

**The Experience of Qualified BME Clinical
Psychologists: An Interpretative
Phenomenological and Repertory Grid Analysis**

Volume 1

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ABSTRACT

Aim: Knowledge of the experience of qualified BME clinical psychologists in clinical practice is currently lacking in the research literature. The aim of the current study was to explore the lived experience of qualified BME clinical psychologists currently employed in the National Health Service (NHS). By investigating this under-researched topic, the study hopes to shed light on the impact on clinicians' personal and professional identity of practicing within a profession that lacks cultural diversity. It is hoped that the results of this study will contribute to ongoing efforts to diversify the profession, improve our knowledge of the experience of BME groups in the helping profession and also challenge current misconceptions concerning the BME experience.

Method: A mixed method qualitative approach was employed for this study. Repertory grids and semi-structured interviews were conducted with six female qualified BME clinical psychologists who are currently working in the NHS. They had been qualified between three and sixteen years. Their repertory grids were analysed using Idiogrid and their accounts were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four master themes emerged from the analysis and were supported by the findings from the repertory grids showing that BME clinical psychologists feel that they stand out as different on account of their ethnic difference. The analytic procedure also highlighted how participants have to find a way to negotiate their cultural and professional values whilst also sitting with the uncertainty of their experiences in the profession. The final theme relates to the privilege that participants held in making it as a clinical psychologist.

Implications: Initiatives to increase cultural competency and sensitivity need to be addressed by the profession. Efforts to increase ethnic diversity should be followed through to ensure practitioners are not left on the fringes of the profession on account of their minority ethnicity.

1.0 INTRODUCTION

1.1 Background

A valued and diverse workforce has been argued to be beneficial for client care (Kline, 2014). The importance of a diverse healthcare profession is highlighted by the increasing rates of individuals from minority groups (Rees, Wohland, Norman & Boden, 2011). This is reflected in one of the Department of Health's key objectives, to increase the diversity of its workforce (DH, 2003). The poor representation of Black and Minority Ethnic (BME) groups in clinical psychology is well documented (e.g. Daiches, 2010; Helm, 2002; Turpin & Coleman, 2004). Relatively sparse in the literature are studies documenting what it is like working in a profession that is less representative of the population it serves.

This current research study aims to provide an insight into the everyday lived experience of BME practitioners within the profession of clinical psychology. I will start this chapter by briefly considering current societal issues and the wider social context before detailing issues of cultural diversity in clinical psychology specifically. This will be followed by considerations of the history of racism and its impact on the current make-up of the workforce of clinical psychologists in the UK, paying particular attention to the recruitment of BME trainee clinical psychologists. I will then review what has been done by the profession thus far in addressing these issues before highlighting the ongoing challenges for the profession. A narrative of how I came to do this research will follow on from this in order to be reflexive. Important concepts in race and culture discourse will be highlighted after which I will consider identity theories relevant to the current study. In particular, there will be some consideration of cultural identity theories and a review of how this is negotiated with professional identity. A systematic review of the literature concludes the chapter, giving a rationale for the current study.

1.2 Societal issues & wider context

1.2.1 Historical perspective

The development of an individual's identity cannot be understood outside of their historical context. That the past has an impact on the present is a basic truism (Foner & Alba, 2010). In this regard, slavery, colonialism and caste systems should be considered in discussions of race relations within institutional practices. The exploitation of BME groups through the slave and colonial process was systematic in its devastation (Sivanandan, 1999).

According to Carter, Harris and Joshi (1987), the British government in the 1950s played a major role in perpetuating the view that Black immigration was a problem, further reinforcing the concept of Britishness that is grounded in colour and culture. Although the government was keen to restrict immigration to the UK, the 1948 Nationality Act was a seeming contradiction of this, as it gave legal status to UK citizenship to both Britons and 'colonial' British subjects (Hansen, 1999). The increased influx of immigrants to the UK in the context of a society keen to 'preserve the homogenous racial character of British society' (Carter *et al.*, 1999) gives some insight as to the social and political context of being from an ethnic minority background in Britain in the 1950s.

The legacy of slavery and the way in which BME groups were viewed cannot be overlooked. Take for example the notion of the Black man as aggressive and dangerous (e.g. Francis, 2002). It is perhaps this widely held view that has dominated current thinking of the Black man and continually results in unfair and disproportionate stop and searches (Bowling & Phillips, 2007) and the use of seclusion and restraint practices (Bolton, 1984).

1.2.2 The current picture

The current cultural context in the UK serves as the backdrop for this study. Societal biases against ethnic minorities, refugees, asylum seekers and immigrants

are a reminder of the necessity for professions and institutions to be more responsible in their practices. Various institutions, including the police force, football associations as well as the NHS have all had to admit to institutional racism (Daiches & Golding, 2005). This highlights the ongoing journey towards a more inclusive and culturally sensitive society.

The next section will give an overview of some of the current issues with cultural diversity in clinical psychology as a profession. It will highlight what has been done to address these issues and consider what the remaining challenges are.

1.3 Cultural diversity and sensitivity in clinical psychology

1.3.1 Historical perspective

Historically psychology, alongside other disciplines, was involved in creating an ideology of racial difference that was often used as a tool of oppression (Pickren, 2009). Examples of this include the use of intelligence testing to 'prove' the inferiority of non-whites, which occurred up until the 1990s. The widely accepted discourse of the time, namely that ethnic minority groups were inferior to White people, allowed for racist practices to go unchallenged.

There is also evidence to suggest that racist ideologies were present in the early development of modern psychology. Jung's view of Black people as primitive helped to shape his theories of the mind, and Freud believed that the mind of *savages* was similar to the mind of a neurotic (Fernando, 2002).

There are many more such examples, which are beyond the scope of the current discussion. It could be argued that psychology has a shameful past in terms of the use of psychological knowledge and practice to justify and aid racism and discrimination, at times causing harm and pain to individuals and groups and impacting on perceptions in society.

1.3.2 The current picture

Clinical psychology in the UK is a relatively high-status profession with regards to salary and the requirement of a doctorate to practice. The aims of the profession are to alleviate distress, promote psychological wellbeing, and contribute to psychological knowledge through research. It tends to attract a predominantly White middle-class female workforce (Goodbody & Burns, 2011).

The lack of diversity in the profession has been an issue of contention for many decades. As of 2013, it was reported that there are 9.6% qualified BME clinical psychologists in England (Health and Social Care Information Centre). In the UK, the BME population is now 14.1% of the overall total in England and Wales, not including the 'White Other' demographic (Office National Statistics, 2011). Given that the last census was undertaken in 2011, these figures might well be inaccurate, and so caution needs to be taken when drawing conclusions. However, despite this, the poor representation of BME groups in clinical psychology is well established.

Difficulties in recruiting and retaining BME psychologists start at the point of selection and earlier. Statistics from the Clearing House for Postgraduate Courses in Clinical Psychology show that applicants from BME backgrounds are less likely than their White counterparts to successfully be accepted onto clinical training courses. In 2014, 84% of applicants were from a background classified as White though the acceptance rate was 91%. Furthermore, 7% of the applications came from applicants from an Asian background; however, the acceptance rate was 3%. Mixed race applicants made up 3% of the applications; however, just 2% were successful. This was the same for Black applicants. Applicants in the 'Other' ethnicity category made up 2% of applicants, but only 1% were successful in gaining entrance onto clinical training. These statistics are particularly concerning given that psychology at undergraduate level remains a popular choice for BME students (Turpin & Fensom, 2004; Williams, Turpin & Hardy, 2006). Statistics

have shown that this has largely been a stable feature of trends in acceptances to clinical psychology doctoral programmes. Figure 1 gives an overview of the trend over the last four years.

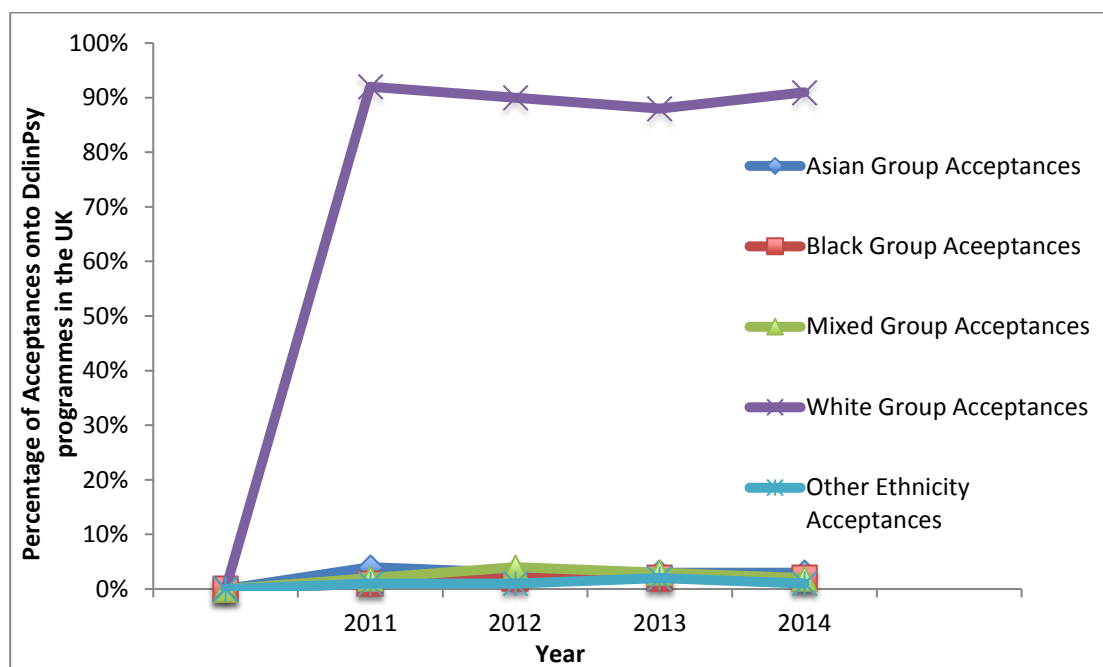


Figure 1: Yearly rates of acceptances onto Clinical Training Programmes by Ethnicity between 2011 and 2014

Despite legislation, policy, and activism aimed at preventing racial discrimination, it appears that clinical psychology, as a profession has been unable to reverse this trend seen in the recruitment and retention of BME clinical psychologists.

This difficulty is also highlighted in many areas of clinical psychology practice, including the disparity in treatment of BME groups in mental health services (De Maynard, 2006). For example, it is well documented in the literature that there is an overrepresentation of BME service users in psychiatric and forensic settings. Conversely to this, they are massively underrepresented in clinical psychology services (Williams *et al.*, 2006). There is also evidence that suggests that BME groups generally have higher rates of diagnoses of mental health difficulties compared to the White majority (e.g. Commander, Sashidharan, Akilu & Wildsmith, 1999; Sainsbury Centre for Mental Health, 2002). Furthermore, BME

groups are more likely to be offered drug treatments rather than psychological therapy, more likely to have their children taken into care (Singh & Clarke, 2006) and have past negative experiences of statutory services (Williams *et al.*, 2006). The inequalities in access to mental health services and the disparities observed in 'who gets what' serve to illustrate the importance of a more diverse workforce whereby the issues faced by ethnically diverse communities can be addressed with cultural sensitivity.

The issue of diversity within professional contexts is important as it ensures that individuals are not discriminated against and have fair access to practice in different professional contexts. It is also crucial that services reflect and represent the communities in which they serve. According to Turpin and Coleman (2010), "the diversity of clinical psychology as a profession is a key factor in whether or not we achieve the goal of facilitating access to services that reflect individuals' own particular culture and personal identities" (p. 17). With initiatives such as Improving Access to Psychological Therapies (IAPT) aiming to widen access to 'hard to reach groups', it is important to understand the experience of minority groups who often form a large part of these hard to reach communities.

1.3.3 What has been done?

Over the years, there have been major legislative developments in relation to the plight of BME groups in British society. The Race Relations Act (1965, 1976) was one such piece of legislation, which was intended to protect from discrimination on grounds of race. However, it is widely accepted that despite these developments there are still many and significant examples of discrimination that exist in relation to employment, housing, education and other services and furthermore, that often this is indirect rather than direct e.g. institutional racism (Anwar, 1991).

Clinical psychology specifically has also tried to address the growing awareness of ongoing racism and discrimination in society and the profession. I will highlight a

few ways clinical psychology has responded over the years, including training culturally competent clinicians, attracting a more diverse workforce, etc.

The British Psychological Society (BPS) and Health Care Professions Council (HCPC), a regulator of certain health care professions, including clinical psychology, require that all accredited training courses should be able to show evidence of addressing issues of race and culture in their training programmes (BPS, 2015; HCPC, 2015). The development of training materials such as the award winning training manual by Patel *et al.* (2000) made recommendations for trainers on how to consider and integrate issues of race and culture in all aspects of training.

In 2004, two projects were undertaken to examine the ethnic makeup of the profession: the English Survey of Applied Psychology (BPS, 2004) and the BPS/DCP Widening Access Project (Turpin & Fensom, 2004). This was in response to criticism regarding the lack of reliable data concerning the ethnic composition of the profession. The BPS/DCP report (2004) made several recommendations of which there has been some variable success.

One initiative that has been active over the last decade is the pan-London Widening Access Initiative. This scheme targets BME graduates and provides careers advice and a mentoring scheme and has also been rolled out across training courses in the UK (Smith, 2016). According to Turpin and Coleman (2010), there has been significant progress in raising an awareness of clinical psychology as a career to BME undergraduates as well as addressing some of the potential inequalities in the application process.

1.3.4 Ongoing challenges

Despite these developments there remains much work to be done to tackle inequalities in the application process and the resultant low number of BME clinical psychologists. Furthermore, this does not address understanding the experiences of BME psychologists once they are in the profession, which I will consider next.

I will now give an explanation of how I came to this study and why I chose ethnic diversity over other aspects of diversity that continue to be underrepresented in clinical psychology.

1.4 Self-Reflexivity

1.4.1 How I came to this study

According to Elliott, Fischer and Rennie (1999) researchers should declare their values, beliefs and assumptions that may enable the reader to orient them to alternative perspectives in addition to the perspective, and possible biases, being offered in the research. As such, I will make transparent my background and beliefs which inform my perspective and in turn impact on aspects of the current piece of research. Furthermore, I write in the first person to take account of myself within the research (Webb, 1992).

I am an individual who identifies as being 'Black British'. I am of West African (Nigerian) heritage, though I was born in the UK. My cultural heritage plays an important role in my identity and how I perceive, experience and navigate the world around me. Having two different cultures as a framework growing up has led to my unique perspective on how I relate to those around me and behave in different situations. Growing up, I had to learn how to make compromises between the demands of my cultural heritage and host country culture. It has been an ongoing process whereby I have strived to integrate my dual identities.

The importance of my background becomes apparent when attempting to understand how I came to the study and its relevance to me. Challenging

experiences as a trainee clinical psychologist brought to the forefront issues around my personal identity within a context where I felt exposed as different. I suspected that this was to do with the blatant nature of my difference: skin colour. During moments like these, I would remind myself of the transient nature of the training and the fact that it would eventually come to an end. However, it led to reflections on 'what will my experience be like when I qualify?' These reflections prompted a consultation of the literature to gain an insight into my questions. I was surprised to find that there was very little research that explores the experience of BME clinical psychologists. The literature contained studies looking at the experience of trainee BME clinical psychologists and the difficulties they faced (e.g. Shah, Wood, Nolte & Goodbody, 2012). This encouraged me to take this research a step further and explore the experience of BME clinical psychologists.

1.4.2 Privileging race over other aspects of diversity

In line with being reflexive, I will here account for why I have privileged race over some of the other Social GRRRAACCEEESSS (SG), which are also visible and difficult to disguise. SG is an acronym that was developed by Burnham (1992, 1993, 2012) and stands for gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality. The salience of the SG varies, depending on different contexts, times and situations. According to Totsuka (2014), aspects of SG may vary in their visibility or invisibility (whether it is visually present and obvious) and in their being voiced or unvoiced (whether it can be named or discussed), and importantly, this can change over time. Within clinical psychology, women represent the majority with regards to gender. In 2014, women accounted for 82% of applicants for the doctoral training and 83% of acceptances onto the training (Leeds Clearing House Website). A study into the male experience could have been a possibility, but was less salient to me as a female in the profession.

The next section will provide an overview of some important concepts in race and ethnicity discourse to give some clarity in a field where there are many definitions

and much debate as to how to think about cultural diversity.

1.5 Important Concepts/Terminology

The construct 'Black' has been used in a variety of complex ways in social science literature (Brunsma & Rockquemore, 2002). This is also true of everyday usage of the term. Being 'Black' historically referred to the colour of one's skin; the use of such labels has allowed for heterogeneous groups to be grouped together and analysed (Carlson & Chamberlain, 2004). However, it has also been used to refer to "identity, a marker, a social category, a statement of self-understanding, indeed a socially imposed parameter of the self; *however*, the terrain of identity is increasingly multifaceted, fluid, and dynamic – a negotiated terrain not encapsulated in one colossal concept" (Brunsma & Rockquemore, 2002, p. 103). Hence as a term, its usage varies widely.

It is important to note here the criticisms that have been levied at use of the term 'Black'. The Black/White binary as a concept appears to neglect the diversity in society and in fact overlooks those in society who do not necessarily identify as 'Black' or 'White', e.g. Chinese or South Asian people. A permanent all-encompassing term may not exist that serves the purpose of describing ethnic groups in a way that is not conceptually or politically problematic. For the purpose of this research, the term Black will be used to describe individuals who identify as being 'Black or Black British'.

Whiteness is something that is most visible to those who are excluded from the normative practices encompassed by it (Frankenberg, 1993). The implications of being firmly situated in Whiteness and not possessing an awareness of what this entails will be discussed later in relation to White privilege.

'Minority Ethnic' refers to any ethnic group who are in a minority in comparison to the majority ethnic group. Ferns (2007) highlights that minority ethnic can refer to both Black and White ethnic groups. The shared assumption regarding Minority

Ethnic groups is that they are vulnerable to discrimination on the basis of their ethnicity.

1.5.1 Race, Culture & Ethnicity

The terms ethnicity, race and culture are often used interchangeably and can often cause confusion, as there remain similarities between the concepts. However, there are also differences between them and I shall briefly clarify the terms to ensure their use in this research is made clear.

Definitions of ethnicity include the idea that membership of an ethnic group is voluntary (Banton, 1983). This is in comparison to race whereby one's race is predetermined and cannot be chosen. Ethnicity has been described as both relational and situational as it refers to the relationship between groups rather than within them (Eriksen, 2015). According to Phukon (2002), ethnicity is "an organizing principle used by a group of people in order to differentiate themselves from other groups in terms of race, kinship, language, customs, mode of living, culture, religion and so on" (p. 1).

The concept of race is based on the idea that there are distinct, ascribed, permanent racial categories that can be defined by phenotype (Helm & Talleyrand, 1997). However, race does not exist as a biological reality (Phinney, 1996). The lack of evidence to support the notion that race exists as a biological construct has not, however, halted the practice of treating or studying individuals as though they belong to racially defined groups. Race is better understood as a social construct rather than a biological one. Witzig (1996) defines the social construction of race as hailing from social perception that has no scientific evidence. Furthermore, as a term, "race is associated with a dangerous assumption that the world is split into distinct dichotomies, [and] that there is more than one human race, thus ignoring the wealth of cultural and ethnic diversity" (Clarke, 2008, p. 518).

There is a growing acceptance of the difficulties associated with race as terminology. However, possibly less understood is the problematic use of the term ethnicity that leads to the pathologizing of certain groups (Clarke, 2008). Ethnicity is often used as a term to describe 'the other', and it is not uncommon for the term to be ascribed to 'bothersome' minorities. The equating of White to the normative position has arguably led to the notion of White as being 'culture-free'. Consequently, when ethnicity is discussed, it is referred in relation to non-White groups. This then negates the idea that we all have a culture and an ethnicity. The use of ethnicity as a construct allows for negative characteristics to be attributed to the 'other'. This highlights the difficulty of identifying oneself in relation to the other. According to Clarke (2008), defining oneself based on the other can lead to identity formation based on who we do not want to be. Essentially if one ascribes negative attributes to the other, this allows for an ideal self to be formed. The overrepresentation of BME groups in psychiatric settings is arguably a way in which society seeks to denigrate the other in order to perpetuate the idealization of the majority group.

It has often been the case that researchers have taken the position of studying other cultures from a normative position (Nolte, 2007). The implication of such an approach is that Whiteness is seen as the norm and other cultures are evaluated in relation to this standard, taking a deficit approach to the study of 'the other'. As Nolte (2007) asserts, White is also a colour and culture is something possessed by all.

A way of life that is common to a group is often described as culture. Due to its dynamic and changing nature, it has been difficult to define culture and many writers have attempted to do so giving different definitions of what culture is (Fernando, 2002). Sue and Sue (1990) define culture as consisting of the "things that people have learned to do, believe, value and enjoy in their history. It is the totality of ideals, beliefs, skills, tools, customs and institutions into which each member of society is born" (as cited in Patel *et al.*, 2000, p. 44).

As previously stated, the concepts of race, ethnicity and culture are often confused and their interrelatedness in various contexts can make it difficult to disentangle them. Of importance are the ways in which these terms are applied to people. Once labelled as belonging to a social group on the basis of one's 'race', ethnicity or culture, one runs the likelihood of being stereotyped as possessing the traits that have been afforded to that group (Fernando, 2002).

1.5.1.1 Race & Racism

Though the terminology of race has been highlighted as an unhelpful frame from which to understand cultures, it is a surface level marker that has implications for how individuals interact. Race and racism are social constructs, which are primarily determined by an individual's skin colour (Witzig, 1996). The Cambridge English Dictionary defines racism as "the belief that people's qualities are influenced by their race and that the members of other races are not as good as the members of your own, or the resulting unfair treatment of members of other races".

Racism is distinguished into different types. Old-fashioned racism refers to the overt discrimination whereby individuals may publicly show their hatred for another person based on their race (McConahay, 1986). Modern racism, in contrast, is deemed to be discriminatory practices, which are more subtle, covert and disguised (Pedersen & Walker, 1997). Racial microaggressions is another term used to describe daily and commonplace verbal, behavioral, or environmental humiliations; these are not necessarily always intentional, but communicate derogatory or negative racial slights toward people of colour (Sue *et al.*, 2007).

The influential MacPherson report (1999) that came about as a result of an inquiry into the racist murder of Black teenager Stephen Lawrence concluded that institutions should examine their policies and practices to ensure that sections of

the community are not disadvantaged. It could be argued that institutional racism is also present in the NHS. For example, there is evidence to suggest that the NHS recruitment process favours White applicants over BME applicants disproportionately (Kline, 2014). Whether or not this and other such examples can be argued to be clear evidence of institutional racist practices is one question, but it does highlight an ongoing problem. Furthermore, it highlights another important issue to consider, namely that of White privilege.

1.5.1.2 White privilege

McIntosh (1992) defines this as a set of unearned, often unrecognized rewards afforded an individual on the basis of their skin colour. This taboo subject is so because of the unease associated with the dominance that is conferred to one group whilst subjugating another and the denial or silence around this. Associated with White privilege are concepts of power and race relations. Though I cannot fully review the literature on White privilege here, it is vital to note its relevance to this study. White privilege may be argued to play a significant role in the overrepresentation of White clinical psychologists in the profession.

I will now look at how issues of ethnic difference can influence different aspects of a clinical psychologist's professional life such as in the therapy room and in supervisory relationships. I will then go on to address the development of a professional identity in the context of one's cultural identity and the challenges that can arise when it is being negotiated.

1.6 Issues of race and culture in the therapy room

The therapy room is one example of where complex dynamics can be played out between individuals. Tuckwell (2002) argues that racial identity issues are

interwoven into therapy as both the client and therapist draw on their perception of themselves and each other as racial beings. Though I will not address all the possible ways in which working with ethnic difference pervades therapeutic encounters, I will briefly describe some problems that have been reported in the therapy room in relation to ethnicity. Joseph (1995) commented on her experience of status contradiction whereby a White client is confronted with the presence of a BME clinician who traditionally may be thought of as holding a low status/position. Status contradiction (Littlewood & Lipsedge, 1982) can also happen in other ethnic encounters where the therapist is Black and the client is also Black. This can have implications for the psychological wellbeing of the clinician who is faced with such encounters in their working lives, especially if acted upon by the client. It is important to recognize how racial identity dynamics impact on therapeutic encounters for all involved.

Another example is found in a study conducted by Patel (1998), where the unusual power dynamics arising between White clients and Black therapists were explored. In the therapy room, both held a different kind of power i.e. membership of the dominant privileged group versus being in a high status professional role. She found that Black therapists used various strategies to manage difficult feelings if they perceived clients to be trying to gain power by making covert racist comments. Strategies included attempting to prove their competence or asserting their power.

In summary, the literature indicates that there are many ways in which complex racial dynamics can impact on clinicians, and this is one aspect that will be explored in the current study.

1.7 Issues of race and culture in supervisory relationships

The supervisory relationship is a further arena where racial and cultural dynamics can come into play. For example, it has been reported that in cross-cultural supervision, there can be a tendency for supervisors to overtly avoid discussing

issues of race and culture in supervision. In a study by Constantine and Sue, (2007) it was found that many Black supervisees felt that their White supervisors either minimized or dismissed discussions about race or cultural issues in supervision. The impact of this may be the silencing of supervisees within this relationship. Conversely, in their 1999 study, Wieling and Marshall found that supervisees reported better supervisory experiences with supervisors of a different racial background to them than with someone of the same background.

As there have been limited studies conducted on this issue in the UK, it is difficult to make conclusions as to the experience of supervisees in cross-cultural supervisory relationships. The literature in this area would benefit from further research to establish the nature of supervisor relationships in cross-cultural dyads. However, it remains of importance to highlight various areas within clinical practice where issues of race and culture may result in challenging experiences. Again, this area will be returned to in the current study.

I will now consider the role that ethnicity plays in identity development. I will then explore what it means to have a professional identity and examine how multiple identities are negotiated.

1.8 Identity

In contemporary society, questions of identity, group membership and representation pervade daily interactions (Howarth, 2002). Identity refers to the psychological relationship that an individual has to specific social categories. It is an important concept as it is central to how individuals make sense of who they are and how they respond to their environment (Pratt, Rockmann & Kaufmann, 2006). In the context of this research, it is important to consider the role of ethnicity in the overall framework of identity development, be that personal or professional. "Ethnic identity development consists of an individual's movement toward a highly conscious identification with their own cultural values, behaviors, beliefs, and traditions" (Chavez & Guido-DiBrito, 1999, p. 41).

1.8.1 Identity Theories

There are many proposed models of 'racial' identity development (e.g. Cross, 1971; Helms, 1993; Parham, 1989). In these models, it is considered how the racial perception of others intersects with one's racial perception of self. Problematic in these models is the assumption that a conscious racial identity is developed following encounters with other racial groups. Though this may play a role in an individual's identity development, there is less of an emphasis on what is learnt from one's family and community.

1.8.2 Considering Context in Identity Development

The development of an individual's identity as well as collective identities, cannot be understood without giving recognition to the context from which one hails. Ethnic identity is to a large extent defined by context; it is not usually problematic until one considers it in relation to a contrast group i.e. the majority culture (Phinney, 1990). As such, context is highly relevant to consider when discussing identity formation and development.

1.8.3 Professional Identity

Professional identity is defined as the beliefs and values that comprise an individual's self-concept as a professional (Slay & Smith, 2011). That all people working in a similar professional context share the same professional identity is not necessarily true (Ellis, 2006). Despite consensus in the literature confirming that when one's work role changes, one's identity changes also, the process by which this occurs remains to be understood (Ibarra, 1999).

I will draw on Kelly's Personal Construct Theory (PCT) to discuss how individuals may develop and negotiate their professional identity. According to Kelly (1963),

“man looks at his world through transparent patterns or templets which he creates and then attempts to fit over the realities of which the world is composed” (p. 9). Though the ‘templets’ are not always a ‘good fit’, Kelly posited that it is these templets, or constructs as Kelly named them, that make the world a more predictable place in which individuals can make sense of it. A central tenet of this theory is that individuals create their own way of seeing the world in which they live and not vice versa.

Ellis (2006) argues that for an individual who has worked in a professional role for a number of years, it is expected that they will have a construct system that is well developed and helpful in allowing them to cope with the daily demands of the role. As Kelly (1955, 1963) asserts in his Construction Corollary, though time does not repeat itself, individuals can begin to observe recurrent themes in the ongoing process of life. From these observed themes, one can begin to predict what is anticipated to come, not as a direct replication but as a guide as to what may be expected based on prior experiences. As with the scientist who in conducting his/her experiments must revise predictions that are proven false, individuals too are in need of modifying their construing should their experiences invalidate their predictions. Similarly, when predictions are validated through experiences, these are strengthened and the constructs remain intact (Ellis, 2006).

For individuals whose professional identity construct system is not well developed, there may be a reliance on their personal construct system to anticipate events (Ellis, 2006). If for example an individual has experienced discrimination in their personal lives and this has been a pervasive aspect of their life experiences, this may form the basis of their construct system on race relations. It may then be a construct system that is activated for use in their professional life whilst they are developing a professional identity and coming to understand the dynamics within their profession. The employment of one’s personal construct system in a professional arena may or may not be a good fit with their professional role.

1.8.4 Negotiation of Multiple Identities

Naturally, multiple identities need to be negotiated, though for some groups the meaning assigned to aspects of their identity is not owned by them, but is instead ascribed to them via social constructions (Harris, 2007). For BME clinical psychologists practising in a profession that construes itself as 'White' (Patel *et al.*, 2000), there may be challenges that arise when attempting to incorporate aspects of one's cultural identity into one's professional identity.

Having a professional role arguably provides the holder with power (Goodbody & Burns, 2011), privilege (Slay & Smith, 2011) and a degree of autonomy (Benveniste, 1987). However, it has been argued that stigmatised individuals are afforded less prestige due to their 'tainted' identities (Slay & Smith, 2011). According to Piore and Safford (2006) one's social identity is integral to one's work career. In a predominantly White profession such as clinical psychology, BME clinicians may struggle to integrate the identity of a clinical psychologist with their existing sense of self (Tan & Champion, 2007).

According to cultural contracts theory (Jackson 2002), identities are negotiated when in contact with others. The theory assumes that everyone has a cultural worldview, which facilitates how people function in their environments. Even when individuals seek to preserve their core identity, they "are constantly involved in subtle value exchanges...these exchanges are considered cultural contracts" (Jackson & Crawley, 2003, p. 30). The theory provides an interesting frame from which to consider how minority clinicians may negotiate their identities within a profession that lacks ethnic diversity. In their cultural contracts within the profession, minority psychologists will either decide to conform to the dominant cultural community or resist efforts to assimilate.

1.8.5 Intersectionality

Intersectionality refers to the relationship between the multiple dimensions of one's social identity. According to Cole (2009), "intersectionality makes plain that gender, race, class, and sexuality simultaneously affect the perceptions, experiences, and opportunities of everyone living in a society stratified along these dimensions" (p. 179). Paying attention to intersectionality is crucial in research as overlooking this may render one's research incomplete or biased (Cole, 2009). Thus, the current study aims to consider this within the research.

1.9 Review of the Literature on Race and Culture in Clinical Psychology

On conclusion of the background review and an overview of the current context, I will now go on to review the research literature in this area, giving a clear rationale for why this study is being conducted.

1.9.1 Literature Search Strategy

The literature review to be presented next was undertaken with the aim of looking systematically at previous research that has been conducted on the experience of BME clinical psychologists in clinical practice in the UK. Scopus, Web of Science, PubMed, Google Scholar and the University of Hertfordshire Library Search Engine were utilised in conducting the literature search. The phrases "BME", "clinical psychology", "clinical psychologist", "minority ethnic", "diversity", "Black", "NHS" and "racism" were chosen as key terms to facilitate the systematic searches of the databases. Due to the paucity of research in this specific area, when relevant articles were identified, *related articles* searches were implemented on databases such as Google Scholar. Also, the references of relevant articles were reviewed to aid identification of other pertinent research in the area.

Figure 2 provides an overview of the literature search process showing the number of articles the search identified, the exclusion and inclusion of relevant articles and the final number of papers to be reviewed in the literature review.

Articles excluded included those that did not relate to the profession of clinical psychology, e.g. studies relating to the experience of counselling psychologists (Watson, 2006), family therapists (Rastogi & Wieling, 2004) and psychotherapists (Morgan, 2008). Articles were also excluded if they were not in relation to the British context. This was an important criterion as there are cultural differences between countries and research conducted in other cultural contexts may overlook important contextual factors that are specific to the UK.



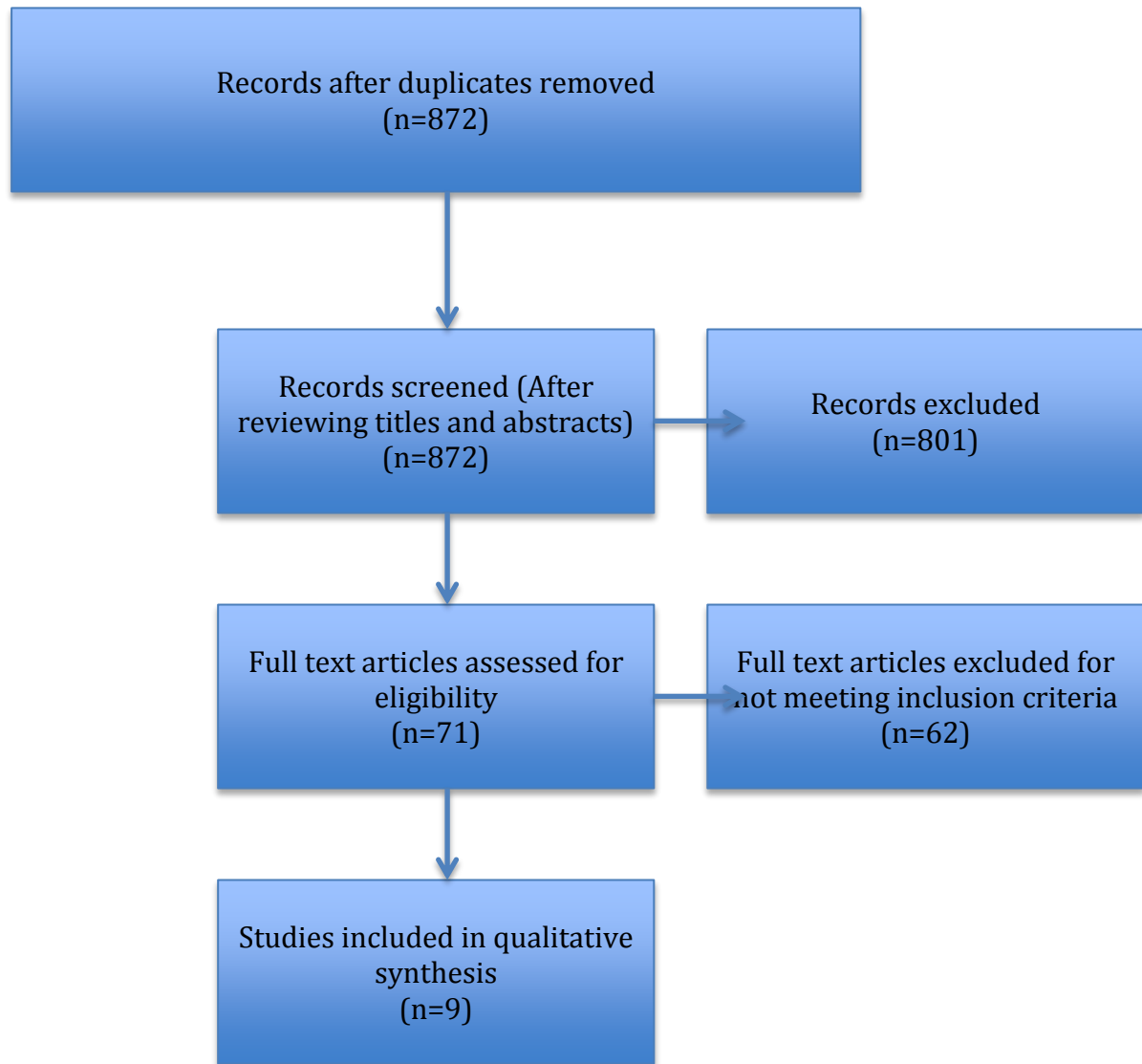


Figure 2: Flow diagram of literature search process

I will now report on this systematic review conducted of the literature. The review includes discussion papers as well as research studies due to the lack of research in this area. The studies reported are mostly qualitative in nature and as such are mostly small scale with small sample sizes.

1.9.2 Literature Review

A search of the literature highlighted the lack of studies looking into the experience of qualified BME clinical psychologists. What was mostly found in the literature were discussion papers considering why the profession lacks diversity and reflective papers discussing some of the challenges of being a trainee BME clinical psychologist. It is important to note that many doctoral theses were found that looked at the experience of trainee clinical psychologists from BME backgrounds. However, many of these were not published and so therefore did not meet the criteria to be included in this systematic literature review.

Table 1. Literature review summary table

Author & Date	Date	Aims of Paper/Study	Themes	Findings
Adetimole, Afuape & Vara	2005	A reflective account of the authors' experience of being trainee clinical psychologists from BME backgrounds	<ul style="list-style-type: none"> • Insidious Racism • Identity development • Positive Blackness as invisible • Credibility 	Discussion paper
Alleyne	2004	An investigation into the specific experience and nature of workplace conflict for BME professionals in NHS, education and social services	<ul style="list-style-type: none"> • Workplace oppression not overtly about race and cultural difference • Conflict frequently initiated by subtleties in comments and behaviour that target aspects of individuals race or cultural identity 	<p>NHS workers reported worse outcomes out of the three groups</p> <p>There was evidence of internalized oppression</p> <p>Workplace oppression contributes to Invisible injuries in black workers</p>
Bender & Richardson	1990	To consider the ethnic composition of Clinical Psychology in Britain	<ul style="list-style-type: none"> • Clinical Psychology is in a poor position to meet the needs of certain groups due to its lack of diversity • The image and perceived stance of psychology is impacted should profession remain unrepresentative of populations it serves 	<p>Failure to act on diversifying profession could lead to profession being regarded as racist</p>

Goodbody & Burns	2010	To study the disciplining role of psychological discourses about Personal-Professional Development (PPD) and their contribution to perpetuating social power inequalities	<ul style="list-style-type: none"> • Power • Identity and status • Personal and Professional development • Difference and discrimination • Dilemmas 	PPD found to be a way To regulate unequal social relations via practices of the self. BME psychologists challenged the dominant discourses of PPD
Meredith & Baker	2007	Investigation of the attraction of professional clinical psychology to minority ethnic applicants	<ul style="list-style-type: none"> • Undergraduate students being committed to changing the ethnic make-up of clinical psychology • Struggle between community (feeling rejected) and profession (drawn to its success) • Clash between ethnic minority specific needs and majority specific provision 	Demonstrated the complexity of thinking in BME individuals towards clinical psychology as a profession
Patel & Fatimilehin	2005	A reflective piece concerning the authors' observation that racism is endemic with the profession of clinical psychology	<ul style="list-style-type: none"> • Struggle against racism • Eurocentricity of psychological approaches • Responsibility • Being positioned as an expert • Resistance to change 	Reflective Paper

Rajan & Shaw	2008	Qualitative study looking at the experience of trainee clinical psychologists	<ul style="list-style-type: none"> • Feeling fearful of standing out • Being positioned as an expert • The struggle to integrate personal identities with professional identities 	The values of dominant/majority groups can become embedded in institutional thinking Mentor schemes for BME trainees recognized as being potentially useful
Shah, Wood, Nolte & Goodbody	2012	Qualitative study looking at the experience of trainee clinical psychologists	<ul style="list-style-type: none"> • The hardship of not being White • Negotiating multiple identities • The challenges and dilemmas of highlighting race and culture issues 	BME trainees encountered avoidance in their experiences of training
Turpin, & Coleman	2010	Appraisal of how the profession has tackled the challenges of diversity	<ul style="list-style-type: none"> • Difficulties in accessing the profession for BME individuals • Cultural diversity defensiveness • Cultural knowledge within clinical psychology not acted upon 	Discussion Paper

Although the low recruitment and retention of BME clinical psychologists is well documented (Williams, *et al.*, 2006), few studies have actually enquired into the experiences of BME clinical psychologists in clinical practice. Most endeavours have tended to focus on the experience of trainee BME clinical psychologists. These have reported findings concerning personal identity issues (Shah *et al.*, 2012), being positioned as an expert on issues of diversity (Rajan & Shaw, 2008) as well as experiences of racism (Adetimole, Afuape & Vara, 2005).

As a reflective account, Adetimole *et al.*'s (2005) paper gives some insight into the difficulties of being a BME trainee clinical psychologist. To begin with, they describe the challenges they encountered in writing the paper, as they did not want to feel as though they were betraying the profession. They discuss societal discourse around what it means to be Black, i.e. deficient, different and damaged and specifically refer to experiences of insidious racism. Interestingly, they felt that the mentor scheme created as an initiative for prospective BME applicants to clinical training seemed to suggest that BME issues could only be addressed "outside of a White institution". Amongst other suggestions, they suggest that it is important that supervisors utilize the supervisory relationship as an opportunity to explore these issues. In critiquing this paper, it is important to note that it is a subjective account of three people's experience of clinical training. Although it is important not to dismiss this as irrelevant, it is also vital to acknowledge that this paper may not reflect the experience of all BME trainees.

One study that has focused on majority and minority groups within the profession is by Goodbody and Burns (2011). In their qualitative study, they looked at the psychological discourses about personal-professional development and their contribution to maintaining social power inequalities. They found that for BME participants, there were tensions between personal and professional identities, which arose from instances of discrimination. They also found that for *all* the psychologists who took part in the study, tensions between their personal identities and professional culture were managed by them increasingly allowing and integrating their personal selves in their work. The study was able to highlight

how for White participants, “the context marker was the invisible and unquestioned characteristic of privilege as social power and lived knowledge” (p. 306). Unfortunately, there was a lack of voice from BME males in the study. Despite this, the study had many strengths including its location in a critical psychology perspective. This stance allowed for an analytical dissection of the processes at play within the profession without privileging particular dominant discourses.

In another qualitative study, Rajan and Shaw (2008) explored the experiences of eight BME trainee clinical psychologists in the UK. Important themes that emerged from the research included participants feeling as though their ethnicity was advantageous in entering the profession. Speaking out was highlighted as an issue for participants who risked feeling isolated and labeled. Another important theme highlighted in the research was that participants felt that there were many blind spots in their training whereby things had not been thought out by training courses, for example, racism in client related work, racism whilst on rural placements and the impact of discussions on race and diversity within the cohort. The study positively shed light on the BME trainee experience, but the sample was made up solely of females. Although this made the sample homogenous, as is required by IPA, again little is known about the experience of male BME trainees.

In Shah *et al.*'s (2012) qualitative study, nine trainee BME clinical psychologists were interviewed about their experience of training. A phenomenological approach was taken similar to that of Rajan and Smith's (2008) study. A key finding of the research was that trainees often experienced resistance to talking about race and culture both in the classroom and in their supervisory relationships. Another issue highlighted from the research was the dilemma for trainees concerning who should carry the burden of raising race and culture issues. Related to this was the fear that by raising BME issues one would become further marginalised. The study concluded that there was a need for training courses to be more aware of race and culture issues in the training context, particularly in relation to supervisors feeling confident to raise these issues, thus

making trainees feel more comfortable in having these conversations. What this study failed to show was whether White trainees find it challenging to raise race and culture issues also. An exploration of this view would provide an insight into whether this is a challenge faced by BME trainees or all trainees irrespective of ethnicity. In spite of this criticism, the study gives an insightful perspective into the experience of BME trainees.

In their 2005 paper, Patel and Fatimilehin address whether over the years things have changed within clinical psychology in relation to claims that the profession is racist. They take alternative perspectives on claims such as that BME students are not attracted to the profession, hence why the profession lacks ethnic diversity. They speak on their experiences as still being rife with examples of racism and concerns as to whether the profession is willing to change. The authors of this paper had been qualified in the profession for 15 years at the time of writing this reflective piece. This allowed for a discussion of their experiences over a significant period of time, in contrast to studies with trainee BME clinical psychologists who have less experience within the profession. However, as critiqued of Adetimole *et al.*'s (2005) paper, it is important to acknowledge the subjectivity in their account and the fact that their experiences may not be a reflection of how all BME clinical psychologists experience the profession.

Meredith and Baker (2007) employed Q methodology to investigate the attractiveness (or otherwise) of a career in clinical psychology for BME undergraduate psychology students. They found that there were various juxtaposed narratives expressed in the data including clinical psychology being a good profession, but a fear that the odds of becoming a clinical psychologist are not worth it. Also, views expressed included the difficulties in gaining a training place and the clear disadvantages faced by BME applicants to gain a training place. A further conflict acknowledged in the data was that of being drawn to a 'White profession' at the cost of feeling rejected by one's community. This study provides a useful insight into the views of clinical psychology as a profession to BME

applicants as it highlights that though there is some cynicism towards the profession, there are also aspects of the profession that are seen positively. The study sample was small and it is hard to know how representative these views are of other BME undergraduate psychology students. Also recognized by the authors was the fact that the researchers were from a White British background, which may have possibly hindered the results of the study and the willingness of participants to be open about their views.

In 2004, Alleyne published her doctoral research on the experience of BME workers in three institutional settings including the NHS, social services and education. 30 participants took part from various professions including psychology, nursing and social work, amongst others. A qualitative research methodology was employed using phenomenology, hermeneutics and heuristic principles. Various themes emerged including two major themes around internal and external factors. Internal factors were related to the reactions and feelings that were reported by the respondents whilst external factors were concerned with management structures, which were usually dominated by White males. It was the interaction between these two factors that was reported as being influential in the experience of stress in the workplace. Importantly, the study indicated that workplace oppression was not overtly about race. Subtle comments about individuals' cultural identity were usually the instigators of conflict for many participants. In trying to deal with workplace conflict, participants noted collusive management structures, which further reinforced trauma in the workplace. This study provides an interesting insight into the experience of BME workers, including clinical psychologists. The spread of professions and institutions makes it difficult to highlight specifically the experiences of particular professional groups. However, the study importantly sheds light on some of the challenges faced by BME workers. A limitation of the study was that there were only three Asian workers included in the sample. There were also few males represented in the sample.

In summary, the above research highlights that for BME clinical psychologists both qualified and trainees, their ethnicity is often the overriding factor in how they are positioned within the profession. Despite the lack of published research in the area and the reliance on reflective accounts to highlight the experience of BME clinicians, there is evidence to suggest that clinical psychology, as a profession, is a challenging profession for some BME psychologists and much remains to be done to address the inequalities within the profession.

1.9.3 Gaps in the Literature

There have been some insightful studies that give an account of important issues in relation to cultural diversity in clinical psychology. However, this review highlights that there is still a significant gap in our knowledge of key issues, one of which is the experience of BME clinical psychologists in the profession and the impact of their experiences on their view of their professional identity. Furthermore, as identified earlier in the introduction, more is needed on our knowledge of supervisory relationships where clinicians are from different ethnic backgrounds.

1.10 Conclusions and Rationale

Psychology's relationship with race and culture has had a tumultuous history. Over the years, there have been efforts to address the lack of diversity within the profession, with attempts to improve the recruitment and retention of BME clinical psychologists and increase cultural awareness and competence. This commitment to make the profession more diverse has had varying success, but evidence shows that there is still some way to go.

Despite this progress, the literature review suggests that there is a real need to understand the experience of BME clinical psychologists in the UK. The absence of this in the literature provides a rationale for why such a study is needed. The current research in this area provides a perspective on the trainee experience and

it is possible that once qualified these issues are experienced differently.

An important point to note is the fact that qualitative studies are often not afforded the same respect as quantitative studies and as a result of this, studies looking at the experience of individuals, which by their nature will be qualitative, are not so visible in peer-reviewed journals. Tong, Sainsbury and Craig (2007) assert that a perception persists that qualitative research is second-class research and Greenhalgh *et al.*, (2016) have recently powerfully challenged this.

2.0 RESEARCH QUESTION

The main research questions of the study were derived from the gaps in the literature as well as my personal interest in the professional context I was working towards. Thus, informed by the aims of the study, the research question were as follows:

- How do BME clinical psychologists experience and make sense of being part of the profession of clinical psychology?

Sub-questions were:

- What are the implications of being a BME clinical psychologist in the profession?
- What issues (positive/negative) relating to being a BME clinical psychologist arise in clinical practice (e.g. professional development, supervision, therapy, interactions with colleagues, etc.)?
- Do clinical psychologists talk about their experiences of being a BME clinical psychologist within the profession in the same way as is revealed by a less direct method of exploring their construing of these experiences?

2.1 Importance of current study

The area that has been left largely unattended is the experiences of BME psychologists in the profession, who are a minority group. There is a need to acknowledge and attempt to address the challenges that could potentially come from this position. In a society where institutional racism is still a reality, it is important to understand the experiences of BME clinical psychologists in their day-to-day professional lives. Though some work has been done with trainee clinical psychologists, qualified BME clinical psychologists' experiences have hardly been attended to.

3.0 METHODOLOGY

The methodological approach taken by this study was informed by the research questions, as recommended by Willig (2008). Previous studies have made clear that for some clinical psychologists it is challenging being an ethnic minority within the profession and that this position creates further issues in the working lives of a BME clinician (e.g. Rajan & Shaw, 2008; Shah *et al.*, 2012). Furthermore, there have been numerous reflective accounts that have documented a belief that racism is endemic within clinical psychology as a profession (e.g. Adetimole *et al.*, 2005; McInnis, 2002; Patel & Fatimilehin, 2005). To facilitate an understanding of the experience of BME clinicians in the profession, a qualitative research design was employed by the current study, utilizing a phenomenological approach. This section will explore the rationale behind this and give details of the recruitment of participants, the collection of data and its analysis and the ethical considerations that were made throughout the study.

Epistemology is concerned with knowledge and how we 'know' what we know (Snape & Spencer, 2003). It is important in research as one's epistemological position shapes the pursuit of knowledge of the research and the methods that are employed to access the phenomena under investigation (Agnew and Brown, 1989). Making these explicit will be the aim of the following sections; in order to frame the researcher's own position.

3.1 Epistemological Stance - Critical Realism (Constructive Alternativism)

Constructive alternativism underpins the theory of PCT. It is a philosophical stance that asserts that there are many different ways in which an event can be construed and thus, to a degree, individuals construct their reality. From this position, it is understood that "reality does not directly reveal itself to us, but rather it is subject to as many alternative ways of construing it as we ourselves can invent; hence the variety of human experience" (Adams-Webber, 1989, p. 1). Important to note here, though, is that although there are many interpretations of the universe, according

to Kelly (1955), the universe is real. Constructive alternativism is not logically incompatible with certain realist assumptions (Adams-Webber, 1989). On the one hand, Kelly holds that there is an independent reality; on the other hand, that it is only through our constructs that we can access that reality (Bagheri Noaparast, 1995). What Kelly termed constructive alternativism is today known as critical realism (Bazeley, 2013).

Critical realism, a stance that I the researcher hold, is based on the assumption that there is no complete knowledge and though a reality exists, it is only 'imperfectly apprehendable' (Guba & Lincoln, 1994). Inherent in this view is an acknowledgement that the production of knowledge is subjective, which brings this position in line with constructionist approaches. Bunge (1993) explains that for the critical realist, the way in which facts are perceived depends in part on our beliefs, which is particularly true in the social realm.

3.2 A Qualitative Approach

Qualitative approaches are concerned with the exploration, description and interpretation of the personal and also social experiences of people and/or groups (Smith, 2008). Qualitative research, of which there are many different examples, involves the collection of data from participants via various methods, an example of which is verbal report i.e. interview transcripts (Smith, 2008). Given the paucity of research in this area, a research design that could expand on the understanding of this group of individuals was preferred. Experience is a complex concept and qualitative research aims to provide what Geertz (1973) described as 'thick' descriptive accounts of the topic of interest.

3.3 Research Design

The current study employed a qualitative approach, Interpretative Phenomenological Analysis (IPA), to explore, describe and interpret the lived experience of BME clinical psychologists within the profession of clinical

psychology. To enhance the understanding of this group of individuals' experience, an additional method was included in the research design: repertory grids. Repertory grids have the benefit of being able to elicit implicit or well-guarded aspects of BME clinical psychologists' experiences that may be difficult to discuss in a semi-structured interview. This adds to the study's aim of making sense of participants' experiences and their own way of making sense of these experiences.

The literature indicated the need for a systematic qualitative investigation that would expand on the findings from previous studies, but that would also give credibility to experiences that are both sensitive and understudied.

3.3.1 Repertory Grids

The repertory grid (Kelly, 1955) is a technique that allows us to understand a person's worldview or experience in their own terms rather than using a standard conceptual framework, which may not fit with how the person sees the world. As such, it is a tool that provides a perspective on the way in which an individual views themselves and the world. Repertory grids were chosen as a methodological approach (in addition to IPA) as it was felt that the information provided by the repertory grid interview would help to provide a different framework from which to understand the meaning of participants' lived experience. Furthermore, repertory grids can tap lower levels of cognitive awareness (Winter, 2003), reducing the effects of social desirability on answers given by participants (Neergaard & Leitch, 2015) and thus possibly allowing for a more insightful perspective into the experience of participants.

Grids are a useful approach in the study as they not only give meaning to an individual's experience, but also they can tell us the structure of an individual's belief system, e.g. superordinate and subordinate constructs. Furthermore, grids are able to indicate similarities and differences in the ways in which an individual perceives elements of their experience, e.g. their self and their ideal self, or another

individual. An advantage of the repertory grid technique is that it is oblique in nature. As participants are generally not aware of what is being measured, this can allow an examination of areas that may be difficult to access using conventional methods (Bannister, 1965).

Repertory grids (Appendix A) consist of four main parts, these are: topic, elements, constructs, and ratings (Blagden, Winder, Gregson & Thorne, 2014). The topic is the focus of each grid and concerns a specific realm of discourse, i.e. in this study ethnic identity. Elements relate to the topic of the grid and often take the form of people (Slater, 1969). Elements proposed as relevant to the current topic and used in the study included: "Self as I really am", "Self at work", "Ideal self", "Self as a trainee", "Self prior to training", "BME Clinical Psychologist", "White Clinical Psychologist" "Ideal Clinical Psychologist", "How my BME clients see me", "How my White clients see me", "How my BME colleagues see me" and "How my White colleagues see me". Constructs are elicited by the systematic comparison of a set of elements (Jankowicz, 2005). In line with the central tenets of PCT, all the constructs were elicited from the participants rather than supplied to them. This was to ensure that the constructs were personally meaningful to each participant. The elicitation of the constructs was completed using the triadic method. The triadic method involved showing participants three element cards and asking them how two of them are alike, but different from the third. Past studies have recommended between 10 and 12 constructs as sufficient to gain an insight into an individual's construing of a particular topic (Blagden *et al.*, 2014). Following elicitation of constructs, participants were asked to rate the elements on them using a seven point rating scale.

3.3.2 Interpretative Phenomenological Analysis

IPA is primarily concerned with an examination of an individual's lived experience (Smith, Flowers & Larkin, 2009). It was thus the qualitative methodology of choice to understand clinical psychologists' own lived experience of their profession. There are two major theoretical underpinnings of IPA; one is phenomenology, the

other hermeneutics. Phenomenology refers to the philosophical approach to the study of experience (Smith *et al.*, 2009). The concerns of phenomenology broadly cover thinking about what constitutes the human experience, what this feels like and what this means to individuals. The value of this approach concerns how an individual's lived experience can be examined and understood. Common features of phenomenological approaches include the focus on the wholeness of experience, the focus on individual meaning-making as opposed to causal explanation, the use of first-person accounts to describe experience and the researcher being reflexive (Moustakas, 1994). A key aspect of IPA research is that in attempting to understand the human experience, an interpretative process occurs. This is because it is acknowledged that as it is not possible to directly access an individual's world, interpretation must take place. The theory of interpretation is known as hermeneutics. Also important is the double hermeneutic that is involved in IPA. This refers to the researcher's interpretation of the participants' interpretation. It thus renders the researcher into a dual role as being both like and unlike the participant. To further explain, the researcher like the participant is a human being who tries to make sense of their social world. However, unlike the participant, the researcher is not the focus of investigation and is only able to access the participant's experience through their account of it. In essence, the meaning making process is twofold, with the participant's meaning making being what Smith *et al.* (2009) calls 'first-order' and the researcher's sense-making 'second order'.

The semi-structured interview is the exemplary method for IPA as it allows flexibility, facilitates rapport and produces richer data. For example, a structured interview limits what the participant can say due to the predetermined interview schedule and the requirement to ask questions in the same format and sequence for each participant (Smith, 2008). IPA was chosen, in addition to the repertory grid, as the more appropriate qualitative method as it aims to give voice to research participants. As mentioned before, the experience of BME clinical psychologists within clinical practice has seldom been researched. It was thus felt

that a methodology that would give voice to the participant was vital and necessary. In IPA, the person in context is key (Larkin & Thompson, 2003). By focusing on the meaning of the experience and how this is significant for the individual, IPA is idiographic in nature. In idiographic studies, claims can be made about the individuals under investigation as the focus is on individual cases as opposed to groups or larger populations.

Other qualitative approaches were considered, but deemed inappropriate for the aims of the study. For example, the aim of Discourse Analysis is to explore how meaning is negotiated through the language that is employed. Ultimately, the discourse analyst is concerned with what participants are doing with their language and their talk. It was considered that such an approach would take away from trying to understand the actual experience of participants, which was the main aim of the study. A Narrative approach was considered given that this would allow for participants to give an account of their stories of being clinical psychologists from BME backgrounds. Murray and Sools (2014) describe narrative as an organised interpretation of a sequence of events. This approach allows order to be brought to disorder and can provide a structure to an individual's sense of self. Though a potentially useful framework and methodology for the study, IPA was felt to be more in line with generating themes from a relatively small, homogenous sample, whilst maintaining an idiographic lens.

3.3.3 Mixed Methodological Approach

The core premise of a pluralistic methodological approach is that knowledge is accumulated in a variety of different ways and from a variety of different sources (Barker & Pistrang, 2005). Feyerabend (1975) asserted, "a scientist who wishes to maximize the empirical content of the views [s]he holds and who wants to understand them as clearly as [s]he possibly can must therefore introduce other views; that is, [s]he must adopt a pluralistic methodology" (p. 30). The utilization of a pluralistic methodology in this study has its strengths and limitations. To

begin with I will address the potential dilemmas derived from the research question that indicated the employment of a mixed methods design.

It has been acknowledged in the literature that BME groups can sometimes experience difficulties in their profession, which is distressing as well as marginalizing (Goodbody & Burns, 2011). It was reflected upon when designing the study how accounts given by participants during the semi-structured interviews might be tempered in such a way as to protect the self, the profession (due to perceived loyalties), and even the researcher. The introduction of the repertory grid was a way in which to consider whether individuals would talk about their experiences in the profession as is revealed by a less direct method of exploring their construing of these experiences.

Epistemic privilege is a feminist notion that refers to the idea that oppressed 'insiders' have knowledge of their oppression that those who do not share in the oppression do not have access to (Narayan, 1988). Further to this, problems can arise in dialogues with 'outsiders' due to the emotions involved and the subsequent impact this can have on the oppressed individual's sense of self. The employment of a heuristic methodology that claims a constructivist view of knowledge could arguably add to this problem of understanding the oppressed lived experience. The use of a methodology that takes into account an individual's construct system was thought to be a useful way to add further understanding to a topic that has received little attention in the research literature despite being an important issue for the profession of clinical psychology.

The concept of epistemic oppression thus relates to the idea that the powerful in society have an influence over how our understanding of the social world is structured (Fricker, 1999). It is this notion that gives importance to the use of the repertory grid technique in that not only will IPA give voice to clinicians' experience of the profession, it will frame it in such a way that gives meaning to their experience rather than the frame which society's dominant discourse may

impose.

Discussing the experience of being marginalized or oppressed can be very difficult (e.g. Adetimole *et al.*, 2005). By moving beyond the descriptions given in a semi-structured interview, the repertory grid technique can promote a more elaborated understanding of what those experiences mean for the individual particularly with reference to the sense of self. It has been recognized that oppressed individuals in some contexts where they open up about their experiences feel the need to be careful in how they talk about their experiences due to feelings of guilt (Adetimole *et al.*, 2005), an awareness of other people's anxieties (Roy, 2002), anger (Wagner, 2005) or even suspiciousness (Samuel, 2004).

To ensure the semi-structured interview and the content of this did not act as a primer for the elicitation of constructs, the repertory grid interview was conducted first and where possible also on a different day.

The strengths of such an approach include the added value of incorporating multiperspectivity. No one approach on its own can provide the richness given by the use of more than one methodological approach. According to Mason (2006), when trying to understand the lived experience of individuals in a social reality, one must take a multidimensional approach, as these phenomena are not easily understood along a single dimension. She argues that there is multidimensionality to lived experience and in order to make sense of this, researchers need to think creatively about the methods that they employ.

Difficulties with pluralism in research include the fact that multiple reality perspectives may clash and/or be inconsistent. From a critical realist perspective, as people interpret the world differently, this would not be problematic.

The combined use of both IPA and repertory grids has been demonstrated to be a successful blend of methodologies (e.g. Blagden *et al.*, 2014; Gerrish, Neimeyer &

Bailey, 2014). With repertory grids, like IPA, the focus is on understanding an individual's social world and both methodologies allow for individuals to share their own way of sense making.

3.3.4 Triangulation

Triangulation refers to a process whereby multiple researchers, methodologies, theories or sources are converged to assess the consistency of a study's findings. Where different perspectives converge, it can be argued that there is mutual confirmation and as a result plausible results (Madill, Jordan & Shirley, 2000). The use of the two methodologies in this research provides a way of triangulating the data, to a degree, and therefore enhancing the validity of the study.

3.4 Quality in Qualitative Research

Concepts of reliability and validity employed in quantitative research have been rejected for use in qualitative methods of inquiry (Morse, Barrett, Mayan, Olson & Spiers, 2002). It has been recognised that these standards do not easily map onto qualitative methodologies and as such should not be used as the criteria to assess quality (e.g. Barker, Pistrang & Elliot, 2002). To illustrate this point, according to Madill *et al.* (2000), a certain degree of extrapolation is required when inferring meaning from data within qualitative approaches. Thus, qualitative research is often criticised for the amount of subjectivity afforded to the researcher. However, due to the epistemological underpinnings of qualitative research, the positivist assumptions do not apply and as such there is no aim to find an objective truth. Various authors have provided formulations for achieving quality standards in qualitative research (e.g. Elliot *et al.*, 1999; Lincoln & Guba, 1985; Patton, 2002). I have chosen to apply to this research Yardley's (2008) framework for evaluating the validity of qualitative research. In these guidelines particularly pertinent to qualitative research are issues of sensitivity to context, commitment and rigour, coherence and transparency and impact and importance. These will be considered in detail later in the discussion.

3.5 Participants

3.5.1 Recruitment

Participants of the study were recruited through a snowballing methodology (Patton, 2002). Clinical psychologists known to the researcher were invited to contact other BME clinical psychologists they knew with an invitation email and poster (Appendix B). This method of recruitment identified 8 participants, who were sent a participant information sheet (Appendix C), answering any questions they may have had regarding the study and to help ensure they were able to make an informed decision as to whether they wished to participate. Of the 8, 5 declined to take part. As this method was not successful in recruiting the required number of participants, further recruitment strategies were employed. This included emailing clinical psychologists identified via an online social networking service. This strategy identified a further 3 psychologists, 1 of whom eventually declined to participate. As this method of recruitment again did not satisfy the number of participants needed for the study, emails were sent to various organisations and persons that were known to have contact with BME clinical psychologists within the London area. This included the BPS and clinical tutors from London-based Clinical Psychology Doctorate training programmes. From this strategy, 4 further clinical psychologists were identified, 1 of whom took up the invitation to take part. The decision to recruit from the London area was twofold. Firstly, it was to ensure that the travel demands on the researcher would not adversely affect the research, as each participant was to be interviewed on two separate occasions. Secondly, it was felt that to increase the homogeneity of the sample, clinical psychologists employed in the city might share various experiences, which may be different from clinical psychologists employed in more rural areas, for example. Due to challenges recruiting participants for the study, the final sample included two clinical psychologists who were based outside of London.

3.5.2 Inclusion & Exclusion Criteria

Potential participants were asked to complete a screening questionnaire to ensure that they met the inclusion criteria of the study (Appendix D). The use of a homogenous sample is required by IPA. To fulfil this requirement, only clinical psychologists were included in the study. Furthermore, all participants were identified as coming from a Black and Minority Ethnic group, as defined by the Office of National Statistics. This included participants from a Black African, Black Caribbean or Black Other background, as well as Asian Indian, Asian Pakistani or Asian Bangladeshi background. Although membership of an ethnic group is something that is subjectively meaningful to the person concerned, participants were required to look as though they were from an ethnic background other than White by definition of skin colour. Skin colour was identified as an important criterion due to its salience in race relations. According to Bar-Haimô, Saidelô and Yovel (2009), “the tendency to use skin colour to categorize faces into different races seems almost automatic and unavoidable” (p. 145). As such, individuals who self-identified as belonging to a White ethnic minority group were not included within the study.

Clinical psychologists recruited to take part in the study were required to be currently working within the NHS with a clinical population. It was also required that participants had been qualified for at least two years, to ensure they had experience working as a clinical psychologist post-clinical training.

3.5.3 Participant Demographic Information

Table 2: Demographic Information of Participants

Pseudonym	Ethnicity*	Gender	Years Post Qualification
Mary	Black British	Female	6-10
Natasha	Black British	Female	6-10
Farida	Asian British	Female	<5
Serena	Black British	Female	<5
Saima	Asian British	Female	6-10
Priya	Asian British	Female	>15

**In being mindful of helping to keep participants anonymous, no further information about ethnic background is given*

3.6 Ethics

The University of Hertfordshire Health and Human Sciences Ethics Committees with Delegated Authority (ECDA) granted ethical approval for the study. The approval notification can be found in Appendix E. The study also adhered to the BPS (2009) Code of Conduct and Ethics.

3.6.1 Informed Consent

As an ethical consideration, participants were required to consent to participation and were asked to sign a consent form (Appendix F). In order to obtain informed consent, participants were sent information sheets giving them full details of the study, including its aims, methods and intended use(s) of the results. Furthermore, participants were advised of their right to withdraw from the study at any time without giving a reason and of their right not to answer any specific questions. This was done to ensure that participants did not feel constrained by their initial decision to take part.

3.6.2 Potential Distress

Though it has been recognised that qualitative research interviews can have a positive effect on participants (e.g. Murray, 2003), it was recognised that the interviews could also potentially cause distress for some whilst reflecting on upsetting issues. Due to this possibility, it was felt that it would be vital that participants were given the opportunity to decline further involvement. Further

to this participants were offered the opportunity to debrief following completion of the interviews.

3.6.3 Confidentiality

Participants were advised of the study's obligation to maintain their confidentiality. They were given full details of how this would be ensured by the secure storage of data and the use of pseudonyms to protect their identity. This was particularly pertinent to this study as clinical psychology is a relatively small profession. Considering the even smaller number of BME clinical psychologists within that number warranted an approach that would protect their identity. Furthermore the intended dissemination of the current study in professional literature that would potentially be read by their colleagues meant that I had a duty of care to ensure that it would be highly unlikely for the identity of the participants to be recognised. For example, during the analysis of the data information that could identify the work location of participants was removed or changed to ensure anonymity.

Also required to maintain confidentiality was the transcription service, which was asked to complete a confidentiality agreement (Appendix G).

3.7 Data Collection

3.7.1 Interviews

Participants decided the location of the interview. It was important that participants felt comfortable and that interviews were conducted in an environment free from distractions (Jankowicz, 2005). 5 chose to be interviewed

at work, whilst 1 chose to be interviewed at an independent location, in a public place.

Repertory grid interviews were conducted with each participant. These lasted between 60 and 90 minutes. Following completion of the repertory grid interview, the semi-structured interview was conducted. The interview schedule was informed by the literature (see Appendix H). Questions were flexible and allowed for the participants to elaborate on their own accounts without being stifled by the interview schedule. The themes covered in the semi-structured interview included the following:

- Pre-clinical training expectations of the profession
- The experience of being a trainee clinical psychologist from a BME background
- The experience of being a qualified clinical psychologist from a BME background
- The impact of ethnic identity on therapeutic relationships
- The impact of ethnic identity on professional development

These interviews were audio recorded and lasted between 45 and 75 minutes. The first two interviews were transcribed personally to allow myself to be immersed in the data as recommended in IPA. The last four transcripts were transcribed by a transcription service. In order to ensure that I could still be immersed in the data fully, as in the initial two transcripts, the audio recordings of the interviews were listened to as well as reading and re-reading the transcript. Once all 6 interviews were transcribed I was able to move to the next phase of the study, data analysis.

3.8 Data Analysis

3.8.1 Repertory Grid Analysis

Data from the repertory grid interviews were analysed using the software programme Idiogrid, version 2.4 (Grice, 2007). Idiogrid is a computer software programme that allows for the administration, management and analysis of self-report data. The data provided from the grids were analysed to give information regarding participants' construing of the profession and their own identity within it. Employment of such statistical analyses allowed for an insight into any discrepancies between the self at work and the ideal clinical psychologist, for example as well other such combinations.

3.8.1.1 Repertory Grid data

A slater analysis was used to analyse the individual grids of participants. I will now explain the data that was derived from the repertory grids.

3.8.1.2 Principal Component Analysis

Principal Component Analysis (PCA) gives an account of the patterns and spread of variance within a grid (Slater, 1977), the results of which are depicted in a plot of elements in construct space derived from loadings of the elements and constructs on the first two principal components. The horizontal axis of the plot derived from this analysis shows the first principal component (PC1), otherwise known as the participant's major dimension of construing, and this accounts for the largest amount of variability in the grid. The second principal component (PC2) is represented by the vertical axis and accounts for the second largest amount of variability in the grid. Elements are plotted within the grid along these axes according to how much they are represented by the components, whilst the constructs fall around the grid in relation to their loadings on the components.

3.8.1.3 Element Euclidean Distances

The Slater analysis also provides element Euclidean distances (on a scale from 0 to 2) indicating how differently each element is construed from each other. A distance of 0 indicates that two elements are construed identically, whilst distances rarely go above 2 (Winter, 1992). A distance of less than 0.5 would indicate that two elements are construed as very similar whilst a distance of more than 1.5 would indicate that two elements are construed very differently.

3.8.1.4 Superordinate and subordinate constructs

Construct correlations are provided by the Slater analysis indicating the degree of similarity in the meaning of each construct with each other. According to PCT, constructs are hierarchical. Superordinate constructs are those constructs that sit at the top of the construct system. If superordinate constructs are impermeable, new constructs are not easily subsumed. Subordinate constructs are more peripheral and lower down in the hierarchy of an individual's construct system. Superordinancy tells us how important a construct is to someone and the percentage sum of squares gives an indication of this.

3.8.1.5 Implicative Dilemmas

An implicative dilemma analysis was also performed. Implicative dilemmas (ID) are types of cognitive conflicts whereby "a personal construct on which change is desired is associated with another construct on which change is undesirable" (Feixas, Montesano, Erazo-Caicedo, Compañ, & Pucurull, 2014, p. 31). An ID is composed of discrepant and congruent constructs. Discrepant constructs usually indicate some sort of dissatisfaction; whereas congruent constructs can reveal personal qualities that an individual wishes not to change. IDs arise when change as reflected in a discrepant construct is connected to change on a construct for which this change is not desirable (Feixas *et al.*, 2014).

IDs are highlighted by examining all correlation coefficients between construct pairs and identifying whether there are any construct pairings that have a different relationship direction than would be expected (Winter, 1992).

3.8.1.6 Direction cosines between constructs and elements

Direction cosines provide a calculation of the relations between constructs and elements (Brown & Chiesa, 1990). By calculating the degree of correlation between elements and constructs, one can make inferences about the nature of the relationships between the various selves and how they are seen.

3.8.2 Interpretative Phenomenological Analysis

Data from the semi-structured interviews were analysed using IPA, according to Smith *et al.* (2009) guidelines. The stages of the analytic process included the following:

1. Transcribing the interview data of two interviews and listening back to recordings of each allowed immersion in the original data. The four remaining transcripts were transcribed professionally. Following on from this, each transcript was read and re-read. Completing this step in such a way allowed for the participant to become the focus of the analysis. To further ensure this, I kept a research journal allowing me to bracket off my own thoughts, ideas and reflections.
2. Initial noting. This phase of the data analysis involved exploring the semantic content of the transcripts. A table was constructed (See Appendix I) to allow for notes to be made alongside the transcript. The noting during this phase was an opportunity to start identifying the specific ways in which the participants were talking, thinking and making sense of their experiences. The commenting process involved three different types of annotation: descriptive, linguistic and conceptual comments.

3. Developing emergent themes. At this point in the analytic process, patterns and relationships between the exploratory notes were identified in order to recognize and pull out emergent themes. According to Smith *et al.* (2009), the task at this stage is to produce a concise statement of what was important across the various exploratory notes.
4. Searching for connections across emergent themes. Here, the themes were mapped out according to how I felt they fit together. This included arranging themes according to their ordinancy, similarities, differences, context (temporal and/or cultural) and frequency. The themes were then organised in a table.

This process was completed for each participant's transcript. When all of the transcripts had been analysed and all had tables with their emergent themes, the data analysis continued with all of the data in order to look for patterns across cases.

3.8.3 Independent Audit

To demonstrate the credibility of the themes derived, two supervisors engaged with the coding of two separate transcripts. This was done to ensure that the themes were plausible. To further strengthen the credibility of the themes, peer checks were undertaken by a group of novice researchers who were independent to the research. This process of independent audit involved the researchers coding the transcript and subsequently discussing any discrepancies that were found and engaging in a process of revision to ensure that various views were utilised in providing a trustworthy account of the data.

A similar process took place with the repertory grid data with one supervisor analysing the grids independently.

3.8.4 Repertory Grids and IPA analysis

Once the repertory grids and semi-structured interviews were both analysed independently, the master themes from the IPA were looked at alongside the repertory grid data. This analytic process involved considering the contradictions and overlaps between the content and structure of the grid data and the master themes from the IPA.

3.9 Self-reflection and reflexivity

Reflexivity is important to qualitative research (Shaw, 2010) as previously highlighted in the introduction chapter. To allow the reader to reflect on how my social positioning may have interacted with the research process, I will provide further information about my experiences as a BME trainee clinical psychologist as well as some insight into my personal and cultural beliefs.

As a third year trainee clinical psychologist studying in the UK towards a doctoral degree I am the only Black British African in my year. I hold my religious beliefs very dear to me, in a profession that is described as a secular enterprise (Begum, 2012). I have studied in a context where BME role models in the form of tutors and supervisors have been few. On my clinical placements I have had very limited experience of working with BME groups with the exception of my forensic placement where BME groups are overrepresented. These statements about my time as a trainee, give a small glimpse about the way in which training as a BME psychologist has left me feeling out of place.

In many ways I have felt like the underdog throughout my academic and professional career. As a Black female, I am aware of the oppressions that my cohort faces and I feel aligned to this struggle. In taking this position I feel an affinity to marginalised groups, which is apparent in my choice of therapeutic models such as Narrative models as well as in my clinical practice and the groups which I am drawn to working with. This research has both personal and

professional significance for me. Not only will I embark on a career as a Black female psychologist, I also hope to one day raise a family and want to contribute to a society where equality in the workplace is not just a goal but also an actual reality.

4.0 RESULTS

This section will present the findings from the IPA on the experience of qualified BME clinical psychologists. From this analysis, it is hoped that the reader will be given an insight into the everyday lived experience of working as a BME clinical

psychologist in the NHS. Following presentation of this data, I will then present the findings from the repertory grid analysis. I will give an overview of particular aspects of the grid, which are pertinent to answering this study's research questions. Finally, the chapter will conclude with a side-by-side analysis of participants' emergent themes and their construct systems from the repertory grids.

4.1 Interpretative Phenomenological Analysis

It is important to first note that the analysis presented is just one possible interpretation of the data gathered. Being socially situated within the profession, as a BME trainee clinical psychologist, will have undoubtedly contributed to my perspective and despite attempts to remain reflexive throughout the research process I am aware that I cannot fully escape this subjectivity.

Participants provided generous accounts of their experiences. However, due to word limitations, these cannot be presented fully. I will attempt to provide as detailed a narrative as possible to convey my interpretation of the essence of my participants' experiences. Verbatim quotes¹ are used throughout to highlight themes and illustrate participants' accounts.

Four master themes emerged from the analysis:

- Standing out as different
- Negotiating cultural and professional values
- Sitting with uncertainty
- The privilege of being a clinical psychologist

An overview of the themes with subthemes to be presented is given in Table 3:

Table 3: Master themes

Master theme 1: Standing out as different

¹ For ease of readability, quotes have been amended with the following ... to denote repeated words, pauses, and other speech disfluencies such as umm.

-
- Feeling like an outsider
 - The double edged sword of standing out
 - Being positioned as the expert
-

Master theme 2: Negotiating cultural and professional values

- The dilemma of remaining true to myself
 - Searching for credibility
-

Master theme 3: Sitting with uncertainty

- Difference: the elephant in the room
 - Working hard to interpret the unspoken
-

Master theme 4: Feeling privileged to be a clinical psychologist

- Valuing gaining a professional identity
 - Feeling proud of making it
-

4.2 Standing out as different

4.2.1 Overview

Three subordinate themes comprised this master theme: 'feeling like an outsider', 'the double-edged sword of standing out', and 'being positioned as the expert'.

This theme relates to the experience of standing out on account of one's difference. The visible difference of participants' ethnicity was pervasive in the way they were positioned in the profession and how they felt as a result. The challenge associated with this theme for many participants was the questioning of what connotations people hold of them on account of their BME identity. There was a sense that being an ethnic minority came with societal stereotypes that they would have to contend with. There was also a sense that standing out as different had its advantages.

4.2.2 Feeling like an outsider

Feeling like an outsider was something that was an implication of standing out as different. A quote that captures the essence of this is from Serena², who remarked during her interview that:

There are the times when ... my difference is really quite loud in a way and that's probably the only way I can express it
Serena

Inherent in the loudness of ethnicity is the inescapability of one's ethnicity and the experiences that occur as a result. For example, Farida spoke about people suggesting she got onto training on account of her ethnicity:

There were people who kind of suggested that 'well yes you would get on. You know that it would be easier for you to get on 'cause they're trying to have [a] more diverse ... workforce'
Farida

Farida could not switch off her ethnicity and instead had to endure assumptions about the reasons for her success in gaining a training place. Most of the participants in this study described often feeling like an outsider. They described how this position made them feel quite vulnerable and was quite crushing in some ways as is reflected in Serena's quote:

Sometimes it can feel quite silencing ... and I suppose I sometimes ... feel like I have to kind of really buoy myself up to be able to speak to what I might be seeing or experiencing. And I think particularly working in this area; sometimes it could possibly make you feel quite vulnerable

'Feeling like an outsider' was related to making participants feel isolated within the profession. Mary described going along to conferences and often finding that she was "the only *brown* person in the room". Though this was described as being something that she was fine with and used to experiencing, it left me wondering how she has possibly come to a resigned position of just accepting the way things

² Pseudonyms are used throughout this chapter in line with maintaining participants' confidentiality

are in the profession in relation to lack of ethnic diversity. Acceptance of this outsider position may be an example of one way in which she attempts to cope with the feelings associated with feeling isolated. Alternatively, there may be a possibility that this is something that is difficult to acknowledge and instead one just shrugs this off as being tolerable. Other participants were not so accepting of this position and instead felt that there was a need for them to feel more integrated within the profession rather than on the fringes of it. When asked about what some of the challenges are about being a BME clinician, Priya remarked:

What I said about feeling sort of marginal, on the fringes and not part of the mainstream. When I first qualified ... I think at that time it felt much more challenging [as] ... it felt like almost like being an outsider and not being part of the mainstream

Feeling marginalised as a newly qualified psychologist may reflect the challenges that clinical psychology has faced over the years in relation to its lack of ethnic diversity, as Priya reflects on her experience in the initial stages of her career. There was a sense that this has changed over time and she has been able to feel more integrated within the profession in more recent years. This may be as a result of the increasing number of BME clinical psychologists or even the conversations that are being had around difference and diversity. It may also reflect her developing her skills as a clinical psychologist and thus feeling more confident within the profession in managing the position as a minority within the profession.

For Natasha, feeling like an outsider extended far beyond the profession:

I think my experiences have always been on the outside of things so either outside racially or the outside professionally of all my friends, I think I've got a real desire to belong somewhere

The desire to belong was echoed in many of the psychologists' stories of seeking integration in the profession. Feeling rejected was one way in which participants came to feel as though they were outsiders. The visibility of their minority status meant that even with clients there were experiences of feeling rejected on account

of their ethnicity. In an example given by Farida, she explained how some families refused to see her based on their first encounter with her:

When I work in quite an affluent part of town ... there are families who will just say 'I don't think you'll understand my family, I don't think you get us ... you're not like us enough so can I see somebody else?' ... So some people aren't afraid to just say 'no, I don't think that ... you and I fit based on ethnicity' basically

Feeling rejected in particular encounters was invalidating to who they were as professionals as well as personally. For Serena, she described clients refusing to work with her as the worst part of being a minority clinician in the profession. Though this was not an experience that participants described as having often, it was an experience that most had encountered in their clinical practice. For Priya, she was able to reflect on how a White client refusing to work with a BME psychologist is often perceived more negatively than if this were to happen conversely, with a BME client opting to terminate therapy with a White psychologist. This may be a reflection of the discourses around race relations and the assumption that majority groups are more likely to be rejecting of minority groups, whereas the opposite may also be true.

Importantly, there was an emerging account that seemed to suggest that feeling like an outsider becomes easier as one gains experience within the profession and becomes more confident, as was suggested by Priya:

[There] was a time when of course I myself wasn't confident enough to speak loudly enough and ... I think ... it feels much less challenging ... now because culture is much more of a mainstream discussion

For Priya, the fact that race and culture issues are now more widely spoken about has had the positive impact of allowing her to feel more confident in standing out and raising issues of culture herself, which she would not have done previously. In 'feeling like an outsider' participants described feeling on the margins of the profession of clinical psychology and for some in other contexts of their lives too. For some, this went beyond a feeling, to actively being rejected on the basis of their

ethnicity. The most painful experiences, described by many participants, were when White clients refused to work with them solely due to their ethnicity. Despite this, there was a sense from some of the participants that with time they came to accept this position they found themselves in in the profession.

4.2.3 The double-edged sword of standing out

Standing out on account of one's ethnicity was deemed as having both positive and negative implications for participants. One noted negative aspect of standing out is the implication for how one carries oneself in the profession:

Within the profession actually being a rarity sometimes means that I put much more pressure on myself ... to make sure that I am good enough ... and to keep meeting that standard so on the one hand it's ... a good thing but on the other hand ... it creates quite a lot of stress for me actually
Serena

Striving to be good enough was a key theme in Serena's interview reflecting the daily challenges that she faces in not wanting to live up to the negative stereotypes and connotations that have historically been assigned to BME groups. This was also true for most of the participants:

It's something that I still carry today. That I still have to constantly prove myself, and so I'm the person that will get there early and leave later. You know my reports will be like of a probably more detail than they need to be. So I'm constantly trying to prove myself and I think that comes back from like a script that comes from my mother where she was like you're black and you're female you're going to have to work twice as hard as everybody else
Natasha

Mary also reported hearing this rhetoric whilst a trainee. She recalls:

Having a mentor who told me well you know of course you've got to work twice as hard to prove yourself as anybody else because you're from an ethnic minority background ... but I thought ... she obviously wouldn't have said that to anybody else ... so I felt there was that added pressure there

Due to this feeling of having to work harder or carrying the burden of being a 'good enough' BME practitioner, some felt as though it would be nice to not have to stand out as Mary stated:

I suppose it's a double-edged sword because ... sometimes it's nice to blend into the background to be anonymous and just be like everybody else

The desire to be like everybody else may speak to the perception of there being a normative position of being White and not having to account for one's actions, as a BME psychologist might have to do. It seemed that for some, feeling pigeonholed into a particular position was a direct implication of standing out as different and thus being seen as more capable of working with difference.

When I came to work in xxx ... they appointed me and another psychologist and I got put in the North of the patch because there was more diversity there
Saima

This example suggests that Saima was placed in a particular area on account of her ethnicity. Experiences like this may not hold relevance for everyone; however, if this pervades one's experience of clinical practice, it could arguably feel quite frustrating and unfulfilling to feel that one's only role is to fit into a particular box.

Standing out as different also had positive implications. For example, Saima discussed the possibility of her ethnicity putting her at an advantage in securing a place on training and getting assistant posts:

I don't know if it was officially sort of they were positively discriminating or sort of off the record but it ... certainly did seem to help

Though this was purely speculative on Saima's part, it was interesting to note how her ethnicity was taken into account for how or why she was accepted into particular roles and positions. For Serena:

As much as it's ... hard to be the rarity, actually there's something quite special about being the rarity sometimes

Though Serena did not elaborate on what made being the rarity something special, for Mary there was a sense that standing out was "okay if one was welcomed":

You do feel that you stand out and sometimes that's okay if you feel like you're being welcomed and it's inclusive and other times it's not okay if it feels like there's an expectation for you to do something or perform in some way or that perhaps ... you're not in your position in a fair way ... it's just because of your background rather than your ability

Mary

Mary touches on an important issue relating to this theme, which is that of the uncertainty of whether accomplishments are due to one's background rather than ability. As highlighted in quotes mentioned elsewhere, participants often have to contend with stereotypes about positive discrimination being a factor in their success. Knowledge of this then fuels thoughts in participants as to whether there may be any truth to this, bringing into question their own abilities.

In situations where standing out meant that participants were either treated unfairly or experienced something particularly invalidating, participants had to make the choice of whether to address this or not. This was a dilemma for some, with many suggesting that they often had to make the decision as to which 'battles' they fought and which they left unaddressed. This dilemma highlights how daily experiences, encounters and seemingly harmless interactions often carry with them exhausting worries which likely involve participants having to consider thoughtfully what their experiences mean and why they unfold in the way that they do.

'The double-edged sword of standing out' is a theme that highlights the myriad of ways in which standing out can be experienced both as a benefit and a burden, and the intricacies of participants coming to decide which is the preferred position.

4.2.4 Being positioned as an expert

'Being positioned as an expert' is a theme that focuses on how others in the profession perceived them as clinicians. Owing to their BME identities in the profession, participants spoke of their experiences as being positioned as experts on issues of race and culture. Serena explained that:

It's almost as though sometimes you're positioned as the expert and it's like I'm not, I can only really talk to what ... I've understood or what I know, which can be valuable to the team but I think it's [about] how do we then kind of ... think a bit more widely ... as a team about difference and diversity?

For Mary, she found this a challenge, which possibly added to the burden of being a BME psychologist:

Another challenge is this idea that you somehow will have this insight into every ethnic minority experience or every Black person's experience

This added to the list of assumptions that participants encountered in their clinical practice in relation to their ethnicity. Others framed this positioning as an expert as a positive thing and regarded themselves as almost able to provide a cultural consultation:

There are times when it's really positive ... and when people are really interested to find out what you know ... or people kind of come to you ... almost for cultural consultation
Farida

When considering the differences between participants and whether they found being positioned as an expert as a positive or frustrating experience, I wondered whether for those who found it to be a positive thing, this was something that was a boost for their confidence and hence something to be valued.

The experience of being positioned as an expert on cultural matters went as far back as their experiences in training. Mary recalled how:

Sometimes in lectures someone would turn to me and go 'so, what's the opinion of you know the Caribbean community?' And I'm like I don't know I'm not Caribbean (laughs) and even if I was, doesn't mean I speak for every single Caribbean person you know!

This quote shows how in being positioned as the expert others would sometimes expose their lack of cultural sensitivity. Participants were left with the fall out of trying to understand whether these encounters were due to people's ignorance, misunderstanding or genuine desire to understand.

In summary, this theme highlights an experience that nearly all of the participants had of being positioned as having a particular knowledge based solely on one's ethnicity. The irritation was clear for some who found it to be a common feature in their clinical practice, yet for others it was seen as a strength to be able to offer a cultural consultation. The common thread for all participants in this theme was the need to highlight the caveat that the responsibility of understanding people's cultures lies with everyone as all cultures are different and cannot be assumed to all be the same.

4.3 Negotiating cultural and professional values

4.3.1 Overview

There were two subordinate themes comprising this category: 'the dilemma of remaining true to myself' and 'searching for credibility'. This master theme describes the ongoing challenge of participants trying to manage their cultural and professional identities. To be presented in this theme are experiences of coming to find that their cultural values sometimes clashed with their professional values and having to find a way to negotiate between the two.

4.3.2 The dilemma of remaining true to myself

Some participants spoke of the difficulties that arose from working in a predominantly White profession. This included the subordinate theme of trying to find a way to hold on to one's cultural identity in the face of theories, ways of working and professional ways of being that may not necessarily be compatible

with their cultural identity. A good example of this was a dilemma that Priya encountered when starting out in the profession working in the community. She found that many of her BME clients had different expectations of how to work therapeutically and would often enquire into personal details such as her marital status and cultural heritage. This posed difficulties for Priya, who had been trained to consider professional boundaries. She said:

Coming from a professional perspective its like am I allowed to tell them this? What will happen if I tell them this? I'm not being a good psychologist, or I'm bending all the rules; I'm breaking all the rules...

This dilemma which caused her some anxiety was particularly pertinent to her as she was from a background whereby she expected that these are the kinds of questions people may ask and expect to receive an answer. Furthermore, if she declined to answer these questions she feared not being able to build a rapport with these clients and essentially failing to build a therapeutic alliance, which was important in her role of increasing access to psychological therapies for BME communities.

Natasha felt sure that in trying to stay true to her personal and cultural values she was ultimately jeopardising her desire to feel integrated within teams that she worked in:

We have signed up to the NHS to do a job and it feels that to be part of the team you have to let go of some of those values. And I'm not necessarily willing to ... so although I desire integration, I don't always get it because I don't let go of things

For Serena, there was a sense that she is trying to learn how to stop moderating herself in order to fit in, and instead try to stay true to her own values:

There are times when I feel like I am or I have done, moderated myself in order to be in certain groups. And I think that goes across my lifetime ... in some ways [I'm] now learning to do that less. So actually yes I am a Black clinical psychologist but that doesn't take away anything [from] me

Serena

This affirmation of dual identity (both being Black and a clinical psychologist) highlights that there may have been a point where being a clinical psychologist was equated to White clinical psychologist and it is taking time to not equate the profession with an ethnic background. This also suggests that Serena previously felt that 'Black' was seen more negatively and she had to put on a mask as it were to function in the profession. Both Natasha's and Serena's examples highlight how as a BME clinician within the profession it was important for participants to hold on to their sense of self, amidst the professional values that are taught and expected from clinical psychologists.

In the following example, Farida describes the pressure from the perspective of not just her personal cultural values but also her community's. She describes how in the profession:

You do need to be able to speak up for yourself and you do need to stand up for yourself and be able to portray yourself ... to the best of your strengths ... and that's something that, I think actually you know gender wise ... that women generally are socialised against ... particularly from a British Asian point of view ... that's something that people particularly try to teach out of you ... and you do get those ... other pressures from ... cultural community groups and thinking well you know ... you're gonna get a doctorate ... who's gonna want to marry you?

In terms of the communities that you're ... from I think ... there are some people who see ... psychology as a ... white western thing ... and think that you've sold out or become white or a coconut

Farida

How Farida managed the cultural expectations from her community and her desire to train as a clinical psychologist are interesting to consider as well as the cultural values that had been instilled in her and the values that she felt were important to possess as a clinical psychologist. I wondered whether she found this difficult to compromise on, or whether she wished to compromise at all. Instead of the split between one's professional and cultural identity, it seemed important

for most of the psychologists in the study to find a way of becoming more integrated in their identities:

I think the challenge is how do you integrate yourself into all the different teams without necessarily compromising who you are and your identity... It's like I go on the ward and do I say 'wahgwanin' or do I just say 'hello' ... it's one of those things that's always difficult or people look at you selling out or you're sort of trying to be white or you're above your station...

Natasha

Saima described how she has been able to integrate her cultural and professional identities in a way that felt comfortable for her.

I've become less split as I've got older ... when it comes to [issues of diversity]... we sort of really box up around stuff and there's white stuff and you couldn't let the two cross over whereas now I feel like ... that's more about being as I really am so there's much more overlap ... and I don't know whether that's to do with being a clinical psychologist or ... just put it down to getting older ... sort of finding a way of integrating that's comfortable and not dismissing or rejecting either

Saima

The above extracts from participants' accounts gives a sense of a type of developmental process that they undergo. From starting out as 'split' to coming to a place where they feel more integrated, participants have to navigate this challenge in their own way. The possibility of being seen as rejecting or dismissing one's cultural self was not just important for the participants' sense of self, there was also an indication that it may have had something to do with the perception of them from their friends, families and communities.

I think there is something in being one of very few so there's almost a um a sense of you having to be quite secure in your identity, to kind of hold on to it.

Serena

In summary, maintaining their cultural identity was clearly important to these psychologists, as was feeling as though they were still credible members of the profession, which brings us to the related subordinate theme of being seen as credible.

4.3.3 Searching for credibility

In their daily lives working as clinical psychologists, there were some reported experiences whereby participants felt as though they were not seen as psychologists. One participant described being mistaken for a student nurse on her first day of work in an inpatient setting. She spoke of introducing herself as Doctor as a way of *putting it out there straight away*.

I think people are surprised 'cause when people first see me ... they assume I'm a student or a nurse ... And I think people constantly reassess whenever they talk to me, because it's kind of like 'oh, you know quite a lot, yet you don't look like you would or my experience of black people as social workers or nurses or something like that' and actually putting it into this profession is quite difficult for people

Natasha

Feeling angry was common amongst participants who felt that they almost have to justify their presence in the profession. Mary reported hearing colleagues speaking to an assistant psychologist who wished to apply to clinical training programs. He had been advised:

'Don't apply to that university', which is where I trained, 'because you won't get on because you're not from an ethnic background because that's what they do in that university - they kind of help people from an ethnic background get ahead'. And there was almost an implication that it's not that you got on that training course because you were good, it's just because it was a PC³ thing to do, and that's really quite offensive ... so I do wonder that ... whether sometimes people do think that ... that's how you got ahead ... which is not the case at all, I don't think I've been handed anything

One almost wonders how Mary then carries herself in the profession to demonstrate how good she is and how capable she is as a BME clinical psychologist. Priya cited the journey she has made from feeling like a fraud to gradually being confident in her role as a psychologist and not worrying about others' perceptions of how she works:

³Politically Correct

It was sort of from ... starting off and feeling like I was some kind of fraud and cheat and I'm not being a true clinical psychologist and I can't tell anybody because this is terrible, to ... you know gradually gaining confidence in my practice ... there are different ways of working ... and you can do that and you can still be a professional, you can still be a psychologist ... you can adapt your ways of working and it [is] still legitimate.

In summary, there was a sense that these psychologists were carrying the burden of their ethnicity and needed to be seen as credible clinicians in their own right. This was not present for all participants however and some appeared to feel comfortable in their role as a BME clinical psychologist.

4.4 Sitting with Uncertainty

4.4.1 Overview

This master theme was comprised by the following two subordinate themes: 'difference: the elephant in the room' and 'working hard to interpret the unspoken'. This major theme was characterised by a consistent thread throughout participants' accounts whereby many of their experiences within the profession, whether positive or negative, were questioned as having something to do with their ethnicity. There were accounts of feeling frustrated at not knowing whether this was the case or not and this seemed to reflect a constant struggle to make sense of their experiences.

4.4.2 Difference: the elephant in the room

Most of the participants felt that their ethnicity was somehow the 'elephant in the room' that was not addressed both with supervisors, in teams and with clients. Furthermore, the avoidance encountered around this left the dilemma for participants as to whether they would raise it as an issue or leave it to go unspoken.

I think there have been, certainly with some supervisors or managers it's been actually something that you don't talk about its ... the elephant in the room almost ... and that in itself means that I've had to kind of moderate myself in terms of what I bring in terms of my identity 'cause it's almost like ... it's something that the supervisor or manager can't bear

Serena

At times I felt initially that the ... cultural aspects of my work were not being sufficiently taken on board and worse for supervision I wanted to raise those more I often felt there was less of a space for that

Priya

With BME clients, the experience was slightly different. It was reported by many of the participants how these clients acknowledged their BME identities and saw them as an advocate or an ally.

BME clients I've worked with have definitely seen me as wanting to advocate or be their friend ... it's not done maliciously, but wanting me to go beyond my boundaries, so like to help with housing or you know, sort of like benefits and things like that, which isn't my role in the therapy. So I think there's a big pull, and then trying to explore how that feels when someone that looks like you, you don't often get a chance to meet, who probably understands you maybe better culturally isn't willing to help you. So that's been quite challenging at times

Natasha

Having one's ethnicity overlooked in situations seemed to be the essence of this theme. Being able to have colleagues and clients acknowledge their ethnicity when it mattered was important to participants, who described feeling invalidated when this did not happen. Ultimately the responsibility was left to them to bring into discussions issues of race and culture, which in many ways would raise another dilemma for participants, which is that of '*being the person who always brings up race*' as one participant put it.

4.4.3 Working hard to interpret the unspoken

This theme describes the effortful struggle that participants engage in when trying to make sense of their experiences. From considering the intentions behind others'

actions, to making sense of their current standing in the profession, participants often considered to what extent their racial identities impacted on this.

I mean I can't ever know really but sometimes I have wondered particularly in the past couple of years when I've been trying to progress my career to a more senior level, when I've gone for interviews and haven't been successful and I think you know what ... do people think I won't fit into their ... department ... into the existing staff group? I can never truly know

Mary

This quote gives an example of one way in which participants have to take their ethnicity into account in their working lives. For Mary, she was unsure whether or not it was useful to consider her BME status as a possible reason for why her career had not progressed as some of her peers' careers had. The psychological impact of this is described by Mary who felt that:

It would be easier almost if someone were explicitly racist to your face and said I don't like you because of this ... or I don't think you're capable because of this ... it's like well, I can dispute that ... if it's unsaid, if it's insidious its harder to deal with, or even know that it's there! And you think 'am I being oversensitive?' ... 'Have I got a chip on my shoulder?' I don't know ... so yeah, there is a lot of 'I don't know' because ... none of it is explicit

The complexity of trying to make sense of situations by using a racial lens or not seemed to be a challenging task with little space in the workplace to think about and process this. Knowing how to address situations where race may have played a role then has to be considered in coming to a resolution:

Picking my battles... deciding which things I'm going to challenge. Or which things do I just have to let slide or what do I store up for later. I think remaining professional and not getting too emotional 'cause then whatever you're saying gets lost, and it becomes about you as a person and your ethnicity

Natasha

Farida was able to reflect on complex interactions that might be construed racially by concluding:

Sometimes I think when with colleagues and also with families you ... try to think about what the intention behind a comment or an action was

Ultimately, there was a sense that for all the participants, every interaction had the possibility of needing to be analysed through a racial lens. The implication of this was the overwhelming emotional effort of constantly second-guessing the meaning behind their experiences.

4.5 The privilege of being a clinical psychologist

4.5.1 Overview

This master theme captures the subordinate themes of valuing having the professional identity of a clinical psychologist and feeling proud of having made it. The theme highlights the ways in which being a clinical psychologist enhances one's sense of self and can contribute to feeling confident in one's professional achievement. Having attained the status and power associated with being a clinical psychologist there is the sense that participants feel they are in a privileged position, one that has taken much struggle and sacrifice.

4.5.2 Valuing gaining a professional identity

Being a clinical psychologist was something that many of the participants explicitly described as valuing in that they were able to recognise their professional status or identity as something to be proud of:

To me it feels really rewarding; like I'm doing something really valuable ... it still is a sort of a comfortable position, which you are more sort of really aware of and grateful for
Saima

I reflected on whether this was to do with the fact that as there are few BME psychologists in the profession, participants have come to realise just what they have managed to achieve. Alternatively there may have been a sense that they were able to overcome obstacles that women and ethnic minority groups face in wider society.

Some participants felt it important to highlight that their working lives as BME clinical psychologists were not filled with daily stressors and hassles. In fact, Mary felt it important to stress that:

I don't want to create an impression that you know I'm hard done by or ... every day's been a battle, you know nothing like that at all and especially in my job like I say of the most part on a day to day [basis] I just kind of do my job and I get on with people and I go home and it's not an issue ... I guess I didn't want to be too down on the profession or too down on the issues or the challenges that you might face or that I might face or have faced

This theme speaks to the experience of being a BME clinical psychologist in terms of how participants feel about their professional identities. Though not true for all the participants, the theme suggests that there is some value seen in their role as BME clinicians.

4.5.3 Feeling proud of making it

The struggle and lengthy journey into the profession meant that for many of the participants they held a sense of pride in making it as a clinical psychologist. From participants' stories one can see that there was an 'against all odds' theme around this topic. Considering the lack of ethnic diversity in the profession and claims of clinical psychology being racist, there was almost disbelief for some that they had indeed made it:

I'm really proud of ... being a clinical psychologist. I worked really hard to get here I think and I care a lot about the profession and I care about what it stands for and what it represents ... I think [about] all the things ... I had to develop in order to get here ... being kind of determined and ... strong-willed and focussed and all of those things that got ... me through that journey. So I'm quite proud of having developed that range of skills

Farida

For others holding pride was difficult and felt uncomfortable, though there was a sense that it was quite an accomplishment nonetheless to have made it as a clinical psychologist:

I think that there is something in being able to have achieved what I have achieved ... I suppose [it] brings around ... a sense of confidence in myself ... that I have been able to ... get this far but I think there's also something that other people carry for me which is the sense of pride ... and I'm not so comfortable with carrying that

Serena

This theme highlights a positive aspect of qualifying as a BME clinical psychologist as participants feel a sense of pride in their accomplishment.

4.6 Repertory Grid Analysis

The next section will be a presentation of the repertory grids for all six participants. I will explain the content and structure of their grids with a particular focus on how they construe their current selves at work and their idea of the ideal clinical psychologist. Other pertinent relationships within the grid that are useful in answering my research question will also be highlighted, for example that between 'self as I really am' and 'self at work'.

4.6.1 Mary's Repertory Grid

Principal Component Analysis

Mary has a tight construct system. This is indicated by the large amount of variance accounted for by the first principal component (81.39%). To give some

context, in a study by Ryle and Breen (1972) the mean percentage of variance in a group of 'normal' participants of the first principal component was found to be 39.4% (in a grid consisting of sixteen constructs and sixteen elements). Winter (1992) advises that in a smaller grid, the percentage would be expected to be higher. Of all the participants in the study, Mary's construct system was deemed to be the most tightly organised. Tight construing is a strategy that is implemented when individuals face imminent anxiety (Ellis, 2006). Anxiety, according to Kelly (1955), refers to "the recognition that the events with which one is confronted lie outside the range of convenience of one's construct system" (p. 495). This may be an indication that for Mary she is only partially able to make sense of her experiences and that too many of the implications of her experiences are obscure. Tight construct systems suggest unidimensional construing and there is some research evidence that validation can lead to a tightening of construing (Rehm, 1971). Validation is defined as "the subjective compatibility between construct prediction and outcome" (p. 267). An alternative explanation of Mary's tight construing might therefore be that her experiences within the profession are in line with her predictions, further reinforcing her construing of the profession.

In Mary's grid, the ideal clinical psychologist is construed in these terms:

- Expert (Special)
- Has responsibility
- Resilient

This is indicated in her ratings of these elements, and by their position in the plot (Figure 3). As indicated in the number of ratings of these elements that are close to the midpoint, and their position close to the origin of the plot, Mary does not have an elaborated view of BME psychologists.

(EED) between these elements supports this, with the distance between 'self as I really am' and 'ideal clinical psychologist' scoring 1.45. This highlights the negative view of the personal and professional self in comparison to the 'ideal'.

Similar elements in the grid include 'BME clinical psychologist' and 'White clinical psychologist', the distance between which was 0.18, suggesting that these two elements are construed almost identically.

Superordinancy

The most superordinate construct for Mary was 'General (Not unique) – Expert (Special)', with a percentage sum of squares of 16.84%. This construct is thus more important to Mary than the other constructs. It is the construct which the 'ideal clinical psychologist' sits most closely to (on the expert/special pole end of the construct) and its superordinancy is supported by the fact that this element is the third highest in its salience. The least superordinate construct for Mary was 'complacent – striving to be the best', with a percentage sum of squares of 1.26%.

Salience

The Idiogrid output suggests that Mary construes 'self prior to training' as more salient than any of the other elements in the grid. This is evidenced by its accounting for the highest sum of squares (24.77%) of any of the elements in the grid. The least salient element was 'BME clinical psychologist', with a score of 0.75%. This would suggest that this is the least clearly defined element for Mary, which is surprising given that she herself is a BME clinical psychologist.

Implicative dilemmas

No IDs were found in Mary's grid when the following elements were compared:

- Self at work vs. Ideal self
- BME clinical psychologist vs. Ideal clinical psychologist
- Self at work vs. Ideal clinical psychologist

4.6.2 Natasha's Repertory Grid

Principal Component Analysis

Natasha has a loose construct system, which is highlighted by the relatively low percentage of variance accounted for by the first principal component (37.42%). Loosely organised construct systems are indicative of constructs that are not highly interrelated. There is research evidence to suggest that loose construing may be a result of serial invalidation of individuals' constructions (in individuals who initially had a more tightly organised construct system) (Winter, 1992). When an individual construes too loosely, this can result in an inability to make concrete predictions about the world, which can lead to anxiety.

In Natasha's grid, the ideal clinical psychologist is construed in these terms:

- Integrated (within the team)
- Colour Aware

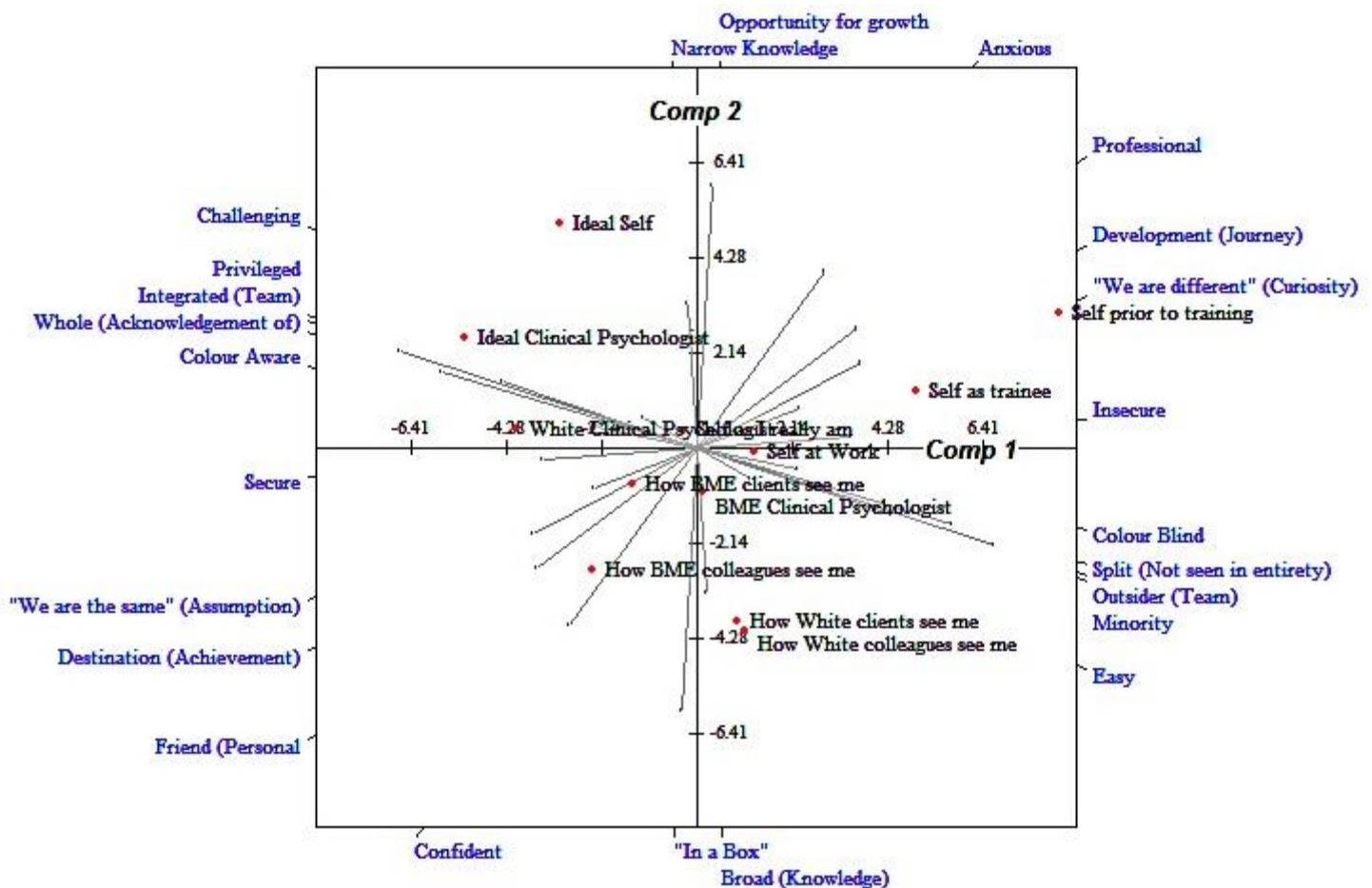


Figure 4: Graphical representation of Natasha's repertory grid

Distance and Proximity within the Grid

For Natasha, it can be seen from the plot (Figure 4) that 'how White clients see me' and 'how White colleagues see me' differ from the 'ideal clinical psychologist' as they are in opposite quadrants. This suggests that it is her impression that both colleagues and clients from non-BME backgrounds do not see her as possessing the traits of an ideal clinical psychologist. 'How BME colleagues see me' and 'how BME clients see me' are situated in the same quadrant of the plot, but in a different quadrant to the situating of 'how White clients see me' and 'how White colleagues see me'. This would suggest that there is a clear difference for Natasha between her view of how clients and colleagues see her based on their ethnicity. Also, 'how BME colleagues see me' and 'how BME clients see me' are closer to her view of 'the ideal clinical psychologist'. However, the elements relating to how BME people see her are closer to the origin of the plot, indicating that they are less clearly defined.

The similarity in Natasha's construing of 'how White clients see me' and 'how White colleagues see me' is evident from their proximity in the plot of her grid. The standardised EED between these two elements is 0.49, the lowest distance within the grid amongst any of the elements.

When compared to all the elements in the grid, 'self at work' is seen as furthest from the stereotype of a 'White clinical psychologist', with a standardised EED of 1.13. It would appear for Natasha that issues of race and ethnicity are important in how she construes her professional identity. Also interesting to note is the similarity in construing of 'self at work' and 'self as I really am'. With a distance of 0.58, this indicates that when at work Natasha is able to stay true to who she is.

Superordinancy

The most superordinate construct for Natasha is 'Outsider (Team) – Integrated' with a percentage sum of squares of 14.21%. Like Mary, this superordinate construct is the construct that the 'ideal clinical psychologist' sits closest to (on the

‘integrated’ pole of the construct) of all the elements. The least superordinate construct is ‘Secure – Insecure’ with a percentage sum of squares of 3.92%.

Saliency

Similar to Mary, the most extremely perceived element in the grid is ‘self-prior to training’, which suggests it is the most clearly defined element for Natasha. The least salient element in Natasha’s grid is ‘self as I really am’, with a percentage sum of squares of 3.10%. ‘Self as I really am’ may be the least salient element as the topic of the grid relates to one’s professional identity and this element is less representative of the topic at hand.

Implicative dilemmas

6 IDs were found in Natasha’s grid when the following elements were compared:

- Self at work vs. Ideal self (4 IDs)
- BME clinical psychologist vs. Ideal clinical psychologist
- Self at work vs. Ideal clinical psychologist (2 IDs)

Natasha construes the ‘self at work’ as “professional”, whereas the ‘ideal clinical psychologist’ is construed as a “friend”. The dilemma for Natasha is that a “friend” tends to be “in a box”, which is the opposite of having “opportunity for growth”. So in moving closer towards being the ideal clinical psychologist, Natasha would have to give up being a professional who is seen as having an “opportunity for growth” and move towards being “in a box”.

4.6.3 Farida’s Repertory Grid

Principal Component Analysis

Farida has a relatively loose construct system, which is highlighted by the percentage of variance accounted for by the first principal component. Farida’s first principal component accounted for 56.97% of the variance. Overall there is a clustering of elements close to the origin of Farida’s grid (Figure 5), suggesting that the elements are not extremely perceived and not well defined.

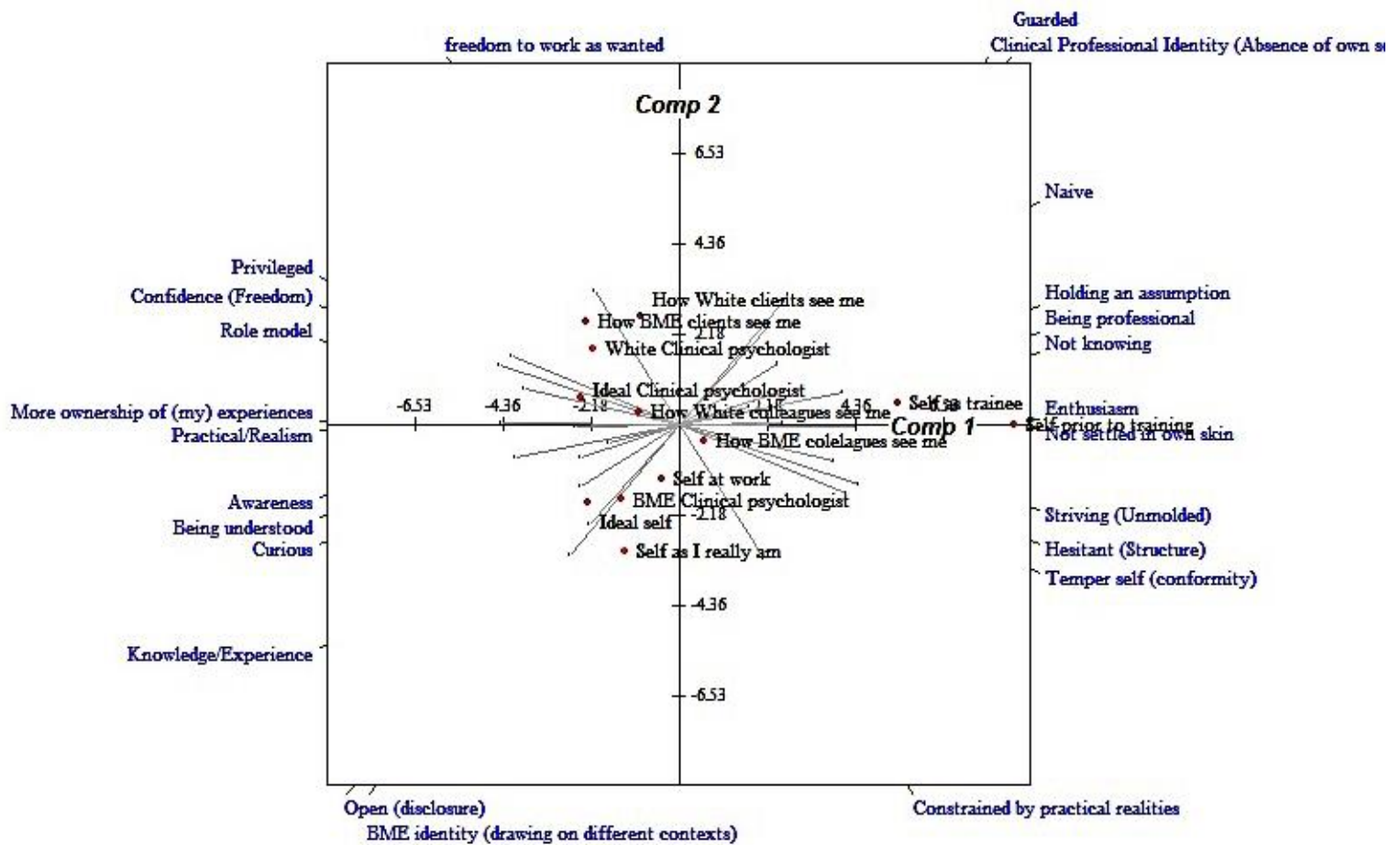


Figure 5: Graphical representation of Farida's repertory grid

Distance and Proximity within the Grid

'BME clinical psychologist', 'self at work', 'ideal self' and 'self as I really am' fall within the same quadrant of the grid for Farida and are close together, suggesting that these elements are construed similarly. The standardised EED between these elements supports this with the distance between 'self at work' and 'self as I really am' as 0.55; the distance between 'BME clinical psychologist' and 'self at work' as 0.50; a distance of 0.69 between both 'self as I really am' and 'self at work' and 'ideal self' and a distance of 0.55 between 'BME clinical psychologist' and 'self as I really am'.

Superordinancy

'Hesitant (structure) – Confidence (freedom)' was the most superordinate construct in Farida's construct system with a percentage sum of squares of 13.13%. This was followed by the construct 'privileged-temper self (conformity)' with a percentage sum of squares of 11.80%. The least superordinate construct in Farida's construct system was 'curious - holding an assumption', with a percentage sum of squares of 3.93%. This appears to be the least important construct to Farida in the system.

Salience

The most extremely perceived element in the grid is 'self prior to training,' with a percentage sum of squares of 32.34%, which suggests it is the most clearly defined element for Farida, like Mary and Natasha. The two least meaningful elements in the grid are 'how BME colleagues see me' (2.15%) and 'self at work' (2.37%).

Implicative dilemmas

7 IDs were found in Farida's grid when the following elements were compared:

- Self at work vs. Ideal self (7 IDs)
- BME clinical psychologist vs. Ideal clinical psychologist
- Self at work vs. Ideal clinical psychologist

One example of an ID that was revealed by the analysis was the following: 'Self at work' is construed as "Practical/Realis[ti]c" whereas the 'Ideal self' is construed as "Enthusias[ti]c". The dilemma for Farida is that an "Enthusias[ti]c" person tends to be "Guarded", which is the opposite of the preferred pole of being "Open". If Farida were to work towards becoming an "enthusias[ti]c" person, this would mean also becoming "Guarded".

4.6.4 Serena's Repertory Grid

Principal Component Analysis

Serena has a relatively loose construct system, which is highlighted by the percentage of variance accounted for by the first principal component. Serena's first principal component accounted for 53.62% of the variance.

For Serena, the ideal clinical psychologist is construed in these terms:

- Relaxed self (be me in entirety)
- Holistic integration
- Aspiration to true self

The plot (Figure 6) shows that Serena perceives 'self as trainee' in a more extreme way than the other elements within the grid. This element is situated very close to the construct poles "separated", "unsureness" and "trying to figure out how to be consolidated". This would suggest that these constructs define well 'self as trainee'.

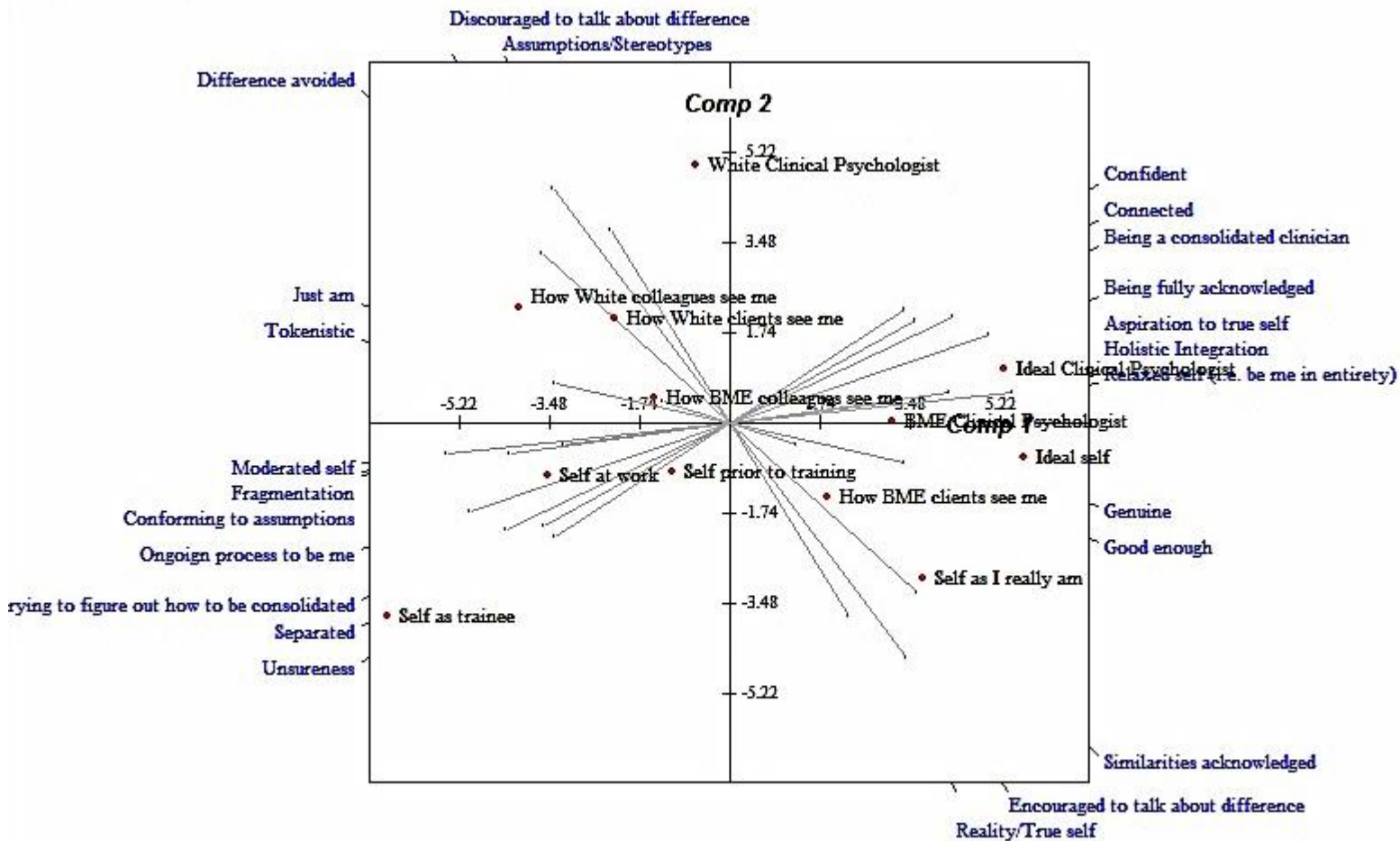


Figure 6: Graphical representation of Serena's repertory grid

Distance and Proximity within the Grid

It can be seen from Serena's plot (Figure 6) that she sees her 'self at work' as slightly different from 'self as I really am'. The standardised EED between these two elements is 1.06. Other elements with large distances include 'self at work' and 'ideal clinical psychologist' (EED= 1.40); and 'self at work' and 'ideal self' (EED= 1.33). The distances between these elements are suggestive of Serena feeling as though whilst at work she does not function as how she thinks an ideal clinical psychologist should. This may speak to the length of time Serena has been qualified as a clinical psychologist in comparison to some of the other participants in the study who have been in the profession for longer and may feel as though

they have had the time to develop as a clinical psychologist and possibly moving closer to the ideal clinical psychologist.

'How White colleagues see me' and 'how White clients see me' are in close proximity to each other and are also situated in the opposite quadrant to 'self as I really am'. Also situated in opposite quadrants of the plot are the 'ideal clinical psychologist' and 'self at work', showing their dissimilarity.

The discrepancy for Serena between how she construes her 'self at work' and 'self as I really am' may be suggestive of her experiencing guilt in Kellyan terms. Guilt is defined as "the awareness of dislodgement of the self from one's core role structure" (Bannister & Fransella, 1986, p. 23). In this instance, Serena construes herself as 'genuine' and 'good enough'. However, the 'self at work' is construed as the 'moderated self', as being a 'fragmentation' and 'conforming to assumptions'. In doing things that she does not see herself as doing had she been true to the type of person she sees herself as being, this may lead to feelings of guilt.

Superordinancy

The most superordinate construct for Serena was 'Relaxed self (be me in entirety) – moderated self'. This construct had a percentage sum of squares of 13.31%. "Tokenistic – Genuine" was the least superordinate construct, with a percentage sum of squares of 4.09%.

Salience

The 'ideal clinical psychologist' was particularly salient for Serena, with a percentage sum of squares of 13.85%. The only other element that was more salient was 'self as trainee', with a percentage sum of squares of 19.93%. This suggests that 'self as trainee' is the most salient element for her.

Implicative dilemmas

11 IDs were found in Serena's grid when the following elements were compared:

- Self at work vs. Ideal self (2 IDs)

- BME clinical psychologist vs. Ideal clinical psychologist (6 IDs)
- Self at work vs. Ideal clinical psychologist (3 IDs)

An example of an ID revealed by the analysis was the following: 'Self at work' is construed as going through an "On-going process to be me", whereas the 'Ideal self' is construed as "Being fully acknowledged". The dilemma for Serena is that someone who is "Being fully acknowledged" tends to be a "Good enough" person. This is in contrast to being just as she is. So in moving closer towards the 'ideal self' Serena would have to forsake being who she is, i.e. "just am" and become "good enough".

4.6.5 Saima's Repertory Grid

Principal Component Analysis

Saima has a relatively tighter construct system than some of the other participants in the study, which is highlighted by the higher percentage of variance accounted for by the first principal component. Saima's first principal component accounted for 64.87% of the variance.

For Saima, the ideal clinical psychologist is construed in these terms:

- More capable
- Non-judging
- Closer to the ideal

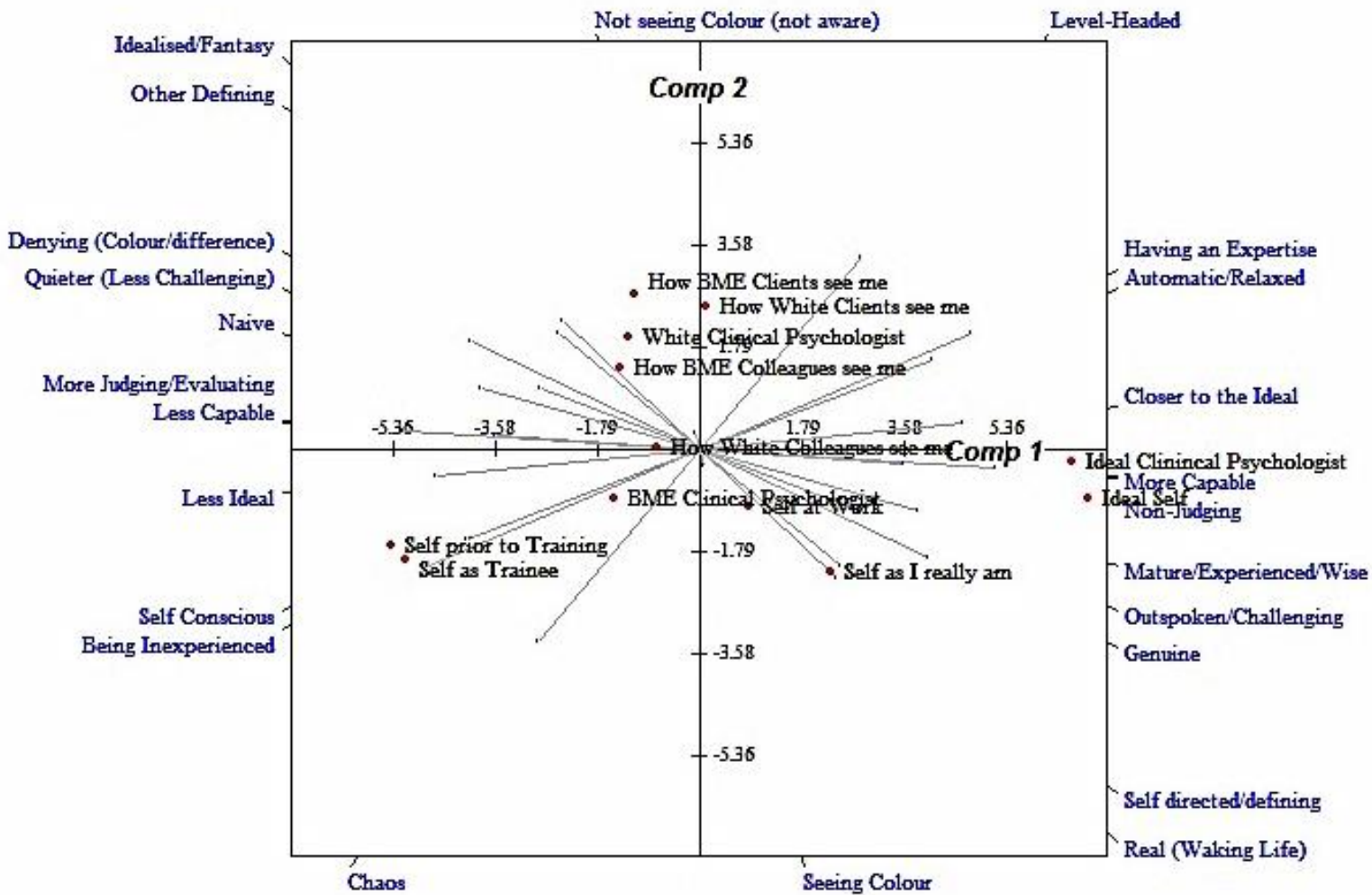


Figure 7: Graphical representation of Saima's repertory grid

Of all the participants, Saima appears to have the most positive view of herself, with 'self as I really am' and 'self at work' positioned in the same quadrant as the 'ideal self' and the 'ideal clinical psychologist' (See Figure 7).

Distance and Proximity within the Grid

'Self at work' and 'self as I really am' are construed in a very similar way. The standardised EED between these two elements is 0.50. This tells us that for Saima she sees herself at work as being very similar to who she really is, leaving little room for experiencing Kellyan guilt.

Superordinancy

'Being inexperienced – Having an expertise' is the most superordinate construct for Saima, followed closely by being 'less capable – more capable'. These two constructs appear to be interrelated and it is therefore not surprising that they feature closely in their superordinancy. Least superordinate of the constructs for Saima is 'not seeing colour – seeing colour'.

Salience

Saima's most salient elements were 'ideal self' and 'ideal clinical psychologist'. The most subordinate elements were 'how White colleagues see me' and 'self at work'.

Implicative dilemmas

No IDs were found in Saima's grid when the following elements were compared:

- Self at work vs. Ideal self
- BME clinical psychologist vs. Ideal clinical psychologist
- Self at work vs. Ideal clinical psychologist

4.6.6 Priya's Repertory Grid

Principal Component Analysis

Priya has a relatively loose construct system, which is highlighted by the percentage of variance accounted for by the first principal component. Priya's first principal component accounted for 56.51% of the variance.

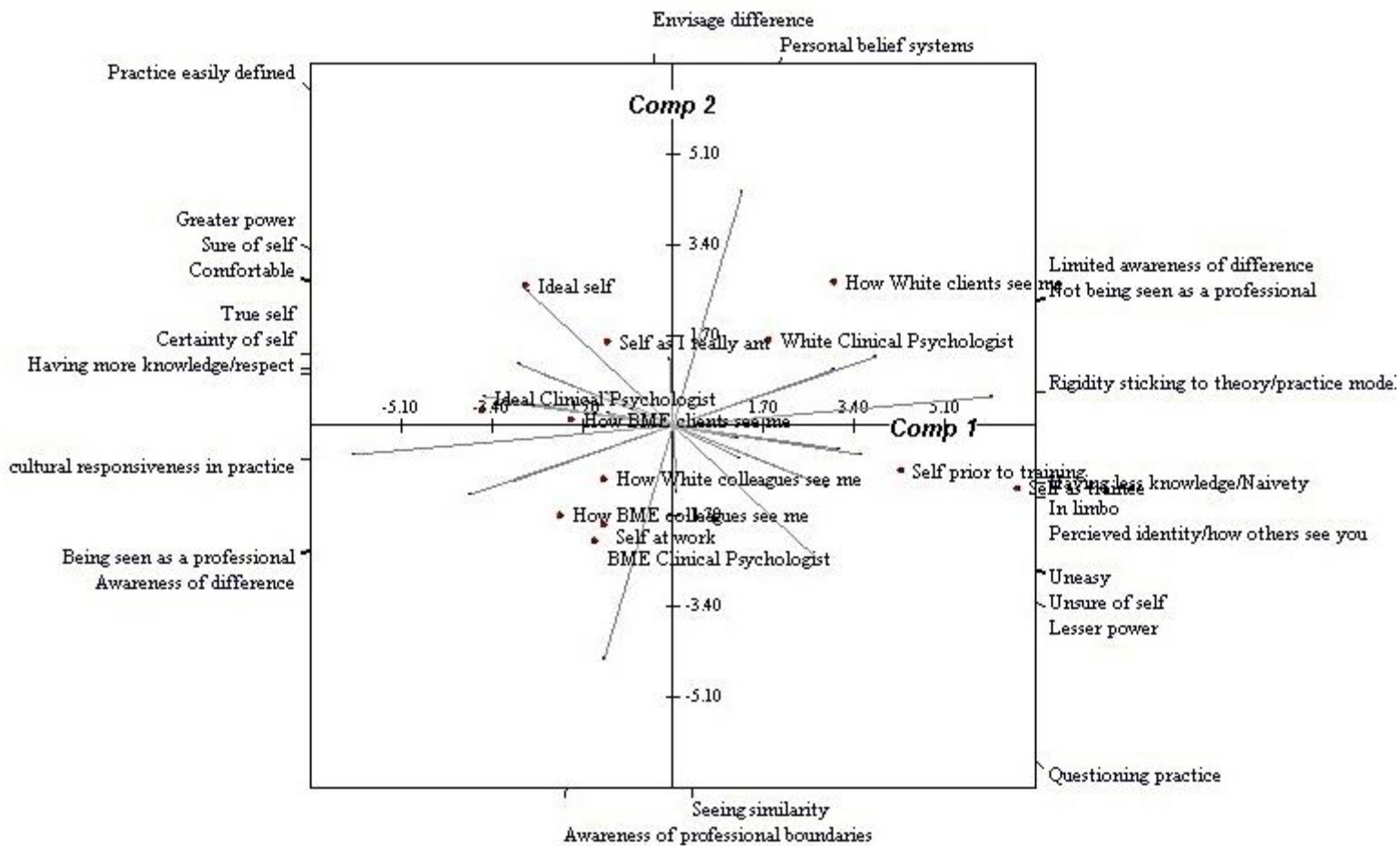


Figure 8: Graphical representation of Priya's repertory grid

Distance and Proximity within the Grid

For Priya 'self as I really am' and her idea of the 'ideal clinical psychologist' were construed in a very similar way. The distance between these two elements is 0.54. Figure 8 provides a graphical representation of Priya's grid.

Superordinancy

The most superordinate construct for Priya was "cultural responsiveness in practice – rigidity sticking to theory/practice models", with a total sum of squares of 21.45%. The least superordinate construct for Priya was 'greater power – lesser power', this had a percentage total sum of squares of 2.45%.

Salience

Of all the elements, the most salient for Priya was 'self as trainee', with a percentage sum of squares of 24.39%. The least salient element for Priya was 'How White colleagues see me', with a percentage sum of squares of 2.20%.

Implicative dilemmas

4 IDs were found in Priya's grid when the following elements were compared:

- Self at work vs. Ideal self (4 IDs)
- BME clinical psychologist vs. Ideal clinical psychologist
- Self at work vs. Ideal clinical psychologist

One ID highlighted from an analysis of Priya's grid was the following: the 'self at work' is construed as having an "Awareness of professional boundaries" whereas the 'ideal self' is construed as being attuned to one's "Personal belief systems". The dilemma for Priya is that someone who is attuned to their "Personal belief systems" tends to be seen as "Not being seen as a professional" person. So if Priya were to move towards her view of her ideal self, she would be attuned to her personal belief systems at the expense of not being seen as professional, which would be undesirable for her.

4.7 Comparison between participants' repertory grids

I will now give an overview of the six participants' grids, noting similarities and differences between them.

View of self as a clinical psychologist

With the exception of Serena, all the participants appeared to see themselves as fairly to very similar at work to 'self as I really am' (See Table 4). This would suggest that overall as a sample most of the participants are able to integrate their personal identities into their professional identities. Serena, who sees her 'self at work' and 'self as I really am' as somewhat dissimilar, is interestingly the psychologist in the sample who has been qualified for the shortest amount of time.

This may provide some evidence for participants feeling more comfortable in their personal identities within the profession as time goes on.

Table 4: Standardised Element Euclidean Distances comparison between self at work and self as I really am

Participant	Self at work vs. Self as a I really am
Mary	0.60
Natasha	0.58
Farida	0.55
Serena	1.06
Saima	0.50
Priya	0.78

Table 5 indicates how each participant construes a BME clinical psychologist in comparison to their ideal self, as reflected in the distances between these elements. Rather interestingly it is Serena whose ideal self is construed as being closest to a BME clinical psychologist. This would be consistent with her view of BME clinical psychologists, whom she construes as being able to be their “relaxed self (i.e. be me in entirety)” (0.79)⁴, it’s not an “ongoing process to be me” (-0.81) and not “conforming to assumptions” (-0.82). This similarity in construing of the ideal self and a BME clinical psychologist was not true for Saima, who construes the two very differently. Overall most participants appear to see their ideal self as not dissimilar to their idea of a BME clinical psychologist.

Table 5: Standardised Element Euclidean Distances comparison between Ideal Self and BME Clinical Psychologist

Participant	Ideal Self vs. BME Clinical Psychologist
Mary	0.71
Natasha	1.00
Farida	0.72
Serena	0.59
Saima	1.35
Priya	0.93

⁴ Direction cosines between constructs and elements

For all but one participant, the most meaningful elements for participants interestingly were their identities around the time of them being a trainee (See Table 6). Even for those who had been qualified for a significant length of time this was still a salient element. This is interesting considering the presence of elements that are closer to where they are now in the profession, i.e. ‘self at work’ or ‘self as I really am’. It is possible that this highlights the significance of the self earlier on in their careers within the profession as crucial in their identity formation. How participants saw colleagues was the least salient element for the majority of the sample regardless of their ethnic background. This may suggest a less clear view of how colleagues perceive them as elements with low salience have often been rated near the midpoint on most constructs (Winter, 1992).

Table 6: Comparison between participants between the most and least salient elements

	Most Salient Element	Least Salient Element
Mary	Self prior to training	BME clinical psychologist
Natasha	Self prior to training	Self as I really am
Farida	Self prior to training	How BME colleagues see me
Serena	Self as trainee	How BME colleagues see me
Saima	Ideal self	How White colleagues see me
Priya	Self as trainee	How White colleagues see me

It is pertinent to note that for Mary a BME clinical psychologist is the least salient element. This was true for all of the participants whose idea of a BME clinical psychologist featured very low in the rankings of salience and will be considered in more detail in the discussion.

View of others’ perception of self compared to the ideal clinical psychologist

Most of the participants construed how they thought their BME clients saw them as closer to the ideal clinical psychologist than their White clients, with the exception of Farida and Saima. Four out of the six participants had standardised EED’s between ‘How White clients see me’ and the ‘Ideal clinical psychologist’ between 1.10 and 1.34, which suggests that these elements are seen as somewhat

dissimilar (see table 7). This provides some support for the idea that participants construe their BME clients as seeing them in a more positive light than do their White clients.

Table 7: Standardised Element Euclidean Distances comparison between participants

	How BME clients see me vs. Ideal clinical psychologist	How White clients see me vs. Ideal clinical psychologist
Mary	0.31	0.60
Natasha	0.96	1.11
Farida	0.69	0.57
Serena	0.81	1.17
Saima	1.32	1.10
Priya	0.59	1.34

4.8 An integrated analysis of the grids and IPA

In this final section of the analysis, the IPA and repertory grid analysis will be presented together to further illuminate the findings of the six participants' experience of being a BME clinical psychologist within the profession of clinical psychology. In trying to answer the research question of whether clinical psychologists talk about their experiences of being a BME clinical psychologist within the profession in the same way as is revealed by a less direct method of exploring their construing of these experiences, I will now present a side by side analysis of the repertory grids and IPA data.

Various aspects of the repertory grid results that map on well to the IPA results will be used in the analysis. For example for some themes derived from the IPA analysis, constructs elicited from participants may be the most appropriate to present for that theme. For other themes, standardized EEDs may be utilized in order to do a comparative analysis. As no known study has been conducted using repertory grids and IPA in this way this segment of the research is novel.

As mentioned previously with the IPA analysis, it is important to stress that the

analysis presented here is just one way of making sense of the data and there may be alternative constructions that can be made concerning the data. Owing to my interpretation of participants' constructions of their experiences of the profession, I acknowledge the double hermeneutic and the subjectivity in the analysis.

4.8.1 IPA Master themes vs. Repertory Grid constructs

In this section I will highlight constructs that were elicited from the repertory grid interviews and attempt to see whether there is some congruence with the master themes that were identified by the IPA. Upon review of the elicited constructs by the participants the following constructs were identified as having particular significance to the theme of standing out as different (See Table 8).

Table 8: Constructs captured by IPA master theme I

Standing out as different	
Participant	Elicited constructs
Mary	'Revered-Ignored'
Natasha	'Outsider (team) – Integrated (team)'
Farida	No relevant construct elicited
Serena	'Separated - Connected'
Saima	'Other defining – Self-directed/defining'
Priya	'Uneasy - Comfortable'

Of the four participants who spoke about *feeling like an outsider* in the profession in their interviews, three of these have this as a construct within their construct system. These constructs seem to reflect the master theme of standing out as different. This gives some support for the idea that clinical psychologists are able

to talk about their experiences of being a BME clinical psychologist within the profession in the same way as is revealed by a less direct method of exploring their construing of these experiences.

Table 9: Constructs captured by IPA master theme II

Negotiating cultural and professional values	
Participant	Elicited constructs
Mary:	'Guarded – Relaxed'
Natasha:	'Whole (acknowledgment of entirety) – Split (not seen in entirety)'
Farida:	'Privileged – Temper Self (conformity) 'Clinical professional identity– BME identity' 'Not settled in own skin – More ownership of (my) experiences'
Serena:	'Relaxed self (i.e. be me in entirety) – Moderated Self' 'Fragmentation – Holistic integration' 'Just am – Good enough' 'Tokenistic – Genuine' 'On-going process to be me – Being fully acknowledge' 'Conforming to assumptions – Aspiration to true self' 'Trying to figure out how to be consolidated – Being a consolidated clinician'
Saima:	'Automatic/Relaxed – Self-conscious' 'Denying (colour/difference) – Genuine'
Priya:	'True self – Perceived identity/how others see you' 'In limbo – Certainty of self'

The master theme *negotiating cultural and professional values* appears to be supported by a significant number of constructs elicited with all six participants (See Table 9). For more than half of the participants, more than one construct was

elicited relating to the theme of negotiating cultural and professional values. Taking both the elicited constructs and the master theme from the IPA, it would be fair to say that this theme is an important one in relation to the experience of BME clinical psychologists in the profession. Again, it provides support for the idea that though experiences may be challenging and difficult to talk about, participants have shared in the semi-structured interview similar themes as have been uncovered by an indirect methodology.

Table 10: Constructs captured by IPA master theme III

Sitting with uncertainty	
Participant	Elicited constructs
Mary:	‘Unknowing - knowledgeable’
Natasha:	‘Colour aware - Colour blind’ ‘Anxious – Confident’
Farida:	‘Hesitant – Confidence’ ‘Awareness – Not knowing’
Serena:	‘Difference avoided – Similarities acknowledged’ ‘Unsureness - Confident’
Saima:	‘Denying (colour/difference) – Genuine’ ‘Not seeing colour (not aware) – Seeing colour’
Priya:	‘Uneasy – Comfortable’ ‘Unsure of self – Sure of self’ ‘Envisage difference – Seeing similarity’ ‘In limbo – Certainty of self’

Like the two previous themes, ‘sitting with uncertainty’ features in the elicited constructs of all the participants in the study (See Table 10). Rather interestingly, the constructs elicited across participants have a similarity in their use of the

terms ‘unsure’, ‘in limbo’ and ‘not knowing’. This may speak to the uncertainty that participants spoke about in their semi-structured interviews in relation to never quite being certain of the meaning of some of their experiences and having to try and find a way to make sense of things to gain some insight into their experiences.

Table 11: Constructs captured by IPA master theme IV

The privilege of being a clinical psychologist	
Participant	Elicited constructs
Mary:	‘Revered – Ignored’
Natasha:	‘Privileged – Minority’ ‘Destination (Achievement) – Development (Journey)’
Farida:	‘Privileged – Temper self (conformity)’
Serena:	No relevant construct elicited
Saima:	‘Mature/experienced/wise – Naïve’ ‘Being inexperienced – Having an expertise’ ‘Less capable – More capable’
Priya:	‘Being seen as a professional – Not being seen as a professional’ ‘Greater power – Lesser power’

With the exception of Serena, from whom no relevant construct was identified as being reflective of this IPA master theme, all other participants had a construct that could reflect this theme in some way.

This overview of the IPA and repertory grid data appears to provide a degree of triangulation in this research. Though the aim of the research was not to find ‘truth’ in the positivist sense, the congruence between the IPA and repertory grid demonstrates an element of credibility to the analysis.

4.8.2 Points of convergence

I will now present here an example of one IPA subordinate theme where there is much convergence with the repertory grid analysis. It is important to recognise that there were many areas between both methodologies, which converged. However, due to limits of space I am unable to present all of these here.

4.8.2.1 The dilemma of remaining true to myself

Mary did not talk about the dilemma of remaining true to herself, and her repertory grid supported this as she sees her 'self at work' as similar to 'self as I really am' (EED=0.60). Natasha in her interview described how she does not achieve integration, as she does not subjugate her cultural values as a way to fit in. This is supported by her repertory grid that shows a standardised EED of 0.58 between 'self at work' and 'self as I really am'. Serena, who has been qualified for the least amount of time and who spoke in her interview extensively about feeling the need to moderate herself within the profession, has the largest distance between 'self as I really am' and 'self at work' (1.06). Farida, like Mary, made no mention of feeling the need to moderate herself in the profession. Her repertory grid supported this with a difference between 'self at work' being seen as similar to 'self as I really am' (EED=0.55). Saima asserted in her semi-structured interview that:

[I] do try to be genuine, I think the way that I am in my work isn't that different ... to who I am so I don't feel like I put on a sort of ... costume and you know get into role when I come to work particularly.

This quote is reflected in Saima's repertory grid, in which the EED between 'self as I really am' and 'self at work' shows that she sees the two as very similar, with a distance of 0.50. For Priya the EED between these two elements was 0.78, which supports her not mentioning this particular theme in her interview as she sees these two elements as fairly similar.

For the four participants who described the dilemmas associated with remaining true to themselves, the repertory grid analysis appears to suggest that this is a dilemma that they are able to resolve at some level, as they are able to be who they really are at work despite the hard emotional work that goes into this.

4.8.3 Points of divergence

I will now present here an example of where there is some divergence between the IPA and the repertory grid analysis. Unlike the high incidence of convergence found amongst the analyses, there were fewer noted areas of divergence between the IPA and repertory grid analysis, thus highlighting the utility of the mixing of these methodologies to triangulate the data.

4.8.3.1 Talking versus construing

Saima described many incidences of feeling pigeon-holed throughout her career as a psychologist. However, the cosines between constructs and elements reflected a relationship of 'self at work' being seen as not being "other defining" (-0.63). This would suggest that Saima construes her 'self at work' as being "self-directed/defining". This discrepancy may suggest that Saima is "self-directed/defining" whilst at work as much as she can be despite the experience of feeling pigeon-holed.

Mary in her interviews acknowledged how she wished to not be too down on the profession (as was highlighted in an earlier quote). However, the cosines between constructs and elements reflected a relationship of 'self at work' being seen as "not held in high regard" (0.64) and not "revered" (-0.79). This would reflect a negative experience of the profession though Mary described the profession more positively in relation to her experiences. This may suggest an attempt to protect the self from acknowledging the painful way in which Mary understands her positioning within the profession.

There may be different reasons for the discrepancies noted in the two examples above. One of the possible reasons may be that people can sometimes express their constructs incompletely, thus presenting a contaminated version of their constructs (Kelly, 1963). Also, as personal constructs are primarily *personal*, they may not always be easy for an individual to share.

I will now discuss the implications of the findings.

5.0 DISCUSSION

In this chapter, I will summarise the findings of this study in relation to my research questions. The discussion will consider previous research as well as relevant sociological and psychological theories. I will then provide a critique of the methodology before ending with the clinical implications of the study.

5.1 Summary of findings

5.1.1 Issues arising in the profession for BME clinical psychologists

Given the historical and contextual framework of clinical psychology, it can be argued that Whiteness has been situated in the normative position within the profession as much as within wider society. As the norm, it often goes unchallenged. Others become referred to in relation to this normative position. The naturalized dominance of Whiteness meant that participants' ethnicity was at times exposing in encounters with White clients/colleagues as a BME clinician. This can have the effect of feeling the need to moderate oneself in order to temper one's minority ethnicity. In particular instances this was humiliating for participants for example when clients terminated therapy. This leads to the pressure to conform and maintain the status quo, which takes deep-level hard work and is often at the expense of something else. For many, the compromise was to either stay 'different' and be disconnected, or conform and put in the hard work to adapt to a norm that is perceived to be of more intrinsic value. McIntosh's (1992) example of white privilege is relevant here in that as a White woman "I can go home from most meetings of organizations I belong to feeling somewhat tied in, rather than isolated, out-of-place, outnumbered, unheard, held at a distance, or feared" (p. 98). The findings of the current study highlight the importance for clinical psychology as a profession to seriously consider the implications of BME colleagues not having this experience.

The pressure to conform is reinforced by experiences of feeling isolated within the profession, at points during their careers. This was often the case early on in their careers and particularly whilst trainees, supporting the findings of Shah *et al.*,

(2012). The isolation described was as a result of standing out as different in the profession where the significant majority of their colleagues were White. The permanence of their visibility was something that participants had to find ways to cope with, reflecting the results of Rajan and Shaw's (2008) study.

Another challenge for participants was the subtlety of racism. According to Sue *et al.* (2007) "racial microaggressions are potentially present whenever human interactions involve participants who differ in race and culture" (p. 284). This may shed some light on why participants often felt the need to question their experiences using a racial lens to make sense of them. Due to various fears around how they might be perceived and the implications of voicing their concerns, participants instead sat with their uncertainty about the intentions of others around them. Using a racial lens may have been fueled by the knowledge that all interactions have the potential to have racial implications. In trying to determine whether an interaction had racial connotations or not, participants had to go through the hard and effortful emotional work (Hochschild, 2003), especially so as not to be seen as the victim in situations. It is also important to highlight that this occurs not just between ethnic groups but within them also, as was true for one participant in the study.

In PCT one might consider the possibility of colleagues being unable to construe their colleagues' constructions. It is important for those who work in the same professional role to be able to construe certain experiences in similar ways (Ellis, 2006). Commonality of construing may reduce issues that arise when BME clinicians feel that they are left carrying the burden of raising race and culture issues or having to second-guess their daily experiences. In one participant's experience of being abused by a client, her colleagues were more thoughtful of the needs of her clients than her own. She described this as a humiliating experience where she pondered "what about me?" Had her colleagues been able to construe her constructions, this may have been less of an invalidating experience for her. The painful feelings that this evoked had to be processed in isolation due to the lack of support from colleagues. Thus it is seen how by not being acknowledged,

clinicians can come to be silenced. This reinforces the need for the profession to engage in the risks associated with facilitating non-discriminatory communication, which by its nature involves uncertainty and new knowledge (Krause, 2002).

5.1.2 Issues arising in clinical practice for BME clinical psychologists

Examples provided in participants' accounts included clients terminating therapy with them, colleagues' and supervisors' avoidance of discussing race and culture issues and not being taken seriously as a clinical psychologist. These issues arose to varying degrees for participants, but are important to consider in the context of diversifying the profession and encouraging more applicants from BME backgrounds to consider a career as a clinical psychologist.

Psychologists often consider their power as clinicians in the clinical encounter and the impact that this power may have on their clients and clinical work (Goodbody & Burns, 2011). What has probably been less considered is the power that a client brings into the room with their Whiteness. According to Nakayama and Krizek (1995), Whiteness wields power though its position is largely unarticulated. This lack of articulation may be underlying the dilemma faced by participants in this study about whether or not to actively bring their ethnicity into the room. According to Burnham and Harris (2002) it is unacceptable to only raise issues of culture if it is seen as a problem or emerges spontaneously. Rather there may be a role for clinicians to move towards "safe uncertainty" (Mason, 2015). This may be actualised through a process of "letting go of the certainties of authoritative discourses and truth claims and subjecting them to critical scrutiny" (Pollard, 2008, p.4).

When participants found they were being positioned as experts on diversity issues some rejected this to not feel like a "prisoner of identity" (Burnham & Harris, 2002). Patel *et al.* (2000) described how BME trainee clinical psychologists are often positioned as experts on 'Black issues'. It would appear that from participants' accounts of their experiences, this continues into the daily working

life of a BME clinical psychologist. Why some White therapists do not take more responsibility for thinking about issues of diversity may be a reflection of the fear of taking a risk and getting it wrong or seeing their BME colleagues as a quicker way to access the knowledge they seek (e.g. Nolte, 2007). Burnham and Harris (1996) make the observation that in moving towards a culturally competent place, clinicians must be willing to be 'clumsy rather than clever'. The willingness to take risks may relieve the burden on BME practitioners to be the experts on what many in the study agreed that there is no homogeneity in culture and we must all do our own thinking on issues of difference and diversity. It is possible that White therapists fear charges of racism on matters of race and culture and thus avoid raising these issues in their professional lives (e.g. Sue, 2013). Other possible reasons may include fears of realising their own racism (Sue, 2013), fear of confronting White privilege (Magnet, 2006; Sue, 2013), and a fear of having to take personal responsibility to end racism (Magnet, 2006; Sue, 2013). In Sue's (2013) study, they found that White participants feared 'opening a can of worms' and were thus apprehensive about approaching such discussions around race and culture.

Society's seeming pre-emptive construing of minority groups mean that Blackness and Englishness are potentially seen as mutually exclusive. Two participants described the experience of clients speaking to them over the phone and upon seeing them in person both had the clients express disbelief when they met them and realized they were Black. The White client declined to continue the work, with the Black client remarking to the psychologist that they should not forget where they have come from. The dilemma for clients who encounter a clinician from a BME background may be a reflection of wider societal opinion that ethnic minorities are victims in need of service input rather than the opposite position of being a service provider (Patel, 1996). This may support literature that purports there to be overt racism as part of the working lives of BME clinicians (e.g. Adetimole *et al.*, 2005).

The colour-blind attitude is one that is often adopted by those who wish to not engage in discussions around ethnic diversity. Other protocols adopted include what Sue (2013) calls politeness protocol and academic protocol. These norms of relating to racial dialogue perpetuate the silence that is often experienced by marginalized groups; and has arguably been internalized by BME clinicians who sit with uncertainty rather than engage in race talk, which may expose them to microaggressions in the workplace (Sue, 2013).

5.1.3 Issues concerning identity development for BME clinical psychologists

Clinical psychology is largely made up of White professionals, which increases the likelihood of standing out for BME psychologists and perhaps the need to “choose” which side of the cultural fence one operates from. BME clinicians are thus faced with the dilemma of their biculturalism. Biculturalism refers to the internalisation of more than one culture (Benet-Martínez & Haritatos, 2005). Though all participants were born in the UK, they also had the salience of their ethnicity as an important identity marker. Negotiating their biculturalism was thus a part of the struggle for participants who were faced with majority minority discourses. The implication of this was feeling the need to operate from a place of proving themselves to be worthy clinicians. This may have been a perceived stereotype threat; the feeling that others would judge them according to the stereotypes attached to their minority groups (Roberson & Kulik, 2007). Whether accurate or not, it was a position that many of the participants found themselves in. This reflects the notion of internalized racial oppression (Freire, 1970) whereby people absorb the values espoused by an oppressor and believe in the misinformed ideals of the oppressor (Alleyne 2004).

The process of negotiating multiple cultural identities is a complex one (Benet-Martínez & Haritatos, 2005). Despite the multifaceted nature of negotiating multiple identities, it was important for participants to integrate their cultural identity into their professional roles. Further compounding this dilemma was not feeling safe enough to consider these issues in the workplace. Instead participants

described finding places outside of the professional arena to consider their experiences with not feeling comfortable in the profession.

Most participants' experience of integrating their cultural values within their professional roles was an active process of coming to decide what was acceptable professionally and what aspect of their identity needed to be moderated. According to Slay and Smith (2011) in societies where stigmatized BME individuals have been stereotyped as non-professionals and people with limited prospects or potential, they may possess a restricted awareness of who they may become professionally. Further reinforcing this is the lack of role models from whom to learn. Thus, this was a challenging aspect of being a BME psychologist, namely contending with little guidance through their journeys.

The need to negotiate cultural and professional values was heightened by the participants' beliefs and that of their community. Conflicts arose for some participants whose cultural group could not marry the idea of them being both Black/Asian and a psychologist with charges being brought against one participant of being a 'coconut' or selling out for example. Stigma consciousness (Pinel, 1999) may serve to explain the process by which participants chose which values would be most compatible with their professional identities and those that would not. For example, some decided not to address particular issues, for fear of being labeled the 'angry Black woman'. The fear of stigma inhibits some aspects of participants' cultural identity, and as a result their identities are subjugated. This is embedded not only in their racial identities but their gender as well (Bell, 1990).

The outsider within standpoint (Collins, 1986) can help to theorize about issues of integrating multiple identities, including the personal within the professional. This concept suggests that for marginalized groups who undergo a socialization process to fit into the dominant group, they acquire the insider skills of thinking in and acting according to that particular standpoint. However, due to the marginalized groups' experiences (*both prior to contact and after initiation*), they may carry with them "special perspectives and insights . . . available to that

category of outsiders who have been systematically frustrated by the social system" (Merton, 1972, p. 29). As such, their outsider allegiances may inspire against their choosing full insider status, and they may be more apt to remain outsiders within. In many ways this suggests that participants would need to assimilate into a perspective that is quite different than their own to become fully-fledged insiders, something they may not be fully invested in at the expense of losing their outsider allegiances.

According to Phinney (1990) ethnic identity structure and quality may change over time. This may be due to particular contexts, the time spent within that context, and the way individuals explore and resolve issues pertaining to the implications of their ethnic group membership. An interesting finding of the study was the fact that for all of the participants their concept of a White clinical psychologist was more salient than their concept of a BME clinical psychologist. This is surprising given their identities as BME clinical psychologists. This may be due to the majority position held within the profession by White clinical psychologists. It may also suggest issues in ethnic identity quality in the context of a profession that has very few clinical psychologists from BME backgrounds. Furthermore, it may also allude to a desire of these clinical psychologists to have their professional identities at the forefront of their working roles rather than their ethnic identities. This might support the idea that clinicians are dissatisfied with being pigeon holed as being a BME clinical psychologist and instead wish to just be a clinical psychologist. This may serve the purpose of maintaining a relatively simplified identity structure (Roccas & Brewer, 2002), the consequence of which is being able to maintain the status quo and have a sense of closure on issues regarding multiple in-group memberships.

Presently, clinical psychology is arguably a challenging context for BME psychologists to operate within given their minority status due to the calls for increased ethnic diversity but the slow progress in achieving this. This is supported by the findings of Goodbody and Burns (2011) who found that "the context marker for Black identities was inequality, creating predominantly social

identities functioning in the borderlands of the profession's discursive territory which therefore posed a challenge to reconcile with the insider discourses of the person and the profession" (p. 306). Therefore, if clinical psychology is to be an environment that supports the personal-professional development of BME clinicians, much has to be done to diversify the profession to limit the experience of being a minority and offering opportunities to think critically about minority majority discourses in the profession.

5.1.4 Implications of being a BME clinical psychologist in the profession

This study found that there were personal and professional implications of holding a minority position in the profession. Implications included being positioned as the expert on issues of race and culture, having to constantly question the intentions behind the actions of others and seeking a way to maintain one's cultural identity. These often took the form of dilemmas for participants who had to come to a decision on how they behaved, how they related to others and how they came to make sense of their experiences. This is supported by the findings of Goodbody and Burns' (2011) study that found critical tensions often exist for minority clinicians between their personal experience, professional discourses and identities. Further to this, in their study, being a minority within the profession was associated with personal distress and resistance to dominant power relations.

Feeling low in confidence in their role was another implication of being situated in the minority position for participants in this study. It is important to consider the implications of this in the context of clinical psychologists being encouraged to take up more leadership roles and whether this makes it more challenging for BME psychologists to ascent the *snowy White peaks* of the profession. More positively, clinicians described growing in confidence with time. This may reflect a resignation to the fact that they were minorities in the profession and was something to accept rather than engage with the myriad of ways in which it impacted on their confidence. Alternatively it may be a reflection of the skills

developed over time and this being evidence enough for them rather than expecting affirmations from those around them as to the worth in their work.

A positive implication of their BME identities was the pride and intrinsic satisfaction that participants experienced possibly due to them contributing to new positive ideas of BME females that transcend traditional negative stereotypes (Bell, 1990).

5.2 Personal construct theory

Using a PCT framework to theorize about the experience of the BME clinical psychologist, in line with my critical realist epistemological position, gives an alternative way of making sense of participants' experiences. Though the theory will not be described in great detail here, as this is beyond the scope of this research, there are important assumptions within the theory that are relevant and will be given consideration.

The first of these assumptions is the Construction Corollary. This corollary states that individuals anticipate events by construing their replications. This refers to the ways in which people perceive themes that reoccur in their environment and use this as a way of anticipating or predicting what is to come based on these recurrences. For participants in the study who have experienced challenges throughout their clinical training one can begin to conceptualize how they may have come to anticipate their experiences as qualified psychologists. This supports previous studies that have advocated for training courses to be explicit in their support of BME trainees in relation to their experience of difference.

Another corollary to be discussed here is the Sociality Corollary. This corollary states "to the extent that one person construes the construction processes of another, he may play a role in a social process involving the other person" (Kelly, 1955, p. 104). There are implications of this corollary in this research as this corollary speaks to the ways in which individuals can adjust their own behavior based on their predictions of what others may do. Though this is a mutual process,

it is important to acknowledge that a person may understand another person better than the other person understands them. Also, to be able to engage in effective social interactions with others, we must be able to construe other people's personal constructions. The results of this study point to a possibility that clinical psychology as a profession is lacking somewhat in sociality on issues of diversity. Adopting 'thinking spaces' as is utilized in the psychotherapeutic tradition may allow for increased sociality between professionals.

Using Feixas, Geldschläger and Neimeyer's (2002) classification system for personal constructs (Appendix J) one can see how the constructs elicited for participants were mostly relational, intellectual/operational and constructs concerning ideological or distinct values. To give some context, Feixas *et al.*, (2002) propose there to be eight different construct categories in their classification system. The constructs elicited by participants on their experiences within the profession point to the contextual nature of the experiences within the profession. How they see themselves in relation to their colleagues and clients is particularly important for how they anticipate and experience the profession.

The salience of their trainee identities in the repertory grid analysis highlighted the importance of supporting trainees in their development. The trainee experience becomes vital when thinking about how previous experiences inform current understanding. So for example in Kellyan terms, in our daily encounters, the way that we make sense of that experience is channelized by the constructs formed in previous encounters, i.e. the trainee experience may colour the way in which a qualified clinician now makes sense of their current professional habitus.

5.3 Implications of the research

5.3.1 Clinical implications for the profession and for clinical practice

Participants reported feeling proud of being successful in their ambitions to train and qualify as clinical psychologists in what is known to be a competitive profession. However, despite this there was a clear theme that emerged from the research, which was that BME clinical psychologists endure challenges in their

professional roles. I will suggest some recommendations for the profession to consider in light of the findings highlighted earlier.

Recommendations for the profession

Supervisor training should focus on training supervisors to be more confident in being “clumsy rather than clever” (Burnham & Harris, 1996). In raising issues of race and culture routinely with all supervisees this will ensure that issues are not left to BME practitioners to raise, and may relieve the burden that BME psychologists experience. It may contribute to clinicians feeling supported in the workplace to consider and reflect on issues that may be impacting on their clinical work and professional development.

All clinicians in the profession should be encouraged to take risks in particular on issues of diversity by constructively engaging with issues of difference (Mason & Sawyer, 2002). This needs to be a genuine endeavour to ensure it is not seen as a tokenistic exercise, thus defeating its purpose. CPD courses highlighting best practice on working in a culturally sensitive and competent manner may be one way in which this is implemented.

As this research suggests a move towards greater integration of identity and growing confidence over time for participants there may be a role for mentoring prior to and during clinical training as well as for newly qualified psychologists. This may provide a safe space to consider issues around integrating the cultural self within the professional arena (e.g. Daniel, 2009).

There should be an on-going focus on recruitment initiatives to move towards greater diversity within the profession, including addressing obstacles to recruitment. This may alleviate the sense of loneliness experienced by participants in this and previous studies. Recruitment into leadership positions may also serve to demolish perceptions of the profession as being racist or the view of elite professions as having *snowy White peaks* (Kline, 2014).

Training courses should encourage a deconstruction of Whiteness so that what Nylund (2006) terms critical multiculturalism can be embraced. This approach subverts racism and undoes the status quo of power discourses. In addition to this, efforts to improve the experience of BME trainee clinical psychologists, including courses explicitly stating their commitment to supporting trainees (Patel *et al.*, 2000), need to be maintained as this appears to be a vital aspect of a psychologists professional development. Furthermore, teaching on race and culture issues needs to focus on working effectively cross-culturally, not just with clients, but also amongst professionals, including e.g. in multi-disciplinary teams (Burns & Kemps, 2002).

Acknowledging the existence of institutional racism may highlight that there remains much work to be done on making services inclusive of minority groups.

Recommendations for Clinicians

The outsider within standpoint (Collins, 1986) may provide some support for encouraging White clinical psychologists to become allies of BME clinicians. The support of colleagues may lessen the threat of relinquishing their outsider allegiances, only to feel isolated within the profession. Becoming an ally would involve breaking the invisibility of privilege by keeping a list of one's privileges and helping others see them, for example (Bishop, 2002).

As the clinical utility of the repertory grid is well established, there may be a place for clinicians to utilize this tool more extensively in clinical practice such as in supervision (e.g. Marrow, Macauley & Crumbie, 1997). As one example, it may be used in supervisory relationships to provide a way of routinely discussing issues of race and culture in a way that is particularly meaningful as it considers the personal and professional dimensions, which clinicians are using to make sense of their professional lives. Supervisors and their supervisees can jointly design repertory grids that would serve the purpose of highlighting areas of concern, e.g. through the identification of implicative dilemmas, or alternatively as a way of opening up discussions around the supervisees' experiences within the profession

in relation to cultural issues. Alternatively a tool such as the Cultural Attitudes Repertory Technique (Neimeyer & Fukuyama, 1984), which has been designed and used to explore counseling trainees' cultural attitudes that would have otherwise remained implicit in their clinical work, may be employed as a useful tool in supervision.

5.3.2 Areas for further research

An interesting study would be one in which a male sample was recruited to understand the experience of BME male clinical psychologists in the profession, who are more of a minority group than BME female clinical psychologists. This would provide an insight into gender in relation to race in the profession. A study that replicates this research would also be valuable in order to enhance the validity of the study. Conversely, a study enquiring into the experience of clinical psychologists in the dominant position, i.e. the White female perspective might further illuminate their experience of working in a profession that lacks ethnic diversity. This would also give voice to trying to understand key issues such as why clinicians do not take more responsibility in doing their own thinking around issues of difference for example.

Further research needs to be conducted on the experience of minority clinicians in the profession to illuminate issues that are encountered and consider whether these are common experiences

This study demonstrated the possibility of a developmental journey that psychologists undergo whereby though there are challenges in the early stages of their professional lives, there is also a confidence that emerges and allows for the dilemmas that were present to not be so pertinent. A longitudinal study that can give more understanding to this process would be beneficial. Likewise a study looking at the experience of BME clinical psychologists who have been qualified for a significant period of time would be a worthwhile endeavour.

5.4 Critical evaluation

In this section I will critique this study considering its strengths and weaknesses. To evaluate this research, I will employ Yardley's (2008) framework for evaluating the validity of qualitative research. Owing to consideration of the mixed methodological approach I will also consider Barker and Pistrang's (2005) quality criteria under methodological pluralism where appropriate.

5.4.1 Sensitivity to context

Yardley (2008) points to researchers utilising relevant theoretical and empirical literature as part of being sensitive to the socio-cultural context of the research. This was adhered to in the initial stages of the research whereby a consultation of the literature highlighted key research that has been conducted into the experience of trainee BME clinical psychologists and theories around identity development. It was this clarification from the literature that highlighted the absence of research to understand the experience of qualified BME clinical psychologists.

Sensitivity to context also requires for researchers to consider the position and perspective of participants who are to take part in research. A consideration of this was one of the reasons for implementing a pluralistic methodological approach whereby participants could utilise an alternative way of sharing their experience of the profession via the use of a repertory grid. Other ways in which sensitivity was demonstrated included offering participants the opportunity to choose the location of the interviews, thus maximising their feelings of security and comfort. It was important for participants that they felt that they could express themselves freely.

During the analysis stage, I considered the various reasons why views were expressed and why other views may have been suppressed. For example, I pondered on the potential distress that voicing particular experiences may have had on participants and took into account the apprehension of participants to

share experiences, which may have made them easily identifiable within the profession.

5.4.2 Commitment and rigour

Through thorough data collection, in-depth data analysis, methodological competence and a comprehensive engagement with the topic researchers can show their commitment and rigour to the research process (Yardley, 2008). The introduction chapter is evidence of my commitment to the topic and extensive engagement with research in the area. In order to have a good understanding of the area I read widely to ensure a good overview of relevant ideas, themes and theories.

A rigorous approach was taken in this research by utilising independent researchers to assist with the coding of some of the interview transcripts. This was a way of providing credibility checks of the analysis and ensuring that my analysis of the data was plausible. Where divergent codes were highlighted, I engaged in discussions with the independent researchers whilst also returning to the transcript to review my codes and ensure that the final codes were grounded in the data. Up to five different researchers engaged on this process with researchers from different backgrounds being invited to take part in this process. This allowed for a broader perspective on the data and for interpretations to be considered which may not have been apparent to me due to my own biases.

Supervision was utilised as a space to reflect on potential biases, with one supervisor having conducted research in this area and being from a BME background herself.

5.4.3 Coherence and transparency

The transparency of the research process can be seen through the provision of sufficient quotes and excerpts from the interviews. Further to this, appendices give transparency in that an example of a participant's analysed transcript is provided as well as an example output of one participant's repertory grid analysis

(Appendix L). A clear reporting of what was done, in this study, and why is another way in which the research demonstrates transparency.

Insight into the inevitable influence that a researcher brings to the research made it important for me to remain reflexive throughout the research process e.g. through the use of a reflexive research diary (Excerpt can be found in Appendix M). I have given explicit consideration to the ways in which I may have influenced the research. This transparency allows the reader to approach the research and hold this in mind when engaging with my own interpretation of the data.

5.4.4 Impact and importance

Smith *et al.*, (2009) state that true validity concerns the extent to which research is useful and tells the reader something important. As stated earlier, the rationale for this study is to give some insight into the experience of BME clinical psychologists in the context of working in the NHS, in the UK. Much has been done to address the lack of ethnic diversity in the profession, with some success albeit quite limited. This study was relevant to giving voice to this group that has been understudied.

Given that “the experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts” (Kline, 2014, p. 39), this study is important to understanding the experience of BME psychologists.

5.4.5 Reliability of repertory grids

Kelly (1955) argued against conventional reliability tests and instead asserted that reliability is “a measure of the extent to which a test is insensitive to change”. (Bannister & Fransella, 1971, p. 76). Constructs may change over time and this is a part of individuals making sense of their world like the scientist that Kelly (1955) argues us to be.

5.5 Strengths and limitations of the study

The study uniquely combined two constructivist methodologies to give voice to a group of individuals that have received little attention in the research literature despite the importance of such studies. The strength in utilising two methodologies is the degree of triangulation that this offered. Studying one phenomenon from multiple perspectives is of value to the IPA analyst, who can develop a more complex account of the experience under investigation (Smith *et al.*, 2009).

It is important to consider the study's limitations. In particular, one surprising aspect of the current study was that recruitment proved particularly difficult. There may have been many reasons for this. One reason may be due to the study design and the way in which recruitment was undertaken. A more strategic design could have been employed to ensure that the research invitation reached an even wider audience than it did. Another possible reason for the lack of willingness to participate in the study may be due to the desire for some individuals to retain their identity as a clinical psychologist and not a BME clinical psychologist. This is further supported by a statement made by one professional who was invited to assist in the recruitment of participants and cited that "I know that black and minority professionals are sick and tired of being pigeon holed by their ethnicity".

Some doctoral theses have been conducted on the experience of BME trainee clinical psychologists (e.g. Murat, 2012; Patel, 1996 and Shah *et al.*, 2012). Furthermore there have been articles documenting the challenges of being from a BME background in the profession. Concerns around the size of the profession may have contributed to the decision-making process of potential participants. Clinical psychology is a relatively small profession (Caine & Golding, 2006). When one considers the percentage of minority clinicians within that small number, it thus becomes understandable why there may have been reluctance to take part, as clinicians may have feared that they may have been easily identifiable.

As a result of difficulties recruiting participants, the sample size was smaller than anticipated, though idiographic studies by their nature do not need large samples (Smith *et al.*, 2009).

5.6 Self-reflexivity

I felt pressure to do the research justice throughout the research process. At times this may have hindered the research, with me striving to capture every aspect of every participant's experience, an impossible feat. I thought about this in my reflective journal where I noted the desire to not perpetuate difficult experiences faced already by participants by silencing aspects of what they had shared in their interviews. As a BME trainee clinical psychologist, I felt an affinity to all my participants in our insider perspectives of being females within the profession and also having dual cultural heritage. In writing an account of their experiences, I wondered how much of my own experiences seeped through into my trying to make sense of their sense making. On a methodological level I could address this through the reflexivity and transparency strategies described above. However, on a more personal level it was personally thought provoking.

5.7 Conclusions

Using a pluralistic research methodology incorporating constructivist data collection methods, this study attempted to explore the experience of BME clinical psychologists working in the NHS. The findings highlight some important issues that appear to be reflective of psychologists' experiences from their time as trainees. Challenges highlighted in previous studies on the experience of BME trainees were indicated as relevant issues including being positioned as the expert on issues of race and culture, feeling isolated within the profession, and trying to find a way to integrate their cultural identities with their professional identities.

As a small sample, this study does not account for the experience of all BME clinicians in the profession. However, it gives an insight into a previously understudied group of individuals. This research thus adds to and enriches existing research in the area and should be read alongside this. The implications of this research have been discussed as well as suggestions for future studies in this area.

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Appendix A: Blank Repertory Grid

	Emergent Construct	Elements											Implicit Construct	
		Self as I really am	Self at work	Ideal Self	Self as trainee	Self prior to training	BME C. Psychologist	White C. Psychologist	Ideal C. Psychologist	How BME colleagues see	How White colleagues	How BME clients see me		How White clients see
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														

Appendix B: Invitation email and poster

Dear xxxx,

My name is Elizabeth Odusanya and I am a second year Trainee Clinical Psychologist at the University of Hertfordshire. I am looking to explore how Clinical Psychologists from Black and Minority Ethnic backgrounds experience the profession of Clinical Psychology. This research aims to provide an insight into the everyday lived experience of BME practitioners within the profession of clinical psychology. It also endeavors to uncover how this group of individuals makes sense of their experience and how they negotiate their professional identity against the backdrop of their cultural identity. Results from such a study may prove useful in attempts to diversify the profession, improve our knowledge on the experience of BME groups in the helping profession and also challenge current misconceptions concerning the BME experience.

For my project, I am looking to recruit 6-8 Black and Minority Ethnic Clinical Psychologists. To participate, you would be asked to take part in two audio-recorded meetings, which should last for approximately 1 hour per session. One interview will be a repertory grid interview and the second will be a semi-structured interview. This can take place on the same day if it is convenient for you. The setting will be your choice to ensure confidentiality and comfort. This may very well be your own home, should you wish so.

Repertory grids are a technique that allow for us to understand a person's worldview or experience in their own terms rather than using a standard conceptual framework, which may not fit with how the person sees the world.

The meeting will involve talking to me about your experiences of being a qualified clinical psychologist and also your journey to becoming a clinical psychologist. I am aware that telling your story may potentially be a difficult process and that some questions I may ask you might experience as sensitive. If any of the questions are found to be particularly upsetting you do not have to answer them. Participation in this study is your choice completely. You are welcome to ask any further questions before this decision is made. If you decide that you wish to take part in the study, you will be provided with the participation information sheet to help your decision further.

If you are willing to consider participation, please feel free to contact me on the email address below or telephone me on .xxxxx xxx xxx, for further

discussion and information about this project. Also, if you know of a BME Clinical Psychologist who would be suitable for this study and interested please feel free to provide their contact details so they can be invited to participate in the study.

This study has been approved by the ECDA who have raised no objections on ethical grounds (Protocol number: LMS/PG/UH/00381) However, if you wish to complain or have concerns relating to this investigation please do not hesitate to contact my project supervisor.

Thank you for your time and consideration.

Kind Regards,

Ms Elizabeth Odusanya
Trainee Clinical Psychologist
Chief Investigator
University of Hertfordshire
o.e.odusanya@herts.ac.uk

Dr Lizette Nolte
Research Tutor
Project Supervisor
University of Hertfordshire
l.nolte@herts.ac.uk

The Experience of BME Clinical Psychologists: An Interpretative Phenomenological and Repertory Grid Analysis



Elizabeth Odusanya¹, Dr Lizette Nolte¹, Dr Snehal Shah², Prof David Winter¹
University of Hertfordshire¹, Hertfordshire Partnership NHS Foundation Trust (HPFT)²

Introduction

Background

The poor representation of BME practitioners in clinical psychology is well documented (See Figure one). In 2013, it was reported that there were 9.6% BME clinical psychologists in England (Health and Social Care Information Centre). In 2011, in the United Kingdom (UK), the BME population was numbered at 14.1% of the overall total in England and Wales, not including the 'White Other' demographic (Office National Statistics, 2011).

Clinical Psychology and Diversity

The diversity of clinical psychology as a profession is key to facilitating access to services that reflect our clients' culture and personal identities (Turpin & Coleman, 2010).

Though the low recruitment and retention of BME clinical psychologists is often cited in the literature (Williams, Turpin & Hardy, 2006), few studies have researched the experiences of BME clinical psychologists in clinical practice.

Existing studies, have tended to focus on the experience of BME trainee clinical psychologists. These have reported findings concerning personal identity issues (Shah, 2010), being positioned as an expert on issues of diversity (Rajan & Shaw, 2008) as well as experiences of racism (Adetimole, Afuape & Vara, 2005).

Personal Construct Psychology and Identity

"Questions of identity, group membership and representation pervade daily interactions in contemporary societies" (Howarth, 2002, p1).

According to Howarth (2002), identities are always constructed through and against representations

PCP allows for the window to be opened to take a glance into the professional identity narrative of the BME clinical psychologist without relying on language and any associated assumptions.

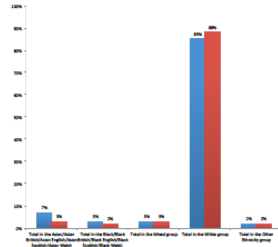


Figure 1. Applicants to DclinPsy (2013 Entry) and Acceptance rates

Aims

This proposed piece of research aims to:

- provide an insight into the everyday lived experience of BME clinicians within the profession
- uncover how this group of individuals makes sense of their experience and construe their professional identity within the context of their cultural identity

Rationale

IPA is primarily concerned with an examination of an individuals' lived experience (Smith, Flowers & Larkin, 2009).

With repertory grids, one can map the psychological space between Ps' constructs, thereby providing a more insightful understanding of their personal experience and their underlying meaning making of it. Furthermore, repertory grids lead us away from understanding clients from our own personal or professional dimensions, and rather encourage us to make sense of their experience from their own construct system (Bannister, 1965).

The combined use of both IPA and repertory grids has been demonstrated to be a successful blend of methodologies (Blagden *et al*, 2014)

Methods and Materials

Design

A mixed method design is to be employed

Recruitment

- purposive sampling approach
- 6-8 BME clinical psychologists

Data Collection

Repertory Grid Interview

- Repertory grids are a technique that allow for us to understand a person's worldview or experience in their own terms rather than using a standard conceptual framework, which may not fit with how the person sees the world.

Semi Structured Interview

- The meeting will involve talking to me about your experiences of being a qualified clinical psychologist and also your journey to becoming a clinical psychologist. I am aware that telling your story may potentially be a difficult process and that some questions I may ask you might experience as sensitive. If any of the questions are found to be particularly upsetting you do not have to answer them.
- Participation in this study is your choice completely. You are welcome to ask any further questions before this decision is made. If you decide that you wish to take part in the study, you will be provided with the participation information sheet to help your decision further.

Clinical Implications

Results from such a study may prove useful in attempts to diversify the profession, improve our knowledge on the experience of BME Clinical Psychologists and challenge possible misconceptions concerning the BME experience.

If you are interested in taking part...

If you are willing to consider participation, please feel free to contact me on the email address below for further discussion and information about this project. Also, if you know of a BME Clinical Psychologist who would be suitable for this study and interested please feel free to provide their contact details so they can be invited to participate in the study.

This study has been approved by the ECDA who have raised no objections on ethical grounds (Protocol number: LMS/PG/UH/00381) However, if you wish to complain or have concerns relating to this investigation please do not hesitate to contact my project supervisor.

Dr Lizette Nolte
Research Tutor & Project Supervisor
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Contact

Elizabeth Odusanya
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Appendix C: Participant information sheet

Participant Information Sheet

Title of Study:

The Experience of Qualified Clinical Psychologists from BME groups: An Interpretative Phenomenological and Repertory Grid Analysis

Researcher:

Elizabeth Odusanya
Trainee Clinical Psychologist
o.e.odusanya@herts.ac.uk

You are being invited to take part in a research study. Please take the time to read the following information. Please contact the email above provided if you would like more information.

What is the purpose of the study?

The proposed study aims to explore the experience of clinical psychologists from BME groups. The study recognises that there is a current lack of knowledge available on the experience of being a minority clinician in the field of Clinical Psychology, and therefore aims to improve our understanding in this area.

Do I have to take part?

No. It is up to you to decide whether or not you wish to take part. If you do, you will be asked to sign a consent form. Upon recruitment, should you decide that you no longer wish to take part, you have the right to withdraw at any time.

What does the study involve?

All participants will be invited to take part in a repertory grid interview and a semi-structured interview. The interviews will be audiotaped and should last for approximately 60 minutes each. Interviews will be arranged to take place at a location that offers confidentiality and is most convenient for you.

What is a repertory grid interview?

The Repertory Grid Test was devised within the context of Personal Construct Psychology (PCP) by Kelly (1955/1991), the first purely constructivist approach in clinical and personality psychology. It is designed to explore the subjective worlds that people live in. Please see for more information: Bannister, D. (1965). The rationale and clinical relevance of repertory grid technique. *The British Journal of Psychiatry*, 111(479), 977-982.

Will my information be kept confidential?

The handling, processing, storage and destruction of your data will be compliant with the Data Protection Act 1998. To ensure confidentiality, all personal information will be coded. Consent forms and demographic information will be stored separately and securely from the tapes and transcripts to avoid

identification. All information that is collected from you during the course of this research will be kept anonymous. Anonymised verbatim quotes may be used in the final report.

What will happen to the results of the study?

The aim will be to publish the results of the study. A summary of the findings will be made available to you, on request, prior to submission for publication. Please note that your details will remain confidential and anonymous throughout any subsequent reports or publications.

What are the advantages and disadvantages of taking part?

The results from this study may help to inform our understanding of the experiences of BME clinical psychologists and understand the implications of working in a profession that lacks diversity. Further to this, it may provide support for the diversification of Clinical Psychology in the UK.

You may find answering questions about your personal experiences distressing. You can terminate the interview at any time should it become distressing for you. Also, all participants will be offered the opportunity to debrief at the end of the interviews.

What if there is a problem?

Any complaints regarding the conducting of the research will be addressed. If you have any concern about any aspect of this study you should ask to speak to the researcher who will do her best to answer your questions. If you remain unhappy and wish to complain formally you can do so by contacting the project's Research Supervisor, Dr Lizette Nolte (email address: l.nolte@herts.ac.uk).

Who has reviewed the study?

This study has been granted approval from the University of Hertfordshire Research Ethics Committee who have raised no objections on ethical grounds. Due to the academic nature of the research this project has also been subjected to a formal and peer review by the University of Hertfordshire's Doctoral Programme in Clinical Psychology.

Thank you for considering being a part of the study

Appendix D: Participant screening questionnaire
Participant Screening Questionnaire

Please complete all questions and return to o.e.odusanya@herts.ac.uk

1) What is your ethnic group?

Choose ONE section from A to E, and the appropriate box to indicate your ethnic group.

A White

British

Any Other White background, please write:

B Mixed

White and Black Caribbean

White and Black African

White and Asian

Any Other Mixed background, please write:

C Asian or Asian British

Indian

Pakistani

Bangladeshi

Any Other Asian background, please write:

D Black or Black British

Caribbean

African

Any Other Black background, please write:

E Chinese or other ethnic group

Chinese

Any Other, please write in

1) What is your country of birth?

England

Wales

Scotland

Northern Ireland

Republic of Ireland

Elsewhere, please write in the present name of the country

2) How would you describe your gender?

Female

Male

Transgender

3) Age: _____

4) What year did you qualify as a Clinical Psychologist? _____

5) Are you currently working in the NHS?

Yes

No

If yes, for how many years have you been working in the NHS as a clinical psychologist? _____

Thank you for your time

Appendix E: Ethical Approval



**UNIVERSITY OF HERTFORDSHIRE
HEALTH & HUMAN SCIENCES**

ETHICS APPROVAL NOTIFICATION

TO Elizabeth Odusanya
CC Lizette Nolte
FROM Dr Richard Southern, Health and Human Sciences ECDA Chairman
DATE 06/05/15

Protocol number: **LMS/PG/UH/00381**

Title of study: The Experience of Qualified Clinical Psychologists from Black Minority and Ethnic groups: An Interpretative Phenomenological and Repertory Grid Analysis

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 06/05/15

To: 30/09/16

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix F: Participant consent form

PARTICIPANT CONSENT FORM

Title of Project: The experience of BME Clinical Psychologists: An Interpretative Phenomenological and Repertory Grid Analysis

Name of Researcher: Elizabeth Odusanya, Trainee Clinical Psychologist
Protocol number: LMS/PG/UH/00381

To be read and signed by the participant:

I confirm that I have read and understood the participant information sheet provided to me in relation to the above study. I have had the opportunity to consider the information, ask questions and have had my queries addressed sufficiently.

I understand that it is completely my choice as to whether I take part in this study or not. I also understand that should I wish to no longer take part in the study I can withdraw at any time.

I consent to the repertory grid interview and semi structured interview being audio recorded.

I understand that relevant sections of transcribed interviews collected in this study will be looked at by authorised persons from the University of Hertfordshire. Anonymised sections of transcribed interview data may also be looked at by academic and professional assessment bodies in order to assess the quality of this doctoral research study. A transcription service may be employed to assist in the transcription of data collected during the interviews. All aforementioned persons will be bound by confidentiality and will have a duty to you as a research participant to keep all data as private and confidential.

I agree to the use of anonymised quotes from my interview being used in publications.

I agree to be contacted for my comments on the findings of the study. Should I change my mind, I am aware that I can decline involvement at any time.

I agree to take part in the aforementioned study.

Participant Name: _____

Participant Signature: _____

Date: _____

Researcher Name: _____

Researcher Signature: _____

Date: _____



**Transcription Agreement
Doctorate in Clinical Psychology
University of Hertfordshire**

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

X ('the discloser')

And

Transcription service ('the recipient')

The recipient agrees 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 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.

Signed:.....

Name:.....

Date:.....

Appendix H: Interview schedule

On coming to be a psychologist

- Could you give me a brief history of why and how you came to be a clinical psychologist?
- How would you describe yourself as a clinical psychologist?
- What does being a clinical psychologist mean to you? *Prompt: How does it impact on how you see yourself? How do you think it impacts how others see you?*

Experiences within the profession

- Could you tell me about your experience as a clinical psychologist being from BME background? *Prompt: with your clients/with your colleagues/with your supervisor/in relation to your professional development...how did that make you feel?*
- What did you expect it to be like working as a clinical psychologist (in relation to your ethnicity)? *Prompt: Is this different or similar to your experience now?*
- How do you feel about diversity within Clinical Psychology? *Prompt: How do you feel you are viewed as a BME clinical psychologist?*
- What are some of the challenges of being a minority clinician? *Prompt: What's the worst thing?*
- What are some of the positives of being a minority clinician? *Prompt: What's the best thing?*

Reflections on ethnicity and professional identity

- How does your ethnicity (minority status?) influence your clinical practice?
- How does being a BME clinical psychologist influence how you see yourself? *Prompt: personal identity...professional identity*
- On a day-to-day basis, how do you cope with the challenges you mentioned earlier?
- What is your hope for the future of the profession?

Appendix I: Farida transcript analysis

Emergent Themes	Original Transcript	Exploratory Comments
<p>The young hopeful self</p> <p>Meeting with resistance from family</p> <p>Emotional burden</p> <p>Feeling Lucky</p> <p>Working hard</p> <p>The young hopeful self</p> <p>Feeling overwhelmed</p> <p>Facing the impossible</p>	<p>So first question I wanted to ask was um how and why you came to become a clinical psychologist?</p> <p>20: How I came to be a clinical psychologist? E: Yes. 20: Um I knew I was going to be a clin er psychologist from when I was like 13 because I was in a um my family were abroad for a while and I was in an international school and they had a school counsellor on site um and I remember thinking oh that's a cool job. Um and saying to my parents at the time and they were kind of oh don't you want to be something else psychologists that's quite a hard job to to be, it's kind of emotionally quite draining. They tried their best to kind of redirect me somewhere else um.. But then, yeah then it it just fell that way that I did end up being a psychologist. I think A level results went in that, in in my favour in that way. E: Yeah and um in terms of that journey, what what was it like for you cos I know a lot of people talk about sort of challenges of getting onto clinical training, that sort of thing. What what was that like for you? 20: It was it was hard. I think er to begin with I don't think I understood completely what a clinical psychologist was um I kind of did, I'd looked at the BPS website at what a clinical psychol... what the different kinds of psychologists do and I felt a clinical psychologist sounds about, sounds like the thing that I want to do. Um but then my undergrad degree was psychology and clinical psychology and at the time I thought that, that that meant that I could like bypass training.. I really had no clue and then I then um I met, just, a family friend was a psychiatrist at xxxxx so arranged for me to meet one of the trainee clinical psychologists um there at the time. So I went and kind of talked to her and she really um explained the road ahead in a way that was really kind of very scary I thought oh no. And what have I just done. And then um and then getting on to, after I did my degree, getting assistance jobs felt impossible really um so</p>	<p>Certainty-'knew she'd be CP' since 13, international school, experience of seeing school counsellor, 'cool job' –why? Did she get counselling? Told parents- met with some scepticism about emotional drain of job- 'hard job'. Wanted to redirect her, but she stayed focused- wanted to prove them she could do it? Pride? 'fell that way' 'a-levels in her favour' sounds like luck- but she must have worked hard! Undermining her hard work?</p> <p>Hard work of getting onto training. Not knowing what a CP was, researching using BPS, liked sound of it- what did she think CP did at time? Clueless about how to become CP.</p> <p>Talking to family friend-psychiatrist-linked to CP, explained "road ahead"- 'scary-on no' fear, realisation of work? "what have I done"- enormity of task- felt like she got it wrong?</p> <p>Impossibility and struggle to get AP posts</p>

<p>A journey of struggle- get onto training</p>	<p>I struggled with that for a while. Um and then decided to actually go and do a Masters see if it would help get on training and also just get jobs, get assistant jobs. Um which eventually it did. I did, while I was doing my Masters I was also, I also did a voluntary research assistant post um and you know kind of thinking about the controversies of of honorary posts and you know the kind of, the way that that it might maintain the kind of elitist thing. I mean that's not what I was thinking at the time, at the time I was thinking it's great, you know I've got some experience, I've got some experience. But now... But actually yeah no I so I was doing the Masters at the same time that I was doing the research assistant thing which was probably three hours every two or three weeks. Um and then at the same time I was working weekends and evenings in medical records doing kind of filing and things, just to kind of, just to get through.</p>	<p>Having do more study to 'help'- 'eventually' helped- drawn out/long process. Working voluntarily. Juggling multiple things.</p>
<p>Feeling guilty/colluding with an elitist system</p>	<p>Um and but then the honorary assistant post led to er my er paid assistant's post and I think they, they were at the same Trust so there's something about um having been there and being familiar with um with that particular Trust and with that system. And it it kind of is like who you, who you know? I mean my supervisor was different, it was a different team and a different project that I got the paid post for, but I think just the fact that I'd been around for a couple of years helped. Um so in that way yeah I don't see so that kind of that does further the idea of it's who you know and it can be quite an exclusive club and quite difficult to get onto assistant posts. But yeah it was that was part of the struggle was getting a Masters and then getting a..</p>	<p>Reference to Elitism? Didn't realise at the time, that she was working so hard to get on, power, blinded by desire to get onto training, looking back and realising injustice? having to 'get through' – struggle, push.</p>
<p>A journey of struggle- getting onto training</p>	<p>Um and but then the honorary assistant post led to er my er paid assistant's post and I think they, they were at the same Trust so there's something about um having been there and being familiar with um with that particular Trust and with that system. And it it kind of is like who you, who you know? I mean my supervisor was different, it was a different team and a different project that I got the paid post for, but I think just the fact that I'd been around for a couple of years helped. Um so in that way yeah I don't see so that kind of that does further the idea of it's who you know and it can be quite an exclusive club and quite difficult to get onto assistant posts. But yeah it was that was part of the struggle was getting a Masters and then getting a..</p>	<p>Fitting into a system- getting your foot in the door. 'who you know'. Having to be around for a couple of years- do your time and then you'll get noticed, become part of the system. Part of an exclusive club, - do you have to be a certain way to gain access? Please right people? Work hard?</p>
<p>'It's who you know'</p>	<p>Um and but then the honorary assistant post led to er my er paid assistant's post and I think they, they were at the same Trust so there's something about um having been there and being familiar with um with that particular Trust and with that system. And it it kind of is like who you, who you know? I mean my supervisor was different, it was a different team and a different project that I got the paid post for, but I think just the fact that I'd been around for a couple of years helped. Um so in that way yeah I don't see so that kind of that does further the idea of it's who you know and it can be quite an exclusive club and quite difficult to get onto assistant posts. But yeah it was that was part of the struggle was getting a Masters and then getting a..</p>	<p>Fitting into a system- getting your foot in the door. 'who you know'. Having to be around for a couple of years- do your time and then you'll get noticed, become part of the system. Part of an exclusive club, - do you have to be a certain way to gain access? Please right people? Work hard?</p>
<p>Fitting into difference/wanting a sense of belonging</p>	<p>Um and but then the honorary assistant post led to er my er paid assistant's post and I think they, they were at the same Trust so there's something about um having been there and being familiar with um with that particular Trust and with that system. And it it kind of is like who you, who you know? I mean my supervisor was different, it was a different team and a different project that I got the paid post for, but I think just the fact that I'd been around for a couple of years helped. Um so in that way yeah I don't see so that kind of that does further the idea of it's who you know and it can be quite an exclusive club and quite difficult to get onto assistant posts. But yeah it was that was part of the struggle was getting a Masters and then getting a..</p>	<p>Fitting into a system- getting your foot in the door. 'who you know'. Having to be around for a couple of years- do your time and then you'll get noticed, become part of the system. Part of an exclusive club, - do you have to be a certain way to gain access? Please right people? Work hard?</p>
<p>Colluding with an elitist system</p>	<p>And I think with applications and getting onto training, getting through training as well, I think there were times when you feel a bit um you feel a bit disadvantaged is the wrong word. It feels a bit maybe that it's a bit harder um but I've got nothing to compare that to in a way.</p>	<p>'getting through training' – struggle/push. Says disadvantaged but withdrew? Why? 'harder', can't compare to anyone else?</p>
<p>A journey of struggle</p>	<p>E: I was going to ask what do you mean by harder.. 20: You know.. I don't I don't.. Yeah. I don't know whether it is or not. Um sometimes I think er like with written work I I remember feeling sometimes that that I found it quite difficult compared to other people um but but again maybe that's just</p>	<p>Hesitation, 'I don't' 'umm', etc. Feels like she wants to say something about</p>
<p>Feeling different</p>	<p>E: I was going to ask what do you mean by harder.. 20: You know.. I don't I don't.. Yeah. I don't know whether it is or not. Um sometimes I think er like with written work I I remember feeling sometimes that that I found it quite difficult compared to other people um but but again maybe that's just</p>	<p>Hesitation, 'I don't' 'umm', etc. Feels like she wants to say something about</p>

<p>The struggle to speak about the unspoken</p>	<p>well you know when it's going well you don't notice and then when it's not then you think oh dear... And your fantasy is that everybody else gets this and I just don't.</p>	<p>unfairness/it being harder but can't. why is it hard to speak about? Taboo? Unspoken? Blaming self?</p>
<p>Facing cultural barriers</p>	<p>E: Yeah.. 20: Um but I think there is something about language and about um yeah about kind of how you put together an academic piece of work that I don't feel comes as naturally to me as it comes to some people. And my my explanation for that in a way is is the kind of living with multiple languages and um and it you know when when you're learning all the kind of grammar and sentence structure and all that then living in a family where where English isn't a first language and where where you don't have the same support. Um so yeah sometimes I kind of think I don't know what to write.. [laughter]. Um.. E: How many languages do you speak? 20: Seven. E: Oh wow ok, yeah.</p>	<p>Some things don't come naturally-academic. Bilingual, exposure to different languages, when English isn't first language. Systemic differences, less support from family, English driven course, feels like other people can get help from family?</p>
<p>Feeling different</p>	<p>20: So.. Yeah so I think there are times when when that when the academic side of it feels diff difficult or <u>different</u>, but I think that's just coming from m, that might not be a BME background thing, it might just be that that my family's very medical but but it's not academic in the same way psychology would have to be is much more wordy and much more language orientated. E: Yeah..</p>	<p>Difficulty with academia due to language barrier. Not attributed to BME but medical family background. Difference between medical and psychology- more language focused/reflective? Feels more academic? Report writing/reflective/research etc?</p>
<p>Feeling different Experiencing stereotypes Not being taken seriously as a CP Being othered</p>	<p>20: Um yeah and then you get on to training and then then people, there <u>there were people who kind of suggested that well yes you would get on, you know that that it would be easier for you to get on cos they're trying to have more diverse er work for us</u> and so you're I think everybody when you get on training has a bit of that <u>imposter syndrome anyway</u> and when people from your cohort or people who are qualified who just happen to work in your placement or whatever say that um that it's you know it's easier for you to get on because you're from a BME background. You think oh maybe I don't really deserve to be here maybe <u>they kind of went easier on me because</u> they want more BME clinicians. And then you know then you fail a piece of work and you th..say this this is what I was talking.. that I shouldn't be on this course. Um but you</p>	<p>Other people's opinions on getting on-easier if BME- diversification of psychology- different to how she felt-'hard work'. Feels like an imposter-doesn't belong, other people claim it's easier to get on, despite her struggle, minimizing, lost confidence.</p>

Internalised racism	forget that actually everybody has failed at least one piece of work, nobody goes th... I don't think anybody goes through without.. [laughter] maybe they do, who are these people!	Failing coursework- it being expected by others- pressure to prove worth/ show people she deserves a place.
Protecting/defending the self	Um you know.. but they're probably the ones who don't get corrections on their thesis. Um so yeah so so there's kind of, there's points at which you you do struggle and I think also the the need to be really assertive and er vocal with your opinions and structured and and that is something that, for me culturally, is is a struggle. Um	Having to defend the self against other seeing her as having easy ride/imposter Repetition of struggle.
A journey of struggle	because [sigh] you know without meaning to complain to David Cameron's er comments from the weekend about people being traditionally submissive... But um	Perceived ideal of CP- assertive, vocal, - goes against her cultural norms- political influence, English vs her family/cultural views. Bicultural influence. Gender differences in how women should behave, how to balance personal/family views when they conflict with professional identity?
Feeling different	but there is a thing about how it's not it's not nice for for girls or for women to be too strong in their opinions or too vocal about their opinions or so and but I think in my family that was never overtly said but I think the way that you're socialised is that you don't speak up so much. Um but with training being the way it is and getting onto courses being as it is, it it's almost the opposite of of that, you do need to be able to	Having to defend/protect the self- against people thinking you have an easy ride? Being vocal 'speak' 'stand up'
Being covered in stigma	speak up for yourself and you do need to stand up for yourself and be able to portray yourself in um to the best of your strengths. Um and that's something that, I think actually you know gender wise I think that's something that women generally are socialised against um but I think particularly from a British Asian point of view I think that's something that's particularly um that people particularly try to teach out of you. Um yeah and you do get those those those other pressures from from kind of cultural community groups and thinking well you know you're gonna get a Doctorate you know who's gonna want to marry you, you're gonna be you know because you'll be really qualified and so you know who's gonna who's gonna want to marry someone with a Doctorate I think well actually if they're going to be intimidated by that maybe I don't want to marry them.	Cultural values- expectations of getting married, stigma attached to education of women, part of her rebels against this – 'if intimidated I don't want to marry etc) – so cultural conflict of belonging/trying to balance to cultures. Family/community views on study? – less supported?
Protecting/defending the self	Um so it's all about you know what will happen. And because of the the unpredictable nature, cos you don't know when you're gonna get an assistant's job, and then you don't know how long you're gonna be an assistant before you get onto training, so you can't give a timescale so again like because like with the Asian community with marriage being such a [sigh] such a kind of central part to everything, they are like well	Unpredictability of getting on training vs certainty of marriage in 'Asian' community-clash. Other people wanting
Negotiating between cultural and professional identity		
Meeting with resistance from the community		
Resisting cultural expectations of women		

Facing a culture clash	<p>you know, how when when is that gonna happen and how are you going to, because you can't say after two years, after three years, after five years cos you don't know when you're gonna get on, when you're gonna get through. Um so that's something that people find really difficult to handle and that's something that I kind of struggled with trying.. <u>It was a conversation like I had to keep having with people from the community</u> and I think that there are peo.. other people that I know who did psychology at undergrad who wanted to be clinical psychologists who weren't as able to be as persistent and as yeah as firm in their kind of their their explanations and their need to kind of keep going with with this so they they were kind of lost to psychology because er it is so hard.</p>	<p>some certainty about marriage- external pressure.</p>
A journey of struggle	<p>E: Right. And I suppose moving on and thinking about now that you are a clinical psychologist, how would you describe yourself, as a clinical psychologist?</p>	<p>Multiple struggles, getting onto training, being on training- defend self, external struggles – community.</p>
Working hard	<p>20: ...how would I describe myself as a clinical psychologist... um I think hopefully open and curious and respectful. Um quite systemic in terms of theoretical approaches and er but also kind of critical, with a lot of critical and community ideas, so thinking about um yeah <u>thinking about power a lot and my position in terms of what my power is and the power or lack of for the families that you see.</u> Um and I think about myself as a clinical psychologist who is more than just, it's more than just being about that one-to-one or one family to one um in a room, it's also kind of supporting the social aspects of somebody's difficulties. Whether that's going to team around the child or social services meetings for for one family or writing housing letter for one family or whether it's about um you know writing to the government or or lobbying or you know contacting policy makers about things that I'm concerned about on a wider level. So I think that's that's as important with my role as a clinical psychologist, um as a kind of the clinical work.</p>	<p>Victims 'lost to psychology' too hard- have to be persistent,</p>
Reflecting on ones power	<p>E: And in terms of you talking about your journey to become a clinical psychologist, and some of the challenges that that's brought with it. How do you think that now impacts</p>	<p>Open, curious, respectful, systemic- due to family/community influence drawn to this? critical/community. Power.- advocate/ empowering/</p>
The self as an advocate	<p>E: And in terms of you talking about your journey to become a clinical psychologist, and some of the challenges that that's brought with it. How do you think that now impacts</p>	<p>More than just a therapist one to one- social/contextual factors – because they're important in her experience?</p>

<p>Working hard</p> <p>The self as an advocate</p> <p>Resisting cultural expectations of women</p> <p>A journey of self-discovery</p> <p>A journey of struggle</p> <p>A journey of self-discovery</p> <p>Making sacrifices</p> <p>Meeting with resistance from the community</p> <p>Rebuilding the self</p>	<p>on I suppose how you see yourself but also what does it mean to you to be a clinical psychologist now, given that sort of challenge?</p> <p>20: Yeah I think I'm <u>I'm really proud of of being a clinical psychologist</u>. I worked really hard to get here I think and I care a lot about the profession and I care about what it stands for and what it represents. I like to have a voice and a view on that and um so... yeah what was the rest of the question?</p> <p>E: I guess how does it impact on how you see yourself, almost.</p> <p>20: Yeah and I think all the things that that I had to develop in order to get here. I think maybe they were there already, but um but I see those as kind of part of like the characteristics as well in terms of being kind of determined and and strong-willed and focussed and all of those things that <u>got got me through that journey</u>. So I'm quite proud of having developed that range of skills. Um yeah um so that's how I see myself, but I think a lot of it was there before so I think always been very political. Even I even remember kind of being three or four years old and being quite kind of really interested in you know maybe because I grew up in a mining village in Scotland in the 80s so it's what's Thatcher doing then? I'm looking at... you know and so I knew the c.. I knew everybody in the cabinet at age of four or five, so um so maybe some of it was there. But yeah I think I think there is that kind of that it is really important and it is really, and <u>you're really aware of the sacrifices that you've made to get there</u>. Um because you do have to um you do have to be very focussed and very single-minded with it, and part of doing that especially through training was about I wouldn't say <u>socially isolating myself</u> but um definitely having to turn down a lot of family gatherings and family events kind of getting a bit of a reputation for for being the one who always says no to things. Um but then having to <u>rebuild that social life</u> after training, um so yeah so just kind of <u>being really aware of the sacrifices that I've made to get there, so I think, yeah think I had to invest in it and so yeah and it's worth it.</u></p> <p>E: And how do you think it, being a clinical psychologist sort of impacts on how other people view you or see you?</p>	<p>Pride, worked hard, cares about profession, likes to have a 'voice' – goes against family cultural values- women less vocal as she said earlier?</p> <p>Had to develop things in self? Determined, strong willed, focused, got her through- again 'having to get through' emphasising the struggle. Pride in skills.</p> <p>Political. Was interested as a child, impact of Thatcher on immigrants? Childhood influences.</p> <p>Having to make sacrifices, being single minded, focused, like an athlete, - having to 'turn down' social invites- getting a reputation in family saying 'no'. Got a reputation for saying no, not getting married, etc. Work of rebuilding life after training-</p> <p>Investment –worth it. Making sacrifices. Too much invested in career which makes it hard to talk about disadvantage earlier?</p>
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<p>Being misunderstood-professionally</p>	<p>20: Um I think there's different groups of people, there's one, there's one group of people who don't really know what that means, like they think that that makes you like a counsellor who just sees depressed people all the time, um and you have to kind of explain what what the role of a clinical psychologist is and you're back to writing your form again... Um so yes so there's people who don't really know what that means. Um but then often they'll see your name and they'll see the Doctor bit so they they kind of they think it's impressive because of the title. Um and I think I think other people see, people who are kind of in my family or my extended family er would see me as being quite hard working and committed to to that job, um without really understanding, again without really understanding what it is, you know. Um so I've got cousins who've got kids who are like three and seven and I was just kind of exp...and I think he, he was just asking well what do I do with this three year old, she's very very strong willed. Its like oh yeah, this this this and..., so I just kind of er talk through a few things um and like oh so is this, is this what you do in your job? Like, yes this is what I do in my job, this is what I've been doing since ages.. So um so I think they don't really understand the finer, the ins and outs of it, they know that it's a kind of psychologist and they know that it took a lot of hard work to get there, so they're impressed because of that. Um but in terms of what what clinical psychologists do as a profession I think people don't really know so much. Um like, yeah..</p> <p>Other people who are who are clinical psychologists er probably see me in in that in a way that I was talking about being kind of quite politically motivated and quite kind of community and clinical psychology driven, but also kind of working clinically in this kind of setting. Um so just happen, having those ideas in my kind of day to day work.</p> <p>E: Ok. Could you tell me about your experience as a clinical psychologist being from a BME background, um it's quite a broad question so..</p> <p>20: ..tell you about my experience of being a clinical psychologist from a BME background...</p> <p>E: Yeah, so I suppose, there's a few different areas I wanted to think about, so in terms of your experience with your clients, with your colleagues, um I think those were the two main ones..</p>	<p>Other people have different perceptions of CP. Being seen as a Counsellor-explain the difference</p> <p>Others as impressed by title- Dr status.</p> <p>Other people's lack of understanding about CP></p> <p>Family see her as hard working/committed.</p> <p>People don't understand finer details of job- frustration? Acceptance? When people don't understand leads to misunderstandings Others acknowledge hard work involved-impressed</p> <p>Other CPs view her as politically motivated, community/clinical</p> <p>Range of positive/negative experiences.</p> <p>Experiences of being matched with clients in terms of ethnic background-being seen as expert/sharing something with families from same background.</p>
<p>Being seen as a status</p>		
<p>Being seen as hard working</p>		
<p>Being misunderstood-professionally</p>		
<p>The self as an advocate</p>		

<p>Speaking about the unspoken</p>	<p>20: Yeah. I think there's, <u>there is a range of experiences that I've I've had. Um some of those were sometimes positive, sometimes a bit less so.</u> Um so I remember going to a placement actually before I qualified, but um where in the referral meeting or something they were saying oh so this family, we've known them for for some years and we've had limited progress with them but you know this is a British Asian family so we thought that if they see you then something different might happen. I think they <u>they talked about it very carefully um they didn't say well you're British Asian, they're British Asian so maybe it will maybe it will fix it. You know they didn't say anything like that but er but I think that was the hope with it because there were more similarities that that that a different kind of progress might happen.</u> As it happened it did... [laughter].</p>	<p>Struggle for people to name it in meeting, skirted around issue, taboo, maybe that's why she found it hard to talk about disadvantage earlier? Maybe that's why she wants to advocate!</p>
<p>Highlighting the homogeneity of culture</p>	<p>So so that was um that was interesting but also it was interesting for me and for that family because um because I was able to remember that actually in the same way that a white British clinician when they see a white British family or client isn't going to be exactly the same as them, so you still have to stay curious and stay open to those things you know and and one of the examples I always give is the mum from that family said oh you know and then my Grandmother did this and it all...and you know what Asian Grandmothers are like. And I was able to say well I've got I've got two, they're both very different, tell me about yours. So so kind of just noticing when we were both making assumptions that well actually this is just the British Asian way you know. Well no actually hang on you know what what do you mean by that and what do I mean by that. Um so not taking it as read that just having similar background would make us be on the same page.</p>	<p>Focusing on individuality of experiences despite shared culture/ethnicity.</p>
<p>Highlighting the heterogeneity of culture</p>	<p>Um but the other thing that's that has happened is that I'm able to do sessions in er different languages so I think so I do them do sessions sometimes in xxxx and or xxxx um where where that's the family's first language; um sometimes because the English isn't very strong and sometimes er because it's just easier for those families to to get their head around certain ideas if we're able to to use both the languages. Um so those have been quite positive things.</p>	<p>Not making assumptions when sharing background-</p>
<p>Highlighting the heterogeneity of culture</p>	<p>Um but the other thing that's that has happened is that I'm able to do sessions in er different languages so I think so I do them do sessions sometimes in xxxx and or xxxx um where where that's the family's first language; um sometimes because the English isn't very strong and sometimes er because it's just easier for those families to to get their head around certain ideas if we're able to to use both the languages. Um so those have been quite positive things.</p>	<p>In clinical practice- multiple languages are 'positive' in comparison to in academia/writing where it makes things harder.</p>
		<p>Anger of client associated with visible cultural markers of her being Muslim. Being visibly different.</p>

<p>Being 'covered' in stigma</p> <p>Being visibly different</p>	<p>Um I think there have been times when it's been difficult as well um so I remember, I went to I went to, during my adult placement I went to an adult in-patient psychiatric unit and there was a woman who um saw me and got very angry and was shouting and saying you know she's got to to leave I want her out of here because and it's all her fault. Cos I think she had a son who had died in Iraq who was a soldier um and then seeing somebody who looked very obviously Muslim she was like well this is your fault, it's your fault and you've got to go. Um so so that was, <u>that was my first thing of oh this can be quite, this can be difficult.</u> But I think with that you you could still have some sympathy because you could understand that within the context of her being quite unwell and you know and her life circumstances.</p>	<p>Difficulty of situation- having to sympathise with clients situation.</p> <p>Being seen as a 'bad fit' due to visible cultural/ethnic differences.</p>
<p>Being 'covered' in stigma</p>	<p><u>There were other times so you know when I work in quite an affluent part of town then um there are families who will just say I don't think you'll understand my family, I don't think you get us, you're not, you're not like us enough so can I see somebody else. Um so yes so some people aren't afraid to just say no, I don't think that you're you and I fit based on ethnicity basically.</u> Um so, yeah so there have been those kinds of times and there are times also when um when people can get quite abusive in sessions and that can be a really tricky to think to think about. Um I think they're, and you can take that to supervision you can take it to team discussions as well but <u>there's something a bit exposing about about saying you know this happened to me,</u> because you know when you get called kind of racist names or when you get told certain things, there's something a bit, there is something a <u>bit humiliating</u> about that and then having <u>to kind of re-live it with a team</u> can be quite difficult especially I think the very first time it happened was when and then people were trying to understand it from the point of view of the family.. I was thinking wh... just... what about me! I can see I can see that side of it as well but it was a very, they, <u>it's a very difficult conversation to have but I think as I get more qualified maybe as I get more senior or more experienced in having that conversation sadly um or have a er a kind of more long term relationship with my colleagues, it's it's easier to have that conversation um but at the</u></p>	<p>Facing abuse in sessions – tricky.</p> <p>Worries about discussing verbal abuse with colleagues- feels exposing, humiliating, shame- trauma- 'relive it' – bad experience of people emphasising with family- left her feeling othered? Not taken into consideration?</p>
<p>Feeling exposed or humiliated</p> <p>Being 'covered' in stigma</p>	<p><u>Time and experience may help to make conversations about racial differences/abuse easier? 'tricky' thing to manage.</u></p>	<p>Time and experience may help to make conversations about racial differences/abuse easier? 'tricky' thing to manage.</p>
<p>The psychological impact of stigma</p> <p>Being othered?</p>	<p>Balance between therapeutic stance (empathy) and NHS policy of zero tolerance of abuse. Protecting the self?</p>	<p>Balance between therapeutic stance (empathy) and NHS policy of zero tolerance of abuse. Protecting the self?</p>

<p>The dilemma of how to manage racism as BME a therapist</p>	<p><u>same time it's it's tricky. I think it's tricky for everyone to know how to handle it when it gets abusive because you know because what happens to those ideas of unconditional positive regard for for the family that you're seeing and at what point does, do you think well actually no because the NHS policy is that we don't tolerate um abuse towards staff you know.</u> So at what point do we say no and I think yeah and you're worried about what complaints might come out of it and so it's quite, it's quite difficult to to do anything with that kind of experience sometimes.</p>	<p>Worry about complaints, career, all she invested, sacrificed? Sometimes difficult to do anything with these types of experiences-<i>how is this processed?</i></p>
<p>Being positioned as a cultural expert</p>	<p>E: ...and you spoke, you've touched a little bit about what it's like when you're dealing with those difficult situations, um with clients, with colleagues. What's your experience like with colleagues more generally in the profession. Have you, do you have a similar or different experience with colleagues, or?</p>	<p>Offering cultural consultation. Being seen as a strength to a team because of ethnic background as well as experience of working in BME services. Port of knowledge for team.</p>
<p>Being a strength to the team</p>	<p>20: I think similar in some ways. Again you know <u>there are times when it's really positive um and when people are really interested to find out what you know um or people kind of come to you for almost for cultural consultation.</u> So you know so here I'm seeing this Muslim family or this British Asian family or this family from this other background. Not just because of my background but because they know that I've worked in BME services as well, um so you know so what do you think about you know what do you think might be going on for them. Just to er just to see if if there was some meaning to an event that they they didn't understand or they didn't have access to. So there <u>there are sometimes when it's quite positive and I'm seen as a strength to the team in that way.</u></p>	<p>Offering cultural consultation. Being seen as a strength to a team because of ethnic background as well as experience of working in BME services. Port of knowledge for team.</p>
<p>Experiencing insensitivity</p>	<p>Um um I think there are times when colleagues, I think colleagues who know you less well maybe, for for whatever reason, or.. not always colleagues that don't know you so well, but you can sometimes get comments like I've had um one person at a service that I went to, I did work with her in an open plan office we kind of sat near each other and she was just like oh it's such a shame that we don't get to see your hair. And I was thinking, well, really? And and so... [laughter] really? And I... and you're a therapist?</p>	<p>People who know you less well, make inappropriate comments – lack of awareness from colleagues in same profession.</p>
<p>Being 'covered' in stigma</p>	<p>Um you know so just kind of, so <u>sometimes you get those comments which are well</u></p>	<p>People who know you less well, make inappropriate comments – lack of awareness from colleagues in same profession.</p>

<p>Standing out as different</p> <p>Feeling different</p> <p>Trying to make sense of experiences</p> <p>Feeling misunderstood</p> <p>The psychological impact of stigma-rumination</p> <p>Facing silent collusion</p> <p>The elephant in the room</p> <p>Speaking about the unspoken</p>	<p><u>meaning I think um but just maybe just not aware of what what the implication of that is.</u> Um or um or things like so kind of when you're trying to arrange going out as a group of kind of trainees or um colleagues and saying and one person sent around an email so oh are you coming? If you're coming then we'll think about something else otherwise we were just going to go to the pub. I was thinking oh.. So in an email to everyone to like this many people you've named me as being the one who's gonna be the awkward one. That and so people sometimes I think don't don't always see how that can be experienced. I think it's <u>intention was to be inclusive but actually went about it in such a stupid way that that it was the opposite thing you know.</u></p> <p>Um but yeah so <u>sometimes I think when with colleagues and also with families you you try to think about what the intention behind a comment or an action was.</u> Um but <u>at the same time I think you do get a momentary jolt and you think oh and that's when you remember that actually I imagine that people understand me better than maybe they do.</u></p> <p>E: Yeah... How about in relation to um being with supervisors, what what's it like being a psychologist from a BME in those sorts of relationships?</p> <p>20: <u>Um I think it depends on the supervisor um obviously; um but there are times when it it's just there in the background.</u> I suppose when you're focussing on your own on the clinical work um and you're thinking about and you're able to talk about your ideas and their ideas and I think that's a good supervisory relationship um where or you can kind of say well this is what I understand this to be; this is what I um and whether and and then for that.. Sometimes it's helpful for that to be pointed out like oh you know and and that's some... Cos sometimes my supervisor will say and that's something that you're very good at noticing because of these things, you know. Um so yeah so sometimes it's it again it can work well um when we're able to talk openly about a particular issue. Sometimes it can be a bit difficult um I'm trying to think of when it's been.. It's one of those things where you wonder, I I had a meeting, a team around the child meeting recently where I think the family's experience <u>my</u></p>	<p>Lack of cultural sensitivity from colleagues</p> <p>Being excluded through inclusion- being outed/othered, made to feel different. Being seen as a problem, getting in the way of usual plans.</p> <p>Having to see beyond and look deeper into well intentions of things said that might be offensive. Protect the self? Questioning, do people understand her or is it lack of awareness? Uncertainty?</p> <p>BME Lurking in the background-not spoken about in supervision. Whose responsibility is it to raise this?</p> <p>Supervisors as identifying strengths based on BME identity. – able to talk openly.</p>
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<p>The self as an advocate</p> <p>Being seen as a 'victim'?</p> <p>Speaking about the unspoken</p> <p>Speaking about the unspoken</p> <p>Bring Covered in stigma</p>	<p>understanding of it is er kind of comes from everybody else having a kind of an institutional racism about it just kind of having a disconnecting cultural understanding of where this family's coming from. Um and so I felt very much pushed into a position of defending the family against this this team um and then the worry in supervision is kind of being the one who always talks about racism or being the one who always brings this up. But I don't think I am and I think I've you know and <u>sometimes when when it happens to me when families when a parent will say I don't want to work with you I want somebody else then it's really helpful for my supervisor and my manager to then be the ones who say well that sounds a bit racist and for it to not have to always fall to me.</u></p> <p>E: Yeah...</p> <p>20: <u>Because I think when I think there is there are times when you're white british colleagues have to speak up or they have to they have to have that conversation for you because you're because of their position.</u> Um yeah so it's it's up to the people who in terms of kind of power hierarchy so people who hold the power to to use their voice as well you know. Um mmm..</p> <p>E: I wonder in your experience, has that been the case that you've felt that your you know white british colleagues have been able to do that or do you find that they're more reluctant to maybe or maybe not even aware to sort of raise...something?</p> <p>20: I think different colleagues are more or less aware depending on maybe their own journeys or their own work so kind of white British colleagues who work in for example BME services or who work in a very critical or community psychology background are more aware of power differences and more able to spot and talk about those things. I think er a white British male of a of a middle class background who has only ever done CBT is less aware um or.. Maybe I mean not less aware, I think if you if you said oh this is the thing that happened to me I think they would all be equally shocked about it, but then in terms of what you do next I, you know and what you do with that feeling I think ah yeah different colleagues would would support you in different ways. Um yeah so like I had somebody recently in this building, not a patient just somebody who</p>	<p>Institutional racism, unintentional? Not listening to the family? Being able to identify with families, drawn to defend families, being forced to defend families in the face of racism, but being seen as a troublemaker, 'the one who' being labelled.</p> <p>Being able to call discrimination/racism what it s. being able to vocalise vs not being able to.</p> <p>Power, hierarchies, others needing to advocate, have a voice on her behalf, when talking about racism, to avoid her being labelled as 'the one who always' Who takes responsibility for raising race and culture issues</p> <p>Individual precipitating factors</p> <p>Differences in White British colleagues in terms of advocating, speaking up-the difficulty of speaking about power/difference. Something you need experience in. Experience of shock, but little follow through. People don't always know what to do next.</p>
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<p>Being Covered in stigma</p>	<p>was here, saying um that I shouldn't be allowed to work here cos er and we should be like France and not allow scarves in public places and [inaudible] This is my place of work actually, you know and kind of and really saying that that yeah that I shouldn't be here and it was disgusting or something.</p> <p>E: Was that a complete stranger?</p> <p>20: A complete stranger in the lift, yeah. Somebody who had come to visit somebody else. So it wasn't even, so yeah um and then I was able to come in and kind of just vent about that and some people were like oh yes, everybody was like oh that's awful. Um then I told some other people and they were like no you should you should, that's actually something you could go to the police with, you know and this is how you do it. And so I think some people were more practical and more more thinking about empowering me in that situation and other people were just oh well that's outrageous and that shouldn't happen. So yes so you had a kind of scale of people's responses.</p>	<p>Being made to feel different by patients, others feeling like she doesn't belong, visible difference, all the societal prejudices the hijab represents.</p>
<p>Facing silent collusion</p>	<p>Um then I told some other people and they were like no you should you should, that's actually something you could go to the police with, you know and this is how you do it. And so I think some people were more practical and more more thinking about empowering me in that situation and other people were just oh well that's outrageous and that shouldn't happen. So yes so you had a kind of scale of people's responses.</p> <p>E: How how do you feel about your or what has been your experience being a clinical psychologist from a BME background in terms of your sort of professional development. So is there anything you can maybe speak about in terms of what that's been like and as a qualified psychologist?</p>	<p>Stigma surrounding head scarf- colleagues responses ranged from trying to empower (go to police) to disempowered (empathic but no practical response)</p>
<p>Tricky professional development</p>	<p>20: Um my <u>professional development since qualifying I think it's a tricky one because um I think well you know um the first thing to say is that I think that I've had access to to all the CPD courses that I've wanted to go on and and that in terms of having time off from it, um but I think because of where the NHS is at the moment so those kinds of opportunities are quite difficult in terms of because a lot of them have to be self funded or largely self funded and they're quite expensive, so um so in that way we're not kind of develop developing professionally as maybe somebody who qualified seven or eight years ago would be. Um and I think also in terms of moving up the bandings er because there aren't jobs or because of the way that um you you know often now if you want to get an 8A position for example then you have to leave the service that you're in and you think well and so you can sometimes get stuck in a you know if I wait a bit longer I might ... they might change this job cos actually I really like this job or so you can sometimes get caught in in that. Um <u>I don't think that's to do with being from</u></u></p>	<p>'tricky' professional development- funding issues</p> <p>Issues with professional development</p>
<p>Feeling different</p>	<p>Um <u>I don't think that's to do with being from</u></p>	

<p>Feeling grateful</p>	<p><u>a BME background I think that's a kind of wider state of the NHS um but I don't know whether some of those things that that I was talking about before training about kind of not being as assertive or the kind of agenda ideas that come up whether that's part of not being as pushy for or not negotiating as hard and just being grateful that you've got a job you know..</u></p>	<p>Universal struggles with professional development</p>
<p>Feeling grateful</p>	<p>E: Yeah..</p>	<p>Some things like not being assertive, being grateful for a job- BME</p>
<p>Others sense of entitlement</p>	<p>20: Um because I do see other other colleagues who are who seem more able to when they're moving jobs or or going into a new contract being able to negotiate all this stuff and that it just wouldn't occur to me, I'd just be like you know yeah yes please [laughter] yes please where do I sign, you know and they're like no no I don't want this I want more and I want this or I want more days off or I want a longer more study leave or I want.. And people enter into negotiations and that's not something that that I do and I wonder whether it is part, whether it's just me or that it's part of of that thing of actually it's not nice for a woman to be so demanding. Or it's not nice or</p>	<p>More of a sense of entitlement for non BME CPS= harder to negotiate for BME due to cultural differences in how women behave? – having to work harder, give more, expect less.</p>
<p>Feeling grateful</p>	<p>actually as a BME clinician you're just lucky that we're letting you work here, you know, that's not what anybody says but there's there's a kind of internal, I suppose that internalised racism bit where where you think you know I should I should just be grate.. just keep your head down and just work hard and just be grateful for what you've got and and so maybe feel less able to make those demands or to go into those kinds of negotiations.</p>	<p>Cultural/gender differences in negotiation Feeling lucky/grateful – expects to be treated differently, not negotiate, ask for more.</p>
<p>Exploring the heterogeneity of culture</p>	<p>E: That's interesting to think about um.. Um I have quite a few questions that I still want to ask so, I think you've touched on some of these already um.. I suppose I'll move on to some more reflective questions about the impact of your ethnicity on your professional identity. How would you say your sort of ethnicity influences your clinical practice?</p>	
<p>Acknowledging multiple truths: social constructivist position</p>	<p>20: Um I think kind of living in different cultures um helps me to to to be aware that that different people find different meaning from the same thing. Um or people fi.. have a different understanding of each thing so it helps me to to remember to explore that and to not assume that because I would find it a particular way that that somebody else would find it that way as well, you know. Um so you know so when a parent said that their dad passed away six months ago, then it's not oh then I'm really</p>	<p>Bicultural influence, meanings assigned to things, not make assumptions, be curious, open to exploring meaning, not</p>

<p>Facing silent collusion</p> <p>Being 'covered' in stigma</p> <p>Experiencing microaggressions</p>	<p>sorry, how sad for you, but actually how is that? Um and to find out yeah I think that it helps me to be more curious because I'm just because in my day to day life professionally and personally um things have, different people take different meanings from from something.</p> <p>And I think also being able to explain things um or yeah to to use non jargon language I suppose and to to try to illustrate things because again living different languages and trying to explain different experiences to different generations of my family well why is it like this.. So because I've been doing that from a very early age so it that bit of socialising families to a model or kind of finding a way of talking about something that means something to the people in front of you, that that comes easier.</p> <p>E: What would you say are some of the challenges of being, and again I think you've touched on this a little bit already, um what are some of the challenges do you feel are of being a minority clinician within the profession?</p> <p>20: <u>I think there is there is that kind of that institutionalised racism that we've talked about. Um and you don't know where it's going to come from because we don't really um because we don't talk about it in the same or you don't expect it to happen so something when it does happen you're quite blind-sided by it.</u> Particularly if it's something that's very overt and very er blatant um but actually I think it happens in in lots of subtle ways that are are less less easy to challenge um and less easy to point out to people without coming across as a victim. Um and I think that that's a challenge. Whether that's for yourself or whether it's for a family that you're seeing, that when you can when you see that this is this is something that's structurally not fair um then then I think some sometimes colleagues find that quite difficult to to take on. Some colleagues more than others I think colleagues who maybe haven't been as disadvantaged or who don't who you know we talk about the kind of the invisible back pack of privilege so <u>I think people for whom their privilege is quite invisible where they're not quite so aware I think you know I've had comments from colleagues where I've said you know it was really difficult when this family said they they didn't want a Muslim or Asian therapist or you know um and then they said well you know that's just</u></p>	<p>assigning meaning or cultural ways of doing/responding onto people. Is this linked to her feeling like people do this to her in the workplace with the pub situation etc?</p> <p>Breaking things down, simplistic, draws from early experiences – systemic – generations</p> <p>Institutional racism. Unexpected, take her by surprise, different types of racism, overt and blatant vs subtle. – harder to point out, worry you'll be seen as a victim.</p> <p>Invisible back pack of privilege: lack of awareness from colleagues whose privilege is invisible</p>
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<p>Being seen as the same as everyone else</p>	<p>life you have to suck it up and I get told they don't want to see me they want to see somebody else and I was like mmm... yeah... but no.... So so yeah so the more subtle challenges are difficult to to raise um yeah and I think you do have um.. ..what are the disadvantages, that was the question wasn't it, what are the disadvantages.. E: Yeah the disadvantages or challenges.. 20: Yeah. E: ..yeah you sort of experience. 20: And I think socially as well like in terms of the communities that you're you're from I think um there are some people who see er psychology as a as a white western thing um and think that you've sold out or become white or a coconut or you know um so you get that kind of thing from people within the community as well who don't quite understand what the job's about.</p>	<p>Being treated like everyone else, dismisses the visible differences of her wearing a hijab. Makes her colourless. Colourblindness – invalidates her experiences.</p>
<p>Meeting with resistance from the community</p>	<p>E: Yeah and then I guess on the flip side what would you say are some of the positives and again I know you've touched on this already, you were talking about how it can be quite nice to be able to bring your self to to the, like can you think of any other ways in which it's beneficial being from a minority background as a clinician? 20: I think maybe that that you've got lived experience of the power hierarchies whether that's kind of again ethnicity or gender or faith or you know across the graces but but having a kind of deeper richer experience of of the power hierarchies and you can talk to the families about that and talk to other um other clinicians and er kind of assistants and trainees as well and kind of say actually it is possible and it's hard but I mean yes it is hard for everybody else as well and it's hard in different ways um but but it's also OK to talk about it and um yeah I think that's a that's an advantage to to being from.. yeah.</p>	<p>Stigma from within own community- being seen as 'selling out, coconut, bounty'- lack of awareness</p>
<p>The self as an advocate</p> <p>Speaking about the unspoken</p>	<p>E: Yeah. How would say you feel about diversity within clinical psychology? 20: Um I think I feel quite frustrated about the profession as a whole. I think there are some I think there are lots of clinicians who do um er do care about diversity I think you know the inclusion and diversity document recently came out um from the BPS or was it DCP? Um so I think people there are people who do care about diversity and</p>	<p>Lived experience of oppression, hierarchies, using experience to talk about things, opening up dialogue about unspoken, hard to talk about things – increasing awareness, having a voice</p>
<p>Feeling frustrated</p>	<p>E: Yeah. How would say you feel about diversity within clinical psychology? 20: Um I think I feel quite frustrated about the profession as a whole. I think there are some I think there are lots of clinicians who do um er do care about diversity I think you know the inclusion and diversity document recently came out um from the BPS or was it DCP? Um so I think people there are people who do care about diversity and</p>	<p>Frustration – profession doesn't care about diversity.</p>

Facing silent collusion	<p>they do think that we need a more diverse profession and I agree with that because we need to reflect the experiences of people that we are meant to be helping. And I think if we have within our teams a richer bank of experiences we're better able to support other people. But I think also in terms of kind of social mobility why shouldn't you know why shouldn't this be a profession that's accessible to everybody who's who is able to to kind of to be a thoughtful and professional clinician, um and why should it be just for people who are able to afford honorary assistantships or who have been to the best schools or you know so all of those things I don't... I do think it's important for for any profession to be diverse but I think especially for this one because we're talking about people's experiences, I think it's important for our profession to be diverse. Um I don't think it is, and I think it feels that actually it's taking steps backward rather than forwards um in terms of diversity I think things like the race and culture faculty being disbanded was a huge blow um and it's really hard to think to see the BPS, the DCP taking diversity seriously when there's when there was this faculty within the DCP that um that other faculties and other divisions looked up to and we want to be more like them. And that they were putting that the output was was so great and the influence um you know just so important and then for on a minor technicality for it to be disbanded. And it just, it it had the feeling of that they were just waiting for you know just give us any excuse, any and I'm sure that's not the case but it did just feel like you know for the smallest thing especially when you hear that actually other faculties had similar difficulties but they were supported through them, um and this one wasn't. Um and I think that kind of that institutional racism played out or, and also the kind of the unfortunate thing of that of it being [inaudible] the <u>the white british man at the top of the tree got to say what the the ethnic minorities were and weren't allowed to do, you know and actually no we're gonna shut this down.</u> Um I think that was a huge blow.</p> <p>I think the way courses are selecting candidates now er for training um is going towards the less and less diverse route um because um you know although they're looking at academic skills but I think they're um I think, it sounds like an odd thing to say but it's almost too academic because I think just because somebody's got great A</p>	<p>Social mobility-making the profession more accessible, becoming more representative of client group.</p> <p>Profession taken a step back in terms of diversity.</p> <p>Feeling suspicious of motives of the disbanding of the faculty</p> <p>The challenges of institutional racism Race and power</p> <p>Identifying on-going challenges with recruitment</p>
The self as an advocate		
Using a racial lens to make sense of experience		
Institutional racism		
Feeling sad		

	<p><u>clinicians a different way of understanding things as well.</u> So I think actually the the people who who for me in my life have have the strongest handle on diversity and ethnicity and and thinking about power and thinking about institutionalised racism and um micro aggressions and all of those things are actually white British clinicians um so I don't think it's it's the preserve of a BME clinician but I think that that by bringing your life experiences you can add to those discussions and add people's um understandings.</p>	<p>Having positive experiences with colleagues who have a handle on race and culture issues</p>
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Appendix J: Classification system for personal constructs

Construct category	Definition	Example
Moral	Constructs concerning the moral values of the element, e.g., their kindness, generosity and fairness	Good-bad Altruist-egoist Humble-proud Respectful-judgmental Faithful-unfaithful Sincere-insincere Just-unjust Responsible-irresponsible
Emotional	Constructs concerning the degree of emotionality or sexuality of the element described, to his or her emotional attitude towards life or with regard to certain specific feelings	Visceral-rational Warm-cold Optimist-pessimist Balanced-unbalanced Happy-sad Satisfied-unsatisfied Sexual-frigid
Relational	Constructs concerning all of those aspects that describe types of relationship with others	Extroverted-introverted Pleasant-unpleasant Direct-devious Tolerant-authoritarian Conformist-rebel Dependent-independent Peaceable-aggressive Sympathetic-unsympathetic Trusting-suspicious Strong-weak
Personal	Constructs concerning a variety of characteristics traditionally pertaining to the area of personality, character or way of being. It excludes those traits typically thought of as moral, relational or emotional, since these have been included in previous areas	Active-passive Hardworking-lazy Organized-disorganized Decisive-indecisive Flexible-rigid Thoughtful-shallow Mature-immature Self-acceptance-self-criticism
Intellectual/operational	Constructs concerning skills, abilities and knowledge both at the intellectual and operational levels	Capable-incapable Intelligent-dull Cultured-uncultured Focused-unfocused Creative-not creative
Values and interests	Constructs concerning ideological, religious or distinct values as well as diverse interests and hobbies	Conservative-liberal Traditional-progressive Idealist-materialist Spends little-spends money Athletic-bookish
Existential	Constructs concerning central existential projects or appraisals, often of the respondent's own core sense of self or life, bearing on issues of purpose, meaning or ultimate direction	Purposeful-purposeless Growth-stagnation Fulfillment-emptiness
Concrete	Constructs concerning concrete, as opposed to abstract, features or positions of people, as well as their actions	Attractive-ugly Male-female Has family-is single Rich-poor Talks quickly-talks slowly Has much time-has little time

Appendix K: Recurring themes across participants

Master Themes	Participants						Present in over half sample?
	1	2	3	4	5	6	
Standing out as different							
Feeling like an outsider		✓	✓	✓		✓	YES
The double edged sword of standing out	✓	✓	✓		✓		YES
Being positioned as the expert	✓		✓	✓	✓	✓	YES
Negotiating cultural and professional values							
The dilemma of remaining true to myself		✓	✓	✓	✓		YES
Searching for credibility		✓	✓		✓	✓	YES
Sitting with uncertainty							
Difference: The elephant in the room	✓	✓	✓	✓	✓		YES
Working hard to interpret the unspoken	✓	✓	✓	✓		✓	YES
Feeling privileged to be a clinical psychologist							
Valuing gaining a professional identity	✓		✓	✓	✓	✓	YES
Feeling proud of making it	✓	✓	✓	✓	✓	✓	YES

Appendix L: Priya repertory grid output

Slater Analyses for Blank Grid

Original Grid (Blank Grid)

	Self as I really am	Self at work	Ideal self	Self as trainee	Self prior to training	BME Clinical Psychologist	White Clinical Psychologist	Ideal Clinical Psychologist	How BME colleagues see me	How White colleagues see me	How BME clients see me	How White clients see me	
Limited awareness of difference	1.00	2.00	1.00	3.00	3.00	1.00	4.00	1.00	1.00	2.00	2.00	4.00	Awareness of difference
Questioning practice	3.00	3.00	1.00	5.00	6.00	3.00	2.00	3.00	3.00	3.00	2.00	2.00	Practice easily defined
Personal belief systems	6.00	2.00	6.00	4.00	5.00	2.00	4.00	4.00	2.00	3.00	4.00	6.00	Awareness of
professional boundaries													
Being seen as a professional	5.00	6.00	6.00	3.00	4.00	6.00	4.00	6.00	6.00	6.00	6.00	3.00	Not being seen as a
professional													
Having less knowledge/Naivety	2.00	2.00	2.00	4.00	5.00	2.00	2.00	1.00	2.00	2.00	2.00	3.00	having more
knowledge/respect													
Uneasy	2.00	2.00	1.00	4.00	3.00	3.00	2.00	1.00	2.00	2.00	2.00	3.00	Comfortable
Unsure of self	2.00	3.00	1.00	4.00	4.00	3.00	2.00	1.00	2.00	3.00	2.00	4.00	Sure of self
Cultural responsiveness in practice	6.00	6.00	6.00	1.00	3.00	6.00	2.00	7.00	6.00	6.00	6.00	4.00	Rigidity sticking to
theory/practice models													
Envisage difference	4.00	4.00	4.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	2.00	6.00	seeing similarity
True self	6.00	5.00	7.00	5.00	6.00	6.00	6.00	6.00	6.00	5.00	6.00	4.00	Perceived identity/how
others see you													
Greater power	4.00	3.00	4.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	5.00	3.00	lesser power
In limbo	2.00	2.00	2.00	6.00	3.00	2.00	2.00	1.00	2.00	2.00	2.00	3.00	Certainty of self

Grid Deviations

	Self as I really am	Self at work	Ideal self	Self as trainee	Self prior to training	BME Clinical Psychologist	White Clinical Psychologist	Ideal Clinical Psychologist	How BME colleagues see me	How White colleagues see me	How BME clients see me	How White clients
see me												
Limited awareness of difference	-1.08	-0.08	-1.08	0.92	0.92	-1.08	1.92	-1.08	-1.08	-0.08	-0.08	1.92
Questioning practice	0.00	0.00	-2.00	2.00	3.00	0.00	-1.00	0.00	0.00	0.00	-1.00	-1.00
Personal belief systems	2.00	-2.00	2.00	0.00	1.00	-2.00	0.00	0.00	-2.00	-1.00	0.00	2.00
Being seen as a professional	-0.08	0.92	0.92	-2.08	-1.08	0.92	-1.08	0.92	0.92	0.92	0.92	-2.08
Having less knowledge/Naivety	-0.42	-0.42	-0.42	1.58	2.58	-0.42	-0.42	-1.42	-0.42	-0.42	-0.42	0.58
Uneasy	-0.25	-0.25	-1.25	1.75	0.75	0.75	-0.25	-1.25	-0.25	-0.25	-0.25	0.75
Unsure of self	-0.58	0.42	-1.58	1.42	1.42	0.42	-0.58	-1.58	-0.58	0.42	-0.58	1.42
Cultural responsiveness in practice	1.08	1.08	1.08	-3.92	-1.92	1.08	-2.92	2.08	1.08	1.08	1.08	-0.92
Envisage difference	0.17	0.17	0.17	-0.83	-0.83	0.17	0.17	0.17	0.17	0.17	-1.83	2.17
True self	0.33	-0.67	1.33	-0.67	0.33	0.33	0.33	0.33	0.33	-0.67	0.33	-1.67
Greater power	0.33	-0.67	0.33	-0.67	-0.67	-0.67	0.33	0.33	0.33	0.33	1.33	-0.67
In limbo	-0.42	-0.42	-0.42	3.58	0.58	-0.42	-0.42	-1.42	-0.42	-0.42	-0.42	0.58

Note. Deviations from construct means.

Descriptive Statistics for Elements [Blank Grid]

	Means	Sum of Squares	Percent Total Sum of Squares
Self as I really am	0.09	7.35	3.86
Self at work	-0.16	7.52	3.94
Ideal self	-0.08	17.52	9.19
Self as trainee	0.26	46.52	24.39
Self prior to training	0.51	26.52	13.90
BME Clinical Psychologist	-0.08	8.85	4.64
White Clinical Psychologist	-0.33	15.35	8.05
Ideal Clinical Psychologist	-0.24	14.69	7.70
How BME colleagues see me	-0.16	8.19	4.29
How White colleagues see me	0.01	4.19	2.20
How BME clients see me	-0.08	9.02	4.73
How White clients see me	0.26	25.02	13.12

Note. Values are based upon deviation matrix in which construct means were removed from the original grid scores.

Total SS: 190.75

Element Direction Cosines (correlations)

	Self as I really am	Self at work	Ideal self	Self as trainee	Self prior to training	BME Clinical Psychologist	White Clinical Psychologist	Ideal Clinical Psychologist	How BME colleagues see me	How White colleagues	How BME	How
see me												
clients see me												
White clients see me												
Self as I really am	1.00											
Self at work	-0.41	1.00										
Ideal self	0.74	-0.26	1.00									
Self as trainee	-0.49	-0.40	-0.66	1.00								
Self prior to training	-0.26	-0.42	-0.58	0.77	1.00							
BME Clinical Psychologist	-0.23	0.82	-0.15	-0.36	-0.38	1.00						
White Clinical Psychologist	-0.39	-0.42	-0.13	0.35	0.15	-0.55	1.00					
Ideal Clinical Psychologist	0.58	0.34	0.63	-0.90	-0.70	0.33	-0.43	1.00				
How BME colleagues see me	-0.09	0.75	0.11	-0.57	-0.59	0.82	-0.47	0.63	1.00			
How White colleagues see me	-0.13	0.86	-0.08	-0.58	-0.54	0.66	-0.53	0.50	0.72	1.00		
How BME clients see me	0.27	0.09	0.50	-0.55	-0.50	0.10	-0.20	0.51	0.36	0.34	1.00	
How White clients see me	-0.06	-0.38	-0.23	0.40	0.28	-0.54	0.39	-0.58	-0.76	-0.38	-0.60	1.00

Note. Values reflect angle cosines (correlations) between elements in the full component space.

Element Euclidean Distances

	Self as I really am	Self at work	Ideal self	Self as trainee	Self prior to training	BME Clinical Psychologist	White Clinical Psychologist	Ideal Clinical Psychologist	How BME colleagues see me	How White colleagues	How BME	How
see me												
clients see me												
White clients see me												
Self as I really am	0.00											
Self at work	4.58	0.00										
Ideal self	2.83	5.57	0.00									
Self as trainee	8.49	8.31	10.10	0.00								
Self prior to training	6.40	6.78	8.31	4.36	0.00							
BME Clinical Psychologist	4.47	1.73	5.48	8.37	6.86	0.00						
White Clinical Psychologist	5.57	5.66	6.08	6.56	6.00	6.08	0.00					
Ideal Clinical Psychologist	3.16	3.87	3.46	10.39	8.31	4.00	6.56	0.00				
How BME colleagues see me	4.12	2.00	4.80	8.77	7.21	1.73	5.83	3.00	0.00			
How White colleagues see me	3.61	1.41	4.80	8.19	6.48	2.24	5.29	3.32	2.00	0.00		
How BME clients see me	3.46	3.87	3.74	8.83	7.14	4.00	5.39	3.46	3.32	3.00	0.00	
How White clients see me	5.83	6.56	7.21	6.63	6.08	7.07	5.00	7.87	7.42	6.08	7.21	0.00

Element Euclidean Distances (standardized)

	Self as I really am	Self at work	Ideal self	Self as trainee	Self prior to training	BME Clinical Psychologist	White Clinical Psychologist	Ideal Clinical Psychologist	How BME colleagues see me	How White colleagues see me	How BME clients see me	How White clients see me
Self as I really am	0.00											
Self at work	0.78	0.00										
Ideal self	0.48	0.95	0.00									
Self as trainee	1.44	1.41	1.71	0.00								
Self prior to training	1.09	1.15	1.41	0.74	0.00							
BME Clinical Psychologist	0.76	0.29	0.93	1.42	1.16	0.00						
White Clinical Psychologist	0.95	0.96	1.03	1.11	1.02	1.03	0.00					
Ideal Clinical Psychologist	0.54	0.66	0.59	1.76	1.41	0.68	1.11	0.00				
How BME colleagues see me	0.70	0.34	0.81	1.49	1.22	0.29	0.99	0.51	0.00			
How White colleagues see me	0.61	0.24	0.81	1.39	1.10	0.38	0.90	0.56	0.34	0.00		
How BME clients see me	0.59	0.66	0.64	1.50	1.21	0.68	0.91	0.59	0.56	0.51	0.00	
How White clients see me	0.99	1.11	1.22	1.13	1.03	1.20	0.85	1.34	1.26	1.03	1.22	0.00

Note. Values are standardized around the expected distance between random pairings of elements. For this grid: 5.89.

Eigenvalue Decomposition

	Eigenvalue	% Variance	Cumulative %	Scree
PC_1	107.79	56.51	56.51	*****
PC_2	33.38	17.50	74.01	****
PC_3	18.78	9.84	83.85	***
PC_4	14.37	7.53	91.38	***
PC_5	6.54	3.43	94.81	**
PC_6	4.93	2.59	97.40	**
PC_7	2.77	1.45	98.85	*
PC_8	1.26	0.66	99.51	*
PC_9	0.63	0.33	99.84	*
PC_10	0.27	0.14	99.99	*
PC_11	0.03	0.01	100.00	*

Element Loadings

	PC_1	PC_2
Self as I really am	-1.23	1.56
Self at work	-1.28	-1.87
Ideal self	-2.75	2.61
Self as trainee	6.47	-1.18
Self prior to training	4.27	-0.85
BME Clinical Psychologist	-1.46	-2.18
White Clinical Psychologist	1.80	1.60
Ideal Clinical Psychologist	-3.57	0.26
How BME colleagues see me	-2.09	-1.71
How White colleagues see me	-1.28	-1.01
How BME clients see me	-1.92	0.10
How White clients see me	3.04	2.68

Note. Values for plotting elements in the component space.

Element Eigenvectors

	PC_1	PC_2
Self as I really am	-0.12	0.27
Self at work	-0.12	-0.32
Ideal self	-0.26	0.45
Self as trainee	0.62	-0.20
Self prior to training	0.41	-0.15
BME Clinical Psychologist	-0.14	-0.38
White Clinical Psychologist	0.17	0.28
Ideal Clinical Psychologist	-0.34	0.04
How BME colleagues see me	-0.20	-0.30
How White colleagues see me	-0.12	-0.17
How BME clients see me	-0.18	0.02
How White clients see me	0.29	0.46

Construct Loadings

	PC_1	PC_2
Limited awareness of difference	3.04	1.04
Questioning practice	2.73	-2.51
Personal belief systems	1.28	4.39
Being seen as a professional	-3.80	-1.31
Having less knowledge/Naivety	3.12	-0.43
Uneasy	2.42	-0.97
Unsure of self	2.87	-1.15
cultural responsiveness in practice	-5.97	-0.53
Envisage difference	-0.08	1.25
True self	-1.23	0.23
Greater power	-1.25	0.61

In limbo 3.54 -0.55

Construct Eigenvectors

	PC_1	PC_2
Limited awareness of difference	0.29	0.18
Questioning practice	0.26	-0.44
Personal belief systems	0.12	0.76
Being seen as a professional	-0.37	-0.23
Having less knowledge/Naivety	0.30	-0.07
Uneasy	0.23	-0.17
Unsure of self	0.28	-0.20
cultural responsiveness in practice	-0.58	-0.09
Envisage difference	-0.01	0.22
True self	-0.12	0.04
Greater power	-0.12	0.11
In limbo	0.34	-0.09

Note. Values for orienting (drawing) constructs in component space.

{Graph Created: Blank Grid / PC_1 vs. PC_2 (Slater)}

Implicative Dilemmas for Blank Grid

Elements Compared: Self at work vs. Ideal Clinical Psychologist
 Scale Midpoint set as Discrepancy Criterion = 4
 Construct Congruence Criterion = 0.2

Discrepant Constructs

Note. Total number of Discrepant Constructs = 0

Congruent Constructs

Limited awareness of difference
Questioning practice
Being seen as a professional
Having less knowledge/Naivety
Uneasy
Unsure of self
cultural responsiveness in practice
True self
In limbo

Note. Total number of Congruent Constructs = 9

Undifferentiated Constructs

Personal belief systems
Envisage difference
Greater power

Note. Total number of Undifferentiated Constructs = 3

Implicative Dilemmas

*Note. Total number of Implicative Dilemmas = 0
Percentage of Implicative Dilemmas = 0.00*

Dilemmas in Sentence Form

Note. No Dilemmas were found in the grid.

Implicative Dilemmas for Blank Grid

Elements Compared: BME Clinical Psychologist vs. Ideal Clinical Psychologist
Scale Midpoint set as Discrepancy Criterion = 4
Construct Congruence Criterion = 0.2

Discrepant Constructs

Note. Total number of Discrepant Constructs = 0

Congruent Constructs

Limited awareness of difference
Questioning practice
Being seen as a professional
Having less knowledge/Naivety
Uneasy
Unsure of self
Cultural responsiveness in practice
True self
In limbo

Note. Total number of Congruent Constructs = 9

Undifferentiated Constructs

Personal belief systems
Envisage difference
Greater power

Note. Total number of Undifferentiated Constructs = 3

Implicative Dilemmas for blank Grid

*Note. Total number of Implicative Dilemmas = 0
Percentage of Implicative Dilemmas = 0.00*

Dilemmas in Sentence Form

Note. No Dilemmas were found in the grid.

Elements Compared : Self at work vs. Ideal self
Scale Midpoint set as Discrepancy Criterion = 4
Construct Congruence Criterion = 0.2

Discrepant Constructs

Personal belief systems

Note. Total number of Discrepant Constructs = 1

Congruent Constructs

Limited awareness of difference
Questioning practice
Being seen as a professional
Having less knowledge/Naivety
Uneasy
Unsure of self
cultural responsiveness in practice
True self
In limbo

Note. Total number of Congruent Constructs = 9

Undifferentiated Constructs

Envisage difference
Greater power

Note. Total number of Undifferentiated Constructs = 2

Implicative Dilemmas

Dilemmas Summary [Discrepant::Congruent]

	Self at work [Dis]		Ideal self [Dis]		
			Self at work [Con]		Ideal self
[Con]					
Pearson Correlation					
Personal belief systems:: Limited awareness of difference	2.00	6.00	2.00	1.00	0.25
Personal belief systems:: Being seen as a professional	2.00	6.00	6.00	6.00	-0.48
Personal belief systems:: Having less knowledge/Naivety	2.00	6.00	2.00	2.00	0.27
Personal belief systems:: cultural responsiveness in practice	2.00	6.00	6.00	6.00	-0.21

Note. Total number of Implicative Dilemmas = 4
 Percentage of Implicative Dilemmas = 6.06

Dilemmas in Sentence Form

Self at work is construed as "Awareness of professional boundaries"
 ...whereas Ideal self is construed as "Personal belief systems"
 The dilemma is a(n) "Personal belief systems" person tends to be a(n) "Limited awareness of difference"
 person (r = 0.25)

Self at work is construed as "Awareness of professional boundaries"
 ...whereas Ideal self is construed as "Personal belief systems"
 The dilemma is a(n) "Personal belief systems" person tends to be a(n) "Not being seen as a professional"
 person (r = 0.48)

Self at work is construed as "Awareness of professional boundaries"
 ...whereas Ideal self is construed as "Personal belief systems"

The dilemma is a(n) "Personal belief systems" person tends to be a(n) "Having less knowledge/Naivety" person (r = 0.27)

Self at work is construed as "Awareness of professional boundaries"

...whereas Ideal self is construed as "Personal belief systems"

The dilemma is a(n) "Personal belief systems" person tends to be a(n) "Rigidity sticking to theory/practice models" person (r = 0.21)

Appendix M: Excerpt from reflective journal

Reflective diary entry: February 2015

I am in the process of writing my major research project (mrp) proposal. I am required to populate a list of 10 key references. Reviewing the literature is making me think about the discourse of race and racism. It feels tricky because the literature highlights racism as being part of the experience of BME groups in different contexts and arenas. However, how do I manage this to ensure that knowledge of this doesn't influence/bias the lens with which I look at conducting the research? I don't want to have a bias towards the experience of BME individuals based on previous research, but it is important to acknowledge this if this is what the literature is saying. I will need to pay attention to this closely.

Reflective diary entry: February 2016

Following a lecture on Gregory Bateson's "The ecology of mind"⁵ several thoughts connected with me in relation to my mrp. One particular idea is that of frames and how one views the world. I can't help but reflect on my interest in African American history and Native Indian history and the fact that studying these at undergraduate level will have had a profound impact on my frame and way of looking at issues of cultural relations. I wonder had a White British female conducted this study, what differences there would be in how we both conceptualise issues on race and culture. Though I feel I have been thorough in how I have attended to the literature, I can't help wondering where my frame has led me. I need to remain aware of what is being excluded by my psychological frame.

⁵ Bateson, G. (2000). Steps to an ecology of mind. London: University of Chicago Press.