 2000; Seale, 1999). Thus, it is imperative that the researcher demonstrates openness regarding the steps taken to assure quality and gives evidence to support this process (Meyrick, 2006).

Quantitative research is broadly assessed on the criteria of reliability, validity, and generalisability. That is, how likely it is that the same results will be replicated by different researchers (Yardley, 2008), how successful the research is in measuring the phenomenon it claims to (Goodman, 2008), and whether the findings can be applied to wider settings or populations (Sandelowski, 2004; Stephens, 1982), respectively. However, it can be argued that it is inappropriate to assess qualitative research, which is markedly different in terms of procedure and philosophy, using quantitative criteria (Yardley, 2008). Qualitative research does not subscribe to the concept of objectivity in order to assess reliability, as the subjective role of the researcher is actively used as a tool to make sense of the data (Jacobson & Mustafa, 2019). Furthermore, the idea of qualitative research capturing one reality as valid is complicated by the belief in multiple truths within a truly qualitative paradigm (Coolican, 2018). Finally, generalisability in its quantitative form can be viewed as unhelpful for assessing qualitative research, as findings are considered to be context-specific (Denzin &

Lincoln, 2017). To illustrate the process of quality assurance within the current research, the researcher drew upon a variety of methods, both theoretically dependent and neutral. The following sections will outline this process of critical analysis using theoretically neutral qualitative quality principles proposed by Yardley (2000, 2008), as well as the TA specific 15-point checklist devised by Braun and Clarke (2006), detailed in Appendix M.

Yardley's (2000, 2008) quality principles are comprised of four components: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to Context

Sensitivity to context refers to the extent to which the interpretation of the data encapsulates the context, both locally within the researcher-participant interaction, and broadly with respect to the wider social context of the participants (Yardley, 2000). Qualitative research can achieve this by consulting relevant theoretical and empirical literature to situate the research. The current research aimed to embed historical and contemporary theory and literature in an interdisciplinary manner, acknowledging the complex and multifaceted ways in which race, racism, and racial trauma can be understood. Sensitivity to context can be further achieved by maintaining a focus on the socio-cultural context which shapes the ways in which participants understand the phenomenon under investigation. The researcher remained mindful of the impact of the amplification of the BLM movement in the summer of 2020 on the areas of interest explored by participants, which the semi-structured interview design allowed flexibility for (Smith, 1995). The researcher considered amending the topic guide to include a question directly related to the impact of the BLM movement on clinical practice, as this topic organically arose in many of the earlier interviews. However, it was acknowledged that this was a representation of the researcher's own agenda and could potentially move the data away from participants' own areas of interest. Nevertheless, as a Black woman, currently in training on the clinical psychology doctorate, the researcher owned her influence on the data process, making use of a reflective log, and regularly seeking alternative interpretations through research supervision, consultation with an expert by experience, and member checking with participants.

Member checking, or respondent validation, is a commonly used practice within qualitative research, whereby participants are invited to provide feedback on the trustworthiness of the analysis in relation to their experiences (Lincoln & Guba, 1985; Seale, 1999). This method is particularly useful in qualitative research as the results are developed through the researcher's own lens and interpretation of the phenomena. Member checking can be a way of minimising the possibility of misrepresenting participants' experiences (Braun & Clarke, 2013). Within the context of a critical realist paradigm, it is not simply enough to report participants' experiences exactly as they express them; the addition of the researcher's own subjective values and theoretical understandings is essential to the analytical process (Taylor, 2001). The researcher therefore sought a method of member checking which invited participants to complement the analysis rather than assess the researcher. Thus, the current research adopted Tracy's (2010) strategy of member reflections, in which there is not a focus on a single reality, but instead a process of *"sharing and dialoguing with participants about the study findings, and providing opportunities for questions, critique, feedback, affirmation, and collaboration"* (p.844). All 13 participants had indicated that they were interested in taking part in this exercise. All were contacted by email and sent a copy of the candidate themes, with a brief written explanation as to how the researcher had developed them. Participants were given two weeks to respond via email. A total of five participants responded to this invitation. Of those who responded, four participants expressed that the analysis accurately reflected their own experiences. The fifth participant highlighted aspects of the analysis which she felt had not fully captured her experiences of her own racial identity as a psychologist. The researcher also consulted with Dr King again at this stage, who shared praise for the analysis and made recommendations for linking back to key literature. The researcher then revisited the analysis process in light of the feedback received. A visual thematic map was used to develop hierarchical relationships on three levels: overarching themes, main themes, and subthemes (see Appendix N).

Commitment and Rigour

Commitment and rigour relate to the level at which the researcher has achieved an in-depth engagement with the research, through data collection, depth of analysis, and methodological competence and skill (Yardley, 2000). The researcher demonstrated commitment to the topic of racial trauma personally, as a Black woman of Jamaican heritage who has lived experience of racial trauma interpersonally and intergenerationally, and professionally. Professionally, the researcher held experience of formulating racial trauma in the context of clinical work in a specialist refugee service, as a trainee clinical psychologist. Commitment was further achieved through the level of methodological competence and skill possessed by the researcher as a doctoral student with experience of conducting qualitative research using TA. The level of rigour achieved in the current research was impacted by practical limitations imposed by the reality of conducting doctoral research in collaboration with the clinical and academic demands of the Doctorate in Clinical Psychology. Thus, it was not possible to adopt a combination of analytical approaches using triangulation (Denzin, 2017; Lincoln & Guba, 1985), or to introduce multiple perspectives from other stakeholders, such as service users or mental health professionals from other disciplines. Notwithstanding these limitations, the current research achieved a good level of rigour by developing the depth of the analysis using multiple perspectives from participants and an expert by experience, as well as by seeking to recruit an ethnically diverse sample to achieve thorough data collection.

Transparency and Coherency

Transparency and coherency concern the presentation of the data analysis, including the clarity and strength of the researcher's argument in addressing the phenomenon of interest and answering the research question (Yardley, 2000). The current research achieved transparency in the presentation of the data by seeking to meticulously detail the research process. In this way, future researchers will be able to appraise the interpretations made by the researcher with in-depth knowledge of the decisions made and the justifications of such decisions. This is accompanied by a section on reflexivity earlier in this chapter, which openly and unapologetically relates the researcher's own experiences, motivations, morals, and values to the formation of the research. Coherence is traditionally achieved by ensuring a good fit between the research question, the research paradigm, the methodology, and the analysis and interpretation of the data. This is explicitly detailed in the write up of this thesis, which can be considered to have successfully explored the understanding and experiences of 13 NHS psychologists addressing racial trauma in their clinical practice.

Impact and Importance

Impact and importance reflect the relevance of the research to the community for whom the findings have direct implications for. This typically includes service users, communities, health care professionals, researchers, and policy makers (Yardley, 2000). The current research established relevance for the psychological profession during the pilot stage with clinical psychologists. The researcher also worked collaboratively with an expert by experience to monitor the potential for the current research to influence the socio-cultural context of racialised communities in the UK. These implications are further explored in the implications and recommendations section of the discussion chapter.

Ethical Considerations

The current research was conducted in accordance with the BPS Code of Human Research Ethics (2014) and Code of Ethics and Conduct (2018). Additionally, best practice guidelines on conducting research with human participants during COVID-19 were consulted at the point of recruitment (BPS, 2020b).

Ethical Approval

The current research was submitted for ethical review by the Health Research Authority (HRA) on 24th March 2020, and ethical approval was obtained on 11th May 2020 (see Appendix O). Upon receipt of approval by the HRA, the research was submitted for internal review by the Research & Development (R&D) department within NELFT, who confirmed capacity and capability for the research to proceed on 5th June 2020 (see Appendix P). Finally, ethical approval was received from the University of Essex Research Governance Team on 11th June 2020 (see Appendix Q). In response to COVID-19 restrictions, a non-substantial amendment was approved on 19th May 2020 allowing for interviews to be conducted remotely using Zoom (see Appendix R).

Informed Consent

Participant Information Sheet. The participant information sheet was developed in collaboration with Dr Colin King. The purpose of the information sheet was to provide potential participants with sufficient information about the aims and procedure of the study, to allow them to make an informed decision about whether to take part (see Appendix S). Dr King shared concerns about using the term “BAME”, which is often used as a method of grouping all individuals who do not fall under the dominant ethnic group of White British, and as such risks homogenising distinct groups (Commission on Race and Ethnic Disparities, 2021), or “othering” them from the White majority (Chawla, 2017). Dr King suggested that explicitly stating that the research was concerned with racial trauma experienced by individuals of Black and Asian heritage was important, so as to situate them as stakeholders central to the research.

Consent Form. The consent form was developed to provide a written account of the agreement that participants had given to take part in the study (see Appendix T). This included information about how data would be handled, used, and disposed of at the end of the study, as well as information about anonymity, to ensure that participants were aware that they would not be identifiable from their responses. In line with BPS requirements, participants were also made aware of their right to decline to take part, to decline to answer any questions, and to withdraw from the study completely at any time if they wished (BPS, 2014). Participants were also invited to consent to participate in an optional member checking exercise at the point of data analysis; this was indicated on the consent form.

Participants were given sufficient information about the details and aims of the current research to allow them to make an informed decision about whether to participate, via the PowerPoint presentation, participant information sheet, and consent form. Participants were made aware that whilst participation in the research was related to their employment with NELFT, it was not mandatory and would not affect their professional status whether they participated or not. Participants were given the opportunity to ask questions before consenting to take part, and also during and after the research process. Once participants were satisfied with the parameters of the research, written consent was obtained.

Right to Withdraw

Participants were informed of their right to withdraw from the current research at any point. The right to withdraw was applicable up until the point their data had been anonymised and collated with other data items.

Confidentiality & Anonymity

Guidelines stipulate that research should endeavour wherever possible to omit or redact personal information which could potentially identify participants or any other individuals (BPS, 2014). This was of particular importance considering the lack of diversity within the psychology profession with regards to gender (Baker & Nash, 2013; Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], 2020), and ethnicity (CHPCCP, 2020; Davenhill et al., 1989; Scior et al., 2016; Turpin & Coleman, 2010; Williams et al., 2006). This meant that detailing the service and borough that participants worked in increased the chances of compromising anonymity. As such, where demographic information is referred to throughout this thesis, details about profession, gender, age, service, and London borough are grouped together across the sample. Participants are discussed using pseudonyms, in an effort to bring to life the interview excerpts referred to within the final thesis (Tolich, 2010).

Data Management

All personal information collected within the research was anonymised using participant numbers and pseudonyms to ensure that no participants were identifiable from the write-up of the research. Data containing identifiable information (e.g., consent forms and demographic sheets) were kept separate from interview recordings. All data were stored securely as encrypted electronic files and only accessed by the researcher and academic supervisors of the research. This included Zoom recordings, which were saved securely and deleted from the researcher’s university Zoom account following each interview. All data use and storage complied with the Data Protection Act 2018 and the regulations of the University of Essex. All participants were made aware of how their information would be used and stored via the participant information sheet. Participants were made aware that their data would be kept for five years after the completion of the research, to allow for any amendments to be made to the final write up of the research.

Risk

Interviews were conducted remotely using Zoom teleconferencing software, in line with guidelines recommended by the Government and the BPS related to the COVID-19 pandemic (BPS, 2020b). This ensured the physical safety of both the researcher and participants.

Protection from Harm

The current research involved discussing racism, a topic which is highly emotive and distressing, particularly to those directly impacted by its effects. Whilst participants were asked to discuss their experiences from a professional perspective, it is also likely that the content of the interviews may have resonated personally for participants, most notably those from Black and Asian racialised backgrounds. There may also have been a possibility of participants feeling persecuted or judged when discussing racism in relation to their practice. The researcher balanced this with the potential advantages of taking part. Notably, this included the opportunity to reflect on clinical practice and to contribute to organisational change for the benefit of service users who have been historically marginalised within mental health services. The potential for distress and vicarious trauma from discussing the psychological impact of racism to the researcher as a Black woman was also considered

(Dickson-Swift et al., 2009; Palmer, 2017). The researcher made use of research supervision, a reflective log, and personal therapy, to process this, as well as organising a research schedule which allowed for breaks and self-care.

Debriefing

Participants were invited to take part in a debrief at the end of the interview, to allow for any reflections or arising issues to be discussed. The debrief was optional, reflective of the researcher's awareness of the position of seniority that the participants held within the research dyad, as qualified psychologists. Information about avenues for further support were also included in the participant information sheet.

Dissemination

This thesis has been submitted to the University of Essex in partial fulfilment of the Doctorate in Clinical Psychology qualification. Participants who expressed interest in receiving a copy of the final thesis will do so following confirmation of successful completion. The mental health services from which participants were recruited will also receive a copy of the final thesis, and initial plans have been made to present the final results. There are also plans to disseminate the results more widely by presentation at conferences, such as the University of Essex Staff-Student Research Conference and the NELFT R&D annual conference, amongst others. The results will now be prepared for submission to a peer-reviewed academic journal relevant to the topic of the research.

Chapter Four: Results

Chapter Overview

This chapter presents the findings from the current research. Firstly, the study sample is presented, in order to situate the results within the population they were drawn from. Next, the themes and sub-themes generated from the thematic analysis will be presented, using verbatim extracts from participants to support the researcher's interpretations. Where reference is made to participants, pseudonyms are used, and potentially identifiable information is redacted to preserve anonymity.

Participants Recruited into the Study

Twenty-two NELFT staff members expressed interest in taking part in the current research. Of these, six people were not eligible to participate due to not being trained as a psychologist or working in NELFT services outside of the four London boroughs. Four people did not respond to further communication after expressing initial interest in the study. A total of 13 people were recruited and consented into the study. Appendix U details the pseudonyms assigned to each participant and Table 4 summarises key demographic information. In the interest of maintaining confidentiality and anonymity, demographic information has been separated from assigned pseudonyms.

Table 4
Key participant demographic information

Demographic	Number of participants						
Job Title	Clinical Psychologist (11)	Counselling Psychologist (2)					
Gender	Male (2)	Female (11)					
Age (years)	26-34 (4)	35-44 (4)	45-54 (5)				
Ethnicity	White British (6)	White Irish (1)	White Other (1)	Black Caribbean (1)	Black African (1)	Asian Indian (2)	Asian Pakistani (1)
London Borough (North East)[1]	Barking & Dagenham (4)	Havering (2)	Redbridge (6)	Waltham Forest (8)			
Current Service	Early Intervention in Psychosis (6)	Acute Services (1)	Mood, Anxiety & Personality Disorder Pathway (1)	Psychosis Pathway (1)	Home Treatment Team (1)	Refugee Care Pathway (2)	Child & Adolescent Mental Team (1)
Average Length of Time Qualified (years)	10						
Average Length of Time in Current Service (years)	7						

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[1] N.B. (N= 13), however London borough figures reflect that some participants worked across multiple boroughs.

Thematic Analysis

Upon completion of 13 interviews, reflexive thematic analysis was used to identify two overarching themes, five main themes, and 13 sub-themes. Table 5 presents all themes.

Table 5

Overarching themes, main themes and sub-themes developed from reflexive thematic analysis

Overarching Themes	Main Themes	Sub-themes
The writing is on the wall	**Navigating racial trauma as new territory**	Where is racial trauma in psychological assessment and formulation guidelines?
		The accumulation of racism leaves us feeling helpless and hopeless
	Bearing witness	Speaking up
		When you know better, you try to do better
		Validating the narrative
		The numbers don't lie
	The system perpetuates racial trauma	An inherent sense of powerlessness
		We are not innocent as psychologists in the NHS
Come so far, got so far to go	**Same storm, different boats**	I am a White psychologist navigating my privilege
		I am a psychologist from a racialised community, and this is nothing new to me
	We need meaningful change, not performative change	2020: The year of a racial awakening?
		The revolution will not be televised
		The change needs to be collaborative

Overarching Theme One: The writing is on the wall

The first overarching theme encapsulates the process of participants coming to understand and identify racism, and the importance of this awareness for them as psychologists working in ethnically diverse areas across North East London. This overarching theme is comprised of three main themes and eight sub-themes. Each theme begins with a summary of key findings, followed by a critical interpretation in relation to the research question, using direct quotations to exemplify points made.

Theme One: Navigating racial trauma as new territory. The first theme presents racial trauma as a clinically novel area, which many participants felt unprepared to respond to and work with as psychologists. This appeared to stem from an absence of evidence based psychological models and approaches from which to draw upon to understand the links between racism and psychological distress, pointing to a gap in clinical and counselling psychology training curriculums. In the absence of formal training, perceptions of racial trauma were sculpted from participants' own life experiences and/or observations of the world around them (e.g., being from a racialised community, or self-educating using books or the media). This theme makes an important comparison between racial trauma, and other forms of trauma, such as childhood sexual abuse, the latter of which is experienced in clinical practice as more tangible to navigate. As is evident in accounts shared by participants, the often subtle and covert nature of racism in Britain leaves an uncertainty about the role of psychological therapy in alleviating distress, especially given the likelihood that Black and Asian service users will continue to experience racism across the lifespan.

In order to recognise and work with racial trauma, participants first needed to understand its origins and the ways in which it presents. This theme draws together participants' curiosity about the term and experiences of exploring disclosures of racism with service users. The first sub-theme, *"Where is racial trauma in psychological assessment and formulation guidelines?"* relates to the ways in which participants described racial trauma, predominantly as a term that is not clinically recognised in the UK and was largely not considered by mental health services prior to the amplification of the BLM movement in 2020. Indeed, many participants themselves had not heard of the term until the movement and commented that this was not a term that was used by clinicians when discussing clinical diagnosis or presentation. The second sub-theme, *"The accumulation of racism leaves us feeling helpless and hopeless"* reflects the persistent and pervasive nature of racism as both overt and covert, existing across many levels: interpersonal, internalised, structural, generational, and vicarious. Ultimately, this left many participants feeling helpless to make a meaningful difference to the lives of service users from Black and Asian racialised communities.

Where is racial trauma in psychological assessment and formulation guidelines?

Most participants were not familiar with the term racial trauma as a mental health diagnosis, as is the case with PTSD. Without the familiarity of an evidence base upon which their training and practice was based there did not appear to be a protocol to follow. As a result, participants described a myriad of conceptualisations of racial trauma. Darren and Mabel reflect on the absence of the term within the trauma dialogue in their respected services:

> *"There is no diagnostic label that you can put on your [electronic patient record system] you know homepage that gets you a certain treatment route for racial trauma [...] I mean that's not really a term we use at work I would say [...] So, I think people probably would talk about it as trauma general, and then the content would be racial or otherwise on the basis of experiences that happened to feature that. So, I don't think it's ever talked about in the setting I work in anyway, erm as a particular type of trauma necessarily"* (Darren)

> *"I suppose that term to be used isn't necessarily something that I've always used as a frame for kind of thinking about it"* (Mabel)

For Jennifer, attending to competing demands in a psychological assessment (often the first meeting between a psychologist and a service user) meant that she often felt unable to explore the possibility of racial trauma in sufficient depth. She describes how this presents challenges for her routinely asking service users directly about this:

> *"I don't think I overtly ask about racial trauma in assessment, because actually, I don't know if that's right or wrong, it's just that we're at the moment I don't consciously ask about that, and I think that's because people come with so much stuff and I've got an hour and I'm trying to get the overview of where they're at with the understanding they're within a racist system"* (Jennifer)

Jennifer's reflection here is interesting, as she works in a specialist refugee service, predominantly with service users from Black and Asian racialised communities, for whom racism, xenophobia, and marginalisation are often core reasons for distress. As such, she describes holding in mind the potential for racial trauma as a lived experience for her clients but does not always translate this into voicing this and gaining the service users' perspective. She later goes on to ponder whether service users are likely to be forthcoming or not with sharing their experiences of racism, especially with her as a White woman, for whom racism is not a lived experience. For this reason, it seems even more important to her to be the one to name racial trauma. Nancy, however, who works in a psychosis service, where trauma is often a large contributing factor to psychological distress, believes this is reflective of trauma more broadly:

> *"I don't think clients bring it up overtly [...] I've kind of realised that I have to ask more explicitly, that people are less likely to bring things to me. I will definitely ask*

> *about, or if something sort of feels like, you know racial trauma, I'll be kind of asking about that and putting it, putting that language to it"* (Jennifer)

> *"I also realise that if you don't ask about things then people won't necessarily think to bring things up, so this is true of trauma in general. I remember reading a paper of kind of actually, if you don't ask people about their traumatic experiences, they're not gonna just spontaneously tell you"* (Nancy)

Interestingly, the inherent dynamic nature of being a psychologist was a helpful quality in adapting their existing knowledge of "traditional" trauma responses to better understand and empathise with service users' experiences:

> *"A lot of the people that I've worked with have either, you know had some form of abuse, whether it's physical abuse or kind of emotional abuse as a result of their race that has led them, that has you know been, felt traumatic for them. And often they have you know symptoms related to trauma"* (Ameera)

> *"You know, in general I can understand many things that my clients have experienced even though I've never experienced them myself"* (Susan)

A pertinent area of concern within this sub-theme was the lack of an operationalised definition of racial trauma, perhaps reflective of the complexities of race and racism as evolving social constructions. Isaac speaks to this point:

> *"So, for me it feels like we're back again to the question of what even is racial trauma in the first place? ((laughs)) Like how are we operationalising this thing for us as a service?"* (Isaac)

The accumulation of racism leaves us feeling helpless and hopeless. Isaac likens the experience of racial trauma to the way that a tap "drips" whilst Shreya reflects on the trajectory of an individual's life following racial trauma:

> *"I think when I think of racial trauma and like everyday life experiences, I just often think about like just like this drip, drip thing that happens to people who maybe are not White erm, and how a lot of that is really unsaid, and how the impact of that isn't really thought about or even acknowledged"* (Isaac)

> *"I guess when I hear racial trauma, I think of erm experiences, erm predominantly difficult experiences that've come about as a result of somebody's race, erm their ethnicity, erm, kind of the effect, the impact that has on somebody's life going forward, erm. And I guess that the trauma part of that highlights the fact that it can have such a developmental or a lifelong effect on somebody's life"* (Shreya)

The concept of racism as an insidious and expected experience for people from racialised communities left many participants feeling as though they were fighting a losing battle, working with the aftermath with the knowledge that they were tending to wounds which would very likely be reopened later. Edith and Mabel describe feeling "helpless" and "hopeless" when faced with this reality, with Edith experiencing a "block" when attempting to progress with this work, in a way which feels harder than when working with other forms of trauma, such as sexual abuse. As White psychologists, what stands out here is that the "block" that Edith describes seems to almost represent a physical point at which the conversation about racial trauma stops. In comparison to the earlier point of Isaac (a psychologist from a racialised community) about racial trauma as a dripping tap, this suggests there may be a limit to the progress White psychologists feel they are able to make when navigating racial trauma:

> *"How do I talk with them about it? So, I do talk with them about it, but it feels more help- I feel more helpless, than if we were talking about you know some abuse, erm, sexual abuse in childhood. Because that, I feel like we can you know we can work on that, but with erm racial trauma and racial abuse it feels like, how do you work on that other than trying to help someone manage how it feels? Because you know, if somebody's talking about erm, the impact of childhood sexual abuse or childhood bereavement or whatever it is you can, you can try to help them to find a way to live and reach their potential in spite of that. But with something like racial abuse you kind of think, there's gonna be a ceiling or a block at some point"* (Edith)

> *"I'm thinking specifically about a case we had recently of a young Black man who was sectioned by the Police, which is absolutely not what the team had wanted to happen. And his mum was devastated that it had happened. And it just, when we were talking about it as a team, it just felt like there was this sense almost like of hopelessness of like 'what is gonna change?' 'How do we change this?' And I wonder again if that's sometimes just like almost like puts the fire out of people wanting to kind of think about these things"* (Mabel)

Theme Two: Bearing witness. The second theme presents novel and interesting findings surrounding the approaches adopted by psychologists when working with racial trauma in practice. Here, participants tapped into basic clinical skills required of psychologists, such as active listening, conveying empathy, and validating/ normalising responses. Responses included being wary of institutional figures such as the Police, as being adaptive forms of survival for people from racialised communities. This is an interesting deviation from traditional conceptualisations of trauma symptoms, such as flashbacks, hypervigilance, and avoidance, which usually locate the problem within individuals, and make up the dominant discourse of the medical model. Here, we see an attempt to externalise racial trauma as a product of unjust systems within society, an important finding currently absent from the narrative around poor mental health outcomes for members of racialised communities.

This theme explores the concept of working with racial trauma in a psychological capacity as a form of bearing witness to the reality of racism and its effects. Working with racial trauma was a task that required participants to use their professional status in a myriad of ways, not limited to the therapy room. This theme brings these efforts together. The first sub-theme, *"Speaking up"* reflects that speaking up against racial inequality in mental health services includes both the act itself and the consequences which unfold in the aftermath. The second sub-theme, *"When you know better, you try to do better"* relates to the decision-making process in adopting either a passive or an active approach to addressing racial trauma. The third sub-theme, *"Validating the narrative"* brings together participants' use of validation to bring the experience of racism "to life" and communicate to service users that their accounts were seen and believed. The fourth sub-theme, *"The numbers don't lie"* represents the well-established statistics detailing racial inequality in the access, experiences, and outcomes of mental health care for service users from Black and Asian racialised communities, acting as a call to action for psychologists to bear witness to the reality of racial injustice.

Speaking Up. Participants described an interesting dance between speaking up to hold individuals and the mental health system accountable for perpetuating racial inequality and keeping the peace for fear of repercussions. Whether participants willingly bore witness to racial trauma by taking active positions as advocates for clients from racialised communities was influenced by their own racial identity, the service they worked in, and their view of how much power they held within the system to influence change if they did speak up. This was not as dichotomous as White vs non-White participants. However, it became apparent that for psychologists from racialised communities, this work was an extension of the advocacy role they adopted in their personal lives. Conversely, for White psychologists, this seemed to be an additional part of the role that they did not necessarily sign up for. This led to an interesting period of internal bargaining for some White participants, as was the case for Fiona, who works in an early intervention in psychosis service. Here, she recalls a difficult situation where she contemplated confronting a consultant psychiatrist regarding views expressed about a young woman. Fiona was concerned that prejudiced views were being shared, influenced by the young woman's race. She reflects on the inner conflict she experienced at the time of the conversation, as to name a person as racist felt like a heavily loaded accusation. Fiona further reflects on what she might do differently should she be faced with this situation in the future:

> *"I suppose I felt like it was such a serious thing to say and that very little people are racist, like as in you know because you were, you were going to be, I was going to be saying to you, saying to somebody, just say you're the consultant, like 'I get the sense that this is coming from a perception that you have about this young woman because of the colour of her skin like?' So, like that would be deemed me calling him racist, and that I could get in trouble I think?"* (Fiona)

> *"So, I think if someone was to say, 'are you accusing him of being racist?' I think I'd have more of a way of understanding what I'm talking about rather than there's this black and white concept of 'you're racist and you're not' and 'being racist is horrific"* (Fiona)

Other participants, however, took a more absolute stance in seeking disciplinary action for racially prejudiced practice. Darren, who works across inpatient wards, where instances of prejudice and discrimination are often pronounced, shares his own experiences of raising safeguarding concerns against staff members working in his service:

> *"I'm probably quite quick to refer to things like safeguarding [...] I've multiple times had to report people within like staff for poor practice or for prejudiced practice"* (Darren)

Many participants also positioned themselves as advocates for the voice of their service users. Neelam describes advocacy as a key part of her role as a psychologist, and her attempts to engage the wider team in case formulations to help understand and reframe the ways in which service users are presenting. Edith shares a powerful account of using her professional status to collaborate with members of the criminal justice system, in order to prevent a service user going to prison, whom she believed had been wrongly accused of a crime on the grounds of racism:

> *"For me advocacy is a huge part of the work with the clients I work with. So, allowing you know your colleagues to know actually 'you know what there may be a reason why they're behaving in this way, let's try and understand that let's try and find a way of connecting with our clients' And you know and thinking about what their narrative is and how can we help to navigate that"* (Neelam)

> *"I think with that particular client with the court case that really was, I just thought 'I don't know what to do'. I mean on the actual day I remember I was able to sort of spring into action because the probation officer called and said, 'if you can get us a report, we can make sure he doesn't get a custodial sentence' so I was able to do that"* (Edith)

These positions of advocacy are interesting, as they seem to have different motivating factors. Neelam, who is of Asian heritage, uses her own experiences of racial trauma, at times within the NHS, to advocate for her service users. Edith is White, and the above account seems to represent an act of using both her status as a psychologist and her White privilege to influence the criminal justice system's treatment of a Black man.

When you know better, you try to do better. Regardless of where they believed themselves to be on their journey of exploring racial trauma, all participants recognised that working in an area as ethnically diverse as North East London required them to maintain a focus on this as a potential area of psychological distress for those within the populations that they served. All 13 participants were knowledgeable of the ethnic demographics of their respected boroughs:

> *"I think [name of London borough] is obviously a very diverse borough, so I think, in terms of access to services and you know equity offers and things like that, I think it's not surprising that we're getting a higher proportion of people from ethnic minorities in our services"* (Ameera)

> *"Some people really don't give a shit and they don't even pretend. And then there'll be some people that are interested and do care. But you know it's [name of London borough] and the population is, erm, you know there's a high percentage of Black and Asian erm people that access the service. So, they need to get interested, to improve and update their practice"* (Winnie)

Reviewing her caseload also encouraged Fiona to evaluate the characteristics of different cultural groups, offering the view that categorising them into "Black" and "Asian" risked missing the nuances that distinguish them:

> *"I don't think we have had those conversations enough in our teams about how do we engage Black clients over how do we engage a Pakistani family. Because a Bengali and Pakistani family are very different. That's like saying an Irish and English family are the same- we're not. We're from totally different countries, totally different cultural backgrounds. So, but we do, I think we often start to subgroup people as you know Asian and Black. You know what I mean? Rather than kind of really trying to think about the intricacies of those particular groups and what is going to be helpful"* (Fiona)

When weighing up the options of staying silent or having difficult conversations about racial trauma in which they might "get it wrong", participants were generally willing to navigate the conversation with service users. Most White participants believed that repairs were possible if they were honest as and when impasses occurred:

> *"This is something that you might not get right so it's important that you know you (it's still good to try) and not be too scared not to try anything. But erm, that you might say something that's unhelpful to people as well. And I think I've had less awareness of that, thinking because I was a nice person everything will be okay"* (Paula)

> *"I guess it's about pre-conversations [...] erm I suppose so, I suppose a shared agreement I suppose between the two of you that actually erm, this is a space where this can be talked about erm. But also, I suppose a shared understanding that I suppose, yeah so I suppose I might want to disclose or say you know, 'as a White person you know, I'm not sure how, you know whether I'm gonna say the right things about this but you know, I'm really interested to hear what you've got to say on this subject, and you know perhaps if I say something that doesn't quite fit properly you know perhaps you'll let me know?"* (Susan)

Validating the narrative. Validation and normalisation of the impact of trauma is an important component of psychological therapy, especially where individuals have been denied the reality of their experiences, by perpetrators, bystanders, and society. This is very often the case with racial trauma, given the subtlety of microaggressions and the impact of the accumulation of racism on mental health. Participants recognised their communicative skillset as an asset in exploring racial trauma with service users. Nancy suggests that racial trauma should be approached in a similar way to other events widely considered to be traumatic, such as the death of a loved one. Edith speaks to validation as a method of helping service users to feel as though their injustice is heard, seen, and believed.

> *"I wonder if with particularly racial trauma, whether it's worth just naming it as a trauma. Because I do wonder if people just see it as 'well this is what life is like' and don't necessarily conceptualise it as traumatic? In the same way as you know ((pause)) the death of a parent might be seen as traumatic. So, I wonder if it's about, there's something about validating people's experiences as 'that is actually something we'd consider as traumatic and that shouldn't have happened and that that is a valid trauma experience, if you like"* (Nancy)

> *"And maybe that's the thing that erm,* we *can try to do is to help people feel that you know, we're on, yeah we're on your side, we hear the injustice."* (Edith)

Paula goes a step further than this, normalising the experience of paranoia when formulating with a service user who she believed was experiencing difficulties obtaining employment because of his race. She believes it makes sense that this man would feel personally discriminated against, and tries to move away from the paranoia narrative which would suggest that this is an internal problem:

> *"I was once formulating for paranoia and actually I think of a Black man [...] and him feeling he was erm, there was some erm racial discrimination in terms of some jobs he wasn't getting, erm. And I think it was all entangled with the paranoia but a sense like you know these things happened in reality that's gonna make you then be under threat more"* (Paula)

In order to truly validate the narrative of the service user, participants often found themselves integrating evidence-based approaches, such as trauma-focused CBT and EMDR, with community led approaches, which helped to situate distress within the context of systemic racism perpetuated in British society. Both Winnie and Nancy speak to the experience of working with Black men who have been left traumatised following altercations with the Police, both interpersonally and vicariously:

> *"One of the [people] I'm working with [...] one of the themes is about you know police harassment and being stopped by the Police and erm. And that you know, that's one of the things we're working on. And then having that fear physic- you know hypervigilant when he sees the police and then they stop him because he's looking, you know looking around [...], but he's not looking dodgy looking around, he's hypervigilant he's having you know ((pause)) a symptom [of] PTSD. So, you know so, I'm doing it within a particular model CBT and EMDR, but I'm definitely also bringing into to the work [...] how that must be and erm, and normalising that for him you know. That's erm, a normal experience to be wary of the Police because of the police brutality that exists. So erm, that's not him being paranoid, that's him being careful and cautious"* (Winnie)

> *"A young Black man who had quite, he had a PTSD event. So, it was that he was erm arrested by the Police in quite a violent way and, since then has developed quite a lot of PTSD symptoms. So, for example, he can't go outside in the night now because if he sees the moon, it reminds him of the like the torch in his eyes. And what we were talking a bit about was just how to balance this idea of, you know we want him to be able to go out at night and stuff, we don't want the moon to trigger his PTSD experiences, but we also wanna be careful about, you know he is a young Black man. The Police probably are, well they <u>are</u> a danger to him, more than other people. So, you don't want to kind of erm, desensitise him to the risk that the Police pose to him"* (Nancy)

Here, both Winnie and Nancy recognise the limitations of traditionally Westernised psychological approaches, which are often deficit focused and locate the problem within the individual. This focus often serves to neglect wider external factors, such as discrimination, marginalisation, and oppression, which both contribute to and worsen the experience of psychological distress.

The numbers don't lie. The ill treatment of Black men within UK society spanned many interviews, with participants turning to statistical evidence of racial disparities within the mental health system. This ultimately acted as a call to action for participants and prevented them from turning away from these issues within their clinical practice. Educating themselves in this way further represented a desire to bear witness to issues faced by service users within the multi-disciplinary setting within which they sat as psychologists. Darren and Mabel refer to the overrepresentation of Black men detained under the Mental Health Act 1983 with involvement from the Police, criminalising the experience of psychological distress:

> *"We have a really clear evidence base that says that you know, young Black men are just gonna be more likely to be detained by 136*[2] *erm, that are erm. But what do we deem as more problematic behaviours? What do we deem as erm, the type of erm behaviour that we, that we think needs sort of acute treatment? Which and who receives more restrictive interventions?"* (Darren)

> *"I think the most obvious thing that springs to my mind is about the fact that you've got what I believe is sort of institutional racism in the sense of Black people being much more likely to be sectioned, erm and sectioned with the involvement of the Police as well, erm. And I think that that in itself as an experience is hugely traumatic for people and their families as well"* (Mabel)

Jennifer wonders how these well-established statistics could be used to challenge racially prejudiced practice, such as the overdiagnosis of Black men as experiencing psychosis in comparison to their White counterparts. She advocates for a pause before diagnoses are made, to allow alternative hypotheses to be explored:

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[2] Section 136 of the Mental Health Act 1983 gives the Police the power to take an individual to a place of safety (often a mental health inpatient unit) if they believe they are experiencing mental distress and need "care or control" (Mind, 2017).

> *"A lot of the problems in mental health services are grounded in research. We've got stats, we should be better versed in them to be able to have those arguments. To be able to step in when yet another young Black guy's about to be diagnosed as psychotic and be saying 'hang on a minute we know that this is erm, you know we know that people are being over diagnosed, why? What, let's think about this. Is this, is this an accurate diagnosis? Could we wait? Could we see what's going on? Could we erm arrange a psychology assessment before a psychiatric diagnosis is given? Could we actually ask what's going on?"* (Jennifer)

Nevertheless, the psychology profession is not immune to such racial disparities, evidenced by recent audit data within NELFT, highlighting racial inequities in referrals to psychology, with Black men yet again bearing the brunt of these shortcomings:

> *"There was an audit done of all of the cases that we're seeing and whether there was any clinical or demographic factors which were impacting on people being offered psychology, erm agreeing to have psychology, and then people staying in sessions, so, if they stayed in for more than five sessions. And what we found was that kind of, particularly Black men, were not, across the four boroughs [...] Black men were not being offered psychology they were not accepting it as often, and they were not staying in it when they were offered it"* (Nancy)

Theme Three: The system perpetuates racial trauma. The third theme builds upon the second theme, in identifying structural inequalities within British society as contributing factors to both the onset and the perpetuation of racial trauma. The theme begins with participants looking outwards to the structures of British society which often seem wired to set racialised communities up to fail, one of which is the NHS. Here, participants draw upon the prevalent disparities in access, experiences, and outcomes for these communities when entering the mental health system and reflect on how powerless they feel to such longstanding inequalities. This is accompanied by a willingness to turn inwards and reflect on how they themselves, as psychologists, may have been complicit in perpetuating such disparities, by failing to speak up against racism in services, or neglecting the importance of race and racism in therapeutic relationships.

All participants raised the perpetuation of racism and subsequent racial trauma by structural operations of power and racial subjugation within British society. This theme reflects the honesty with which participants approached their own contributions to this system. The first sub-theme, *"An inherent sense of powerlessness"*, represents participants' sense of feeling powerless to change the ways in which mental health services operate against members of racialised groups. The second sub-theme, *"We are not innocent as psychologists in the NHS"*, describes the recognition of participants' own complicity within the system, as individuals holding professional status within the NHS as a statutory organisation.

An inherent sense of powerlessness. Working in the NHS exposed participants to the harsh reality that, despite being members of the helping professions, the services they represented did not always reflect the values of equality upon which the NHS was originally built. Isaac and Mabel highlight the connotations associated with terms commonly used to describe Black communities in mental health services. They argue that the "hard to reach" narrative situates the problem within the person, often neglecting wider contextual factors, which are out of the individual's control:

> *"In terms of ethnicity and race you know, those are our, and I'm air quoting, 'hard to reach' kind of populations. And you know in the borough that I'm in in terms of ethnic minority people, Black people are the majority group in terms of the minority group, so it just feels like we don't really have access to those people"* (Isaac)
>
> *"Throughout working in mental health, I guess I've noticed that quite often like, for example, young Black men might be called 'hard to reach' or like 'difficult to engage', or something like that. And I think even that just likes locates the problem like this is something about <u>you</u> that <u>you</u> don't want to engage with us"* (Mabel)

As a result, services appeared to lack curiosity in understanding potential barriers to accessing mental health services for members of racialised communities, an experience which Jennifer believes begins at the very beginning of the process with GP services:

> *"I think a lot of people are missed. I think it's really hard. We, I know it's really hard to access services, to access our service, cos people have said, people go all round the houses erm. One of our ex-clients that I do some sort of teaching with, she co-facilitates on our group. She talks about how it took her years to build up the courage to even tell her GP about the difficulties she'd experienced. So, I think there is, I think there are a lot of people not getting the help that they need"* (Jennifer)

Other participants wondered about the effects of these racial prejudices on multi-disciplinary staff making referrals to psychological services. Often positioned as the gatekeepers to the finite resource of psychology provision, participants wondered if inadvertently these biases were influencing the referral decision making process:

> *"It could be that the offer is made less wholeheartedly, whether it's the care co-ordinators, there is a sense that this person might not [engage]"* (Paula)

We are not innocent as psychologists in the NHS. Examining the complicity of mental health services in the perpetuation of racial trauma led to a shift in focusing on ways in which the psychological profession, and ultimately them as individuals, may also be complicit, regardless of intentionality. Mabel and Jennifer reflect on the glaring omissions made by psychologists to act when faced with evidence of racism:

> *"There's no way to look around it, like Black men are more likely to get sectioned, more likely to be on community treatment orders. But yet it just seems to continue to happen. So, we definitely are doing something that contributes to this problem"* (Mabel)

> *"I think that psychologists notoriously sit on the fence, erm. I'm very aware that I have done that in various ways and I think we need to be more proactive I think, as in proactive, I think we need to be more vocal. I think we need to be calling a spade a spade and calling out racism"* (Jennifer)

Fiona admits that her own practice has not always involved taking sufficient action to demand justice for service users subject to racism in the mental health system. She questions why she had not previously turned to the standard Trust procedure of incident reporting via Datix[3]:

> *"I have not been actioning that and like doing enough Datixes, which is our kind of Trust guidance you know if there's a complaint or, you know that you record it. Erm, haven't been doing them"* (Fiona)

Ameera and Mabel consider themselves privileged to be members of a profession that is often placed upon a high pedestal. Ameera describes her assumptions before entering the profession that psychologists promote inclusivity, whilst Mabel adds that many of the protective spaces afforded to psychologists, such as supervision, where issues such as racial trauma can be widely explored, would be deemed a luxury in other professions, such as nursing:

> *"Yeah, cos I guess you come into psychology with a slightly rose-tinted view of er, of the profession, that it's gonna be all kind of inclusive"* (Ameera)
>
> *"We as psychologists are so privileged in the time that our training gives us and even just the friends that you make on the course that you talk to about 'I really wanna say*

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[3] Datix is the name of a patient safety incident reporting system designed to record unintended or unexpected incidents.

> *this the right way how do I talk to this person about this?' Or supervision, and I think erm, not all other professions get that luxury"* (Mabel)

One participant reflects on the intersecting identity of being a Black psychologist, and the competing experiences of both privilege and oppression, which can seem to exacerbate the power dynamics of the therapeutic relationship. Here, the pseudonym has been removed in order to further protect the anonymity of the participant:

> *"I think as well, people make assumptions about me being a Black clinical psychologist. Like people make all those assumptions because of like how you look, how you talk, your mannerisms and you know your profession. So sometimes those things act as barriers, cos in a way people are sort of like 'oh so are you a sort of like a sell-out or are you sort of like a bit of an imposter?' So, I think that can get in the way"*

Finally, an interesting narrative formed amongst many participants concerning the idea of the characteristics of a "typical psychology client", as one which traditionally disadvantages men, individuals from racialised communities, and those diagnosed with psychotic presentations. Participants attempted to make sense of the impact of this discriminatory narrative on the demographics of psychological services, drawing on interactions with referring clinicians:

> *"What I know happens when you refer is that you get, you either get the really difficult patients that are not actually good for psychology but that that people are struggling to do something with them. Or you get people who are very amenable clients, and I think there's also this idea, and often female as well, kind of. When you're left with a referral process, and I also wonder if there's also, you know, there's probably some demographic factors you know for example race that mean that people don't get referred because they're not seen as psychology clients typically"* (Nancy)

> *"I think psychology is just as bad for that erm, for example how many of my colleagues you know say to me 'Look this person is someone to prioritise for this, maybe more like DBT [dialectical behavioural therapy] interventions, or maybe more trauma-based interventions' or whatever. And we know for a fact that you're more likely to get that kind of intervention if you're say a young White female than say an older Black male"* (Darren)

Overarching Theme Two: Come so far, got so far to go

The second overarching theme concerns participants' journeys to positioning themselves as activists of social justice and the facilitators and barriers associated with adopting this stance as psychologists. This overarching theme is comprised of two main themes and five sub-themes. Each theme begins with a summary of key findings, followed by a critical interpretation in relation to the research question, using direct quotations to exemplify points made.

Theme Four: Same storm, different boats. The fourth theme presents unique findings related to how psychologists' own racial identities influenced both their perception and navigation of racial trauma with service users from Black and Asian racialised communities. Despite a shared professional identity as psychologists, participants' relationships with their own racial identities contributed to very different frames of reference within which to explore racial trauma. Whilst the complexities of race cannot be easily dichotomised into "White" and "non-White", this theme represents the differences in the way participants approached the topic of racial trauma as psychologists, through the negotiation of their own personal understandings of race, and in some instances, experiences of racism. In this way, participants could be seen to be navigating the same "storm" of racism and racial trauma, but from different perspectives, based on how they came to understand their own racial identity and that of others.

The first sub-theme, *“I am a White psychologist navigating my* privilege*”,* reflects the journey of White participants grappling with feelings of guilt, shame, and responsibility for the hierarchical position of the “oppressor”. This was simultaneous with remaining mindful of the possibility of being viewed as the “White saviour” when undertaking this work. The second sub-theme, *“I am a psychologist from a racialised community, and this is nothing new to me”,* represents the contrasting experiences of participants who, by virtue of the fact that they themselves were from racially minoritised communities, understood racial trauma as a personal reality, and at times a reminder of their own subjugation as employees within the system of the NHS.

I am a White psychologist navigating my privilege*.* To be a White psychologist exploring racial trauma with service users from Black and Asian backgrounds was an experience which participants recognised as a mirror image of the UK, as a racialised society within which their experiences were widely disparate from those of their service users. This required participants to tune into an experience that they themselves would never be privy to and appeared to magnify the “us vs them” power dichotomy already in existence in therapy. Fiona reflects on coming to terms with the impact of racial differences as an experience which she was largely afforded the opportunity to ignore as a member of the dominant and default White race:

> *“I suppose I never thought about what it's like to then have to be seen as different, cos I can walk around the UK and people will think I'm from the UK”* (Fiona)

In the absence of first-hand experiences, White participants shared concerns about their ability to fully relate to and empathise with the issue. Edith speaks to this feared inauthenticity of asking about racism feeling like a “tick box exercise”, which service users were able to see through.

> *“I don't like things to be a tick box, cos then I think you're not then engaging the person. They might just sit there and think ‘that White person is just asking me about racism because that's what they have to do rather than they're actually interested in knowing what that felt like for me’[...] I mean nobody wants that as a therapist”* (Edith)

In contrast, Susan positions her Whiteness as disadvantageous to herself as a psychologist, as she believes it prevents her from fully understanding the lived experiences of Black and Asian service users:

> *“I just feel at a total disadvantage because I'm White and so how can I ever actually erm really understand?”* (Susan)

Mabel describes wrestling with the internal battle of whether to ask about race or not, internalising this as a personal reflection of herself should she make a mistake or speak out of turn. She interestingly comes to a new understanding of this during the interview, stepping back to identify these anxieties as a product of her own defences in the context of White fragility:

> *“I feel sometimes like this nervousness of ‘oh am I just gonna be perceived as like this person who wants to be seen as this like White Saviour and bringing up race when actually it's not relevant to bring up?’ So, there's one thing about my own anxiety in relation to how I might be seen for bringing it up which (.) I think basically it probably triggers off a fear of White fragility maybe of feeling like ‘am I gonna get defensive cos someone then questions me about why I'm bringing it up?”* (Mabel)

For some participants, this fragmented understanding of racism as a White person led them to question whether they were appropriately qualified to engage in this work. Jennifer acknowledges the underrepresentation of Black psychologists available to service users in the NHS and portrays this lack of choice as further exemplifying the oppression imposed by Britain as a racially politicised country:

> *"In NHS services there's not really much choice, and I think I'm, as in you know if somebody wants to go and see a Black psychologist in the private sector they can go and choose that, whereas in [the] NHS there's not much choice. And I think I'm quite aware of that, erm, and aware of what people's experience might be of working with a White psychologist, erm, who's part of a system that is quite oppressive. Or you know broadly like sort of political country that's quite oppressive"* (Jennifer)

Edith reflects on implications of this for her own British heritage. This leads her to actively research her own family history, in response to curiosity about her family name matching that of her service user, and the possibility of this representing a colonial link:

> *"One of my clients who's Black British Caribbean, his partner is also Black British Caribbean. She has the same surname as me and erm ((pause)) I thought about that and I did discuss it with the client, because I was concerned that she might think that my family were slave owners and that's how we've got the same name"* (Edith)

For Fiona and Paula, who were not White British, the experience of being migrants themselves and negotiating the process of acculturating in Britain appeared to create a sense of being an outsider-within. This placed them in a position where they felt more in tune with the experience, yet still on the periphery of understanding the visual difference that comes with being from a Black or Asian background:

> *"I'm not a British person, coming from an outside culture to this culture, erm, with the complexity that has it makes it a little bit observer. So, I think I've always been interested as being a migrant"* (Paula)

> *"I think I used to be very struck and maybe it was because it resonated with me as well, about how difficult it must be to move from another country. Like I got that bit and I talked to people a lot about you know how tricky that is and not having the language or not having your family close by"* (Fiona)

Overall, there was a general consensus that for White participants there was at least some level of discomfort associated with exploring racial trauma. Susan named this discomfort as a barrier to providing this support for service users. She shares concerns about the potential adverse effects of contributing to further re-traumatisation if she were to "get it wrong":

> *"I guess there's the slight discomfort of 'oh how do I talk about this? I suppose 'am I talking about this in the, I suppose in the right way? Am I erm, am I using the right words? Am I showing the right amount of empathy erm and understanding? Or you know am I getting this wrong in some way and therefore creating further damage?' So, I suppose that would be a barrier within me, sort of a concern of not being entirely comfortable I suppose with the topic"* (Susan)

I am a psychologist from a racialised community, and this is nothing new to me. For participants from Black and Asian racialised communities, exploring racial trauma in their professional lives intersected with their own personal experiences of navigating the world. Shreya attributes her understanding to her childhood upbringing, whilst Neelam uses her shared experience as a relational tool to engage with clients:

> *"I think my understanding has been definitely influenced massively by my own experience and understanding growing up. Erm, so, I'm not sure how much of an understanding I would have had without having that that history myself"* (Shreya)

> *"And I will kind of self-disclose that, I will say you know 'I can relate to that' erm and I think, whereas some of my White colleagues may have problems connecting with certain clients I may not, because of that experience and the fact that I am not a kind of White middle-class psychologist"* (Neelam)

Winnie echoes Neelam, suggesting that as a Black psychologist inhabiting a professional role of power, she challenges the stereotypical narrative of Black people as disproportionately affected by psychological distress:

> *"There's the whole you know role modelling pro social modelling, in terms of there being erm, a Black psychologist, a Black therapist erm. And so that we, you know, we're not only you know the recipients of help, but we are the providers as well"* (Winnie)

However, carrying this responsibility was not without emotional burden, and for some participants from racialised communities this felt almost too much to bear. Here, participants bravely shared their own lived experiences of racial trauma, and of fighting for racial equality. This gives a nuanced perspective to the findings, as these participants are navigating racial trauma with their service users and within themselves. Isaac gives a powerful account of living with racial trauma as a physical experience within the body, not dissimilar to experiences associated with PTSD. Hyper-vigilance could consume his life and impact on his daily functioning, whilst hypo-vigilance could make him vulnerable to potential threats. Winnie echoes this, alluding to the collective "baton" that is passed between people from racialised communities to share the labour of fighting for equality when it becomes too much for the individual:

> *"Sometimes it's almost like if you become too aware of racial trauma, it's almost like it can just paralyse you and stop you from actually getting to where you need to get to or doing what you need to do. So, there's always this weird dance of like being aware*

> *of it and like being a bit like 'I will stand up for myself if anything comes up I need to find ways to navigate this if anything comes up' but then also having to hold this weird position where you're like 'yeah I'm aware of it but I can't let it dominate me"* (Isaac)

> *"That's the type of person I was, so I was active and doing community activism for a long time. And there's been, there have been years where I haven't been doing anything cos you just get exhausted, and you have to pass the baton on [...] and it's that extra emotional labour that erm I'm having to do, and I'm willing to do but depending on some days my threshold is higher than others"* (Winnie)

A further disclosure from Ameera further serves as a stark reminder that as professionals, participants are not immune from their own experiences of racial trauma. She describes racist altercations with service users who had expressed not wanting to engage in psychological therapy with her due to her ethnicity. She reflects on the subsequent lack of support from her supervisor, leading her to question her profession:

> *"I suppose this is racism the other way around when people don't wanna work with me because of my ethnic background. I think that's when I've struggled to have those conversations because I think then it becomes very personal about me [...] I was working in an area that is a bit more kind of, predominantly White and has erm a reputation of having erm, more racist ideas and I didn't feel very supported or kind of by my supervisor at the time, or able to explore those issues that came up for me. So, I think that did leave me feeling a bit disappointed I suppose with my kind of, yeah profession at the time, and also hurt"* (Ameera)

Neelam reflects on the presence of power she experiences as a barrier to career progression, and subsequently to contributing to higher level service development beyond the therapeutic space. This relates to the increasing influence that is granted with seniority in the profession, at levels where structural change to address racial injustice is more likely to come to fruition. Reflecting on the success of her colleagues, she wonders whether her experiences would have been different had she been White:

> *"When I think about my own experiences you know I have huge issues around authority figures, erm, around how, you know around control, power all of those things. Erm, around not feeling ((sighs)) entitled in the same way as my White colleagues ((pause)) and that's very much you know when I think about my own experience of working in the NHS you know, the reason may I, why I may have not have progressed in the* same *way as my White colleagues have. Because there isn't that sense of entitlement"* (Neelam)

Finally, regardless of their lived experience of belonging to racially minoritised communities, this was not always an indicator that participants wanted to champion this work in psychological services. Winnie concludes that she cannot speak on behalf of all racialised communities and suggests that the area of diversity and inclusion is one of niche expertise, which she should not be expected to possess simply because of the colour of her skin:

> *"It's actually another field. I mean I know bits but I'm still not a diversity and inclusion expert"* (Winnie)

Theme Five: We need meaningful change, not performative change. The fifth and final theme moves the findings from reflection to action, highlighting the complexities associated with making meaningful racial change within an inherently flawed mental health system. With the backdrop of the BLM movement ever present, participants reflect on why such deeply tragic and painful events have led to a worldwide call to action, and for a localised call for change within the mental health system and in psychological services. Interestingly, the findings focus on the preparatory work participants felt was needed to ensure that any change was well intended; for example, by involving key stakeholders, such as service users, carers, and wider communities, in the development and provision of services. The final theme captures the collective desire for racial change voiced by all participants, and the acknowledgement that whilst historically this change has often paid lip service to actions which never materialised, they wanted this time to be different. This involved looking inwards to identify ways they could educate themselves and identify their own areas of development, as well as outwardly analysing their services and the psychological profession.

The first sub-theme, *"2020: The year of a racial awakening?"* explores the influence of the socio-political context within which the participants find themselves at the time of the interviews, following the murder of George Floyd, a Black man in Minneapolis, USA, at the hands of a White Police officer, and the emergent rise of protests across the world, in the aftermath of this. The second sub-theme, *"The revolution will not be televised"* is a nod to American soul and jazz poet Gil Scott-Heron's 1971 song of the same name, speaking to participants' beliefs that true change is unlikely to be sustained through statements of intent and raising awareness of racial injustice alone. The real revolution takes place in one's mind first and foremost, leading to changes in the way one lives their life. The third sub-theme, *"The change needs to be collaborative"*, reflects the consensus amongst participants that ultimately meaningful and sustainable change requires a community approach, between frontline clinicians, service users, grassroots organisations, and senior leadership and commissioning bodies.

2020: The year of a racial awakening? The racialised context of 2020 was inescapable from all 13 participants' accounts, but in a variety of ways. For some participants, the outpouring of coverage via the news, social media, and through various organisations, such as NELFT, acted as somewhat of a wakeup call to the continued existence of racism in British society. It seemed almost as if this had been lying dormant below the surface, until the harsh reality of the video coverage of George Floyd’s murder had forcibly demanded that those who had shut their eyes to the violent disposability of Black lives “wake up”. Fiona, a White participant, speaks to this revolutionary climate as a form of permission for her to even voice the word “race”, whilst Nancy reflects on this as a societal wakeup call:

> *“I don't think I've I have ever mentioned the word racial, you know ‘is this a race thing?’ I think for some reason Black Lives Matter has made me feel like I can say that now?* (Fiona)

> *“I think that like even societally though people are now starting to wake up to the fact that racism is still a thing”* (Nancy)

Conversely, Neelam and Ameera question the authenticity of the increased attention towards racial injustice, a battle which has been fought by many for centuries, but which only now seems to have captivated the whole world. They speak about this as a juxtaposition; the fight for racial justice gaining momentum, alongside the incredulity that the dominant majority had now decided that this was an important issue, after yet another Black life had been lost:

> *“Why has this just come up now? [...] Why are talking about it now? Why now? What just because of this incident in America? But this has been going on for generations? Why are we talking about it now? Why is it not something that we’ve addressed before? What only now have you come to the realisations about how Black people are treated? But not just Black people. Black minority ethnic groups?”* (Neelam)

> *“I think with Black Lives Matter that might look different right now in the current climate, but I think traditionally there has been a sort of sense of ‘let’s not like it’s a taboo topic and let’s not kind of talk about it as much”* (Ameera)

Many participants credited the recent amplification of the BLM movement to conscious changes in their clinical practice. Fiona describes this as a useful segue to opening up the conversation with Black men in particular, to explore the vicarious trauma perpetuated by graphic images and narratives in the news. She acknowledges that for many Black communities, this was an experience of collective grief and pain:

> *"I can hear myself in my sessions more frequently now being able to kind of use the Black Lives Matter kind of concept as a way in, like to say, you know 'what's it been like with everything that's been going on in the news as a young Black man? What's that like?' And you know 'are those factors that you erm, that seem familiar to you?' And 'is that something that would be helpful for us to think a little bit about in terms of your journey and your life?'* (Fiona)

Others had channelled their efforts into encouraging conversations within their psychology teams and wider services, using the multifaceted skillset they possessed through their psychology training. Winnie devised a questionnaire to evidence the impact of George Floyd's murder on staff members systematically, whilst Isaac's team organised workshops to facilitate reflective spaces:

> *"So, what [the team] did in terms of the response to the Black Lives movement this year erm, [the team] put out a questionnaire to the team in terms of thinking about erm, the impact of the Black Lives movement and the erm violent death and how that's impacted on the staff team"* (Winnie)

> *"In our psychology team because we've had erm, we made a kind of concerted effort to talk about since the Black Lives Matter stuff has come to the forefront, to have accountability as a psychology team so to erm, we've started a series [...] like amongst the qualified psychologists to have erm workshops to just begin to talk about the issues"* (Isaac)

Whilst most participants spoke of the benefits of this racial awakening for educating White people about racism, Paula shares her initial observations of this platform also empowering Black people to speak up about the injustices they have endured:

> *"I think it's also from my point of view from what I've seen is a lot of people who perhaps felt erm, unable or scared to talk about things as a Black person, they're now speaking up, so it's become easier"* (Paula)

The revolution will not be televised. Participants expressed that raising awareness and generating discussions, whilst useful first steps, were inadequate in the long term in facilitating meaningful structural change. Fiona and Ameera ponder upon whether once the news coverage has subsided and the protestors have dwindled there will be the same commitment to the cause:

> *"I think that's the bit that's gonna be more interesting I think as we move forward in this kind of way of after Black Lives Matters, and trying to think about not just being these reflective clinicians that are aware of these issues, but actually putting in clear new action points"* (Fiona)
>
> *"I think it's become very much the norm to have these conversations at the moment. I'm sure that storm will pass probably but ((pause)) at the moment it feels important"* (Ameera)

Paula expresses impatience that the conversation often ends with reflection and a desire to move towards actioning change sooner rather than later. Isaac shares these concerns about reflection and awareness not being enough, but further questions the motivations of those engaging in this work, if the benefits are not geared towards changing the lives of those affected:

> *"I don't want to reflect for a year and then act later. I want to start trying out some changes and then we learn from that and we reflect [...] I think I we need to do something now and not wait so that's what I mean [...] I don't think it's just action, in terms of reflection is good, but yeah I guess if I had to choose one, I'd rather have action than reflection"* (Paula)

> *"If you're not helping people to change their lives or giving them some sort of power to actually change their lives then who is this actually for? Is this for you as a professional to kind of you know to [erase] your guilt or whatever it might be? Or to feel that 'oh yes look at me I'm making a difference. I'm raising awareness'. I'm like does awareness by itself make people's lives better? I don't know so."* (Isaac)

The change needs to be collaborative. Many participants acknowledged that they could not effect change without input from all stakeholders. First and foremost, Mabel and Susan point to the importance of service user collaboration, asking for honest feedback on the strengths and limitations of current service provision, and ideas for change from those who will be most affected by these decisions. Mabel also highlights the need to avoid tokenism and exploiting service users, by reimbursing them for their knowledge, expertise, and time, if the goal is to be truly collaborative:

> *"So, like actually we need to consult and learn from the people that we serve about this, and pay them for their time importantly"* (Mabel)

> *"Within mental health services, they actually need to involve I suppose clients in sort of erm service networks as it were to [...] actually ask clients what, I suppose, yeah 'what works about this service in terms of I suppose acknowledging race and racial trauma?' What's not working?' and 'Are there, are there things actually that we're doing that I suppose creates more distress?'* (Susan)

Nancy makes a connection with the principles of community psychology here, as she wonders whether more work can be done to engage with grassroots organisations, who know their members well and are already contributing to this work. She reflects on the authenticity this brings, in a way that manualised training packages can sometimes lack:

> *"I also wonder about the fact that, we're not I don't think we're linking with our local communities that well, and I think actually the best people to tell us about some of the stuff that's going on for them in our communities are the people who live in those communities ((laughs), rather than some training package that's delivered across the NHS."* (Nancy)

Finally, accounts from some participants suggested that at an organisational level, NELFT's position appeared to be openness to keeping the conversation going, attracting attention at a senior management level, as Mabel and Winnie report. Shreya also notes the introduction of new "anti-racist forums" within the Trust:

> *"I feel pretty lucky that I have like a really great supervisor that's you know, really wanting to think about these things. And erm, that in the psychology leadership that we also have someone that you know [...] the person you know at the top of the tree for the [service] that was like 'right we're talking about this we're gonna spend time on this we're gonna think about it"* (Mabel)

> *"In my organisation we're talking about it a lot, we're building, erm we're part of anti-racist forums erm, where we're trying to seek change and we're trying to understand people"* (Shreya)

> *"So, we had reflective practice sessions and then a follow up questionnaire, and then the next bit where [we] kind of fed back to the management team, did a bit of a thematic analysis on that, fed back to the management team"* (Winnie)

Chapter Five: Discussion

Chapter Overview

This chapter provides a critical appraisal of the current research, making links with existing literature and relevant legislation on the topic of racial trauma, to position this research as a novel addition to the field. Firstly, the main findings will be discussed in relation to the research aims and the existing literature and psychological theory addressed in chapters one and two. Secondly, the strengths and limitations of the research will be discussed. Lastly, the findings will be placed within the context of clinical, research, and policy implications, and corresponding recommendations will be made.

Research Aim and Summary of Findings

The current research aimed to explore NHS psychologists' understanding of racial trauma, and their experiences of exploring this with service users from Black and Asian racialised communities. To the best of the researcher's knowledge, this is the first research study to qualitatively explore racial trauma with NHS qualified mental health professionals in the UK, specifically psychologists. Therefore, this thesis contributes to efforts to diversify psychological understandings of trauma (Hartmann et al., 2019). Thirteen psychologists were interviewed about their experiences. Reflexive thematic analysis was used to interpret two overarching themes, five main themes and 13 sub-themes. The findings correspond with previous quantitative research studies conducted in the US that highlight a paucity in mental health practitioners' self-reported competencies and dearth of training in identifying and treating racial trauma (Hemmings & Evans, 2018). The current research provides qualitative accounts to further substantiate these findings, suggesting that the absence of clinical guidance is an important contributing factor in how psychologists understand and experience addressing racial trauma. These findings further corroborate with those interpreted in the thematic synthesis in chapter one, specifically related to the upholding of wider societal racial attitudes within mental health services (Bassey & Melluish, 2012; Burkard et al., 2014), the emotional burden of addressing racial trauma on psychologists from racialised communities (Knox et al., 2003; Reddy, 2019; Sunderani & Moodley, 2020), and the pressure to "get it right" experienced by White psychologists (Grimmer & Schwantes, 2018; Verdinelli & Biever, 2013).

The qualitative design adopted within the current research further yielded more intricate findings concerning the multifaceted experiences of psychologists recognising and addressing racial injustice indirectly in their spheres of influence within mental health services. This highlights the difficulties faced by psychologists when navigating the balance between advocating for racial injustice and moving towards actionable change in NHS organisations. Furthermore, the current research sheds light on the different experiences of psychologists from racialised communities in comparison to White psychologists, interweaving the influence of lived experience on motivations to address racial trauma. Ultimately, the current research represents a complexity of experiences related to psychologists addressing racial trauma which has not been captured in previous studies. This thesis suggests an intersectional experience, relevant to the systemic perpetuation of racial trauma in mental health services, the navigation of psychologists' own racial identities, and the impact of socio-political climates on psychological practice.

Main Findings

Conceptualising Racial Trauma

The current research highlights the inconsistency of racial trauma as an operationalised term. This reflects a wider issue in the racial trauma literature pertaining to whether racial trauma should be viewed as a sub-component of PTSD, or whether it represents a unique set of experiences and symptomology which warrants its own evidence base (Carter & Pieterse, 2020; Carter, 2007; Carter et al., 2013; Comas-Díaz et al., 2019; Kirkinis et al., 2018; Roberson & Carter, 2021). Participants recognised the absence of items directly related to racial trauma in commonly used standardised psychometric assessment tools for trauma and reflected on their own limited confidence in incorporating racism into psychological assessment and formulation. This relates to Carter and Pieterse's (2020) warnings of the problems associated with viewing racial trauma through the lens of PTSD, namely due to the subtle, insidious, and prolonged experience of racial microaggressions, which do not necessarily reflect imminent violence, death, or injury as described in the DSM-V. However, despite a lack of clinical attention, participants readily shared their own conceptualisations of racial trauma, citing racial profiling, institutional racism, overt hate crimes, covert microaggressions, generational and vicarious contributing factors, suggesting that the concept of racial trauma is not entirely intangible.

In making sense of racial trauma, participants experienced a sense of helplessness and hopelessness related to the ongoing and relentless experience of racial trauma, which they experienced as qualitatively different from other forms of trauma, such as historic childhood sexual abuse. Participants recognised the ways in which racism is tolerated, and in some instances upheld, by British society, illustrating the magnitude of the task of eradiating racial injustice. This has interesting implications for the process of trauma therapy; for example, Herman's (1992) model of complex trauma recovery. The first stage of the model begins with the establishment of safety, including basic health needs, a safe living environment, and management of trauma symptoms. Herman (1992) states *"Many patients are unable to move forward in their recovery because of their present involvement in unsafe or oppressive relationships. In order to gain their autonomy and their peace of mind, survivors may have to make difficult and painful life choices"* (p.100). The current research presents challenges to this idea of safety, as a liberty which is not afforded equally to members of racialised communities. This is evident in well-established racial disparities across healthcare, social care, education, and criminal justice systems. This renders the idea of safety used here as a reductionist baseline, which does not consider the role that racism plays in the appraisal of one's safety. Thus, the current research suggests a disparity in psychological models of trauma and the lived experience of racial trauma.

Coloniality and Racial Trauma as a Critical Discourse

Whilst participants recognised and explored the presence and impact of institutional racism within mental health services, there seemed to be a limit to the extent to which this was attributed and related to their perceptions of racial trauma. Most notably, the colonial history of the British empire explored within chapter one of this thesis (Du Bois, 1915; Okuefuna, 2007; Topolski, 2018), and pivotal to understanding how racism is re-enacted within mental health services, was largely absent from the current findings. This is an important finding in itself and highlights an area which the current research perhaps paid less attention to, or that participants felt less comfortable with discussing. However, whilst not directly attributed to coloniality, participants recognised the systems of power within which they worked, depicted within the theme *"The system perpetuates racial trauma"*. This suggests an awareness of coloniality and its impact on the experiences of racialised communities, albeit peripheral to the practice of psychology.

Nevertheless, the current research makes an important contribution to a critical discourse surrounding racial trauma within mental health services, which appropriately considers the effect of societal and systemic oppression within the UK on the onset and maintenance of racial trauma. This directly addresses recommendations made by Hartmann et al. (2019) as an area of future research interest. The sub-theme *"The numbers don't lie"* encapsulates participants' testimonies against the longstanding racism experienced by members of racialised communities in the UK, most notably Black men. Participants expressed concerns with the excessive force used when treating Black men, including detention, physical restraint, and community treatment orders. The involvement of the Police in the journey to accessing mental health services mirrors Fanon's (1952) conceptualisation of the Black man as the "phobogenic" (fear-causing) object, which is projected by the White man by way of racial scapegoating. This is ignited in this instance by perpetuating the narrative of the Black man as dangerous, aggressive, and violent, even during periods of significant psychological distress. This echoes a prolific finding within contemporary literature (Kleider-Offutt et al., 2017, 2018; Nadal, 2017; Walker, 2020).

Findings from the current research present participants' attempts to incorporate understandings of how institutions such as the NHS and the criminal justice system contribute to the experience of racial trauma. This contextualises trauma within the colonial origins of oppression which serve to maintain dependence on the coloniser through dependency on a medicalised mental health system (Gagné, 1998). This reflects what Hartmann et al. (2019) believed to be the perpetuation of narratives of hardship and the subordination of racialised groups. Further related to this are Carter's (2007) initial concerns regarding the conceptualisation of racial trauma as a clinical condition, which risks locating distress within the individual and neglecting the cumulative impact of racial trauma, often intersecting across generations (Comas-Díaz, 2016).

Participants in the current research expressed interest in incorporating community psychology approaches into their practice, to facilitate an appreciation for this history and magnify the strengths of communities in a way which reframes the hardship narrative. This reflects the sixth CRT principle of storytelling as a method of placing the power of telling the narrative with members of racialised communities themselves (Stefancic & Delgado, 2000).

This relates to Fanon's (1952) psychoanalysis of racialisation; his anticolonial stance suggests that in order to engage in healing for racialised communities, the colonial systems which perpetuate such trauma must be abolished. Whilst the abolishment or complete decolonisation of systems is certainly a farfetched solution in the short term, the current research does represent one of the first attempts to engage racial trauma as a critical discourse within a psychological framework. In this way, the current research encourages thoughtfulness of the risk of further pathologising racialised communities by denoting racial trauma as a psychiatric diagnosis. Labelling the experience of racial trauma as a diagnosis may misinterpret the lived experience of racial trauma, in a way which focuses more on the symptomology rather than the systemic factors perpetuating the trauma itself. The practice of formulation and reflective practice represent unique areas within which psychologists may encourage critical discourse surrounding this when working with service users from Black and Asian racialised communities.

Psychologists as Therapists and Activists

Participants in the current research described the predicament of speaking up against the perpetuation of racist attitudes in mental health services as a potential threat to their professional credibility. Here, the very act of labelling an act as “racist” appeared to hold consequences for participants, reflecting ideas posited by social comparison theory (Festinger, 1954; Turner et al., 1979) and of group conflict theory (LeVine & Campbell, 1972; Sherif, 1966, 2015). To that end, speaking up against the in-group (in this case, the Eurocentric standards upon which healthcare practices are based), is feared to jeopardise the position of power which one assumes through membership of the group, and thus the privileges which propel the advancement of the in-group. This is further complicated by the idea that individuals seek out membership of groups which they believe affirm positive appraisals of themselves (Tajfel et al., 1979; Tajfel, 1974; Turner et al., 1979). Thus, for participants in the current research, the realisation that the group with which they are associated (i.e., the psychological profession) could be perpetuating racially oppressive ideologies could invoke an identity crisis, whereby speaking up could result in being derogated to the out-group themselves, and negatively appraised as such. This could provide a lens through which to view silence in the context of racism (Lee et al., 2018; Premkumar et al., 2018; Sue, 2016), a concept which the current research suggests is further compounded by the risk of derogation at an organisational level.

Findings from the current research present a novel and interesting finding regarding the role of psychologists as activists, and a consideration from participants that their influence as senior professionals could afford them the opportunity to use their voice to effect change. Despite the absence of explicit guidelines regarding the role of psychologists in social justice affairs (Hailes et al., 2020), there have been historical contributions made by psychologists regarding social issues (Nadal, 2017). This is evident in the inception of designated sections of the BPS, such as the Psychology of Women and Equalities, Political Psychology, and the Psychology of Sexualities sections (BPS, 2021b), as well as the introduction of the working group “Psychologists for Social Change” (Psychologists for Social Change, 2021). Affinity with these groups is often viewed as an optional and additional role, based on the specialised interests of members, as opposed to a duty of care in respect of the populations the profession serves. Participants in the current research seemed to grapple with the belief that they could “do better” at effecting change for service users from racialised communities, and the sense of not knowing how to, a finding echoed by Nadal (2017). This appeared to represent a desire to move beyond exploring racial trauma within the interpersonal exchange (i.e., therapy), and towards the community and structural level, namely a move from the micro level to the macro and meso levels as defined by Bronfenbrenner's (1977) ecological systems theory.

The findings support a shift in the traditional role of the psychologist and suggest that further guidance is required from representative bodies such as the BPS and the Association of Clinical Psychologists (ACP) to operationalise and support psychologists in this imperative work. It may be speculated that the current socio-political climate surrounding racism at the time of conducting this thesis may have influenced these findings, both for the participants and the researcher.

The Racial Identity of the Psychologist

In the negotiation of themselves as catalysts for social change, participants shared many of the dilemmas described by Nadal (2017) in his conception of the "psychologist-activist". These included ethical concerns and professional boundaries, the balance of remaining neutral or apolitical as psychologists, the need to balance psychologists' self-care, and the absence of advocacy training in psychology. These dilemmas seemed to be further complicated by participants' relationships with their own racial identity, serving as a reminder that psychologists inevitably enter the therapeutic dyad with their own biases, morals, values, and belief systems (King et al., 2017; Sleater & Scheiner, 2019). For participants belonging to the White ethnic group, the navigation of privilege and doubts about competency to address racism and racial trauma might represent Fanon's (1952) description of projection. Fanon adopts the term to explain attempts made by White people to disembody themselves from feelings of guilt stemming from one's own complicity with racism. Hook (2004) argues that this mechanism only "*uses racism to explain racism*" (p.120). In contrast, the cost-benefit analysis made by psychologists from racialised backgrounds seemed to reflect considerations for their own psychological wellbeing, and in some cases their own experiences of racial trauma. At an amplified level, Fanon might describe this in the context of the “neurosis of Blackness” (Fanon, 1952; Hook, 2004). This may help to conceptualise participants’ desires to almost compartmentalise their race whilst at work, as an act of self-preservation. Supported by contemporary literature concerning the psychological impact of racism on healthcare staff, this topic has received particular research interest following racialised events across the past year (Brathwaite, 2018; Likupe & Archibong, 2013; Majors, 2020; Mollica & Fernando, 2020). Thus, the current research brings the concept of racial trauma to life and suggests that whilst the aim of this study was to explore experiences in relation to clinical work with service users, there exists an identified need to further explore and support these experiences at a staff level.

Strengths and Limitations

Research Paradigm

The decision to underpin the current research within a critical realist paradigm was made intentionally, with prior knowledge of the ways in which positivist paradigms have objectively studied race and racism, giving rise to well established statistics of racial inequalities in mental health (DHSC, 2018, 2021b; Memon et al., 2016). In this vein, the current research successfully combined a realist ontological position and an interpretivist epistemological position. As such, there is recognition for the reality of racism within the NHS as a product of British society, as well as a desire to seek knowledge about how and why these inequalities persistently and pervasively present through the lived experience of members of the system. It is however acknowledged that the current research represents the experiences of psychologists as service providers, as opposed to service users directly impacted by the aforementioned disparities and racial trauma. Nevertheless, the critical realist paradigm allowed for ownership of this position, and for implications and recommendations to be realistically drawn later in this chapter.

Operationalisation of Racial Trauma

Whilst the current research presents evidentiary support for the existence of racial trauma as an area of clinical concern, inferences should be drawn with caution regarding the absence of a unified definition of racial trauma. The current research aimed to adopt an exploratory framework to satisfy the primary aim of gaining an insight into participants' own understandings of the term racial trauma, and how it may present in their clinical work with service users from Black and Asian racialised communities. This is in line with the use of exploratory frameworks to address under researched topics (Coolican, 2018). Thus, it is entirely probable that the conceptualisation of racial trauma presented in the current research incorporates multiple understandings, based on personal experiences, current understandings of psychological trauma, and the amplification of the term racial trauma following the uprisal of the BLM movement in 2020. The researcher opted not to provide participants with a baseline explanation of racial trauma, in contrast with Hemmings and Evans (2018). This was decided in collaboration with Dr King and was intended to reflect the researcher's interpretivist approach to understanding racial trauma as a subjective and personal experience. To provide a baseline explanation of racial trauma would be to assume that it would be possible for participants to be on an equitable level regarding racism and racial trauma, which would only neglect the nuanced and intersectional identities that each individual participant brought to the research.

Study Sample

Whilst the researcher endeavoured to recruit purposively to capture the demographics of the psychological profession in North East London, the process of recruitment replicated inherent diversity issues prevalent in the psychology profession. Initial recruitment attempts attracted many White, female psychologists (38% of the sample). According to most recent statistics, this reflects the dominant picture within the profession, as 88% White and 80% female (Longwill, 2015), a trend which has been persistent across time (Baker & Nash, 2013; Turpin & Coleman, 2010; Williams et al., 2006). Nevertheless, the researcher was interested in moving beyond this dominant narrative and diversifying the sample, to give voice to psychologists from underrepresented backgrounds. This was especially important within the context of the topic of racial trauma, and the potential for this contribution to the literature to be dominated by those with identities aligned with the WEIRD demographic (Arnett, 2016; Henrich et al., 2010). Thus, the researcher further specified the purposive sample to encourage psychologists who identified as non-female and those from racialised communities to participate.

Reflecting on possible reasons for the low uptake of psychologists from racialised communities, it is important to view the current research within the current socio-political context of the UK. For those with lived experience of racial trauma, participating in a research interview to discuss this topic, at a time of heightened racial tension following the murder of George Floyd and the subsequent BLM protests, may have evoked psychological distress. Furthermore, at a time where conversations about race, racism, and racial trauma have been more prominent amongst White communities, participating in this research may have motivated White psychologists to participate, in an effort to avoid the silence response which is often associated with racism. Indeed, had the current research been conducted a year pre or post 2020, or more generally at times where there is less media and news coverage of racial injustice, it would be interesting to witness whether the same recruitment observations would be present. Nevertheless, the final study sample was successful in the active recruitment of underrepresented groups in the psychology profession; within the sample of 13, there were two male participants and five participants from Black and Asian racialised communities.

The sample size of 13 participants recruited in the current research is well placed within the recommendations for thematic analysis (Braun & Clarke, 2013; Terry et al., 2017), which is a noteworthy strength considering the implications of the COVID-19 pandemic (BPS, 2020b). This is particularly relevant for the recruitment of NHS staff, who are considered to be keyworkers and have experienced increased pressure and demand as a result.

Interview Process

During the period in which the interviews were conducted (July-December 2020), face-to-face interviews were not permitted according to UK government guidelines. Although the video function of Zoom as an alternative modality mitigated against the loss of important aspects of communication to some extent, it is still likely that there may have been elements missed in the absence of face-to-face interactions (Hillman et al., 2015; User Research Community, 2021). This is especially important in the context of sensitive topics (McCann & Polacsek, 2020), such as racial trauma. In the absence of physically meeting participants, it was more difficult for the researcher to assess non-verbal communication which may have indicated that participants were experiencing distress. This was an unavoidable limitation however, and it is hoped that efforts made by the researcher to ensure participants were comfortable and aware of the right to withdraw, take breaks, or skip any questions, went some way in addressing this.

Implications and Recommendations

Clinical

The current research interrogates mental health services and the NHS as unfit for purpose with regards to access, experiences, and outcomes for service users from Black and Asian racialised communities. The coercive and restrictive treatment of Black men in acute and psychosis services in particular highlights the reality of the iatrogenic effects of mental health services, a stark familiarity almost 70 years since Fanon's (1952) original analysis of the dehumanisation of Black bodies. Findings from the current research have important implications for how services are structured and provided. This includes, but is not limited to, the Westernised expectation of psychologists as solely talking therapists, who are only accessible via other statutory services who act as gatekeepers (e.g., GPs). The current research demonstrates that providing flexible, holistic care should take ownership of the harmful impact of mental health services for racialised communities. Furthermore, there is scope to contribute to the learning and development of psychologists in the area of racial trauma. However, it should be noted that such systemic change is likely to be gradual and requires input from all involved in the system. This should be held at the forefront of service development and provision and considered in conjunction with the individual recommendations outlined below.

The current research further identifies several areas of practical development for the psychology profession and the mental health system in general. As this research was conducted within NELFT, the findings can be localised to provide clinical recommendations for this Trust; however, many recommendations can also be applied to NHS psychological services nationally.

Firstly, the current research points to an organisational culture inherently impacted by systemic racism, the effects of which are negatively experienced by staff from racialised communities. At a Trust level, NELFT has set out a number of initiatives to address racial inequalities within the organisation, such as the Ethnic Minority Staff Network (EMN) and the Equality Diversity and Inclusion (EDI) Team. These initiatives exist with the primary aim of improving working environments through the career progression and improvement of experiences of staff from ethnic minority backgrounds (NELFT, 2021). However, the current research indicates continued disparities between the aims of these initiatives and the lived experiences of staff from ethnic minority backgrounds. Thus, these findings provide justification for the very existence of these initiatives, whilst suggesting that this work is ongoing and that these disparities remain of significance to the organisation.

Secondly, the findings suggest considerable variation in the degree to which psychologists feel competent in providing services which are sensitive to experiences of racism and racial trauma. This points to disparities in psychological service provision, which in turn influences access to, experiences of, and outcomes for service users from racialised communities. This is further problematised by the absence of clear competency guidelines in relation to racial trauma by NICE (2018), HCPC (2015) and the BPS (2017a), subsequently resulting in ad hoc practice based on clinician's own personal experiences or independent efforts to educate themselves on such issues. It is noteworthy that statements of intent and position papers have been published in the period since the interviews in response to the amplification of racial injustice in the past year (ACP, 2020; BPS, 2020a; HCPC, 2020). Nevertheless, existing competency frameworks lack consistency and measurable guidelines upon which clinicians can be assessed. It is therefore recommended that psychological services review the competencies upon which psychologists are routinely appraised, and specifically include expectations and guidance for the provision of assessment, formulation, and treatment of racial trauma. Competency reviews should be supplemented by a requirement to demonstrate how these competencies are being met, including professional development plans where necessary. As a core requirement of the psychological profession, supervision is well placed as a space within which to support the development of this skill (BPS, 2017a). This may be supported by existing guidelines (Pieterse, 2018), however should be adapted to suit local populations. The current pilot of the PCREF initiative set out in the White paper on the reformations to the Mental Health Act 1983 presents a timely opportunity to introduce organisational competencies related to the exploration of racial trauma (DHSC, 2021b). It may be beneficial for participating Trusts to implement this at the point of national rollout in 2022, extending the breadth of the initiative beyond the Act and incorporating this into wider community mental health services.

At a local level, the current research has direct implications for informing the NELFT EMN strategy, most notably strategic objective 3 *"address health inequalities impacting black and ethnic minority populations in NELFT demographics"* (NELFT, 2020, p.43). The findings point to an underrepresentation of service users from racialised communities within psychological services, which may be of particular interest to the EDI Team, who will be responsible for leading on this objective. Furthermore, the development of psychological competencies for working with racial trauma may also be of interest to local Quality Improvement projects to systematically monitor this.

Thirdly, the current research potentially suggests developmental needs in the training of psychologists in the NHS. Many participants expressed that incorporating race and racism into their clinical work was not routine practice. The findings suggest that at present, there are limitations in the training of qualified psychologists who are knowledgeable and confident in working cross-culturally with service users from racialised communities, recognising racial trauma, and examining both privilege and oppression within clinical relationships. Current BPS guidelines for both clinical and counselling psychology doctoral training programmes include competencies related to working with diversity (BPS, 2019a, 2019b); however do not specifically mention working with experiences of racism or racial trauma. It is also hoped that the current research will be used to inform the current Health Education England (HEE) EDI initiative currently in progress across 27 clinical psychology doctoral courses in the UK (BPS, 2021a). Specifically, the findings suggest that race and racism are not featured prominently within teaching curriculums. It is hoped that these findings will be considered as supporting evidence, alongside existing studies advocating for national diversification and decolonisation (Ahsan, 2020; Pillay, 2017; Wood & Patel, 2017, 2019). This is imperative to ensure the qualification of psychologists who are able to appropriately meet the needs of modern-day British society. In acknowledgement of the re-enactment of racial trauma in professional spaces described by participants in the current research, it is vital that the experiences of trainees from racialised communities are seen, heard, supported, and appreciated within these spaces.

Finally, the current research suggests disparities between the experiences of psychologists from racialised communities in comparison with White psychologists. Specifically, participants reported on the weight of the emotional burden of both personally experiencing and professionally advocating against racial trauma. Furthermore, participants were often unfairly placed in tokenistic positions of expertise on all issues related to race and racism, thus neglecting the nuanced and multifaceted experiences between and within racialised communities. These findings are already well established and persistent within the NHS generally (Kline, 2014; WRES, 2021), and in the current and aspiring trainee population (Addai et al., 2019; Bawa et al., 2019; Prajapati et al., 2019; Tong et al., 2019). Thus, the current research acts as a further call to action and evidences the inherent and systemic manner in which these disparities exist within psychology. It is recommended that NHS Trusts translate wider national statistical data into their own localised services, combining this with conscious efforts to seek out and bear witness to the qualitative experiences of staff from racialised communities. This could include directly asking for feedback through surveys, interviews, or focus groups, as well as indirectly through the robust reporting of racial discrimination, using appropriate sanctions which reflect a no tolerance policy on racism. These findings are of increased importance within ethnically dense areas such as North East London, where 39% of the NELFT workforce is from a racially minoritised background (NELFT, 2020), in comparison with the national average of 21% across the NHS (WRES, 2021). These interpretations and recommendations should be considered in the context of the small sample size of the current research, and wider generalisations should be supported by further research, as explored later in this chapter.

Policy

The current research is submitted at a time of significant national transformation across NHS mental health services, in line with the NHS long term plan (NHS, 2019). Firstly, echoing previous organisational polices (DHSC, 2018, 2021b; DoH, 2005, 2010; Independent Mental Health Taskforce, 2016), the findings suggest that issues surrounding racial inequalities in mental health services are well established, yet poorly addressed. It is recommended that these findings are viewed in relation to previous policy initiatives to understand and address the reasons for the persistent inequalities faced by racialised communities.

Secondly, the current research suggests limitations in the applicability of NICE guidelines for psychological trauma to experiences beyond the scope of PTSD diagnostic criteria. Current guidelines include a sub-section on the impact of culture on the treatment of psychological trauma, yet neglect racial and cultural considerations in experiences associated with the development of such trauma (NICE, 2018). It is therefore recommended that further research undertaken within NICE includes efforts to meaningfully incorporate racial trauma into clinical guidelines. Furthermore, approaches such as community psychology (Kagan et al., 2019), critical psychology (Parker, 2007), liberation psychology (Afuape & Hughes, 2015), and the tree of life narrative approach (Ncube, 2006), offer an alternative lens through which to view psychological distress. In contrast to traditional psychological approaches, these approaches are distinct in naming the inherent systemic ideologies and practices which maintain marginalisation, and draw upon the strengths and resilience of communities to promote recovery (Chavez-Dueñas et al., 2019). The ethos of these approaches promotes a message which has only recently begun to gain traction in the wider psychology sphere (Buki, 2014; Hailes et al., 2020; Kozan & Blustein, 2018; Nadal, 2017). Development of the evidence base to promote such approaches as options for first lines of treatment may be a beneficial step towards providing racially and culturally appropriate trauma assessment and intervention tools. This should include assessment tools which demonstrate robust validity and reliability, perhaps drawing upon the limited racial trauma assessment tools developed in the US (Carter et al., 2013; Torres-Harding et al., 2012; Williams et al., 2018a; Williams et al., 2018b). However, these should be adapted to suit the needs of UK populations.

At a local level, the current research is well placed to inform the recently initiated NELFT mental health transformation programme, aiming to transform mental health services in the next 3 years (NHS, 2019). This is a collaborative programme, involving local health and social care partners and service users in North East London. One of the key principles of this programme is the movement towards trauma-informed care and to a community psychology model. The intention is to work in partnership with service users and carers, and to collaborate with voluntary sector and local authority organisations. The current research enriches local knowledge of the existing health inequalities in North East London which the transformation programme aims to address, specifically identifying racial disparities which are present in the local populations, yet poorly addressed in current service provision. The transformation programme represents a timely introduction of new ways of working of which consideration of racial trauma should be embedded.

Further Research

As an exploratory study, the current research fundamentally provides preliminary support for racial trauma as a concept of interest within the UK. Further research is needed to establish a robust evidence base for the consideration of racial trauma in routine clinical practice. Firstly, further research is required to explore the prevalence of racial trauma in the UK, and more specifically in mental health service user populations. Anecdotal case studies shared by participants in the current research suggest a high prevalence, however, the use of robust quantitative methodology would further leverage this and provide tangible justification for the aforementioned clinical and policy recommendations.

Secondly, it is acknowledged that the current research does not capture the voices of service users with lived experience of racial trauma. Future research should endeavour to incorporate these experiences, as well as experiences of disclosing racial trauma within a psychological therapy setting. This could substantiate or challenge the current findings, building on previous recommendations by Hemmings and Evans (2018). It is important to embed findings within communities, with a recognition of their diversity and heterogeneity, as has been demonstrated in the developing literature base in the US (Awad et al., 2019; Gone et al., 2019; Hartmann et al., 2019; Skewes et al., 2019). Members of racialised communities are often labelled as "hard to engage" in healthcare research. Factors influencing this include mistrust following the historical abuse of racialised communities in research settings (Brawley, 1998; Scharff et al., 2010; Thomas & Quinn, 1991), lack of racial diversity in research teams (Muhammad et al., 2015), language barriers (Gill et al., 2013; Rooney et al., 2011), mistrust of the healthcare system (Armstrong et al., 2013), and poor accessibility to research opportunities in socially deprived areas (Brown et al., 2014; Waheed et al., 2015). As such, racial health disparities are frequently unaccounted for in the literature, further perpetuating poor clinical outcomes amongst these communities (Chen et al., 2005; Hussain-Gambles et al., 2004). To facilitate meaningful change, it is imperative that researchers actively seek to identify barriers to diversifying recruitment methods. In qualitative research this could include consulting with grassroots community organisations during the design stages, to understand the nuances of the communities of interest and how the research will be of service to them. Further, snowball sampling could be used to encourage recruitment by proxy. Consideration of the impact of researchers' own racial identities on the ability to create a safe and comfortable environment should also be a requirement (NIHR, 2018).

Thirdly, the prominent socio-political context within which the current research has been conducted, namely the global amplification of racial injustice, may have influenced the findings, evidenced by the frequent references made to the BLM movement. The use of a cross-sectional design is limited to a snapshot of the timeframe within which the research is conducted. Future research may wish to consider use of a longitudinal design, to observe the impact of changing societal attitudes towards racism and the amplification of racial trauma on the practice of applied psychology.

Finally, the current research is underpinned by a myriad of theories, stemming from psychology, sociology, history, and biology, demonstrating the influence of and correspondence with other disciplines to holistically understand racial trauma. This propels Hartmann et al.'s (2019) recommendation of engaging racial trauma as a critical discourse using interdisciplinary inquiry, and recognises racial injustice as a human rights issue. This prompts a critical appraisal of the suitability of traditional models of trauma (i.e., those focused on PTSD), or whether more nuanced psychological models are required to comprehensively understand racial trauma. This is a potential new area of research interest, which is timely and relevant to the profession at present.

Participant Reflections

Towards the end of the interviews, some participants offered reflections on the process of taking part. For many participants, taking part evoked emotional responses, reflective of the sensitive nature of the topic. All participants recognised the duty they held as psychologists to take this discussion further and influence change in their respective services. A sub-sample of reflections are included below. Fiona shares her emotional response to the interview process, coupled with a newfound inspiration to engage in further development, whilst Susan reflects on the interview as a catalyst to examine her own ignorance. Neelam adds her feelings of excitement that the examination of racial trauma is finally gaining a seat at the table within the psychology profession:

> *"It's actually been quite emotional to do this interview in some ways, but hopefully I feel like inspired to be better as a clinician and to be more aware of racial trauma and aware, but also like I say, like action things, not just kind of go along. Not being afraid to have these conversations"* (Fiona)

> *"I mean talking about it I suppose does make me feel, I suppose erm, fairly ignorant, I suppose, on the on the whole topic. Well, I mean that is, it's a good thing to, I suppose, actually start having these conversations, because that is the way to reduce ignorance"* (Susan)

> *"This is something I'm kind of really excited about because it's finally, you know, my sense is it's finally on the table. People are beginning to take notice, or there's a sense of a more openness to have those difficult conversations. So, I think we're in a really exciting time"* (Neelam)

Conclusion

In summary, as the first study of its kind, the current research makes a significant contribution to the racial trauma literature, specifically in reifying the presence and importance of this within a UK context. The main findings suggest that the experiences of NHS psychologists exploring racial trauma is an endeavour which moves far beyond the therapeutic dyad and extends to the racialisation of British society. The navigation of this system is further impacted by psychologists as individuals with their own racial identities, and their own racialised experiences, which they inevitably bring to the professional domain. During a time of significant restructure and transformation of mental health services locally and nationally, the current research acts as a call to action for the psychological profession and wider NHS mental health services. This call to action urges the consideration of racial trauma as a framework worthy of clinical, policy, and research attention, in the best interests of the richly diverse communities it serves.

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Appendices

Appendix A

Systematic Literature Review Search Strategy using the SPIDER framework
(Cooke et al., 2012)

Category	**Search Terms**
Sample- Mental health professionals	1) “professional” OR “staff” OR “clinician” OR “practitioner” OR “therap*” OR “counsel*” OR “psychiatr*” OR “psycho*” OR “psychological therap*” OR “nurs” OR “social work*” OR “occupational therap*” OR “family therap*” OR “systemic therap” OR “art therap*”
Phenomenon of **I**nterest- Racial dialogue	2) “race” OR “raci” OR “ethnic*” OR “divers*” OR “cultur*”
Phenomenon of **I**nterest-Clinical practice	3) “therap*” OR “supervis*” OR “consult*” OR “reflect*” OR “practice” OR “meeting*” OR “session*” OR “appointment*” OR “assess*” OR “formulat*” OR “intervention” OR “liais*” OR “screening” OR “clinic”
Evaluation- Experience	4) “experience*” OR “perspective*” OR “perc*” OR “explor*” OR “view*” OR “reflect*” OR “attitude” OR “belie*” OR “understand” OR “aware*” OR “evaluat*” OR “feel*” OR “emotion*”
All categories	5) #1 AND #2 AND #3 AND #4

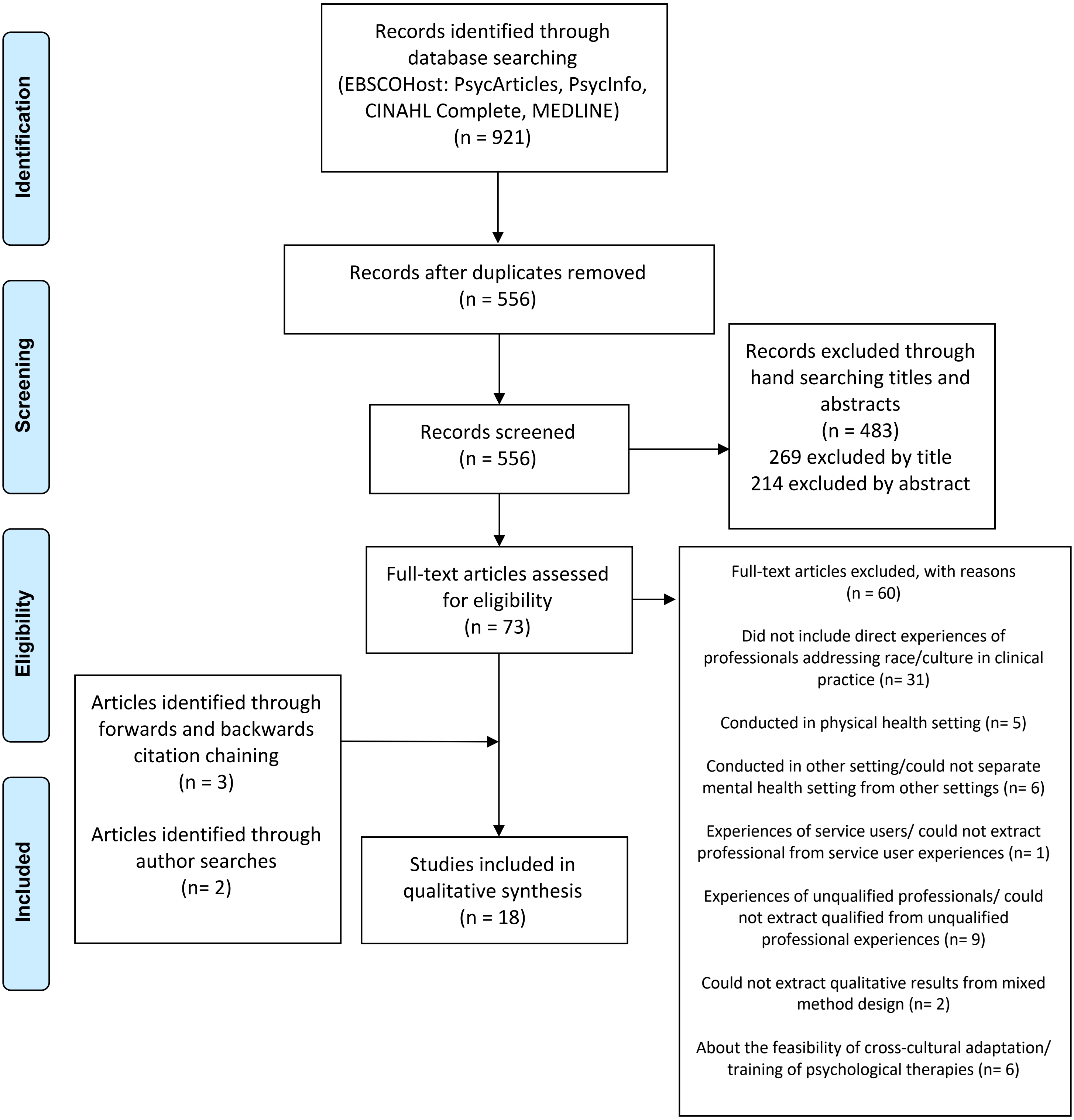
Appendix B

Systematic Literature Review Search Term Groups and Results

Search Term Groups	**Results**
1	1,663,346
2	468,263
3	2,289,976
4	2,057,056
(1) AND (2) AND (3) AND (4)	921

Appendix C

Systemic Literature Review
PRISMA Flow Diagram



Appendix D

Key Study Characteristics of Articles Included in the Thematic Synthesis

Author/Year	Aims	Design	Sample Size	Ethnicity	Job Discipline	Setting	Country	Analysis Method
Aggarwal et al. (2016)	To examine how patients, clinicians, and administrators define the meanings and practices of cultural competence in one hospital (pg.2)	Qualitative focus groups	18	Caucasian (10) Hispanic/Latino/a (2) Black/African American (2) Asian (4)	Psychiatrist; Psychologist; Social Worker; Credentialed Alcoholism and Substance Abuse Counsellor	Psychiatry department of metropolitan hospital	USA	Iterative open coding, constant comparison, and neutral questioning for theory generation (Strauss and Corbin 1998)
Atkins et al. (2017)	To explore how White clinicians, who were nominated for being multiculturally engaged, describe their awareness development (pg.673)	Qualitative interviews	12	White Canadian	Psychologist (7) Social Worker (4) Psychiatrist (1)	Hospital (4) Community counselling services (1) Universities (3) Private practice (2) Penitentiaries (2)	Canada	Grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998)
Bassey & Melluish (2012)	To capture therapists' views on the relevance and influence of culture in their clinical work, their experiences of delivering CBT to BME clients, and their experiences of training (pg.225)	Qualitative focus groups	10	Not stated	IAPT Therapists	NHS Improving Access to Psychological Therapies (IAPT) Services	UK	Template analysis (King, 1998)
Burkard et al. (2006)	To examine therapists' use of self-disclosure in cross-cultural counselling (pg.5)	Qualitative consensual qualitative research interviews	11	European American	Professional Counsellors (2) Psychologist (9)	Not stated	USA	Consensual qualitative research methodology

Author/Year	Aims	Design	Sample Size	Ethnicity	Job Discipline	Setting	Country	Analysis Method
Burkard et al. (2014)	To explore clinical supervisors' experience of providing difficult feedback in cross-ethnic/racial supervision (pg.314)	Qualified interviews	17	European American (9) African American (3) Asian American (2) Biracial (1) International (1) Latina (1)	Clinical Psychologist (7) Counselling Psychologist (10)	Not stated	USA	Consensual qualitative research (Hill et al., 2005; Hill, Thompson, Williams, 1997)
Fuertes et al. (2002)	To explore (a)How European American therapists engage African American clients in counselling (b) What problems or difficulties did they encounter in helping the client I What skills or special interventions they used (pg. 765)	Qualitative interviews	9	European American	Clinical Psychologist (1) Counselling Psychologist (8)	University counselling services (4) Private practice (3) Mental health agencies (2)	USA	Consensual qualitative research methodology (Hill et al., 1997)
Grimmer & Schwantes (2018)	To discover what strategies music therapists use to work cross-culturally in another country, what their personal experiences have taught them, and how they integrate themselves into the culture. (pg.23)	Qualitative interviews	3	European American	Music Therapist	Child & Adolescent settings	Finland, Singapore, New Zealand	Microanalysis (McFerran & Grocke, 2007)
Kang & Moran (2020)	To explore inpatient staff experiences of seeking to meet the religious and cultural needs of BAME inpatients on mental health wards (pg.115)	Qualitative interviews	9	White British (6) African (1) Indian (2)	Consultant Psychiatrist; Psychiatric Nurse; Healthcare Assistant; Occupational Therapist; Deputy Ward Manager; Ward Manager	NHS Acute inpatient unit	UK	Framework thematic analysis (Gale et al., 2013)

Author/Year	Aims	Design	Sample Size	Ethnicity	Job Discipline	Setting	Country	Analysis Method
Keselman & Awais (2018)	To explore how cultural humility manifests in the perspective and cross-cultural interactions described by medical art therapists (pg.78)	Qualitative interviews	6	Not stated	Art Therapist	Not stated	USA	Cross-case analysis (Stake, 2006)
Knox et al. (2003)	To interview therapists about their experiences of raising and not raising the topic of race in specific cross-racial dyads (i.e., African American therapist–European American client; European American therapist–African American client). (pg.471)	Qualitative interviews	12	African American (5) European American (7)	Psychologist	Not stated	USA	Consensual qualitative research methodology (Hill et al., 1997)
Nelson et al. (2001)	To explore ethnicity in the family therapy process, ethnicity issues for the family therapist, ethnicity issues for the client family, therapeutic strategies when ethnicity is an issue, and recommendations for ethnicity training and supervision of future family therapists (pg. 363)	Qualitative interviews	29	White (21) Black (1) Mexican (1) Asian (1) (not stated but from Germany, Norway, Australia and Finland [5])	Family Therapist	Not stated	USA	Ethnographic content analysis (Altheide, 1987)
Reddy (2019)	To explore and illuminate the lived experience of South Asian therapists working within South Asian women's organisations (pg.4)	Qualitative interviews	8	Indian (4) Pakistan (2) Bengali (1) Sri Lanka (1)	Social Worker	South Asian women's organisations	USA	Phenomenological analysis methods (Moustakas, 1994)

Author/Year	Aims	Design	Sample Size	Ethnicity	Job Discipline	Setting	Country	Analysis Method
Rosenfield (2020)	To explore the countertransference experiences of psychodynamically-trained Caucasian therapists (pg.61)	Qualitative interviews	7	Caucasian	Social Worker (4) Clinical Psychologist (1) Marriage & Family Therapist (2)	Not stated	USA	Inductive grounded theory (Corbin & Strauss, 2008)
Sunderani & Moodley (2020)	(a)How do therapists specifically use self-disclosure with their clients and with clients from a similar and differing cultural background? (b)Under what circumstances do therapists hesitate to disclose and/or refrain from disclosing to clients from both a similar and differing cultural background? (pg.744)	Qualitative interviews	9	Canadian/British German (1) Anglo-Saxon/American (1) Guyanese/East Indian (1) Jewish Canadian (2) Czech-Canadian/White (1) Ukrainian/Canadian (1) Ukrainian (1) Canadian/White/Eastern European (1)	Social Worker (3) Psychologist (3) Psychotherapist (3)	Not stated	Canada	Constant comparative method (Fassinger, 2005)
Taylor et al. (2006)	To develop an understanding of how therapists working with Latino families construct the idea of cultural competence in the counselling room (pg.429)	Qualitative narrative interviews (Co-research model [Lobovits & Seidel, 1999)	9	Latino	Family Therapist	Community agencies	USA	Not stated
Verdinelli & Biever (2013)	To explore experiences among bilingual therapists who self-identified with an ethnic background other than Latina/o on their professional and personal language development and to understand how cultural variables such as language and ethnicity were perceived (pg.229)	Qualitative interviews	14	White/European American (13) African American (1)	Clinical Psychologist; Counselling Psychologist; Marriage & Family Therapist; Counsellor; Other related fields not specified	Community Mental Health Centre (9); Prison Community Mental Health Centre (1); Hospital (1); Private practice (2); Private practice/school (1)	USA	Constant comparative method

Author/Year	Aims	Design	Sample Size	Ethnicity	Job Discipline	Setting	Country	Analysis Method
Yon et al. (2018)	To explore the ways in which two therapists working within a specialist cultural service challenge the core cultural beliefs of a family undertaking therapy, and whether this can be done in a way that is compatible with creating and maintaining a positive therapeutic alliance (pg.183)	Video-assisted qualitative interviews (including interpersonal process recall [Kagan, 1980])	2	British Pakistani (1) White French (1)	Systemic Family Therapist	NHS Family therapy service (culturally specific)	UK	Thematic analysis
Zaharopoulos & Chen (2018)	To explore the nature of the retrospective experiences of helpful and difficult racial-cultural events in group therapy as perceived by eight White group therapists and six group therapists of colour (pg.629)	Qualitative interviews	14	White Black Asian Hispanic	Group Therapist	Hospitals, Veteran administrations; Counselling centres; Private practice	USA	Grounded theory (Strauss & Corbin, 1998)

Appendix E

Quality appraisal of articles included in the thematic synthesis (CASP, 2018)

	Article **Key-** ✓= yes ✗= no ?= can't tell																	
Qualitative Appraisal Criteria	Aggarwal et al. (2016)	Atkins et al. (2017)	Bassey & Melluish (2012)	Burkard et al. (2006)	Burkard et al. (2014)	Fuertes et al. (2002)	Grimmer & Schwantes (2018)	Kang & Moran (2020)	Keselman & Awais (2018)	Knox et al. (2003)	Nelson et al. (2001)	Reddy (2019)	Rosenfield (2020)	Sunderani & Moodley (2020)	Taylor et al. (2006)	Verdinelli & Biever (2013)	Yon et al. (2018)	Zaharopoulos & Chen (2018)
Was there a clear statement of the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	?	✓	✓	✓	✓	✓	✓
Is a qualitative methodology appropriate?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Was the research design appropriate to address the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Was the recruitment strategy appropriate to the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix E

Quality appraisal of articles included in the thematic synthesis (CASP, 2018)

Qualitative Appraisal Criteria	Aggarwal et al. (2016)	Atkins et al. (2017)	Bassey & Melluish (2012)	Burkard et al. (2006)	Burkard et al. (2014)	Fuertes et al. (2002)	Grimmer & Schwantes (2018)	Kang & Moran (2020)	Keselman & Awais (2018)	Knox et al. (2003)	Nelson et al. (2001)	Reddy (2019)	Rosenfield (2020)	Sunderani & Moodley (2020)	Taylor et al. (2006)	Verdinelli & Biever (2013)	Yon et al. (2018)	Zaharopoulos & Chen (2018)
Was the data collected in a way that addressed the research issue?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Has the relationship between researcher and participants been adequately considered?	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✗	✗	✗	?	✗
Have ethical issues been taken into consideration?	✓	✓	?	?	?	?	✓	✓	?	?	?	✓	?	✓	?	?	✓	✓
Was the data analysis sufficiently rigorous?	✓	✓	✓	✓	✓	✓	✓	✓	✓	?	✓	✓	✓	✓	✗	✓	✓	✓
Is there a clear statement of findings?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix E

Quality appraisal of articles included in the thematic synthesis (CASP, 2018)

Qualitative Appraisal Criteria	Aggarwal et al. (2016)	Atkins et al. (2017)	Bassey & Melluish (2012)	Burkard et al. (2006)	Burkard et al. (2014)	Fuertes et al. (2002)	Grimmer & Schwantes (2018)	Kang & Moran (2020)	Keselman & Awais (2018)	Knox et al. (2003)	Nelson et al. (2001)	Reddy (2019)	Rosenfield (2020)	Sunderani & Moodley (2020)	Taylor et al. (2006)	Verdinelli & Biever (2013)	Yon et al. (2018)	Zaharopoulos & Chen (2018)
How valuable is the research? (Have the researchers considered this?)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

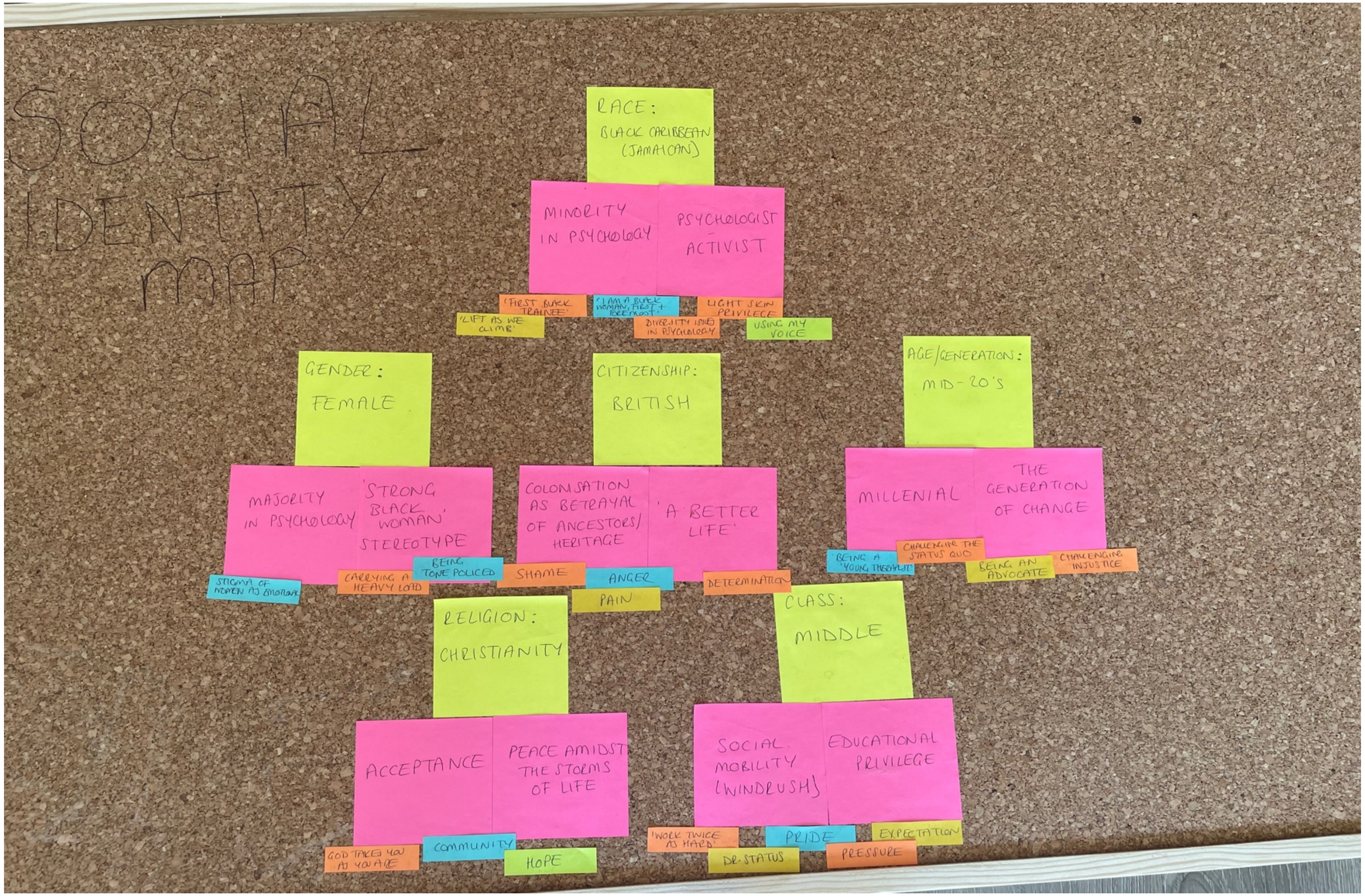
Appendix F

Prevalence of Analytical Themes Across Studies in Thematic Synthesis

	Analytical Themes				
Study	**Bias is in the eye of the beholder**	**The power of self-disclosure**	**Navigating the relevance of race and culture in the therapeutic space**	**Mental health services a microcosm of a racialised society**	**There is always a lesson to be learned**
Aggarwal et al. (2016)	*	*	*		*
Atkins et al. (2017)	*	*	*	*	*
Bassey & Melluish (2012)	*	*	*	*	*
Burkard et al. (2006)	*	*	*		
Burkard et al. (2014)	*	*	*	*	*
Fuertes et al. (2002)		*	*	*	*
Grimmer & Schwantes (2018)	*	*	*		
Kang & Moran (2020)	*		*	*	*
Keselman & Awais (2018)	*		*	*	*
Knox et al. (2003)	*		*	*	*
Nelson et al. (2001)	*	*	*		*
Reddy (2019)	*	*	*	*	*
Rosenfield (2020)	*	*	*	*	
Sunderani & Moodley (2020)	*	*	*		*
Taylor et al. (2006)	*	*	*	*	*
Verdinelli & Biever (2013)	*	*	*	*	*
Yon et al. (2018)	*	*	*	*	*
Zaharopoulos & Chen (2018)	*		*	*	*

Appendix G

Researcher Positionality Map



University of Essex

Appendix H

Participant Demographics Sheet

NELFT NHS
NHS Foundation Trust

Participant Demographics Sheet for Exploring UK mental health practitioners' awareness of racial trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.

Participant ID Number:

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: ....

Prefer not to answer ☐

Age: 18-25 ☐ 26-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+ ☐

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 background ☐

Other ethnic group
Arab ☐

Any other ethnic group ☐

Occupation: ……………………………….

Current Job Role: …………………………

Length of time qualified: …………………...........

Current service: ……………………….........

Borough: ....

Length of time working in current service: …………….........

Appendix I

Interview Topic Guide

Topic guide for Exploring UK mental health practitioners' awareness of racial trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.

Introduction

1. Recap aims of study (refer to participant information sheet V1.1 13/07/2020).
2. Obtain informed consent.
3. Remind participant about confidentiality, right to withdraw, and the option to skip any questions or take a short break during the interview at any time.
4. Answer any final questions before the interview commences.

Perceptions of racial trauma

- **What is your interpretation/understanding of the term racial trauma?**

- **What factors do you think contribute to an individual experiencing racial trauma?**

- **What is your understanding of how the service users that you work with may be affected by experiences of racism?**

Implications for assessment and treatment/ intervention

- **Tell me about your general experience of working with service users from Black and Asian Minority Ethnic (BAME) backgrounds?**
  Prompts: How ethnically diverse is your case load? Do you think this is reflective of the geographical area you work in? Why/why not? Are there any ways that you adapt your approach to accommodate working with these service users? If yes, tell me more about this.

- **Has there ever been a time when a service user has disclosed an incident(s) of racism to you/ a member of your team? Tell me about this in as much detail as you can (maintaining confidentiality to the service user).**
  Prompts: How did you respond? Were there any barriers you experienced in addressing this topic? If so, what were they? Did anything make it easier for you to address this? If so, what? What was the outcome for the service user? How do you think you handled this situation? Would you do anything differently?
  (If no previous experience)- Hypothetically, if a service user were to disclose an incident(s) of racism to you, how would you anticipate this interaction to go? How would you respond? Would you anticipate any difficulties/barriers? What would make this easier?

- **What factors do you think may be important to consider during the assessment/ formulation process when working with a service user who has experienced racial trauma?**

- **What factors do you think may be important to consider during the treatment/intervention process?**

- **Are there any ways in which you think mental health services may contribute to or worsen the experience of racial trauma?**

Implications for service provision- Ideas for change

- **At present, how effectively do you think mental health services address the relationship between racism and trauma?**

- **Are there any ways you feel you could be better supported to appropriately address experiences of racial trauma in the future? What would this look like?**

- **Are there any changes you think are necessary for mental health services to appropriately address these experiences?**

Concluding questions

- **Is there anything else that we have not discussed that you think would be useful to share?**
- **What else do you think should be asked in this type of interview?**

(Off record)- Anyone else you can recommend for me to speak to about this?

Optional Debrief

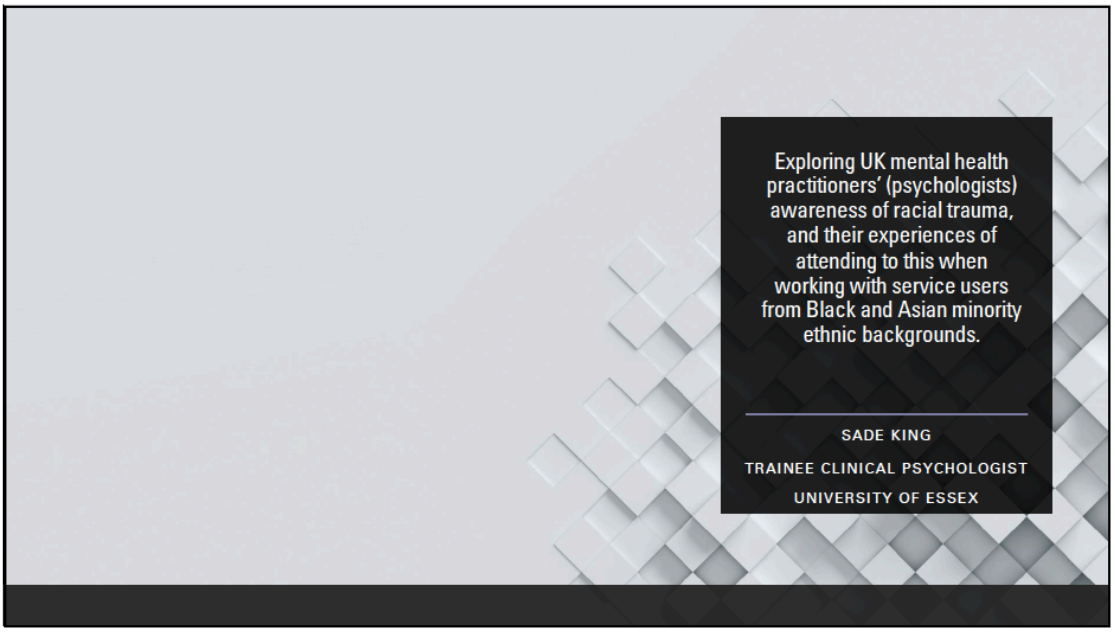
- **How did you find talking about this today?**
- **I wonder if you have any reflections you would to share about speaking about this topic for you today? Has anything resonated with you personally that you would like to share?**

Allow participant to reflect on their experiences of taking part, and signpost to relevant sources of support if necessary (e.g., NELFT Occupational Health service, IAPT, Samaritans).

Thank you for your participation.

Appendix J

Recruitment PowerPoint Presentation

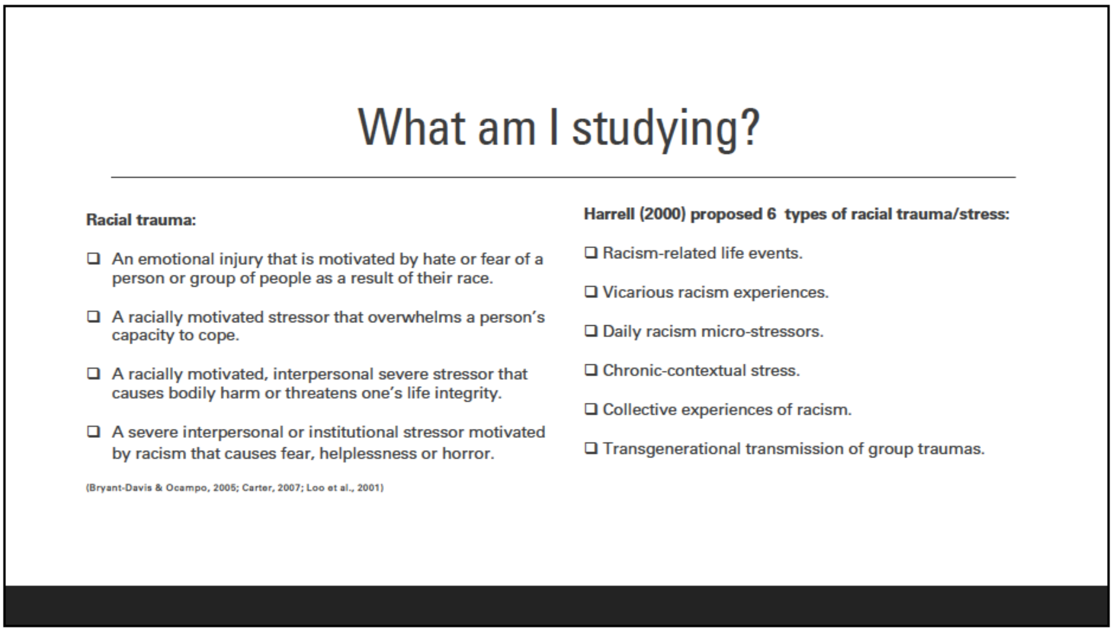


Exploring UK mental health practitioners' (psychologists) awareness of racial trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.

SADE KING

TRAINEE CLINICAL PSYCHOLOGIST

UNIVERSITY OF ESSEX



What am I studying?

Racial trauma:

- ☐ An emotional injury that is motivated by hate or fear of a person or group of people as a result of their race.
- ☐ A racially motivated stressor that overwhelms a person's capacity to cope.
- ☐ A racially motivated, interpersonal severe stressor that causes bodily harm or threatens one's life integrity.
- ☐ A severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness or horror.

(Bryant-Davis & Ocampo, 2005; Carter, 2007; Loo et al., 2001)

Harrell (2000) proposed 6 types of racial trauma/stress:

- ☐ Racism-related life events.
- ☐ Vicarious racism experiences.
- ☐ Daily racism micro-stressors.
- ☐ Chronic-contextual stress.
- ☐ Collective experiences of racism.
- ☐ Transgenerational transmission of group traumas.

Why?

On a societal level...

Black individuals are 5 times more likely to have force used against them by the Police than White individuals

(Home Office, 2019).

Racially motivated crimes accounted for 76% of hate crimes in the UK in 2018/19.

(Home Office, 2019)

Black women are 5 times more likely to die in childbirth than White women, Asian women are twice as likely.

(MBRRACE, 2019)

At the time of the 2011 Census, 3% of the UK population were black. Black individuals are more than twice as likely than White individuals to die in Police custody, making up 8% of these deaths.

(ONS, 2011)

London has the highest ethnicity pay gap in the UK, with ethnic minority groups earning 21.7% less than White employees on average.

(ONS, 2019)

Pupils from Black Caribbean backgrounds are nearly 3 times more likely to be permanently excluded from school than White pupils.

(Department for Education, 2020)

Despite making up just 14% of the population, men and women from Black and Asian minority ethnic backgrounds (BAME) make up 25% of prisoners, while over 40% of young people in custody are from BAME backgrounds.

(The Lammy Review, 2017)

Why?

And within mental health services...

Black individuals are 4 times more likely to be detained under the Mental Health Act (1983) than White individuals.

(Department for Health & Social Care, 2018)

Black individuals are 8 times more likely to be given a Community Treatment Order.

(Department for Health & Social Care, 2018)

Black individuals are more likely to be diagnosed with schizophrenia, even when displaying similar symptoms to their White counterparts.

(BPS, 2017)

Mental health services within the UK are largely based on Eurocentric paradigms and world-views.

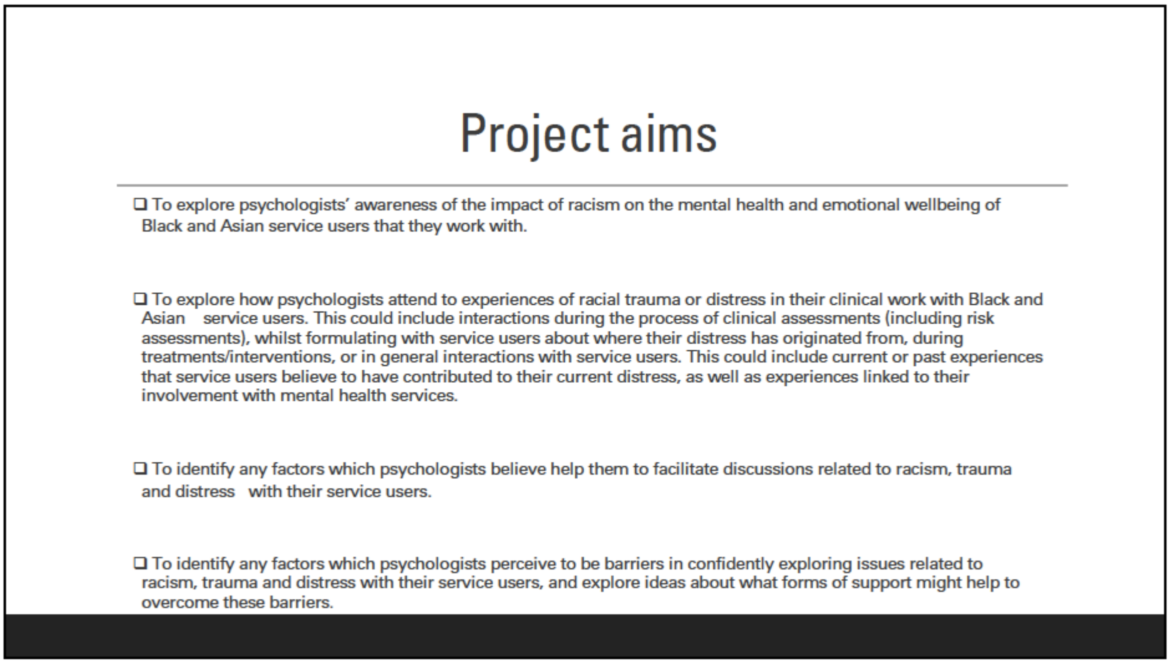
(Fernando, 2003)

Individuals from Black and Asian ethnic minority backgrounds are more likely to enter mental health services through the Criminal Justice System, more likely to receive compulsory treatment, and less likely to access psychological therapies.

(Mind, 2019)

Individuals from Black and Asian ethnic minority backgrounds are underrepresented in helping professions, such as Clinical Psychology.

(BPS, 2016; Clearing House for Postgraduate Courses in Clinical Psychology, 2018)



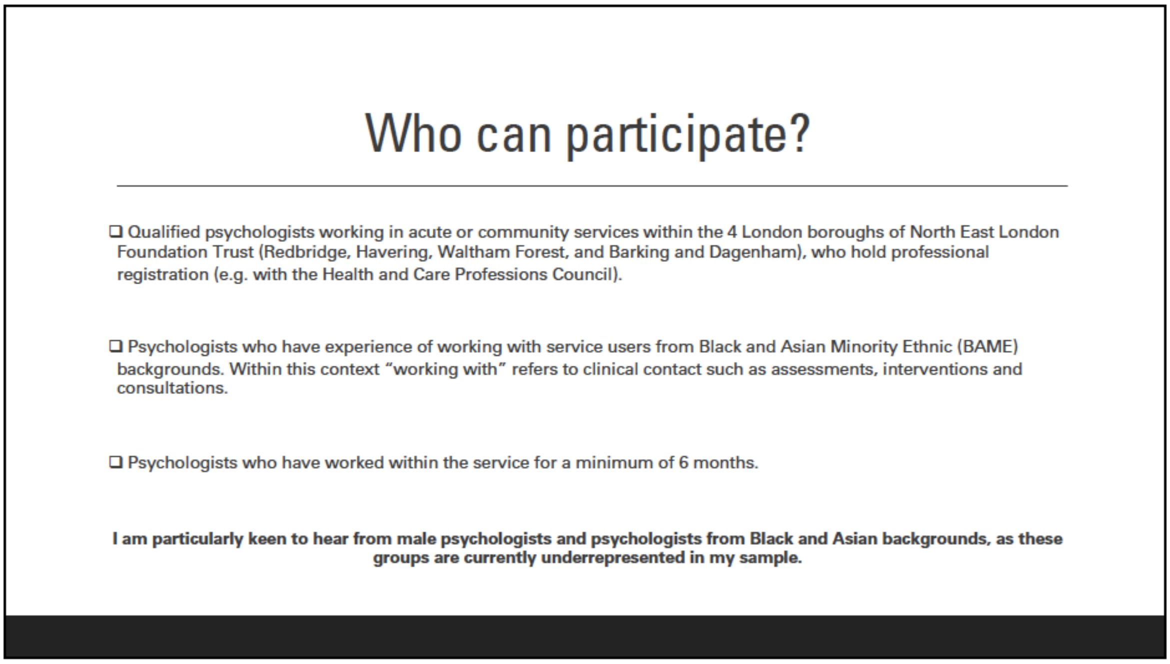
Project aims

☐ To explore psychologists' awareness of the impact of racism on the mental health and emotional wellbeing of Black and Asian service users that they work with.

☐ To explore how psychologists attend to experiences of racial trauma or distress in their clinical work with Black and Asian service users. This could include interactions during the process of clinical assessments (including risk assessments), whilst formulating with service users about where their distress has originated from, during treatments/interventions, or in general interactions with service users. This could include current or past experiences that service users believe to have contributed to their current distress, as well as experiences linked to their involvement with mental health services.

☐ To identify any factors which psychologists believe help them to facilitate discussions related to racism, trauma and distress with their service users.

☐ To identify any factors which psychologists perceive to be barriers in confidently exploring issues related to racism, trauma and distress with their service users, and explore ideas about what forms of support might help to overcome these barriers.



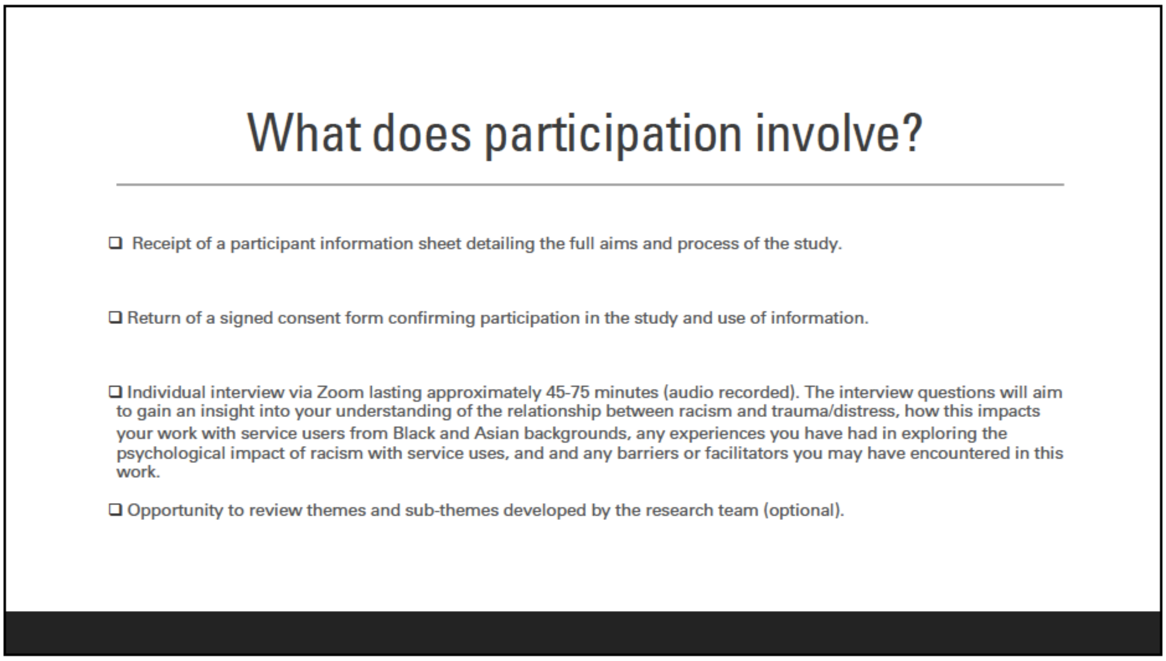
Who can participate?

☐ Qualified psychologists working in acute or community services within the 4 London boroughs of North East London Foundation Trust (Redbridge, Havering, Waltham Forest, and Barking and Dagenham), who hold professional registration (e.g. with the Health and Care Professions Council).

☐ Psychologists who have experience of working with service users from Black and Asian Minority Ethnic (BAME) backgrounds. Within this context "working with" refers to clinical contact such as assessments, interventions and consultations.

☐ Psychologists who have worked within the service for a minimum of 6 months.

I am particularly keen to hear from male psychologists and psychologists from Black and Asian backgrounds, as these groups are currently underrepresented in my sample.



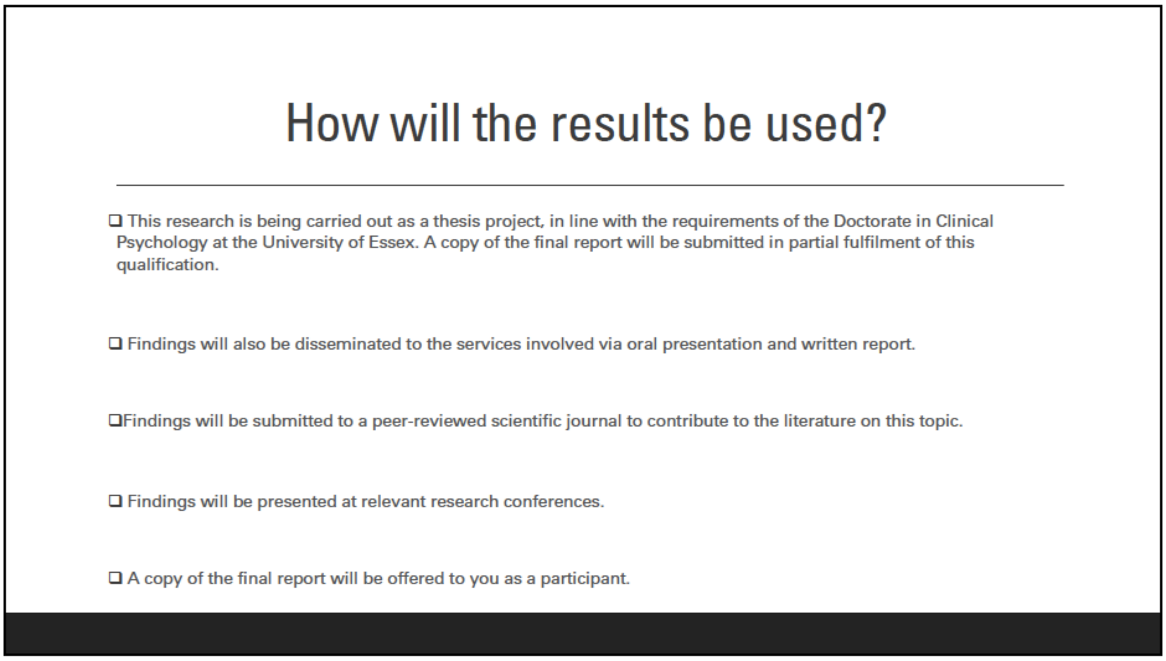
What does participation involve?

☐ Receipt of a participant information sheet detailing the full aims and process of the study.

☐ Return of a signed consent form confirming participation in the study and use of information.

☐ Individual interview via Zoom lasting approximately 45-75 minutes (audio recorded). The interview questions will aim to gain an insight into your understanding of the relationship between racism and trauma/distress, how this impacts your work with service users from Black and Asian backgrounds, any experiences you have had in exploring the psychological impact of racism with service uses, and and any barriers or facilitators you may have encountered in this work.

☐ Opportunity to review themes and sub-themes developed by the research team (optional).



How will the results be used?

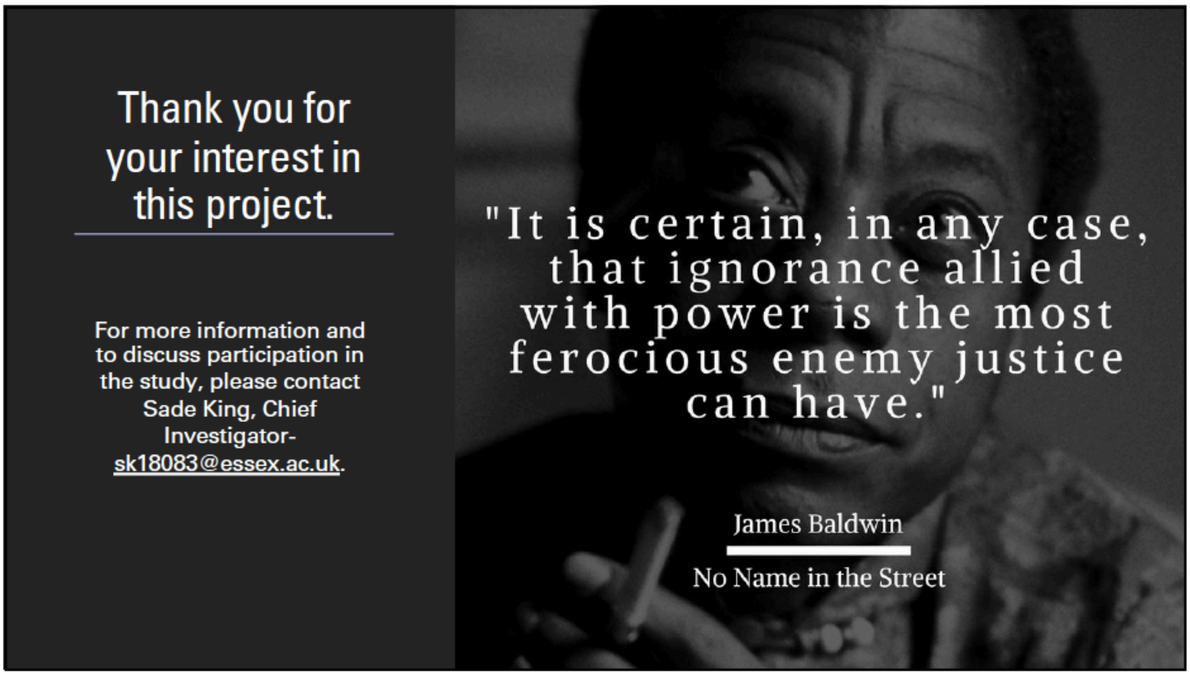
☐ This research is being carried out as a thesis project, in line with the requirements of the Doctorate in Clinical Psychology at the University of Essex. A copy of the final report will be submitted in partial fulfilment of this qualification.

☐ Findings will also be disseminated to the services involved via oral presentation and written report.

☐Findings will be submitted to a peer-reviewed scientific journal to contribute to the literature on this topic.

☐ Findings will be presented at relevant research conferences.

☐ A copy of the final report will be offered to you as a participant.



Thank you for your interest in this project.

For more information and to discuss participation in the study, please contact Sade King, Chief Investigator- sk18083@essex.ac.uk.

"It is certain, in any case, that ignorance allied with power is the most ferocious enemy justice can have."

James Baldwin

No Name in the Street

Appendix K

Worked Example from Coded Transcript (early stages)

Interview Data	Codes
INT: Yeah. And when you're thinking about erm an individual who might have experienced racial trauma or something that could be labelled as such, what, you you mentioned some of those erm sort of like systemic factors and personal factors and stuff, could you give some examples of some of the factors that you think would contribute to somebody having that experience of racial trauma?	
Mabel: Yeah erm (.) I suppose the first thing that pops into my head is so the context I work in [service] and so (.) you know (.) I think the most obvious thing that springs to my mind is about the fact that you've got what I believe is sort of institutional racism in the sense of Black people being much more like to be sectioned (.) erm and sectioned with the involvement of police as well erm and I think (.) that that in itself as an experience is hugely traumatic for people and their families as well and I think (.) you know that just sends huge just like (.) mass amount of problems for it being really understandable why why someone might not want to even engage or work with our services when that's been their experience (.) erm I think I remember learning on training about like the circles of fear (.) theory and that's always really stuck in my head that you know the fear of mental health services and then if you've been sectioned erm (.) how that's going to affect your willingness or opening openness to kind of wanting to seek more support and help (.) erm (.) and then I also think I guess in more systemic ways and erm the other thing that also pops into mind is about like erm and you know this is something that's being spoken about a lot (.) now in clinical psychology but ((inaudible)) and how that erm can really have an impact on people I think can be I guess I'm thinking more specifically in relation to mental health services but in access to support and services maybe more like primary care based support erm (.) yeah in terms in terms of like having more I guess like Eurocentric styles of treating mental health difficulties and (.) you know perhaps not always being open to thinking about how	Knowledge of racial disparities in mental health care Mistrust Vicarious impact of mistrust of services amongst Black and Asian communities Complicity Retraumatisation Challenges to addressing racial trauma Psychology's colonial history Treatment models are Eurocentric Cultural differences in conceptualisations of mental distress Culturally sensitive practice Institutional power and racism

to understand mental health problems from other cultural perspectives and just I think how damaging that can be erm and how traumatic that can be as well.	
INT: Yeah, thank you for that. Erm I guess you mentioned some really interesting things that I just kind of wanna touch on in this next set of questions, which is around sort of your experience clinically. Just generally, could you tell me a bit about your experience about working with service users from Black and Asian backgrounds? Is it something that, it sounds like it comes up frequently in your service, you mentioned over representation of Black men, I wondered if you could say a bit more about that?	
Mabel: Yeah yeah (.) are you just so that I've got it are you interested specifically about now or like (.) always and since since I've been working in mental health or kind of more specifically since being qualified?	
INT: I guess let's start with since you've been in your current role, and then we can explore some other bits if you've got other experiences as well, if that's alright?	
Mabel: Yeah yeah yeah erm ((pause)) so I guess (.) I when I think about answering that question I think about it both in terms of like direct clinical work but then also very much about like (.) you know the conversations and sometimes lack of conversations that that happen in teams as a whole I think erm (.) but yeah the team I'm in at the moment (.) erm the part of London we're in is a really diverse team area of London and so you know obviously it is a really diverse erm group of people that we're serving erm (.) and I suppose we were thinking recently actually about how we'd looked at a audit of access to psychological therapies erm and about how erm there was no difference across different different ethnic groups of like offerings but there and no difference in engagement and also in outcomes I think it was but there was a difference in uptake (.) erm which we're kind of trying to think about why that might be and what could be going on there (.) erm and (.) erm yeah which I've just found myself kind of thinking about a lot in terms of erm how we offer it and when we offer it erm (.) and what might be going on there as well so I think in terms of like (.) yeah the job I do now it's it's very much feels very much	Knowing the population that we serve NELFT serves a diverse population Pressure to get it right Facilitators to addressing racial trauma Tools for addressing racial trauma Using questionnaires to start the race conversation Institutional power and racism Racism is met with silence Silence(d) Staff diversity issues Uncertainty about racial trauma

present a lot of the time in working with people and (.) I suppose if I I'm thinking about how I find that sometimes I find it ((pause)) and especially at the moment I feel this real pressure to want to like get it right for people to say the right thing at the right time as well and (.) you know feel like this pressure to ((sighs)) I guess to to want to make it as possible for someone to want to engage in working with me given all the experiences they might have had and the kind of context that we find ourselves in at the moment as well erm (.) and one of the things that I have found useful in the team I'm in now is one of the questionnaires that we do as part of the assessment for psychology erm (.) it's called the International Trauma Questionnaire (.) they have a specific question in at in it about experiences of discrimination (.) erm and so I often find that as a really for some people if it hasn't come up already like a really helpful way of like opening up a conversation erm (.) and sort of putting it on the table as like 'this is something that's important for us to think about if you want to to think about it and talk about it' so I think for like my personal practice I've found that really really helpful tool to use erm (.) and then (.) I said the other bit that it makes me think about is more like generally in the team and I was thinking with my supervisor about how we as a team are like a really diverse team that really reflects the group of people the demographic of the people that we work with (.) but yet we were saying it's really interesting how sometimes there is a lot of silence when actually (.) it kind of feels like something to do with race or racism or someone's racial trauma perhaps is the elephant in the room so to speak and like just (.) I guess it's really made us think about how even when you do have a really diverse team that's not enough that it doesn't mean that kind of important conversations do happen or yeah important parts of the formulation are thought about explicitly (.) so I suppose that something that's kind of been on my mind a lot recently in terms of my experience of talking about race and racial trauma in mental health services.	
INT: And if you had to hypothesise about that silence, where do you think that stems from in your service?	

Mabel: Yeah really interesting so (.) from my personal perspective and this is something I've thought about with my supervisor erm (.) I think that there's something that happens and this is my own stuff to work through completely where I feel like so there's probably two or three White members of the team and I feel sometimes like this nervousness of 'oh am I just gonna be perceived as like this person who wants to be seen as this like White Saviour and bringing up race when actually it's not relevant to bring up?' so there's one thing about my own anxiety in relation to how I might be seen for for bringing it up which (.) I think basically is probably triggers off a fear of White fragility maybe of feeling like 'am I gonna get defensive cos someone then questions me about why I'm bringing it up' for example erm (.) and then another thing I think (.) that happens is sometimes I feel like (.) to take an anti-racist stance is almost seen as being like a political stance and so people don't talk about it so for example I guess I'm specifically thinking about like erm (.) you know the more recent period with discussions around like Black Lives Matter etc. and just (.) noticing that we we when when it did get brought up in conversation there was almost some like (.) resistance to bring it up with our clients and I don't know but I wonder if what's behind that is it being seen almost like a political thing to do to talk about it on those lines but (.) which I find really frustrating because it's absolutely not a political erm issue so I think I think that's one thing and then I'm sure another part of it is maybe about like the system itself and how that (.) pushes teams to operate in this like quite tick boxy manner sometimes and like (.) you know risk trumps everything and whether it just closes down headspace to think about things from a more erm (.) like systemic way if that makes sense and about all the different parts of ourselves the team but also the service users as well and so I wonder if that just doesn't leave much room sometimes for for thinking about those things erm (.) and then the last one I think sometimes is about how (.) because I'm thinking specifically about a case we had recently of a young Black man who was sectioned by the police which is absolutely not what the team had wanted to happen and his mum was devastated that it had	Being a White Psychologist Psychologists have their own racial identity Fear of getting it wrong Fear as a White person bringing up race Black Lives Matter has raised awareness of racial inequalities Black Lives Matter has given permission to talk about race and racism Making change Racial activism Racial awakening Challenges to addressing racial trauma Institutional power and racism

happened (.) and it just when we were talking about it as a team it just felt like there was this sense almost like of hopelessness of like ‘what is gonna change?’ ‘How do we change this?’ And I wonder again if that’s sometimes just like (.) almost like puts the fire out of people wanting to kind of think about these things.	

Appendix L

Stage 3 of TA: Generation of candidate themes from codes (early stages)

1. The Writing is on the Wall			2. Come So Far, Got So Far to Go	
1.1 We don’t use that term *1.1.1. Where is racial trauma in the DSM/ICD?* *1.1.2. The trauma of racism accumulates* *1.1.3. The injustice of racism leaves us feeling helpless*	**1.2. Bearing witness** *1.2.1. Speaking up* *1.2.2. When you know better, you do better* *1.2.3. Validating someone’s story* *1.2.4. The numbers don’t lie*	**1.3 The system perpetuates the trauma** *1.3.1. An inherent sense of powerlessness in society* *1.3.2. We are not innocent as psychologists in the NHS*	**2.1 I have a racial identity too** *2.1.1. I am a White psychologist who is waking up to the reality of racism* *2.1.2. I am a psychologist of colour and this is nothing new to me*	**2.2 We need meaningful change, not performative change** *2.2.1. 2020: The year of a racial awakening?* *2.2.2. The revolution will not be televised* *2.2.3. The change needs to be collaborative*
1.1.1. Service users do not voluntarily name racial trauma; Racial trauma is not a commonly used term; Racial trauma is not routinely asked about; Racial trauma is not on the agenda; Race is the elephant in the room; What constitutes as racism is unclear; Concerns about terminology when naming racial trauma; Racial trauma evokes known trauma symptoms; Racism as a taboo topic; Trauma guidelines do not include racial trauma; **Example interview quotes:** *“I wonder if with particularly racial trauma whether it's worth just naming it as a trauma*	1.2.1. Naming racial injustice; Desire to talk about race more; Encouraging conversations about race in the team; Desensitising clinicians to talking about race; Fear of judgement from colleagues; Psychologists as advocates for the service user’s voice; Challenging diagnosis; Calling out racism is a serious accusation; Race should be a mandatory topic of conversation; Feeling empowered to call out racism; Challenging the hard to engage rhetoric; Fighting for	1.3.1. Racism as a systemic problem; Racial trauma at the hands of the criminal justice system; Wider contextual factors of distress; Societal factors contribute to racial trauma; The odds are stacked against them from the start; Institutional racism marginalises people in a covert manner; Political levels of racism; Socioeconomic stressors contribute to poor mental health for ethnic minority communities;	2.1.1. Fear as a White person bringing up race; Recognising White privilege; Perceived limitations of being a White therapist; White psychologists as a representation of oppression in the system; The power of being a White psychologist in the NHS; There is a limit to how much we can understand as White psychologists; Owning one’s own complicity with racism; You can mean well and still be complicit with racism; Seeking a safe space to get it wrong **Example interview quotes:** *“I suppose within myself the I suppose there’s the erm (.) I guess the there’s the slight discomfort of*	2.2.1. Racial awakening; The Black Lives Matter movement has given permission to talk about race and racism; The Black Lives Matter movement has raised awareness of racial inequalities; The journey of recognising racism in the UK; The racial awakening is nothing new for people of colour; Inspiration to do better; **Example interview quotes:** *“Another thing I think (.) that happens is sometimes I feel like (.) to take an anti-racist stance is almost seen as being like a political stance and so people don't talk about it so for example I guess I'm specifically thinking about like erm (.) you know the more recent period with discussions around like Black Lives Matter etc. and just (.) noticing that we when it did get brought up in conversation there was almost some like (.) resistance to*

because I do wonder if people just see it as ‘well this is what life is like’ and don't necessarily conceptualise it as traumatic?” (P2) *“I mean that’s not really a term we use at work I would say... So I think people probably would talk about it as (.) trauma general and then the content would be racial or otherwise on the basis of experiences that happened to feature that so I don't think it's ever talked about in the setting I work in anyway (.) erm as a particular type of trauma necessarily” (P3)* 1.1.2. Trauma accumulates; Retraumatisation; Internalised racism; Racism is perpetuated across the lifespan; Generational racial trauma; Racial trauma has long lasting effects; Racial trauma is pervasive and persistent; The reality that racism is an ongoing trauma **Examples interview quotes:** *“I think when I think of racial trauma and like everyday life*	justice vs maintaining peace; **Example interview quotes:** *“I suppose I felt like (.) it was such a serious thing to say and that very little people are racist like as in you know because you were (.) you were going to be I was going to be saying to you saying to somebody just say you're the consultant like ‘I get the sense that this is coming from a perception that you have about this young woman because of the colour of her skin like?’ So like that that that that would be deemed me calling him racist and that I could get in trouble I think?” (P1)* 1.2.2. Knowing the populations that we serve; NELFT serves a diverse population; I may get it wrong, but I am trying;	**Example interview quotes:** *“In my experience people often worried about saying things are difficult or saying their housing’s horrible or saying this country has a lot to be desired politically or that people are racist and actually it's okay to say those things you know we can talk about those things here’(P11)* 1.3.2. Psychology can be hard to reach for racialised communities; Perceptions of a “good” psychology client; We are complicit in a racist system; The medical model disadvantages people of colour; The mental health system disadvantages people of colour; The NHS is not immune to systemic racism; Treatment models are Eurocentric; Mental health services are a microcosm of the power structures of society; The NHS is not designed with racialised communities in mind; The mental health system has made little progress; The psychology profession is not immune to	*‘oh how do I talk about this? I suppose ‘am I talking about this in the I suppose in the right way? Am I erm am I using the right words? Am I showing the right amount of empathy erm and understanding? Or you know am I getting this wrong in some way and therefore creating further damage?’ So I suppose that would be a barrier within me sort of a concern of (.) not being entirely comfortable I suppose with the topic” (P5)* 2.1.2. Emotional labour for people of colour; People of colour navigate issues that White people do not; Picking your battles; The isolating experience of being in “White spaces”; Shared racial identity does not mean shared life experiences; **Example interview quotes:** *“So racial trauma is I think is a newish term but (.) knowing about knowing the impact of racism has been something that I've known for a long time personally (.) professionally on on all sorts of grounds” (P12)* *“I suppose the way I work with clients is that I try and be quite transparent so I will let them know that yeah I tot- I understand*	*bring it up with our clients and I don't know but I wonder if what's behind that is it being seen almost like a political thing to do to talk about it on those lines but (.) which I find really frustrating because it's absolutely not a political erm issue” (P7)* *“It’s something we're beginning to talk more with especially with Black Lives Matters erm (.) for me you know (.) why has this just come up now? It’s you know why are talking about it now?.. Why now? What just because of this incident in America? But we’ve this has been going on for generations? Why are we talking about it now? Why is why is it not something that we've addressed before? (.) What only now have you come to the realisations about how Black people are treated? But not just Black people Black minority ethnic groups? (.) So it's a conversation we’re beginning to have in teams but it but it's being something that's not been spoken about it's not been something that (.) you know certainly through my career been something that's been addressed” (P9)* 2.2.2. Tokenistic nods to diversity in psychology training are not enough; Awareness is not enough; Where do we go when we have had the race conversation; Talking about racism does not necessarily mean change; Race as a tick box exercise;

experiences I just often think about like just like this drip drip thing that happens to people who maybe are not White erm (.) and how a lot of that is really unsaid and how the impact of that isn't really thought about or even acknowledged” (P13) 1.1.3. Feeling helpless and hopeless; Powerless; **Example interview quotes:** *“How do I talk with them about it? So I do talk with them about it but it feels (.) it feels more help- I feel more helpless (.) than if we were talking about (.) you know some abuse erm sexual abuse in childhood because that I feel like we can you know we can work on that (.) but with erm racial trauma and racial abuse it feels like how do you work on that other than trying to help someone manage how it feels because you know if somebody’s talking about erm (.) the impact of childhood sexual abuse or childhood bereavement or whatever it is you can you can try to help them to find a way to live and reach their potential in spite of that but with something like racial abuse you kind of think (.) there's gonna be a*	**Example interview quotes:** *“Some people really don't give a shit and they don't even pretend and then there’ll be some people that are interested and do care but you know it's [borough] and the population is erm you know there’s a high percentage of Black and Asian erm people that access the service so they need to get interested to improve and update their practice now so” (P13)* *“This is something that you might not get right so it’s important that you know you (it’s still good to try) and not be too scared not to try anything but erm (.) that you might say something that's unhelpful to people as well and I think I’ve had less awareness of that thinking because I was a nice person everything will be okay.” (P6)* 1.2.3. Offering the space to talk about racism; Naming	racism; Mental health services as a war zone; The therapy room is a microcosm of society; As a psychologist I cannot know everything; **Example interview quotes:** *“I think that psychologists notoriously sit on the fence erm (.) I'm very aware that I have done that in various ways and I think we need to be more proactive I think as in (.) proactive I think we need to be more vocal I think we need to be calling a spade a spade and calling out racism and not publishing articles that say that you know (.) ‘we shouldn't be (.) you know we shouldn't be addressing socioeconomic social political context that that's not our job’ like if that is not our job what is our job” (P11)* *“So within my pathway we look at like auditing things recently to say are we having a good erm ((pause)) distribution of kind of parity of care and like is the service actually reaching*	*where they may you know they’re coming from okay I don't totally understand because I'm not may have not gone through the exact experience but I have some understanding of it erm (.) and (.) and I will kind of self-disclose that I will say you know ‘I can relate to that’ erm (.) and I think (.) whereas some of my White colleagues may have problems connecting with certain clients I may not because of that experience and the fact that I am not a kind of White middle-class psychologist ((laughs))” (P9)* *“So that's the only thing for me I notice that at the moment there is a lot of pressure (.) like a lot of like ‘oh what's your viewpoint? What's your viewpoint?’ And I'm sort of like (.) yeah no I might wanna share I might not I'm still just trying to like survive ((laughs)) and like manage and with all this stuff that's happening pandemic etc personal stuff so (.) yeah it's an interesting time I think again it's just constantly navigating stuff and just trying to figure out okay which are the bits that I actually want to take part in and then which are the bits where I’m like no I'm actually good I don't want that so.” (P13_*	**Example interview quotes:** *“And then I think for other clients they just sort of like ‘mm I don’t really wanna talk about this this isn't really what I came here for’ I think they just find that it's jarring and again it's like ‘well what's the point of talking about this? What does this lead to?” (P13)* *“I think it's become very much the norm to have these conversations at the moment I'm sure that stone will pass probably but ((pause)) at the moment it feels important. I think with a lot of things there's often like a peak in these conversations and there's a lot of talk about things changing and you know happening and then (.) as time goes by our priorities take over and it kind of fades away in the background again” (P8)* *“I feel like ((pause)) as psychologists it would just be great to have more opportunity to have (.) and I guess I'm saying this as someone who's you know only graduated last year and I wish there had been more training (.) more thought to this on training and more time and explicitly like learning about this and how we erm (.) might adapt our practices etc. to think about racial trauma etc.” (P7)* 2.2.3. Consulting experts by experience; We can learn a lot from our service users; Moving towards trauma informed services; Moving from what is wrong with you to what happened to you; Learning is constant; Identifying areas where

ceiling or a block at some point” (P4)	racism as an exploratory exercise with clients; Hearing someone’s story; Holding in mind the possibility of racism; If you don’t ask questions, you won’t get answers; The relief of finally being able to talk about racism; Encouraging conversations with clients; Therapy as a safe space; Learning to sit with discomfort of racism; Curiosity; Validating racism as a traumatic experience; Naming racial trauma in formulations; Psychological assessments are incomplete without information about race; Earning trust to facilitate disclosure; Exploring racism as an ongoing process; **Example interview quotes:** *“And maybe that's the thing that erm (.) we can try to do is to help people feel that you know we're on yeah we're on your side we we hear the injustice.” (P4)*	*out to the right kinds of people on the basis of what we expect to be coming through erm (.) so that then makes you think about like selection bias for certain interventions and I think psychology is just as bad for that erm (.) and for example how many of my colleagues you know say to me ‘Look this person is someone to prioritise for this maybe more like DBT interventions or maybe more trauma-based interventions’ or whatever and we know for a fact that you're more likely to get that kind of intervention if you're say a young White female then say older Black male like as a (.) you know probably the two ends of ends of the spectrum” (P3)*		education is needed; Psychologists for social justice; Anti-racist initiatives are being built within NELFT; Active involvement in raising the profile of racial trauma; **Example interview quotes:** *“In my organisation we're talking about it a lot we're building (.) erm we're part of anti-racist forums erm where we're trying to seek change and we're trying to understand people as well as have a have the ideas of (.) with a view to maybe provide some action in the future erm (.) but the but the main aim is to kind of understand people and see what people's experiences are because until we know that specific to psychology erm (.) we won’t really know how to how to forward” (P10)* *“I think erm (.) I feel pretty lucky that I have like a really great supervisor that’s you know (.) really wanting to think about these things and erm (,) that in the psychology leadership that we also have someone that you know...* *the person (.) you know at the top of the tree for the [service] that was like ‘right we're talking about this we're gonna spend time on this we’re gonna think about it’ erm (.) so at the moment no but I'm acutely aware that I guess like (.) when you get to stages of like doing you've gotta have buy in haven't you from like managers and higher up managers and those sorts of things” (P7)*

	1.2.4. Knowledge of racial disparities in mental health care; Black men are disadvantaged by the mental health system; Black men are traumatized by the mental health system; Validating real threats to Black men; People from racialised backgrounds are treated harshly in inpatient settings; Inpatient wards are a source of racial trauma; Service audits provide evidence of racial disparities; **Example interview quotes:** *"So you've got such a kind of history I suppose of like Black men particularly being hi- like diagnosed much more highly than White men in terms of like (.) schizophrenia and erm so I suppose it's it's I suppose my kind of concept of it is this idea that once they get into the system something seems to happen that can be quite traumatic in terms of how they're perceived and erm*			

	the medication that sometimes can be prescribed, or the use of restraint and Acuphase" (P1) *"I think we need to bring in the real like research more you know we've got a lot a lot of the problems in mental health services are grounded in research we've got stats we should be better versed in them to be able to have those arguments to be able to step in when (.) yet another kind of young Black guy's about to be diagnosed as psychotic and be saying 'hang on a minute we know that this is erm (.) you know we know that people are being over diagnosed we why what let's think about this is this is this an accurate diagnosis? Could we wait? Could we see what's going on? Could we erm arrange a psychology assessment before a psychiatric diagnosis is given? Could we actually ask what's going on?" (P11)*			

Appendix M

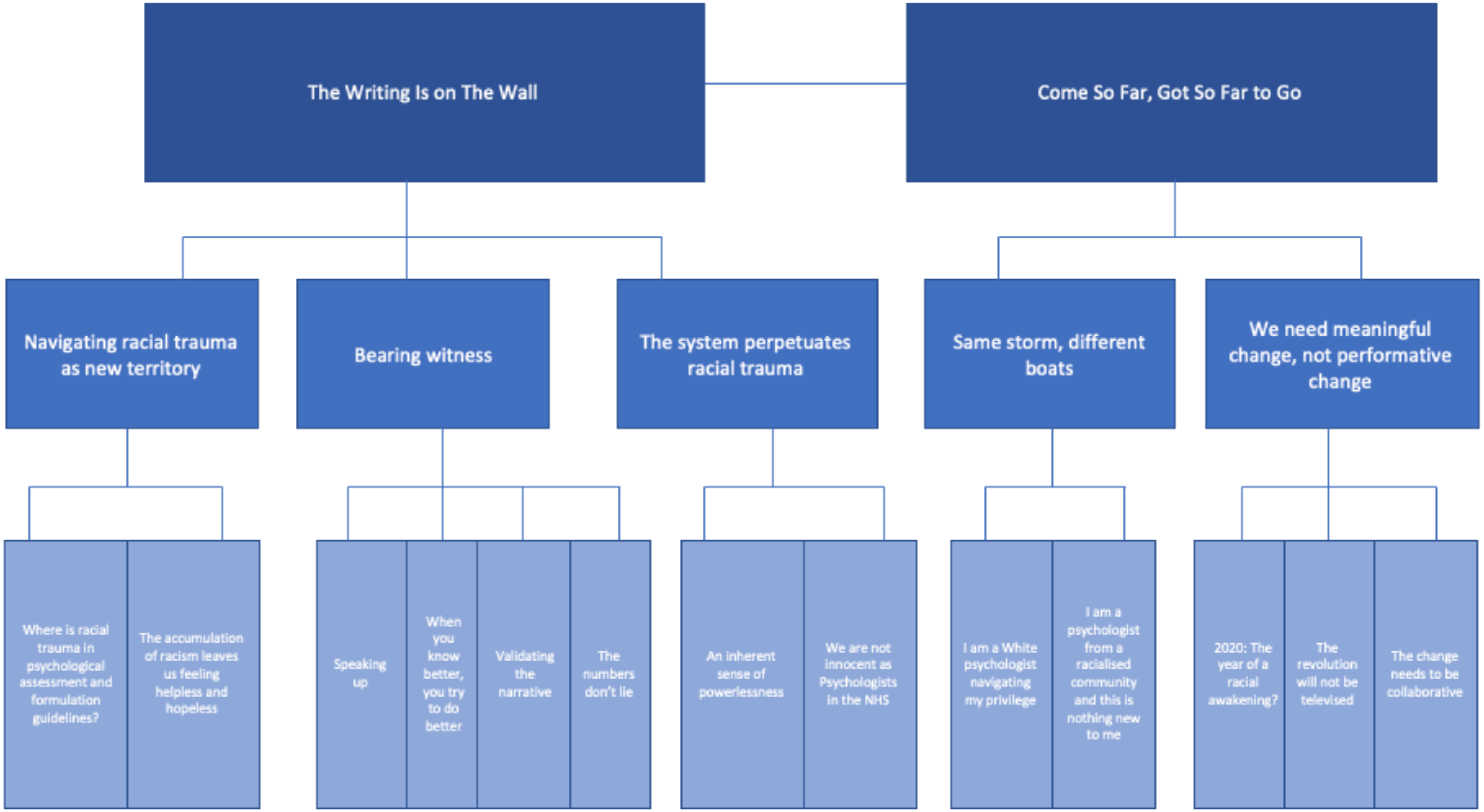
Quality Appraisal of Thematic Analysis using Braun & Clarke's 15-point Quality Criteria Checklist (2006)

Process	No.	Criteria	Criteria met in the current research?
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for "accuracy"	✓
Coding	2	Each data item has been given equal attention in the coding process	✓
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), instead the coding process has been thorough, inclusive and comprehensive	✓
	4	All relevant extracts for each theme have been collated	✓
	5	Themes have been checked against each other and back to the original data set	✓
	6	Themes are internally coherent, consistent and distinctive	✓
Analysis	7	Data have been analysed- interpreted, made sense of- rather than just paraphrased or described	✓
	8	Analysis and data match each other- the extracts illustrate the analytic claims	✓
	9	Analysis tells a convincing and well-organised story about the data and topic	✓
	10	A good balance between analytic narrative and illustrative extracts is provided	✓
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once over-lightly	✓
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated	✓
	13	There is a good fit between what you claim to do, and what you show you have done- i.e., described method and reported analysis are consistent	✓
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis	✓
	15	The researcher is positioned as *active* in the research process; themes do not just "emerge"	✓

Appendix N

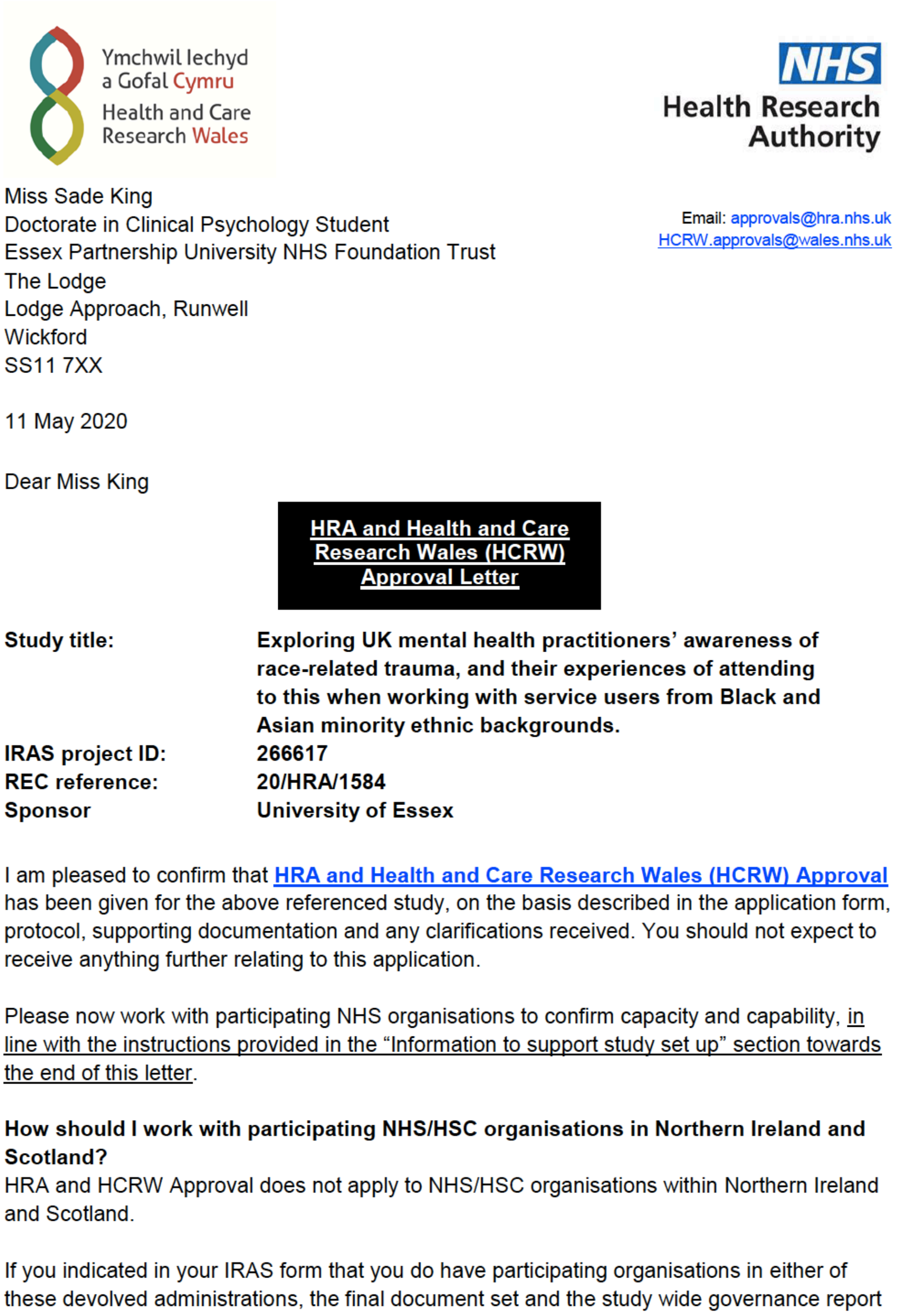
Thematic Map

How do NHS Psychologists understand the term racial trauma and explore this within their clinical work with service users from Black and Asian racialised communities?



Appendix O

HRA Ethical Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Miss Sade King
Doctorate in Clinical Psychology Student
Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach, Runwell
Wickford
SS11 7XX

11 May 2020

Dear Miss King

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring UK mental health practitioners' awareness of race-related trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.**
IRAS project ID:	**266617**
REC reference:	**20/HRA/1584**
Sponsor	**University of Essex**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

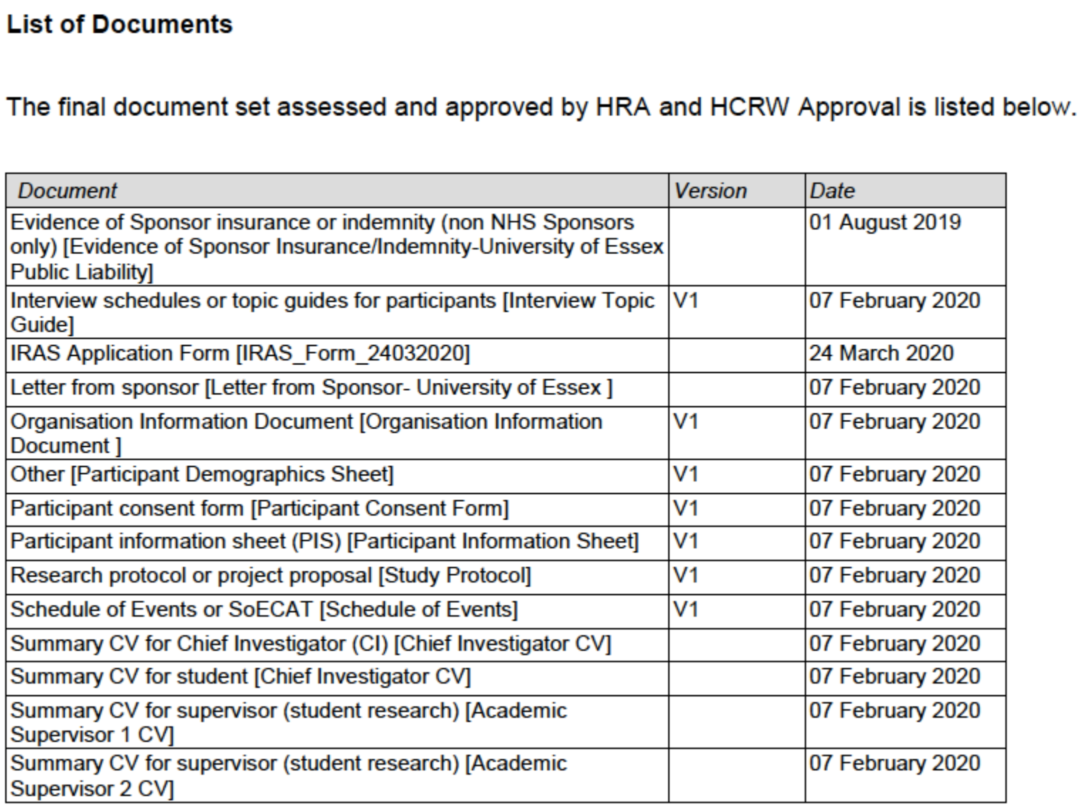
Your IRAS project ID is **266617**. Please quote this on all correspondence.

Yours sincerely,
Sharon Northey

Approvals Manager

Email: approvals@hra.nhs.uk

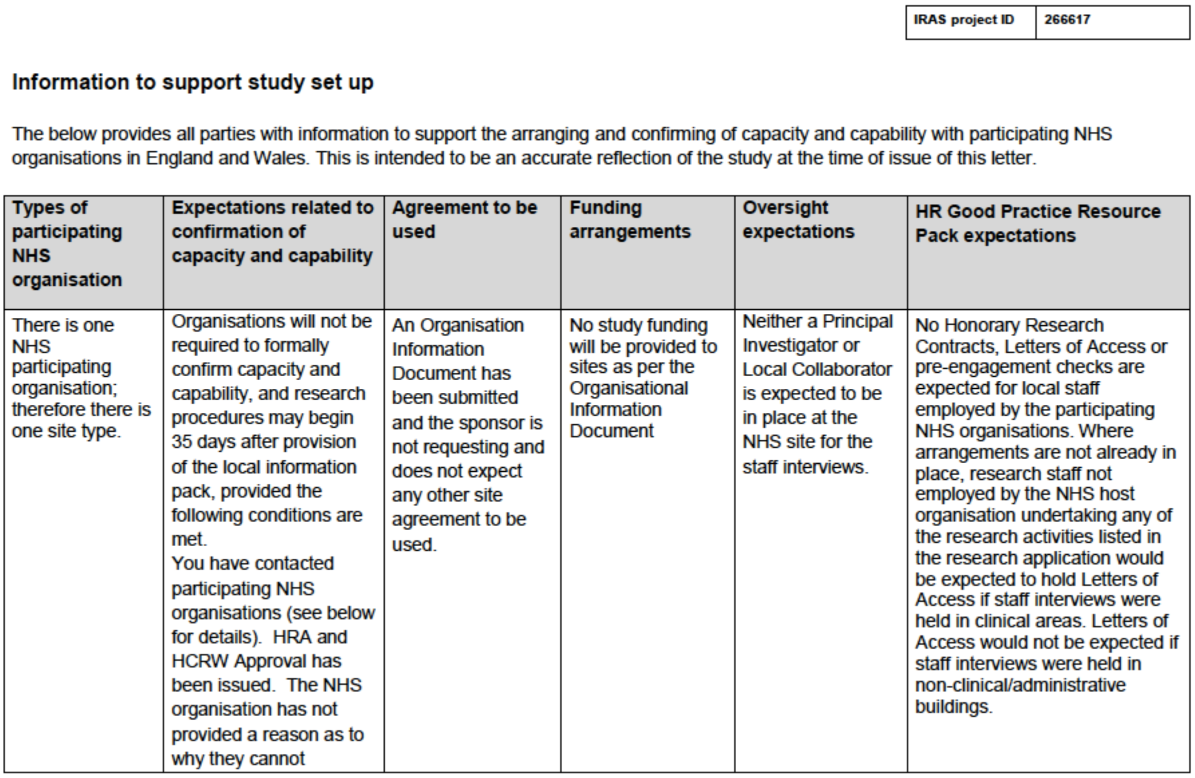
Copy to: *Ms Sarah Manning-Press*



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor Insurance/Indemnity-University of Essex Public Liability]		01 August 2019
Interview schedules or topic guides for participants [Interview Topic Guide]	V1	07 February 2020
IRAS Application Form [IRAS_Form_24032020]		24 March 2020
Letter from sponsor [Letter from Sponsor- University of Essex]		07 February 2020
Organisation Information Document [Organisation Information Document]	V1	07 February 2020
Other [Participant Demographics Sheet]	V1	07 February 2020
Participant consent form [Participant Consent Form]	V1	07 February 2020
Participant information sheet (PIS) [Participant Information Sheet]	V1	07 February 2020
Research protocol or project proposal [Study Protocol]	V1	07 February 2020
Schedule of Events or SoECAT [Schedule of Events]	V1	07 February 2020
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		07 February 2020
Summary CV for student [Chief Investigator CV]		07 February 2020
Summary CV for supervisor (student research) [Academic Supervisor 1 CV]		07 February 2020
Summary CV for supervisor (student research) [Academic Supervisor 2 CV]		07 February 2020



IRAS project ID	**266617**

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	**Expectations related to confirmation of capacity and capability**	**Agreement to be used**	**Funding arrangements**	**Oversight expectations**	**HR Good Practice Resource Pack expectations**
There is one NHS participating organisation; therefore there is one site type.	Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. You have contacted participating NHS organisations (see below for details). HRA and HCRW Approval has been issued. The NHS organisation has not provided a reason as to why they cannot	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the Organisational Information Document	Neither a Principal Investigator or Local Collaborator is expected to be in place at the NHS site for the staff interviews.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if staff interviews were held in clinical areas. Letters of Access would not be expected if staff interviews were held in non-clinical/administrative buildings.

	participate. The NHS organisation has not requested additional time to confirm. You may start the research prior to the above deadline if HRA and HCRW Approval has been issued and the site positively confirms that the research may proceed. You may now provide the local information pack for your study to your participating NHS organisations in England and/or Wales. If you have not already started to provide the local information packs to participating NHS organisations in Northern Ireland and/or Scotland please do so when you are ready. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. The password to access the R&D contact list is Redhouse1.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix P

Confirmation of Capacity and Capability from North East London NHS Foundation Trust

Confirmation for Study 266617

Dervish Victoria <Victoria.Dervish@nelft.nhs.uk>

Fri 05/06/2020 15:28

To: King, Sade O <sk18083@essex.ac.uk>
Cc: Wood Lisa <Lisa.Wood@nelft.nhs.uk>;Horton Fiona <Fiona.Horton@nelft.nhs.uk>;Allen Kellie <Kellie.Allen@nelft.nhs.uk>

Dear Sade King,

Study Title: Exploring UK mental health practitioners' awareness of race-related trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.

IRAS Ref: 266617

I am writing to acknowledge receipt of your HRA approval letter dated 11th May 2020 for the above study.

North East London NHS Foundation Trust confirms participation based on the relevant Organisation Information Document.

May I take this opportunity to wish you every success with your study here at NELFT.

Victoria Dervish

Senior Research and Development Officer
Research and Development Department
1st Floor Maggie Lilley Suite
Goodmayes Hospital
Barley Lane, Ilford, Essex.
IG3 8XJ

Tel: 0300 555 1200 Ext. 64478

NelftResearch NelftRD @NELFTResearch

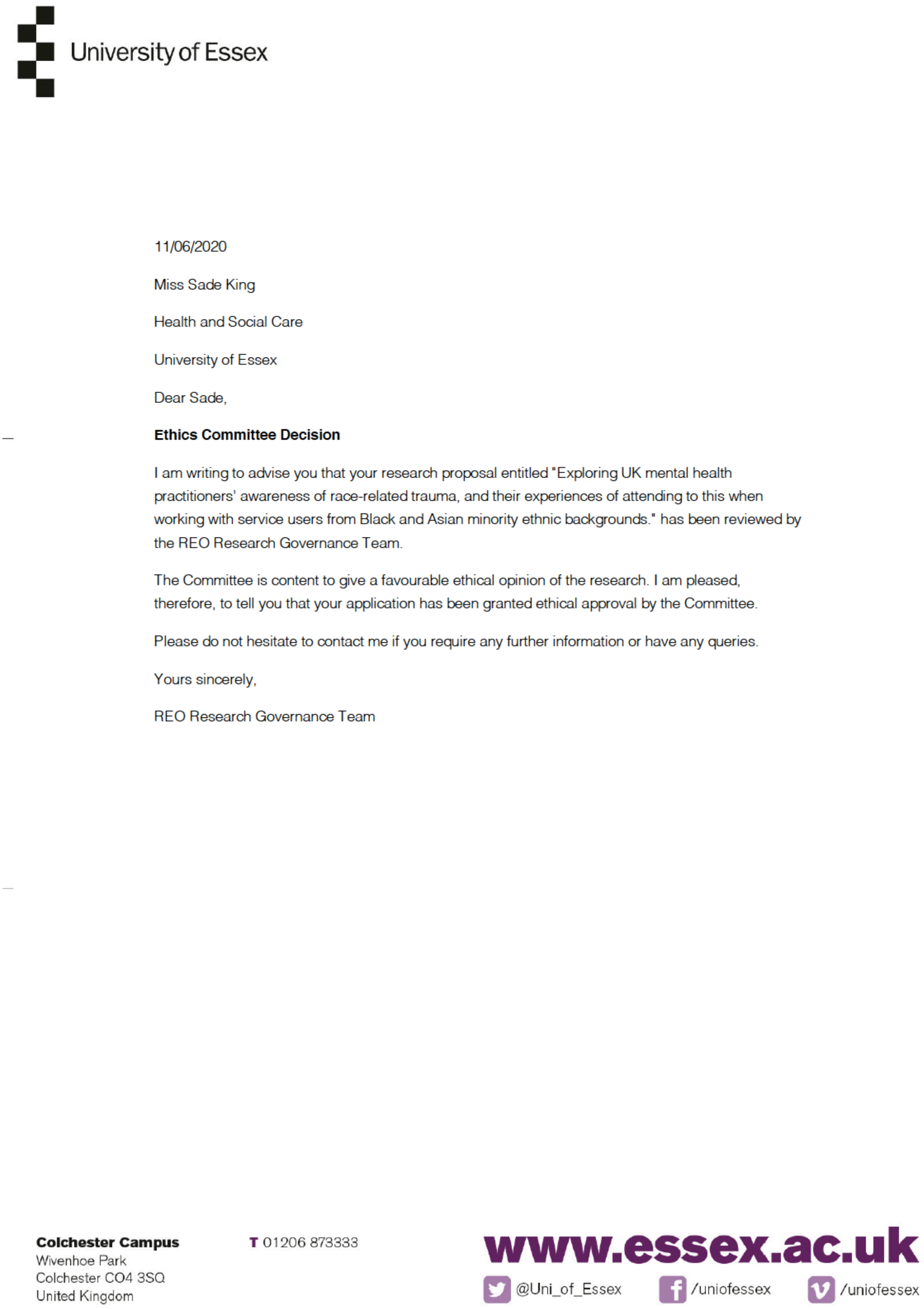
NELFT NHS
NHS Foundation Trust

NELFT NHS Foundation Trust

https://outlook.office.com/mail/search/id/AAQkADYwYzE0OWVmLTExNjAtNGI0Yy04MTljLTliZjI0ZjllNWFlMwAQAOgzmg4x6ksmvDzPFJVW2iI%3D 1/1

Appendix Q

University of Essex Ethical Approval



University of Essex

11/06/2020

Miss Sade King

Health and Social Care

University of Essex

Dear Sade,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Exploring UK mental health practitioners' awareness of race-related trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds." has been reviewed by the REO Research Governance Team.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

REO Research Governance Team

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

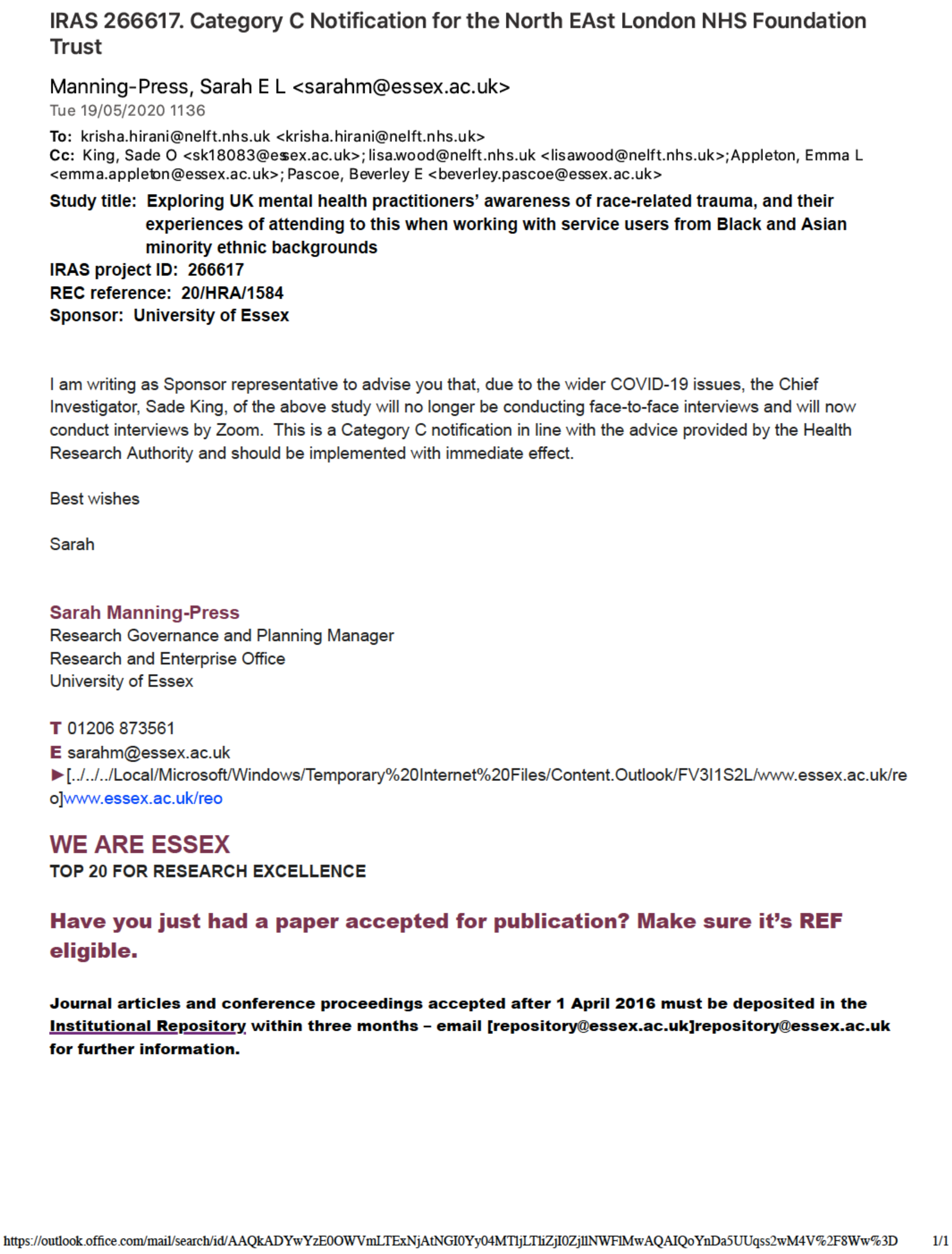
T 01206 873333

www.essex.ac.uk

@Uni_of_Essex /uniofessex /uniofessex

Appendix R

Category C Non-Substantial Amendment Approving Remote Interviews



IRAS 266617. Category C Notification for the North EAst London NHS Foundation Trust

Manning-Press, Sarah E L <sarahm@essex.ac.uk>
Tue 19/05/2020 1136

To: krisha.hirani@nelft.nhs.uk <krisha.hirani@nelft.nhs.uk>
Cc: King, Sade O <sk18083@essex.ac.uk>; lisa.wood@nelft.nhs.uk <lisawood@nelft.nhs.uk>;Appleton, Emma L <emma.appleton@essex.ac.uk>; Pascoe, Beverley E <beverley.pascoe@essex.ac.uk>

Study title: Exploring UK mental health practitioners' awareness of race-related trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds
IRAS project ID: 266617
REC reference: 20/HRA/1584
Sponsor: University of Essex

I am writing as Sponsor representative to advise you that, due to the wider COVID-19 issues, the Chief Investigator, Sade King, of the above study will no longer be conducting face-to-face interviews and will now conduct interviews by Zoom. This is a Category C notification in line with the advice provided by the Health Research Authority and should be implemented with immediate effect.

Best wishes

Sarah

Sarah Manning-Press
Research Governance and Planning Manager
Research and Enterprise Office
University of Essex

T 01206 873561
E sarahm@essex.ac.uk
►[../../../Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/FV3I1S2L/www.essex.ac.uk/reo]www.essex.ac.uk/reo

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Have you just had a paper accepted for publication? Make sure it's REF eligible.

Journal articles and conference proceedings accepted after 1 April 2016 must be deposited in the Institutional Repository within three months – email [repository@essex.ac.uk]repository@essex.ac.uk for further information.

Appendix S

Participant Information Sheet

Participant Information Sheet for Exploring UK mental health practitioners' awareness of racial trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.

Thank you for your interest in this research project. This study is being carried out in line with the requirements of the Doctorate in Clinical Psychology course, at the University of Essex. Before you decide whether to take part, it is important that you understand the purpose of the research and what taking part will involve. Please take time to read the following information. You are welcome to contact the research team with any questions or concerns, using the contact information at the bottom of this sheet.

What is the project about?

This research is interested in exploring how trauma resulting from racism experienced by service users from Black and Asian minority ethnic (BAME) backgrounds is understood and addressed in mental health services. There is existing research which highlights the potentially traumatic effects of racism, however little is known about how this is addressed in mental health services, so it is hoped that this project will fill this gap.

Am I eligible to take part?

If you are a qualified Psychologist working in any of the acute or community services within NELFT, in any of the 4 London boroughs (Redbridge, Havering, Barking & Dagenham, and Waltham Forest), and have been doing so for at least 6 months, then you are eligible to take part.

Do I have to take part?

No- participation in this research project is voluntary. This is not a requirement of you within your role as a member of staff, and your employment will not be affected if you decide not to take part.

Can I withdraw from the project if I change my mind?

Yes- you can withdraw from the study at any time and do not need to give a reason. If you choose to withdraw, any identifiable information will be removed from the study. Data which is not identifiable may be retained if it has already been combined with other interview transcripts, however this information will be anonymised.

What would taking part involve?

If you decide you would like to take part, please contact the Chief Investigator (Miss Sade King) using the email address at the bottom of this sheet. The Chief Investigator will then be in contact to arrange a suitable date and time to meet with you via Zoom teleconferencing software. Prior to the interview, you will be sent a consent form via email to sign and return to the Chief Investigator, which confirms your understanding of the aims of the research and agreement to take part. You will also be sent a demographics sheet to complete. Following this, you will be sent an invitation to join a 1-1 Zoom meeting with the Chief Investigator. The invitation will include a password which is individual to your interview, and you will be prompted to input this in order to access the meeting. Please note: You do not need a Zoom account to join the meeting. You will be prompted to click on the link detailed in the email invitation and this will take you to the meeting.

The interview will last approximately 45-75 minutes and will involve questions about your experiences of working with service users from BAME backgrounds, and their experiences of racism and discrimination. The aim of the questions is to gain an insight into your awareness of the relationship between racism and trauma, how this impacts on your work with service users, and any ideas for change you may have to support you in your work with service users who may experience racial trauma. There are no right or wrong answers to the questions that will be asked; the researchers are interested in your own personal experiences.

The discussion will be audio recorded using the recording function on Zoom, as well as on a Dictaphone as a backup. The interview will then be transcribed by the Chief

Investigator, at which point your data will be anonymised using a pseudonym and you will no longer be identifiable. You may be contacted at a later date during the analysis stage to check themes for accuracy, if you have identified that you wish to be contacted for this. Direct anonymised quotes from the interview may be used in the overall report and in future publications of the research.

What are the possible disadvantages of taking part?

Exploring service user experiences of racism, and the support they receive from services, is a topic which may be emotionally difficult to discuss. At any point during the interview you may decide not to answer any questions, take a break or withdraw your participation from the study without communicating a reason. A full debrief will be offered following the interview, where you will be invited to share your reflections about taking part if you wish to do so.

What are the possible benefits of taking part?

It is hoped that the findings of this research will provide a deeper insight into staff experiences of addressing racism within their clinical practice, and any barriers and facilitators that they perceive in doing so. This can potentially be used to inform service developments and NHS policies, as well as identify staff training needs.

What will happen to the results of the project?

This research is being carried out as a thesis project, in line with the requirements of the Doctorate in Clinical Psychology at the University of Essex. The findings will also be disseminated to the services involved via oral presentation and written report, as well as submitted to a peer-reviewed scientific journal to contribute to the literature on this topic. A copy of the final report will be offered to you as a participant.

Is my information confidential?

Yes- all information that you provide within the study will be kept confidential. Your data will be anonymised using a pseudonym, meaning that you will not be identifiable in any way. Data will be stored in line with the Data Protection Act (2018) and University of Essex data protection policies and will be password protected. Only the

Chief Investigator (Miss Sade King) and academic supervisors (Dr Lisa Wood and Dr Mary Kennedy) will have access to the data.

How will my information be used?

The University of Essex is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Essex will keep identifiable information about you for five years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we use your information by contacting the Information Assurance Manager on 01206 874853.

Miss Sade King will keep your name and contact details confidential and will not pass this information to The University of Essex. Miss Sade King will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from the University of Essex and regulatory organisations may look at your research records to check the accuracy of the research study. The University of Essex will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. Miss Sade King will keep identifiable information about you from this study for five years after the study has finished.

Who has approved this project?

The research project has received the relevant ethical approvals and sponsorship from the University of Essex. Ethical approval has also been obtained from the NHS Health Research Authority (HRA), and the Research & Development (R&D) department at North East London NHS Foundation Trust.

What if I have a complaint?

If you wish to raise any concerns or complaints about this research project, in the first instance please contact the Chief Investigator: Miss Sade King, Trainee Clinical Psychologist- sk18083@essex.ac.uk

If you are not satisfied with the initial response, please contact Dr Lisa Wood, Clinical Psychologist and Academic Supervisor- ljwoodm@essex.ac.uk, or Dr Mary Kennedy, Lecturer and Academic Supervisor- mrkenn@essex.ac.uk.

If you remain unsatisfied and wish to make a formal complaint, please contact the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ- sarahm@essex.ac.uk

If you have any questions or would like to discuss anything further before deciding whether to take part, please contact the research team using the following contact emails:

Chief Investigator: Sade King, Trainee Clinical Psychologist- sk18083@essex.ac.uk
Lead Academic Supervisor: Dr Lisa Wood, Clinical Psychologist- ljwoodm@essex.ac.uk
Second Academic Supervisor: Dr Mary Kennedy, Lecturer- mrkenn@essex.ac.uk

Thank you for taking part in this research project.

University of Essex

Appendix T

Participant Consent Form

NELFT NHS
NHS Foundation Trust

Participant Consent Form for Exploring UK mental health practitioners' awareness of racial trauma, and their experiences of attending to this when working with service users from Black and Asian minority ethnic backgrounds.

Participant ID Number:

Please initial box

1. I confirm that I have read the information sheet dated 07/09/2020 (Version 1.2) for the above study. ☐
2. I have been given the opportunity to ask questions and the researcher has answered them appropriately. ☐
3. I understand that my participation is voluntary. I understand that I am free to withdraw at any timewithout giving any reason for my withdrawal. If I choose to withdraw from the study, all identifiable data collected will be withdrawn from the study. Any data that is not identifiable will be anonymised and retained (e.g. interview transcripts). ☐
4. I agree for my participation to be audio recorded for the purposes of the study only. ☐
5. I understand that my data will be stored securely, in line with the Data Protection Act (2018). ☐
6. I understand that direct quotes from the interview that I participate in will be included in the final report of the study, but that my information will be anonymised and I will not be identifiable from this. ☐
7. I agree to be contacted at a later date to be involved in the data analysis process, by checking themes identified by the researcher for accuracy (optional). ☐
8. I would like to be sent a copy of the final written report (optional). ☐
9. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Researcher	Date	Signature

Appendix U

Table of participant pseudonyms

Interview Number	Pseudonym
1	Fiona
2	Nancy
3	Darren
4	Edith
5	Susan
6	Paula
7	Mabel
8	Ameera
9	Neelam
10	Shreya
11	Jennifer
12	Winnie
13	Isaac