“My whole training I’ve been trained to work with diversity, no-one has taught me how to work with similarity”: Exploring how Black Clinical Psychologists in the UK experience working with racially similar clients

Tamara N. Sancho

A thesis submitted for the degree of Doctorate in Clinical Psychology

School of Health and Social Care

University of Essex

October 2024

Acknowledgements

"Trust in the Lord with all your heart; and lean not on your own understanding. In all your ways acknowledge him, and he shall direct your paths." Proverbs 3:5-6

Praise God for all he has brought me through to get to this point. Thank you, Lord.

Thank you to all the Black clinical psychologists who stood before me, especially those who helped me along the way. To my consultant Dr Jacqui Kodjokuma, thank you for offering a space of validation, support and important reflection. Most crucially, thank you to the Black psychologists who offered their time, experiences and honest reflections. I have learnt so much from you all and will forever be grateful as without you this project would not have been possible. I hope I have been able to retain the essence, heart and important nuance of the insights you shared with me.

To my supervisors, Dr Jasmeet Kaur and Dr Danny Taggart thank you for offering encouragement and hope during the challenging moments. Your thoughtful reflections and flexibility to offer guidance when needed were greatly appreciated.

To my dear friends on and off the course, thank you for always believing in me and for offering support in various ways throughout the years.

To my partner Rohan, thank you does not seem like enough. You have been by my side at every step, from undergraduate applications to the submission of this doctoral thesis. I love and appreciate you and your support more than words could say. Thank you for everything.

Thank you to my siblings Joel and Nadea, and my father for always encouraging me and putting a smile on my face. A special thank you to my mother, Dr Michelle Sancho. You were the first Black psychologist I ever knew, and you offered me the most crucial example of representation to not doubt what is possible. Thank you for your unwavering support through each stage of my life and career. I could not have done this without you.

Lastly, thank you to my grandparents who set a strong precedent for the value of knowledge and education. I am so blessed to have spent all of my doctorate journey until the final year living with my grandma. Your never-ending care, nurture and love kept the path smooth. It was difficult completing the final stage of this journey with you no longer here. Knowing how much it meant to you for me to get my "PhD" kept me going. I look forward to meeting again, until then lots of love. I dedicate this thesis to my grandma, Linda Usilla Graham.

Table of Contents

List of Tables

List of Figures

Abstract

Background: For Black populations, pathways to mental health services are complex, and representation in the clinical psychology profession is low. Numerous initiatives in the UK aim to improve diversity for clinical psychologists and service-users. However, changes in literature seem slow in responding to increasing racial diversity in clinical psychology. For instance, when cultural sensitivity is considered for ethnic minority clients, focus placed on therapist–client differences implicitly assume therapists are from ethnic majority backgrounds. This prevents consideration of therapist–client similarities for ethnic minority practitioners.

Aim and Methodology: A critical realist qualitative paradigm was taken using reflexive thematic analysis to explore how Black clinical psychologists in the UK experience working with racially similar clients. Semi-structured interviews were conducted with a purposive sample of 16 Black clinical psychologists.

Findings: This study highlights the double-edged nature of racial integration into practice for Black clinical psychologists in same-race therapy. Racial similarity enhanced connection and cultural understanding offering safety to explore other intersectional identities with clients. However, assumptions and judgements needed monitoring as they risked arising from racial overidentification. Furthermore, differing intersectional identities both prevented and led to alternative forms of connection. Similarly, multifaceted factors influenced accessing support about same-race therapy from racially similar or different supervisors. The desire to depart from Eurocentrism both in clinical practice and when Black clients and clinical psychologists help-seek were expressed by participants. Failures, obstacles and the hope of enhancing the integration of race and culture into training and the wider profession were highlighted.

Conclusion: Overall Black clinical psychologists find racial similarity in therapy beneficial, but challenges with overidentification and the integration of race into practice must be recognised. Recommendations discuss advancements for culturally sensitive practice and the need to explore similarity and difference when considering diversity to improve psychology services and the profession for all.

Chapter One: Introduction

Chapter Overview

In this chapter I start by outlining my relationship to the research project. I then highlight the terminology used throughout the thesis and provide a historical overview of the emergence of Black populations in the UK. I move on to examine contemporary experiences and disparities that exist for Black communities in society, healthcare and the clinical psychology profession. This will lead onto exploring the attempts to address racial disparities, the ideas surrounding cultural sensitivity and the use of theoretical positions to understand racial dynamics in therapy. The chapter concludes offering a rationale for the following chapter's systematic review of literature exploring Black therapists' experiences of racial similarity in therapy internationally. This will offer a justification for the current study's research questions which focus on the experiences of racial similarity for clinical psychologists (CPs) with Black heritage in the UK.

Positioning of the Researcher

All qualitative research has a context since it takes place during a specific timeframe between two or more individuals. Therefore, it is important for researchers to shed light on the context in which their research is conducted for the reader to better understand the relevance and applicability of the findings to a particular context (Dodgson, 2019). The reflexive awareness of one's context in qualitative research is defined as the critical self-evaluation of the researcher's positionality (Berger, 2015). This process encourages analysing the influence of one's position on the research development and result (Dowling, 2006). Given the importance of positioning the voice of the researcher within qualitative research I have decided to write in both third person, to centre the participants and research, and first person to allow narrative informed by my personal opinions and reflections. Throughout this thesis I have

thought about my use of language to decide where first or third person accounts are best suited to balance between situating the literature, participants and myself within the study.

Personal Relationship with the Research Project

My journey to this thesis topic began in 2018 during the placement year of my undergraduate degree. During this time, I worked in a research clinic for young people where barriers and facilitators to support for anxiety were being explored. I had also started working as a healthcare assistant in a forensic unit with adult males. The representation of ethnic minorities in forensic settings in contrast to the minimal ethnic diversity of service-users accessing early intervention services in the clinic were striking. This sparked my initial interest in understanding barriers and facilitators in the context of ethnic minority experiences in mental health services. Throughout my career the lens my projects have adopted have varied. As an undergraduate I started with a systematic literature review looking at barriers and facilitators for ethnic minority communities broadly. Then my dissertation explored the barriers and facilitators Black Afro-Caribbean undergraduates encounter when accessing mental health services. More recently my literature review during the first year of the doctorate explored the barriers and facilitators perceived by Black communities around accessing services. I clearly established a fascination and duty to amplify the seldom heard voices of marginalised racialised communities. However, it was not until I started my first placement on the doctorate where a seed was planted to adopt a new lens within the context of understanding racialised groups.

The first client I was allocated in my first placement on the doctorate was a mixed-race woman with Black heritage. This was my first time providing therapy to a racially similar client. I found this experience different from any other therapeutic encounter I had before, all of which had been with clients that were racially different from me. Something distinct about this experience was that continuously I found aspects of my own identity brought to the therapy room. This made me realise I never had to fully integrate aspects of my cultural and personal

identity into the workplace before. I realised all I had ever known was to work with difference. As such, I had never had to consider or experience working with racial similarity. What brought the similarity to light even more is that the client and I were also of a similar age, gender, were both Christian and ethnically both had Black Caribbean heritage. I noticed that the racial similarity was something that appeared to provide solidarity for the client as she described feeling more able to discuss aspects of her culture and race due to this racial similarity. I recalled the recommendations previous research I had conducted indicated about a need to diversify the clinical psychology profession. However, I began to question how professionals make sense of and utilise this shared aspect of identity to strengthen therapeutic outcomes if this is not something that is considered for ethnic minority groups during training.

I started to notice that every time I would sit in a lecture where race or culture was considered there would be an implicit focus to reflect on difference when working with ethnic minority clients. I started to ask myself what happens if I am working with an ethnic minority client whose own culture and race is similar to my own? How can I also work with cultural 'competence' then? I also wondered how many other psychologists might have faced similar realisations or experiences when working with racial similarity. Thus, the topic of my thesis became clear. I pivoted the gaze I once had on the need for more ethnic minority groups to be able to access and engage in services, to that of the perspective of an ethnic minority psychologist. I asked myself, if we can get more ethnic minority communities in services and if they are able to work with psychologists of a similar heritage, what do we know about how this is experienced? and what might the benefits or potential pitfalls be? As such, my journey to the topic of understanding the experiences of ethnic minority groups in mental health services continues. I hope that in this project I have been able to answer the personal and professional questions for both myself and for others that have asked similar questions. As a member of the Black community, a doctoral researcher and a trainee CP I feel an ethical drive

to use my platform to showcase the experiences and perspectives of those whose voices are often forgotten. I hope to join the great work of other writers and activists who, as Dera (2021) describes, use research as an "act of resistance and a tool for storying untold and marginalised narratives".

Language and Key Terms

Language has been described as critical to articulate, retain and challenge power relations in society (globally, nationally and within institutions), in local communities and within interpersonal communication (Talbot, 2019). As such, it is important to examine and define the key terms that have been used throughout this thesis. These key terms have been summarised below.

Race

The concept of 'race' originated from philosophers and anthropologists such as Buffon in the 18th century, who used geographical location and phenotypic traits like skin colour to put people into pseudo-scientific racial groups (Montagu, 1942). The term has now been discredited scientifically since it was revealed that there is over 80 percent genetic variation between individuals from the same racial group, rather than between those from different racial groups (Zuckerman, 1990). Therefore, rather than being a biological marker of difference, it has been proposed that race is a social-political construct (Smedley & Smedley, 2005). The term 'race' has a long history that legitimised the oppression of ethnic minorities through colonisation, slavery and apartheid (Durrheim et al., 2009) by situating them as 'inferior races' (Pickren, 2009). As such, it is widely accepted that race has more to do with domination, power and oppression than with biological differences (Omi & Winant, 2014). As a result, the use of the construct in psychological research is contended (Helms et al., 2005). However, within this thesis the historical underpinning and validity of the construct is refuted, yet the subjective

meaning is seen as salient in the lives of racialised communities (e.g., Comas-Diaz & Jacobsen, 1991).

Black

The term 'Black' has been used as a cultural and political social construct to refer to people of African and Caribbean descent (Gaine, 2005). Historically, being Black referred to an individual's skin colour and was used to group heterogeneous people into a single category despite differences in social, political, and cultural identity (Davidson & Patel, 2009). However, between the 1960s and 1980s in Britain identification with 'Blackness' started to be used positively by more African and African-Caribbean communities to come together against racial discrimination in a quest for racial justice (Alexander 2002; Sudbury, 2001). As such, Mercer (2020) describes Blackness as representing symbolic unity which arose due to visible racial difference and similarity in the context of racial oppression and colonial history. Due to the term 'Black' being both a descriptive and political term it is used in a capitalised format in this thesis.

Culture

'Culture' encapsulates the shared characteristics of any group or society such as language, social roles, dress codes, beliefs, family patterns, child-rearing practices etc. and are passed down intergenerationally (Shankar, 2009). Fernando (2004) highlights that rather than holding a restrictive definition, culture is perceived to be an adaptive array of values and worldviews that are abided by, created, and evolve continuously. However, in high-income countries culture is often naively associated with skin colour and an aspect of an individual group that is perceived to be 'different' from the dominant group (Bhugra & Bhui, 2018). In this thesis culture will be viewed as a dynamic and complicated universal construct that people use to both create and in turn become shaped by (Patel et al., 2000).

Ethnicity

'Ethnicity' describes the social group an individual belongs to and is either identified with by others or themselves due to an amalgamation of cultural and other factors including ancestry, religion, language, diet, and physical features traditionally associated with race (Bhopal, 2014). Since the term 'ethnicity' encapsulates the role of culture, language, and history in the construction of subjectivity and identity (Hall, 2006), the term is often used interchangeably with culture. However, ethnicity differs to culture in its combination of both racial heritage and cultural background (Shankar, 2009). Furthermore, unlike race, ethnicity is adaptable and involves an element of choice (Fernando, 2010). Despite the significant differences between race, culture, and ethnicity the terms are used interchangeably in literature because the identities are socially constructed and can become discursively entangled (Gunaratnam, 2003). In this thesis I aim to understand how participants make sense of their clients and their own identities using language that is preferred by them.

Black Asian and Minority Ethnic groups (BAME), Global Majority or Racialised?

The terms 'BAME' and 'BME' are often used interchangeably in the UK to capture people who do not identify as White British. These terms have become popular and are used widely to describe all ethnic minority groups, though there is a lack of consistency in how these terms are used across government (Race Disparity Unit, 2021b). Further challenges are presented when all groups are combined using a monolithic acronym (Commission on Race and Ethnic Disparities, 2021) since these groups are heterogeneous across different context variables such as ethnicity, social class, and language (Shankar, 2009). Additionally, within this group ethnic disparities exist (Department for Education [DfE], 2021a) that are not accounted for when the terms 'BAME' or 'BME' are used. As such, public sector organisations were called to discontinue the 'BAME' acronym due to its controversy following a recent

commission on race and ethnic disparities (The Sewell Report, 2021). Therefore, in this thesis these terms will not be used when referring to ethnic minority groups.

In contrast to the terms ‘BAME’ and ‘BME’ more recently the term ‘global majority’ has been developed to describe ethnic minorities. It was developed to challenge and contextualise the perception that ethnic minority groups in western countries are minoritised (Lee et al., 2023). It has been suggested that the term helps highlight that Black, Indigenous, and ‘People of Colour’ comprise the majority of the world, and it centres and challenges who truly holds power (Portelli & Campbell-Stephens, 2009). However, the term ‘global majority’ has been critiqued for no longer including White minoritised groups (Fuller, 2013). It also uses the term ‘majority’ out of context thereby distorting the need to capture minoritised experiences and perpetuates the same problematic narratives that ‘BAME’ does in reverse by minoritising White groups who are not part of the global majority (Sixsmith, 2023). For these reasons the term global majority also will not be used to describe ethnic minority groups in this thesis.

Initially developed in the context of racial formation theory, racialisation is a sociological term that extends racial meaning to racially unclassified relationships, groups, or social practice (Omi & Winant, 1986). This term differs from terms such as BAME, BME and ethnic minority since it focuses on the semantics ascribed to racial groupings inherently derived from power and social dominance. For instance, racialised groupings are placed on communities by the majority group without consent and vary according to place and time (Gonzalez-Sobrino & Goss, 2019). For this thesis, census-specific categories such as ‘Black Caribbean’ and ‘Black African’ will be used, or ‘Black’ will be used to encapsulate a mixture of ethnic groups that identify as having Black heritage. Where an umbrella term is required for those who do not identify as White, ‘ethnic minority’ and ‘racialised’ will be used interchangeably to describe these communities.

Racially Similar/Same-Race Therapy Dyads

The terms 'racially similar' and 'same-race therapy dyads' describes a therapeutic pairing between the therapist and their client in which both parties identify as sharing the same race (Meyer & Zane, 2013). There are numerous terms that are used interchangeably to refer to this therapeutic matching such as 'racial matching', 'racial concordance' and 'intra-racial' therapy dyads. Although 'ethnic matching' is a similar term used to capture the shared ethnicity between a therapist and their client, racial matching will be focused on throughout this thesis given that this captures a broader range of nuanced identities in the therapy dyad (e.g., capturing dyads that are racially similar but ethnically different). In this thesis the terms 'racially similar' and 'same-race therapy dyads' will be used to describe therapeutic pairings where the therapist and client share a racial heritage.

Intersectionality

Intersectionality refers to the intersection between multiple social identities (e.g. race, class, and gender etc.) that connect to provide a holistic understanding of privilege and oppression (Crenshaw, 1989, 1991). This concept was initially used in US law to examine the varied experiences of Black women in the criminal justice system, however intersectionality is now applied broadly in healthcare, for example it is used in the assessment and treatment of mental health problems (Burnham, 2018; Tang & Pilgrim, 2017; Totsuka, 2014). This framework showcases the heterogeneity that exists in the Black community. As such, adopting an intersectional approach within this thesis is crucial to explore the varied ways that racial similarity in the therapeutic dyad is experienced for Black CPs.

Cultural Competence, Sensitivity or Humility?

The cultural competency model originated within the USA as a response to the need for health care practitioners to have the skills to work with people from diverse socio-ethnic groups (Hoge et al., 2005). Cultural competency has various definitions, one describes it as a set of

attitudes and actions that indicate skills in establishing, maintaining, and successfully ending a therapeutic relationship with clients from diverse cultural backgrounds (Lee et al., 2019). There has also been critique of the focus on cultural 'competence' as it implies a dichotomous relationship between competence and incompetence (Shankar, 2009), instead there is a shift in language and frameworks to adopt terms such as cultural 'humility' (Mosher et al., 2017) and 'sensitivity' (Meyer & Zane, 2013) amongst others. Therefore, in this thesis the terms cultural 'sensitivity' and 'humility' will be used to describe this concept. The term cultural 'competence' will only be used when cited literature uses this term. Furthermore, inverted commas will be adopted when referring to the term due to the criticism against it.

The Historical and Socio-Political Context of Black People in the UK

Before exploring the relevance of Black racial identity in therapy it is important to outline the societal and historical experiences surrounding Black identity in the UK. As such, this section begins by outlining the historical and contemporary socio-political context of Black people in society and its implications on healthcare. Following this, later sections will move on to highlight disparities for Black people in mental health services and the clinical psychology profession.

Emerging Black Identity in Britain – A Journey Through Adversity

The history of the Black African and Caribbean community in Britain covers over two millennia (Adi, 2019). Although the presence of African people in ancient and Roman Britain is becoming uncovered (Thompson, 1972), little is known about this presence for almost one thousand years following the end of the Roman rule in Britain. A significant part of the history of Black people in Britain cannot be understood accurately without acknowledging the context of Britain's relationship with Africa, Europe, and the Americas, particularly the colonial relationships that began in the sixteenth century. The European trade of enslaved African people took place to meet the demands for labour in the Americas in the fifteenth century and led to irreparable changes across the world (Scanlan, 2020). Britain profited from the transatlantic slave trade; however, in the seventeenth and eighteenth centuries Britain also had a slave empire with colonies of enslaved African workers across the Caribbean, the North and the South Americas (Scanlan, 2020). Black slaves and descendants were able to retain native skills and traditions despite efforts to restrain and remove African culture, such as literary customs of oral storytelling for example African folktales of the tortoise and hare (Walvin, 1994).

Although slavery was profitable for the British one might argue the violence pricked at the conscience. For instance, in 1772 a British court declared that the rights colonial

slaveholders had over the people they ‘owned’ did not extend to Britain meaning enslaved people could sue for their freedom, but only on British soil (Scanlan, 2020). In 1807 Parliament passed an Act abolishing the British slave trade. By 1833 slavery was abolished in most of Britain’s colonies. However, the law that ended slavery in the British empire required people who had been enslaved to continue working for the people who had claimed to own them for as long as six years (Scanlan, 2020). At the same time, British slaveholders received £20 million in compensation for their lost claims to human beings. Scanlan (2020) argues that the money “sullies greatly the moral purity of the act” and suggests that cynics might state that emancipation was accomplished “not so much by the force of truth as by the power of money”.

Following the abolishment of slavery in Britain in the nineteenth-century Black people continued to make major contributions to Britain. Siblon (2016) analyses the major contributions Black people made in the two World Wars and highlights the absence of official memorials to reflect this big sacrifice. After World War II the Windrush Era is a notable period that marked the arrival of people emigrating from the Caribbean to Britain in 1948-1971 who were employed to help re-construct the UK. The migration of people from Africa took place in the 1960s typically as seafarers arriving unofficially at ports or to study and improve prospects in their home country (Daley, 1998). However, racism was an ever-present threat for migrants and residents from Africa and the Caribbean during the post-war period. There were racist attacks in Birmingham, Liverpool, and London during the 1940s, long before the infamous Notting Hill riots of 1958 where White groups displayed hostility and violence towards the Black community (Jenkinson, 2009). In the late 1960s Black people in Britain became politically active in new organisations, some influenced by the Black Power and civil rights movements in the US (Kelley et al., 2015). By the 1980s various race riots took place including the 1981 Brixton riots which were led by mostly Black youth protesting police brutality, high unemployment rates and poor housing (Brenton, 2010). Understandably, Black racial identity

in the UK is shaped by experiences of slavery, immigration, racism alongside African and Caribbean cultural influences (Alleyne, 2002).

The words of Ignatius Sancho appear relevant when reflecting on the journey Black people have made in British history. Ignatius Sancho was an abolitionist, composer, actor, writer and the first known Black Briton to vote in a British election. He gained fame in his time as "the extraordinary Negro", and to eighteenth-century British abolitionists he became a symbol of the humanity of Africans and immorality of the slave trade. The *Letters of the Late Ignatius Sancho, an African* (Sancho, 1782) were published two years after his death and are one of the earliest accounts of African slavery written in English by a former slave of Spanish and English families. My family speculate as to whether Ignatius Sancho is an ancestor of our own Caribbean family history. A history which unfortunately can never truly be known due to the impact of slavery in the removal of generational knowledge. In the passage below are the words of Ignatius Sancho in a letter critiquing British colonialism and slavery:

> *"In Africa, the poor wretched natives blessed with the most fertile and luxuriant soil- are rendered so much the more miserable for what Providence meant as a blessing: - the Christians' abominable traffic for slaves…it is a subject that sours my blood…make human nature thy study—wherever thou residest—whatever the religion—or the complexion—study their hearts." (Sancho, 1782)*

The pleas from Sancho to turn away from exploitation and focus on humanity still ring true. This begs the question, what are the prospects and experiences for Black communities in Britain today in the 21st century?

The 21st Century Blues of Disparities for Black people in Britain

Education. The Commission on Race and Ethnic Disparities (2021) highlights that Black Caribbean children have poorer attainment than students from other ethnic groups. It has

been suggested that a lack of representation of Black identities in the curriculum and staffing alongside a failure to communicate to the parents of Black Caribbean learners about how the system works (Tikly, 2022) may offer some explanation for poorer attainment. Additionally, lower teacher expectations and negative stereotypes of Black students, along with the uneven and at times culturally insensitive application of school behaviour management policies, may explain the rates of exclusion for Black students (Demie, 2021).

The Prison Pipeline. Mixed White and Black Caribbean alongside Black Caribbean children have the third and fourth highest permanent exclusion rates respectively, following the highest rates from Gypsy and Roma children (DfE, 2024). Furthermore, over time between 2006 and 2020 the rate of permanent exclusions for young people from Black and mixed backgrounds has been shown to be consistently higher than the national average (DfE, 2024). This is particularly concerning given that school exclusions to pupil referral units (PRU) have been associated with imprisonment, which is often described as the 'PRU to prison pipeline'. For instance, 89% of young prisoners in 2017-18 report having been excluded from school (HM Inspectorate of Prisons, 2018).

Criminal Justice. In terms of Black people's experiences of policing, data reports that Black people are nearly five times more likely to be stopped and searched (GOV.UK, 2024) and are on average 8.6 times more likely to have weapons like tasers used against them (TASERD, 2023) by the police than White people. Furthermore, the proportion of ethnic minority deaths in police custody where restraint or force was used is over two times greater than it is for other ethnic groups in police custody (Inquest, 2024). In 2020 the death of George Floyd caused by a Minneapolis police officer sparked global protests and marked the resurgence of the Black Lives Matter (BLM) movement across the world. Joseph-Salisbury et al. (2020) reports that the protests led UK activists to emphasise the importance of

acknowledging the existence of British racism and led to calls to highlight that the UK is not innocent from similar injustices for Black people that take place in the US.

Socioeconomic Status and Employment. The inequalities highlighted in early education and the criminal justice system can also be seen for Black communities in socioeconomic status and employment. For instance, the earnings gap between White, Black Caribbean and Black African graduates is reported to widen over time. For every £1 of White British wealth, Black Caribbean households have around 20p, and Black African households have approximately 10p (Khan, 2020). Even a decade after graduating White graduates have been found on average to earn more than Black African and Caribbean graduates (The Centre for Social Justice, 2020). When factors that might affect earnings are controlled for evidence suggests that Black male graduates experience the harshest pay disparity compared to their White British peers. In addition to receiving lower earnings on average than their White counterparts, Black people are overrepresented in insecure jobs (Blundell et al., 2021) and as of 2018 Black people were found to have the highest rate of unemployment (The Centre for Social Justice, 2020).

Social Determinants of Health. The challenges Black people face by having disproportionately high rates of socio-economic deprivation has been linked to determinants of health status. For instance, deprivation has been reported as a significant risk factor to Black mothers having disproportionate outcomes of premature and low birthweight babies (Burris & Hacker, 2017). Furthermore, in 2018-20 for Black women the risk of maternal death was statistically significantly over three and a half times higher compared with White women (Knight et al., 2021). Evidence suggests that the increased rates of maternal mortality for Black women happen because services are often culturally insensitive with resultant poor communication (Kapadia et al., 2022). In addition to maternal mortality, rates of infant mortality, cardiovascular disease and diabetes are highest for Black and South Asian

communities (Raleigh, 2023). Likewise, child overweight and obesity rates are higher for Black African and Caribbean children than for other ethnic groups (NHS Digital, 2022). Overall, levels of diagnosed ill health are higher in Pakistani, Bangladeshi and Black Caribbean groups than for those from other ethnic backgrounds (Evandrou et al., 2016). Literature indicates that there are numerous challenges those with Black backgrounds are likely to experience across education, employment, socioeconomic status, policing, and physical health. Therefore, many factors may predispose and precipitate mental health difficulties in the Black community. As such, it is important to ask the following question, what are the experiences of those in the Black community regarding gaining access to and engagement with mental health services in the UK?

Black Communities and Mental Health Services – 'Hard to Reach' Groups or Services?

Rates of Distress

Compared to White people, Black African and Black Caribbean people are two to eight times more likely to be diagnosed with severe mental health difficulties (Bignall et al., 2019). Social determinants such as employment, income, housing, and exposure to criminality have been linked to the development of mental health problems and are issues more likely to impact Black African and Black Caribbean people (Hatch et al., 2011). In addition to the factors highlighted, the societal racism that Black communities receive also contribute to poor mental health leading to psychological distress and a decline in mental functioning (Hackett et al., 2020). Beyond the aetiology of psychological distress for Black communities another explanation for the higher rates may be the role of the practitioners in the distribution of diagnoses to Black people. For example, Black African people are more likely to receive a severe mental health diagnosis, such as schizophrenia, than White people who present with similar symptoms (Gajwani et al., 2016). However, despite higher rates in the diagnosis of

mental health conditions when compared to the general population, most Black people do not receive the appropriate care they need (Bhui 2001; Wagstaff et al., 2012).

Barriers to Service-Access

Pathways to support with mental health issues for Black service-users tend to be more complex than other ethnic groups (Bhui & Bhugra, 2002). For instance, Black populations are reported to be less likely to have access to (Wessley, 2018) and seek (Bignall et al., 2019; Dyer & Gilbert, 2019) relevant support for their mental health. When Black people do access professionals their referrals from GPs to mental health services have been shown to be well below average, whilst referrals by the police and courts have been almost two times higher (Suresh & Bhui, 2006). Additionally, regardless of diagnosis and socio-demographic factors, Black clients have been shown to be more likely to be detained under the Mental Health Act 1983 than other ethnic groups (Singh et al., 2007). Lubian et al. (2016) reports that this group is overrepresented in inpatient mental health services and underrepresented in primary care mental health services. Literature suggests that Black service-users access statutory services at crisis rather than in the earlier stages of the development of mental health difficulties.

Barriers to Service Engagement

Black people's experiences of mental health services are likely to be restrictive since the highest rates of detention occur for Black African people. For instance, Black people are more likely to be placed under a section 136 order where they enter acute mental health services through police involvement, and they are five times more likely to be detained under the mental health act 1983 (NHS Digital, 2022). When Black people seek support from services, they are less likely to be offered psychotherapy or be prescribed antidepressants (McKenzie et al., 2001). Furthermore, when they engage in therapy the outcomes for Black people are often less effective and, in some circumstances, cause harm (Rabbiee & Smith 2013; Sewell et al., 2021). Black communities have reported experiencing racism when accessing mental health services.

This has been described as creating mistrust of professionals and was reported to be associated with hopelessness, a lack of agency and poor perceptions of effectiveness (Devonport et al., 2023). When Black people engage in talking therapies they are reported to often discontinue or prematurely leave services that may have supported their mental health (Cooper et al., 2013).

The Black community's low access to psychological therapy in the UK has led to them being labelled as 'hard-to-reach' (De Maynard, 2009). Edge and MacKian (2010) argue that this blames this marginalised group, suggesting they have had the option to choose to not access support offered. Whereas even when the Black individuals try seeking therapy, barriers such as cultural assumptions, negative stereotypes, culturally insensitive and inappropriate therapeutic approaches contribute to disengagement (Whitley et al. 2006). In addition, Smith et al. (2020) highlight how the inequalities Black service-users face in receiving early intervention from mental services might be exacerbated by the Covid-19 pandemic. Given the challenges Black communities face as service-users in accessing and having positive engagement with statutory mental health services, it is relevant to consider how the presence of a racially similar practitioner would be experienced. It also leads to consideration of the experience of statutory mental health services for Black communities from the perspective of a service provider. The following question arises, what is access and engagement in the clinical psychology profession like for Black people?

Disparities for Black Aspiring, Trainee and Qualified CPs

Given the challenging disparities Black communities encounter in wider society, it is unsurprising that Black people face further hurdles in the clinical psychology profession. Historically, aspiring CPs from ethnic minority backgrounds were more likely to be rejected at shortlisting for not meeting the academic requirements (Scior et al., 2007), and less likely to get a place on the clinical psychology doctorate (Scior et al., 2015). A lack of role models, limited resources in the family, poverty and institutional racism are factors that lead to a sense

of not belonging in education and negatively impact attainment (Sanders & Rose-Adams, 2014). As this chapter has highlighted, such factors are more prevalent and thus are more likely to impact aspiring psychologists with Black heritage. The likely impact of these barriers are apparent when doctorate courses opt to use A-level and research exams to shortlist candidates. Furthermore, Janally (2020) reports that applicants with ethnic minority backgrounds may feel they "are not good enough" due the educational advantage of their White peers. Despite the barriers Black aspiring psychologists face it is encouraging to note that since the increased focus on racial equity following the murder of George Floyd in the US, and the 60% expansion of spaces on the clinical psychology doctorate in 2020 (NHS England, 2019), a shift appears to have happened for Black aspiring CPs in their applications to the doctorate.

In 2019 Black applicants made up 5% of all applicants but made up 10% of those with a successful place (Clearing House for Postgraduate Courses in Clinical Psychology, 2023). Therefore, representation doubled for Black applicants who accepted places compared to when they applied. The percentage of Black applicants with successful applications has increased each year since then. In 2022 applications from Black applicants remained similar at 5.7%, however they now make up 23.2% of successful applicants. This means that Black applicants are now nearly four times more represented as successful applicants compared with when they initially apply. As such, their representation within the cohort of successful applicants has doubled post the Covid-19 pandemic that took place in 2020. As the representation of Black trainee CPs appears to be increasing it is important to consider the following question, what is the experience like for Black applicants once they are on the clinical psychology doctorate course?

Trainees from ethnic minority backgrounds are often the only people from racialised groups on cohorts, sometimes across multiple years (Prajapati et al., 2019). Course staff mirror this with minimal racial diversity in the team. As such, ethnic minority trainees are reported to

face dilemmas in discussing culture and race with their peers and supervisors (Shah, 2010). Clinical Psychology training and conceptualisations of therapeutic practice more broadly over rely on Eurocentric models (Ade-Serrano & Nkansa-Dwamena, 2024) due to the lack of diversity and cultural awareness within the psychology profession (Newland et al., 2015). The focus on Eurocentric models could cause issues for ethnic minority trainees. For example, Eurocentric values may cause tension with their cultural narratives resulting in teaching becoming an isolating environment. Due to the incongruence between their cultural or racial identities and their professional identities (Goodbody, 2009), it is understandable that ethnic minority trainees often struggle to maintain their 'professional' identity without suppressing their cultural identity (Shah, 2010). Given the challenges that Black trainees face during training it is important to also consider whether similar difficulties are faced upon qualification for Black CPs.

Although Black applicants are now making up 23.2% of successful candidates on the clinical psychology doctorate (Clearing House for Postgraduate Courses in Clinical Psychology, 2023), Black CPs only make up 1% (190) of CPs in the UK (Health and Care Professions Council [HCPC], 2023). Therefore, Black CPs are still underrepresented in the profession given that Black people make up 4.2% (2.4 million) of the UK population (Office for National Statistics, 2022). It is concerning that this population is four times underrepresented within Clinical Psychology compared to the general population. It must also be noted that the impact of the recent increase in successful Black applicants will not be seen for several years in the qualified CP population since these candidates need to complete the 3-year doctoral training. As such, one might expect the representation of Black CPs to improve over the next few years.

Odusanya et al. (2018) reports that ethnic minority CPs often feel pressure to conform to be like their White peers earlier in their careers. This leads to a compromise where ethnic

minority psychologists either choose to remain "different" resulting in a sense of disconnection or conform and adapt to a norm that is perceived to be like their White counterparts. This supports previous studies that describe an incongruence between ethnic minority trainees' personal and professional identities. Interestingly, participants were better at integrating their personal and professional identities when they had been qualified for longer. Odusanya et al. (2018) argues that recruitment into leadership positions is important for Black CPs to reduce perceptions of the profession as racist and change the view of the profession as having "snowy white peaks" (Kline, 2015).

The opportunity for progression for Black CPs is particularly important given that the NHS reportedly treats ethnic minority staff less favourably than White staff in their recruitment, career progression and discipline (Kline, 2015). McNeil (2010) highlights that Black CPs sometimes report needing to minimise their Black identity within their role due to this being associated with negative stereotypes of incompetence. They also reported wanting to be viewed as having competence beyond that of the 'cultural expert'. Furthermore, they described conversation around culture and ethnic difference as potentially dangerous due to stereotypes associated with being Black. Instead, participants reported working hard to be viewed as a 'good doctor' that would be recognised for their competence and professional credentials as opposed to only being known due to being the Black psychologist in the team.

Attempts to Address Racial Disparities for Clients and Psychologists

Numerous local and national policy initiatives have aimed to improve the access to and experience of clinical psychology training and mental health services for Black communities. The Stuart Hall report (Ashe, 2021) highlighted 589 different recommendations made by 13 racial equity commissions between 1981-2021 that have been either ignored or abandoned (e.g., Care Quality Commission [CQC], 2011; Department of Health [DoH], 2005; The Sewell Report, 2021). The Delivering Race Equality report (DoH, 2005) aimed to address deep-rooted

race-related problems so that the cultural sensitivity of services for ethnic minorities could be improved. However, this policy was widely criticized since it failed to address racial inequalities. Furthermore, it has been argued that ethnic inequalities within many mental health services are still entrenched, have become consistently worse in almost every area and need improvement (Sewell, 2009).

The current challenges reported by Black aspiring, trainee and qualified CPs are concerning and contradict the NHS Long Term Plan's (NHS England, 2019) goals to improve equality and diversity within the NHS workforce. In addition to the NHS Long Term Plan's goals (NHS England, 2019) to support ethnic minority professionals and the Five Year Forward View for Mental Health's (DoH, 2010) goals to support ethnic minority service-users, an action plan was developed by Health Education England (HEE, 2021). The plan has nine actions with the goal of having sustained, effective action on inclusion and anti-racism before, during and after training to help build a more diverse workforce reflecting the population. The plan highlights the need for course staff, supervisors, and the curriculum to aid the development of a meta-competency around antiracism and reflection on race and ethnicity. This indicates the increased relevance for the enhancement of cultural sensitivity for CPs. Furthermore, government legislation advocates the need for culturally sensitive staff in mental health services (DoH, 2003). The British Psychological Society (BPS) has also made recommendations that suggest a need for cultural sensitivity within practice (BPS, 2017). This poses the question, what does developing skills in cultural sensitivity involve?

Embedding Cultural Sensitivity in Practice

Cultural 'Competence'

The concept of cultural 'competency' has been explored extensively in counselling literature (Sue et al., 1992; Ratts et al., 2016). There are different theoretical models of how to develop skills in cultural 'competence'. Regardless, all models assume that improving the

therapist's skills in working with a culturally diverse range of clients will improve therapeutic outcomes, thereby reducing inequities in access and the effectiveness of services for ethnic minority groups (Brach & Fraser, 2000). Although Bassey and Melluish (2013) highlight ways for counselling psychologists to practice with cultural 'competence', there is limited consistent guidance on the development of this skill within clinical psychology. However, to practice with cultural sensitivity it seems important for therapists to address similarities and differences within the therapeutic dyad and consider how these values interact, exist together, and are negotiated in therapy (Lee et al., 2019).

Similarity and Difference in Therapy Dyads

Research suggests that perceiving oneself as similar or dissimilar in the therapist dyad impacts the trajectory of the therapeutic alliance (Murphy et al., 2004). Much of literature has been developed around the view that similarities in the therapy dyad aid the therapy process, whilst differences are viewed as creating barriers to connection. The theory underlying the positive assertion for therapist-client similarity originated from social psychology theory. For example, affinity bias suggests people prefer to identify with individuals they view as similar (Festinger, 1954). Additionally, Social identity theory (Turner et al., 1979) indicates that people tend to identify strongly with 'ingroup' shared characteristics which lead to a sense of acceptance and belonging. As a result, literature began asserting that clients may benefit in receiving therapy from therapists with a similar racial or cultural background (Mitchell, 1983). For instance, empirical studies have found cultural matching with Black service-users to address cultural barriers and so deemed this similarity as necessary for those requiring culturally specific support (Secker & Harding, 2002; Warfa et al., 2006). Contrastingly, empirical research has also suggested that therapist matching does not impact the progress or outcome of therapy (Kimpara et al., 2016) and can have a negative effect (Comas-Díaz & Jacobsen, 1991). Furthermore, regardless of a similarity occurring in one aspect of identity,

given the role of intersectionality it is hard to determine how other identities and factors may influence the therapy experience. Although, literature appears inconclusive in determining how beneficial therapeutic similarities are or on the contrary how detrimental difference is, a skewed emphasis on difference seems to have taken place when considering cultural sensitivity in clinical psychology.

Cultural 'Incompetence' in the Application of Cultural Sensitivity

Much of the literature in clinical psychology constructs 'cultural competence' as a skill to support White professionals to work effectively in cross-cultural situations (Bhui & Bhugra, 2002; McGoldrick et al., 1996). As such, in literature ethnic minority status is often perceived as a client issue from the perspective of the White therapist (Iwamasa, 1996). Therefore, despite the literature appearing to expand in response to the changes within the demographics of the UK society, changes seem slow in responding to growing diversity within the clinical psychology profession demographic itself (Paulraj, 2016). For example, the BPS practice guidelines (BPS, 2017) for cultural 'competence' refer to this skill as "an ability to work with difference", suggesting that working with racially diverse (i.e., racialised clients) automatically means working with difference. This highlights one of the many challenges that Black CPs face since their experiences are often ignored in literature. Furthermore, since same-race therapy dyads can enable culturally sensitive care (Meyer & Zane, 2013), same-race therapy offers another avenue to reduce mental health disparities for ethnic minorities. However, guidance on cultural 'competence' focuses on considering ethnic and cultural difference as opposed to the nuance that may arise with both similarity and difference. As such, I pose the following question, how can Black CPs consider how to practice with cultural sensitivity when working with clients who also have Black heritage?

Racial Identity Theory: Applied to Racial Dynamics in Therapy

Racial identity theory could help in considering how race impacts social interaction. The theory describes how people make sense of their racial positionality and perceptions about race (Thrower et al., 2021). Helms's (1990) racial identity social interaction model (RISIM) could be used to understand how concepts from racial identity theory and power dynamics describe the racial dynamics that occur in therapy dyads. Racial dynamics in dyadic relationships involve various schemas, moving from individuals inhabiting racially unsophisticated (e.g., racial evasiveness) to more integrative and self-affirming racial identity (Thrower et al., 2021). The RISIM proposes that racial identity schemas can be described by four types of instructor-student relationships in trainee therapist supervision: (a) regressive, student exhibits more advanced racial identity development than the instructor; (b) progressive, higher levels of self-affirming racial identity schemas; (c) crossed, schemas are from opposite ends of the racial identity spectrum; and (d) parallel, use of similar racial identity schemas. The model argues that instructors should have progressive instead of regressive schemas, since the latter results in harmful student experiences. Although this model could explore racial dynamics in same-race therapy dyads, it's focus on racial dynamics restricts the varied experiences and intersectional factors that might impact therapist-client similarities and differences. Furthermore, the overemphasis on linear stage development (Ponterotto & Pedersen, 2006), lack of empirical evidence and Helms's traditional focus on White identity development suggests that the model may not encompass the racial identity experiences of non-White individuals (Carter, 1995) such as Black CPs.

Psychoanalytic Theory: Applied to Racial Dynamics in Therapy

Psychoanalytic theory could be used to consider factors in a Black CP's experience of practicing with cultural sensitivity with Black clients. Transference is an important concept within psychoanalytic theory that Lijtmaer (2014) defines as the patient's emotional reactions

to the therapist based on the client's perception of who the therapist is culturally in relation to ethnicity, race, religion, and other factors. Countertransference has been defined by Lijtmaer (2014) as the therapist's emotional responses to the client's interactions, influenced by the client's ethnicity, race, religion and other factors. Foster (1998) developed the term cultural countertransference to emphasize the cultural and relational component to transference. Curry (1964) also describes a further stage called pre-transference which is defined as fantasies and values therapists hold toward races. This could include the stereotypes therapists and clients may believe about different cultures. Dhillon-Stevens (2011) highlights how a Black therapist needs to undertake two processes concurrently: to be available therapeutically for the client and the material the client brings, whilst also having an awareness of their own processes and experiences as a Black individual that may be triggered or reinforced by the client. This is described as a difficult tension to hold within the dyad and could be described as 'recognition trauma' that awakens harmful experiences related to racism (McKenzie-Mavinga, 2009). A psychoanalytic perspective would argue that when transference, countertransference and pre-transference interplay in the therapy room there can be highly charged emotions, however it can be important for culturally sensitive care when used therapeutically (Minikin, 2022).

Tang and Gardner (1999) report that ethnic minority therapists are by definition schooled on two cultures. One being their own cultural norms and values, whilst the other includes Westernised theoretical and developmental frameworks they have been trained in. Due to this they argue that ethnic minority therapists are more attuned to transference that relates to culture and can draw on various rich stereotypes and projections. Alternatively, they share how ethnic minority clients may choose to work with a racially different therapist due to worrying that the therapist would have too many cultural values the client is trying to escape. Indeed, a psychoanalytic approach appears to offer a framework to understand what may be occurring for Black CPs and their Black clients to support culturally sensitive practice.

However, the reflections from Tang and Gardner (1999) were shared over 20 years ago and comprise only one Black therapist who did not receive training from a CP's framework in the UK. As such, these reflections and concepts may not capture the nuance of the experience for Black CPs working with Black clients in the UK. Furthermore, traditional psychoanalytic theory centres internal processes, unconscious dynamics and does not explicitly incorporate wider socio-political issues like racism, structural inequality and cultural identity (Layton, 2006). Therefore, psychoanalytical theory as a model is limited in its ability to fully explore how racial dynamics impact therapy, particularly for Black CPs and clients.

Summary

The literature presented identifies challenges Black communities face in wider society, healthcare and in clinical psychology services both as service users and providers in the UK. I have also highlighted the limits of current conceptualisations of cultural sensitivity for racialised CPs. I have considered relevant issues and theories that showcase a need to explore how same-race therapy is experienced by Black CPs. Therefore, it is important to uncover what empirical studies have already been conducted in this area. As such, in the following chapter a qualitative systematic literature review was conducted to explore the available evidence on Black therapists' experiences of working with racial similarity to illuminate the impact this has on the therapeutic dyad.

Chapter Two: Systematic Literature Review

Chapter Overview

This chapter provides further exploration of literature through an in-depth examination of empirical studies capturing Black therapists' experiences of same-race therapy dyads. An analysis and evaluation of a culmination of findings are conducted with conclusions drawn from existing research to identify gaps that offer a rationale for this current study's aims and research questions.

Introduction

Systematic literature reviews are a core component of academic research since they enable knowledge to progress by building upon previous work that exists. As such, reviews of current relevant literature help gather the breadth and depth of the existing body of work, highlight gaps to explore (Xiao & Watson, 2019) and offer recommendations for future research and clinical practice (Fink, 2019). In this next section, I will present a literature review of the studies that address the following question: "How do Black therapists experience racial similarity in therapeutic dyads?". A qualitative systematic literature review was chosen as opposed to other qualitative reviews such as a meta-ethnography since systematic reviews offer a comprehensive overview of existing empirical literature useful for highlighting gaps and guiding future studies (Gough et al., 2017). Alternatively, though a meta-ethnography also identifies gaps in literature, the approach is more suited to develop new frameworks rather than outlining areas for research expansion (Noblit & Hare, 1988).

Although a similar literature review (Hamilton, 2023) was recently published and was the first to explore this topic, the current review differs for several reasons. Hamilton's (2023) review focused exclusively on Black therapists in America, and it included quantitative studies alongside literature that was not peer-reviewed. As such, this current review will offer insights

across the African diaspora internationally and it will focus on qualitative peer reviewed literature. Literature without peer review will be excluded since these studies offer greater risk for the inclusion of methodological issues or biased outcomes (Paez, 2017) in the review which might compromise reliability and quality of the findings. Furthermore, though Hamilton (2023) reviews the same topic, the review was restricted to exploring how the sociocultural experiences of Black therapists shape therapeutic interactions with Black clients. The current review on the other hand, offers a broader overview to capture how Black therapists experience same-race therapy dyads. Therefore, this review might draw on therapists' sociocultural experiences and beyond to understand the various insights that Black therapists provide regarding the key features of same-race therapy dyads. This review question aims to capture what is currently known, evaluate the quality of available literature on this topic and highlight gaps in knowledge.

Method

A qualitative design was used in the review since this is helpful to capture in-depth and varied individual experiences of racial similarity/difference in therapy dyads. I used Thomas and Harden's (2008) method of Thematic Synthesis (TS) since it was developed to conduct reviews addressing questions that help evaluate and explore the effectiveness of existing practice (Barnett-Page & Thomas, 2009). This is particularly important when moving from the descriptive to the analytic phase of meta-synthesis (Thomas & Harden, 2008) and is beneficial in exploring experiences of current practice in racially similar therapy dyads. The review process followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009).

Search Strategy

A scoping search (including Cochrane Library and the Centre for Reviews and Dissemination databases) was conducted before starting the search to identify reviews that had been completed in this topic area. An electronic database search was conducted in December

2023 using CINAHL Ultimate; PsycINFO; PsycARTICLES and MEDLINE (via EBSCOHost). Alerts for relevant papers were set to be received before findings were synthesised. Searches were completed using different terms related to the following four important concepts in the research question: racial similarity; therapy dyad; Black; and therapists (see Appendix A). More terms were found by considering key terms used in relevant research and by gaining suggestions from the research team. Search terms were truncated to identify key literature (e.g., simil* = similar, similarity). Boolean operators 'AND'/'OR' were also used to find relevant literature.

Inclusion and Exclusion Criteria

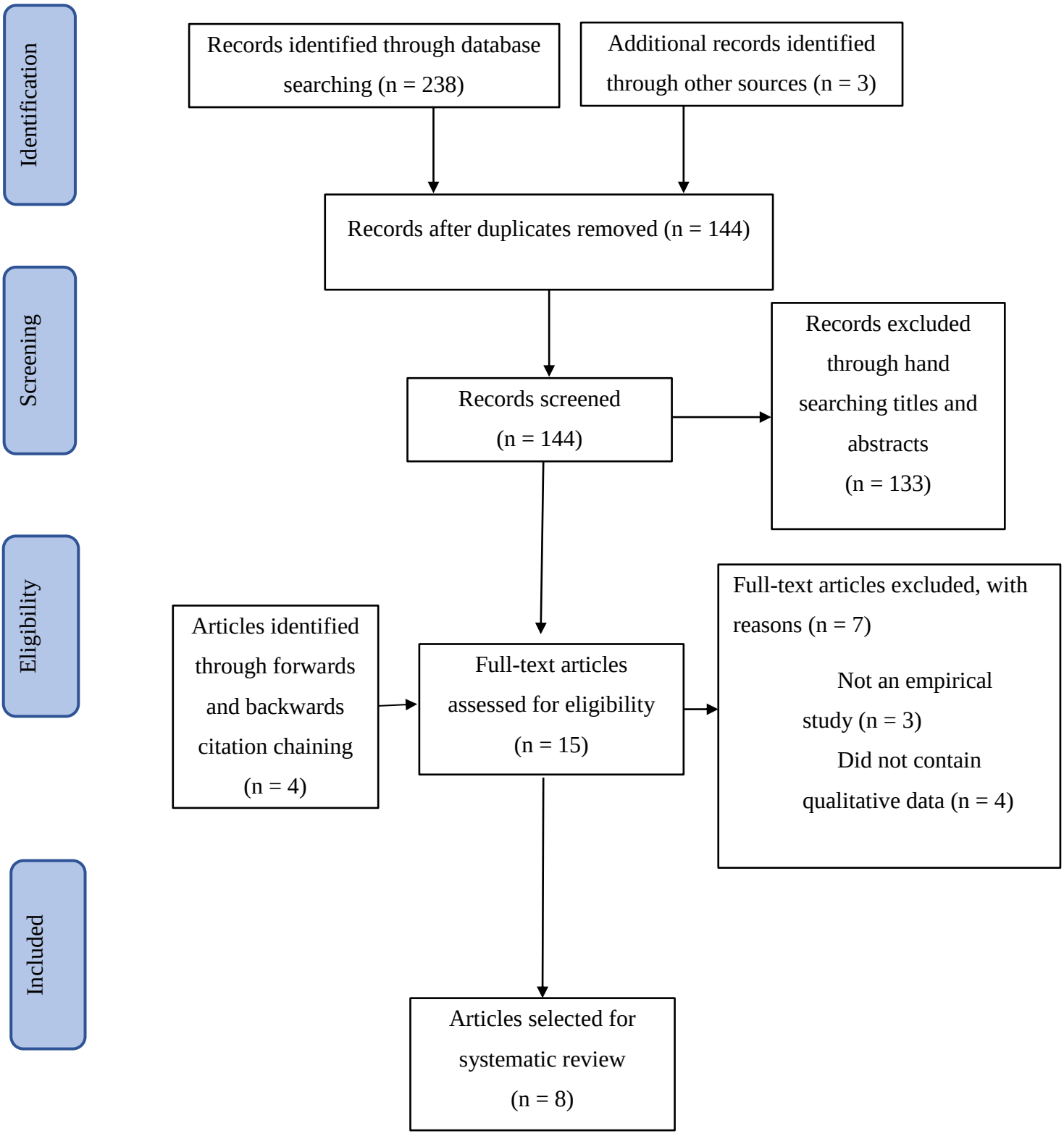
Papers that met the following inclusion criteria were selected for the review: (a) studies containing reference to racial similarity in therapeutic dyads, (b) including data from Black therapists, (c) studies including qualitative data, (d) published in English, (e) peer-reviewed empirical studies, (f) published in any time period, (g) published in any geographical area. Papers were excluded if they (a) focused on the experiences of service users instead of therapists or (b) did not focus on therapists that identified as having Black heritage.

Screening

The results that were initially identified through the databases were exported to Mendeley reference manager and duplicates were removed. Results were screened using their title and abstract followed by full text. To identify the final articles, forward and backward citation chaining was used to highlight relevant papers in the reference lists of included literature (via Web of Science), and to identify papers that had since cited the included articles (using Google Scholar). The screening process is outlined in Figure 1.

Figure 1

Systematic Literature Review Flow Chart



Synthesis

The initial two stages of TS (Thomas & Harden, 2008) were followed: (1) open line-by-line coding of the results and discussion sections reported in the chosen papers and then (2) organisation of codes to develop descriptive themes. Initial codes were grouped into categories based on commonalities and differences and, where necessary, new categories were constructed to represent the meaning of each code. The categories of descriptive themes were then organised into a hierarchical structure to support the conceptual development of analytical themes. Then, in the third and final stage, the descriptive themes were applied to the initial review question to generate analytical themes that go further than the original studies (Thomas & Harden, 2008) and answer the review question.

Reflexivity

Sensitive to how my own racial identities and prior experiences shape my interpretations, I feel it is important to offer some transparency regarding the construction of themes. At the time of conducting this review I was offering therapy as a trainee CP working with racially diverse children on a specialist placement. As such, my own knowledge and assumptions were likely held about racially similar therapy dyads. Furthermore, since I am from a Black British Caribbean background, I have both personal and professional influences on how I perceive Black therapists and their experience of working with racial similarity. This also influenced how the data have been interpreted, developed and presented in this review.

Results

Search Results

A recent systematic literature review (Hamilton, 2023) identified 2 papers. The search found 238 additional papers, which reduced to 141 when duplicates were removed. Screening titles and abstracts resulted in excluding 133 articles, resulting in 11 articles left. Forward and backward citation chaining identified 4 more papers. This left 15 papers to screen at full text.

Once full-text screening was completed the final number of articles included in the review was 8.

Study Characteristics

The literature review identified eight suitable articles, all of which used a qualitative methodology. The papers included were chosen because they reported on Black therapists' experiences of working with Black clients. However, only three studies specifically investigated the aims of this literature review to capture the therapists' perception of the impact of racial similarity on the therapy dyad. Most studies were based in the USA (n= 6) with one based in the UK (n= 1) and South Africa (n= 1) respectively. Overall, experiences were gathered from 124 mental health professionals including psychotherapists with varied licenses, psychiatrists, clinical psychologists, counselling psychologists and social workers. Study sample size ranged from 2-38 participants. Two studies were conducted via online video calls and many studies were conducted in person (n= 5). One study utilised both in person and the telephone as methods to conduct interviews dependent on feasibility for the participant. For most studies the entire sample consisted of Black therapists (n= 5), however a minority included participants from other races (n= 3). Where studies included multiple races only data that was explicitly reported as deriving from Black participants was included in the data analysis for this literature review. See Appendix B for further detail about the key study characteristics for all eight papers.

Quality Appraisal

The methodological quality of the final eight articles was assessed using the qualitative Critical Appraisal Skills Programme checklist (CASP, 2018). Each article was evaluated against 10 questions based on three broad areas: relevance, rigour and credibility (CASP, 2018). All papers had good methodological quality with clear and appropriate aims. The only study that took place in the UK (Brooks-Ucheaga, 2023) offered important insights into Black

therapists' experiences of supporting Black clients regarding the relevance of racism. However, since the study design included only two participants the remit of the findings was limited where the paper could only be considered a pilot study as opposed to offering contributions from a full-scale research project. Furthermore, the lack of information regarding the recruitment strategy used left it ambiguous as to how appropriate the recruitment strategy was for the aims, and left it unclear as to why the study included only two participants.

Three studies could be strengthened by acknowledging researcher-participant relationships (Bell-Tolliver, 2009; Bell-Tolliver & Wilkerson, 2011; Long, 2022). In Long (2022), although it was reported that the lead researcher was part of the same faculty that participants were based in which may have caused reluctance from those that declined participation, the race of the researchers was not reported. This omission was a limitation since the paper focused on the presence of racial identity in psychotherapy, and so it is unfortunate that the presence of racial identity within the researcher team was not addressed in the article given its relevance to the study. For Bell-Tolliver (2009) and Bell-Tovier and Wilkerson (2011), as well as the relationship between researchers and participants not being reported, the researchers also being African American therapists was minimally considered or discussed throughout the article.

In Bell-Toliver (2009), Bell-Tolliver and Wilkerson (2011) and Goode-Cross (2011) it was also unclear whether ethical approval had been received as this was not reported. Furthermore, Bell-Tolliver (2009) and Bell-Tolliver and Wilkerson (2011) did not explicitly report obtaining consent from their participants either. However, Bell-Tovier and Wilkerson (2011) were able to consider the relationship between the participant and client identities to some degree as they highlighted the role the participants' religion could play in creating potential blind spots when working with clients of the same religion. As such, some findings from both papers were helpful in answering the aims of the literature review.

Bartholomew et al. (2023) and Goode-Cross and Grim (2016) were the two studies with the strongest methodological rigour and no flaws in relation to the CASP checklist. Both studies detailed how they acknowledged the researcher-participant relationship by highlighting the race of the those in the research team. The studies showed strong reflexivity where at the start of the studies they identified their prior beliefs, cultural and professional identities and reflected on how they informed the study. Bartholomew et al. (2023) also enhanced the credibility of the study by ensuring data interpretations were grounded in the data. It was reported that a research member was intentionally recruited to include someone who is Black and involved in clinical practice given that the team initially were all non-Black and worked primarily in academia.

All papers detailed a rigorous analysis process and had clear conclusions linked to their aims. However, in Greenberg et al. (2018) some findings that were relevant to the literature review could not be analysed because the study included both Hispanic and Black participants and for some quotes the participant's race was not specified. Regardless, Greenberg et al. (2018) demonstrated strong methodological rigour throughout the rest of paper and the aims and findings were particularly relevant to the aims of this review given that it focused on exploring intersectionality in racially similar and different therapy relationships. The quality appraisal was not used to eliminate articles, but instead it was used to sharpen awareness of the strengths and limitations of reviewed papers. The quality appraisal of the articles is detailed in Appendix C. A meta-synthesis of the main findings will be presented in the following section.

Synthesis of Main Findings from Literature Review

TS of the papers in the review led to the development of six analytical themes: *The role of the therapist's racialised lived experience*; *Higher stakes and responsibility*; *Boundaries and blind spots*; *It's not always just about race: The impact of intersectionality and context*; *Learning how to navigate racially similar therapy dyads*; *The role of racial prejudice and racism*. Five sub-themes were also identified. The themes and sub-themes are represented in Table 1.

Table 1

Table of Themes from the Thematic Synthesis

Analytical Themes	Sub-themes
The role of the therapist's racialised lived experience	Cultural and racial solidarity Increased engagement and trust
Higher stakes and responsibility	
Boundaries and blind spots	
It's not always just about race: The impact of intersectionality and context	
Learning how to navigate racially similar therapy dyads	A gap in formal training and the evidence base Practice makes 'perfect' The role of Black mentors, supervisors and peers
The role of racial prejudice and racism	

Theme: The role of the therapist's racialised lived experience

All eight studies highlighted how the therapist's racialised lived experience impacts racially similar therapy dyads. Within this analytical theme, six of the eight studies highlighted a sub-theme that captured the impact of cultural and racial solidarity in same-race therapy (Bartholomew et al., 2023; Bell-Tovier, 2009; Bell-Tovier & Wilkerson, 2011; Goode-Cross, 2011; Goode-Cross & Grim, 2016; Long, 2022). Five studies also identified a sub-theme that highlights how the therapist's racialised lived experience acts as a facilitator for racially similar clients' engagement and trust in the therapy process (Bartholomew et al., 2023; Bell-Tovier, 2009; Goode-Cross, 2011; Goode-Cross & Grim, 2016; Greenberg et al., 2018).

Sub-theme: Cultural and racial solidarity. The idea that similarity between the therapist's own culture and race in racially similar therapy dyads led to solidarity was supported by six studies (Bartholomew et al., 2023; Bell-Tovier, 2009; Bell-Tovier & Wilkerson, 2011; Goode-Cross, 2011; Goode-Cross & Grim, 2016; Long, 2022). In Goode-Cross and Grim (2016) participants described how this sense of racial and cultural solidarity led to "*an unspoken level of comfort"* that is not often found in cross-racial dyads. Participants in this paper also spoke about being able to have a shared language with their Black clients by using references that are "*culturally based"* and the ability to start with *"common ground"* where their clients appreciate being able to *"code-switch"* with their Black therapist (Goode-Cross & Grim, 2016, p. 39). For example, in Bell-Tovier and Wilkerson (2011) the African American therapists were able to apply the Black church's concept of *"testifying"* to therapy to instil hope for their Black clients and encourage Black families to share strengths and accomplishments that challenge the narratives surrounding the difficulties they were experiencing (Bell-Tovier & Wilkerson, 2011, p. 62).

In non-western countries there were further implications for language when Black clients were able to work with Black therapists. In Long (2022) a therapist based in South

Africa described how it was *"powerful"* to be able to communicate to their client in the client's mother tongue despite this being difficult for the therapist as it was the therapist's second language (Long, 2022, p. 454). The participant highlighted how language enabled shared understanding since moving away from speaking English changed the way that the client was able to engage in therapy. Long (2022) describes how restricting clients with Black heritage whose native tongue is not English to speak in English in therapy could be experienced as colonizing. All examples offered in the studies regarding the impact of racial and cultural solidarity in same-race therapy dyads derive from the understanding that comes from the analytical theme that the therapist's racialised experience plays a role in the dynamics in same-race therapy.

Sub-theme: Increased engagement and trust. The Black therapist's lived experience was shown to facilitate engagement and trust for racially similar clients in five studies (Bartholomew et al., 2023; Bell-Tovier, 2009; Goode-Cross, 2011; Goode-Cross & Grim, 2016; Greenberg et al., 2018). In Goode-Cross (2011) a participant described how for some Black clients "*there's already kind of a personal connection that has already been established in advance of really even beginning to work together"* (Goode-Cross, 2011, p. 371). As such, for some Black clients just the knowledge that they will have a racially similar therapist creates a connection that might facilitate engagement and trust before they even meet their therapist. In Greenberg et al. (2018) a participant shared how their client refused to speak to anyone else. The therapist reported that working with someone racially similar was the client's *"comfort zone".* The participant described how people *"tend to gravitate more toward"* what they are *"familiar"* with (Greenberg et al., 2018, p. 74). In this instance the client's preference to engage with someone who was racially similar facilitated engagement in same-race dyads whilst acting as a barrier for engaging in a cross-racial therapy dyad. Black families were described in Bell-Tovier (2009) as *"starving for Black help"* (Bell-Tovier, 2009, p. 303). This suggests how the

possibility of having a racially similar therapist for Black clients is needed to facilitate access and engagement to therapy.

Theme: Higher stakes and responsibility in same-race therapy dyads

Three of the eight studies (Goode-Cross, 2011; Goode-Cross & Grim, 2016; Greenberg et al., 2018) highlighted how Black therapists feel a higher sense of responsibility and how the stakes feel higher when working with racially similar clients. In Goode-Cross (2011) a participant shared that *"the stakes are higher on both sides",* revealing that Black therapists may perceive that the feeling of higher stakes is mutual for both the therapist and client (Goode-Cross, 2011, p. 371). In Greenberg et al. (2018) a participant shared how their sense of responsibility originates from the socio-political historic context for African Americans. They reported the following:

> *"I feel a…heightened sense of obligation…because given the history of this country…African Americans are not seen as being equal…and our cases of brutality and injustice . . . are continuously overlooked."* (Greenberg et al., 2018, p. 73)

A therapist in this study reported that they feel more emotionally *"invested in Black students",* though they specified that they do not "*work any harder"* but are *"more invested"* (Goode-Cross, 2011, p. 372). This sense of emotional investment was described by a participant who stated the following:

> *"They just tug on me more, and so I feel more and have to do more in order to feel okay. And they need more, often."* (Goode-Cross, 2011, p. 371)

There appears to be an emotional pull that Black therapists may experience causing more emotional investment in their racially similar clients alongside a sense that these clients need more support than the average client. In Goode-Cross (2011) participants also described

the multiple roles, often familial, that they feel they serve for their racially similar clients. A participant reported the following:

> *"You may not know the many roles that you serve…I might be mama, aunty, cousin, whatever whoever needs me to be at that point in time."* (Goode-Cross, 2011, p. 371)

A participant in Goode-Cross (2011) shared how they may also serve the role of a mentor as they shared that *"there's always an aspect of mentoring that enters in the relationship"* (Goode-Cross, 2011, p. 371). Thus, these three studies highlight how Black therapists can experience a sense of responsibility and higher stakes when working in racially similar therapy dyads.

Theme: Boundaries and blind spots

Five studies (Bartholomew et al., 2023; Bell-Tovier & Wilkerson, 2011; Brooks-Ucheaga, 2023; Goode-Cross, 2011; Goode-Cross & Grim, 2016) suggest a need for Black therapists to be aware of their own blind spots and consider the use of boundaries in racially similar therapy dyads. In Goode-Cross (2011) a participant spoke of the need to "*be careful not to blur the lines of therapist and personhood"* (Goode-Cross, 2011, p. 371). This caution captures the complex identities Black therapists hold between their identity both as a Black individual and as a therapist. This dual identity held consequences in Black therapists' daily lives outside work. In Goode-Cross and Grim (2016) a participant describes this impact as they stated the following:

> *"I think one of the difficulties with Black clients in a town this small and where there are not so many of us, I often see clients outside of here at other functions…I'm going to see somebody that I see in therapy, so I think that's difficult, being able to manage those dual relationships."* (Goode-Cross & Grim, 2016, p. 41)

In Goode-Cross and Grim (2016) a participant described how *"boundary setting"* is "*really important"* since some clients *"need the motherly connection"* with their Black therapist whilst others do not. They report that this *"self-awareness"* is crucial to give a racially similar client what they need as an individual as opposed to assuming all racially similar clients would desire the same thing (Goode-Cross & Grim, 2016, p. 41). Another participant in this study shared the risks of not enforcing boundaries in racially similar dyads and shared that they *"might not have pushed them in the way they needed to be pushed"* and *"might not have helped them develop something they may have needed to develop".* They shared that this happened because they were *"so busy caring about . . . being helpful"* (Goode-Cross & Grim, 2016, p. 42).

In Brooke-Ucheaga (2023) a participant described how sharing cultural similarities with Black clients such as being *"from the same part of Africa"* that the therapist is from could make the therapy feel *"very emotive"* for the therapist since *"the experiences are too familiar"* and the therapist felt like they would *"understand them too much to not be affected emotionally"* (Brooks-Ucheaga, 2023, p. 7). In this study a similar difficulty was reportedly experienced by racially similar clients where they *"want to stay far away from anyone who belongs to their culture".* The participant hypothesised that this may be due to concerns regarding *"issues around their privacy"* despite the service having a confidentiality policy (Brooks-Ucheaga, 2023, p. 7). These studies highlight the complex emotions and interactions that may be evoked in same-race dyads. As such, the studies suggest that it is important for Black therapists to monitor their blind spots and enforce boundaries where necessary both for their own wellbeing as well as for their clients.

Theme: It's not always just about race: The impact of intersectionality and context

Of the eight studies, four illustrated how consideration of intersectional identities and the wider context is crucial for understanding the various ways Black therapists experience

working with racially similar clients. In Goode-Cross (2011) a participant shared how despite the racial similarity between the therapist and client there may be *"significant cultural differences"* that cause differences in perspective (Goode-Cross, 2011, p. 371). For example, in Greenberg et al. (2018) a Black social worker spoke about the barriers such as the *"language barrier"* and different *"accents"* that arose due to cultural differences. The participant shared that some racially similar clients ask them *"Who are you? You're just an immigrant. You just got here. What do you know? How much do you have to help or support me?"* demonstrating intra-racial discrimination and xenophobic mistrust around the therapist's competence based on them having migrated from a different country (Greenberg et al., 2018, p. 72). Alternatively, a participant in Greenberg et al. (2018) described how their gender as a male led to *"positive reactions"* from their client given that *"in the community"* they would not see *"a lot of Black males in a particular position"* (Greenberg et al., 2018, p. 71).

In Long (2022) a participant shared how the perception of the psychology profession as being a *"White trade"* and a "*a privileged sort of field"* might make Black clients question the therapist's relationship to Blackness. This led the therapist to hypothesise that their client might wonder if they will be *"Black enough to understand",* causing the client to question whether the therapist would "*be able to relate with"* them (Long, 2022, p. 454). The service context also appeared to play a role in how Black therapists experienced working with racially similar clients. Goode-Cross and Grim (2016) noted that the lack of Black clients in counselling centres, schools, and hospitals appeared to make therapists more likely to report experiencing their work with Black clients as more interesting and fulfilling. Whereas for participants in community settings, differences in the therapist's higher socioeconomic status became a point of contention and disconnection with many Black clients and often contributed to clients distrusting them. It was reported that this may have been exacerbated by the fact that participants in community settings often described having nonvoluntary clients, which was far

less likely in alternative therapeutic settings. These studies demonstrate how impactful the wider context and the intersectional identities that the therapist and client hold are in influencing same-race therapy dyads.

Theme: Learning how to navigate racially similar therapy dyads

Four studies provided insight into how Black therapists learn to navigate working with racially similar clients. Within this analytical theme, all four studies highlighted a sub-theme that identified a gap in formal training and the evidence base used by therapists regarding navigating racially similar therapy dyads (Bartholomew et al., 2023; Brooks-Ucheaga, 2023; Goode-Cross, 2011; Goode-Cross & Grim, 2016). Learning how to navigate this phenomenon through clinical practice was captured as a second sub-theme by two of these studies (Goode-Cross, 2011; Goode-Cross & Grim, 2016). These two papers were also used to develop a third sub-theme that describes the significance of the role of Black mentors, supervisors and peers in supporting Black therapists to learn how to navigate racially similar therapy dyads.

Sub-theme: A gap in formal training and the evidence base. Four studies identified a gap in formal training and the evidence base used by therapists regarding navigating racially similar therapy dyads (Bartholomew et al., 2023; Brooks-Ucheaga, 2023; Goode-Cross, 2011; Goode-Cross & Grim, 2016). In Goode-Cross and Grim (2016) a participant reported that *"there were no courses in diversity"*. They shared that the learning they received that was relevant to navigating racially similar therapy dyads came from *"continuing education…going to conferences and doing workshops"* (Goode-Cross & Grim, 2016, p. 43). Similarly, in Goode-Cross (2011) a participant reported that they could not *"remember there being any training on same-race dyads"* in their *"formalized didactic…training"* and so further learning has come from taking initiative in their *"own time"* (Goode-Cross, 2011, p. 372).

In Brooks-Ucheaga (2023) a participant shared the difficulties they face when working with Black clients based on the gaps in considering racial trauma within the therapy evidence base. They share the following:

> *"It makes it really tricky that I'm trying to fit particular models with the clients' racist experiences, even though it was not designed to do this. Clinically it means that some of the presentations are then perceived as complex just because they don't fit into the identity of being western and being White."* (Brooks-Ucheaga, 2023, p. 8)

Another participant shared the sense of powerlessness that they feel given the lack of guidance in literature regarding racial trauma given the real-world challenges that can perpetuate their Black clients' racial trauma despite their efforts to support their client in therapy. They report the following:

> *"With racism and racial trauma, they are possibly going to continue to experience it again because that is an assigned part of their identity. So, I feel really powerless that I don't know what the end goal or therapy goal is when someone has racial trauma and there's nothing that I can do. So then sometimes I have to skirt around and pick anything that fits into the CBT model to work on instead. I think we need more models that have looked into racial trauma."* (Brooks-Ucheaga, 2023, p. 8)

The above studies highlight the distinct gap in training and the evidence base that causes challenges for Black therapists supporting clients that also have Black heritage.

Sub-theme: Practice makes 'perfect'. Learning how to navigate this phenomenon through clinical practice was captured as a second sub-theme by two studies (Goode-Cross, 2011; Goode-Cross & Grim, 2016). In Goode-Cross (2011) a participant shared how completing relevant reading and using this enabled them to be able to have "*experimented with and explored"* how to navigate working in racially similar therapy dyads (Goode-Cross, 2011,

p. 372). Goode-Cross (2011) report that most participants described learning how to navigate this phenomenon through trial and error. Participants cited that despite using various methods to support their learning, real experience working with Black clients was the most effective way to learn how to work with this population.

Goode-Cross and Grim (2016) also suggest that more clinical experience with racially similar clients supports Black therapists in navigating this phenomenon. They report that early-career participants were more likely to report feeling caught off guard when they started working with Black therapists for the first time when this did not fit with their idealised expectations of mutual affinity taking place with their clients. They report that in contrast, participants that were further in their careers often described the challenges associated with same-race dyads using the past tense, suggesting that they no longer experienced navigating these therapeutic relationships as being problematic now that they became more experienced at navigating this. Both studies highlight the impact that gaining experience of working with racially similar clients has for improving Black therapists' knowledge and ability to work effectively in same-race therapy dyads.

Sub-theme: The role of Black mentors, supervisors and peers. Two papers (Goode-Cross, 2011; Goode-Cross & Grim, 2016) also identified the significant role that Black mentors, supervisors and peers play in supporting Black therapists to learn how to navigate racially similar therapy dyads. For example, Goode-Cross (2011) report that the information participants learnt about working in same-race dyads was gained through interactions with Black faculty, supervisors, and peers. In Goode-Cross and Grim (2016) a participant provided insight into the comfort gained when being supervised by someone who is also an ethnic minority. They reported the following:

> *"When I think about again how vulnerable I was able to be, how comfortable I was with them, and even sometimes discussing issues of race and culture, I think it was always easier for me to do that with a supervisor of colour."* (Goode-Cross & Grim, 2016, p. 43)

Both papers highlight how integral ethnic representation is across training staff faculty, supervisors, and other therapists in the profession. Participants in these papers reported how receiving support from Black colleagues in these roles was helpful in providing a safe space to learn how to navigate working with racially similar clients.

Theme: The role of racial prejudice and racism

Three papers (Bartholomew et al., 2023; Brooks-Ucheaga, 2023; Greenberg et al., 2018) illustrate the role that racial prejudice and racism can have when working with racially similar clients. In Bartholomew et al. (2023) a participant shared that they *"just didn't feel like"* talking about his client's experience of anti-Black racism with his White supervisor (Bartholomew et al., 2023, p. 22). This suggests a sense of energy and effort it may take to risk invalidation by discussing this with a supervisor who does not have the shared experience of being a racial minority.

In Greenberg et al. (2018) racism was also shown to play a role in same-race dyads due to therapists experiencing their client's internalised racism. Greenberg et al. (2018) report that several participants commented about the negative expectations and assumptions clients held about their therapist when they were from the same race or ethnic group. It was hypothesised that these negative assumptions derived from their client's internalized racist perspective that Black social workers could not be competent workers. Both papers highlight how racism can occur in various ways, such as in supporting the client to navigate their own racial trauma and struggling to use supervision to receive support with this depending on the race of the

supervisor. Furthermore, racism can create barriers in working with racially similar clients due to the client's own internalised racism towards their Black therapist.

Clinical Implications

Several studies make recommendations to improve training for Black therapists. Goode-Cross (2011) and Goode-Cross & Grim (2016) highlight that Black therapists had little to no training about issues that arise in same-race therapy dyads. They argue that courses need to incorporate strategies to manage the emotional impact of racial similarity to avoid overinvestment, heightened anxiety, burnout and negative outcomes for themselves and their clients. In the Bartholomew et al. (2023) study, when participants discussed anti-Blackness, they reported experiencing a range of emotions tied to their own identities, racial views and/or lived experiences, and attempted to balance attending to these emotions and their client's needs. As such, greater self-awareness can lead therapists to be better attuned with how comfortable or uncomfortable they are when addressing cultural issues.

Goode-Cross & Grim (2016) and Bartholomew et al. (2023) highlight the potential benefits of enabling cultural comfort when addressing anti-Blackness in therapy through self-disclosure. Participants across numerous studies report that training on multicultural issues does not meet the needs of all students. For example, Goode-Cross (2011) report that if coursework focuses on cross-racial therapeutic interactions since it is designed to teach White therapists to work with ethnic minority clients, or if it is insufficiently broad in scope, Black therapists may continue to graduate feeling ill-prepared for the challenges of working with racially similar clients. Many of the participants in the studies highlighted the role of intersectionality and how cross-cultural interactions can occur among members of the same race based on socioeconomic status, religion and sexual orientation among other demographic factors (Greenberg et al., 2018; Goode-Cross, 2011; Goode-Cross & Grim, 2016). For instance, Brooks-Ucheaga (2023) reports the importance of therapists informing clients if they are from

the same culture to allow clients to choose whether they want to remain in treatment with the therapist given the varied meanings and implications this would have for different people of the same ethnicity.

Goode-Cross (2011) and Goode-Cross & Grim (2016) report that Black trainees benefit from having Black therapists as professors, supervisors, and mentors. This is understandable when considering that African American therapists spoke of feeling apprehensive about discussing their clients' experiences of racism with their White supervisors (Bartholomew et al., 2023). Greenberg et al. (2018) identified that opportunities to create dialogue about intersectionality and race should be taken in individual and group supervision. Furthermore, it was recommended that supervisors and managers should receive training on managing intersectionality in the workplace. Continued education opportunities were also suggested to support supervisors in developing comfort around exploring topics regarding diversity (e.g., microaggressions, stereotypes) and the sociopolitical trends that impact the ethnic minority therapists they supervise and the communities they serve.

Evaluation and Conclusions of the Systematic Literature Review

This systematic literature review is the first to explore Black therapists' experiences of racial similarity across the diaspora. A strength of the evaluated studies is the varied countries, therapeutic professions included, and methods employed across the eight studies. This helps cast a broad lens on the numerous contexts and ways that Black therapists could share their experiences of this phenomenon. This review highlights the role of the Black therapist's racialised lived experience in creating cultural and racial solidarity with racially similar clients. In turn, this solidarity can act as a facilitator to the racially similar client's engagement and trust in the therapeutic process.

The review highlights how in same-race therapy dyads Black therapists often feel that the stakes are higher for their clients and themselves, so they feel a greater sense of responsibility. An emphasis has also been made about the need for boundaries and for Black therapists to be self-aware of the blind spots they may miss due to their own relationship to the similarities that exist between them and their racially similar clients. This review also shows the role that racial prejudice and racism plays in racially similar therapy. It highlights that despite the clear impact that race has in these dyads, race is not the only significant factor at play given the role of intersectionality and the wider context. Given the nuances involved this review shares the importance of Black therapists' ability to learn how to navigate this phenomenon. It shows that there is a gap across various countries in the formal training that Black therapists receive in working with racially similar clients. It reveals the important role that mentors, supervisors and peers can play in the therapist's development, particularly when these figures are also Black. Lastly, it shows that the crucial method to learning is the therapist's exposure to practicing therapy with Black clients over time.

Of the eight studies, only one took place in the UK (Brooks-Ucheaga, 2023) and this study had a small sample of just two Black therapists. Given that Black therapists are not a monolithic group caution should be taken about what the findings of this review might mean for Black CPs in the UK given the distinct socio-political influence of clinical doctoral training and the wider societal context. Only three studies (Goode-Cross, 2011; Goode-Cross & Grim, 2016; Greenberg et al., 2018) were explicitly exploring Black therapists' experiences of racially similar therapy and so there may have been limits on how much could be extrapolated to address the aims of this review. Of these three studies one (Greenberg et al., 2018) at times did not clarify the race of the participant sharing relevant data in the study and so some important findings could not be examined in this review as it was not clear if the participant was Black.

Gaps in the Literature

Several gaps in the literature were identified in this review regarding Black therapists' experiences working with racially similar clients. Although positive and challenging aspects of racially similar dyads were highlighted; information was not gathered to clarify whether the connection is more helpful or detrimental in same-race dyads. Many studies alluded to the fact that the experience level of the therapist influenced how they experienced racially similar therapy. As such, there is a need for further investigation of how various intersectional aspects to identity (e.g., age, years of experience) impact how Black therapists experience same-race therapy. The absence of any exploration of this phenomenon in the UK with Black CPs presents a unique opportunity for this research project to close the gap by exploring how Black CPs in the UK experience working with racially similar clients.

The Rationale for the Current Research Project

The current project aims to explore how Black CPs in the UK experience working with racially similar clients. A further objective is to consider how intersectional identities the psychologist and client hold impact how CPs experience racial similarity in therapy. This might help to explore the same-race therapy dyad whilst capturing myriads of nuanced differences and similarities within this dynamic. Lastly, a final aim is to provide clinical implications for training courses, service providers and CPs to improve the cultural sensitivity adopted when both Black aspiring psychologists are recruited to, and Black communities engage with psychological services. It is hoped that such implications might enable both groups to receive equitable and culturally sensitive experiences delivering and receiving services.

Aim of the Research and Research Questions

This research aimed to explore how Black CPs experience working with racially similar clients. Three sub-questions were explored:

1. *How do CPs with Black heritage in the UK experience working with racially similar clients?*
2. *How do intersectional identities mediate Black CPs' experiences of working with racially similar clients?*
3. *What clinical implications do Black CPs' accounts of working with racially similar clients highlight for practice, supervision, clinical psychology training and service providers?*

Chapter Three: Method

Chapter Overview

This chapter outlines the method used to explore how Black CPs in the UK experience working with racially similar clients. The epistemological positioning, justification for reflexive thematic analysis and research design is discussed. The recruitment, participant sample, data collection and analysis, informed by consultation will be detailed. The chapter concludes by addressing ethical considerations and outlining a quality appraisal of the study.

Epistemological Position

Underpinning all research is its philosophical paradigm, which consists of the research's ontology, epistemology, and methodology (Scotland, 2012). Ontology can be understood as the examination and consideration of reality (Crotty, 1998), epistemology relates to the nature of knowledge (Cohen, 2007), whilst methodology is the strategy behind the use of specific methods in research (Crotty, 1998). Recognising these components of the research paradigm are important to acknowledge how the researcher's epistemological and ontological assumptions shape the methodology (Coolican, 2017). I was drawn to adopting a Critical Realist (CR) epistemology because unlike constructivist and positivist perspectives which reduce ontology (i.e., reality) to epistemology (i.e., human knowledge), whether knowledge provides the lens or container for reality, CR treats the world as theory-laden but not theory-determined (Fletcher, 2017). In other words, whilst CR does not deny that there is a real social world, it appreciates that human knowledge holds a small piece of a deeper reality. I was also attracted to CR due to its ability to highlight explanations for social phenomena and identify suggestions for social change (Bhaskar, 2016).

CR has a realist ontology and a subjective epistemology; agreeing that reality is independent of us, but it argues that knowledge of this reality is understood through the lens of human experience and interpretation (Fletcher, 2017). Within the current study, CR provides a

framework to explore the underpinnings of social phenomena concerning Black CPs' experiences of working with racially similar clients. As such, making sense of Black CPs' social reality must be understood whilst acknowledging wider cultural, historical, and social factors that inform different interpretations of their experiences when working with racially similar clients (Pilgrim, 2019). Therefore, participant data will not be presented as the truth or 'objective' reality but as my interpretation of Black CPs' reality, shaped by the various lenses that I bring (i.e., gender, culture, politics, history, age). This epistemological and ontological stance is underpinned by my assumption that Black CPs' experiences of racial similarity with clients highlights a reality that has a subjective and tangible impact on clinical practice and the wider field of clinical psychology. This assumption informs my approach and the research methodology I have used to explore the study's aims and objectives.

Justification of Qualitative Methodology

A qualitative methodology explores the quality of subjective experiences instead of simply highlighting cause-and-effect correlations (Willig, 2008). A qualitative methodology provides a distinct and well-established framework to study experiences in a way that can otherwise be challenging to contextualise when a quantitative approach is used (Denzin & Lincoln, 1994). Additionally, qualitative methods acknowledge the subjectivity of the interpretation of experiences and the subsequent need for a reflexive approach to be held throughout the research process (Denzin & Lincoln, 2017). Furthermore, the systematic review of literature showed a gap in empirical research exploring Black CPs experiences of working with racially similar clients in the UK. Therefore, a unique opportunity became apparent to use a qualitative approach to explore this phenomenon.

A CR epistemology also aligned well with a qualitative methodology to meet the aims of the study. For instance, a realist ontology felt applicable to the reality of Black service-user and psychologist experiences as ethnic minorities in the NHS and the UK more broadly. This

fact felt important to consider in the wider context of same-race therapy dyads. However, I also felt that a constructivist epistemology is applicable to recognise the influence of the subjective lens that I and the pool of participants would hold to shape the interpretation about experiences of racial similarity in therapy. I also believed that given the significance of dyadic experiences of racial similarity, the project should enable a similar experience between myself as a Black researcher and the Black CP participants. Therefore, adopting a qualitative approach enabled meeting with participants face to face (via video call) which was seen as important to aid reflections on how the data collection process might also inform an intimate understanding of the content of the data. Therefore, a phenomenological sense of similarity between the data collection process and the topic being explored was facilitated (i.e., both involving same-race dyads).

Consideration of Alternative Methodologies and Typologies

When various qualitative methods were explored Interpretative Phenomenological Analysis (IPA), Narrative Analysis (NA) and various forms of TA were considered. IPA can be described as a methodology, meaning it is theoretically bound and has a set framework for how to approach research. For example, IPA has an idiographic focus on using participants that share distinct characteristics alongside it's dual focus on patterns of meaning in small groups of usually 6-8 (Smith & Osborn, 2003). These features of IPA meant that I did not feel the approach suited this study. For instance, since there is limited research on Black CPs' experiences of working with racially similar clients it seemed more appropriate to search for patterns across participant narratives in a larger sample. Given the aim to consider intersectionality, actively seeking heterogeneity (as opposed to the homogeneity proposed for IPA) within the demographic representation in the sample of Black Clinical Psychologists felt important (e.g., varied age, work context, geographic area, years qualified etc.).

NA looks at the stories participants share and how they approach sharing them to organise and understand their lives (Riessman, 2008). The method highlights when individual stories are chosen over different ones (Wells, 2011) and allows consideration of the wider societal context of the stories told (Esin et al., 2014). Furthermore, unlike IPA, NA is flexible in its approach to data analysis (e.g., Ronkainen et al., 2016). As such, regardless of the precise analysis method NA must be clear, systematic and offer insight into the structure of the narrative's functions and psychological or social implications (Josselson & Hammack, 2021). Although it is significant to showcase the stories from Black CPs, I believed that highlighting detailed accounts of the experience using NA (Riessman, 2008) might be harder to communicate to a wide audience compared with the dissemination of recurring themes and shared experiences using a TA approach.

Although TA was my preferred method to use in the current study, various types of TA needed to first be considered. TA can be described as a broad term for methods that highlight, analyse and disseminate themes in data (Braun & Clarke, 2006). Braun and Clarke (2020) report that mistakes in the application of TA often arise due to the assumption that TA has a single approach (Firmin, 2008). Instead, TA can be separated into three typologies, each with varied assumptions and differing theoretical frameworks: codebook, coding reliability and reflexive TA (RTA; Braun & Clarke, 2019). RTA is a comprehensive qualitative approach and unlike codebook or coding reliability frameworks it combines qualitative data collection approaches with a 'fully' qualitative paradigm (Braun & Clarke, 2022). This aligned better with my assumptions and values as opposed to adopting a 'qualitative positivist' paradigm like codebook or coding reliability paradigms (Brinkmann, 2015).

Reflexive Thematic Analysis

RTA (Braun & Clarke, 2006) aims to understand patterns of meaning which fit well with this study's objective of highlighting shared meanings in Black CPs' experiences of the relational complexities of therapy in same-race dyads. As such, the qualitative method used in this study employed RTA (Braun & Clarke, 2006). RTA, also known as a "Big Q" approach (Braun & Clarke, 2019), can adopt both an inductive (bottom-up) approach where themes are developed using raw data (e.g., Crabtree & Miller, 2022) and a deductive or theoretical (top-down) approach drawing from pre-existing theories and literature (e.g., Boyatzis, 1998). Since the systematic and narrative review of relevant literature and theories highlighted themes and concepts that might hold relevance in making sense of same-race dyads for Black CPs in the UK, it is likely at times that themes may have been developed with a deductive influence. However, given the novelty of this study in exploring the phenomenon of racial similarity with a specific population and context in the UK, I aimed to lean more into an inductive 'bottom-up' approach. By adopting this approach, I hoped to enable fluid and creative interpretations of the data and theme development with minimal pre-conceptions.

Given my identity as a Black trainee CP and researcher, I had some influential experiences of working in racially similar therapy dyads. Therefore, as might be understood adopting a CR lens, it is impossible to remove my personal, epistemological and theoretical beliefs and experiences which undoubtedly influenced my relationship with the research process. As such, adopting an RTA approach helped utilise this influence since, unlike in coding reliability TA, for RTA coding is described as a subjective process shaped by the influence of the researcher. Therefore, codes did not need to use positivist means such as establishing inter-rater reliability using other researchers to validate the findings (Braun & Clarke, 2019). Furthermore, the influence of findings from previous literature likely enhanced the analysis by increasing my sensitivity to more implicit aspects of the data (Tuckett, 2005).

Engaging in reflexive dialogues and reflective diaries were useful transparency strategies to recognise and shape the influence of my interconnected subjective beliefs and identities on the analysis process.

In RTA during the analysis stages, themes can be identified at both a semantic (explicit) and latent (interpretative) level (Boyatzis, 1998). The semantic analysis stays at a descriptive level where themes are identified based on participant reports and do not go beyond the obvious surface level explicit meaning of the data (Braun & Clarke, 2006). Whereas the latent level attempts to interpret the significance of the content in patterns to identify and examine underlying beliefs, wider meanings, and ideologies (Braun & Clarke, 2006; Patton, 1990). As part of the analytic process, in this study I aimed to progress from the descriptive (semantic level) to the interpretative (latent level). This method aligned with the CR 'contextualist' approach to theorise the historical and socio-cultural contexts that influence the narratives reported (Willig, 1999). As with a reflexive approach, the above reports about RTA require self-examination to consider the strengths and weaknesses of the methodology.

Strengths and Weaknesses of Reflexive Thematic Analysis

A strength of RTA is its flexibility to be used with different qualitative data types (e.g., documents, focus groups, interviews etc.). Furthermore, its allowance of both inductive and deductive approaches to analysis makes it adaptable to varying theoretical frameworks and research objectives (Braun & Clarke, 2006). Although RTA has become popular due to its many strengths, the flexibility of the approach has been critiqued for lacking rigid guidelines used by other qualitative methods. It has been reported that the lack of guidance could lead to inconsistency in how different researchers might conduct the analysis (Nowell et al., 2017). Braun and Clarke (2019) acknowledge that there can be ambiguity and inconsistency particularly when it comes to determining what constitutes a "theme" as this can be context-dependent and subjective. However, Braun and Clarke (2006) have responded to these critiques

by producing detailed guidelines on the six phases of analysis and have published an article detailing the common mistakes to avoid in TA (Braun & Clarke, 2023) which have been well received and cited in psychology. In addition, it has been argued that consistency concerns can be remedied by being explicit about the epistemological position underpinning the study claims (Holloway & Todres, 2003).

Another disadvantage of RTA compared to more specialized approaches like NA or IPA, is that RTA may lack depth when it comes to understanding the nuances of the use of language (Braun & Clarke, 2013). Alternatively, the use of language as the main metric for analysis has been challenged by CR which asserts that there are some non-verbal dimensions to life (Sims-Schouten et al., 2007). As such, CR is a framework that methodologically aligns well with RTA since the method's flexibility works well to dig deep beneath the surface of 'reality' to capture the underlying ideas that shape the semantic content of language used in the data (Braun & Clarke, 2008). Additionally, it can be argued that RTA still holds a rich and detailed examination process for analysing data. This can be viewed as a strength to the approach in enabling researchers to identify, interpret and report patterns in the data (Braun & Clarke, 2019). Kiger and Varpio (2020) also highlight how the clear description of the analysis process also allows other researchers to evaluate the steps the researchers took in conducting the research.

A significant strength of RTA is its emphasis on the role of the researcher in shaping the interpretation of data and its subsequent encouragement of using reflexivity throughout the analysis process. As such, RTA is strong in its acknowledgement of the inescapable influence of the researcher's perspective and the approach helps promote transparency (Braun & Clarke, 2019). However, some critique the fact that RTA relies heavily on the researcher's subjective interpretation of the data. It has been suggested that overreliance on the researcher's subjectivity can lead to potential biases and limit the consistency of findings (Braun & Clarke,

2019). Additionally, researcher reflexivity can be difficult to measure objectively (Nowell et al., 2017) and so some argue that it can be challenging to establish the validity, credibility and reliability of findings. On the other hand, holding a CR framework I would challenge the positivist need to 'objectively' measure researcher reflexivity. I would posit that any understanding and reporting of reflexivity would always be subjective as is any interpretation of seemingly 'objective' findings from data. Furthermore, as with the limitations of any qualitative methodology, weaknesses in RTA can be mitigated using quality criteria that exist to examine the trustworthiness, rigour and credibility of the research findings (Lincoln & Guba, 1985).

Data Collection

Semi-Structured Interviews

After considering different methods of qualitative data collection (e.g., focus groups, qualitative surveys), semi-structured interviews were chosen as the best suited data collection method for the current study. In qualitative research, semi-structured interviews are the most used data collection method, particularly for those conducting healthcare research (DeJonckheere & Vaughn, 2019), due to the possibility of using numerous forms of data analysis (DiCicco-Bloom & Crabtree, 2006; Willig, 2008). Semi-structured interviews were also chosen to enable improvisation (Lewis-Beck et al., 2012) and the option to follow change in the topic as the interview progresses (Magaldi & Berler, 2020). This data collection method allows a balance between the structured questions and the flexible participant-led nature of the unstructured interview (Smith, 1995). Due to this there is the possibility of moving away from the topic guide when important. The flexibility of semi-structured interviews highlights perceptions and experiences that might not have been expected in the early development of the interview questions but are significant for participants, and as a result alter the course of the interview (Charmaz, 2002). Thus, in line with acknowledging that the experience of working

in a racially similar therapy dyad can be understood from multiple perspectives with varying interpretations, semi-structured interviews were used as the data collection method in this research project. Details of the interview schedule, including use of consultation, will be presented in the next section.

Developing the Interview Schedule

A semi-structured protocol based on existing theoretical and empirical papers on same-race dyads (Ayonrinde, 1999; Comas-Diaz & Jacobsen, 1991; Kelly & BoydFranklin, 2005; Maki, 1999; Goode-Cross, 2011; Goode-Cross & Grim, 2016) was designed to allow probing and the clarification of questions related to the research area. The interview schedule covered various aspects of the experience of working with racially similar service-users. This included the service context and experience of same-race therapy dyads, the impact of intersectional identities, clinical implications in relation to practice, supervision and the clinical psychology profession more broadly. The five-phase semi-structured interview guide developed by Kallio et al. (2016) was used to develop the schedule and included the following phases: (1) to identify prerequisites to using semi-structured interviews; (2) to retrieve and use prior knowledge; (3) formulating and creating a provisional semi-structured interview protocol; (4) piloting the interview schedule; (5) presenting the finalised semi-structured schedule. Phases two, three and four were conducted with various forms of consultation detailed in the following section.

Consultation

To enhance the credibility and rigour of the study various forms of consultation were used (Forero et al., 2018) to help shape and develop the project. It was particularly important that some forms of consultation facilitated my own access to racial similarity with the research development process given that my supervisors in the research team did not have Black heritage. Access to my own racially similar dyads aided my continued understanding, experience and interpretation of the phenomenon of same-race dyads for Black populations.

Researcher Consultation

In January 2023 a consultation session took place with Dr David Goode-Cross, a Black CP based in the USA, who conducted similar research exploring Black therapist experiences of working with racial similarity (e.g., Goode-Cross, 2011; Goode-Cross & Grim, 2016). This consultation involved discussing the aims and findings of the research already conducted in this field and potential avenues this current project could have in building upon existing knowledge. Dr Goode-Cross offered reflections based on research conducted and shared that in clinical training there often is not enough emphasis placed on integrating identity as a Black person with the emerging identity as a CP. As such, he suggested that it would be helpful for the current study to highlight what the process of this integration entails for Black CPs. Dr Goode-Cross also suggested exploring the impact of same-race therapy on therapeutic outcomes given that it might hold relevance to the medical literature on 'race concordance' (i.e., racial matchings) by highlighting such clinical implications of the phenomenon.

In the session Dr Goode-Cross shared how a relational pull was apparent between Black therapists and their Black clients regardless of the therapeutic model used. It was suggested that participants often felt a sense of needing to hold secrecy about the pull they experienced towards their Black clients. As a result of the consultation session, I included some questions in the schedule around the outcomes and process of developing confidence in same-race dyads. We both held curiosity about whether the findings around the relational pull and urge to retain some secrecy would also be found with Black CPs in the UK given the cultural differences between the US and the UK. I also noted that Dr Goode-Cross's research had typically focused on Black therapists who reported positive connotations to working in same-race dyads. This made me more curious about the role of intersectionality in the current study. Therefore, I intentionally kept the interview questions broad to be led by the participant as to the positive or negative experiences that might exist when working in same-race therapy dyads. I also aimed

for a balance between questions eliciting positive and more challenging aspects to the experience.

Peer Consultation

Another trainee CP from a different doctoral course contacted me in April 2023 as we were both conducting similar research. This peer was conducting research on similarities and differences in therapy dyads via qualitative surveys for CPs in the UK. We continued meeting throughout the course of this project to offer peer consultative spaces for each other. I found this process helpful since, despite both projects exploring intersectionality, as researchers we held differing epistemological positions and utilised different methodological approaches. Therefore, these peer consultation sessions supported the development of my own thinking, rationale and position as I continued conducting this research.

Main Project Consultant

When embarking on this project I recognised the importance of participatory action research (Baum et al., 2006) in which participants take ownership of their stories by actively contributing to the research that relates to their reality. Participatory action research aims to equalise power in knowledge production and enable the participant voice to share their input in the development of a project. Unfortunately, it was beyond the scope of the current project given the limits of conducting research as part of my doctoral training for the research to be co-produced to an equal level with research participants. However, I was inspired by this notion and was also aware of the limitations the lens I would hold as a trainee CP who during the project had not yet completed training or worked in same-race dyads as a qualified CP. As such, I sought to recruit a consultant for the project who could use their 'expert-by-experience' status both as a Black CP who had exposure to same-race therapy dyads and as someone who had also conducted a research project with participants from the Black community. I believed insight into racial similarity within both research and therapy could also be drawn on in

consultation to offer further ecological validity to the project (Faulkner et al., 2011; Noorani, 2013). Through informal conversations with Black CPs, I noted how Black CPs can often be drawn on and expected to contribute to projects and support aspiring racialised psychologists without financial compensation. As such, I decided it would be important to compensate the consultant for their continued involvement in the project. Therefore, there was a need to clearly outline the level of involvement and commitment needed from them.

I determined that 8 hourly sessions (funded by a research fund from the University of Essex) would be sufficient and could be scheduled to take place throughout different stages of the project. I used social media (e.g., Facebook, Instagram and a WhatsApp group for Black trainee and qualified CPs) to help recruit a consultant. The consultant recruitment process was also helpful in generating initial awareness from potential future participants about the study. The recruitment led to successfully finding a consultant, Dr Jacqui Kodjokuma, who fit the criteria I was seeking regarding being a Black CP with clinical and research experience regarding racial similarity. A contract was developed (Appendix D) to outline the agreement to a commitment of 8 hourly sessions over the course of the project. The impact of the first five consultation sessions which took place before participants were recruited will be outlined below to highlight the impact the sessions had on the development of the project before data collection took place. The impact of the sixth session can be seen under the ethical considerations section, and reporting about the impact of the final two sessions can be seen in Table 2.

First consultation session. The first session took place in December 2022. The consultant offered a containing and validating space where the racial similarity between the consultant and I appeared to facilitate a sense of familiarity and comfort to reflect on the project. We explored the project aims, and the consultant offered suggestions of what to notice when examining self-reflexivity throughout the project. She suggested noticing assumptions I

may be making about participants and the data based on shared racial identity. I noted a sense of feeling validated in the project aims by someone who understood the rationale and need to explore racial similarity in therapy for Black communities without this necessarily needing to be explained in the depth required with non-Black colleagues. Interestingly, the process of engaging in a racially similar dyad throughout the consultation process enabled relational processes and themes to arise that resonate with the thesis findings reported in later chapters.

Second consultation session. In this session we examined the demographic questionnaire used as part of recruitment. This was helpful as it supported my justification and rationale as to why I had chosen each question and helped me notice what questions I initially had not included. We reflected on the need to have an eligibility criteria about how long participants need to have been qualified for. She shared that the participant should have had an adequate amount of time away from completing doctoral training so that they can reflect on this and have enough time to have gained some experience of working with racial similarity. We agreed that 6 months would be a sufficient minimal amount of time needed for participants to have been qualified for to engage in the study. The consultant shared reflections on the impact of service context and geography on the experience of same-race therapy dyads and so we included relevant items in the questionnaire. Lastly, we agreed that including an item that captured different ranges for the number of racially similar clients that participants had worked with would also be important when recruiting to gain varying exposure to same-race dyads in the participant sample.

Third, fourth and fifth consultation sessions. In the third session we explored the interview schedule together. In the fourth and fifth sessions we completed a mock interview with the consultant as the interviewee. The consultant reflected on her experience of conducting research with racially similar clients and the ease in assuming understanding in interviews by not asking follow-up questions. As such, I decided to include in the introduction

a part where I stated to participants that I might ask for further clarity to answers that I might feel I understand, but for the purpose of the interview and to not making assumptions follow-up questions will be asked where necessary. We agreed that stating this felt important to prevent participants feeling confused or misunderstood when further clarifying questions were asked at times. The consultant reflected on how important the questions around intersectionality were in capturing the nuanced experience of racial similarity.

Finalising the Interview Schedule

In addition to the consultation sessions, I completed a mock interview with one of my thesis supervisors, Dr Jasmeet Kaur, who identifies as a CP and clinical psychology doctoral course staff member with Punjabi heritage. Feedback from this led to moving the case reflection questions to before a section focusing on the role of intersectionality. This was to help clinical cases be recalled before intersectionality could then be factored in. I explored the interview schedule with my second thesis supervisor Dr Danny Taggart who is a CP, Acting Program Lead for the doctorate and identifies as having White Irish heritage. Through this discussion the need to draw on episodic examples of clinical case examples was emphasised and so I ensured prompts around offering concrete case examples were included in the schedule to gain a good sense of the phenomenological experience of same-race dyads. An informal conversation with another racialised CP was also helpful in the development of the research schedule. They suggested self-reflexivity within the interview by asking the participant to reflect on the impact of the interviewer's racial identity on the interview experience for them at the end. This seemed important to capture given the parallel experience of racial similarity in the interview dyad. Lastly, I experienced the interview schedule as an interviewee to reflect on the experience of responding to what the questions were eliciting. After this the interview schedule was finalised (Appendix E) in line with the final phase of the semi-structured interview schedule development process (Kallio et al., 2016).

Participant Criteria

Participants were invited to participate in the current study if they met the following criteria. They needed to be qualified CPs who self-identify as having Black heritage. Participants only needed to identify as having some Black heritage and so did not need to identify solely as Black (i.e., they could have dual heritage). I opted for this because I recognised that in my own experience of same-race dyads the experience had been poignant despite my client also having different racial heritage as a mixed-race individual. As such, I hypothesised that the same might be experienced by a mixed-race CP. I also felt it was important to capture the nuance and intersecting identities affiliated with Black racial heritage. The research team agreed to focus on CPs as opposed to applied psychologists more broadly to capture the implications for the context of clinical psychology training. This distinction was needed because different types of training courses would likely carry a differing ethos and focus which might make the applicability of findings about experiences of training hard to extrapolate and disseminate to training course providers more broadly. However, it is hoped that findings from this study would still be useful for all psychologists and psychological practitioners.

Participants were required to have worked in the UK as qualified CPs for a minimum of six months to increase the likelihood of having experience of same-race therapy in the UK since qualification. Qualified status was determined by confirming that participants held professional registration with the HCPC. Participants needed to have some experience of working clinically with service-users who identified as being from a background with a similar racial heritage (i.e., needed to have Black heritage). Clinical work with clients was considered as direct work with service-users (e.g., assessment, formulation or treatment). Lastly, there was no specific requirement regarding the type of service participant experiences were based in. For example, participants could have worked in statutory (e.g., NHS), third sector or private

services. Those who expressed interest in participating in the study were excluded from participation due to either being pre-qualified members of staff (e.g., trainees) or not being CPs (e.g., psychotherapists).

Recruitment

A target sample consisting of between 6-15 participants was selected since Terry et al. (2017) recommend between 6-15 participants for UK professional doctorates that use TA. Given the novelty of the project and the need to have heterogeneity within the sample the aim of 15 participants was set. Purposive sampling, a method that recruits groups who share specific experiences or characteristics, was adopted to recruit participants (Creswell & Poth, 2016). This was necessary since the study focused on participants who collectively have the experience of being Black psychologists that have worked therapeutically with service-users of racially similar backgrounds. Snowball sampling is reported as a valuable sampling method in studies where the topic might be emotive and personal, as a trustworthy source could encourage others in the population of interest (Boehnke et al., 2011; Noy, 2008). Therefore, a snowball sampling method was also adopted to improve the sampling process where enquiries were made for participants to signpost colleagues that might be eligible to participate in the study. Posters seeking research participants (Appendix F) were advertised on Facebook, LinkedIn, Instagram and Twitter. Research posters were also sent to relevant groups or organisations that include Black CPs (e.g., a Black Trainee and Qualified CP WhatsApp group, organisations like the Black, African and Asian Therapy Network [BAATN] and Clinical Psychology Doctoral courses etc.).

Ethical Considerations

On 26th October 2022 the University of Essex Health and Social Care department granted ethical approval for this project; Protocol number: ETH2122-1437 (Appendix G). The BPS Code of Human Research Ethics (Oates et al., 2021) were used to ensure the project

adhered to the ethical guidelines. Before detailing the research procedure, some of the significant codes of ethics will be detailed below in relation to how they were addressed in the project.

Informed Consent

To ensure that participants provided informed consent before engaging in the study they all received an information sheet (Appendix H) before completing a consent form (Appendix I). The information sheet described the research aims, the procedure of engagement required to participate, the benefits/risks, and how participant data would be stored. Participants were invited to ask any questions about the information provided in the information sheet. Once participants were satisfied with the parameters of the research, they were able to offer written consent by completing the consent form. On the consent form participants were also invited to consent to participating in an optional member checking exercise at the point of data analysis. At the beginning of the interview, in addition to the written consent provided further verbal consent was sought to record the interview.

Confidentiality and Anonymity

Research guidelines highlight the importance of researchers endeavouring where possible to redact or omit personal information that could potentially identify participants or any other individuals (BPS, 2021). This was particularly important considering the lack of racial diversity in the clinical psychology profession (HCPC, 2023; Scior et al., 2015; Turpin & Coleman, 2010). Given this the demographic information referred to in the reporting of this study has been grouped together across the sample. All personal data collected in transcripts were anonymised or redacted and participants were assigned pseudonyms and research ID's. Data with identifiable information was stored separately from interview recordings. All data was saved securely as encrypted electronic files. Furthermore, participants were offered the chance to review their transcripts and offer feedback on preferences for any further level of

redaction or anonymisation of information needed to preserve their anonymity. With the use of a transcription service a non-disclosure contract was signed (Appendix J) to ensure that the transcriber would also retain the anonymity and confidentiality of the participants. In this agreement it was confirmed that the transcriber would also delete the audio recorded interviews following the completion of transcription.

Right to Withdraw

Participants were reminded that their participation in the study was voluntary. They were informed of their right to withdraw from the study at any point without giving reason for this until their data had been anonymised and collated with other data items.

Risk of Harm

It was anticipated that discussion around racial trauma could arise when talking about issues of race and therapy which could generate distress for participants. Participants were reminded about their right to skip questions or stop the interview if needed. Due to some limitations to verbal and social cues over video call, I intentionally paused frequently and offered participants the chance to receive interview questions in the chat to allow participants time and more mediums to process and respond to questions. At the end participants had the option to engage in a debrief on the interview to allow for reflections or issues to be discussed.

There was a possibility of participants feeling judged or concerned about the impact of the discussion on the interviewer (given my status as a Black trainee CP) when discussing challenges in their clinical practice and the profession. I aimed to use my clinical skills in offering an empathetic, non-judgemental space whilst preserving my role as a researcher by maintaining resilience and professionalism to not impact the interviewee's perception of the capacity of the interviewer. However, the potential for distress and vicarious trauma to impact me when discussing experiences related to race and clinical training had to be considered

(Dickson-Swift et al., 2009). Risks associated with this were mitigated through supervision, using a reflective log and utilising peer support from trainees. Furthermore, a sixth consultation took place with the main project consultant during the interview process. This session was supportive in helping me to consider discussion points and initial themes as they appeared to arise in the interviews. The meeting also helped me process and reflect on challenging topics that arose during the interviews as well as planning continued avenues for exploration as the interviews progressed.

Procedure

Participants that expressed an interest in taking part in the study received a survey including the information sheet, consent form, demographic questionnaire and prompts for participants to provide their preferred contact details. Participants were then screened by the researcher to ensure they met the inclusion criteria. Their consent form and questionnaire data were downloaded and saved onto an encrypted file. Participants that met the inclusion criteria received a study invitation to choose a date and time for the interview. All interviews were conducted via video call to aid the flexibility of participation, and the recruitment of CPs based across the UK. Participants received an encrypted auto-generated link for the interviews which took place via video call on Zoom.

At the beginning of the interview participants were reminded of confidentiality and were informed that they did not have to answer all the questions if they felt uncomfortable. They were informed about their rights to have a break or withdraw from the interview at any point. Participants were also offered the chance to receive interview questions in the chat once they were asked to aid mediums of processing and responding to questions. After initial introductions took place participants were asked for verbal consent to record the interview both on Zoom and using an encrypted Dictaphone. Demographic questionnaires were used briefly to aid the interviews at times to contextualise participant reflections and acknowledge the

number of racially similar clients they initially reported having worked with. To assist participants in reflecting on the role of intersectionality an image of the Social GRRRAAACCEEESSS (Burnham, 2018) was screenshared with participants for a portion of the interviews. The interviews lasted between 60-90 minutes. At the end, participants had an opportunity to debrief about their experience of taking part. They were also offered the chance to receive their interview transcripts once transcribed to check they were anonymised to their preference. Half of the participants (n= 8) opted to receive their interview transcript to review for anonymity. Interview recordings were transferred from the video calling system and Dictaphone to a personal computer where they were saved as encrypted files. Four Zoom generated transcripts were checked against the recorded interviews for accuracy and finalised by the primary researcher. The remaining audio files were sent to the professional transcriber under a non-disclosure agreement. All transcripts were then checked against the interview recordings and manually checked for accuracy.

The transcripts were anonymised, and participants were assigned ID's and pseudonyms. As part of the anonymisation process any information that could potentially compromise confidentiality (e.g., personal/service names or cities/towns) was redacted or anonymised (e.g., broadening the geographic location to regions of the UK). Transcripts were sent to the participants who opted to receive them. Participants were invited to check that the transcripts they were anonymised to their preference, and they were told they had two weeks to respond if they wanted any further redactions or anonymisation to take place. Two participants requested brief amendments to redact potentially identifiable information. One more participant shared that no specific information needed further anonymisation from their transcript. However, they expressed concern about the potential for multiple 'chunking' of information from the transcript if multiple pieces of data were included in the final report which could then lead to participants becoming more identifiable. This participant was reassured that

this concern will be held in mind in how participant information will be presented in the final report and so data included would represent the array of participant data so that no single individual would be over-reported which might put them at risk of becoming more identifiable. The participant was also reminded that demographic information for participants will be grouped together to avoid individuals becoming identifiable too. Once amendments were made to the two transcripts requested all transcripts were finalised and were ready for analysis to be completed using RTA.

Data Analysis

Data analysis using RTA involves the following phases (Braun & Clarke, 2006, 2022): (1) familiarisation with the data; (2) generating initial codes; (3) generating initial themes; (4) developing and reviewing themes; (5) defining, refining and naming themes; (6) writing the report. These stages can be approached flexibly to suit the research question and data (Braun & Clarke, 2022). The steps taken to engage in the stages of RTA are outlined in Table 2. A quality assessment of the RTA was also completed against Braun and Clarke's (2006) 15-point checklist (see Appendix K).

Table 2

Six Phases of Reflexive Thematic Analysis (Braun & Clarke, 2006, 2022)

Phases of Reflexive Thematic Analysis	Analysis Steps
Phase 1: Familiarisation with the data	Initial reflections were noted following the interviews with some initial codes and themes represented in drawings (Appendix L). The audio recordings were listened to, and transcripts read repeatedly. Familiarisation was enhanced by noting individual reflections and patterns of initial codes and themes through notes and mind maps for each transcript and the data set as a whole.
Phase 2: Generating initial codes	Initial codes were semantically (explicitly) and predominantly latently (implicitly) generated. The codes were noted on the transcripts (Appendix M) and extracted to an excel spreadsheet. Co-occurring codes were grouped across different participants in the spreadsheet. Distinct codes were placed towards the end of the spreadsheet if they could not initially be grouped with other participant codes. A non-linear and adaptive process was used to engage dynamically over time in adjusting and moving codes as interpretations evolved.
Phase 3: Generating initial themes	The whole data set of codes were then reviewed to create more distinct and concise groupings. The process of interpreting the latent connection between codes was aided by developing mind maps of seemingly connected codes (Appendix N). Once code groupings had been refined, they were categorised into 48 ‘candidate themes’ (Appendix O).
Phase 4: Developing and reviewing themes	The initial ‘candidate themes’ were reviewed and refined by grouping themes that appeared to share a connection to others. I tried to avoid being led by the descriptive seemingly explicit connections between themes and so used spontaneous reactions to the connection between themes guided by colour matching to aid in this creative process. Following this, four initial themes and three subthemes were developed (Appendix P). A seventh consultation session with the main project consultant also aided in considering how the initial themes might be understood by the participants. Further drawings were created to help clarify the key concepts underlying the themes. The themes were then checked against the coded extracts, the initial candidate themes and the data set. After this, one overarching theme, six themes and 11 subthemes were developed and represented in a preliminary thematic map (Appendix Q).

Phase 5: Refining, defining and naming themes	All the participants had consented to engage in member checking (Creswell & Miller, 2000). As such, they were all invited to reflect via video call on the themes and sub-themes that had been developed. Nine participants expressed interest and eight engaged in reflexive discussions about the findings (some with small groups and some individually due to differences in availability). Interestingly, most participants also utilised the meeting as an opportunity to connect with peers in the field. The discussions aided my reflections about my interpretation of the data and prompted further interpretation about the connection between themes. The themes were also reviewed by the supervisory team who advised to refine names for some of the themes. The final eighth consultation session with the main project consultant helped in reviewing the final themes and sub-themes to reflect on the implications these might have for the write up in the report.
Phase 6: Writing the report	The current report summarises my interpretation of the narrative accounts provided by participants to address the aims of the study. These accounts are discussed in the findings and discussion chapters. The report is supported by data extracts that illustrate the complex nuanced experiences expressed. The implications of these findings are also discussed.

Critical Appraisal and Self-Reflexivity

In the following section, a quality appraisal of the study and further positioning of myself within the research will be presented.

Critical Appraisal of the Current Study

Emphasis on the validity, reliability and universal replicability of research typically used to critically appraise quantitative studies are not appropriate for a qualitative research paradigm given their epistemological underpinning in positivism (Smith, 2003). As such, the qualitative CASP (2018) criteria used in the systematic literature review was used to critically appraise the quality of the current research project as can be seen in Table 3.

Table 3

Critical Appraisal of the Current Study using CASP (2018) Criteria

Qualitative Appraisal Criteria **Key:** ✓= Yes ✗= No ?= Cannot tell	**Criteria**	**Evidence for meeting the CASP criteria**
1. Is there a clear statement of the aims of the research?	✓	The aims of this study were to explore how Black CPs in the UK experience working with racially similar clients. The aims and research sub-questions were clearly stated in Chapter two.
2. Is a qualitative methodology appropriate?	✓	A qualitative methodology appeared appropriate to explore Black CPs' experiences of same-race therapy dyads using explorative and open-ended questions to gain this insight. Adopting this methodology also facilitated an adaptive and flexible approach to respond dynamically to the data collection and analysis. This dynamic approach enabled in-depth and breadth of nuanced reports to be gained for the complex topic explored.
3. Was the research design appropriate to address the aims of the research?	✓	The systematic literature review highlighted a gap in qualitative research exploring Black CPs' experiences of racial similarity in therapy. A qualitative methodology appeared suited to address the research aims given this gap in the literature. Furthermore, RTA was chosen due to its flexible and transparent stance which aligned well with a CR epistemology. The use of various forms of consultation and pilot interviews also affirmed the relevance of using a qualitative research design for the research topic.
4. Was the recruitment strategy appropriate to the aims of the research?	✓	The study used both purposive and snowball sampling to improve the recruitment of participants. Using a snowball strategy was particularly effective as signposting from trusted sources often helps increase interest and engagement from research participants (Berg, 2014).

5. Was the data collected in a way that addressed the research issue?	✓	Participants were interviewed via video call which enabled use of a semi-structured interview to allow for open-ended in-depth questions to be asked. Offering the interviews virtually also enabled flexibility in attendance which was important given the busy context of working as a CP. Additionally, conducting virtual interviews meant that the sample could contain more diversity to include psychologists working across the UK. Further details about the collection process are outlined in the early parts of this chapter.
6. Has the relationship between the researcher and participants been adequately considered?	✓	Considering my 'insider-outsider' (Dwyer & Buckle, 2009) positionality as both a Black trainee CP and primary researcher in the study, it was important to situate myself transparently and use different mediums to recognise how my personal lens subjectively shaped the project. Recognising my influence on the project was achieved by positioning my relationship to the project in the introduction chapter and by writing reflexively where appropriate throughout the report. Additionally, regular supervision, using various forms of consultation, using a reflective log (Appendix R), making reflective notes/observations and using reflective member checking sessions were also helpful methods to consider the relationship between the participants and myself as the primary researcher.
7. Have ethical issues been taken into consideration?	✓	Ethical issues have been reflected on and addressed throughout the project. The ethical considerations section of this chapter particularly highlights the consideration of ethical issues. Furthermore, a thorough risk assessment to address environmental, situational and psychological risks to participants was conducted and approved by the Ethics Committee.
8. Was the data analysis sufficiently rigorous?	✓	An in-depth and rigorous analysis of the data was outlined in the analysis section which detailed the dynamic and iterative steps taken to develop the final themes. As part of the analysis process quotes were extracted to represent themes including different facets within the dominant narratives. Reflective member checking sessions with participants also helped develop my interpretation and understanding of the impact of the findings. Although the

		purpose of these meetings was not to 'credibility check', participants shared that overall the findings were representative and consistent of the experiences reported in the interviews.
9. Is there a clear statement of findings?	✓	A summary of the research findings in relation to the research sub-questions are highlighted at the beginning of the discussion chapter.
10. How valuable is this research?	✓	The current study is the first to look at Black CP's experience of same-race therapy dyads. The findings contribute to a field often saturated with studies that typically explore experiences of therapy with racialised clients from a White therapist perspective. As such, it is hoped that this study will help to amplify the voices of this marginalised group of racialised CPs. The findings from the study offer significant clinical implications for how equitability, diversity and inclusivity can be conceptualised and operationalised for CPs, mental health practitioners more broadly, training courses, supervisors, service providers and the field of clinical psychology. It is hoped that advancements can be made to enhance the experience of clinical psychology for all, particularly for marginalised clients and practitioners from racialised backgrounds.

Self-Reflexivity

Reflexivity is an important way for qualitative researchers to ensure rigor and quality in their work and is the gold standard for establishing trustworthiness (Teh & Lek, 2018). For instance, highlighting the researchers' values, knowledge, experiences, biases, and beliefs improves the credibility of the study and acknowledges how knowledge is co-constructed through the researcher-researched relationship (Cutcliffe, 2003; Finlay, 2002). An integral part of self-reflexivity is one's capacity to examine their own social identity to reflect on how this interacts with the population being studied (Day, 2012). As a Black British Caribbean female trainee CP, I bring many personal and professional experiences and perspectives relevant to this study. To aid in my transparency about aspects of my identity, opinions and values that influenced the study, I completed two tiers of the 'Social Positionality Map' (Jacobson & Mustafa, 2019) which can be seen in Appendix S. I have also included excerpts from my reflective log taken from different stages of the research project, including the interpretation and analysis of the findings. Supervision from the research team and engaging in consultation helped me reflect on my position, assumptions and beliefs that I brought to the inception, development and writing up of this research project.

I consider myself to be an 'Insider-Outsider' (Dwyer & Buckle, 2009) researcher and this positioning in the study greatly informed how I approached, engaged with and interpreted the findings. Throughout the study I regularly reflected upon the role that my 'insider' positioning through my racial and professional similarity to the participants might have. Such reflections were integral to my own growing understanding of the impact of racial similarity and intersectionality being investigated in the project. I noted how in interviews the visible racial similarity between myself and participants often fostered a sense of familiarity, trust and solidarity. When listening to interviews and reading transcripts at times I noticed myself experiencing humour, joy and a sense of empowerment mixed with sadness, confusion and

disempowerment when positive and challenging experiences related to race within clinical psychology were shared.

At times participants noted an ease and trust in offering their insights and expressed a desire about something meaningful arising for our community of incoming Black CPs in the field. Sometimes this led to a sense of hope and excitement for the future and other times this resulted in a pressure and anxiety about how I would 'accurately' interpret and present their trusted stories. This pressure could be heightened considering that my participants could be deemed my more powerful superiors as qualified CPs. Indeed, in a clinical capacity my participants could be my clinical supervisor with the power to pass or fail me as part of my doctoral training. Yet, as research participants I also held a power in interpreting and telling their stories carefully whilst preserving their anonymity given the few Black CPs in the profession.

Occasionally I found myself feeling emotional when aspects of my culture as a Black British Caribbean individual were reflected upon in interviews. I felt a sense of pride that these personal aspects of myself could be brought to an academic and predominantly White institution. Alternatively, I found my 'outsider' position as a trainee and researcher helpful at times to ensure I retained a sense of openness and curiosity. I learnt to expand beyond our racial and professional similarities to explore and capture the meaning of the reflections shared by each individual participant. Such reflections illustrate the complexity of intersecting similarities and differences which have been important to recognise within myself. These reflections often mirror the stories at the very heart of this research project.

I have noticed my positioning evolve as I have developed throughout the years of training too. I recognise the limits of my perspective and position as a trainee who has never worked as a qualified CP. However, my personal and professional perspectives have evolved

both due to my involvement in this project and the fact that I too am soon to become a qualified CP. Given this shift in my evolving identity, the initial underlying questions I held have expanded beyond ‘how can Black CPs be supported to practice with cultural sensitivity when the client’s race is similar to their own?’. Through this study I have learnt that there are some innate understandings and adaptations Black CPs hold that come from a deep-rooted connection and understanding of the racial and cultural context of Black clients. These findings gathered in the study will be presented now in the next chapter.

Chapter Four: Findings

Chapter Overview

The following chapter presents the study's participant demographics and thematic findings developed from RTA of the 16 interviews. Verbatim extracts from the participants will be used to illustrate how the data was interpreted. Where reference has been made to participants, pseudonyms have been used and potentially identifiable information has been redacted to preserve anonymity.

Participant Demographics

Twenty-one people expressed interest in participating in the project. Two later reported being too busy to attend and three did not respond to contact attempts to participate in the study. As a result of the demanding interest the initial target sample size was expanded slightly to help amplify the voice of Black CPs through the research. As such, 16 participants were recruited to the study. The sample consisted of 14 females and two male CPs between the ages of 27-49. There were 14 participants who self-identified as Black British (n=9 Black African; n=5 Black Caribbean) whilst two identified as British with mixed racial heritage (n= 1 White and Black African; n= 1 White and Black Caribbean). The sample included participants that had trained across North, East, South, West and Midland regions of the UK. Despite the Western region not being reported in the questionnaire as a place where same-race therapy dyads were experienced, this was later reported in interviews. As such, all regions were also reflected upon in interviews where same-race dyads were experienced.

In addition to questionnaire completion, in interviews further services were mentioned where participants also worked with Black clients. It should be noted that all participants that reported offering private practice also worked in an NHS service. Furthermore, in interviews some participants later reported recalling more Black client encounters than were originally reported. However, interestingly most participants (n= 10) appeared to either self-report having

minimal (‘1-5’) or a relatively high number of contacts (‘20+’) with same-race clients. Table 4 summarises key demographic information gathered from the demographic questionnaire. In the interest of maintaining confidentiality and anonymity, demographic information has been grouped with the number of participants shown in brackets and separated from assigned pseudonyms with each demographic category presented individually in rows (with no correlation to the categories in rows above or below). Appendix T details the list of pseudonyms used for participants.

Table 4

Key Participant Demographic Information

Demographic information	Number of participants				
Gender	Female (14)	Male (2)			
Age in years	27-34 (11)	35-42 (3)	43-49 (2)		
Ethnicity	Black African (9)	Black Caribbean (5)	White and Black African (1)	White and Black Caribbean (1)	
Region worked with same-race client	North of England (3)	Northeast England (1)	East of England (4)	Midlands (2)	Southeast (4)
Service worked with same-race client	Child and Adolescent Mental Health Services (NHS) (3) Weight management (3rd sector & NHS) (1)	Private practice (5) Psychosis (3) Rough Sleepers (1) Forensic (NHS) (3)	Oncology (3rd sector & NHS) (1) Paediatrics (NHS) (1) Refugee (1)	Staff Support (NHS) (1) Learning Disability (NHS) (1) Adult Community Mental Health Team (5)	Community Psychology (1) Perinatal (1) Inpatient (2)
Region completed doctoral training	North of England (3)	Midlands (3)	Southeast (6)	West of England (1)	East of England (3)
Estimated range of contacts with same-race clients	1-5 (5)	6-10 (2)	11-20 (4)	20+ (5)	
Range of time qualified	8 months-19 years				

Note. (N= 16), however service figures show that participants often worked in multiple services. Two participants opted to discuss service/region experience at interview instead.

Reflexive Thematic Analysis

An overarching theme, six themes and 11 sub-themes were created (see Table 5 and Figure 2).

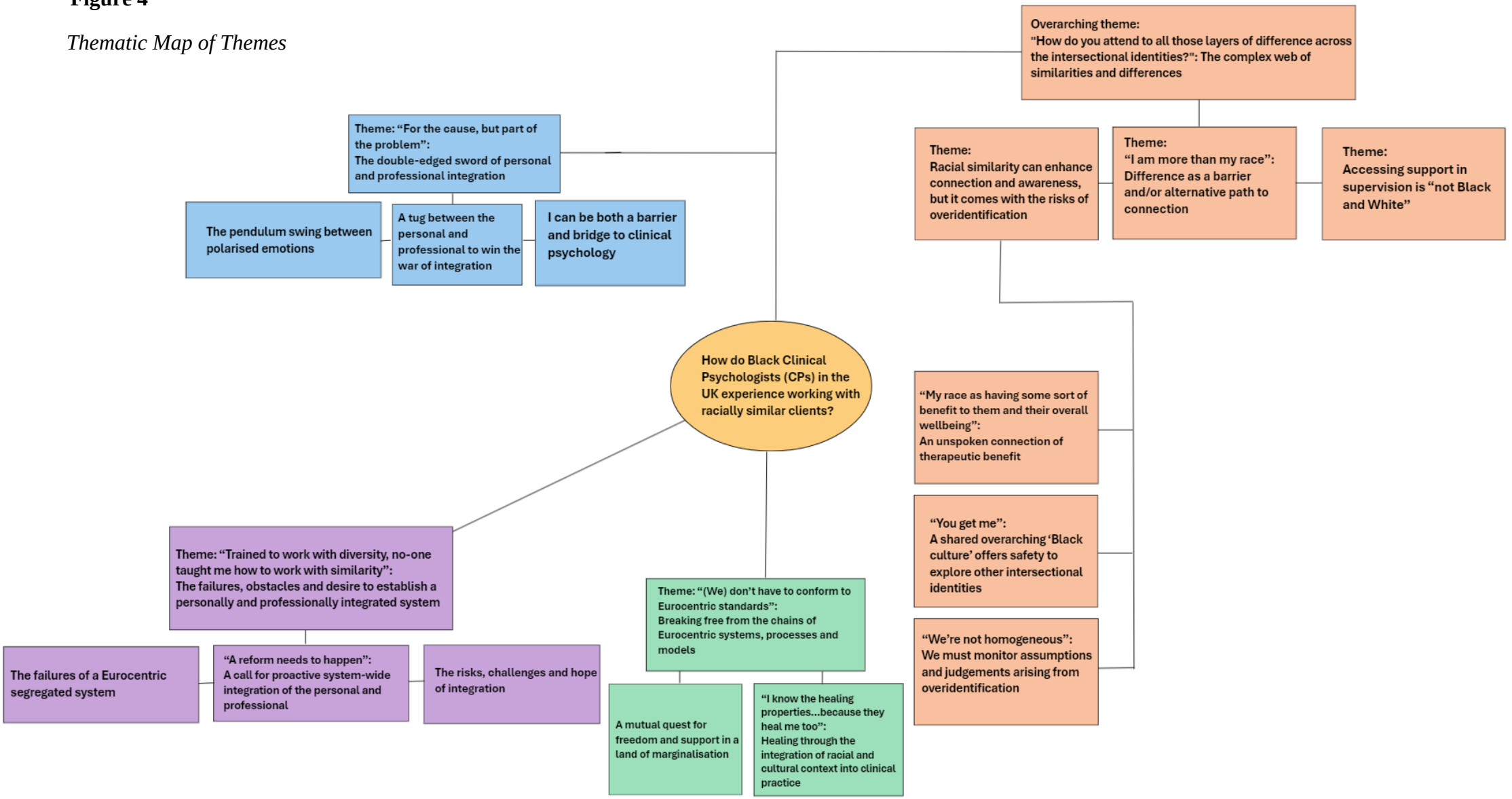
Table 5

Table of Themes from the Current Study

Overarching Theme	Main Themes	Subthemes
"How do you attend to all those layers of difference across the intersectional identities?": The complex web of similarities and differences	**"For the cause, but part of the problem": The double-edged sword of personal and professional integration**	The pendulum swing between polarised emotions A tug between the personal and professional to win the war of integration I can be both a barrier and bridge to clinical psychology
	Racial similarity can enhance connection and awareness, but it comes with the risks of overidentification	"My race as having some sort of benefit to them and their overall wellbeing": An unspoken connection of therapeutic benefit "You get me": A shared overarching 'Black culture' offers safety to explore other intersectional identities "We're not homogeneous": We must monitor assumptions and judgements arising from overidentification
	"I am more than my race": Difference as a barrier and/or alternative path to connection	
	Accessing support in supervision is "not Black and White"	
	"(We) don't have to conform to Eurocentric standards": Breaking free from the chains of Eurocentric systems, processes and models	"I know the healing properties…because they heal me too": Healing through the integration of racial and cultural context into clinical practice A mutual quest for freedom and support in a land of marginalisation
	"Trained to work with diversity, no-one taught me how to work with similarity": The failures, obstacles and desire to establish a personally and professionally integrated system	The failures of a Eurocentric segregated system "A reform needs to happen": A call for proactive system-wide integration of the personal and professional The risks, challenges and hope of integration

Figure 4

Thematic Map of Themes



Theme: "For the cause, but part of the problem": The double-edged sword of personal and professional integration

This first theme highlights the numerous polarising emotions, positions and encounters that Black CP's experience when integrating their personal self as a Black person with their professional identity as a CP in same-race therapy. The subtheme '*The pendulum swing between polarised emotions'* addresses the contrasting emotions participants reported experiencing when interacting with Black clients. *'A tug between the personal and professional to win the war of integration'* describes the conflict participants reported experiencing between their personal selves as Black people and their professional selves as CPs to gain the possible benefits of integration for all. The subtheme *'I can be both a barrier and bridge to clinical psychology'* captures reflections from participants on how their integrated identity as Black CPs could both facilitate or prevent Black clients from engaging with the professional network and the field of clinical psychology.

Subtheme: The pendulum swing between polarised emotions. All participants, like Dominique, described an array of contrasting emotions that were experienced when working with Black clients:

> *"I oscillate between feeling very hopeful and energized to then feeling very hopeless and disenfranchised…they're kind of both sides of the same dilemma…you tip quite quickly from one to the other depending on how things are received…barriers that you face…how isolated you are." (Dominique)*

Participants, like Samuel, often linked their emotions triggered by same-race therapy to the wider context of racial underrepresentation within the profession:

> *"I've never met a Black person in the field of psychology…in terms of someone attending a therapy session seeing a Black person was unusual…part of the joy*

was…knowing that I'll get to work with someone who was Black…it just made me feel quite joyful that this person managed to get through the gate basically because it doesn't happen." (Samuel)

Likewise, Michaela shares enthusiasm about simply being exposed to Blackness in her work:

"I've loved being able to…spend so much time with around Blackness…around so much Black joy, Black strength, Black power." (Michaela)

Participants, like Melissa, often described an anxiety arising from heightened expectations about the trajectory of therapy for their Black clients. This anxiety was also heightened by reduced exposure to same-race therapy:

"At the beginning, because it was so rare, I was really nervous…it meant more to get it wrong with a Black person…if I got it wrong with a White person there are many factors at play…there was an extra pressure or load that felt like getting it wrong with a Black person was a different type of failure. That I'd let the community down, I'd let my family down, I'd let like the Black race down." (Melissa)

Further challenging emotions were experienced by many participants, like Grace, due to familiarity with difficult racialised experiences:

"There's moments of like deep sadness when you relate to some of the experiences, whether that's around racial trauma or…narratives around feeling…rejected within communities…it's working with something that you yourself are navigating through and haven't still got the answers to and trying to make sense of that as well." (Grace)

Similarly, like other participants Renee highlights how the visible similarity can heighten the connection to painful experiences Black CPs witness Black clients endure:

"I connected on a different level it's horrible going to a child's funeral…but this was extra horrible…not just because he was a child, because that would impact anyway, but because he was a child that looked like my little boy which was really hard." (Renee)

Subtheme: A tug between the personal and professional to win the war of integration. Most participants, like Melissa, reported struggling to negotiate their contrasting personal racialised and professional identities:

"There's a tug of war in me that is fighting the internalized western values…I do find myself frustrated or kind of saddened by the ways in which being confronted with Blackness also reminds me of the distance I have from Black culture in some ways." (Melissa)

Samuel expanded on why developing your identity as a CP might resort in losing connections with Black identity as a process of assimilation and he describes the impact this had when encountering a Black client:

"There's not many Black people in the profession…you sort of adapt…change the way you are to fit in…part of the real you, it gets a bit lost in that process sometimes unfortunately…if perhaps I hadn't moved away from my background, I think maybe I would have been more able to acknowledge the racial similarity…so I think it made it harder. I think if I had the strong links maybe I would have felt less anxious." (Samuel)

Tianna shares further implications that the struggle between the personal and professional identities can have for same-race therapy:

"A young man said to me…'Don't you feel like a sellout?'…part of the team who seemingly are detaining him, but also being someone who might understand his background…there was an element of how can you be for the cause, but also part of

the problem?…one of the challenges for me has been…having to put my personal and professional together to think how can this work together?" (Tianna)

Afia offers a different clinical implication about how conflict between the cultural and professional lens can arise when making decisions in same-race therapy:

"We had a very similar cultural background, and she had mentioned something that I had to report…I understood the context in which it happened…but I knew in the context of my job I had to take it further…I really, really struggled knowing that something was culturally okay…but not culturally acceptable here." (Afia)

Contrastingly, Renee offers an example of how the contradicting professional and cultural perspectives can be used for therapeutic benefit with Black clients:

"As a psychologist I felt…this is harsh for this young lad…but actually, as a (ethnic group reference) parent, and she was a (ethnic group reference)…I absolutely could see why she was doing those things…that advantage…I've been able to ask questions that perhaps my White colleagues might feel really uncomfortable asking." (Renee)

Despite the challenges experienced in negotiating two often contrasting identities, participants, like Candice, described the hope that can come from utilising this integration:

"There's something quite joyous about just being able to be yourself…a Black psychologist, and how that can actually help people to connect more with psychology…you can exist in both worlds…that world I can connect with the person but having my foot in the other world I can connect with the system, and I think there is an advantage to having both." (Candice)

Sarah extends the benefit of personal and professional integration to the wider service and profession:

"I've developed a way of harnessing those areas and I'm able to input into service development…the benefits to the wider profession. So, I teach on a lot of DClinPsych courses…that lived experience as a Black person, but also…experience of working with clients who are Black." (Sarah)

Subtheme: I can be both a barrier and bridge to clinical psychology. Participants often spoke about how integrating their identity as a Black individual into their role as a CP could act both as a bridge in connecting clients to the field of clinical psychology whilst also stopping clients from wanting to interact with others. Melissa describes how she can use her connection to clinical psychology and the Black community to help bridge gaps in understanding psychological language for Black clients whilst also supporting her own personal and professional development too:

"Our language is different to…psychological literature and so I like almost being an interpreter. I get to bridge the gap…being an intermediary and an advocate has been something that's definitely broadened my knowledge. It's made me more confident as a professional. It's made me more thoughtful about the biases I have as well in my own life." (Melissa)

Candice provides an example of how the bond and trust developed with a racially similar client can be used to bridge connection to the wider professional network:

"He is still like, 'no I don't want people coming to my house'. I'm like, '…you are worried that they are going to come and try and kill your vibes and stop you from doing what you are doing'…'that's not how it is. They are trying to help you'…he got discharged in the end and I think I made some recommendations for him to have follow-up psychology…that was again a lovely piece of work." (Candice)

Some participants, such as Michaela, described how this connection can stop clients from wanting to engage with non-Black professionals:

> *"Sometimes there's an idea that kind of having a good relationship with myself might improve their relationship to help and they might seek support from other people. But sometimes it's been the opposite…how can young people get bridged back into working with a White professional down the line who might not get them? How can kind of that feel okay for them?" (Michaela)*

Overarching Theme: "How do you attend to all those layers of difference across the intersectional identities?": The complex web of similarities and differences

The question asked by Grace *"how do you attend to all those layers of difference across those intersectional identities?"* underpins the reflections by participants captured in the one overarching theme. The theme overarches three themes: *'Racial similarity can enhance connection and awareness, but it comes with the risks of overidentification'*, *'"I am more than my race": Difference as a barrier and/or alternative path to connection'* and *'Accessing support in supervision is "not Black and White"'*. The overarching theme encapsulates the complex role intersectionality plays in attending to a web of varying levels of simultaneous similarity and difference in same-race therapy and racially similar or different supervisory dyads. To maintain the readability and consistency of the themes and sub-themes, the themes within the overarching theme have been written using the same heading style as the overarching theme.

Theme: Racial similarity can enhance connection and awareness, but it comes with the risks of overidentification

The second theme focuses on the role participants described racial similarity having in increasing understanding and connection alongside subsequent risks of overidentification in

same-race therapy for Black CPs. The subtheme ‘*‘‘My race as having some sort of benefit to them and their overall wellbeing”: An unspoken connection of therapeutic benefit’* describes the impact that visibly sharing a racial identity with Black CPs often had on connecting with Black clients and staff alongside increasing their sense of wellbeing. The initial connection reported through the racial connection could be better understood and enhanced by *‘‘‘You get me”: A shared overarching ‘Black culture’ offers safety to explore other intersectional identities’*, which captured the reports of shared cultural understandings associated with being Black that enabled exploration of other intersecting identities with clients. The third subtheme *‘‘‘We’re not homogonous”: The crucial need to monitor assumptions and judgements arising from overidentification’* describes the need participants highlighted around acknowledging the heterogeneity that exists amongst Black communities given the risks of overidentifying with a shared racial heritage.

Subtheme: “My race as having some sort of benefit to them and their overall wellbeing”: An unspoken connection of therapeutic benefit. Many participants, such as Dominique, reported that their shared racial identity appeared beneficial to the therapeutic relationship before the connection had been explored with clients:

> *"I don’t think any White client has ever…commented on my race as having some sort of benefit to them and their overall wellbeing, or their sense of connection, or…sense of hopefulness…it as a baseline…has been an intervention on its own without me necessarily having to do anything in a way." (Dominique)*

Dominque shares how this racial connection can create a visible difference in Black clients’ sense of safety with Black professionals and can be privileged above the seniority of non-Black colleagues:

"Even if I was maybe the most junior person in the room the family would speak to me…they would look to me for my guidance, reassurance, containment…in a way that they didn't with other people in the room…I was usually one of the few Black people…it felt like it was quite noticeable when that was happening…more assumed level of trust, sense of safety, maybe sense of being seen." (Dominique)

Michaela describes how the racial representation that her presence reflected could offer inspiration to younger clients:

"Young people…getting to see professionals who look like them…opening up the idea that they themselves could you know work in these…majority White fields." (Michaela)

Melissa highlights how being in a location with minimal racial diversity might also heighten the sense of benefit gained for Black clients encountering Black CPs:

"People have described like relief or inspiration in seeing someone in this position, especially since where I am specifically there's like very, very few…clients…tend to be quite excited because this is an anomaly to them." (Melissa)

Grace describes the mutual comfort gained for CPs in response to knowing Black clients benefit from their shared racial identity in same-race therapy:

"I feel a greater level of comfort where I feel less like I have to prove myself…knowing I've been intentionally sought out because of those identities that I hold." (Grace)

Candice shares how the positive impact of increased racial representation through Black CPs can extend to other staff too:

"Some people did say to me, both nursing and patients…'it's nice to see and I value and appreciate a Black psychologist on this ward'. Just the fact that I exist. It's like,

okay, I'm good. One of my people is here. There's something…they can take pride in. You're there, that makes them feel a little bit good." (Candice)

Subtheme: "You get me": A shared overarching 'Black culture' offers safety to explore other intersectional identities. All participants described their clients feeling as though they would *"get them"* due to connecting over various aspects of an overarching 'Black culture'. Faith describes how cultural solidarity enables exploration of other intersectional identities:

"There seemed to be a… flexibility that allows you to question things or explore things with a depth…that comes from…prior knowledge or experience based on the similarities of your culture…this…freedom to talk about maybe their spirituality, for example, and talk about their strength…that hasn't been the case with other clinicians…which would then open an avenue of thinking about other potential resources for this person." (Faith)

Grace offers examples of cultural connections through language that can increase comfort and exploration in therapy:

"There is often a level of comfort that people can…jump into at the beginning of sessions…whether they've had therapy before or not…it feels…colloquial…shared nuances around phrases…or you drop into…whatever accent…there's…a shared…discourse…that allows people to…more readily just think about the different layers of that experience." (Grace)

Similarly, Rochelle describes how a shared cultural connection can also ease the psychologist's comfort to bring themselves and increase their confidence therapeutically in same-race dyads too:

"I feel like I can be authentic because I don't have to code-switch either when I'm with my Black clients…definitely much more relaxed…when Black clients aren't doing what we agreed…there's a lot of like comfortability for me to not just use humor…but also hold people more accountable. Like I can challenge more…I don't feel like I'm doing something wrong or upsetting the client." (Rochelle)

Jonathan also describes the significance a cultural connection can hold for Black CPs who share further ethnic similarities through a shared cultural heritage with clients:

"If you could think about the (country of heritage) as home…it is like going back home and meeting someone and having a good chat or a good connection without actually going home…I value that." (Jonathan)

Participants often described clients as having interest in learning more about Black CPs personally. Melissa shared the benefit of using self-disclosure to utilise the shared racial and cultural connections to overcome the client's perceived difference in the CP given their professional identity:

"I think overcoming that was just being honest and candid that actually outside of being a psychologist, I also had…experienced frustration about what it means to be Black sometimes. And I think being allowed to engage with anger in front of me when perhaps that's what she'd been penalized for and brought her to the service meant that she trusted me to share what was underneath that anger." (Melissa)

Another therapeutic gain is shared by Rochelle who illustrates how shared cultural norms associated with Black identity can positively impact attendance from clients and flexibility offered by CPs in same-race therapy:

"I think about my Black clients who will come to their sessions with only half of their hair braided because they know I won't judge them. And if this was another appointment

they wouldn't have come. But also, I might know how difficult it is to get an appointment with someone, so I might be more flexible to rearrange." (Rochelle)

A further advantage through the enhanced cultural understanding is what Tianna describes as Black CPs' ability to reduce re-traumatising clients by limiting the need for them to re-explain their racial trauma:

"There's been a sense of feeling heard without necessarily having to give everything if that makes sense…I hope that I've been able to give to my clients a level of understanding that says that I get it, but you don't have to give me everything because I understand. And for so many people, that's really important, especially when doing trauma work." (Tianna)

Many participants, such as Tianna, shared the role that shared racial and cultural connections can have in strengthening comfort and safety if this was absent in the service context:

"A sense of familiarity, particularly for these men who have been…forcibly detained…on a schedule that they don't want to be on. To see somebody who might…understand the things that they talk about in a way that professionals don't…I've noticed that it has at times allowed me to…engage people in settings where they have already been deemed really hard to engage." (Tianna)

Participants often reported that therapeutic outcomes in same-race therapy were not different from non-Black clients. However, they reported how the dynamics in therapy felt different. For example, participants like Dominique reported an enhanced sense of physical and emotional intimacy due to the increased comfort in same-race dyads:

"Black clients were more likely to initiate some sort of physical touch...the proximity within the room often felt more kind of familiar, more relaxed, less kind of

threatening…going to…difficult…meetings…them wanting me to hold their hand…or reaching out to hug me. Sharing very kind of intimate personal details very early on in our relationship even if that wasn't necessarily kind of the reason that we were meeting." (Dominique)

Subtheme: "We're not homogeneous": The crucial need to monitor assumptions and judgements arising from overidentification. All participants, like Sarah, described the heterogeneity across Black populations and emphasized the need for assumptions and judgements to be examined to not overidentify with racial similarity in same-race therapy:

"We're not homogeneous…there might be some points of connection because they see me visibly as a Black person…but…if I'm working with a young Black man, I don't hold that experience that he might have with the police…because I'm a female. So…I shouldn't over assume that we are completely the same…they might also over assume things like if they're talking about…getting beatings as a child they will assume that I was raised in that similar context, and I wasn't." (Sarah)

Jonathan offers further insight about what participants reported happening less frequently, where client overidentification about shared racial and cultural heritage with Black CPs could create challenges for therapy due to negative associations with one's own race and culture:

"When she saw me come out it was her worst nightmare because…people…within (country name) heritage…would be more critical of her…she feared then that…judgment…from her own community when she told them about her diagnosis or…psychological challenges…it can happen where you then think will you now be rejected because the person is looking at you thinking that you represent for them the

rejection that they have gotten from their community? But…that…is experienced less frequently." (Jonathan)

Grace presents a further challenge explaining how trying to not overidentify with racial similarity with clients can at times be hard for clients to be receptive to:

"Because of the level of ease and because of the assumed similarities I remember a client getting frustrated that I was asking more questions…a frustration of having to teach me in that moment, and this assumption that you will just know…having to just kind of remind them that whilst we have a shared identity, we might have different experiences, different ways of relating to it, and so it's their session and it's helpful to understand from their perspective." (Grace)

Many participants also described how overidentification with racial similarity can lead to blurred boundaries. Grace shares how this blurring of boundaries can be heightened in remote private practice:

"Sometimes that level of comfort and ease can sometimes slip into the blurring of boundaries…Moreso in private practice…some clients become more and more comfortable given its remote working, then it's wearing a bonnet and then it's in bed…it…indicates a real level of comfort" (Grace)

Khadijah shares how clients can use the sense of racial overfamiliarity to evoke guilt from the psychologist to try to enforce certain actions. However, she acknowledges how similar feelings might be evoked from clients of other races due to their clinical presentation:

"Over familiarization or expectations because I'm Black…she really wanted me to write a letter that I wasn't comfortable writing, but it was very much…'you know what it's like to be a Black person and no one else is going to help me'…that…guilt tripping was…emotionally difficult for me because it tied into…feeling responsible and if I don't

who will?…and I have White clients who have…Emotional Unstable Personality Disorder that I've been drawn into…similar things with but in different ways." (Khadijah)

Afia reflects on the challenging implications of comparative judgements that can arise from CPs in same-race therapy due to overidentifying with similarities and the desire to see Black people succeed:

"It was more like peer supervision…I could feel myself getting annoyed…there's something about hearing their story and thinking…but we're the same age…our experiences were quite different, but I was like there's no reason for her to be there…wanting to…pull people along because…I want to see you in the same place I am…there's something in that the pull…it might be detrimental to the therapeutic relationship as well as a help." (Afia)

Participants, like Faith, frequently referenced the need to self-monitor assumptions or judgements when working with racial similarity:

"There's an awkwardness for me in that I'm constantly having to be really mindful and present and slow to speak because I need to make sure it's not coming from a place of, I know this dynamic, but instead coming from a place of curiosity…just because something feels really familiar doesn't mean…I know where this is going." (Faith)

Significantly, Dominique highlights how challenging assumptions arising due to overidentification can be managed using curiosity:

"The assumptions that can come…because you share a similar…skin tone…like worries and projections…can…surface. But…you can just be a bit more curious about that." (Dominique)

Theme: "I am more than my race": Difference as a barrier and/or alternative path to connection

All participants emphasized, as illustrated by Jonathan, the fact that there are many more facets to their identity beyond their race:

> *"I think I am more than my race…I can connect with someone…who is my race, but also feel a stronger connection with someone who is female, who is 90, who is White, right? Yes, so I don't think it is as simple as that." (Jonathan)*

As such, this third theme describes the role that differences between intersecting identities can play in same-race therapy. There was no single way a difference in identities was reported to be experienced, however participants reported ways differences could create barriers to connection by reducing a sense of familiarity or by introducing challenging race-related cultural beliefs about the difference. However, differences in intersecting identities were also reported to facilitate connection through curious exploration of the differing identity or by avoiding race-related barriers that similarity may have created. For instance, Esther describes how being of a different gender to her male clients enabled them to move away from gender norms associated with masculinity:

> *"Had I been a male…I would have got a…different version of their experience…that went into the male stereotypes of being okay and not being vulnerable. Whereas I think being female enabled the patients…to be more vulnerable…sharing…their emotional responses to particular life events…I think gender in the context of having a racially similar background helps with that." (Esther)*

Contrastingly, Grace shares how Black men reported how working with a therapist of a different gender heightens cultural and societal stereotypes about Black men perceived by Black women:

"For one guy, I remember almost there being a hesitation around being vulnerable because of, 'oh, but you, Black women…always expect us to be strong'…he was foreground in…the narratives…he had about expectations Black women have of him…when he's feeling more emotional…on the edge of kind of sadness…he's like…'men don't cry'." (Grace)

Esther reflects on how being younger than her clients at times may have helped older clients view her as someone that could offer a new perspective:

"The clients I am thinking of are generally roughly 10 years older than me at the time…I think being a young Black female helped…I could bring a new way of…understanding their distress rather than the perception of somebody that is quite entrenched in their views." (Esther)

Alternatively, many participants like Dominque shared challenges that arose in same-race therapy with elders due to cultural norms about hierarchy:

"From a cultural perspective…thinking about age…in terms of hierarchy…how you approach your elders in a particular way, it feels…counter…sharing power, talking about things…in slightly more psychological terms…it can feel very new and overwhelming. So, to do that in front of someone that's younger than you. I know that has been quite challenging for many of my clients. But we have still been able to talk about it and name it." (Dominique)

Some participants, such as Rochelle, shared how harmful and discriminatory beliefs could be held within the Black community that oppress intersecting identities such as identifying as homosexual or queer:

"It's really hard when you are positioned in solidarity with each other because of race and then maybe someone shares like an anti-queer belief…or people say things that are

oppressive to other parts of your identity…that can sometimes put a bit of tension on the situation. And so that requires I think harder work in how I navigate that and make sense with that…it makes me think of that old…Southern American saying…'not all skin folk is kin folk'." (Rochelle)

Samuel describes how several intersectional differences *"diluted"* the racial connection between himself and a racially similar client:

"She was half Caribbean and half White. And at the same time, she had the (local area) accent…she used (local area) slang. So she wasn't like the typical Black person that I was used to…maybe the geography diluted the racial side a bit…she did present more like a White teenager…and if she was…a young Black male…there probably would have been a stronger connection there…gender dampened the impact of race…if it was a young Black male…I might have said what I wanted to say about the race." (Samuel)

When reflecting on cultural differences many participants, including Afia, described how this could be used to foster curiosity and connection:

"Somebody who's racially similar but from very different cultures and just getting to understand that…is a good…way to build a rapport…I do always see it as a positive when I get to genuinely be really open and curious about someone's culture and what they might have experienced. And again, that's not to say I wouldn't if someone's culturally similar because…similarities stop somewhere, but it's more like…there's a bit I get to explore and that's quite nice." (Afia)

Theme: Accessing support in supervision is "not Black and White"

Participants highlighted various ways that, as Sarah states, accessing support in supervision is *"not Black and White"* since both racial similarity and difference with supervisors could facilitate or prevent seeking supervision about same-race therapy dyads.

However, most participants, like Faith, preferred the idea of accessing support from a racially similar supervisor about their experience of offering same-race therapy due to experiencing similar benefits to those gained through same-race therapy:

> *"My last supervisor…we have a similar racial background and I found that really helpful…being able to…raise the issues…and not feeling…concerned that there might be a misunderstanding or that someone might feel uncomfortable…or…attacked…just as…that…assumption by the service users…you can…delve…into the issue…without worrying about…dynamics being created as a result of the content…you're bringing." (Faith)*

Sarah compares contrasting experiences of racially different supervisory dyads to highlight the heterogeneity amongst White supervisors and the impact this had on her approach with future supervisors:

> *"Working in a setting where we're predominantly seeing Black men…their focus was on…the formulation…doing CBT and I'm like…I'm being traumatized working here. I'm seeing my Black brothers, my Black…father, maybe I was overidentifying…afterwards…I had a White Irish supervisor…she was…reeling off…race and racism…this is what I was lacking…those very different experiences close together…led me…to name that this is something…I need to talk about." (Sarah)*

Sarah goes on to explain the negative impact that implicit communication from White supervisors can have in indicating a *"White gaze"* overshadowing the supervisory space:

> *"I think it was that it wasn't named. So, for you to kind of bring in someone's ethnicity the White gaze felt like you're doing too much…you need to stick with the CBT…it's implicit, he never said…'don't talk about race and racism here'…but…the way that*

they ask questions about the client and don't name things, it makes it feel like that's not important…to bring into the work or…be thinking about." (Sarah)

Sarah also reflects on the role of intersectional marginalized identities that White supervisors could have which help aid the connection with Black supervisees:

"I think the White Irish supervisor is symbolic because back in the day there were signs that said 'no Blacks, no Irish, and no dogs'. So, there was a unification in the Irish and the Black experience there…they have a certain history with…England as well…they're willing to name it and make a mistake." (Sarah)

Importantly, Sarah also highlights the impact that heterogeneity within Black psychologists can have in meaning that racially similar supervisory dyads do not always facilitate a space to explore race:

"I had a Black supervisor…but when I asked…how she finds working with Black clients…it was like, 'oh, it's the same'…we're not all homogonous. We're not all willing to have this conversation…there's some people who have done the work who are White and they're amazing allies and there's some Black people who…don't want to bring it into this space for whatever reason, and you can't force them. But I do think supervisors play a big role in shaping how comfortable you feel bringing in these topics." (Sarah)

Dominique shares further insights by describing the influence that power and heightened supervisee expectations might have in creating a challenging dynamic to explore race with a racially similar supervisor:

"There can be more hierarchy, more distance, more boundaries put in place than I've noticed with some of the supervisors I've had who are White…when…someone…does have power over you…there isn't…space to think about how us both having…a shared identity…how that's affecting…our experiences…the impact…is more significant

because…I've gone in with the assumption that we're in this together…I don't know that I would have that same assumption if the person didn't share a…racialised identity." (Dominique)

Participants frequently highlighted qualities important for all supervisors to have to foster a safer space to explore race. They often reported the importance of adopting an exploratory approach, stating an anti-racist position and, as Faith describes, being *"genuinely curious and willing to learn…more about other cultures".* Saffron describes the significance of some of these qualities used by her racially different supervisors:

"I think I've been really grateful to have supervisors, none of them have been racially similar to me, but who have been…open, willing and…named an anti-racist stance…it's been very yeah genuine…it's given me…safety to take…what I've been experiencing, and…just get the most from supervision when I can do that." (Saffron)

Theme: "(We) don't have to conform to Eurocentric standards": Breaking free from the chains of Eurocentric systems, processes and models

The fifth theme explores the desire from participants and their clients to feel connected, supported and free to not as Tianna describes *"conform to Eurocentric standards in ways that they might have to in other places in society"*. The subtheme '*"I know the healing properties…because they heal me too": Healing through the integration of racial and cultural context into clinical practice'* captures the innate understanding participants reported having to make adaptations departing from Eurocentric clinical practice with racially similar clients. The second subtheme *'A mutual quest for freedom and support in a land of marginalisation'* highlights Black CPs and clients' parallel process of help-seeking in a context of marginalisation as indicated by participant reports.

Subtheme: "I know the healing properties…because they heal me too": Healing through the integration of racial and cultural context into clinical practice. Participants often referenced how their experiences of healing through culturally relevant experiences informed their incorporation of similar material with Black clients:

> *"When I have my oxtail and my rice and peas washed down with the Ting, it's…food for the soul…makes me feel good. So, when she was talking about that fish and…seasoning…I get how…you need to…nourish your body with that wholesome cultural food…so yeah, I'm going to go on Amazon and see if I can find that seasoning for you because I know how important that is…likewise with…cultural music…oh, just speaks to your soul…likewise with religion…I guess I have faith…I could see that faith was important to her and the problems that she had and how she felt about it. And it was important for her to find a way to reconnect with that and feel okay again. So…let me speak to the spiritual care team and see what can I find in the Bible that's going to help…I know the healing properties of the things that she is talking about because they heal me too and they are not something you are going to see in the guidelines…but intuitively, it's healing stuff so that's what I went with." (Candice)*

Similarly, participants such as Afia described ways culturally relevant content could be incorporated into therapeutic techniques:

> *"I did safe place…she was like, 'that was so calming and so great that I got to go to that space in my head', which reminded her of back home…I could ask her questions, and we can really like flesh out this safe place. And I do think that was part of being racially similar and her knowing that I got her heritage and her culture." (Afia)*

All participants shared how integral it is to consider and ask about the wider contextual challenges or supports (e.g., religious institutions, racially relevant sports groups

etc.) for Black clients. Melissa describes this need to consider the wider context in relation to racial trauma:

> *"There is a bigger chance when it's…the same racial group for the formulation to include the system…the oppressive practices, the racism, the marginalization…will feed in definitely to exacerbating or maintaining or reducing the resources to overcome some of the challenges that clients present with." (Melissa)*

Most participants, like Michaela, reported preferring integrative, systemic and third wave interventions due to their capacity to privilege the wider context for Black clients:

> *"I'm drawn towards models like narrative therapy which have less of a kind of Eurocentric… philosophy running through them. However, at times actually CBT might be the most helpful intervention for someone who is Black. So…don't want to go too far the other way and not use the evidence base…I draw on narrative therapy particularly…to…position problems outside of individuals…the problem is racism, not being Black." (Michaela)*

Esther shares how including racial trauma in the formulation can improve engagement:

> *"They were willing to revisit…things…they…initially said no to…because the formulation was better understood…therefore it made sense why this intervention had been recommended." (Esther)*

Participants, like Esther, often shared how these enhanced formulations not only benefitted the client, but the wider system in understanding the client better too:

> *"It changed my interventions at a systems level…to provide a context to…shift…narratives around the clients as to why they were doing the things that they were doing through the lens of Black heritage and culture." (Esther)*

Many participants reported as Candice states that *"psychology needs to fit to them, not them fit to us"*. As such, many examples of adaptations to models were shared including an illustration from Samuel:

> *"I was…more flexible in the DBT model…sometimes she wouldn't do the diary card…you're meant to…withdraw your attention…from them…I can do that with other people… reducing the likelihood that they're not going to do the diary card. But with her, I just couldn't do that…I'd always…do a lot of validation…I wanted to give her the best chance because I was…rooting for her…she almost dropped out at one point…she said that she doesn't like doing the chains…I said…rather than...writing the chains down…we'll…have a conversation about it…that…worked better…this is someone that…has been told to do things in a particular order and maybe people haven't listened to her…she felt that she didn't fit in. So, when she was saying this isn't really working for me…I…felt the urge to…adapt it…part of me knew…this isn't…in line with the model but…I…felt the need to try and make it work for her." (Samuel)*

Participants, like Melissa, often described needing to change clinical processes for Black clients:

> *"The assessments were less linear…more like stories…I…had to go away and unpick…you could get…a one word answer that fills a box, but have a sense…I've not got this…it didn't fit in that way…they took longer…the formulations…didn't always fit the model…I put extra comments…interventions…less guideline specific…a lot of the NICE guidelines and…interventions…we're taught have…holes…in CBT you have…the core belief…the world is unsafe and…your job…is to address that…for a Black person…in an area…predominantly White where there have been lots of…racist*

physical abuses against Black folk, I'm not going to invalidate…by saying…change your core belief. I'm going to say…how do we…help you survive better?" (Melissa)

Participants, such as Candice, often described a need to slow down the pace of therapy to gradually introduce Black clients to psychology:

"I have got a lot of Black family. You don't chat your business…we kind of titrate it so people start to feel safe…we…walk and talk…I think in an acute setting where people are unwell…you can't go straight to that…but you still contact them…in a community setting there's rigidity and structure. It doesn't leave much space for people to feel safe. I think in the psychology processes of assessment and formulation intervention people need time to get to know people and feel safe." (Candice)

Although all participants recommended considering the clinical adaptations needed, Dominique offers an example of how some Black clients may not initially feel accustomed to departing from Eurocentric ways of working even if this adapted approach is ultimately beneficial to the intervention:

"Having somebody who is more attuned and responding to what they were saying…was too much of a deviation from…following…Eurocentric model of assessment, intervention, and evaluation…whereas actually having someone that is more dynamic, integrative…allowed them to then have a different relationship to the goal for what they expected." (Dominique)

Subtheme: A mutual quest for freedom and support in a land of marginalisation. A parallel process of help-seeking in a context of marginalisation was observed for Black CPs and clients. In regions of the UK where Black groups were described as overpopulating the area clients were reported to be encountered more regularly in services. Aside from this the services where Black clients tended to be reported in within the NHS were services where

clients likely had limited choice in accessing the service and were typically encountering various forms of oppression and trauma. Interestingly, for participants offering private practice the exposure to Black clients appeared to strikingly contrast the paucity in the NHS. Faith explains this difference through the sense of freedom clients gained in same-race private therapy:

> *"90% of the people who…make contact with me have been Black…the sense that I've gotten from these individuals…is wanting the freedom to bring all of themselves…they can bring the aspects of their faith…they…believe…that's not something…they can get within the NHS and they are right to an extent…it depends on the clinician…some people don't want to take that gamble…wanting someone who is of a similar background who was more likely…to understand…cultural dynamics…interacting with their presenting challenges." (Faith)*

Sarah offers further clarity on the difference in the freedom of topics that can be explored in private practice compared with the NHS:

> *"With the private we go into the problem much quicker…because they are…higher functioning in their mental health…in…my NHS role…I need to tentatively introduce these topics because maybe what they're focusing on is just…getting out of bed and attending to their personal care…if I come in speaking about race and racism that might be more re-traumatizing for them when all they're thinking about is managing their voices and doing the day-to-day." (Sarah)*

Saffron shares how limited resources present another challenge, now in considering race in case allocation in the NHS:

> *"It was…a luxury if…we're adequately staffed where I'm not already…fully booked and expecting to be for a long time, to have flexibility…I also don't think I've ever worked*

in a service where there's been another Black psychologist…so that in itself kind of almost puts like a natural limitation." (Saffron)

Saffron's reflection about the limited representation of Black CPs highlights participants' own sense of marginalisation in the NHS. Those based in midland and northern regions of the UK shared more discourses around being the minority.

Although, as highlighted previously, *'accessing support in supervision is "not Black and White"'*. Similar concerns by Black clients about receiving therapy from non-Black psychologists were reported by participants, like Michaela, about accessing support from non-Black supervisors regarding same-race therapy:

"I've got White supervisors who…are great…there is just always a difference in…how much do you get it?...if you want to talk about…Whiteness as…an oppressive force…you never quite know how…they're going to take it…White fragility and wanting to…manage that for them." (Michaela)

Like reports regarding Black clients independently seeking their own private therapy separate to the NHS system or benefiting from consideration of racially similar support networks, similar patterns of help-seeking were observed in participants. Esther describes a solitude process of managing experiences of same-race therapy:

"It has only been through my own reflective processes…my own reading, my own…personal pursuit of thinking about some of these challenges and difficulties I have experienced in the work that I have got to the place that I am now." (Esther)

Many participants, like Rochelle, described the need to seek additional support regarding experiences of same-race therapy dyads and the desire to receive support from a racially similar supervisor they could be "*open*" with:

"I…get much more…informal peer support…than I've ever done for clinical work with White clients…that just highlights…the lack of that knowledge and experience in my formal supervision structures…it is indescribable the difference…like top tier, someone who is also Black also has these experiences…feeling like I can be really open about my experiences, my responses to people." (Rochelle)

Sarah expands on the freedom gained through gaining support from racially similar peers:

"Probably similar to clients that have people that are going to get what you're trying to say at the core of it very quickly without you having to express and explain." (Sarah)

Some participants, like Melissa, shared how teaching and mentoring aspiring racialised CPs feels supportive in building community and reducing marginalisation in the profession:

"I mentor people or…offer free…application support and that to me feels supportive because I'm hopeful that there's more coming. There will be more Black psychologists who will see more Black and racially minoritized clients…I'm also being nourished by the potential picture I see coming forward." (Melissa)

Theme: "Trained to work with diversity, no-one taught me how to work with similarity": The failures, obstacles and desire to establish a personally and professionally integrated system

The final theme captures perspectives on personal and professional integration within wider systems in clinical psychology. The subtheme *'The failures of a Eurocentric segregated system'* highlights failures made by doctoral courses in integrating race and culture into training. *'"A reform needs to happen": A call for proactive system-wide integration of the personal and professional'* describes various desired changes within mental health services and training to improve the personal and professional integration of race and culture into the

profession. The final subtheme '*The risks, challenges and hope of integration'* addresses the risks, obstacles and overall benefits that integration can bring.

Subtheme: The failures of a Eurocentric segregated system. All participants reported ways their doctoral training failed to equip them in navigating same-race therapy. Rochelle offers an example of this failure through her course's insufficient acknowledgement of race:

> *"In the whole three years I trained the word race wasn't mentioned…they didn't address it all. So not only not prepared to work with people from different communities, but…not prepared to train trainees from different communities." (Rochelle)*

However, some participants, such as Sarah, highlighted some ways their course had helped them begin to think about race:

> *"You're thinking about issues around race and racism from the beginning…I suppose it gave some confidence to approaching this. Now, we didn't touch on racial trauma or racism maybe so explicitly…I think with all DClinPsych courses there's still further learning to do but maybe I'm slightly ahead because of (course name)." (Sarah)*

Alternatively, in severe circumstances participants, such as Melissa, reported being re-traumatised by experiencing racial trauma from training:

> *"What it did do was reintroduce me to racial trauma. So, I was more empathetic because the experience of training was traumatic. And so, then I was re-reminded of what it's like to be in a predominantly White space and how painful that can be. So, when I came to therapy, I didn't think they're dramatizing anything because I was fresh out of the trauma myself." (Melissa)*

Participants, like Grace, frequently referenced the shortcoming of courses through the segregation of 'professional' clinical teaching from teaching on 'personal' aspects of identity:

> *"I didn't feel like it prepared us for it…there was an assumption that so far as you know your clinical knowledge that's sufficient and the clinical knowledge…rarely touched on aspects of identity and…how that might show up in…therapy." (Grace)*

Many participants, such as Khadijah, spoke of how diversity would typically be addressed on training as an afterthought:

> *"It would be kind of the last slide, five, 10 minutes at the end, or just…say…think about difference and diversity at the end…bye everyone." (Khadijah)*

Training was often reported by participants, like Dominique, as centering a Eurocentric White lens:

> *"It's centering Whiteness in a way that's actually really harmful and even though the intention was…a conversation around race and racism…I'm very much excluded from this conversation." (Dominique)*

Furthermore, Esther highlights the significant point that what constitutes 'diverse' is typically centred by a White lens:

> *"You are always working with diversity…you don't acknowledge it as working with diversity in clinical psychology because you think that working with diversity is working with minoritized groups. But I guess diversity for me is working with someone that is from a White majority group." (Esther)*

Esther goes on to share the challenge that overemphasis on 'diversity' has on Black CPs when considering similarity:

> *"As a Black clinical psychologist my whole training I've been trained to work with diversity, no one has taught me how to work with similarity…it is distressing to me now as a well-established clinical psychologist…it is…really sad…disheartening, and it makes me quite frustrated." (Esther)*

Participants frequently reported, like Candice, the impact that the course's omission of integrating race and culture into clinical practice had in not offering permission to combine their 'personal' world knowledge with their clinical professional skills:

> *"That was part of the battle for me, where I was doing what intuitively felt right but wasn't taught on the course and that's why there was a lot of internal conflict because the course didn't teach me that." (Candice)*

Participants, like Tianna, often described flaws in courses' attempts to reactively integrate race and culture into teaching in ways that lack significant intention and long-term integration:

> *"When George Floyd was murdered…there was a sudden shift in society, including in Psychology, where these things were all of a sudden added to agendas and…timetables…clumsily…it's a reaction as opposed to being proactive…we now need to move to this being…business as usual because when I was training it didn't feel like that." (Tianna)*

Subtheme: "A reform needs to happen": A call for proactive system-wide integration. All participants described various ways, as Tianna states, *"a reform needs to happen"* to clinical psychology courses and the wider profession to better integrate the 'personal' into the profession. Many participants like Tianna described how the course curriculum needs to be reviewed in collaboration with all stakeholders:

"…that needs to be in collaboration with service users…staff…trainees, with all stakeholders to think…what are priorities for training and what is considered to be core modules…do the competencies lend themselves well to a diverse society?" (Tianna)

Participants, such as Michaela, often reported the need for courses to set the foundation for further teaching by introducing the wider context of race and racism in clinical psychology from the beginning of training:

"One of the most important things for courses is to, at the beginning of training, talk about the inherent Whiteness of clinical psychology…to position clinical psychology in its racist history…rather than…getting right into…what you should or shouldn't say in front of a Black service-user because that…misses the point entirely." (Michaela)

Participants, including Saffron, regularly described the way that the inclusion of 'personal' topics such as race and culture need to be incorporated across training:

"It's not like a one-off lecture or workshop…it's about that cross fertilization…being everywhere…in all of our…research, supervision, on placement experiences, support that we give to supervisors to offer those placements…so that the learning is really joined up…the spaces need to be everywhere for these thoughts and reflections, because the learning will come everywhere…it's around moving away from…having the one off and having that integration." (Saffron)

Participants, like Grace, highlighted the importance of courses valuing and facilitating the integration of lived experience with the clinical skills gained on training:

"Valuing our world knowledge alongside of our clinical knowledge and how that can be used to help enrich the therapeutic environment…there's something about what knowledge we privilege i.e., unless there is an evidence base in the traditional format

of a research paper that's been peer-reviewed…it's…not credible, which is a very western way…of valuing knowledge…working with racial differences and similarities that can be shared rather than waiting until there's a whole load of research around it." (Grace)

One topic that participants, such as Grace, regularly reported needing more attention on in training is racial trauma:

"There needs to be an acknowledgment of racial trauma…to the same degree…as safeguarding…it causes harm…the idea that it's something we…just talk about if it comes up…is not acknowledging the adverse effects of it…taking it a lot more seriously." (Grace)

Esther describes concerns regarding the recent increase in cohort sizes and what this might mean for the quality of experiences for racialized trainees:

"We will inevitably start to see…more trainees from diverse backgrounds…but I think the worst thing they can do is focus on expansion and not…on quality of experience." (Esther)

Participants, like Dominique, emphasised the need for a shared responsibility across systems in the integration of race and culture into the profession:

"We're more likely to burn out if we're not doing it collectively. So, having that wider lens…not just uni, but…other institutions that…involve us like…what is the supervisor's role? What is a leader's role?" (Dominique)

Similarly, Khadijah shares the important point that trainees need to also take accountability of the shared responsibility to address topics of race and culture in training:

"Trainees…sometimes there's fatigue or not this again…we've already got so much to think about we've got to add this on top…that sense of…you guys should fix this…not us…to a degree, that's true, but actually, it's something that we are all…involved in." (Khadijah)

Participants, like Afia, expressed the desire for courses to address similarity as well as difference on training:

"Making sure that we're aware of the nuances…of working with similarities as well as differences and what we do with that…giving it some space." (Afia)

Samuel offers an example of how racial similarity and difference could be explored through role-plays:

"Teaching some of the dynamics that might unfold between that say if a Black person is working with another Black person, if it's a White psychologist working with a Black person…having some role plays…in…hypothetical situations." (Samuel)

Candice offers the example of courses including reflective assignments on racial similarity and difference:

"A reflective assignment where you…reflect on the process of working with someone racially similar and racially different…in every placement if it's possible or…at least once a year." (Candice)

Some participants, such as Grace, expressed a desire for courses to address the use of therapeutic self-disclosure particularly in same-race therapy:

"Thinking about…how to work with self-disclosure, when that's appropriate when it's not." (Grace)

Esther, like other participants, described the need for courses to support trainees to try and work with racially similar and different clients where possible:

> *"There should be a concerted effort…so that trainees have experience of working with communities or people who are racially similar to them and racially different." (Esther)*

Subtheme: The risks, challenges and hope of integration. Participants, such as Sarah, highlighted the challenges posed by limited access to racialised clients depending on the geographic location of courses:

> *"I don't know how much you can gain from talking about it versus having direct experience of it and then being able to reflect on it. So, it's going to be very specific to where the course is located." (Sarah)*

Despite the geographic restrictions courses might be faced with regarding access to ethnic minority clients, participants such as Tianna highlight the significance of courses still integrating skills to meet the varying needs in society:

> *"No matter where you're training…it shouldn't depend on whether you're in a more 'diverse' area or not, we should be skilling up members of the psychology profession that can work with all members of society." (Tianna)*

Participants, like Khadijah, acknowledged how addressing topics related to race and personal identities more broadly risks creating further division between groups in training cohorts:

> *"There's the…danger of creating more separation between the groups…that's really the opposite of what we're trying to achieve. But that could be one of the dangers as one group feels more seen, another will feel less seen…it's almost like that whack-a-mole…how do you address all of that together?" (Khadijah)*

However, participants like Samuel, suggest how acknowledging risks can help spaces feel safer for trainees:

> *"An open discussion…to…encourage ideas and having it be a non-judgmental space, accepting that sometimes people might get it wrong. So that everyone feels able to just share honestly…even if someone gets it wrong…they're willing to learn and it's coming from a good place that's better than someone not saying anything because they're worried about what someone might say." (Samuel)*

Some participants, like Melissa, shared that whilst honest spaces are needed it is also important to have procedures for the impact that such topics can have on racialized trainees:

> *"When White people are learning they often will…say a lot of the things that have been inside them for a long time, they don't realize it's wrong or harmful. But sitting in that room as a racially minoritized trainee, you then are harmed vicariously just so that your peers can learn…there needs to be a really clear procedure for how those moments are managed and clear expectations of what we consider learning and what we consider abuse." (Melissa)*

Participants, like Faith, frequently made references to the fluidity of the experience of racial similarity with clients:

> *"You can continue to have conversations…and…reflections…different things will come to mind, and different recollections will come as you go." (Faith)*

Participants, such as Esther, also often described how difficult it was to verbalize the experience of same-race therapy given the *'felt'* nature of the interaction and limited opportunity to reflect on it:

"I find it difficult to put into words something that is a much-felt experience especially when there has not been in my experience any spaces to reflect and…start that process…it's exhausting to try to put words into something that is not yet cognitive." (Esther)

Given how intangible, fluid and context-dependent racial similarity appears to be it is understandable that participants often describe the experience as being something that cannot be 'taught' but needs to be explored and experienced. Despite the dynamic nature of racial similarity in therapy, reflections from participants like Esther highlight factors that help build confidence to utilise the benefits:

"I am a lot older now…more experienced…I think earlier on in my career…where race and culture weren't discussed or weren't given the adequate space or time to reflect upon, it didn't feel like I had permission to…now I don't need permission anymore." (Esther)

Although participants acknowledged the importance of addressing similarity on training, Michaela highlights the challenge courses face in equipping trainees with knowledge of the fundamentals of therapy before exploring complex topics like racial dynamics:

"When you're…new on training, you're like 'Oh, I need to remember how to do, CBT'… 'what's the model for panic again?' and now when those things just come much more naturally, there's more space to think about…who the person in front of you is rather than what the manual says." (Michaela)

However, Khadijah's reflections illustrate how working with a diverse range of clients meant it was possible to factor in topics like race as a trainee to go beyond core clinical skills whilst training:

"A person might be talking about their Hinduism or…Catholicism, but they'd equally be talking about their race. And so, because of that it was part of my training, but…the courses can do better." (Khadijah)

Lastly, participants like Renee shared reflections on how working with racially similar clients was beneficial for their practice:

"Probably made me a better psychologist who isn't afraid to ask questions…who isn't afraid to say actually you need to factor…in this person's…racial trauma or this person has probably had lots of experience where…people in authority haven't listened to them…I've learnt a lot from those patients." (Renee)

Crucially, participants like Esther often referenced how working with Black clients reignited their passion in their career and helped with their own sense of belonging in the profession:

"Working with clients with Black heritage gave me the opportunity to…think…about my place in the profession…when I was in training…I had experiences of racism and poor responses from…support structures…I really doubted where I belonged in clinical psychology...it gave me the opportunity to…recognize that actually there was a real need for me from a patient perspective…so that more people could access therapy and feel safe…to talk about any of their experiences from a position of I will be understood." (Esther)

Chapter Five: Discussion

Chapter Overview

The final chapter summarises how the key findings of this study address the project's aim and research questions. The findings will be discussed and situated within the context of existing theoretical and empirical literature. The strengths, limitations, implications and suggestions for future research will be shared. I will conclude with my final reflections on the project.

Revisiting the Research Questions

This study aimed to explore how Black CPs in the UK experience working with racially similar clients. Three sub-questions were explored:

1. How do CPs with Black heritage in the UK experience working with racially similar clients?
2. How do intersectional identities mediate Black CPs' experiences of working with racially similar clients?
3. What clinical implications do Black CPs' accounts of working with racially similar clients highlight for practice, supervision, clinical psychology training and service providers?

Summary of Findings

Based on participant accounts Black CPs supporting racially similar clients experience the 'double-edged' nature of emotions, identity negotiation and intermediary client interactions. Such experiences appeared to come with the beneficial integration of their 'personal' racial and cultural selves as Black individuals with their 'professional' selves as CPs. They described the benefits and challenges involved in navigating intersectional similarities and differences between themselves and their clients. Racial similarity received overwhelmingly positive reports of enhancing connection and cultural understanding that offered safety to explore other intersectional identities with clients. However, participants often asserted the need to monitor assumptions and judgements given the undesirable consequences that could arise from both clients and CPs overidentifying with shared racial heritage. Furthermore, reference was often made to the identities clients and CPs hold beyond race where difference could act as a barrier and, at times simultaneously, lead to finding alternative ways to connect with clients.

Given the complex nature of intersectional similarities and differences it is understandable that participants also highlighted the multifaceted factors influencing the experience of accessing support from racially similar or different supervisors. Importantly, participants captured key features beneficial to facilitate exploring racial dynamics in therapy dyads within supervison. Participant reflections on same-race therapy identified important clinical implications for how to offer culturally sensitive practice with Black clients. Reflections on how participants access support when navigating same-race therapy dyads highlight similar patterns of help-seeking in a context of marginalisation between Black CPs and clients. Lastly, participants reported various failures regarding the consideration of race in training. Though the challenges and risks of enhancing the integration of race and culture in such wider systems were acknowledged, numerous ways that doctoral courses and service

providers could improve this integration were shared and the benefits for the profession were highlighted. These findings will now be presented in relation to the research questions and situated within existing literature and theory.

How do CPs with Black heritage in the UK experience working with racially similar clients?

Although all themes are relevant to understanding how Black CPs experience same-race therapy, the first theme '*"For the cause, but part of the problem": The double-edged sword of personal and professional integration'* will be focused on predominantly, with reference made to other themes where relevant, as this offers the most insight into participant reflections on how Black CPs experience same-race therapy dyads. The subtheme '*A tug between the personal and professional to win the war of integration'* corroborates findings from literature about racialised trainee and qualified CPs experiencing incongruence between their racial or cultural selves compared to the Eurocentric values and pressure to conform to Whiteness within the profession (Goodbody, 2009; McNeil, 2010; Odusanya et al., 2018; Shah, 2010). This study extends knowledge about the challenges of personal and professional integration for racialised CPs to the context of racially similar therapy dyads for Black CPs in which this integration can be used for therapeutic gain. The benefits of integration described by participants also confirm assertions from Helms's (1990) RISM and extrapolates such findings to racially similar therapy dyads. For instance, the model proposes that 'progressive' self-affirming racial identity schemas aid better supervisory experiences. Participant reports support this as they suggest that better connection to one's racial identity and the integration of this alongside the professional identity yield better exploration and utility of this connection with clients. However, the 'double-edged' nature of this integration was elucidated in this study.

The subtheme '*I can be both a barrier and bridge to clinical psychology'* offers an example of the conflicting 'double-edged' experiences that can arise in same-race therapy. Participant reports about the function racial similarity can have in facilitating the client and service's understanding and engagement with each other extends the findings from the studies included in the systematic literature review. For instance, several studies described how a shared racial heritage between Black therapists and their clients act as a bridge to psychology by increasing client engagement and trust in therapy (Bartholomew et al., 2023; Bell-Tovier, 2009; Goode-Cross, 2011; Goode-Cross & Grim, 2016; Greenberg, 2018). However, this study explores the steps CPs take to facilitate engagement in therapy through the subtheme *'"I know the healing properties…because they heal me too": Healing through the integration of racial and cultural context into clinical practice'.* Notably, the resilience and utility of Black people to hold onto cultural heritage in this subtheme echoes a similar strength shown through the history of slavery. For example, similar reference was made to the significance of African storytelling which Black slaves retained despite attempts in slavery to eradicate cultural traditions (Walvin, 1994). Interestingly a parallel desire was expressed in this sub-theme where some Black CPs expressed the need to depart from Eurocentric structures of assessment for Black clients. Importantly, this study also illustrates the benefit Black CPs can add to the wider network in supporting the service to better understand the client by factoring racial and cultural context. However, this project builds on insights offered by Greenberg (2018) which indicated that a shared racial heritage could also act as a barrier to engagement with non-Black professionals. For instance, findings suggest both a possible facilitatory and inhibitory function that same-race therapy dyads offer to engagement with the wider professional psychology network.

The impact that Black clients' underrepresentation in mainstream (Bignall et al., 2019; Dyer & Gilbert, 2019; Wessley, 2018) and overrepresentation in crisis statutory mental health

services (Lubian et al., 2016; Singh et al., 2007) has on Black CPs are captured in this study. *'The pendulum swing between polarised emotions'* reveals the joy that Black CPs experience when they do encounter Black clients that find their way into services where they typically are underrepresented. Additionally, given the underrepresentation of Black CPs in clinical psychology (HCPC, 2023), the findings showcase the mutual joy clients were also reported to typically experience when encountering Black CPs too. Such insights are important and should be valued as a mutually beneficial experience enabled through racial similarity that can offer comfort for some Black populations in clinical psychology. This joyous experience is particularly significant in the current context of marginalising for Black CPs and clients in services.

An alternative yet equally crucial finding from this study is the evidencing of reports from Dhillon-Stevens (2011) about the extra cognitive processing required for Black therapists. Findings support the claims where Black CPs needed to both attune to the material brought by clients and their own processes that may be triggered or reinforced as a Black person. In particular, the sadness participants reported experiencing when exposed to the same difficulties they experience as Black individuals offers further illustration of 'recognition trauma' described by (McKenzie-Mavinga, 2009). Lastly, the subtheme *'The risks, challenges and hope of integration'* addresses the dynamic nature of the experience of same-race therapy dyads. Personal and professional development through ageing, confidence gained through years qualified and increased exposure to working with racially similar clients were reported to reduce the likelihood of struggling with a heightened sense of responsibility and anxiety about how to manage and respond to racial similarity. Such reports support findings from literature (Goode-Cross, 2011; Goode Cross & Grim, 2016) about the importance of gaining experience with racially similar therapy dyads, however this study explored factors further

highlighting age and years qualified, and the findings from literature are contextualised within the context of clinical psychology doctoral training in the UK.

How do intersectional identities mediate Black CPs' experiences of working with racially similar clients?

The overarching theme *'"How do you attend to all those layers of difference across the intersectional identities?": The complex web of similarities and differences'* highlights the role that intersectionality was reported to play in mediating Black CPs' experiences of same-race therapy and so will be focused on to address this research question. Within this overarching theme, the theme *'Racial similarity can enhance connection and awareness, but it comes with the risks of overidentification'* is consistent with social identity theories (Turner et al., 1979) which assert that people identify strongly with 'ingroup' shared characteristics. This theme is also supported by empirical literature that highlights experiences of racial and cultural solidarity between Black therapists and clients (Bartholomew et al., 2023; Bell-Tovier, 2009; Bell-Tovier & Wilkerson, 2011; Goode-Cross, 2011; Goode-Cross & Grim, 2016; Long, 2022). However, this study explores such findings in greater depth by highlighting the specific nuances of different intersectional identities such as race and culture separately. Although closely related, the subtheme *'"My race as having some sort of benefit to them and their overall wellbeing": An unspoken connection of therapeutic benefit'* captures the significant role that a Black CP's presence and racial identity has in offering increased representation, connection and comfort with Black clients and staff working alongside them. The subtheme *'"You get me": A shared overarching 'Black culture' offers safety to explore other intersectional identities'* likely plays a role in underpinning the significance attributed to visible representation by exploring the meaning attributed to a shared overarching 'Black culture'. This subtheme is also consistent with reports by Goode-Cross and Grim (2016) about the ability for clients to 'code-switch' and connect through culturally relevant conversation. Alternatively,

as noted by literature, the subtheme *'"We're not homogeneous": We must monitor assumptions and judgements arising from overidentification'* addresses the importance of not overidentifying with racial similarity to hold capacity for nuance, blind spots and assumptions that could arise for both CPs and clients becoming detrimental to the therapy (Bartholomew et al., 2023; Bell-Tovier & Wilkerson, 2011; Brooks-Ucheaga, 2023; Goode-Cross, 2011; Goode-Cross & Grim, 2016).

As discussed in previous studies (e.g., Goode-Cross, 2011; Goode-Cross & Grim, 2016; Greenberg et al., 2018; Long, 2022) the wider context and intersectional identities were reported as significant factors that mediated the experience of racial similarity in therapy dyads. However, within this study the theme *'"I am more than my race": Difference as a barrier and/or alternative path to connection'* helped highlight more clearly the overall trajectory that intersectional differences have in influencing the connection between Black CPs and clients in racially similar therapy dyads. Although all intersectional identities could be experienced and interpreted by both participants and their clients in a myriad of ways, there were some poignant examples or more common experiences. Interestingly, a finding not reported in same-race therapy literature that was commonly reported in this study was that participants and their clients typically experienced racial similarity as more challenging when the client was older than the CP. Challenges arose due to cultural expectations of respect and hierarchy for elders, which has been reported in literature regarding older adults in Black communities (Wylie, 1971). Participants reported that a younger Black individual in a position of higher power where their Black elder was required to be emotionally vulnerable and share explicit intimate details about their personal life presented difficulties for both. Another finding that was not reported in same-race therapy literature was how the sense of racial solidarity could be reduced for CPs that hold identities marginalised by some Black clients such as identifying as part of the lesbian, gay, bisexual, transgender, queer/questioning, intersex, and

asexual/aromantic/agender community. Such findings also corroborate literature identifying an increased prevalence of homophobia within the Black community (Hill, 2013). Similar challenges to connection reported by Long (2022) about reduced perceptions of Blackness were also found in the study. For instance, some clients perceived Black CPs as "sellouts" regarding their affinity to their Black identity due to their affiliation with the NHS, and some participants viewed clients as distant from their Black identity due to them also having White heritage and a different accent associated with their geographic location.

Importantly, again this study revealed a further finding that same-race literature has not yet reported regarding the positive impact intersectional difference can have on same-race therapy. Participants shared that having different cultural and ethnic heritages could offer opportunities for CPs to engage in genuine curiosity about unknown territory which can aid in building rapport. Alternatively, Greenberg et al. (2018) reported challenges that arose from cultural differences and xenophobic attitudes towards immigrants held by Black clients towards their therapist. Furthermore, Goode-Cross and Grim (2016) reported that Black clients who entered services involuntarily and had a lower socio-economic status than their therapist were more mistrusting of their Black therapists. Interestingly, such findings from Greenberg et al. (2018) and Goode-Cross and Grim (2016) were not reported by participants in this study. These differences might represent the heterogeneity that exists within the Black community and might also suggest differing socio-cultural influences from the American context compared with the African diaspora in the UK.

Clinical Implications and Recommendations

This study was undertaken in the context of recent increases in doctoral training places meaning that despite qualified Black CPs currently representing just 1% of the profession (HCPC, 2023), Black applicants now make up 23.2% of successful candidates (Clearing House for Postgraduate Courses in Clinical Psychology, 2023). Given the increasing racial diversity

of the profession there is an increased likelihood of same-race therapy dyads for Black populations. As such, it is concerning that much of clinical psychology literature constructs 'cultural competence' as a skill to support White professionals focusing exclusively on the context of cross-racial therapy dyads. Therefore, the participants in this study offered unique insights that build upon current conceptualisations of cultural 'competency', equality, diversity and inclusion (EDI). A major finding from this study is that the widening of access to clinical psychology has only been completed in a narrow sense (i.e., increased diversity on some courses), but change in research, practice and the application of a diverse range of thinking and understanding is slow. Therefore, external change through the accessibility in recruitment is only the first step. Now there is a need to change the profession from within to break the internal barriers to inclusive, equitable and diverse practice and action. The implications and recommendations from this study's findings help with this process and will now be highlighted in relation to clinical practice, supervision, training, clinical psychology services and the profession more broadly to address the final research question. A summary of key recommendations can be seen in Table 6.

What clinical implications do Black CPs' accounts of working with racially similar clients highlight for practice, supervision, clinical psychology training and service providers?

Clinical Practice. This study reveals the layers of complex processes and experiences associated with racially similar therapy dyads. For Black trainee and qualified CPs, the findings reveal the challenging and beneficial emotions and dynamics that might be experienced when working with Black clients. Black CPs who are younger, newly qualified, in geographical locations with minimal racial diversity, with minimal experience of working with Black clients or integrating their racial and cultural identity with their professional are likely to experience heightened levels of anxiety when navigating same-race therapy. Therefore, such practitioners should receive further support when navigating same-race therapy and, if interested in building

confidence in this area, Black CPs might find it beneficial to consider the racial diversity in the geographic area and opportunities to work with Black clients as part of their development during and beyond doctoral training. Additionally, heightened self-awareness of racial and cultural assumptions and exploration of the client's interpretation of the racially similar dyad is integral to clarify, manage and utilise the impact of racial similarity.

Therapist disclosure is described as a statement revealing something personal about the therapist (Knox & Hill, 2003). Therapist disclosure has been reported to strengthen the therapeutic relationship (Rogers, 1961). This study suggests that therapeutic self-disclosure can be useful to help overcome intersectional differences that create barriers to building trust. Specifically, if deemed beneficial to the client, self-disclosures relevant to race-related difficulties underlying the presenting problem for the client might help enhance the connection between the dyad and models a display of vulnerability that could assist the client's engagement in emotional vulnerability. Where challenges arise due to overidentification or perceived intersectional differences, noticing, naming and exploring this further where appropriate with the client or externally through supervisory support is beneficial to help navigate such difficulties.

Most significantly, the subtheme *'"I know the healing properties…because they heal me too": Healing through the integration of racial and cultural context into clinical practice'* offers insights into culturally sensitive adaptations participants made to clinical practice. Such findings highlight various ways Black clients might benefit from changes made to Eurocentric interventions. All CPs working with Black clients should consider where appropriate the inclusion of culturally relevant materials that could support client wellbeing through different sensory mediums of healing (e.g., exploring access to culturally significant foods, music, faith as a form of healing etc.). It has been argued that the emphasis placed on healing (as opposed to 'disorder') through the mind, body and spirit are rooted in coping through enslavement and

larger African-centred practices of healing (Gallego, 2020). Findings also indicate that where possible culturally relevant content should be included and explored in interventions (e.g., including culturally relevant contexts to aid safe place imagery). Consideration of the wider racial and cultural context that could either predispose, perpetuate or protect Black clients from their distress must be explored and factored within clinical formulations (e.g., the role of racism and race related trauma, culturally relevant support networks such as religious institutions or family etc). Attempting to build trust and gradually pacing the introduction of clinical psychology might be beneficial for Black clients less attuned to Eurocentric language and processes involved in clinical psychology.

Ultimately, being led by the client's needs and preferences are essential to the adaptations made for Black clients. Given the likelihood for experiences of marginalisation it is important to depart from therapeutic models using clinical judgement to offer a validating and, where appropriate, a less formalised approach to therapy to tailor the intervention to the person as opposed to trying to make the client 'fit' the intervention. Such changes might be crucial to the ongoing engagement and outcome of therapy for some Black clients. The suggestions made are consistent with the limited literature that exists offering suggested cultural adaptations to therapy for Black populations. For instance, a six-item framework of recommended cultural adaptations for African-Caribbean people includes the need to use culturally relevant language, concepts, communication, content and to consider influences on the therapeutic alliance and family (Jensen et al., 2021). The specific adaptations suggested offer further clarity and examples of what culturally sensitive practice involves and a more nuanced insight into what needs to be considered for racially similar therapy dyads.

Clinical Supervision. The challenging internal and external processes that Black CPs navigate whilst working with Black clients indicate how integral clinical supervision is in offering support to help utilise the benefits and overcome the challenges. Recent guidance on

supervision for psychologists highlights the need to attend to issues of similarity, difference, diversity and power throughout supervision (BPS, 2024). Although reference is made to the exploration of these topic pertaining to the supervisory dyad, limited guidance is offered on how to navigate exploring these topics in relation to the therapy dyad within supervision. As such, the following recommendations deriving from various themes, particularly *'Accessing support in supervision is "not Black and White"'*, extend the current guidance to factor in how supervision could be used to support with such topics as they occur as part of the therapy the supervisee is receiving supervision about.

Supervisors of Black practitioners offering therapy to a racially similar client must not make assumptions about the trajectory of meaning this similarity will have for clinicians, clients or the client's connection to the wider network. Furthermore, supervisors should attend to the Black CP's sense of responsibility, anxiety and the emotional toll of racial re-traumatisation, whilst also considering intersectional and contextual factors that might mediate the experience. Supervisors should pay particular attention to factors that might present more challenges such as working with clients that are older or hold discriminatory beliefs about aspects of the CPs identity such as sexuality or gender. Supervisors should also explore whether additional support is required due to factors such as the CP being younger, newly qualified, in a geographical location with minimal racial diversity, having minimal experience of working with Black clients or of integrating their racial and cultural identity with their professional self.

Receiving supervision from a racially similar supervisor could offer a heightened sense of racial and cultural solidarity and understanding for Black supervisees. However, as with the experience with clients, assumptions should not be made about the ease or increased challenges that will be experienced in exploring race in supervision based on racial similarity or difference in the supervisory dyad. Instead to support the capacity to use supervision as a supportive space both supervisees and supervisors should establish a shared acknowledgement of the importance

of exploring racial and cultural dynamics from therapy in supervision. The idea that engagement in open discussions about identity and culture on practice and the supervisory relationship is a shared responsibility is a notion supported by literature (Ellis, 2017). Irrespective of racial similarity or difference, supervisors should also offer a space that holds curiosity, sensitivity to and value in exploring the role of race and culture within the therapy. Such skills are relevant to the approach recommended for supervisors to enable open, value driven and empathetic reflexivity in supervision (Bartle, 2015; Dunsmuir & Leadbetter, 2010). Supervisors should demonstrate a genuine interest and willingness to learn about information relevant to understanding the racial and cultural context that Black CPs and clients are experiencing as part of the dynamics of therapy. Black supervisees are likely to hold reservations about a racially different supervisor's capacity and interest in exploring racial dynamics of therapy with them and are more likely to experience shame if challenges arise due to narratives given about the ease and benefits of therapy through racial matching. As such, it is crucial that non-Black supervisors take a lead to initiate exploration, emphasise their interest and adopt a non-judgemental approach to facilitate Black CPs' access to support when navigating same-race therapy.

Training. The findings are relevant to training courses, especially in the context of the recent action plan (HEE, 2021) developed for clinical psychology courses to have sustained and effective actions on inclusion and anti-racism. Although reference to various themes could be made to address this action, most recommendations made by participants derive from the theme *'"Trained to work with diversity, no-one taught me how to work with similarity": The failures, obstacles and desire to establish a personally and professionally integrated system'*. A crucial revelation from participants is the way that 'Whiteness' dominates current understanding and the approach taken to teach and explore issues pertaining to racial and cultural diversity in training. The term Whiteness is not referring to 'being White' as an

individual characteristic. Instead, it describes the racial power that has claimed normative dominance over centuries of colonialism and slavery (Du Bois, 1920; Fanon, 1967). It refers to the lens that racialises the other and is an ideology that reproduces and maintains structures, institutions and practices that reinforce racialised hierarchies for the White majority against racialised ethnic minorities (Patel, 2022).

Within this study Whiteness dominated participant training experiences since discussions about diversity often excluded Black people by presuming that the CP was White. Furthermore, participants highlight how the use of the term 'diverse' fails to consider that racialised trainees are typically used to working with racial difference more than similarity. As such, the current emphasis placed on racial difference fails to factor that for ethnic minority trainees, racial similarity would be the more novel experience. Thus, racial and cultural similarity are just as poignant to consider, especially when discussing racialised clients with ethnic minority trainees from a similar heritage. The current emphasis placed on difference also implicitly presumes that similarities are easier to navigate, when both aspects of identity typically intersect in different ways according to various aspects of identity.

According to the findings, for courses to meaningfully fulfil the aims of the action plan to improve inclusivity and anti-racism (HEE, 2021), any actions enforced by courses should not be time-limited, reactive or superficial. Instead for changes to be sustainable they should be proactive and well-thought through with a racially diverse range of stakeholders (e.g., staff members, trainees, local CPs and service-users). Training curriculums should be reviewed by a diverse representative group of stakeholders to evaluate how integration of the personal and professional self is attended to throughout training in various forms (e.g., teaching, assignments, use of supervision and placement case allocation for exposure to similarity and difference especially for racialised trainees with limited exposure to racial similarity). Specifically, at the beginning of training a foundation and overarching context pertaining to

race and racism in clinical psychology should be set to facilitate engagement in such topics throughout training. Trainees should be informed of the likelihood of pitfalls to be encountered to engage in meaningful open and brave conversations that explore race and culture. However, a procedure and guidance should be shared with staff and trainees about how to respond if topics that facilitate learning for some also create emotional distress for trainees impacted by the content, particularly racialised trainees who might experience heightened levels of racial re-traumatisation.

Courses should continuously evaluate and monitor their ability to integrate trainees' lived experience and world knowledge (especially cultural and racial insights) into clinical practice (e.g., including teaching on how to utilise therapeutic self-disclosure) with the representative group of stakeholders. Training should test various methods of this integration and consider whether competencies in personal and professional development should be taught as a distinct module or instead as a skill that is integrated throughout clinical teaching sessions so that concepts like racial similarity are more meaningfully brought to life. For instance, based on participant accounts, race, culture and particularly racial trauma could more regularly be integrated in clinical content as they would in clinical practice, as opposed to only arising in training through brief infrequent tokenistic gestures a handful of times across the three years of training. Lecturers offering teaching should be prompted to ensure they have attended to personal aspects of identity and marginalisation (e.g., culture, race, sexuality, disability) within their clinical teaching. Clinical supervisors would also benefit from further training and guidance to consider similarity and difference within the supervisory and therapy dyad.

Courses should highlight the importance of there being a shared responsibility amongst trainees, course staff and clinical supervisors to recognise the need to attend to the integration of personal identities and issues as part of training. As such, course staff should also up-skill themselves to ensure that they have a good understanding of the principles of cultural

sensitivity, inclusivity and personal and professional integration themselves before attempting to incorporate such concepts on a wider systemic level. Many of the recommendations highlighted support the actions included in the training action plan (HEE, 2021) regarding leadership commitment, education of staff and supervisors, curriculum review and support offered to racialised trainees. However, the findings from this study help offer further recommendations on how to enforce these actions and contribute nuance and critique to taken for granted ideas like cultural sensitivity that can mask underlying racialised assumptions behind EDI discourses.

Service Policy. The findings from this study help address the aims of numerous government-commissioned initiatives to improve the experience of mental health services for Black communities (e.g., CQC, 2011; DoH, 2005; The Sewell Report, 2021). Participant reports also highlight further recommendations for service policy and guidance to better meet the needs of Black populations. A crucial and novel finding from this study is reported in the subtheme *'A mutual quest for freedom and support in a land of marginalisation'*. Although current statistics show that Black clients are less likely to access support from mental health services (Bignall et al., 2019; Dyer & Gilbert, 2019; Wessley, 2018), reports from Black CPs reveal that accessing and engaging in therapy for Black clients is contrastingly demanded in private practice. The contrast of engagement in private compared with NHS services suggest a failure and dissatisfaction of support offered within the NHS. Therefore, services should try where possible to instil the sense of freedom, support and cultural sensitivity offered by the Black CPs in this study. This is particularly important so that recommended adaptations to practice that trainee CPs engage in on training can be supported and fostered when CPs bring these skills into services.

Current competency guidelines do not offer guidance on how to practice with cultural sensitivity, make cultural adaptations or treat racial trauma by NICE (2018), HCPC (2023) and

the BPS (2017a). To offer improved support to racialised populations a clinical framework and competency guidance should address the need to depart from Eurocentric models. Such guidance should allow for additional sessions for trust-building, less structured conversational styles of therapy and prompts to explore additional racially/culturally relevant sources of trauma and healing. Services should acknowledge that these adaptations to therapeutic models using clinical judgement could help prevent re-traumatising racialised groups by no longer requiring them to fit to Eurocentric standards that do not adequately meet their needs.

Findings also suggest that CPs are not receiving adequate support in services when offering same-race therapy. As such, services should offer opportunities for CPD in therapeutic concepts and models that extend beyond a Eurocentric focus to help all CPs meet the needs of diverse groups. Additionally, NHS Trusts should offer training on racial trauma and should factor similarity and difference in therapy and supervisory dyads when offering training on diversity and inclusive practice. This would aid supervisors and CPs to offer more culturally sensitive practice. Lastly, in addition to some mentoring schemes that exist for racialised staff in the NHS (Sarsah et al., 2022), Trusts should develop formalised support networks and mentoring schemes for ethnic minority CPs to nurture safe, non-marginalising spaces given the therapeutic benefit of racial representation and connection.

Table 6

Summary of Clinical Implications

Clinical implication Area	Key recommendations
Clinical Practice	• Mitigate the vulnerability factors - Further seeking of support and opportunities to gain experience with same-race therapy would be beneficial for Black CPs who have a heightened risk of experiencing challenges in same-race therapy due to having any of the following: limited years qualified, being younger in age, being based in a geographical area with less racial diversity or having a lack of exposure to same-race therapy. • Enhance awareness of assumptions and curiosity - Black CPs in same-race dyads should try to be aware of racial or cultural assumptions that are made without maintaining curiosity and verification from the client. • Racial/Cultural self-disclosure - Black CPs should offer racially or culturally related self-disclosures using clinical judgement to help overcome intersectional differences or to facilitate Black clients' sharing of similar difficulties. • Use culturally relevant forms of healing - All practitioners working with Black clients should consider, where appropriate, how clients could be facilitated to access and engage in different sensory mediums of cultural healing (e.g., exploring access to culturally significant foods, music, faith as a form of healing etc.). • Incorporate culturally relevant content into existing techniques - Where possible all practitioners should explore whether any culturally relevant content should be included in interventions (e.g., including culturally relevant contexts to aid safe place imagery). • Always consider the wider racial and cultural context in the formulation – All practitioners should consider the wider racial and cultural context impacting a Black client's distress within clinical formulations (e.g., the role of racism and racial trauma, culturally relevant support networks such as religious institutions or family etc). • Slower pacing may be beneficial - Attempting to build trust and gradually pacing the introduction of clinical psychology might be beneficial for Black clients less attuned to Eurocentric language and processes involved in clinical psychology. • Be client-led and fit the intervention to the client – For all practitioners any intervention offered, and adaptations made should be based on client preference and needs. This includes departing from typical Eurocentric therapeutic models using clinical judgement to reduce the formality and structure of the intervention and support client engagement. • Notice, name and explore – Where challenges arise due to overidentification or intersectional difference, noticing, naming and exploring this further with the client where appropriate, or externally through supervision, is beneficial to help navigate such difficulties.

Clinical Supervision	• Do not assume - Do not make assumptions about the trajectory of meaning racial similarity will have for clinicians, clients or the client's connection to the wider network. • Notice and explore supervisee emotions - Attend to the supervisee's emotional experience, particularly their sense of responsibility, anxiety and the emotional toll of racial re-traumatisation. • Explore intersectionality and context - Explore intersectional and contextual factors influencing the experience for the supervisee and client. Exploration around experiences with older aged clients or a client's discriminatory beliefs about a marginalised identity the supervisee holds (e.g., LGBTQIA+) should be paid attention to given challenges associated with this. • Notice supervisee vulnerabilities - Pay attention to supervisee vulnerability factors mentioned in the clinical practice section, in addition to the supervisees experience of integrating their racial and cultural identity with their professional self. • Share acknowledgement about race and culture - Both supervisees and supervisors should establish a shared acknowledgement of the importance of exploring racial and cultural dynamics from therapy in supervision. • Demonstrate interest and commitment - Offer a space that holds curiosity, sensitivity to and value in exploring the role of race and culture within the therapy. Non-Black supervisors should take a lead in initiating exploration, emphasising their interest whilst adopting a non-judgemental approach to facilitate Black supervisees' access to support for same-race therapy dyads.
Training	• Proactive collaborative action - Actions made to improve inclusivity, and anti-racism should be proactive and well-thought through with a racially diverse range of stakeholders (e.g., staff members, trainees, local CPs and service-users). • Continuous evaluation of personal and professional integration - Curriculums should be reviewed by a diverse representative group of stakeholders to evaluate how integration of the personal and professional self is attended to throughout training in various forms (e.g., teaching on self-disclosure, assignments, placement case allocation for exposure to similarity and difference and use of supervision). • Laying a racially informed context - At the beginning of training a foundation and overarching context pertaining to race and racism in clinical psychology should be set to facilitate engagement in such topics throughout training. • Attention paid to risks of integration - Trainees should be informed of the likelihood of pitfalls to be encountered to engage in meaningful open and brave conversations that explore race and culture. However, a procedure and guidance should be shared with staff and trainees about how to respond if topics that facilitate learning for some also create emotional distress for racialised trainees impacted by the content. • Trial and error - Test various methods of this integration and consider whether competencies in personal and professional development should be taught as a distinct module or as a skill integrated throughout clinical teaching sessions.

	• Personal integration into clinical teaching - Lecturers offering teaching should be prompted to ensure they have attended to personal aspects of identity and marginalisation (e.g., culture, race, sexuality, disability) in their teaching. • Upskilling placement supervisors - Clinical supervisors should receive further training and guidance to consider similarity and difference within the supervisory and therapy dyad. • Broadcasting a shared responsibility - Highlight the importance of a shared responsibility amongst trainees, course staff and clinical supervisors to attend to personal identities and issues in training. • In-house training - Course staff should receive training in cultural sensitivity, inclusivity and personal and professional integration before attempting to incorporate such concepts on a wider systemic level.
Service Policy	• A need for a culturally sensitive framework - A clinical framework by NICE, HCPC and/or the BPS should be developed and offer guidance on how to practice with cultural humility, and should highlight the need to depart from Eurocentric models where appropriate for racialised clients (e.g., additional sessions for trust-building, less structured options to engage in content and prompts to explore racial/culturally relevant sources of trauma and healing). • Service recognition and support of adaptations - Services should acknowledge that the recommended adaptations to therapeutic models based on clinical judgement to help prevent re-traumatising racialised groups by no longer requiring them to fit to Eurocentric standards that do not adequately meet their needs. • CPD beyond Eurocentric practice - Services should offer opportunities to all practitioners to receive CPD in therapeutic concepts and models that extend beyond a Eurocentric focus to help CPs meet the needs of diverse groups. • Diversify diversity training - NHS Trusts should offer training on racial trauma and should factor similarity and difference in therapy and supervisory dyads when offering training on diversity and inclusive practice. • Formalise support for marginalised racialised staff - Trusts should develop formalised support networks and mentoring schemes for underrepresented ethnic minority groups in the psychology profession to nurture safe, non-marginalising spaces given the therapeutic benefit of racial representation and connection.

Critical Evaluation of the Study

This study is the first of its kind in the UK, broadening empirical understanding to the benefits and challenges of racially similar therapy dyads. It extends previous findings to indicate that overall, according to the participants in this study, Black CPs experience racially similar therapy dyads as more helpful than detrimental. However, the inclusion of the role of intersectionality and findings of the 'double-edged' nature, alongside individual interpretations of the experience illustrate the implausibility of deducing the encounter into a single outcome. Crucially, the application of this study to clinical psychology offers more detailed guidance and recommendations for the profession to better meet the needs of Black communities currently disadvantaged in their experience of services. However, some specific strengths and limitations must be considered when interpreting the findings.

Study Sample

The study had a large sample of 16 Black CPs which is a strength given the limited representation of Black CPs in clinical psychology (HCPC, 2023). Though, it was unfortunate to only recruit two males. However, given that Black CPs make up 1% of the profession and men across all ethnicities make up 17% (HCPC, 2023), the males in this study representing 13% of the sample is likely unfortunately representative of the proportion of Black male CPs currently in the profession. Additionally, the inclusion of a small number of dual heritage CPs meant that some distinct aspects to the experience of working with a Black client as a dual heritage person could not be explored in depth. Namely, the fact that for mixed-race participants they would be simultaneously racially similar and different when working with a Black client. However, interestingly, perhaps due to self-identification with a Black racial identity, most reports from the mixed-race participants were consistent with those who only identified as Black. It was also important to capture the heterogeneity within self-identification with Black identity and how this can intersect with dual heritage too.

Lastly, although some aspects of identity were screened to recruit a diverse sample (e.g., ethnicity, gender, age, years qualified, variability of racially similar experience etc.), other aspects of identity were not screened for (e.g., sexuality, ability, religion). However, findings from relevant empirical research (e.g., Goode-Cross, 2011; Goode-Cross & Grim, 2016) were used to ensure the factors known to mediate the experience of same-race therapy for Black therapists were included in the sample. Additionally, like the experience of encountering a racially similar therapy dyad, the intersections of a person's identity are not immediately known but uncovered and so it was helpful as part of the study to discover what aspects of intersectional identity became apparent and poignant rather than being too deductive through screening.

Study Design

The use of interviews helped offer flexibility to alter the trajectory of findings (Charmaz, 2002). However, the requirement to opt into sharing reflections in an interview likely meant that participants recruited to the study already had an affinity to racial identity and the experience of same-race dyads. Given the diversity within the Black community it is possible that Black CPs who do not subscribe to the conceptualisation of race or who are less integrated with their racial identity in a professional capacity might have different or less positive views and experiences of same-race dyads. Therefore, people holding such perspectives would have been challenging to recruit in this study. Moreover, it is hoped that since the study accounted for the role of intersectionality, such differences in racial identification and the experience of same-race dyads could still be understood using the findings from this study. Another strength of the study's design was conducting the interviews online since this enabled enhanced access to participants from across the UK which offered greater diversity of experiences, contexts and voices. Furthermore, the inclusion of racially different supervisors within the research team helped offer alternative perspectives throughout

the study. However, the fact that both supervisors also held ethnic minority backgrounds aided in a sense of cultural understanding throughout the interpretation and navigation of this project. Using reflective member checking sessions and various forms of consultation, particularly the main consultant, helped centre the voice and perspective of the group being investigated.

Although a strength of the project was its amplification of the marginalised voices of Black CPs, the insight gathered on the client perspective of same-race therapy derived from a third person account. Additionally, this study's novel finding about increased service use and engagement from Black populations in private practice must be interpreted with caution. For instance, it is likely that there are Black individuals who do not seek racially similar therapists in private practice. As such, it is not clear whether there is a similar demand for private therapy for Black clients who do not seek a racially similar dyad. Furthermore, a correlation has been found between low socio-economic status and reduced service use for Black groups (e.g., Cadaret & Speight, 2018). Therefore, if the underuse of NHS services were compared with the increased use in private practice proportionate to the population of Black people in the local area, it is likely that there would still be many Black people not accessing therapeutic support for mental distress. As a result, factors beyond race and culture might also need to be considered in the context of barriers to accessing service support. Though perhaps the role of class indicates multiple forms of marginalisation faced by Black people where, if the means were available, perhaps more Black clients would be seeking private therapy for support outside the NHS. Alternatively, it is also possible that a proportion of Black groups do not feel the need to access support through westernised means such as therapy due to having their own alternative cultural methods of healing (Gallego, 2020).

Reflexivity on Racial Similarity in the Interview Dyad

Being able to make sense of the experience of racial similarity through the interview process was also helpful in aiding my understanding of the phenomenon being explored. At the end of interviews participants were asked to reflect on how racial similarity impacted the way they answered questions. Their reflections help add further depth and offer helpful comparisons to same-race therapy. Some participants shared that they assumed I had a vested interest and that I 'got it' when they were describing their experiences due to our racial similarity. Additionally, some shared a reduced sense of judgement from me because of a presumed heightened understanding. Some participants also shared that they would have felt more suspicious of the intent held by a White researcher given the nature of the topic. Such findings echo those shared regarding client perceptions of racially different CPs and strengthen the approach taken to explore this topic in the study. Participants often reported feeling increased levels of comfort, using more colloquial language and said that at times they needed to remind themselves to explain answers more to not make assumptions about my understanding. This mirrored my need to ask follow-up questions when I noticed myself unconsciously making presumptions of understanding without further exploration in interviews.

Although participants shared that they were able to be more open with me, some shared concerns about whether being too honest about their challenging experiences as Black CPs would be too anxiety-provoking or distressing for me to hear as an incoming Black CP. Whilst others shared a heightened sense of responsibility to 'do a good job' in the interview by protecting and warning me about their challenging experiences through being more open. Such reflections might offer insight into a Black client's desires to be a 'good client' and protect their Black therapist. An interesting revelation from some participants was that they felt their answers would have been the same irrespective of my race, however their sense and feelings

of trust about how nuance of the data would be understood and trusted felt enhanced. These findings feel resonant of reflections about how the external outcomes of therapy with same-race clients do not differ from non-Black clients, yet the quality and dynamic of the therapy was reported to feel different. Such reflections make me question whether the outcomes as measured in external westernised mediums could ever be captured when investigated in Eurocentric ways through research with racially similar therapy for Black populations? Lastly, some participants shared that they gained a sense of community by bringing their voices together when meeting with me, through their collective voices in the interview data and through the member checking sessions. A similar resonance of racial solidarity and connection in a marginalised context was identified through the study findings. Clearly, the opportunity for participant-researcher reflexivity in the project offered an indescribable benefit and strength to the study.

Dissemination

This thesis has been submitted to the University of Essex for the degree of the Doctorate in Clinical Psychology. Participants that confirmed an interest in obtaining a copy of the final thesis report will receive it once successful completion has been confirmed. The thesis report will also be publicly accessible online in the University of Essex Research Repository. I hope to create an infographic of the study results so that the findings could be shared more widely for the public and professionals online. I plan to submit the research to a peer-reviewed academic journal relevant to the topic area (e.g., Cultural Diversity and Ethnic Minority Psychology). It is hoped that this study might inform clinical psychology professionals, training courses, service providers and policymakers to improve the cultural and racial inclusivity and sensitivity of training and clinical practice for all. Dissemination across these settings could happen through the refined summary of key implications and recommendations which could take place using various mediums (e.g., the development of resource prompts,

supervisor/course staff/student teaching or workshops etc.). Lastly, in addition to offering space for personal and professional reflection, it is also hoped that this study might inform further research in the area.

Invitations for Future Research

This study offers numerous significant and novel findings relevant to enhancing the support offered to Black CPs and clients in mental health services. The finding that there is a demand and interest in seeking and engaging in therapy from Black groups in private practice should be explored further. More qualitative and quantitative research exploring the scope of interest in accessing private therapy compared with engagement in the NHS. Such findings might offer more insight into the factors facilitating and preventing service access and engagement in different service contexts. Research exploring racially similar therapy dyads for different racial majority and minority groups and exploring similarity and difference in relation to other aspects of identity should be conducted. Such findings about the experience of similarity are particularly important to explore with White populations. For instance, the racialisation of ethnic minority groups resorts in the significance of race and culture typically only being considered for ethnic minorities. As such, experiences of similarity for White groups are often overlooked despite this group experiencing similarity the most as the racial majority. Furthermore, same-race dyads should be explored from the client perspective. Such findings might offer more insight into, and corroboration of the cultural adaptations made by Black CPs that clients report benefiting from.

If the cultural adaptations recommended in this study are supported by client reports, then further studies using mixed methods should be conducted in services to support the development of policies and frameworks offering guidance for the implementation of treating racial trauma and making culturally sensitive adaptions to practice. Studies examining clinical adaptations of such interventions should carefully consider the way outcomes are measured.

Culturally adapted outcome measures should be used to capture different qualities of clinical significance that common Eurocentric measures might not identify. Lastly, more research exploring the experience of racial similarity and difference in supervision should be undertaken to support the development of culturally sensitive supervisor training.

Conclusion

This study explored how Black CPs experience working with clients that also have Black heritage. Given that literature exploring ethnic minority experiences of therapy are dominated by research conducted from a White-therapist perspective, this study is novel as a large qualitative project gathering insights from racialised therapists. The findings illustrate that contrary to the implicit assumption that similarity is not necessary to consider when exploring diversity, the nuance and complex intersection between similarities and differences should both be examined. The personal and professional integration of Black CPs' racialised and clinical skill set is beneficial in same-race therapy given the heightened unspoken sense of connection. Yet, the multi-faceted benefits and challenges associated with overidentification of racial similarity, and the additional toll and considerations needed when a CP integrates their racialised Black identity into practice must be recognised and explored given the current failures of clinical psychology institutions in supporting with racial and cultural integration. However, the insights to culturally sensitive practice and recommendations made are critical to improve clinical training and support offered through supervision and service delivery. Such findings provide much hope for the future prospect that the clinical psychology profession can offer to all practitioners and services users.

Final Reflections

It is almost hard to recall the young woman who embarked on this journey of discovery to seek permission about whether she could explore aspects of her racial and cultural identity when presented with her first racially similar client in doctoral training. I have been pleasantly surprised by how much this project has moulded my own personal and professional development as much as I have shaped the development of the project. I recall during data analysis feeling overwhelmed by the vast depth and interconnected nature of the topics being explored. I noticed that it was hard to disentangle the intersecting and overlapping content. At times I realised interview quotes could state the same content, yet beneath the surface I could feel and understand the nuanced difference in meaning. This is mirrored in the discussion of findings where it was hard at times to discuss one theme without referring to another. I recognise how this is parallel to the experience of racially similar dyads. On the surface there are many similar overlapping experiences that are not neat or easy to disentangle. However, upon further exploration the breadth and depth of overlapping similarities and differences and implicit felt meanings and nuance can be understood. I hope that now coming to the end of this report you feel and understand the nuance of the topic, whether you identify as racially similar, different or indeed both. I invite you to notice what aspects of the findings you connect more or less with. Furthermore, I implore you to notice your own aspects of similarity and difference with service-users to dig deep beneath the explicit assumptions, and ask yourself how can your own personal and professional integration be explored to enhance your clinical practice, sense of belonging and purpose within your profession too?

References

Ade-Serrano, Y., & Nkansa-Dwamena, O. (2024). Voicing the uncomfortable: How can we talk about race?. *Counselling Psychology Review*, *39*(1), 97-102. https://doi.org/10.53841/bpscpr.2024.39.1.97

Adi, H. (Ed.). (2019). *Black British History: New Perspectives*. Bloomsbury Publishing.

Alexander, C. (2002). Beyond black: re-thinking the colour/culture divide. *Ethnic and Racial Studies*, *25*(4), 552-571. https://doi.org/10.1080/01419870220136637

Alleyne, B. (2002). An idea of community and its discontents: towards a more reflexive sense of belonging in multicultural Britain. *Ethnic and racial studies*, *25*(4), 607-627. https://doi.org/10.1080/01419870220136655

Ashe, S. D. (2021). *SHF Race Report: 40 years of tackling racial inequality in Britain. Stuart Hall Foundation*. https://www.stuarthallfoundation.org/wp-content/uploads/2021/01/SHF-Race-Report-2021.pdf

Ayonrinde, O. (1999). Black, White or shades of grey: The challenges of ethnic and cultural difference (or similarity) in the therapeutic process. *International Review of Psychiatry*, *11*(2-3), 191-196. https://doi.org/10.1080/09540269974375

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC medical research methodology*, *9*(1), 1-11. https://doi.org/10.1186/1471-2288-9-59

Bartholomew, T. T., Pérez-Rojas, A. E., Bledman, R., Joy, E. E., & Robbins, K. A. (2023). "How could I not bring it up?": A multiple case study of therapists' comfort when Black clients discuss anti-Black racism in sessions. *Psychotherapy*, *60*(1), 63. https://doi.org/10.1037/pst0000404

Bartle, D. (2015). Deception and delusion: The relational aspect of supervision explored through Greek mythology. *Educational and Child Psychology*. https://doi.org/10.53841/bpsecp.2015.32.3.41

Bassey, S., & Melluish, S. (2013). Cultural competency for mental health practitioners: a selective narrative review. *Counselling Psychology Quarterly*, *26*(2), 151-173. https://doi.org/10.1080/09515070.2013.792995

Baum, F., MacDougall, C., Smith, D., & Baum, P. F. (2006). Participatory action research. *Journal of Epidemiological Community Health, 60*, 854–857. https://doi.org/10.1136/jech.2004.028662.

Bell-Tolliver, L., & Wilkerson, P. (2011). The use of spirituality and kinship as contributors to successful therapy outcomes with African American families. *Journal of Religion & Spirituality in Social Work: Social Thought*, *30*(1), 48-70. https://doi.org/10.1080/15426432.2011.542723

Bell-Tolliver, L., Burgess, R., & Brock, L. J. (2009). African American therapists working with African American families: An exploration of the strengths perspective in treatment. *Journal of Marital and Family Therapy*, *35*(3), 293-307. https://doi.org/10.1111/j.1752-0606.2009.00117.x

Berg, S. (2014). Snowball sampling: Overview. In J. . Balakrishnan, T. Colton, B. Everitt, W. Piegorsch, F. Ruggeri, Teugels (Ed.), *Wiley StatsRef*: Statistics Reference Online. https://doi.org/10.1002/9781118445112.stat03370

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research*, *15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Bhaskar, R., & Hartwig, M. (2016). *Enlightened common sense: The philosophy of critical realism*. Routledge. https://doi.org/10.4324/9781315542942

Bhopal, R. S. (2014). *Migration, Ethnicity, race, and health in multicultural societies* (2nd Edition.) Oxford: Oxford University Press.

Bhugra, D., & Bhui, K. (Eds.). (2018). *Textbook of cultural psychiatry*. Cambridge University Press. https://doi.org/10.1017/9781316810057

Bhui, K. (2001). Over-representation of Black people in secure psychiatric facilities. *The British Journal of Psychiatry*, *178*(6), 575-575. https://doi.org/10.1192/bjp.178.6.575

Bhui, K., & Bhugra, D. (2002). Mental illness in Black and Asian ethnic minorities: Pathways to care and outcomes. *Advances in Psychiatric Treatment*, *8*(1), 26-33. https://doi.org/10.1192/apt.8.1.26

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). Racial disparities in mental health: literature and evidence review. *Race Equality Foundation*. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf.

Blundell, R., Cribb, J., McNally, S., Warwick, R., & Xu, X. (2021). Inequalities in education, skills, and incomes in the UK: The implications of the COVID-19 pandemic. *Institute for Fiscal Studies*, 1-42. https://ifs.org.uk/inequality/wp-content/uploads/2021/03/BN-Inequalities-in-education-skills-and-incomes-in-the-UK-the-implications-of-the-COVID-19-pandemic.pdf

Boehnke, K., Lietz, P., Schreier, M., & Wilhelm, A. (2011). *Sampling: The selection of cases for culturally comparative psychological research*. In D. Matsumoto & F. J. R. van de Vijver (Eds.), *Culture and psychology. Cross-cultural research methods in psychology* (p. 101–129). Cambridge University Press. https://doi.org/10.1017/CBO9780511779381.007

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical care research and review*, *57*(1_suppl), 181-217. https://doi.org/10.1177/1077558700057001S09

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2008). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology*, *18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2022). *Thematic Analysis: A Practical Guide*. Sage.

Braun, V., & Clarke, V. (2023). Toward Good Practice in Thematic analysis: Avoiding Common Problems and be(com)ing a Knowing Researcher. *International Journal of Transgender Health*, *24*(1), 1–6. tandfonline. https://doi.org/10.1080/26895269.2022.2129597

Brenton, F. (2010, June 13). *Brixton riots*. https://www.blackpast.org/global-african-history/brixtonriots-april-10-12-198

Brinkmann, S. (2015). Perils and potentials in qualitative psychology. *Integrative Psychological and Behavioral Science, 49,* 162-173. https://doi.org/10.1007/s12124-014-9293-z

British Psychological Society (2017). *Practice Guidelines*. https://explore.bps.org.uk/content/report-guideline/bpsrep.2017.inf115

British Psychological Society. (2017a). *Practice Guidelines: Third Edition.* https://doi.org/10.53841/bpsadm.2018.10.2.11

British Psychological Society (2024). *Supervision Guidance for psychologists*. https://doi.org/10.53841/bpsrep.2024.rep178

Brooks-Ucheaga, M. (2023). A qualitative exploration of black psychotherapists' personal experience of racism and the challenges that exist for black therapists who work with clients in therapy who have also experienced racism. A pilot study using interpretive phenomenological analysis. *the Cognitive Behaviour Therapist, 16,* e14. https://doi.org/10.1017/S1754470X23000065

Burnham, J. (2018). Developments in Social GRRRAAACCEEESSS: visible–invisible and voiced–unvoiced 1. In *Culture and reflexivity in systemic psychotherapy* (pp. 139-160). Routledge.ig

Burris, H. H., & Hacker, M. R. (2017, October). Birth outcome racial disparities: a result of intersecting social and environmental factors. In *Seminars in perinatology* (Vol. 41, No. 6, pp. 360-366). WB Saunders. https://doi.org/10.1053/j.semperi.2017.07.002

Cadaret, M. C., & Speight, S. L. (2018). An exploratory study of attitudes toward psychological help seeking among African American Men. *Journal of Black Psychology*, 44(4), 347–370. https://doi.org/10.1177/0095798418774655

Care Quality Commission. (2011). *Count me in Census 2010*. https://www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf

Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive model* (Vol. 183). John Wiley & Sons.

Charmaz, K. (2002). Stories and silences: Disclosures and self in chronic illness. *Qualitative inquiry*, *8*(3), 302-328. https://doi.org/10.1177/107780040200800307

Clearing House for Postgraduate Courses in Clinical Psychology. (2023). Equal Opportunities Data. https://www.clearing-house.org.uk/about-us/equal-opportunities/equal-opportunities-data

Cohen, L., Manion, L., & Morrison, K. (2007). Research methods in education (6th Edition). *London: Routledge.* https://doi.org/10.4324/9780203029053

Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American journal of Orthopsychiatry*, *61*(3), 392-402. https://doi.org/10.1037/h0079267

Commission on Race and Ethnic Disparities. (2021). *Commission on Race and Ethnic Disparities: The Report. https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities*

Coolican, H. (2017). *Research methods and statistics in psychology*. Psychology press. https://doi.org/10.4324/9780203769836

Cooper, C., Spiers, N., Livingston, G., Jenkins, R., Meltzer, H., Brugha, T., ... & Bebbington, P. (2013). Ethnic inequalities in the use of health services for common mental disorders in England. *Social psychiatry and psychiatric epidemiology*, *48*, 685-692. http://dx.doi.org/10.1007/s00127-012-0565-y

Crabtree, B. F., & Miller, W. L. (2022). *Doing qualitative research*. Sage Publications, Inc.

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. In *University of Chicago Legal Forum* (Vol. 1989, No. 1, p. 8).

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. *Stanford Law Review*, *43*(6), 1241-1299. https://doi.org/10.2307/1229039

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice*, *39*(3), 124-130. https://doi.org/10.1207/s15430421tip3903_2

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Critical Appraisal Skills Programme. (2018). CASP Qualitative Checklist. *Critical Appraisal Skills Programme.* https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/

Crotty, M. J. (1998). The foundations of social research: Meaning and perspective in the research process. *The foundations of social research*, 1-256. https://doi.org/10.4324/9781003115700

Curry, A. E. (1964). Myth, transference and the black psychotherapist. *Psychoanalytic Review*, *51*(4), 7.

Cutcliffe, J. R. (2003). Reconsidering reflexivity: Introducing the case for intellectual entrepreneurship. *Qualitative health research*, *13*(1), 136-148. https://doi.org/10.1177/104973230223941

Daley, P. O. (1998). Black Africans in Great Britain: spatial concentration and segregation. *Urban Studies*, *35*(10), 1703-1724. https://doi.org/10.1080/0042098984114

Davidson, S., & Patel, N. (2009). Power and identity. Considerations for personal and professional development. In J. Hughes & S. Youngson (Eds.), *Personal development and clinical psychology*. (pp. 75–88). London, England: Brunner-Routledge, pp. 75–88.

Day, S. (2012). A reflexive lens: Exploring dilemmas of qualitative methodology through the concept of reflexivity. *Qualitative Sociology Review*, *8*(1), 60–85. https://doi.org/10.18778/1733-8077.8.1.04

De Maynard, V. A. (2009). Dissociation in black or black-British people of African and African-Caribbean descent in the United Kingdom. *International Journal of Mental Health*, *38*(2), 37-73. https://doi.org/10.2753/IMH0020-7411380203

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family medicine and community health*, *7*(2). https://doi.org/10.1136/fmch-2018-000057

Demie, F. (2021). The experience of Black Caribbean pupils in school exclusion in England. *Educational Review*, *73*(1), 55-70. https://doi.org/10.1080/00131911.2019.1590316

Denzin, N., & Lincoln, Y. (1994). Handbook of Qualitative Research. *British Journal of Educational Studies*, *42*(4). https://doi.org/10.2307/3121684

Denzin, N., & Lincoln, Y. (2017). *The Sage Handbook of Qualitative Research*. Sage.

Department for Education. (2021a). *GCSE English and maths results: Ethnicity facts and figures.* https://www.ethnicity-facts-figures.service.gov.uk/education-skills-andtraining/11-to-16-years-old/a-to-c-in-english-and-maths-gcse-attainment-for-childrenaged-14-to-16-key-stage-4/lates

Department for Education. (2024). *Permanent exclusions*. https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-exclusions/permanent-exclusions/latest/#permanent-exclusions-by-ethnicity-over-time

Department of Health (DoH). (2010). *Race Equality Action Plan: a five year review*.

http://data.parliament.uk/DepositedPapers/Files/DEP2014 0975/PQ202552_PQ202500_-_Report.pdf

Department of Health. (2005). *Delivering race equality and independent inquiry into the death of David Bennett in mental health care. An action plan for reform inside and outside services. The Government's response to the independent inquiry into the death of David Bennett.* https://documents.manchester.ac.uk/display.aspx?DocID=54691

Dera, N. N. (2021). *A Thematic Analysis Exploring Young Black Men's Experiences of Accessing and Engaging in Psychological Therapy within Primary Care*. [Doctoral thesis, University of Hertfordshire]. https://doi.org/10.18745/th.25177

Devonport, T. J., Ward, G., Morrissey, H., Burt, C., Harris, J., Burt, S., ... & Nicholls, W. (2023). A systematic review of inequalities in the mental health experiences of Black African, Black Caribbean and black-mixed UK populations: implications for action. *Journal of Racial and Ethnic Health Disparities*, 1-13. https://doi.org/10.1007/s40615-022-01352-0

Dhillon-Stevens, H. (2011). Issues for psychological therapists from black and minority ethnic groups. *C. Largo, ed*, 105-116.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, *40*(4), 314-321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: Qualitative research as emotion work. *Journals.Sagepub.Com*, *9*(1), 61–79. https://doi.org/10.1177/1468794108098031

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, *13*(3), 7– 21. https://doi.org/10.7748/nr2006.04.13.3.7.c5975

Du Bois, W.E.B. (1920) *Darkwater: voices from within the veil*. New York: Harcourt Brace.

Dunsmuir, S., & Leadbetter, J. (2010). Professional supervision: Guidelines for practice for educational psychologists. Leicester: *British Psychological Society*. https://doi.org/10.53841/bpsrep.2010.inf177

Durrheim, K., Hook, D., & Riggs, D. (2009). Race and racism. *Critical psychology: An introduction*, *2*.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Dyer, J., & Gilbert, S. (2019). *Independent review of the Mental Health Act 1983: supporting documents. Mental Health Act Review African and Caribbean Group - final report to the review*

chair. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf.

Edge, D., & MacKian, S. C. (2010). Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK. *Ethnicity & Health*, *15*(1), 93-111. https://doi.org/10.1080/13557850903418836

Esin, C., Fathi, M., & Squire, C. (2014). Narrative analysis: The constructionist approach. *The SAGE handbook of qualitative data analysis*, 203-216.

Evandrou, M., Falkingham, J., Feng, Z., & Vlachantoni, A. (2016). Ethnic inequalities in limiting health and self-reported health in later life revisited. *J Epidemiol Community Health*, *70*(7), 653-662. https://doi.org/10.1136/jech-2015-206074

Fanon, F. (1967) *Black skin, White masks*. New York: Grove Press.

Faulkner, A. (2011). Participation and service user involvement. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*, 39–54. https://doi.org/10.1002/9781119973249.ch4.

Fernando, S. (2004). *Cultural diversity, mental health and psychiatry: The struggle against racism*. Routledge.

Fernando, S. (2010). *Mental health, race and culture*. Bloomsbury Publishing.

Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, *7*, 117–140. https://doi.org/10.1177/001872675400700202

Fink, A. (2019). *Conducting research literature reviews: From the internet to paper*. Sage publications.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative health research*, *12*(4), 531-545. https://doi.org/10.1177/104973202129120052

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International journal of social research methodology*, *20*(2), 181-194. https://doi.org/10.1080/13645579.2016.1144401

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., ... & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC health services research*, *18*, 1-11. https://doi.org/10.1186/s12913-018-2915-2

Foster, R. P. (1998). The clinician's cultural countertransference: The psychodynamics of culturally competent practice. *Clinical Social Work Journal*, *26*, 253-270. https://doi.org/10.1023/A:1022867910329

Fuller, K. (2013). *Gender, identity and educational leadership*. A&C Black.

Gaine, C. (2005). *We're All White Thanks: the persisting myth about 'white' schools*. Trentham Books.

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. P. (2016). Ethnicity and detention: are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007?. *Social psychiatry and psychiatric epidemiology*, *51*, 703-711. https://doi.org/10.1007/s00127-016-1181-z

Gallego, M. (2020). 'Cultures of healing': spirituality, interdependence and resistance in the African diaspora. *African and Black Diaspora: An International Journal*, *13*(1), 68-79. https://doi.org/10.1080/17528631.2019.1637144

Gonzalez-Sobrino, B., & Goss, D. R. (2019). Exploring the mechanisms of racialization beyond the black–white binary. *Ethnic and Racial Studies*, *42*(4), 505-510. https://doi.org/10.1080/01419870.2018.1444781

Goodbody, L. (2009). *A critical analysis of the personal and professional development of majority and minority group clinical psychologists: Power, difference and identities* [Doctoral dissertation, Canterbury Christ Church University]. https://repository.canterbury.ac.uk/item/8699x/a-critical-analysis-of-the-personal-and-professional-development-of-majority-and-minority-group-clinical-psychologists-power-difference-and-identities

Goode-Cross, D. T. (2011). Same difference: Black therapists' experience of same-race therapeutic dyads. *Professional Psychology: Research and Practice*, *42*(5), 368. https://doi.org/10.1037/a0025520

Goode-Cross, D. T., & Grim, K. A. (2016). "An Unspoken Level of Comfort" Black Therapists' Experiences Working With Black Clients. *Journal of Black Psychology*, *42*(1), 29-53. https://doi.org/10.1177/0095798414552103

Gough, D., Thomas, J., & Oliver, S. (2017). *An introduction to systematic reviews*. SAGE Publications.

GOV.UK. (2024). *Ethnicity facts and figures*. https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/policing/stop-and-search/latest/#by-ethnicity

Greenberg, J. P., Vinjamuri, M., Williams-Gray, B., & Senreich, E. (2018). Shining the light on intersectionality: The complexities of similarity and difference in the therapeutic process from the perspectives of Black and hispanic social workers. *Smith College Studies in Social Work*, *88*(1), 59-81. https://doi.org/10.1080/00377317.2018.1404363

Gunaratnam, Y. (2003). *Researching 'Race' and Ethnicity: Methods, Knowledge and Power*. London: Sage. https://doi.org/10.4135/9780857024626

Hackett, R. A., Ronaldson, A., Bhui, K., Steptoe, A., & Jackson, S. E. (2020). Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom. *BMC public health*, *20*(1), 1-13. https://doi.org/10.1186/s12889-020-09792-1

Hall, S. (2006). New ethnicities. In *Stuart Hall* (pp. 453-462). Routledge.

Hamilton, A. (2023). Black therapists' experiences with their Black clients: A systematic review. *Journal of Marital and Family Therapy*. https://doi.org/10.1111/jmft.12678

Hatch, S. L., Frissa, S., Verdecchia, M., Stewart, R., Fear, N. T., Reichenberg, A., ... & Hotopf, M. (2011). Identifying socio-demographic and socioeconomic determinants of health inequalities in a diverse London community: the South East London Community Health (SELCoH) study. *BMC public health*, *11*, 1-17. https://doi.org/10.1186/1471-2458-11-861

Health and Care Professions Council. (2023). *Diversity Data: Clinical Psychologists.* https://www.hcpc-uk.org/resources/data/2023/diversity-data-practitioner-psychologists-2023/

Health and Care Professions Council. (2023). *Standards of proficiency: Practitioner psychologists.* https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency---practitioner-psychologists.pdf

Health Education England. (2021). *Improving equity and inclusion for people to access psychological professions training*. https://healtheducationengland.sharepoint.com/sites/MHPe/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FMHPe%2FShared%20Documents%2FPsychological%20Professions%2FNHS%20Funding%20Psych%20Professions%2FExternal%20Comms%20Updates%2FNovember%202021%2FAction%20Plan%20to%20Improve%20Equity%20of%20Access

%20and%20Inclusion%20for%20Black%2C%20Asian%20and%20Minority%20Ethnic%20Entrants%20to%20Clinical%20Psychology%20Training%2Epdf&parent=%2Fsites%2FMHPe%2FShared%20Documents%2FPsychological%20Professions%2FNHS%20Funding%20Psych%20Professions%2FExternal%20Comms%20Updates%2FNovember%202021&p=true&ga=1

Helms, J. E. (1990). *Training Manual for Diagnosiing Racial Identity in Social Interactions*. Content Communications.

Helms, J. E., Jernigan, M., & Mascher, J. (2005). The meaning of race in psychology and how to change it: a methodological perspective. *American psychologist*, *60*(1), 27. https://doi.org/10.1037/0003-066X.60.1.27

Hill, M. J. (2013). Is the Black community more homophobic?: Reflections on the intersectionality of race, class, gender, culture and religiosity of the perception of homophobia in the Black community. *Journal of Gay & Lesbian Mental Health*, *17*(2), 208-214. https://doi.org/10.1080/19359705.2013.768089

HM Inspectorate of Prisons. (2018). *HM Chief Inspector of Prisons for England and Wales Annual Report 2017-18*. https://assets.publishing.service.gov.uk/media/5c06893bed915d7463b34dbe/hmi-prisons-annual-report-2017-18-revised-web.pdf

Hoge, M.A., Paris, M.J., Adger, H.J., Collins, F.L.J., Finn, C.V., Fricks, L., Young, A.S. (2005). Workforce Competencies in Behavioural Health: An Overview. Administration and Policy in Mental Health, 32, 593–631. https://doi.org/10.1007/s10488-005-3259-x

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345–357. https://doi.org/10.1177/1468794103033004

INQUEST. (2024, January 2). BAME deaths in police custody. https://www.inquest.org.uk/bame-deaths-in-police-custody

Jacobson, D., & Mustafa, N. (2019). Social Identity Map: A Reflexivity Tool for Practicing Explicit Positionality in Critical Qualitative Research. *International Journal of Qualitative Methods, 18*, 1–12. https://doi.org/10.1177/1609406919870075

Janally, S. (2020). Addressing the unmet needs of BAME trainees through a system of mentoring. In *Clinical Psychology Forum* (Vol. 331). https://doi.org/10.53841/bpscpf.2020.1.331.6

Jenkinson, J. (2009). *Black 1919: Riots, racism and resistance in Imperial Britain*. Liverpool University Press.

Jensen, E., Carr, R., Degnan, A., Berry, K., & Edge, D. (2021). Exploring service user and family perspectives of a Culturally adapted Family Intervention (CaFI) for African-Caribbean people with psychosis: A qualitative study. *British Journal of Clinical Psychology*, *60*(2), 270-289. https://doi.org/10.1111/bjc.12273

Joseph–Salisbury, R., Connelly, L., & Wangari-Jones, P. (2020). "The UK is not innocent": Black Lives Matter, policing and abolition in the UK. *Equality, Diversity and Inclusion: An International Journal*, *40*(1), 21-28. https://doi.org/10.1108/edi-06-2020-0170

Josselson, R., & Hammack, P. L. (2021). *Essentials of narrative analysis*. American Psychological Association. https://doi.org/10.1037/0000246-000

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing*, *72*(12), 2954-2965. https://doi.org/10.1111/jan.13031

Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Becares, L., & Esmail, A. (2022). *Ethnic Inequalities in Healthcare: A Rapid Evidence Review*. NHS Race & Health Observatory. Advance online publication. https://www.nhsrho.org/wp-content/uploads/2023/05/RHO-Rapid-Review-Final-Report_.pdf

Kelley, R. D., Tuck, S., & Wild, R. (2015). "Black was the colour of our fight": the transnational roots of British Black Power. *The Other Special Relationship: Race, Rights, and Riots in Britain and the United States*, 25-46.

Kelly, S., & Boyd-Franklin, N. (2005). African American women in client, therapist, and supervisory relationships. *Voices of color: First-person accounts of ethnic minority therapists*, 67-89. https://doi.org/10.4135/9781452231662.n5

Khan, O. (2020). The colour of money. *London, UK: Runnymede. https://www. runnymedetrust. org/blog/the-colour-ofmoney-race-and-economic-inequality The Cognitive Behaviour Therapist*, *3*. https://friendsprovidentfoundation.org/wp-content/uploads/2024/01/Runnymede-report.pdf

Kiger, M. E., & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical Teacher*, *42*(8), 846–854. https://doi.org/10.1080/0142159X.2020.1755030.

Kimpara, S., Brunet, H., Beutler, L. E., & Alsante, J. (2016). Client, therapist, and treatment variables: Client-therapist "matching" In S. Maltzman (Ed.), *The Oxford handbook of treatment processes and outcomes in psychology: A multidisciplinary, biopsychosocial approach*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199739134.013.14

Kline, R. (2015). Beyond the snowy white peaks of the NHS. *Race Equality Foundation*. https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/Health-Briefing-39-_Final.pdf

Knight, M., Bunch, K., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S., Kurinczuk, J. J. (2021). *MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19.* https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, *59*(5), 529–539. https://doi.org/10.1002/jclp.10157

Layton, L. (2006). Racial identities, racial enactments, and normative unconscious processes. *The Psychoanalytic Quarterly*, *75*(1), 237-269. https://doi.org/10.1002/j.2167-4086.2006.tb00039.x

Lee, B. A., Ogunfemi, N., Neville, H. A., & Tettegah, S. (2023). Resistance and restoration: Healing research methodologies for the global majority. *Cultural Diversity and Ethnic Minority Psychology*, *29*(1), 6. https://doi.org/10.1037/cdp0000394

Lee, E., Johnstone, M., & Herschman, J. (2019). Negotiating therapy goals and tasks in cross-cultural psychotherapy. *Journal of Social Work Practice*, *33*(4), 447-462. https://doi.org/10.1080/02650533.2018.1504288

Lewis-Beck, M., Bryman, A., & Futing Liao, T. (2012). *The SAGE Encyclopedia of Social Science Research Methods*. Sage Publications, Inc. : http://dx.doi.org/10.4135/9781412950589

Lijtmaer, R. M. (2014). Black, white, Hispanic and both: issues in biracial identity and its effects in the transference-countertransference 1. In *Race, culture and psychotherapy* (pp. 130-138). Routledge.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. California Sage Publications.

Long, C. (2022). Racial identity and uncertainty in psychotherapy: Perspectives of Black clients and their therapists. *International Journal of Applied Psychoanalytic Studies*, *19*(4), 444-461. https://doi.org/10.1002/aps.1737

Lubian, K., Weich, S., Stansfield, S., Bebbington, P., Brugha, T., Spiers, N., ... & Cooper, C. (2016). *Mental health treatment and services*. NHS Digital. https://discovery.ucl.ac.uk/id/eprint/1528613/1/Lubian%20et%20al%20APMS%202014.pdf

Magaldi, D., & Berler, M. (2020). Semi-structured interviews. *Encyclopedia of personality and individual differences*, 4825-4830. https://doi.org/10.1007/978-3-319-24612-3_857

Maki, M. T. (1999). The effects on clinician identification when clinician and client share a common ethnic minority background. *Journal of Multicultural Social Work*, *7*(1-2), 57-72. https://doi.org/10.1300/J285v07n01_04

McKenzie, K., Samele, C., Van Horn, E., Tattan, T., Van Os, J., & Murray, R. (2001). Comparison of the outcome and treatment of psychosis in people of Caribbean origin living in the UK and British Whites: report from the UK700 trial. *The British Journal of Psychiatry*, *178*(2), 160-165. https://doi.org/10.1192/bjp.178.2.160

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

McNeil, S. L. (2010). *'The only black in the village': a qualitative exploration of the experience of black psychologists in Britain.* [Doctoral thesis, University of Birmingham]. http://etheses.bham.ac.uk/id/eprint/3560

Mercer, K. (2020). Identity and diversity in postmodern politics. In *Theories of race and racism* (pp. 577-594). Routledge.

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in CLIENTS'EXPERIENCES of mental health treatment. *Journal of community psychology*, *41*(7), 884-901. https://doi.org/10.1002/jcop.21580

Minikin, K. (2022). Black Identities and White Therapies: Working with Race, Ethnicity and Culture in and Outside the Therapy Room (Conference review). *Psychotherapy & Politics International*, *20*(3), 1-3. https://doi.org/10.24135/ppi.v20i3.11

Mitchell, K. M., & Atkinson, M. B. (1983). The relationship between therapist and client social class and participation in psychotherapy. *Professional Psychology: Research and Practice*, *14*(3), 310. https://doi.org/10.1037/0735-7028.14.3.310

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., Altman, D., Antes, G., Atkins, D., Barbour, V., Barrowman, N., Berlin, J. A., Clark, J., Clarke, M., Cook, D., D'Amico, R., Deeks, J. J., Devereaux, P. J., Dickersin, K., Egger, M., Ernst, E., … Tugwell, P. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7). https://doi.org/10.1371/journal.pmed.1000097

Montagu, M. A. (1942). The genetical theory of race, and anthropological method. *American Anthropologist*, 369-375. https://doi.org/10.1525/aa.1942.44.3.02a00030

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations*, *2*(4), 221. https://doi.org/10.1037/pri0000055

Murphy, M. J., Faulkner, R. A., & Behrens, C. (2004). The Effect of Therapist–Client Racial Similarity on Client Satisfaction and Therapist Evaluation of Treatment. *Contemporary Family Therapy*, *26*(3), 279–292. https://doi.org/10.1023/B:COFT.0000037915.95303.28

Newland, J., Patel, N., & Senapati, M. (2015). Professional and ethical practice in a multi-ethnic society. In *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists* (pp. 191-201). Routledge.

NHS Digital. (2022). *Mental Health Act Statistics, Annual Figures, 2021-22*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2021-22-annual-figures/data-quality

NHS Digital. (2022). *National Child Measurement Programme, England, 2021/22 school year*. https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2021-22-school-year/ethnicity

NHS England. (2019). NHS mental health implementation plan 2019/20–2023/24. *England: NHS England*, 57. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

NICE. (2018). *Post-traumatic stress disorder: NICE guideline*. https://www.nice.org.uk/guidance/ng116

Noblit, G. W. (1988). Meta-ethnography: Synthesizing qualitative studies. *Stage Publication*.

Noorani, T. (2013). Service user involvement, authority and the "expert-by-experience" in mental health. *Journal of Political Power, 6*(1), 49–68. https://doi.org/10.1080/2158379X.2013.774979.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods*, *16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847.

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of social research methodology*, *11*(4), 327-344. https://doi.org/10.1080/13645570701401305

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatowski, R., ... & Wainwright, T. (2021). *BPS code of human research ethics*. British Psychological Society. https://doi.org/10.53841/bpsrep.2021.inf180

Odusanya, S. O., Winter, D., Nolte, L., & Shah, S. (2018). The experience of being a qualified female BME clinical psychologist in a National Health Service: An interpretative phenomenological and repertory grid analysis. *Journal of Constructivist Psychology*, *31*(3), 273-291. https://doi.org/10.1080/10720537.2017.1304301

Office for National Statistics. (2022). *Ethnic Group, England and Wales: Census 2021*. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021#:~:text=%22Black%2C%20Black%20British%2C%20Caribbean,was%202.2%25%20(1.2%20million)

Omi, M., & Winant, H. (1986). *Racial Formation in the United States (1st ed.)*. Routledge.

Omi, M., & Winant, H. (2014). *Racial formation in the United States (3rd ed.)*. Routledge. https://doi.org/10.4324/9780203076804

Paez, A. (2017). Gray literature: An important resource in systematic reviews. *Journal of Evidence-Based Medicine*, *10*(3), 233-240. https://doi.org/10.1111/jebm.12266

Patel, N. (2022). Dismantling the scaffolding of institutional racism and institutionalising anti-racism. *Journal of Family Therapy*, *44*(1), 91-108. https://doi.org/10.1111/1467-6427.12367

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nairdshaw, Z. (2000). Clinical psychology, race and culture: A resource pack for trainers. *Leicester, UK: British Psychological Society*.

Patton, M. Q. (1990). *Qualitative evaluation and research methods. In Qualitative evaluation and research methods, 2nd ed.* (p. 532). Sage Publications, Inc. https://doi.org/10.1002/nur.4770140111

Paulraj, P. S. (2016). *How do Black Trainees Make Sense of Their 'Identities' in the Context of Clinical Psychology Training?* [Doctoral dissertation, University of East London]. https://doi.org/10.15123/PUB.5401

Pickren, W. E. (2009). Liberating history: The context of the challenge of psychologists of color to American psychology. *Cultural Diversity and Ethnic Minority Psychology*, *15*(4), 425. https://doi.org/10.1037/a0017561

Pilgrim, D. (2019). *Critical realism for psychologists*. Routledge. *Psychology Research*, 53–80. https://doi.org/10.4324/9780429274497

Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents* (Vol. 2). Sage.

Portelli, J., & Campbell-Stephens, R. (2009). *Leading for equity*. Toronto: Edphil Books.

Prajapati, R., Kadir, S., & King, S. (2019). Dealing with racism within clinical psychology training: Reflections of three BAME trainee clinical psychologists. In Clinical Psychology Forum (Vol. 323, pp. 20-24). *Psychology Research*, 53–80. https://d1wqtxts1xzle7.cloudfront.net/62064088/21708_CAT-225020200211-52315-ziu8lv-libre.pdf?1581427972=&response-content-disposition=inline%3B+filename%3DClinical_Psychology_Forum_Special_Issue.pdf&Expires=1730239783&Signature=XkBMYnPoUO65xkJh8y93Zy5gYI91wXkWCqH6tDvRWeZYwVP~4EM6obpXAxhxG4oEiEV9Ulzykzp6gjy9D5fxOhyl53Cem7pqM~kmIVGaHkkwHnu9K5OKLY~ShaD3jwJRoO7TbKovay6OdOaXbzftoEPydWcj0x6Bm-hCt7xl27eU3OSub6m5VBaFCHEGO92pGJxMtdWyELMxQ5XcdLe7Ouo7pzlE2l~Po9p6WVmunS3BshZZI-ygjn5jPZ96iaxjyWHVi3zVE6A-ZPgE0~8~hG6eKq4MaOlqB3gVMkFWKYWLHotYi87EKBOfC96~yOUQ6OSiavelOx2gETEunUnfvw__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA#page=22

Race Disparity Unit. (2021b). *Writing about ethnicity. Race Disparity Unit. (2021b).* https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/

Raleigh, V. S. (2021). *The health of people from ethnic minority groups in England*. King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28-48. https://doi.org/10.1002/jmcd.12035

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Company.

Ronkainen, N. J., Watkins, I., & Ryba, T. V. (2016). What can gender tell us about the pre-retirement experiences of elite distance runners in Finland?: A thematic narrative analysis. *Psychology of Sport and Exercise*, *22*, 37-45. https://doi.org/10.1016/j.psychsport.2015.06.003Get rights and content

Sancho, I. (1782). *The letters of the late Ignatius Sancho, an African: To which are added, poems by several hands*. London: J. Nichols.

Sanders, J., & Rose-Adams, J. (2014). Black and minority ethnic student attainment: A survey of research and exploration of the importance of teacher and student expectations. *Widening Participation and Lifelong Learning*, *16*(2), 5-27. https://doi.org/10.5456/WPLL.16.2.5

Sarsah, H., Abraham, M., & Leech, D. (2022). Beyond black and white: an inclusive reciprocal mentoring model to promote diversity, engagement and understanding. *British Journal of Healthcare Management*, *28*(8), 1-5. https://doi.org/10.12968/bjhc.2021.0125

Scanlan, P. X. (2020). *Slave empire: How slavery built modern Britain*. Hachette UK.

Scior, K., Gray, J., Halsey, R., & Roth, A. (2007). Selection for clinical psychology training: Is there evidence of any bias towards applicants from ethnic minorities. In *Clinical Psychology Forum* (Vol. 175, pp. 7-11).

Scior, K., Williams, J., & King, J. (2015). Is access to clinical psychology training in the UK fair? The impact of educational history on application success. In *Clinical Psychology Forum* (Vol. 274, pp. 12-18). British Psychological Society. https://discovery.ucl.ac.uk/id/eprint/1469129

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English language teaching, 5*(9), 9-16. https://doi.org/10.5539/elt.v5n9p9.

Secker, J., & Harding, C. (2002). Users' perceptions of an African and Caribbean mental health resource centre. *Health & Social Care in the Community*, *10*(4), 270–276. https://doi.org/10.1046/j.1365-2524.2002.00372.x

Sewell, T., Aderin-Pocock, M., Chughtai, A., Fraser, K., Kakkar, A., Khalid, N., ... & Cluff, B. (2021). *Report of the Commission on Race and Ethnic Disparities.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf.

Shah, S. (2010). *The experience of being a trainee clinical psychologist from a black and minority ethnic group: A qualitative study.* [Doctoral dissertation, The University of Hertfordshire]. The University of Hertfordshire Research Archive https://uhra.herts.ac.uk/handle/2299/5088

Shankar, R. (2009). Developing Cultural Competence in Clinical Psychology Work with BME Communities. *Clinical Psychology in Practice*, 226-235.

Siblon, J. (2016). Negotiating hierarchy and memory: African and Caribbean troops from former British colonies in London's imperial spaces. *The London Journal*, *41*(3), 299-312. https://doi.org/10.1080/03058034.2016.1213548

Sims-Schouten, W., Riley, S. C. E., Willig, C., & Zotzmann, K. (2007). Female employment as an example method of analysis using women's talk of motherhood, childcare as an example. *Theory & Psychology*, *17*(1),101-124. https://doi.org/10.1177/0959354307073153.

Singh, S. P., Greenwood, N. A. N., White, S., & Churchill, R. (2007). Ethnicity and the mental health act 1983: systematic review. *The British Journal of Psychiatry, 191*(2), 99-105. https://doi.org/10.1192/bjp.bp.106.030346

Sixsmith, B. (2023). *Marginalising the Majority.* The Critic. https://thecritic.co.uk/marginalising-the-majority/

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American psychologist*, *60*(1), 16. https://doi.org/10.1037/0003-066X.60.1.16

Smith, J. (1995). *Semi structured interviewing and qualitative analysis*. Sage. https://doi.org/10.4135/9781446221792.n2

Smith, J. A. (2003). *Qualitative psychology: A practical guide to research methods.* Sage Publications, Inc.

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. *Doing Social Psychology Research*, 53–80. https://doi.org/10.1002/9781119975144.ch9

Sudbury, J. (2001). (Re) constructing multiracial blackness: womens activism, difference and collective identity in Britain. *Ethnic and Racial Studies*, *24*(1), 29-49. https://doi.org/10.1080/014198701750052488

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of counseling & development*, *70*(4), 477-486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Suresh, K., & Bhui, K. (2006). Ethnic minority patients' access to mental health services. *Psychiatry*, *5*(11), 413-416. https://doi.org/10.1053/j.mppsy.2006.08.005

Talbot, M. (Ed.). (2019). *Language and power in the modern world*. Edinburgh University Press.

Tang, L., & Pilgrim, D. (2017). Intersectionality, mental health and Chinese people in the UK: a qualitative exploration. *Mental Health Review Journal*, *22*(4), 289-299. https://doi.org/10.1108/MHRJ-03-2017-0014

Tang, N. M., & Gardner, J. (1999). Race, culture, and psychotherapy: Transference to minority therapists. *The Psychoanalytic Quarterly*, *68*(1), 1-20. https://doi.org/10.1002/j.2167-4086.1999.tb00634.x

TASERD. (2023). *Taser and Social, Ethnic and Racial Disparities research programme*. https://www.ucl.ac.uk/security-crime-science/sites/security_crime_science/files/taserd_report_13_dec_2023.pdf

Teh, Y. Y., & Lek, E. (2018). Culture and reflexivity: Systemic journeys with a British Chinese family. *Journal of Family Therapy*, *40*(4), 520-536. https://doi.org/10.1111/1467-6427.12205

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The SAGE handbook of qualitative research in psychology*, *2*, 17-37. https://doi.org/10.4135/9781526405555.n2

The Centre for Social Justice. (2020). *Facing The Facts: Ethnicity And Disadvantage In Britain. London: The Centre for Social Justice*. https://www.centreforsocialjustice.org.uk/wp-content/uploads/2020/11/CSJJ8513-Ethnicity-Poverty-Report-FINAL.pdf

The Sewell Report. (2021). *The report of the commission on race and ethnic disparities*. https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*(1), 1-10. https://doi.org/10.1186/1471-2288-8-45

Thompson, L. A. (1972). Africans in northern Britain. *Museum Africum: West African Journal of Classical and Related Studies*, *1*, 28-38.

Thrower, S. J., Helms, J. E., & Price, M. (2020). Racial dynamics in counselor training: The racial identity social interaction model. *Journal of Counselor Preparation and Supervision*, *13*(1), 4. http://dx.doi.org/10.7729/131.1313

Tikly, L. (2022). Racism and the future of antiracism in education: A critical analysis of the Sewell Report. *British educational research journal*, *48*(3), 469-487. https://doi.org/10.1002/berj.3776

Totsuka, Y. (2014). 'Which aspects of social GGRRAAACCEEESSS grab you most?' The social GGRRAAACCEEESSS exercise for a supervision group to promote therapists' self-reflexivity. *Journal of family Therapy*, *36*, 86-106. https://doi.org/10.1111/1467-6427.12026

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary nurse*, *19*(1-2), 75-87. https://doi.org/10.5172/conu.19.1-2.75

Turner, J. C., Brown, R. J., & Tajfel, H. (1979). Social comparison and group interest in ingroup favouritism. *European Journal of Social Psychology*, *9*(2), 187–204. https://doi.org/10.1002/ejsp.2420090207

Turpin, G., & Coleman, G. (2010). Clinical Psychology and Diversity: Progress and Continuing Challenges. Psychology *Learning & Teaching*, *9*(2), 17–27. https://doi.org/10.2304/plat.2010.9.2.17

Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist*, *33*(4), 449-478. https://doi.org/10.1177/001100000426905

Wagstaff, C., Farrell, D., & Williams, R. (2011). Disengagement of clients from mental health services. *Mental Health Practice*, *14*(8). https://doi.org/10.7748/mhp2011.05.14.8.20.c8473

Walvin, J. (1994). *Black ivory: Slavery in the British empire*. London: Blackwell.

Warfa, N., Bhui, K., Psychiatry, S., Phillips, K., Nandy, K., Griffiths, S., Warfa, N., Bhui, K., & Phillips, K. (2006). Comparison of life events, substance misuse, service use and mental illness among African-Caribbean, black African and white British men in east London: a qualitative study. *Diversity in Health and Social Care*, *3*, 111-121.

Wells, K. (2011). Narrative Inquiry. *Qualitative Social Work*, *10*(4), 537–545. https://doi.org/10.1177/1473325011425481a

Wessley, S. (2018). Modernising the mental health act: increasing choice, reducing compulsion. *Final report of the independent review of the Mental Health Act 1983.* UK Gov. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montreal. *The Canadian Journal of Psychiatry*, *51*(4), 205-209. https://doi.org/10.1177/070674370605100401

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In D.J Nightinghale & J Cromby (eds) *Social Constructionist Psychology: A Critical Analysis of Theory and Practice.* Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology*. Open University Press.

Wylie, F. M. (1971). Attitudes toward aging and the aged among black Americans: Some historical perspectives. *Aging and Human Development*, *2*(1), 66-70. https://doi.org/10.2190/AG.2.1.h

Xiao, Y., & Watson, M. (2019). Guidance on conducting a systematic literature review. *Journal of planning education and research*, *39*(1), 93-112. https://doi.org/10.1177/0739456X17723971

Zuckerman, M. (1990). Some dubious premises in research and theory on racial differences: Scientific, social, and ethical issues. *American psychologist*, *45*(12), 1297. https://doi.org/10.1037/0003-066X.45.12.1297

Appendices

Appendix A: Search terms used in Literature Search

[Racial Similarity/Difference] AND [Therapeutic Dyad] AND [Black] AND [Therapists]

Racial Similarity/Difference	Therapeutic Dyad	Black	Therapists
Similar* OR Match* OR Ethnicity* OR Race* OR Cultur* OR Cross-Racial* OR Cross-Cultur* OR Cross-Ethnic* OR Minorit* OR Ethnic* OR "Cultural Diff*" OR "Racial Diff*" OR "Ethnic Diff*" OR "Cultural Simi*" OR "Racial Simi*" OR "Same-Race" OR "Ethnic Match*" OR Racial OR "Rac* Match*" OR "Cultur* Vari*" OR "Rac* Vari*" OR "Ethnic* Vari*" OR "Rac* Concordan*" OR "Ethnic* Concord*" OR "Cultur* Concord*" OR "Rac* Discocord*" OR "Ethnic* Disconcord*" OR "Cultur* Disconcord*"	Dyad* OR "Therap* Dyad" OR Therap* OR "Therapist Client" OR "Psychotherap* Dyad*" OR "Patient Therapist" OR "Therapist Patient" OR "Client Therapist" OR "Therapist client" OR Therapist/Client OR Client/Therapist OR Patient/Therapist OR Therapist/Patient OR "Therap* Relation*" OR "Counsel* Dyad*"	Black OR African* OR Caribbean* OR Afro-Caribbean OR OR African-Caribbean OR African-American	Clinician* OR Practitioner* OR Therap* OR Counsel* OR Psychiatr* OR Psycho* OR "Psychological Therap*" OR OR "Family Therap*" OR "Systemic Therap" OR "Art Therap*"

Appendix B: Review Study Characteristics Table

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
Bartholomew et al. (2023)	To understand the experience of therapists' cultural comfort when Black clients discuss experiencing anti-Black racism.	A multiple case study approach using semi-structured interviews.	Convenience and purposeful sampling. Recruited through social media, the researchers' professional networks and scholarly listservs. (n= 5) Two were Black African American therapists. Sample included pre-licensed, fully licensed, master's level trained, a pre-doctoral intern, and postdoctoral fellows. Age range: Not reported	Online video calls, USA	Stake's (2006) approach to multiple case study

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
Bell-Tolliver (2009)	To explore the perspective of African American psychotherapists' identification of strengths in African American families and to discover how they view and use these strengths in therapy.	Qualitative interviews	Snowball sampling recruited from AAMFT annual conferences in Texas, Arkansas and Georgia. (n= 30) African American Psychotherapists Age range: 20-70, majority were 46-55.	Face to face interviews, USA	Miles and Huberman (1994)'s pattern coding and triangulation.
Bell-Tovier & Wilkerson (2011)	To explore how African American therapists use strengths such as spirituality, religiosity and extended family networks when supporting African American families.	A phenomenological approach using qualitative interviews.	Snowball sampling] (n= 30) African American therapists. Sample included the following licences: marriage and family therapy, social work, professional	Face to face interviews in either the participant's office, the investigator's office or in a quiet meeting location at a conference.	Miles and Huberman (1994)'s pattern coding and triangulation.

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
			counsellor, psychology and some with multiple licences. Age range: 20-70, majority were 46-55.	USA	
Brooks-Ucheaga (2023)	To explore and understand the personal experiences of Black therapists who have personally experienced racism. To identify some of the challenges that exist for Black therapists who work with Black clients who have experienced racism and to explore possible solutions to overcome such challenges.	Qualitative semi-structured interviews	Purposive sampling (n= 2) A Black qualified Cognitive Behavioural Therapist (CBT) and a Black trainee CBT therapist. Age range: Not reported.	Online interviews via video calls using Microsoft Teams. UK	Interpretive Phenomenological Analysis (Smith & Osborn, 2003)

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
Goode-Cross (2011)	To examine Black therapists' lived experience of same-race therapeutic dyads.	Qualitative interviews	Purposive and snowball sampling. Recruited using the US Census data, the Association of Psychology Postdoctoral and Internship Centres directory and electronic mailing lists from the American Psychological Association. (n=12) Black psychotherapists Age range: Not reported. Participants had experience ranging from 8 to 30 years of clinical experience and 3 to 27	Ten interviews were conducted in person near or at the participant's office, and two were conducted via telephone due to scheduling conflicts. USA	A phenomenological method by Wertz (2005) was used. A thematic analysis method called meaning condensation was used to examine the transcripts.

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
			years of supervisory experience.		
Goode-Cross & Grim (2016)	To examine how Black therapists experience working in same-race dyads and to compare how these experiences differ based on the therapists' demographic variables and setting-related differences	Qualitative semi-structured interviews	Purposive sampling where participants were recruited using the US Census data, the Association of Psychology Postdoctoral and Internship Centers directory and electronic mailing lists from the American Psychological Association. (n= 38) Black psychotherapists. Sample included psychologists, counsellors, social	Interviews were conducted in person or via telephone. USA	Interpretive Phenomenological Analysis (Smith & Osborn, 2003)

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
			workers and psychiatrists. Age range: Not reported. Participants had experience ranging from 4 to 40 years of clinical experience and 0 to 32 years of supervisory experience.		
Greenberg et al. (2018)	To understand how social workers of colour perceived the impact of racial/ethnic similarity and difference on the therapeutic relationship with their clients.	Qualitative design using focus groups.	Purposive sampling where graduates and current students in Master of Social Work were recruited from a publicly funded urban college in America. (n= 18)	Three face to face focus groups of eight, six and four attendees per group.	Thematic Analysis (Braun & Clarke, 2006)

Author/Year	Aims	Design	Participants/Sample	Study location	Analysis
			Eight identified as Black social workers. This included participants that identified as African American, African and Afro Caribbean. Age range: Not reported.	USA	
Long (2022)	To explore how clients and therapists experience the presence of racial identity in psychotherapy.	Qualitative using an exploratory interpretive approach informed by psychoanalytic interview methodology.	Purposive sampling from a university clinic. (n = 8) Two therapists identified as Black trainee Clinical Psychologists. Age range: 20s-40s.	Face to face interviews at a university office. Johannesburg, South Africa	Principles from psychoanalytic interview analysis (e.g., Cartwright, 2004; Hollway & Jefferson, 2013; Kvale, 1999; Long, 2009; Saville Young & Frosh, 2018; Stromme et al., 2010) were employed to explore the spoken and the unspoken material.

Appendix C: Quality Appraisal for Review Papers

	Qualitative Appraisal Criteria **Key:** ✓= Yes ✗= No ?= Cannot tell									
Article	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Bartholomew et al. (2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bell-Tolliver (2009)	✓	✓	✓	✓	✓	✗	?	✓	✓	✓
Bell-Tovier & Wilkerson (2011)	✓	✓	✓	✓	✓	✗	?	✓	✓	✓
Brooks-Ucheaga (2023)	✓	✓	✓	?	✓	✓	✓	✓	✓	✓

Goode-Cross (2011)	✓	✓	✓	✓	✓	✓	?	✓	✓	✓
Goode-Cross & Grim (2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Long (2022)	✓	✓	✓	✓	✓	?	✓	✓	✓	✓
Greenberg et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓	?	✓

Appendix D: Consultant Contract

Contract between Dr Kodjokuma and Miss Sancho

Dear Dr Kodjokuma,

Thank you for agreeing to provide 'Conducting research with Black Clinical Psychologists that have worked with racially similar clients: Consultation' sessions with myself, Miss Sancho for the duration of my doctoral thesis. This is a written contract to make our agreements final and clear cut.

Actions on the behalf of Miss Sancho:

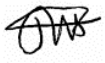
1. Utilise 8x 60-minute consultation sessions with Dr Kodjokuma, a qualified Black Clinical Psychologist and researcher.
2. To provide payment of £40 per session which will total to £320 once all sessions have been attended.

Actions on the behalf of Dr Kodjokuma:

1. Provide 8x 60-minute consultation sessions to Miss Sancho which will aim to fulfil the following:
    - Help shape the topic guide/questions in the interview schedule and theme checking ensuring the topics hold resonance for the participants
    - Provide feedback on the recruitment methods
    - Provide recommendations for relevant literature (if possible)
    - Help the researchers think about language in different aspects of the study (e.g., recruitment poster/key terms/interview questions/title)
    - Provide a participant perspective throughout the development of the project

Thank you for your agreeing to this contract. I look to receiving your invaluable input through these sessions to help the development of this research up until completion of the project in year 2024.

Please sign below:

Tamara Sancho	20.12.2022	
Name of Attendee	Date	Attendee Signature

Jacqui Kodjokuma	20.12.2022	
Name of Session Facilitator	Date	Session Facilitator Signature

Appendix E: Interview Schedule

Project title: Exploring how Black Clinical Psychologists in the UK experience working with racially similar clients

Introduction

1. Revisit study aims and duration of 1-1hr30
2. Acquire informed consent
3. Revisit confidentiality, right to withdraw, and the choice to skip any questions or have a brief break at any time in the interview
4. Sometimes I may ask for clarity on certain questions. This is not necessarily because I don't have some understanding, but it is to capture the data or check I'm not making assumptions
5. Add questions to the chat?
6. Answer final questions prior to the start of the interview & click record

Interview questions: The context of working with racially similar clients

- What drew you to participate in this study?
- In what types of services, locations and roles have you worked with clients that also had Black heritage?
  Prompts: CAMHS vs perinatal, NHS vs private (refer back to later)
- Could you tell me about your experience of working clinically with clients that also had Black heritage?

  Prompts: What types of clinical work have you done with the clients that also had Black heritage at different points in your career? How would you describe your experiences of working with clients that also had Black heritage? What emotional tone or word captures these experiences?- How if at all, did this change over time?

- Did the experience differ from working with racially different clients? – How do you think race played a part in changing the experience?
- How ethnically diverse would you say your caseloads were?
  Follow-Up: In what ways is working with other ethnic minority clients similar/different to working with clients that also have Black heritage?

Interview questions: Clinical implications

Practice:

- What were the benefits of working with clients that also had Black heritage?
  Prompt: Benefit for you vs client, then vs now, service? Can you give an example?
- What were the challenges of working with clients that also had Black heritage?
  Prompt: Can you give an example?
- How did racial similarity with the client impact the clinical work? E.g. assessment, formulation, treatment (model), outcome?
  Prompt: any trends? Any difference in how you approach the clinical work? Difference in case allocation?

Supervision:

- What did/do you use to help manage any challenges or utilise the benefits?
- Did/do you ever use supervision to manage challenges/utilise benefits?
  Follow up: Did you find racial similarity/difference between your supervisor and yourself to impact your use of supervision around these issues?

Interview questions: The impact of intersectionality

- When you consider the intersectional identities (e.g., age/education/religion/class) you and the client held at the time, do you think any of these aspects of identity affected your experience of working with them?
  Prompt: If so how?- can you give an example? Or if not why? (Use social graces as visual aid prompt for reflections)
  Follow-Up: How did these identities/factors interact with racial similarity in the therapeutic relationship?
- How would you say your experience/s of racial similarity with clients may have changed if at all throughout your career (pre, during and post training)?
  Prompt: Change in use of self-disclosure or treatment outcome?
  Follow up: If Yes: What factors do you think may have contributed to this? If no: Do you think the following factors affected your experience of racial similarity with clients?

Prompt: Geography (i.e. diversity of caseload and socioeconomic context), experience of racial similarity vs qualified experience, job role, social context, service type (i.e. CAMHS vs older adult, perinatal vs psychosis, NHS vs private)

- How would you describe your background with racial similarity? How do you think your experience of this in the past might relate to how you experience working with racially similar clients?
  Prompt: less/more racial similarity leading to less/more confidence/enjoyment with racial similarity etc.

Interview questions: Clinical implications continued

Clinical psychology training:

- How effectively do you think clinical psychology training prepared you for the intricacies of working with clients that also had Black heritage?
  Prompt: Considering self-disclosure and the impact of common intersectional identities, the idea of bringing the 'self' to the therapy room? Any ways it helped?
- Are there any ways you feel you could have been better supported to manage/consider the intricacies of working with clients that also had Black heritage?
- Are there any changes you think are necessary for training courses to appropriately address these experiences?
- Do you see any pitfalls in courses addressing racial similarity with clients as a topic in training?
  Prompt: Are there any ways that courses could go about this in the 'wrong' way?

Concluding questions

- How has my perceived racial identity impacted the way you answered these 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?

Optional Debrief

- How did you find talking about this today?

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

  (Off record)- Anyone else you can recommend for me to speak to about this? Advice for recruitment? Review transcript for anonymity?

Thank you for your participation.

Appendix F: Recruitment Poster

University of Essex

Doctorate in Clinical Psychology Research Project

EXPLORING HOW BLACK CLINICAL PSYCHOLOGISTS EXPERIENCE WORKING WITH RACIALLY SIMILAR CLIENTS

Are you a qualified Clincial Psychologist **working in the UK** that identifies as having **Black heritage**?

Have you worked in the UK as a **qualified** Clinical Psychologist for a **minimum of 6 months**?

If the answer is yes, then we invite you to take part in this study!

DID YOU KNOW THAT...

- Minimal research considers practitioners from ethnic minority backgrounds
- When therapist cultural curiosity is considered the focus is often placed on therapist–client differences
- This research project aims to explore how Black Clinical Psychologists in the UK experience working with racially similar clients

WHAT WILL TAKING PART INVOLVE?

- Sharing your invaluable reflections about your experience/s of working (e.g., conducting assessment, formulation or treatment) with a racially similar client (i.e., a client that also has Black heritage)
- An interview (via video call or face to face depending on your preference) lasting around 1 hour
- We welcome experiences from statutory (e.g., NHS), third sector and/or private services

It is hoped that your voice might highlight the clinical implications that same-race therapeutic dyads can have on practice, supervision and clinical psychology training

CLICK ON THE LINK TO FIND OUT MORE ABOUT THIS EXCITING OPPORTUNITY!

Tamara Sancho
Trainee Clinical Psychologist (Lead Researcher)
Email: **ts21150@essex.ac.uk**

This study has recieved ethical approval from the University of Essex Ethics Committee ERAMS Project number:ETH2122-1437

Appendix G: Ethical Approval

University of Essex ERAMS

26/10/2022

Miss Tamara Sancho

Health and Social Care

University of Essex

Dear Tamara,

Ethics Committee Decision

Application: ETH2122-1437

I am pleased to inform you that the research proposal entitled "Exploring how Black Clinical Psychologists in the UK experience working with racially similar clients" has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Any activities requiring NHS-REC Approval:

This approval does not extend to any research activities which would require NHS-REC review and it is your responsibility to ensure you are aware of the requirements and expectations with respect to this.

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Aaron Wyllie

Appendix H: Participant Information Sheet

University of Essex

Participant Information Sheet

Participant Information Sheet for Exploring how Black Clinical Psychologists in the UK experience working with racially similar clients

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 Black Clinical Psychologists in the UK experience working with racially similar clients. There is existing research which reveals that the pathway to service access and engagement is complex for Black service-users. Additionally, a need to improve the diversity of professionals in Clinical Psychology has been highlighted. Yet, minimal research considers practitioners from ethnic minority backgrounds. The current focus placed on therapist–client differences show a gap in consideration of the difficulties that might arise with therapist–client similarities, so it is hoped that this project will fill this gap. This study hopes to gain an insight into your experiences of working with racially similar service-users including the impact of intersectional identities and clinical implications in relation to practice, supervision and clinical psychology training.

Am I eligible to take part?

If you are a Clinical Psychologist that identifies as having Black heritage who has worked as a qualified Clinical Psychologist registered with the Health and Care Professions Council (HCPC) for at least 6 months, then you are eligible to take part. You will also need to have had a direct experience (e.g., assessment, formulation, or treatment) of working clinically with a service-user who identified as being from a background with a similar heritage (e.g., also had Black heritage).

Do I have to take part?

No- participation in this study is completely voluntary. If you decide to take part, you can leave at any time during the process without giving a reason.

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.

University of Essex

What would taking part involve?

If you decide you would like to take part, please finish reading this information sheet. Then complete the consent form in the survey to confirm that you understand the aims of the research and agree to take part. You will then complete the demographics questionnaire on the survey and enter your contact details at the end of this survey. The Chief Investigator (Tamara Sancho) will get in contact to arrange a suitable date and time to meet with you via online video teleconferencing software or face-to-face if appropriate. Following this, you will be sent an invitation to join a 1-1 video call meeting or meet face-to-face at a site on the University of Essex campus based in Colchester with the Chief Investigator.

The interview will last approximately 45-75 minutes and will involve questions about your experiences of working with racially similar clients.The discussion will be audio recorded using the recording function on the teleconferencing software website 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. External transcribers might also be involved in the transcription of the interview. You will be given the option to provide feedback on the transcript to check it is accurate and anonymised to your preference. You also may be contacted later 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 your experiences of working with racially similar service users might lead to conversations around topics that may be emotionally difficult to discuss (e.g., discrimination and racial trauma). 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 support service providers and training courses to consider ways to enhance skills in cultural competence, not only for professionals from ethnic majority backgrounds, but for those from ethnic minority backgrounds too. This has the potential to be used to inform service development, clinical psychology training programmes and 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 may also be

University of Essex

disseminated to professionals/researchers via oral presentation at conferences, as well as submitted to a peer-reviewed scientific journal to contribute to the literature on this topic. Results may also be shared with the public and professionals as an infographic online. 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 as much is possible using pseudonyms, participant numbers and saved as encrypted electronic files, although some identifying data might be retained. Where this is the case since there is a lack of diversity in the psychology profession, demographic information (gender, service, age, profession and location) referred to in the thesis will be grouped together across the sample. Data will be stored in line with the Data Protection Act (2018) and University of Essex data protection policies and will be password protected. The Chief Investigator (Tamara Sancho) and academic supervisors (Dr Jasmeet Kaur and Dr Danny Taggart) will have access to the data.

If external transcribers are involved in the project they will have access to an audio recording of the interview they transcribe, but they will sign a confidentiality/non-disclosure agreement agreeing to the following. They will keep information in the transcript/interview confidential, they will stop transcription immediately if they recognise any parties mentioned and return it to the chief investigator. They will also agree to destroy the transcript and copies of the recordings provided by the chief investigator.

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 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.

The Chief investigator (Tamara Sancho) will keep your name and contact details confidential and will not pass this information to The University of Essex. The Chief investigator (Tamara Sancho) 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

University of Essex

not be able to find out your name or contact details. The chief investigator (Tamara Sancho) 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 University of Essex Human Research Ethics Sub-Committee 2 (ERAMS Project number: ETH2122-1437).

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: Tamara Sancho, Trainee Clinical Psychologist- ts21150@essex.ac.uk.

If you are not satisfied with the initial response, please contact Dr Danny Taggart, Clinical Psychologist, Academic Director and Academic Supervisor- dtaggart@essex.ac.uk, or Dr Jasmeet Kaur, Clinical Psychologist, Clinical Lecturer and Academic Supervisor- jb20603@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: Tamara Sancho, Trainee Clinical Psychologist- t21150@essex.ac.uk

Lead Academic Supervisor: Dr Danny Taggart, Academic Director- dtaggart@essex.ac.uk

Second Academic Supervisor: Dr Jasmeet Kaur, Clinical Lecturer- jb20603@essex.ac.uk

Thank you for taking part in this research project

Appendix I: Participant Consent Form

Q29. Please read through the statements below and select yes if you agree and wish to proceed with the study.

Q28. 1. I confirm that I have read the information sheet for the above study.

- ◯ Yes
- ◯ No

Q26. 2. I have been given the opportunity to ask questions and the researcher has answered them appropriately.

- ◯ Yes
- ◯ No

Q30. 3. I understand that my participation is voluntary. I understand that I am free to withdraw at any time without 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).

- ◯ Yes
- ◯ No

Q31. 4. I agree for my participation to be audio and video recorded for the purposes of the study only.

- ◯ Yes
- ◯ No

Q32. 5. I understand that my data will be stored securely, in line with the Data Protection Act (2018).

- ◯ Yes
- ◯ No

Q33. 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.

- ◯ Yes
- ◯ No

Q34. 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).

- ◯ Yes
- ◯ No

Q35. 8. I would like to be sent a copy of the final written report (optional).

- ◯ Yes
- ◯ No

Q36. 9. I agree to take part in the above study.

- ◯ Yes
- ◯ No

Q37. Your fullname:

Q36. Your signature:

Q13. How would you currently describe your gender identity?
Please specify below:

Ethnicity. Black/Black British

- ◯ African
- ◯ Caribbean
- ◯ Any Black/African/Caribbean background not mentioned above (please specify below)

Ethnicity. Mixed/Multiple ethnic groups

- ◯ Asian and Black African
- ◯ Asian and Black Caribbean
- ◯ White and Black African
- ◯ White and Black Caribbean
- ◯ Any Mixed/Multiple Black ethnic background not mentioned above (please specify below)

Q17. Current job role:

Q18. Overall length of time qualified:

Q19. Current service(s) you work in:

Q20. Service(s) (sector), geographical location(s) and duration in service(s) where you worked with racially similar clients (e.g. CAMHS (private) - Coventry - 6 months):

Q21. Doctoral course where you trained as a Clinical Psychologist:

Q22. Estimated number of clients you have worked with that were racially similar to you (i.e. also had Black heritage):

- ◯ 1-5
- ◯ 6-10
- ◯ 11-20
- ◯ 20+

Q38. Your email address:

Q39. Your phone number (optional):

Q40. Preferred contact method and time to complete interview (e.g. by email, Tuesday's 2pm onwards):

Appendix J: Transcription Non-Disclosure Agreement

Doctorate in Clinical Psychology

University of Essex

Transcription confidentiality/non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Tamara Sancho, Trainee Clinical Psychologist

And

Sonia Wilson

The recipient agreed to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient agrees to stop transcription immediately if they recognise any parties mentioned on the audio recording and to return the recording to the discloser.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Name: Tamara Sancho

Signed: 

Date: 20/9/2023

Name: Sonia Wilson

Signed: S. Wilson

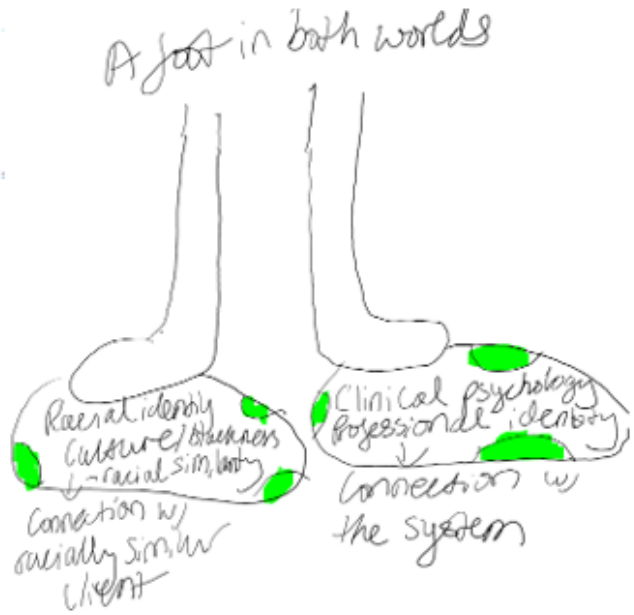
Date: 20/9/2023

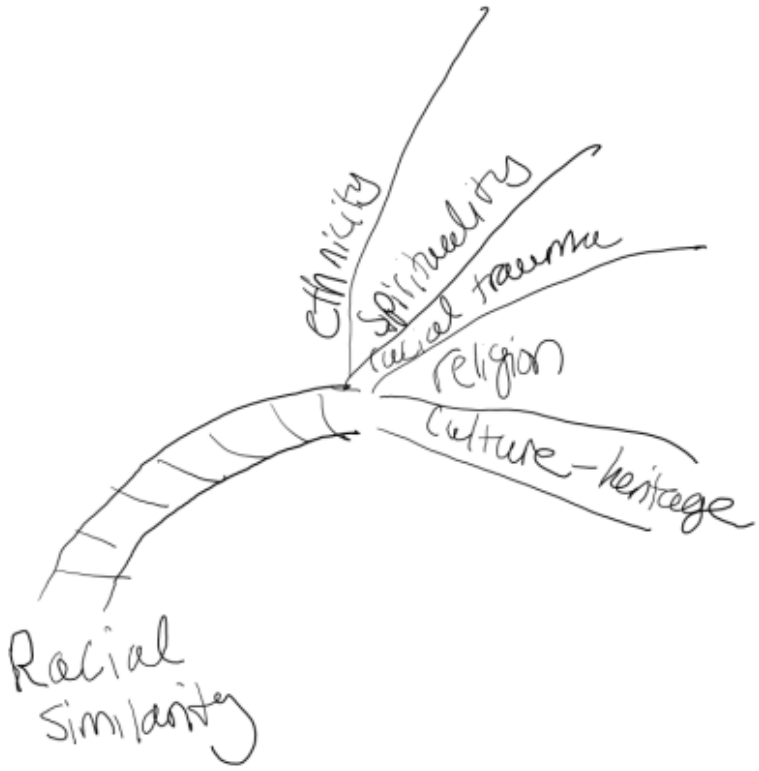
Appendix K: 15-Point Quality RTA Checklist

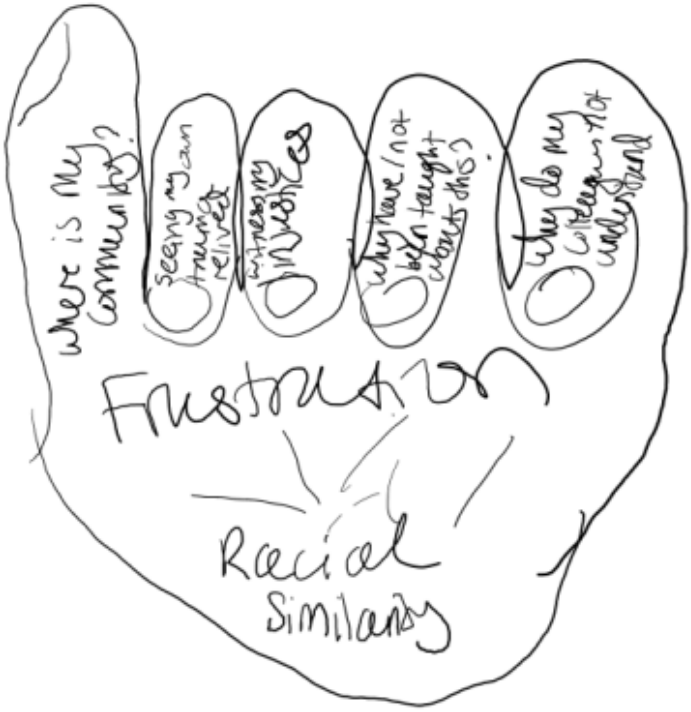
(Braun & Clark, 2006)

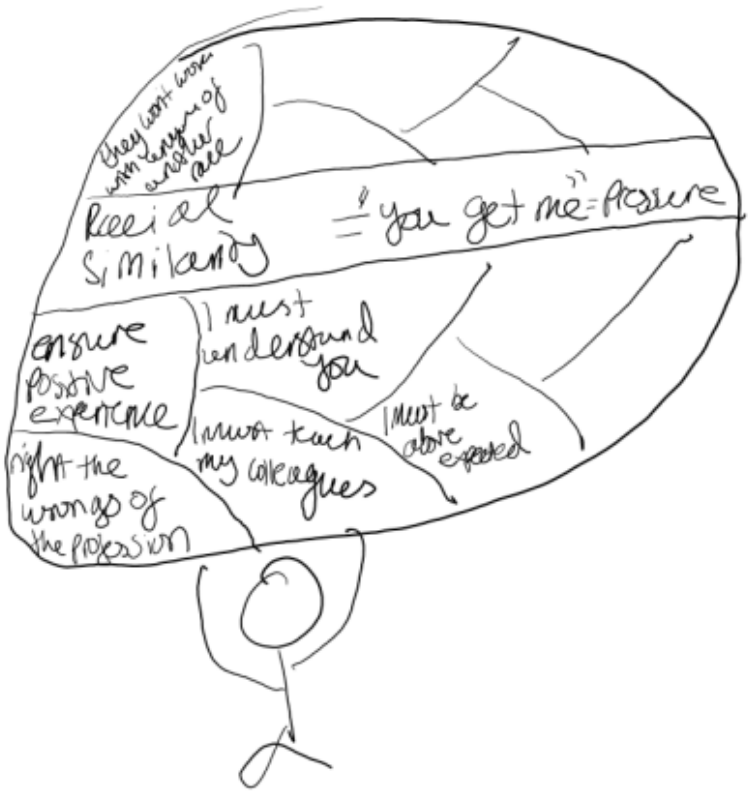
Process	No.	Criteria
Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for all 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 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, analysis are clearly explicated.
	13.	There is a good fit between what you claim you 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 L: Interview Reflection Drawings









Appendix M: Example Transcript with Initial Codes

Cultural similarity & understanding allows for self-disclosure and ask q's relating to cultural heritage/family & gain stories

Able to think of the extra relevant q's to ask

Freedom to have culturally relevant convos (for both CP & client)

They want to work with me as see me as someone that can connect with and get them

And they went. "Oh, God, yeah, it is". And I said, "oh, gosh! And I think my understanding is. It means this it's actually…" they said, "oh, my God!". And just that freedom that meant she could just have those conversations. So freedom, I guess, would be another word I would use to describe what it must, what it feels like for me. But what I think it must feel like for my my patients, that actually they feel that they don't have to censor themselves. They can be all of themselves. I think that when you're a Black client working with a White person Black patient working with a White person, there were probably aspects of yourself that you will censor or not be asked about, because it's just not on that person's radar. But I think this allows me to just think of those questions. Because why wouldn't I think of those questions to ask?

Relief from Black & other minority SUs when see Black CP

No need to censor themselves unlike with White CP where either censor or things missed to ask about (not on radar)

Can bring all of themselves

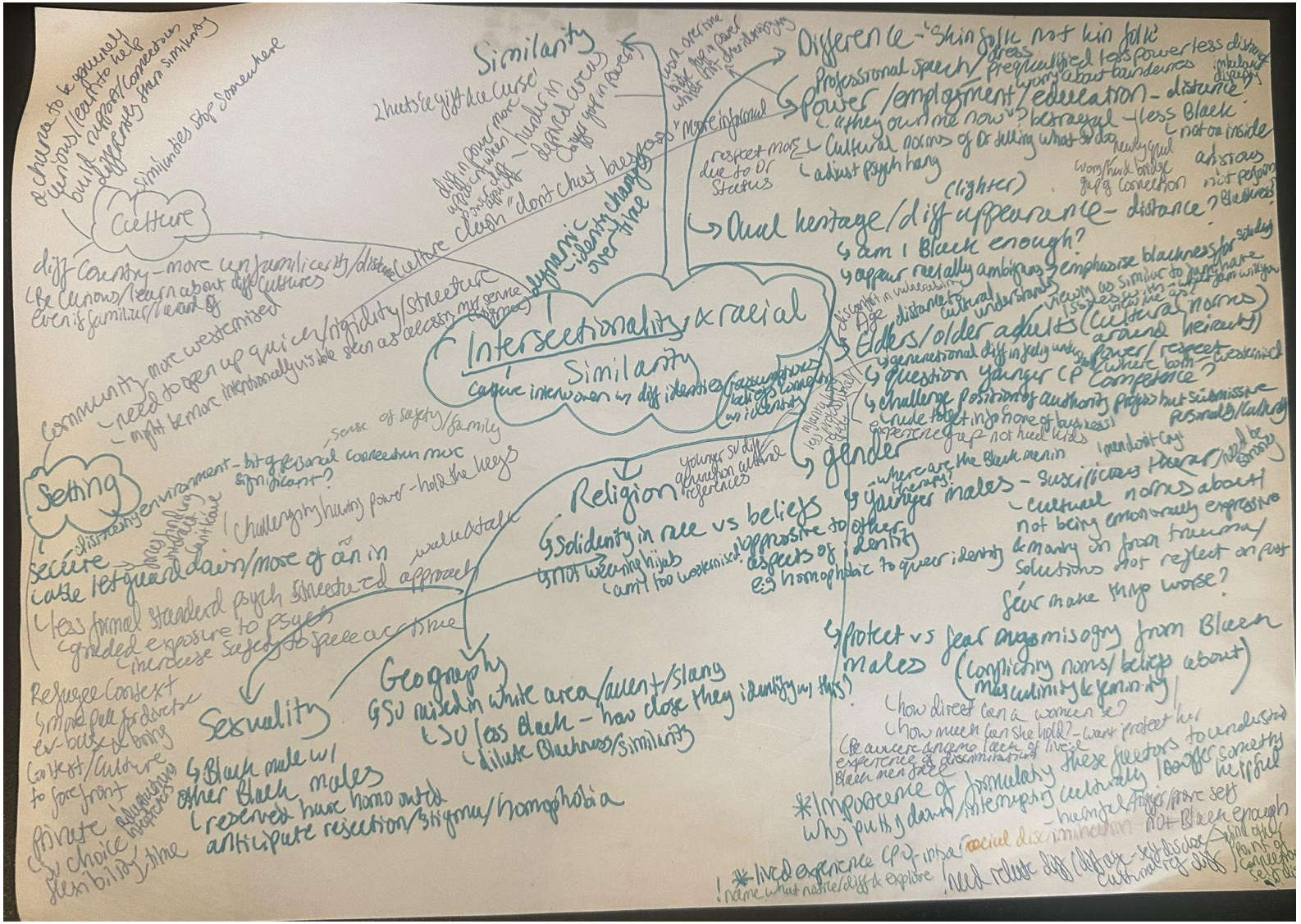
72
00:14:41.360 --> 00:14:56.540
Interviewer: And I was- because a lot of those reflections which were really interesting were from the perspective of what the family would feel. I was curious if there is anything extra, or that you would say in relation to how yeah to a word or an emotional tone that summarizes your felt experience in that? I mean yeah, you mentioned frustration. But yeah, but is there anything else in terms of your experience?

75
00:15:12.330 --> 00:15:17.780
Interviewee: Give me a second. I think yeah, I definitely think frustration in the sense that I'm I'm I'm rare. I am rare to these families, and that that feels frustrating. I think there is some aspect of privilege. I guess that I am I am I'm in a position where I can work with these families, and they want to work with me because they see me as someone similar, and who can who can get them and connect them. You know I can't even open my mouth. You know I I might be a shit psychologist. I don't know. I hope I'm not. But I might be a shit psychologist. But then walking in the room and seeing me brings some relief, like I'm using the word relief again. I think for me. Yeah. Privilege. I think, acceptance. I think some sadness that this is this is so rare. It isn't a norm in any any services that I know of it isn't the Norm. Unless you're working with a specific client group. I think I feel I suppose one of the things I might feel I do feel is a bit of pressure to be good, to be a good psychologist, to not let them down either culturally or as a psychologist.
I think there's a little bit more pressure,

Frustration that I'm rare to these families & sadness that it is not the norm to see them

Pressure

Appendix N: Example Mind Map of Connected Codes

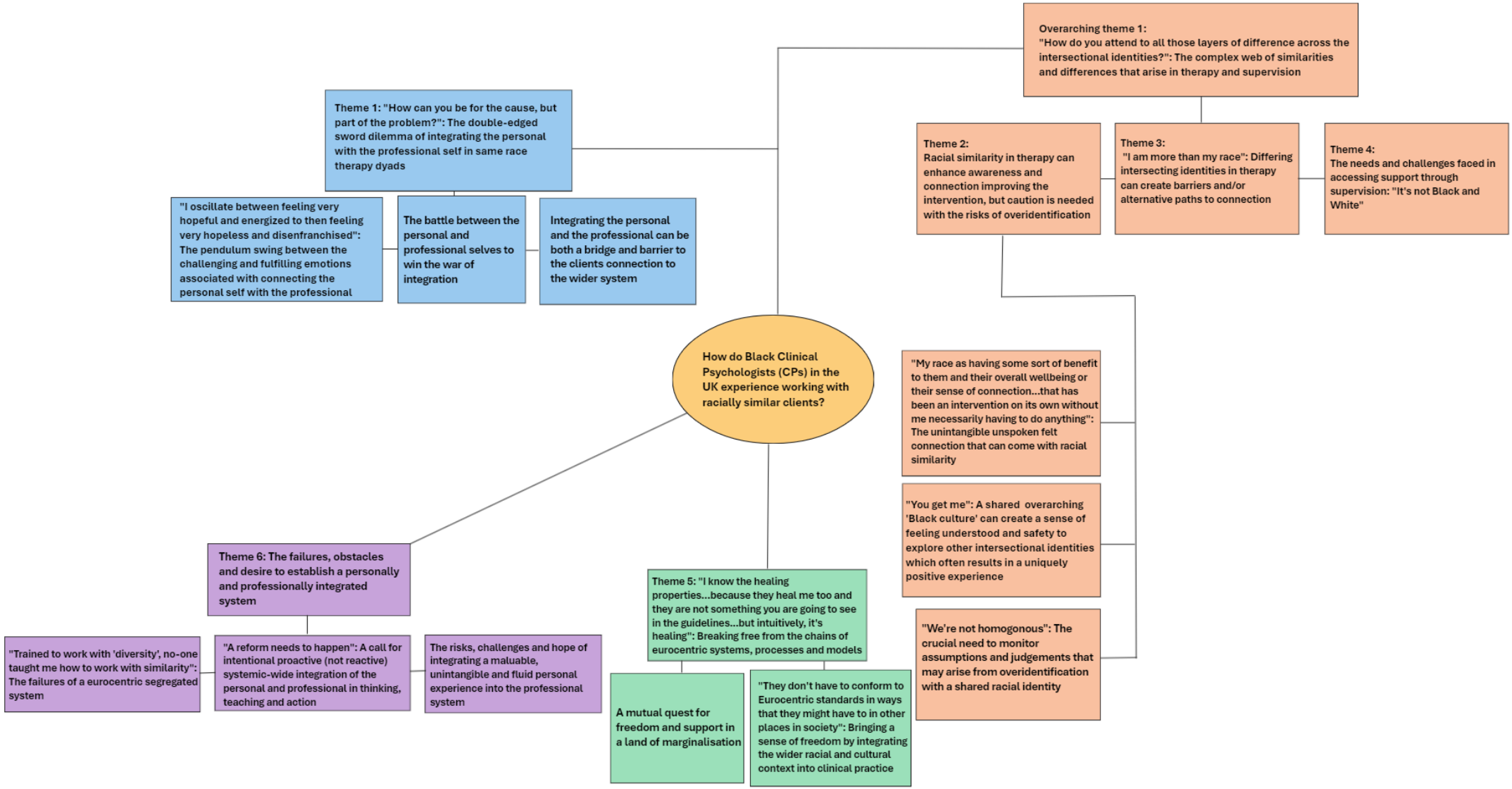


Appendix O: Stage 3 Analysis – Candidate Themes

Candidate themes were developed from grouping codes in columns. Each Excel row represented each participant's interview codes. Candidate themes were colour coded according to underlying connecting concepts to develop refined themes.

Appendix P: Stage 4 Analysis – Initial Refined Themes

Appendix Q: Preliminary Thematic Map



Appendix R: Excerpts from Reflexive Log

Wednesday 21st Dec 2022: First thesis consultation session

I just finished having my first thesis consultation session. It felt nice to have a space to think about my journey to the thesis and openly reflect without feeling like the person would immediately feel a need to correct any 'negative' reflections about the topic. Immediately I felt able to explore why I feel cautious when introducing my thesis topic. I reflected that the reason for this is that I feel the clinical significance of the topic is not immediately obvious to the average non-Black person. We discussed the aims for my project and how helpful it is that they are specific but open since she said when I collect data this will help guide my focus as I may get side tracked at all the different interesting topics that arise. She said that she had not realised the clinical implications of my project to practice, training and supervision so it was interesting to realise I may be more aware of the implications than I think. It was also helpful to gain her thoughts on recruitment, the poster and the language. It was nice to hear that the poster is appealing given that she is the target demographic. I look forward to exploring the categories on my demographic questionnaire we started discussing the relevance of where the psychologist and SU were born as well as ethnicity alone as this shapes culture.

Friday 16th June 2023

After 8th interview: WOW. So interesting. I'll bullet point reflections:

- The suggestion to prompt for reflections around feelings of discomfort/unpleasant feelings when working with racial similairty
- The idea that models cannot be fit strictly when the client is Black. A need for flexibility. It was interesting to see that this may be both because therapists want to please the client so they return but also maybe something about racially diverse people needing adaptation and the fact that this may come from needing to conform so much in wider society. Also interesting to think that the adaptation may not be a requirement from the client only but from a drive in the Black therapist who understands those experiences of conforming.
- I hadn't realised how shameful people can feel about the challenge to speak about unspoken similarity
- It was so helpful to explore their experience of racial similarity in life. I learnt so much. The idea that Black CPs might grow up in racial similarity but this reduces as they progress in the field and there is a choice to adapt to be similar to the majority or not adapt (causing shunning from teams). But the adapting to be similar may lead to the challenge but also joy when confronted with a racially similar client (bringing back the forgotten part of the self)
- It was easier to cover every objective and understand the story of their experience when reflecting on 1 case. (how much is this influenced by the similarity in my own experience of racial similarity and how this influenced the questions I asked? Also meant I could skip the odd irrelevant q which saved some time) It's also helpful when you have done these interviews before as you know what prompts to ask and explore as there is an evidence base for the question you're asking even if it doesn't seem like an obvious link in the moment e.g. asking about the impact of race on the need to adapt the intervention despite it seeming more to do with the participants desire for the client to feel validated
- I feel that every CP comments about how hard it is to articulate and process these experiences for the first time. Asking them questions they have never been asked. It was so important to ask the person what drew them to the study- it provides a context to why and how they are approaching the interview and answering q's.

I am so excited for the findings and the hopeful recommendations/frameworks that might be developed based on these interviews!

Wednesday 4th September 2024 - Reviewing transcript and coding as part of analysis

I had such an emotional reaction where I started tearing up in response to listening and reading back a transcript as part of the coding process. The interviewee spoke about how they intuitively knew about the healing properties of Caribbean foods, music and religion and how being responsive to those needs for the client was more powerful and still effective instead of stereotypical westernised therapy (e.g., BA) that we are taught. I think I instantly connected and resonated with the cultural references she was making and felt so touched by my own relationship with these healing factors that literature does not recognise but that intuitively a lot of us Black people connect with. I'm not sure what was behind my tears. Was it joy, memories and the resonance of understanding and recognising that these aspects of my own culture are being appreciated and shared in the context of my doctoral thesis? Was it the joy of learning through my participant's story telling as another Black Caribbean female Clinical psychologist that this indeed can also be understood as psychological intervention? Was it my recent personal experiences that connect with the power of our food, music and religion as a form of healing and having this brought to my own doctoral research? Or was it the sadness in realising that the intuitive needs of my own community are not taught or acknowledged in my own profession and so in the confines of what we are taught in order to really cater to a lot of people from my community I would need to step away/move beyond that which I have been trained and taught to do as an 'intervention'? Perhaps behind my tears it was all of these factors and more. But how beautiful it is to have these aspects of my community and experience brought to the clinical psychology space through my research. I am so excited at the prospect that these findings might shift and add to the evidence base for Black communities in the UK.

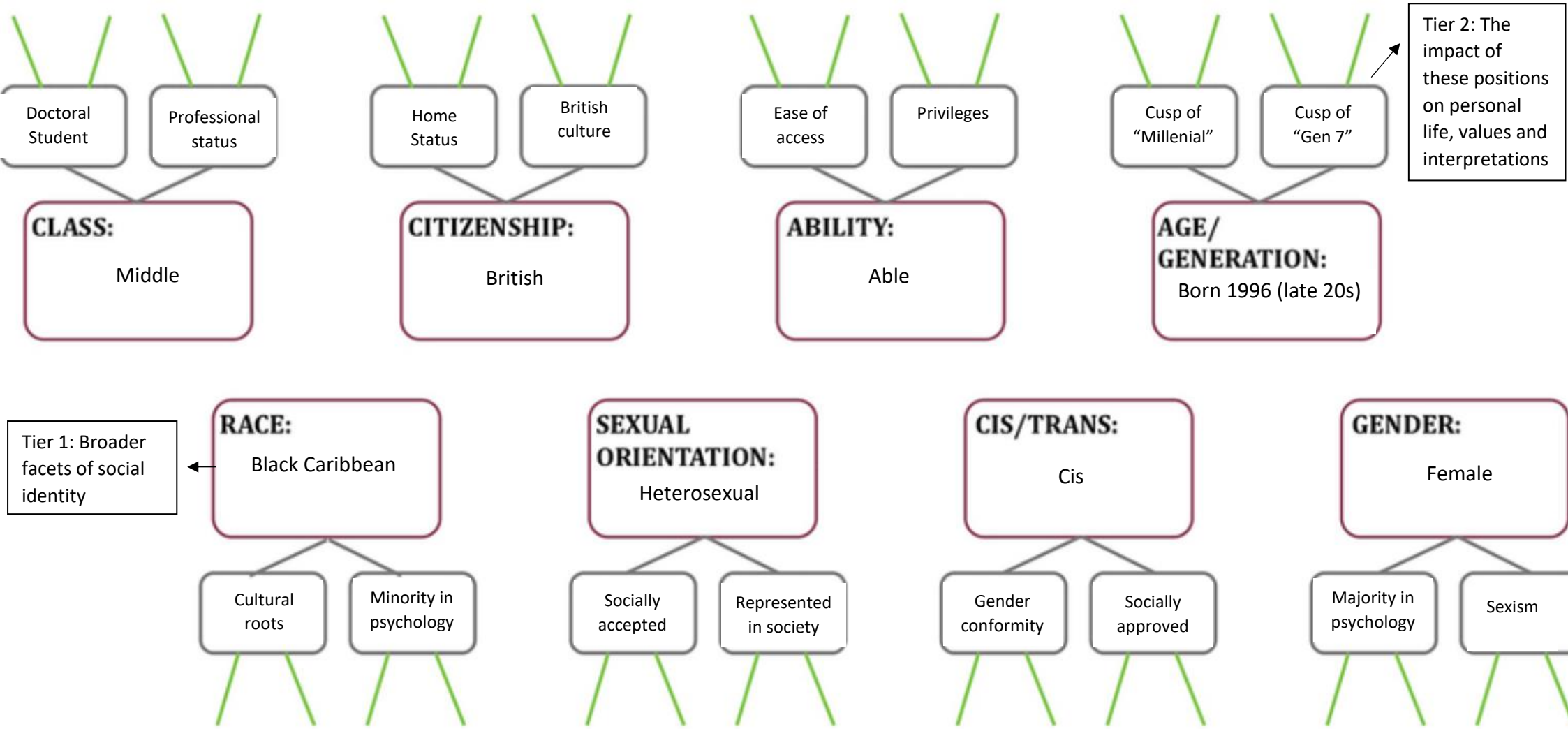
I also feel like the way that I am coding this part of the transcript which was led by the interviewee telling many many different stories of her experiences with racially similar clients, I felt I had to respond and currently have to code in a way that mirrors what various interviewees say needs to happen with some Black clients. The idea that the Black clients engagement and response to psychology may not fit the typical confines of clinical psychology and may need the flexibility and freedom to move all over the place a bit more broadly. And then the interviewer/coder/psychologist needs to make the time to work backwards to make sense of how the story fits the structures we use to make sense of things. I have had to navigate this part of the transcript differently. First listening to the story and highlighting pertinent parts. Go back and find the codes moving between the parts of the story and attuning to what might often be implied in the story but not explicitly always stated the way that in an interview you might typically expect the participant to respond. It feels like a mirroring of the participants experience with their clients (and that of many in the Black community in general) in my experience of analysing and interviewing this Black participant. How interesting!

Friday 27th September 2024 - Reflexive Member Checking Session to Review Findings

Meeting with 2 participants what stood out to me was the following:

- The value in feeling validated in their experiences through the themes, especially regarding the hard to articulate/nontangible felt and fluid sense of the experience
- How the theme around racial similarity enhancing the intervention felt resonant but also the risks of overidentification did too. Though a helpful point was made around who says that overidentification is a problem and why? Who imposes that this is a problem and is this something White people also experience?
- Both shared that they left the interview really appreciating getting the space to reflect on the experience of this similarity as it would not be considered as something to reflect more deeply about by their White counterparts and often comes with an oversimplified assumption on the ease and positives of the experience. One person commented on how specifically it enabled them to really celebrate the accomplishments made in same-race therapy dyads.
- It was interesting to hear a participant expand on the findings around inpatient settings, she shared how working there you are in a more restricted environment but less restricted in your therapy because you have to be more creative to focus on and prioritise engagement over the typical structures of therapy.
- It was interesting to observe the sense of inertia around the theme to enable a reform on a systemic level. Both participants reflected on the idea of why would those in power want to give up their power? They both discussed how Black communities feel the need to create their own systems rather than waiting to be welcomed/embraced in current systems. It was interesting to then observe how my theme about there being a mutual quest for freedom contrasted the need for a reform almost in a form of rebellion that if the system won't welcome us we'll create our own.
- It was interesting to think about who needs to hear this research? Other Black clinicians to validate their experiences and those in power to shape the experience of clinicians (e.g., supervisors, courses, mentors, chief CPs in trusts to gain their thoughts about the findings).
- Lastly it was interesting to think about how this study could offer a language/evidence base to help qualify/name the experience of racial similarity for Black CPs in a similar way that the term micro-aggressions helps people better understand their experiences around racial trauma.
- It was lovely at the end to see that my invitation for the participants to network was taken up quickly. Real life implications/actions around building our own systems through the study (life imitating art/literature?)

Appendix S: Social Positionality Map



Appendix T: Table of Participant Pseudonyms

Interview number	Pseudonym
1	Grace
2	Saffron
3	Rochelle
4	Faith
5	Michaela
6	Sarah
7	Renee
8	Esther
9	Jonathan
10	Tianna
11	Samuel
12	Melissa
13	Khadijah
14	Afia
15	Dominique
16	Candice