Portfolio Volume 1: Major Research Project

Experiences of Black, Asian and Minority Ethnic Clinical Psychology Doctorate Applicants within the UK

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Abstract

Aim

Previous research has looked at the experiences of people from Black, Asian and minority ethnic (BAME) backgrounds who work within the clinical psychology profession. However, these studies have mostly focused on trainees' and qualified clinicians' experiences, leaving little known about experiences of the pre-qualification group. Therefore, the aim of this study was to explore how people from BAME backgrounds make sense of their experience of pursuing a place on a clinical psychology doctorate course in the UK.

Method

A purposive sampling method was used to recruit BAME clinical psychology applicants from an aspiring psychologist group. In depth semi-structured interviews were carried out with eight participants, who were all female. Interviews were transcribed and analysed using interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009).

Results

The results consisted of three superordinate themes. These were "The challenge of negotiating multiple identities and narratives", "Grappling with White privilege" and "Finding value in being a BAME applicant". The themes showed that participants had to navigate between what choosing a career in mental health meant to them and their families, whilst simultaneously having to deal with racism within the workplace and not feeling as though they belonged within the profession. However, despite these challenges, participants were able to find value in being BAME applicants.

Conclusions

The findings illustrated the difficulties BAME applicants faced in relation to their clinical doctorate journeys. Therefore, it is important that more support is provided to people from these backgrounds from earlier stages such as at high school and at undergraduate levels, which remains throughout their journeys via widening access schemes. Additionally, clinical implications for mentoring, supervision and training were also highlighted.

This study provides insight into the experiences of an under researched group of individuals working within the NHS. It speaks to barriers which may be in place for people from BAME backgrounds who are pursuing clinical training. One of the pertinent reasons for diversifying the clinical psychology workforce is so our profession can reflect the BAME population which the NHS serves.

1. Introduction

1.1 Chapter Overview

This research aims to explore the experiences of people from Black, Asian and minority ethnic (BAME) backgrounds, who are applying for clinical psychology doctorate programmes in the UK. In this first chapter, I will define the terms that will be used throughout this report, and then outline my personal and epistemological position to the research topic. I will then explore the historical context, as well as the current representation of people from BAME backgrounds in UK society. This will be followed by focusing on the BAME representation within the NHS workforce. In order to further orientate the reader to some of the key concepts in this study, I will also cover within this chapter an exploration of race and racism (including White privilege), the psychological impact of racism and institutional racism; and the BAME identity within clinical psychology. Finally, a systematic literature review focusing on the experiences of professionals from BAME backgrounds working within the clinical psychology profession will conclude the chapter and will provide the rationale for the current study. Throughout this chapter, a number of different topics will be mentioned, however due to the scope of this research, I will not be able to go into the detail each topic deserves. Instead, an introduction to the concepts is presented here.

The use of self- reflection in qualitative research is valued (Ortlipp, 2008), therefore I will demonstrate my reflexivity during this research by italicising my reflections throughout. A reflective diary was also kept during the entire research process, of which extracts can be found in Appendix A.

1.2 Important concepts and terminology

    1.2.1 Race, ethnicity and culture.

When thinking about people from Black and ethnic minority backgrounds, it is important to consider the terms "race", "culture" and "ethnicity" in order to differentiate between terms which are often used interchangeably. "Race" is determined by genetic ancestry and has therefore been argued as being a permanent attribute (Fernando & Keating 2008), however, this concept has been largely discredited (Phinney, 1996). It is widely accepted that "race" has more to do with power, domination and subjugation than with biological differences (Patel et al., 2000). "Race" is also better understood as a social construct, as opposed to a biological construct. Smedley and colleagues (2005) argue that "race" is a term which is placed within social and historical contexts. It has also been suggested that the term "race" can imply that the world is split into distinct categories or dichotomies which, it is argued, dismisses the complex and rich cultural and ethnic diversity that exists (Bennett & Frow, 2008).

Ethnicity, however, is contextual and is related to group identity and a sense of belonging to a particular ethnic group (Fernando, 2004). It has been suggested that ethnicity, unlike "race", involves a degree of choice, as it is changeable (Fernando, 2004). People who identify as being from the same ethnic group may share a common language, place of origin, history, traditions, values and beliefs and more (Smedley et al., 2005; Parrillo, 1997; Jones 1997). Despite everyone possessing ethnicity, it is often used in relation to "minority" groups where their ethnicity is seen as problematic (Fernando, Ndegwa & Wilson, 2005).

Culture has been defined as involving group practices (such as upbringing), values and beliefs that are contextual and evolving (Fernando, 2010). Similar to ethnicity, it is often assumed by the White majority of people that culture only exists in relation to "the other",

whereas culture is both created by and creates individuals (Patel et al., 2000). It is often the case within research that culture is studied from the position of the cultural norm being Whiteness (Nolte, 2007). Therefore, other cultures are assessed and appraised against this benchmark standard, which may take a deficit approach in studying other cultures (Odusanya, Winter, Nolte & Shah, 2017).

Despite the noted differences, "race", "culture" and "ethnicity" tend to be used interchangeably in literature. The implications of this being that one is placed within a specific social group on the basis of "race", "ethnicity" or "culture". This then increases the likelihood of being stereotyped as having traits which have been assigned to that particular group (Fernando, 2004). Throughout this research, I will use the term "ethnicity" to refer to the ethnic group one aligns to and I will use the term "culture" to refer to the values and beliefs one holds in relation to their identified ethnic group.

1.2.2 Black, Asian and minority ethnic (BAME).

The term "Black" is used throughout everyday language and literature and has historically been used in reference to one's skin colour. It has been argued to be a socially imposed parameter on individuals, despite the fact that one's identity is often seen as being fluid and multifaceted (Brunsma & Rockquemore, 2002).

The Institute of Race Relations (IRR) uses the term BAME to describe people of non-white descent. In addition to BAME, "Black and minority ethnic groups" (BME) are also widely used in literature to refer to a range of people from non-white cultural and ethnic backgrounds. This term therefore excludes White ethnic minorities. There is much debate around the use of BAME and BME as these terms are perceived as convenient labels for all non-white people and does not encompass the unique identities that people have chosen for themselves (www.irr.org.uk).

Throughout this research where the term BME or BAME is used, this will refer to experiences related to visible ethnic differences and will refer to individuals who identify themselves as coming from a Black or Black British backgrounds, Asian (including South Asian) backgrounds or other minority ethnic backgrounds that identify with the BME/BAME term. The terms will be used interchangeably because of how people from these groups have been defined and referred to within the literature. However, it is important to note that the intention behind this is not to exclude, minimalise or deny the significance of other forms of discrimination.

1.3 Personal position to topic

It is important for researchers to be transparent in sharing their personal values, beliefs and assumptions to ensure the reader is privy to alternative perspectives and possible biases that may be offered within the research (Elliot, Fischer & Rennie, 1999). Thus, I will make transparent my own background and beliefs which inform my personal perspective of the current research.

I am an individual who identifies as being female and "Asian British". I am of Mauritian heritage, though I was born in the UK. My cultural heritage plays a key role in my identity and my interactions with the world around me, including how I navigate through this research. Growing up, I had to continually learn how to compromise between my cultural heritage and the heritage of the country I was born in. It is an ongoing process, whereby I strive to integrate my dual identities in a way that remains authentic to me.

Throughout my pursuit of this career, I have felt like an underdog, having to work harder to feel that my accomplishments were valid and have been made to feel unworthy of pursuing a career in clinical psychology. This has left me feeling as though there will always be an uphill battle for me and others from BAME backgrounds, throughout our careers.

I am a final year clinical psychology trainee and am undertaking this research as part of a Doctorate program in the UK. Prior to getting onto this training programme, I studied and worked within the area of psychology for 10 years. I have always been in the minority group, whether that be in a university lecture theatre or in a mental health care setting as a professional. In my ten years in university and work contexts, I have had just two BAME role models in the form of tutors and supervisors. I have very limited experience of working with BAME groups, apart from when working in psychosis or forensic teams, where BAME populations are overrepresented (Fernando, 2017)

It has been both personally and professionally important for me to carry out this research, in the hope that it may bring about organisational change.

1.3.1 How I came to this study.

Although I have always been interested in the experiences of people from BAME backgrounds within different contexts such as: school, work and friendships, I did not initially consider this research as a legitimate option. I originally considered other research topics more directly related to service users. However my passion for this project began after reading around the subject and remembering my own experiences of being a BAME clinical psychology doctorate applicant. I had rarely considered or acknowledged the impact of me being from a BAME background with regards to this career choice, until I was told I would never get onto a clinical psychology doctorate programme because I wasn't from a White British background. Hearing this from a senior clinical psychologist in my first assistant psychologist post was discouraging to say the least. However, remembering this event has enabled me to consider the experiences of being from a BAME background and striving for a place in a highly competitive career.

The combination of my interests and experiences have shaped my research questions within this study. In this vein, I think it is important to consider the concept of "insider research" which brings into question: objectivity, reflexivity and authenticity (Kanuha, 2000). It could be argued that I am too similar or too close to the participants of this study. Whilst there are perceived disadvantages to my position, I believe it has been valuable and has allowed me to step into their shoes and get closer to their lived experiences. However, in an effort to remain aware of my "insider researcher" position and to maintain a level of objectivity, I have endeavoured to bracket my experiences by using a reflexive diary and liaising with my supervisory team and peers. This was facilitated by engaging in a bracketing interview, which was carried out with one of my supervisors. My journal has included reflections on each stage of this research, namely, from recruitment to analysis. Additionally, I used this journal to share reflections on meetings with my supervisors and a peer-based Interpretative Phenomenological Analysis research group. Supervision has played a key role throughout this research journey.

1.3.2 Epistemological position.

In relation to my research, I do not believe that all BAME applicants hold one perspective about their experience of getting onto a clinical training course. I was interested in conducting research which would give voice to the multiple experiences which are embedded within social constructs (Gergen, 2009). Therefore, for the purposes of this research, I have taken a critical realist position (Bhaskar, 1978). This epistemological position suggests that there is an underlying essence of reality that exists independent of human conceptualization (Fade, 2004). Critical realism takes participants' verbal accounts as a close representation of their "truth" and therefore does not deconstruct the participants' experiences too far. However, within this position, it is also acknowledged that the socio-

political context shapes and informs how participants' realities are experienced and expressed. The researcher is acknowledged as an important influence over the research process. Therefore I acknowledge that my perspective, background, history and context have all inevitably been brought to the research and will have influenced the lens through which I have viewed and made sense of participants' stories. This is acknowledged by the double hermeneutic process which is present in IPA (Smith et al., 2009). However, I have endeavoured to bracket these influences as mentioned in the previous section.

1.4 The representation of people from BAME backgrounds in UK society

This section will provide an overview of the historical and current representation of people from BAME groups within the UK, before focusing on the BAME representation within the National Health Service (NHS) and more specifically within the clinical psychology profession.

1.4.1 Historical representation of BAME groups in the UK.

In order to understand one's identity, it is important to consider identity development within a historical context. It is often recounted that the past has a role to play in the present and so it is important to recognise the impact colonialism, slavery and caste systems have on socio political contexts.

In the 17th and 18th centuries, slave trade began to grow within the UK and thus, constructions around white superiority and black inferiority were strengthened (McClintock, 2013). By the mid-19th century, Britain had gained control over a quarter of the world, which included countries such as Australia, Canada, New Zealand, India, Africa and the West Indies. The demands for independence amongst the White colonies grew in the early 20th century, so independence was granted to Australia, Canada and New Zealand (Bric, 2016).

During the mid to late 20th century, the rise in anti-colonial movements such as: the civil

rights movement, the introduction of the United Nations (UN) and human rights legislation,

were instrumental and became part of the socio-political agendas of most countries (Omi &

Winant, 1993). Thus, this became a period where racial and cultural integration was sought.

This legacy of slavery and perceived inferiority is something that influences the way

certain BAME groups are viewed and thus this historical context should not be taken lightly

or overlooked. The views about people of African heritage in the 17th, 18th and 19th centuries

tended to assert that Africa was chaotic and barbaric and that its people were better off as

slaves (Francis, 2002). The view was that slavery would save them from other worse fates.

Thus these views were entrenched over time and have, arguably, shaped and developed the

perception of the Black man being aggressive and dangerous (Francis, 2002).

1.4.2 Current representation of BAME groups within the UK.

Although the UK is viewed as having a multi-cultural society, 87% of the population

are from a White background compared to 13% being from BAME backgrounds (ONS,

2011). Therefore, the dominant norm is informed by White western culture (Patel et al.,

2000).

The setting for this study is embedded within the current cultural context of the UK.

Pressing issues such as austerity in an era of Brexit and increased migration of refugees and

asylum seekers, may have resulted in a rise in cultural hate crime (ONS, 2017). Thus, it is

important for professions to continue to be mindful of their practices and institutional racism;

a term which refers to racism being embedded within an organisation (Baxter, 1988). I will

discuss this in further detail later in this chapter, in addition to the psychological impact of

racism.

1.4.3 Cultural diversity within the National Health Service (NHS) in the UK.

Research has highlighted that a valued and diverse NHS workforce would be beneficial for client care (West & Dawson, 2012). Additionally, one of the Department of Health's key objectives was to increase diversity within its workforce (DoH, 2003).

According to Kline's report (2014), London's NHS workforce is as diverse as the city's population. More than two in five of London's NHS workforce are from a black and minority ethnic background. However, staff from BME backgrounds are disproportionately found in lower grades; are treated less favourably in recruitment, promotion, incremental and performance awards and bonus payments; are more likely to experience bullying and harassment; and are more likely to face disciplinary action or be reported to professional regulators. They are also radically under-represented at senior manager levels (Kline, 2014). Previous research (Esmail 2007; NHS Institute for Innovation and Improvement 2009) has also highlighted concerns about the absence of black and minority ethnic staff from senior NHS roles including Trust Boards.

More recently, the 2016 Workforce Race Equality Data Standard Report (Kline, Naqvi, Razaq & Wilhelm, 2017) showed that whilst there have been some improvements to cultural diversity within the NHS; such as an increase in nurses from BME backgrounds from 2014 to 2016, significant differences still remain. The report highlighted that BME staff are still more likely than white staff to experience bullying and harassment from patients and are still more likely to experience discrimination at work from colleagues and managers (Kline et al., 2017).

1.4.4 Cultural diversity and sensitivity within clinical psychology.

It is acknowledged that there tends to be an under representation of BME groups within voluntarily accessed services, for example out-patient talking therapies; whilst there is

an over representation of BME groups in non-voluntary services, for example inpatient

settings under section (Weatherhead & Daiches, 2010). It has been argued that people from

BAME backgrounds may be averse to accessing non-voluntary services because of issues

related to institutional racism and the lack of mental health professionals from BAME

backgrounds (Fernando & Keating, 2008). Therefore, the diversity of the clinical psychology

workforce is an important contributing factor in ensuring that clients are able to access

services that reflect their own particular culture and personal identities, and also to allow the

possibility of choice surrounding diversity across therapists and psychologists (Turpin &

Coleman, 2010). Thus, I will consider the historical and current perspectives of cultural

diversity within clinical psychology.

1.4.4.1 Historical perspective.

The discipline of psychology was largely developed within the Western context

(Fernando, 2017). This can be problematic when considering cultural differences with

regards to the construction and conceptualisation of mental health.

It could be argued that clinical psychology as a profession has contributed to some of

the earlier racist ideologies. The founder of the *American Journal of Psychology*, Stanley

Hall, published an article to suggest that people from Indian and African backgrounds were

akin to immature children who acted on emotion and impulse (Hall, 1904). Additionally,

clinical psychology was a key tool that used intelligence testing to indicate white superiority,

which aligns with the aforementioned narrative that existed within Western society (Fernando

& Keating, 2008). Key founders within clinical psychology such as Carl Jung and Sigmund

Freud also developed and disseminated racist ideologies. Examples include Jung's theories of

the mind being developed around his view of Black people being primitive and Freud's belief

that there were similarities between "the mental lives of savages and neurotics" (Fernando & Keating, 2008).

Although there are more examples to showcase the role that clinical psychology played within race relations, this will go beyond the scope of this research.

1.4.4.2 Current perspective.

Within the UK, the profession of clinical psychology is one which is viewed as having a reputable status, denoted by the high earning potential and the necessity of having a doctorate in order to practice. The discipline aims to promote psychological wellbeing, alleviate distress and add to the knowledge base of psychology through the means of research (Goodbody & Burns, 2011).

The lack of diversity within the profession has been a controversial area for many years and it has been argued that the ratio of BME professionals is not equivalent to the ratio of the wider BME population within the UK. According to the Office of National Statistics (2011), the BME population accounts for 13% of the total population in England and Wales. In 2013, it was reported that 9.6% of qualified clinical psychologists identified as being from a BME background. Although these statistics could be argued to be somewhat outdated, they highlight the discrepancies between the representations of the BME population in the wider population in comparison to the clinical psychology profession.

Psychology at an undergraduate level is seen as a popular choice for BME students, with the discipline receiving approximately 80,000 applications per annum and producing over 10,000 graduates per year. Students from BME backgrounds represented 12% of students on these courses (Turpin & Fensom, 2004). It appears that the under representation of those from BME backgrounds begins at the selection stage onto DClinPsy courses because

they are less likely to meet basic selection criteria in comparison to their White counterparts (Scior, Gray, Halsey & Roth, 2007).

Statistics from the Clearing House for Postgraduate Courses in Clinical Psychology (Leeds Clearing House, 2016) show that in 2016, 6% of the total applications came from an Asian/Asian British/Asian English/Asian Scottish/Asian Welsh group background and 4% were accepted onto a clinical programme. Additionally, 4% of the total applications came from a Black/Black British/Black English/Black Scottish/Black Welsh group, with only 2% being accepted onto a programme. A further 2% of applicants came from other ethnic minorities (excludes White minorities), with 1% being accepted onto a programme. The question that remains to be addressed is why it appears more difficult for people from BME backgrounds to be accepted onto a clinical course, whilst the opposite is seen for people from White backgrounds. From the same source, it was seen that whilst 81% of the total applications were from people from White backgrounds, 86% of people accepted onto a clinical course were from a White background.

Although there have been attempts to address these issues, such as the Division of Clinical Psychology Inclusion Strategy (BPS, 2015) and widening access initiatives (Scior, Wang, Roth & Alcock, 2016; Turpin & Fensom, 2004); there still appears to be an underrepresentation of BAME clinical psychologists.

The above section highlights that although psychology has moved beyond its historical discriminatory and racist beginnings, there still appears to be a lack of BAME representation amongst the workforce; which may have negative implications for BAME service users. To understand this finding, consideration of the role of race and racism for people from BAME backgrounds within the UK will now be considered.

1.5 Race and Racism

This section will provide an overview of what may constitute as racism, including overt and covert racism, in addition to White privilege. This will be followed by consideration of the psychological impact of racism and will conclude with discussing institutional racism, specifically within talking therapy professions.

Although the term "race" and its use has been shown to be problematic and somewhat unhelpful in terms of understanding cultures, it is a term that holds inferences for how people interact with one another. The term "racism" has been defined variously across literature and formal definitions. The Oxford English Dictionary defines racism as:

Prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one's own race is superior. The belief that all members of each race possess characteristics, abilities, or qualities specific to that race, especially so as to distinguish it as inferior or superior to another race or races.

As mentioned earlier, the term "race" can be seen as a social construct (Smedley et al., 2005). It has also been suggested that racism is a social construct influenced by one's skin colour (Witzig, 1996).

Racism is customarily considered within different categories. Overt racism or discrimination refers to instances where racism is acted on in an unconcealed and unapologetic manner. It has been traditionally seen as a derivative of white supremacy and superiority and can include the observable use of intentionally negative attitudes, ideas, symbols and actions. These actions are usually directed at specific racial groups (Elias & Feagin, 2016). Over the years, overt racism such as this have arguably become less common, however covert types of racism continue to exist. These tend to be more subtle in nature (Pedersen & Walker, 1997) and may include the absence of action of those who act in a racist

manner towards others (Constantine & Sue, 2007). In line with covert racism, is the concept of racial micro aggression. This refers to the daily occurrences of verbal, behavioural or environmental embarrassments which occur in commonplaces such as work environments (Sue et al., 2007). Examples included dismissive looks, gestures and tones. Although these occurrences may be perceived as being harmless, they have the ability to cause psychological distress for the "victims" who tend to be people from non- white backgrounds (Solorzano, Ceja & Yosso, 2000). It has also been suggested that "victims" of racial micro aggression may not interpret the situation in this way and that the interpretation of the event will be based on previous experiences that individual may have had, as well as how sensitive or racially/ethnically conscious they are (Constantine & Sue, 2007).

1.5.1 White privilege.

White privilege refers to a set of rewards which are afforded to an individual on the basis of their skin colour, which is often unearned (McIntosh, 1988). This area is often a point of contention for some, as it is associated with the dominance of White people and the subjugation of people from non-white backgrounds. White privilege can also be uncomfortable to acknowledge and work through for those who align with being White (Nolte, 2007). The role of white privilege is argued to contribute to the over representation of White clinical psychologists (Odusanya et al., 2017) and therefore it is important to recognise this in the present study.

1.5.2 The psychological impact of racism.

It has been documented that the impact of racism can lead to psychological consequences such as higher levels of distress, lower feelings of self-efficacy and greater feelings of powerlessness, helplessness, rejection, loss, depression and hopelessness (Edwards, 2012).

Additionally, there may be a reciprocal process occurring within the individual who experiences these racial micro aggressions; whereby they may internalise other's perceptions as being true and valid and will thus behave accordingly (Henderson, Bernard & Sharp-Light, 2007). Therefore, if someone is perceived as being inferior and unworthy of a position they may act as such until this cycle is broken. This may in turn reduce their self-esteem and may result in the individual internalising these negative views of themselves, regardless of their innate capabilities.

1.5.3 Institutional racism.

The term "institutional racism" was mentioned briefly earlier in this chapter. It refers to a covert form of racism that is embedded within institutions and professions. A key report in the emergence of this term was the MacPherson report (1999) which was written after the racist murder of Stephen Lawrence who was a Black teenager living in London. This report highlighted the number of British institutions which were institutionally racist (Fernando, 2004).

Institutional racism may also be applicable to the NHS. Black employees had the highest levels of reported discrimination against them (Kline et al., 2017). In addition, recruitment processes within the NHS favour the progression of White employees over employees from BAME groups (Kline, 2014).

1.5.3.1 Institutional racism in talking therapy professions.

More specifically, with regards to the clinical psychology profession, institutional racism can affect service users as well as professionals. For the context of this research, I will focus on how institutional racism impacts professionals within clinical psychology. Studies have highlighted the difficulties of covert racism within supervisory relationships, whereby

issues relating to race and ethnicity are somewhat avoided by White supervisors (Smith, 2016).

In addition to supervisory relationships, it has been argued that institutional racism is also embedded within the teaching of psychology within the UK (Fernando, 2017). Psychology teaching tends to be based on the western view of mental health and the assumption of western values and practices being the norm (Smith, 2016). As one could appreciate, this could create a dilemma for professionals from BAME backgrounds if these Western values do not align with their own cultural values and narratives and thus can make the teaching of psychology, an alienating process for those who are not from the "norm" background.

Another key arena whereby institutional racism may occur is within the therapy room. A review of experiences of Black counsellors (Watson, 2006) found that counsellors tended to experience micro aggression rather than overt racism from their White clients, such as clients terminating sessions early or by avoiding issues of race and difference with them. This made it difficult to name and challenge and thus the implications of this were discussed in relation to the therapeutic work done and the development of the therapeutic relationship. Another key study in this area was conducted by Patel (1998). She explored the experiences within cross cultural therapy and found that in this type of relationship, both the client and therapist held different power roles, i.e. being a member of a White privileged group vs holding a high status job. She found that whilst covert racism was still prevalent, Black therapists tended to employ strategies such as asserting their power in order to prove their competence.

Although it is argued that institutional racism is still present within clinical psychology, it is important to recognise the attempts made to address these challenges, such

as the Clinical Psychology Inclusion Strategy (BPS, 2015) and widening access initiatives (Scior et al., 2016) which have been highlighted earlier in this chapter.

While this section looks at the impact of racism on people from BAME backgrounds, another key facet within this research topic is to consider the development and integration of one's identity and how this relates to the experiences people from BAME backgrounds have within the profession.

1.6 The BAME Identity within Clinical Psychology

Within a societal context, it is important to consider one's identity and group memberships as these factors will permeate and influence the daily interactions one has (Howarth, 2002). The term *identity* is key in how people make sense of who they are and how they interact with their environment (Pratt, Rockmann &Kaufmann, 2006).

In addition to considering issues relating to race and racism, it will also be important to consider the development of one's identity as a BAME applicant, including cultural and professional identities and how one navigates and balances these multiple identities within oneself.

1.6.1 Racial identity/ cultural identity.

Many models of "racial" identity have been proposed (Cross, 1995; Helms, 1993). These models focus on the psychosocial development of one's racial identity by considering how the racial perception of others interacts with the racial perception of oneself (Chavez & Guido-DiBrito, 1999). Although this interaction is important to consider, it does not consider what is learnt from one's family and/or community (Odusanya, 2017).

Cultural identity refers to an individual's sense of belonging to a particular cultural group and is largely defined by the context, i.e. the socioeconomic position of that group

(Lago & Hirai, 2007). Thus, the cultural privilege of belonging to a certain cultural group, e.g. White privilege, may influence how members from perceived subordinate cultural groups view themselves and others from the superordinate cultural group (Atkinson, Thompson & Grant, 1993; Phinney, 1990).

A key model was developed by Sue and Sue (2012) - the "racial/cultural identity development model". It was developed in order to understand individuals from minority groups who were attempting to make sense of themselves and their experiences in the context of their culture of origin, the dominant culture and the relationship between these cultures. The model also attempts to consider other dimensions such as gender and class. The model outlines four different stages: "Conformity", which occurs when the individual embraces the White dominant culture, whilst simultaneously rejecting and denigrating their culture of origin. "Dissonance", whereby consideration of minority cultural group strengths are considered which leads to identifying with both their culture of origin and the White dominant culture. The third stage is known as "Resistance", and occurs when the individual completely accepts their culture of origin and rejects the White dominant culture. Finally, the fourth stage is "Awareness" which relates to critical appreciation of all cultural groups. It is important to note that individuals do not go through each stage in a linear fashion and that one's cultural identity is influenced by different situations and contexts (Lee, 2005).

1.6.2 Negotiating racial/ cultural identities within professional identity.

Professional identity has been defined as "a set of beliefs and values that comprise an individual's self-concept as a professional" (Slay & Smith, 2011). The negotiation of multiple identities may vary between individuals who subscribe to the majority cultural group. Within the UK, this will be White British; and those who subscribe to minority cultural groups, such as those from BAME backgrounds. Additionally, when entering a profession which

constructs itself as "White" (Patel et al., 2000), people from BAME backgrounds working within this profession may experience further incongruence between their racial/cultural and professional identities. This may include the difficulties of integrating the "White" professional identity with their existing self (Tan & Campion, 2007).

In line with the models of identity development mentioned earlier, Jackson's cultural contracts theory (2002) postulates that identities are developed and negotiated through social interactions with others. This theory suggests that everyone's world view is culturally based and influences how people interact with their environment. It highlights the difficulties that some people from BAME backgrounds may face in their negotiation of identities within a profession that is known to be lacking in ethnic diversity. Jackson & Crawley (2003) speak of "cultural contracts" which are "subtle value exchanges". This refers to the idea of BAME clinicians making decisions around conforming to the dominant cultural narrative of "Whiteness" or rejecting this and resisting conforming. This ties in with Sue & Sue's (2012) model of "racial"/ cultural identity development.

1.6.3 Intersectionality.

Intersectionality refers to the interactions of multiple domains of oneself and how these interactions influence and shape one's identity. Cole (2009) stipulates that intersectionality is used to "describe analytic approaches that simultaneously consider the meaning and consequences of multiple categories of identity, difference, and disadvantage". It will be important to acknowledge the role of intersectionality within this research as individuals may subscribe to different facets of the majority group of clinical psychology, i.e being predominantly White female within the UK; a female BAME professional may subscribe to the majority group of being female, however may also subscribe to the minority ethnic group. The current research will aim to consider these additional complexities.

1.7 Systematic literature review

In this section, I will present a systematic review of literature that has been conducted on the experience of individuals working within the clinical psychology profession from BAME backgrounds within the UK. The section will conclude with the rationale for this research, the aims of the research and the research question.

It has been noted throughout the literature that the recruitment of people from BAME backgrounds into the profession has been difficult (Williams, Turpin & Hardy, 2006; Smith, 2016). There are few studies which look into the experience of people from BAME backgrounds who do choose to pursue this career path. This literature review will aim to capture all research, theoretical, review, discussion and opinion papers published in peer-reviewed journals which focus on the experiences of people from BAME backgrounds working within the clinical psychology profession. To ensure the search was as comprehensive as possible, studies which looked at experiences of individuals in the pre-qualification stage (including trainee clinical psychologists) and post qualification were included.

1.7.1 Literature search strategy.

Scopus, PubMed, Google Scholar and the University of Hertfordshire library search engine were utilised in conducting the literature search. Combinations of the following search terms can be seen in Table 1. Terms were truncated as appropriate (e.g. clinical psychology* = clinical psychology, clinical psychologist). The search was based on particular inclusion and exclusion criteria which can be seen in Table 2.

Table 1

Search terms used in systematic literature search

Experience		Black, Asian and Minority Ethnic	Clinical Psychology
Experience* Reflection*	AND	Black, Asian and Minority Ethnic AND Black Minority ethnic Minorit* Racism Marginalisation Diversity BME BAME Ethnicity	Clinical Psycholog* Trainee clinical psychology* Assistant Psycholog*

Table 2

Inclusion and Exclusion criteria

Inclusion Criteria	Exclusion Criteria
Relating to BAME experience of clinical psychology profession	Not relating to BAME experience of clinical psychology profession e.g. counselling psychology, family therapy
Peer reviewed empirical studies, theoretical, review, reflection and discussion papers	Not conducted in the UK or based on UK samples
Conducted in the UK and based on UK context	Focus on service user experience
Focus on professionals' experiences	Focus on general experience of clinical psychology profession

Duplicates and those which did not meet the inclusion criteria were excluded, leaving 29

articles. At this stage, papers were excluded if they did not focus on the experiences of people

from BAME backgrounds within clinical psychology (papers which focused on quantitative

data were used to inform the narrative section of this chapter), if they didn't focus on

professionals' experience (such as those focusing on service users), if they didn't focus on the

clinical psychology profession, and if they were not related to a UK context. The full texts of

these articles were screened, leaving nine relevant articles. A flow chart of the search can be

seen in Figure 1.

Figure 1

Systematic Literature Review Flow Chart
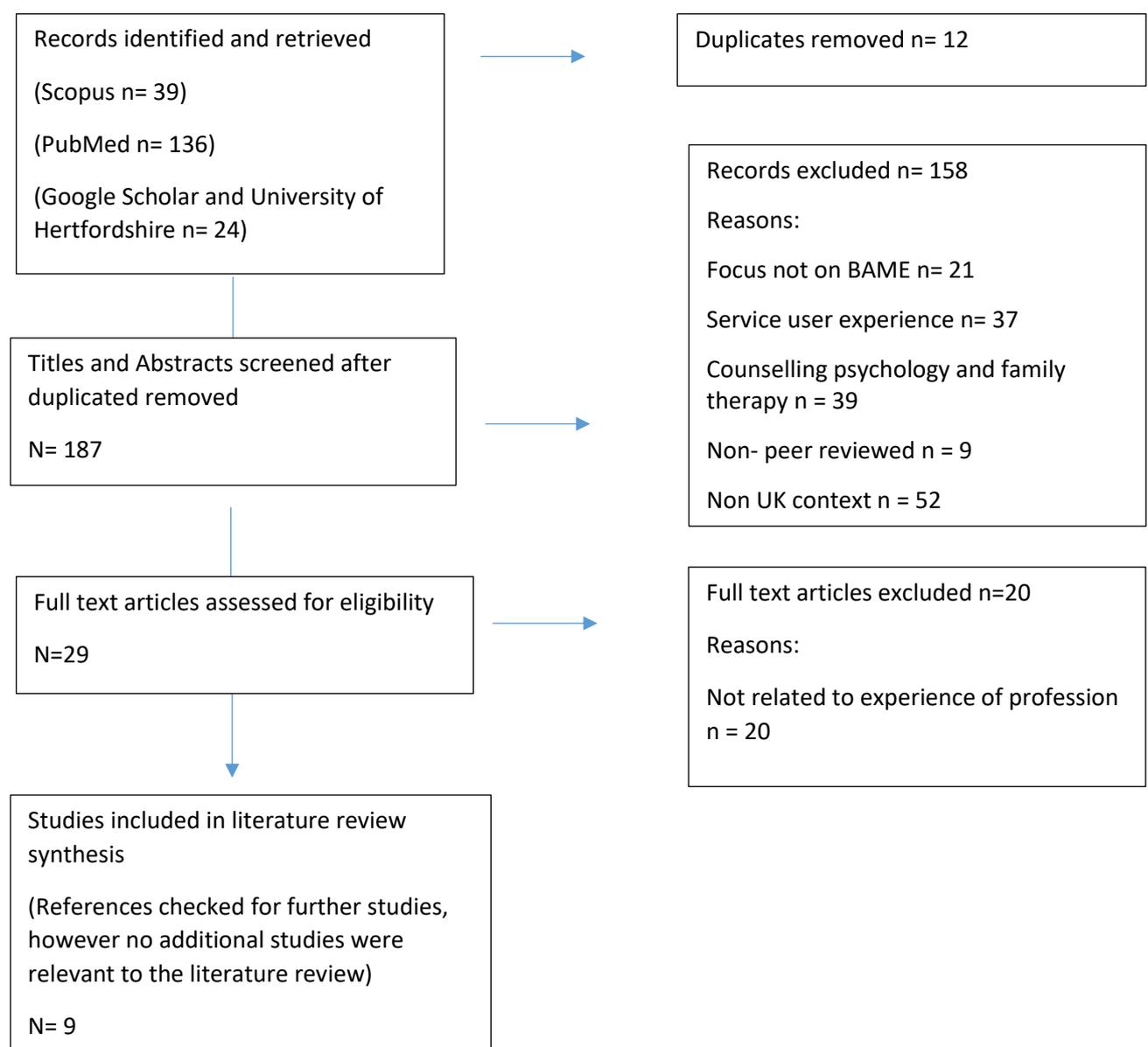
1.7.2 Summary of papers.

Due to the paucity of research within this area, four discussion papers and reflective pieces were also included within the literature review. Seven of the papers reviewed were qualitative and used phenomenological approaches. One study used a survey design and content analysis to look at qualitative data from open ended questions. The remaining study used a mixed methods approach, combining qualitative methodology and analysis (Interpretative Phenomenological Analysis) and repertory grid technique. All of the studies explored the experience of professionals from BAME backgrounds working within the clinical psychology profession. The papers ranged from commenting on pre-qualification experiences, training experiences and post qualification experiences. With regards to the empirical studies, sample sizes varied, the lowest being 6 and the highest being 30. All of the papers were based within a UK context.

A more detailed commentary of the strengths and limitations of each study can be found in Appendix B. Guidelines outlined by Tracy (2010) were utilised in the quality assessment of the research articles. These guidelines were chosen as they provide eight criteria suitable for assessing qualitative studies. Each paper was assessed and evaluated against each of these criteria. A more in depth evaluative analysis of the studies can be found in Appendix C.

I will now discuss the findings of the studies which I have looked at in relation to the stage of the career, i.e. pre-training experiences, training experiences and post training experiences.

1.7.2.1 Experiences of those from a BAME background pursuing a career in clinical psychology.

Three of the studies related to experiences of people from BAME backgrounds who were pursuing a career in clinical psychology. Two of the papers were reflective papers (Kinoauni, Ibrahim, Baah, Hasham & Stamatopoulou, 2016; Dodzro, 2016) and the final paper looked at the member characteristics of the Minorities sub group within the Pre-Qualification group of the Division of Clinical Psychology (DCP) (part of the British Psychological Society); in addition to qualitative responses around experiences of being in the profession (Kinouani et al., 2014).

Kinouani et al. (2014) conducted a survey looking at the demographic data of members of the DCP Minorities group. Seventeen members took part and were also asked open ended questions about reasons for joining the group, questions about the potential obstacles faced on the professional pathway, motivation to continue pursuing a career within clinical psychology and what their views were on how access to the profession could be improved. Descriptive statistics were used to look at the minority characteristics of the members. Content analysis was used to analyse the qualitative data from the open ended questions. It is important to note that the Minorities group was developed with the aim of providing a network for people who identified with being part of a minority group. Thus, this group included people who identified as having disabilities and being part of LGBT populations. The results of this study should therefore be viewed within the caveat that although people from BAME backgrounds formed the largest subgroup of members of the DCP minorities group; not all responses and experiences may be from people from BAME backgrounds. From the content analysis, the authors found that the main obstacles of pursuing this career path focused on the lack of awareness of diversity issues and difference within the profession, having to take low paid jobs or not being able to access relevant

experience or opportunities. Respondents felt motivated to continue their pursuit of clinical psychology as they wanted to make a difference, they enjoyed their jobs and they felt an aptitude and inclination towards the clinical psychology profession.

It does not appear that attempts were made to pull out data for particular groups within the participants, thus making it difficult to ascertain how far the results reflect the views of those from BAME backgrounds. Although the qualitative data provides an initial insight into some of the experiences and thoughts people from minority backgrounds may face, the study utilised a relatively small sample size. At the time of publication, the group had 70 members, although received responses from 17. The authors state this to be low, however it remains unclear why the response rate was low. Therefore, the results from this study may not be generalisable to the experience of other people from minority groups, and more specifically people from BAME groups. Additionally, the study had responses from 1 male, which again, may limit the applicability of these experiences to other males who identify as being within a minority group.

In order to evaluate the survey design aspect of this study, the widely acknowledged concepts of reliability and validity were drawn upon. The study does not state what the aims or research questions are, making it difficult to ascertain whether the study's methods are valid. Additionally, there is no mention of the questions being piloted. This makes it difficult to see if the questions used were reliable in eliciting views of those surveyed. Due to the small sample size, the study may lack in rich rigor (Tracy, 2010). Self-reflexivity is not mentioned throughout the study and thus it is difficult to be aware of the authors' subjective values or inclinations. This makes it difficult to assess the sincerity of the paper. Additionally, credibility of the study can be questioned because of the lack of triangulation techniques or member reflections mentioned.

In addition to this paper, Kinouani et al., (2016) also reflected on their experiences of being interviewed for clinical psychology doctorate courses within the UK. The authors do not explicitly state which minority groups they represent, however they are all members of the DCP Minorities group which included people from ethnic minority groups, as well as people who identify as having disabilities and being part of LGBT populations. This lack of disclosure makes it difficult to establish which experiences are reflective of someone from a BAME background. The authors describe being aware of the underrepresentation of the groups they belonged to and how this led them to be fearful and have reservations about entering this profession. They also explain how their differences were highlighted during clinical interviews when they looked at other fellow applicants which created more anxious feelings for them. They raised questions such as "Do I really have a chance here?" and "Is this profession actually for me?". They also reflect on how they "tried to sound like someone I thought courses would choose". This paper eloquently considers the links between the authors' experiences and theoretical concepts which may explain their experiences, such as "stereotype threat" (Steele & Aronson, 1995) heightening their self-doubt and anxious thoughts in clinical psychology doctorate interviews and "stigma consciousness" (Pinel, 1999) providing an explanation for applicants anticipating bias and thus concealing their "stigmatised" identities. Moreover, it goes beyond a first-person account of the difficulties they experienced in trying to gain a place on a doctorate course and attempts to ground and defend their experiences and the implications of their experiences. Kinouani and colleagues also provide suggestions and implications for how the interview process may move beyond the traditional model and incorporate other methods of assessing applicants, such as using practical structured interviews and situational judgement tests; which are both used in medicine. They argue that this may account for the cultural assumptions that may occur in interviews, such as the desire for applicants to be "confident", "open" and be able to "fit in";

but may not be the cultural norm of how one considers one should be in an interview (e.g. for people from BAME backgrounds). This paper is the only published article which offers insight into minority applicants' experiences of the interview process. However, similarly to the Kinouani et al's (2014) paper, this paper is based on the experiences of people who identify as being a part of a minority group, which may include, but not be specific to the BAME experience. Additionally, as it is a reflective piece, it provides accounts of the subjective experiences of the authors and therefore cannot be taken to represent the views of other BAME applicants.

The third paper which looked at the experience of being from a BAME background in pursuit of clinical psychology training was the only paper to solely offer a male perspective. Dodzro (2016) provides a reflective account on his experiences as a BAME aspiring clinical psychologist attempting to understand the profession. He discusses the underrepresentation of people from BAME backgrounds, but how this underrepresentation is enhanced when considering males from BAME backgrounds. He reflects on how he was unaware of these statistics prior to deciding to pursue clinical training and how this has become a motivating factor for him to continue on his pursuit. The Division of Clinical Psychology Black and Minority Ethnic mentoring scheme is mentioned in this paper, as is the importance of schemes such as this, which aid in promoting understanding and awareness to potential students about the route to clinical psychology training. The author reflects on how he had benefitted from this scheme and how it has enabled him to understand the profession better. Although a key strength of this paper is the insight into the male perspective; as with the other papers, the reflective and subjective nature makes it difficult to apply these experiences to other people from BAME backgrounds.

1.7.2.2 Experiences of trainee clinical psychologists from BAME backgrounds.

Three papers referred to the experiences of trainees who identified as being from BAME backgrounds. Two studies employed qualitative methods to look at the experience of BAME trainees (Rajan & Shaw, 2008; Shah, Wood et al., 2012), whilst the remaining study provided a reflective account looking at the impact of racism on the clinical psychology training experience (Adetimole, Afuape & Vara, 2005).

The reflective account by Adetimole and colleagues (2005) was written in retrospect by three female qualified clinical psychologists who self-identified as being Black and all qualified from the same training course, but at different times. They reflected on their experiences related to racism and identity development whilst they were still on the training course. This paper highlights some important and key elements of the nuances of institutional racism and micro aggressions that occur within the clinical psychology arena; and the implications of this on BAME trainees. Examples of this include lectures focusing on "White people's experience, including White people's experience of us as Black people, further reinforcing and locating difference within Black people" (Adetimole et al., 2005, p. 12-13). They also spoke about their position as Black trainees and how they felt positioned by trainers as "different" and "deprived", thus their concerns would be racialised and they would be viewed as "struggling", whereas their assumption was that White trainees' concerns would not be racialised. In an equally unhelpful way, they felt that their White supervisors overcompensated by this positioning of them and would therefore avoid criticising them and would excessively praise them.

Additionally, they reflect on the difficulties of the drive to recruit more BAME trainees and how this may have led to the assumption that Black trainees were lucky instead of hardworking. In contrast to Dodzro's (2016) opinion, they found that the targeted BAME

mentor schemes perpetuated the idea that people from BAME backgrounds need more support than White peers and that issues related to the BAME experience should be spoken about "outside of a White institution". They also described instances of overt racism, whereby peers would express racist views in front of them. These instances had an impact on what they described as the cyclic processes of identity development which they engaged in. They mentioned going through stages such as conforming to the White British norm, disagreeing with this norm and re-establishing their identities as Black women and recognising being Black as positive; such as the important and unique insights they bring to the profession.

In terms of suggestions for how BAME experiences can be enhanced, the authors mention the role of supervisors and how discussions of race should be occurring within supervisory relationships. Their reflexivity is noted throughout the paper and they mention the personal dilemmas they faced in writing the paper, such as feeling they were betraying the profession; but wanting to remain true to themselves. However, in line with previous critiques, the reflections of this paper may not be representative of other BAME trainees from other courses or even other BAME trainees from this particular course. In terms of the evaluation criteria (Tracy, 2010), with this being a reflective account of the authors' experiences, claims within the account are based on their personal experiences. The paper is written in retrospect over the three year training period. However, the time elapsed between finishing training and writing this paper is not stated. Therefore, it may be worth noting that whilst these are their real and lived experiences, their views and commentary on these experiences may have changed over time. As there is also no evidence of written reflections at the time of these events occurring, it is difficult to ascertain whether they experienced these events in the same way at the time of occurrence.

Rajan & Shaw's (2008) qualitative study utilised semi-structured interviews with eight BAME trainees from different UK courses and employed Interpretative Phenomenological Analysis (IPA) to look at their experiences whilst training. The key themes that emerged from the data included "professional issues" where participants felt that their cultural backgrounds and BAME status was an advantage in terms of entering the profession. Participants spoke about mentioning the importance of cultural diversity within the profession in their application forms and received positive feedback from supervisors about this. However, findings also spoke to the ethnocentricity of mainstream psychological theories and how this can be an alienating experience for some BAME trainees as these ideas are different to the ideas they were brought up with.

Another important theme was looking at the experiences within the classroom and cohort. This encompassed the Eurocentric views and ways of conceptualising mental health within all cultures and the lack of challenge or discussion around this. This meant that participants felt isolated in their cohorts. This also meant that trainees were positioned as being experts of cultural diversity, which often felt as though they were "cheating people".

The final theme referred to the personal impact of training. This theme highlighted the difficulties trainees experienced in integrating their personal and professional identities, such as feeling they needed to forego their cultural and ethnic identities and assimilate into their cohorts and the profession. The study echoed experiences mentioned in Kinouani et al's (2016) and Adetimole et al's (2005) reflective accounts of the difficulties of blending their personal and professional values and beings. This study differs somewhat from Adetimole et al., (2005) with regards to viewing their BAME status as a positive tool in gaining an entry point into the profession. When evaluating the study (Tracy, 2010), the use of quotations throughout the paper highlight the transparency of the data and emerging themes. However,

there is little insight provided about the author's position and vested interest within this research.

In another qualitative study, Shah et al., (2012), interviewed nine BAME trainee clinical psychologists about their experience of training. This study aimed to build on Rajan & Shaw's (2008) and Adetimole et al.'s (2005) studies by exploring further the racial and cultural differences which may occur in working relationships and the strengths and limitations of the BAME trainee clinical psychologist position. A similar study design to Rajan & Shaw (2008) was used, in that semi-structured interviews were carried out with trainees, whose data was analysed using IPA. Building on the previous studies (Adetimole et al., 2005; Rajan & Shaw, 2008), a key finding of this study showed the discomfort, fear and anxiety trainees experienced in raising issues and conversations about race and difference within their cohorts and in supervisory relationships in case they became further isolated and marginalised. The authors conclude that the onus should be on supervisors to raise issues of race and difference, where it previously was with trainees. Therefore, there was a need for training courses to be aware of these issues within the training context.

Another key finding of this study was the safe space trainees felt with other BAME trainees in order to find support. The study also highlights the flexibility and versatility that comes with being from a BAME background, for example, trainees also found that their cultural identity became a factor in connecting with others (although it is unclear whether this connection was in relation to service users or other professionals). When evaluated against Tracy's (2010) quality criteria, the study provides rich rigor in that there are quotes used throughout the paper to illustrate key themes and points. The authors' theoretical assumptions are not made explicit, nor are credibility checks mentioned, making sincerity and credibility difficult to assess. The study has similar findings to previous studies and makes a significant contribution to the evidence base by focusing on the strengths of BAME trainees, as well as

highlighting issues within supervisory relationships and safe, supportive spaces for BAME trainees.

1.7.2.3 Experiences of qualified clinical psychologists from BAME backgrounds.

The final three papers looked at the experience of qualified clinical psychologists who identified as coming from BAME backgrounds. One paper (Patel & Fatimilehin, 2005) provided reflections from two clinical psychologists who had been qualified for 15 years. The latter two papers used qualitative methodology (Alleyne, 2004) and a mixed methods approach (Odusanya et al., 2017) to look at the experiences of qualified clinical psychologists from BAME backgrounds.

Alleyne (2004) looked at the experience of being Black in the workplace and what the impact of this experience had on wellbeing. She employed a qualitative approach using phenomenology, hermeneutics and heuristic principles to analyse semi-structured interviews. Thirty participants took part in the study- eighteen worked in educational services (psychology departments, college and university settings); six were from social services and the remaining six were from the NHS (nurses, midwives, health visitors). Two major themes emerged from the data, which were internal and external factors. Internal factors referred to the feelings which were reported by participants. Examples included the experience of unfairness, harassment and victimisation; and also being "singled out" for discriminatory treatment, in addition to the anticipation of this re-occurring. External factors referred to management structures which tended to be dominated by White males. Examples of external factors included micro and macro aggression, such as failure to notice their presence, meeting silence when a supportive response would normally be expected, White colleagues not making appropriate eye contact when it mattered, repeated instances of isolation and over use of adjectives such as "aggressive", "scary", "angry", "frightening" when referring to Black

people. The interaction between internal and external factors tended to influence the experience of stress within the workplace. When trying to deal with workplace conflict, a collusive management structure was found, which further added to stress experienced within the workplace.

An interesting point within this study was the discussion around the legacy of slavery and colonialism and how this shapes Black people's attachments and relationships with White people. The author suggests that participants viewed their negative work experiences in terms of modern versions of an enslaved past. Examples included participants stating, "White people will never get accustomed to nor comfortable with a Black person in a position of power" and "we always have to work twice-even three times as hard to get to where we want or be on par with the White man".

As with earlier papers, it is important to note that this study did not focus solely on the experience of clinical psychologists. Therefore, the findings may be in relation to experiences from professionals of other disciplines. Additionally, there were limited Asian and male perspectives, thus making the findings difficult to be representative of all experiences BAME psychologists may have. The findings of the paper suggest that two themes emerged from the data, however these themes are not explicitly named and discussed. Additionally, the paper indicates that there are other findings beyond these two themes, making it difficult for the reader to ascertain what the main themes are and how these relate to the research questions stated. In terms of the quality criteria (Tracy, 2010), the lack of quotes throughout the paper may question the transparency of the study and findings, thus adding to the confusion of how themes were derived and what credibility checks were employed. There are also no explicit addressing of ethical considerations. The study does provide resonance through its transferable findings.

In their 2005 discussion paper, Patel and Fatimilehin discuss the struggle against racism faced by BAME service users, participants in research studies and professionals within clinical psychology and whether this had changed over the course of their careers. They comment on the lack of diversity in the profession and consider this issue with an alternative perspective, suggesting that the profession may not be attractive to people from BAME backgrounds because the professions' systems, training programmes and track record excludes people from BAME backgrounds. The authors give an example of a Black parent saying "psychology has nothing to say about Black people". They mention that this may be because of the lack of diversity in psychological ways of working.

As with previous papers, the authors discuss the position that some BAME clinicians are placed in, where they are positioned as being experts on all Black and ethnic minority people. The authors conclude their reflections by stating that there continues to be a lack of acknowledgement of racism from some clinical psychologists and that resistance to change within psychological practice and services still remains. They provide examples of challenging psychologists when using measures and tools which have not been validated with BAME groups, or the perception of BAME populations being difficult to engage in psychological therapy. The authors state that these challenges are often met with resistance to change from other White psychologists. This paper is unique in that the considerations and conclusions made are based over a long span of time and do not just consider the current context. Although the authors recognise some positive changes have occurred, they do not specify these. However, as with previous reflective pieces, this paper is based on subjective experience and opinion and may therefore not reflect the opinions and experiences of other qualified BAME psychologists.

The most recent paper looking at the experience of qualified BAME clinical psychologists utilises a mixed methods approach (Odusanya et al., 2017), combining the use

of IPA and repertory grids. The IPA analysis allowed themes to be drawn out of the entirety of the qualitative dataset, whereas the repertory grids allowed for more detailed analysis into the individual experience. Six participants took part in the study and were all qualified for at least two years. The study echoed findings from previous studies such as the positive aspects of being from a BAME background and how this aided in their entry to the profession (Shah et al., 2012), and the positioning of BAME psychologists as being expert on issues of race and culture based solely on their ethnicity (Patel & Fatimilehin, 2005; Rajan & Shaw, 2008). The study also showed new findings such as clinical training being a key time in professional identity development, with the most meaningful element of participants' repertory grids (for all but one participant) being their identities around the time of being a trainee. The authors suggest that this is when clinical psychologists begin their professional identity development. They also comment on how the integration of personal and professional identities became easier to blend the longer one was qualified. The findings suggested that clinicians felt more pressure to conform to a White norm and felt more isolated when they were in the earlier stages of their careers. It was found that in order to successfully integrate their identities, BAME psychologists had to construct a professional identity that fit with their personal narratives of how they came to their professional roles.

With regards to the quality of the study (Tracy, 2010), ethical considerations, credibility and triangulation checks were explicitly mentioned throughout the report. However, the supplied elements in the repertory grids may have made this less meaningful for participants. The authors' statement of epistemological position is not mentioned, nor is there explicit evidence of self-reflexivity throughout the report. This makes it difficult to understand the researchers' position and what they may have brought to the research.

1.7.3 Literature review summary.

The literature review identified a small number of papers which offer some insight into the BAME experience of the clinical psychology profession. The literature suggests that there are many similarities in experiences across the career span. This included being positioned as an expert on all people from BAME backgrounds and all issues related to race and cultural differences (Patel & Fatimilehin, 2005; Rajan & Shaw, 2008; Odusanya et al., 2017). Three of the papers identified this as a key experience and how this often placed people from BAME backgrounds in uncomfortable situations. Interestingly, these three papers spanned across clinical training and post qualification; implying that these experiences may occur across one's career.

Another similarity was the development of professional identity and the integration of personal and cultural values. This was mentioned across four papers (Alleyne, 2004; Adetimole et al., 2005; Rajan & Shaw, 2008; Odusanya et al., 2017). It appears that the development of professional identity tends to start during clinical training (Adetimole et al., 2005; Rajan & Shaw, 2008) and that this becomes easier the longer one is qualified (Odusanya et al., 2017). The studies mentioned how early in their career, psychologists from BAME backgrounds had to navigate conforming to the White British norm and the difficulties associated with this, such as feeling that they had to sacrifice or conceal their cultural identities. Overtime, these studies documented BAME psychologists beginning to disagree with this norm and detaching from it; and re-establishing their cultural identities within their professional identities.

Issues around overt racism and more subtle experiences of racism were discussed in five papers (Alleyne, 2004; Adetimole et al., 2005; Patel & Fatimilehin, 2005; Shah et al., 2012; Kinouani et al., 2016). These experiences appeared to span one's career, from entering

the profession and trying to gain a place on a clinical doctorate programme (Kinouani et al., 2016) to fifteen years post qualification (Patel & Fatimiliehein, 2005). An explanation for this was offered by Alleyne (2004) who discussed the long term impact of slavery and colonialism and how this may play a role in how people from BAME backgrounds experience and respond to situations and conversations.

The main differences apparent in the literature were around the experiences related to entering the profession. Some trainees felt that being from a BAME background was a positive aspect in allowing them to gain a place on a clinical doctorate programme (Shah et al., 2012; Odusanya et al., 2017) as courses were interested in increasing diversity. However, others felt that this idea took away from their hard work and believed that it perpetuated a notion whereby people from BAME backgrounds need additional help and support in order to achieve the same goals as their White peers (Adetimole et al., 2005).

The papers within this literature review highlight how for BAME professionals, ethnicity is often an important factor in how they are positioned within the clinical psychology profession. Despite the limited research in this area, these papers provide an insight into the experiences of people from BAME backgrounds; and how these experiences change or remain the same across their careers. They also highlight how much remains to be done within the profession in order to address the inequalities people from BAME backgrounds face. However, it is also important to consider that four out of the nine papers were reflective pieces. Whilst these papers provided insight into experiences, they cannot claim to represent the perspectives of other BAME people within clinical psychology, and so have limited transferability. With regards to the remaining empirical studies, all studies used IPA, which aims to look at experiences where little is known. It may have been more helpful for later studies, such as Shah et al., (2012) to adopt a different methodology in order to build on what was already known in

this area, as previous research (Rajan & Shaw, 2008) had conducted an IPA study to look

at the experiences of BAME trainee clinical psychologists. There is no research to date

which looks at the experience of BAME applicants pursuing clinical training.

With regards to each stage of the profession, two small scale studies looked at the

training experience of people from BAME backgrounds (Rajan & Shaw, 2008; Shah et al.,

2012). Again, two studies looked at the qualified experience of people from BAME

backgrounds. Only one small scale study looked at the experiences of those from minority

groups who were at the pre-training stage. However, this study is not specific to the

experiences of people from a BAME background.

An evaluation of the papers showed that the majority of the studies were credible and

rigorous. Their contributions were enhanced by the depth and richness of the accounts

throughout. In terms of the empirical studies, self-reflexivity was only present within one

study (Alleyne, 2004). This meant that there was little evidence of how researchers reflected

on their own roles, epistemological positions and biases which may have influenced the data

collection and findings. For example, Kinouani et al., (2014) do not mention how their

positions as founders of the DCP Minorities group may have influenced participants'

responses and their own interpretations. Additionally, only one study (Odusanya et al., 2017)

made explicit mention of the credibility checks used throughout the study. The lack of this

within the other studies limits the trustworthiness of the findings.

1.8 Conclusions and rationale for current study

As mentioned earlier in the chapter, 12% of applicants to clinical psychology training

come from BAME backgrounds (Leeds Clearing House, 2016) with 7% of these applicants

being accepted onto a course. From the same source, it is also seen that 81% of applicants are

from White backgrounds and 86% of these applicants were accepted onto a course. There is a

need to acknowledge the difficulties that this group experience in order to address them.

Though some work has looked at the trainee BAME experience and the qualified BAME

experience, the pre-training group has scarcely been looked into. Understanding the

experiences of individuals from BAME backgrounds who are attempting to get onto clinical

training is important in order to understand the barriers they may face at this stage. By

gaining an understanding of this, we (as a profession) may be able to address these barriers

and increase the number of BAME applicants getting onto clinical training and thereby

creating more diversity within the clinical psychology profession over time.

1.9 Research question

This study aims to gain knowledge and deeper insight into how people from BAME

backgrounds experience the route to pursuing a place on clinical psychology doctorate

courses. The specific research questions were informed by the gaps in the literature.

What are the experiences of Black, Asian and minority ethnic (BAME) clinical psychology

doctorate applicants within the UK?

Sub- questions:

- What are the implications of being a BAME clinical psychology applicant?

- What are the issues related to being from a BAME background within clinical

  practice?

- What are the issues concerning identity development for BAME applicants?

- What are the barriers and enablers for BAME applicants getting onto clinical training?

- What are the available and desired support systems for BAME applicants?

2. Method

2.1 Overview

This chapter will provide information regarding the methodology used throughout this research project, including the rationale for the choice of Interpretative Phenomenological Analysis.

A review of the theoretical underpinnings of Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009; Smith & Osborn, 2003) will be considered, followed by details of consultation, participants, recruitment strategies, collection and analysis of data. Ethical considerations, and steps taken to meet research quality criteria (Tracy, 2010) will also be discussed.

2.2 Design

A qualitative design was employed, using Interpretative Phenomenological Analysis. This was chosen as it provides rich, in-depth accounts of the personal experiences under examination (Barker & Pistrang, 2015). Given the context of this research, I believed a qualitative design would be appropriate. Qualitative methodologies aim to deepen our understanding of areas where there is little current knowledge (Smith, Jarman & Osborn, 1999). This is particularly appropriate given that there is little research exploring the experience of clinical psychology doctorate applicants from BAME backgrounds in the UK.

2.3 Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) (Smith & Osborn, 2003; Smith et al, 2009) was chosen as the most suitable and appropriate methodology for this research. IPA is predominantly concerned with how individuals create meaning of their life experiences and

how this experience is made sense of (Smith, 2015). This approach follows a phenomenological and interpretivist nature which allows the researcher into people's lived experiences from their own perspective (Taylor, Bogdan & Devault, 2015). As the research focused on exploring participants' experiences of pursuing a place on a clinical doctorate (DClinPsy) programme, IPA was selected as the most suitable methodology.. IPA is considered a robust approach to analysing and understanding people's experiences (Biggerstaff & Thompson, 2008).

I will now provide a brief account of the theoretical underpinnings of IPA, which are based in phenomenology, hermeneutics and idiography. This is outlined to orientate the reader to the rationale for the selection of IPA.

2.3.1 Phenomenology.

Phenomenology is a philosophical approach that aims to study experience (Smith, Flowers & Larkin, 2009). It specifically aims to capture lived experiences (Finlay, 2011) and attempts to seek an in-depth exploration of how sense is made from our personal and social worlds (Smith & Osborn, 2003). IPA is informed by this phenomenological approach and posits that access to participants' experience is through their "experientially informed lens" (Smith, Flowers & Larkin, 2009). This paves the way to gain an "insider perspective" of an individual's experience (Smith & Osborn, 2003), whilst acknowledging that it is impossible to gain full access to the inner worlds of participants. The contributions of Husserl, Heidegger, Merleau-Ponty and Sartre, have helped to consolidate the theoretical underpinnings of IPA (Smith et al., 2009). Within IPA, there is a focus on experiences which are significant to the participant, which in this context is the experience of DClinPsy applicants from a BME background. Heidegger (1962) postulated that we are all a "person in

context", thus, our experiences are connected in relation to others and are to be interpreted by others. This underpins the relation between phenomenology and hermeneutics.

2.3.2 Hermeneutics.

Hermeneutics encompasses the theory of interpretation (Smith & Osborn, 2003). This interpretation is said to consider how an experience appears, and how the researcher influences and facilitates the meaning making process which is related to the experience (Griffin & May, 2012). Additionally, hermeneutics also considers the interplay between the researcher's biases and past experiences, in addition to the new information which is presented to them. IPA therefore involves a "double hermeneutic" (Smith, 2004; Smith, 2015).

In relation to the current study, an IPA approach will involve myself as the researcher, making sense of participants' experiences, who are making sense of their experience of their journey towards pursuing a place on a DClinPsy programme in the UK. Within IPA, first-order meaning making is from the participant, whilst researcher meaning making is considered a second-order process (Smith, Flowers & Larkin, 2009).

2.3.3 Idiography.

An idiographic approach to psychology refers to the specific and unique nature of each individual (Smith, 2015). However, this does not imply that IPA refrains from making generalisations. IPA utilises different ways of making these generalisations, which are done in a more cautious manner (Smith et al., 2009).

Idiography is committed to detailed, in-depth analyses, in addition to emphasising the value of how a particular phenomenon has been understood and experienced by an individual, in a particular context (Smith, Flowers & Larkin, 2009).

IPA is idiographic in nature and is more suited to a small, homogenous sample and aims to gain an in-depth insight into understandings and experiences (Pietkiewicz & Smith, 2014).

2.4 Consideration of other methodologies

A number of other methods of analysis could be suited to this research. Below is an outline of each of these approaches and the rationale for the choice of IPA.

2.4.1 Narrative Analysis.

Narrative analysis (NA) shares IPA's approach to the process of sense making (Smith et al., 2009) and researchers who utilise NA often share the social constructionist position of being sceptical of single truths. When considering NA, I became aware that this methodology is more concerned with the stories that are told over time, how they are constructed, organised and presented (Reissman, 2008). Whilst this temporal aspect of NA may have been useful in considering how participants made sense of their experiences over time, I believed IPA could offer me a deeper exploration of participants' lived experience. This was more in line with my research question. Additionally, NA is primarily concerned with the structure and content of the stories that individuals tell, rather than the meaning making attached to their experiences (Smith et al., 2009). Thus, I believed this would have had reduced emphasis, had I chosen this methodology.

2.4.2 Grounded Theory.

Grounded Theory (GT; Charmaz, 2011; Strauss & Corbin, 1997) shares a number of similarities with other qualitative methodologies, such as using similar sources of data and using interpretations. However, this research project was interested in the experiences of individuals, rather than creating theoretical explanations of how BME applicants feel in their

pursuit of Clinical Psychology training, therefore GT was not considered as the most appropriate option.

2.4.3 Quantitative Design.

Survey designs utilise a quantitative methodology and are a systematic way of gathering information describing attributes from a group of individuals. These attributes attempt to describe the basic experiences of populations (Roever, 2015). A survey design would be useful in using larger sample sizes, however this research project was interested in the depth and richness of participants' experiences; which a survey design may be not be able to capture.

2.4.4 Thematic Analysis.

Thematic analysis (TA) was considered for this research as it aims to identify, interpret and report patterns within data (Clarke & Braun, 2014). However, it has been discussed that TA can often result in broad, descriptive analyses of a number of participants (Hefferon & Gil-Rodriguez, 2011). Although TA is said to be atheoretical, with epistemological flexibility (Aina, 2015), I believed IPA would provide a richer analysis of the data. This is because of the penetrative, idiographic focus of IPA, alongside the use of hermeneutics to understand lived experience (Smith, Flowers & Larkin, 2009).

2.5 Consultation

An initial interview schedule was put together based on previous research with BAME trainee clinical psychologists and newly qualified psychologists. This initial interview schedule was also refined after supervisory meetings. To assist with the development of the interview schedule, I met with an assistant psychologist who identified as being from a BAME background and was on their journey to pursuing a place on a UK DClinPsy

programme. A pilot interview was carried out using this initial interview schedule. Through this process, I was able to reflect with this consultant on their experience of the questions, including wording of questions, how the questions were received and what additional questions might be useful to include. The process of carrying out this pilot interview was necessary in the development of producing a meaningful and valid interview schedule which was in line with the research aims and questions. The data from this pilot interview was not used as part of the final analysis and the consultant was not a participant in the study.

2.6 Participants

This section will provide information on the inclusion and exclusion criteria for the study, which will be followed by the sampling and recruitment strategies used. I will then provide an overview of details of the participants.

2.6.1 Inclusion criteria.

To be eligible to take part, participants were required to identify themselves as coming under a Black and minority ethnic group as defined by the Office of National Statistics. This includes participants who identified as being from a Black African, Black Caribbean or Black Other background, as well as Asian Indian, Asian Pakistani or Asian Bangladeshi background. This criteria posits that the term "ethnic minority" refers to people choosing a category other than "White". This excludes White ethnic minorities. Skin colour was deemed an important criterion due to its importance in race relations (Bar-Haim, Saidel & Yovel, 2009).

The minimum requirement for entry onto the doctoral program is an undergraduate degree and thus only those who had completed their undergraduate degree were included in this study.

2.6.2 Exclusion criteria.

These criteria stipulate that the term "ethnic minority" refers to people who chose a category other than White in the 2001 census. Thus people who self-identified as belonging to a White ethnic minority group were not included in the study.

2.6.3 Sampling strategy.

A purposive sampling procedure was used (Patton, 1990) in order to recruit participants who were able to share their experience of the phenomenon in question (Smith et al., 2009). All participants were recruited from contact with an "aspiring clinical psychologists" group based in London. This was a group which was founded and run by aspiring clinical psychologists and met on a monthly basis in order to provide peer support and a space to discuss matters related to clinical psychology training; such as applications and interviews. Members include people who are hoping to gain a place on a clinical doctorate programme within the UK and were predominantly based in the London and Hertfordshire regions.

2.6.4 Recruitment.

I was invited to give a presentation about the DClinPsy programme I am currently on to the "aspiring clinical psychologists" group. Following this presentation, I gave a brief presentation covering the aims of my study, with an invitation for those who were interested in taking part to contact myself. Consent for this was provided from the organiser of the event in advance of the presentation day. Once initial contact was made, an email was then sent to those who were interested with the research information sheet (Appendix D). Within this email, I was explicit about the aims and purpose of the research. The information sheet gave details of what would be required of the potential participants, along with details on how their

information would be stored and their right to withdraw. Participants who continued to express interest in the study following reading the information sheet were then emailed a demographic form (Appendix E). If eligible to participate, a time and location was arranged for the interview to take place.

2.6.5 The sample.

The final sample of participants included eight females. This number of participants was chosen as it falls within the range stated by Turpin et al., (1997). This number was seen as an appropriate number for doctoral level psychological research using IPA. Additionally, it allows for analysis of similarities and differences between individuals (Pietkiewicz & Smith, 2014). All participants were working within the London and Hertfordshire regions and were all working in roles which were psychologically related, i.e. assistant psychologist, associate practitioner and research assistants. Ages ranged from 24 years to 30 years. Five out of the eight participants attended undergraduate courses whereby they undertook a placement year as part of the degree. In line with IPA's idiographic approach, my intention was to create a homogenous sample. This was achieved by recruiting all female participants who were working within a similar geographical region of the UK. This would allow me to gain an understanding of a particular phenomenon in a particular context (Finlay, 2011). Pseudonyms and other demographic data are outlined in Table 3.

Table 3

Participant demographic information

Pseudonym	Ethnicity	Place of birth
Jasmine	Black British	England
Monica	Black British	England

Priya	Asian British	England
Kim	Black British	England
Fatima	Asian British	England
Elizabeth	Black British	England
Mary	African	Zimbabwe
Charlene	Black British	England

2.7 Ethics

In order to consider and protect the safety and wellbeing of participants, applying for ethical approval was an important aspect of this research (Madill & Gough, 2008). Full ethical approval was sought and approved by the University of Hertfordshire's Health and Human Sciences Ethics Committee. This was granted on 30th October 2017. The protocol number was: LMS/PGT/UH/02983 (Appendix F). The areas below were given particular consideration:

2.7.1 Informed consent.

Informed consent to participate in this study was ensured by providing a detailed information sheet (Appendix D). This information sheet provided key information about the study, including the aim and purpose of the study, the intended method and information about confidentiality. Participants were also informed of their right to withdraw from the study at any time without having to provide a reason and without any penalty. This ensured that participants did not feel obliged to take part in the study. Participants were asked to give their written consent (Appendix G) prior to their interview.

2.7.2 Confidentiality.

As mentioned, prior to their interview, each participant was asked to sign a consent form. They were required to give their permission for the interview to be audio recorded and transcribed by either myself, or a professional transcription service. Participants' names and other identifying information were removed from the write-up of the study and were replaced with a pseudonym. This would ensure their anonymity and confidentiality throughout the research. Data, including audio files and transcriptions, were secured as password protected files on my laptop, which was also password protected. Identifying information such as consent forms were kept securely and separately from audio recordings in a locked drawer at my home address. Identifiable information from hard copies was redacted and stored under their pseudonym.

Participants were informed that audio recordings would be destroyed as soon as my degree had been conferred and any anonymised data would be kept for 10 years post research project submission (June 2028), after which data would be destroyed.

2.7.3 Potential distress.

There was potential for interview questions to remind participants of negative or difficult experiences within their work which may have provoked emotional responses. I assured participants in the information sheet and verbally that they could have a break or terminate the interview at any point and that they were not obliged to answer a question if they did not want to.

At the end of the interview, participants were given time to discuss their experience of the interview and to ask any questions. They were also provided with a debrief sheet (Appendix H) which contained contact details for relevant support organisations.

2.8 Interview schedule

A semi structured interview schedule was developed collaboratively with my supervisors (Appendix I). This was based on relevant literature, drawing on IPA guidance (Smith, Flowers & Larkin, 2009) as well as from consultation feedback following a pilot interview. This was helpful in allowing me to reflect on my interviewing style and how the participant experienced answering these questions. The main topics covered by the interview were their choice of career, their experience of applying for a doctorate course including how being from a BAME background impacted this and what support structures were available or desired by them. It is important to note that although prompt questions on family difficulties in relation to the career were included on the interview schedule in order to facilitate the interview process; these were not used in the interviews. Prompts were also not used to discuss difficulties at work.

2.9 Interviewing procedure

All interviews took place in a location of the participants' choice. Three took place in participants' homes and the remaining five took place in a confidential room at their place of employment. This decision was made as ensuring an environment which is familiar to the participant will support them to share their experiences (Reissman, 2008). Interviews lasted between 45 and 110 minutes.

2.10 Analysis

2.10.1 Transcription.

All interviews were audio recorded and transcribed verbatim. Five of the interviews were transcribed via a professional transcription service, whilst I transcribed the remaining three. All pauses, laughter and other utterances were transcribed to ensure the entirety of the

interview was captured. All transcriptions were checked for accuracy. This service was also required to sign a confidentiality agreement (Appendix J).

2.10.2 Data analysis.

The data analysis followed guidelines recommended by Smith et al. (2009). This involved seven phases which are outlined below.

2.10.2.1 Phase 1: Re- listening, reading and re-reading.

Each transcript was transferred onto a table consisting of three columns, which included reflective and exploratory comments and emerging themes. I read and listened to each transcript several times in order to "immerse" myself in the data (Smith et al., 2009). This allowed me to actively engage within the participant's life world.

2.10.2.2 Phase 2: Making initial notes.

Following this, I made initial notes and reflections. These notes and reflections including anything that seemed interesting or significant in relation to descriptions used, similarities, contradictions and any initial associations that came to mind. This stage involved looking out for descriptive (e.g. events and memories that appeared important to the participant) and linguistic (e.g. use of language, laughter and repetition) comments (Smith et al., 2009).

2.10.2.3 Phase 3: Making interpretations.

After these initial codes, the transcript was then looked at again with a deeper focus on why and how participants made sense of their experiences in a particular way. This involved using:

- Personal insight- Drawing on my own experiences of being a BAME applicant, whilst being aware and bracketing my own experiences; through reflexivity and discussions with supervisors.

- Questioning the data- This allowed for new meanings and interpretations to be found.

- The relationship between the part and the whole- This involved considering parts of the interview and how they related to the whole interview.

All interpretations were kept closely to the original data.

2.10.2.4 Phase 4: Developing initial themes.

This phase involved looking at certain parts of the data, in addition to considering the whole transcript including comments and interpretations. Initial themes which summarised these key features were noted in the left hand column of the transcript table.

2.10.2.5 Phase 5: Finding connections between initial themes.

Once initial themes were identified, connections between them were sought in order to bring them together. Each theme was cut out on a piece of paper, which allowed movement of the theme. They were then discussed with my supervisory team in order to identify ways in which themes were related to one another to form "clusters". These clusters then formed the superordinate themes and subordinate themes. A table was devised which showed the identified superordinate themes and subordinate themes, in addition to extracts from the transcript which illustrated and supported these themes.

2.10.2.6 Phase 6: Next interview.

The above steps were repeated individually for all eight interviews.

2.10.2.7 Phase 7: Looking for connections across all transcripts.

This final phase involved printing all superordinate themes and subordinate themes from each interview onto separate pieces of paper. A similar process to phase 5 took place in that connections and patterns of similarity and relatedness were sought between them, followed by the formation of "clusters". These were then discussed with my supervisory team. Once the final superordinate and subordinate themes were developed, extracts from the dataset were placed into separate word documents in order to illustrate each superordinate theme and subordinate theme. An audit trail of these phases can be found in Appendix K.

2.11 Quality assurances in qualitative research

It is important to note that criteria used to evaluate the reliability and validity in quantitative research may not be applicable or easily transferred to qualitative methods (Barker et al., 2015). Therefore, specifically produced guidelines for evaluating qualitative research (Tracy, 2010) were used to consider the rigor and trustworthiness of this research. Tracy's (2010) framework offers eight criteria for evaluating the quality of qualitative research. These include worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics and meaningful coherence. A table detailing these criteria, including the measures taken to meet these criteria can be found in the discussion chapter and Appendix L. Quality criteria relating to rigor, sincerity and credibility of the study will be addressed in this section.

2.11.1 Rich rigor.

Tracy describes "rich rigor" within a study as having both abundance of data as well as having sufficient richness within the data. This is measured by exercising appropriate time,

effort, care and thoroughness to support claims made within the research. Rich rigor was achieved by carrying out eight in-depth interviews with participants. Additionally, effort and care is demonstrated through the documentation of the data collection and analysis procedure earlier in this chapter. A reflective diary was used throughout the research process (Appendix A) which was used to document thorough reflections about the data. A data audit trail has also been provided in Appendix K in order to substantiate claims made.

2.11.2 Sincerity.

Sincerity within qualitative research is achieved through self-reflexivity and transparency (Tracy, 2010). Self-reflexivity is a term which describes the ability to be aware of one's own subjectivity, bias and possible influence on participants and the data which they provide. For example, I am aware that having been a BAME doctorate applicant, I may have preconceived ideas about what participants may have experienced. However, in an effort to maintain sincerity throughout the research process, I aimed to continuously reflect on what my position and biases may be and how they may have influenced what I saw within the dataset. This self-reflexivity was maintained through each stage of the research process by keeping a reflective diary, through regular discussions with my supervisory team about my feelings and views of the developing themes and analysis and via a bracketing interview. At the beginning of my research process, I engaged in a bracketing interview with my supervisor. This interview focused on my interests in the current project and my own experiences of pursuing a place on a doctorate programme. This was done to ensure that I did not carry out interviews or analyse data with preconceived ideas, based on my own experiences and assumptions. Through this process, I was able to separate my assumptions and experiences from participants' experiences. This has also been demonstrated in the Results chapter, where my reflections can be seen in italics.

Transparency has been sought by outlining the research and data analysis process in this chapter, but additionally by providing an audit trail of how superordinate themes and subordinate themes were derived.

2.11.3 Credibility.

Credibility refers to the plausibility and trustworthiness of the findings. Tracy (2010) describes credibility as "thick descriptions" of the data being provided in the write up, including the liberal use of direct quotations and samples of transcripts and data codes in order to substantiate claims of the study. Moreover, a number of direct quotes have been used in the Results section. An audit trail of a complete transcript can be found in Appendix K Additionally, a section of a transcript was coded by a member of my supervisory team, as well as a fellow IPA researcher. This allowed comparisons and differences to be explored within analysis.

3. Results

In this section, I will present the findings of my Interpretative Phenomenological Analysis (IPA) of the experiences of BAME Clinical Psychology Doctorate applicants.

Three super-ordinate themes emerged and were identified following the data analysis, which will form the basis of this account:

- *The challenge of negotiating multiple identities and narratives*

- *Grappling with White privilege*

- *Finding value in being a BAME applicant*

It should be stated that the IPA analysis presented here is one possible way of meaning making from the material gathered through interviewing participants. It is acknowledged that the double hermeneutic process present in IPA is influenced by the researcher's perspective (Elliot, Fischer & Rennie, 1999) and may have resulted in differing emerging themes for other researchers. However, I have attempted to present a rigorous and systematic account of participants' experiences. A more detailed description of how this was achieved can be found in Chapter 2.

Although all eight participants provided a rich and multi-layered account of their experiences, due to word restrictions, it will not be possible to present all their experiences here. I will aim to represent the overlap, divergence, convergence and idiosyncrasies of participants' experiences throughout the themes presented.

To illustrate my themes, I will use verbatim quotes from the interviewees. The super-ordinate themes and subordinate themes (table 4) will be reported alongside my personal reflections to portray the reflexive contribution to research process.

THE EXPERIENCES OF UK BAME DCLINPSY APPLICANTS

Table 4

Super-ordinate themes and Subordinate themes

Super-ordinate theme	Subordinate theme
The challenge of negotiating multiple identities and narratives	The meaning of choosing a career in mental health
	Negotiating personal and professional values
Grappling with White privilege	The hardship of dealing with racism
	"Black tax" and the struggle of not being White
	The dilemma of fitting in
Finding value in being a BAME applicant	Comfort in connections
	Strengths in diversity
	The gift of resilience

3.1 The challenge of negotiating multiple identities and narratives

This first superordinate theme refers to the complexities that participants faced in navigating and negotiating their multiple identities, as well as the narratives that informed these identities. Participants spoke about their cultural identities and how this influenced their views on mental health, the profession of clinical psychology and the decision to pursue a career in this field. This was informed by familial views in addition to their own personal goals and desires with regards to which career path they chose. Participants spoke of wanting to make changes within the field of clinical psychology which added to the complexity of the

driving factors behind pursuing a career in this discipline and additionally, what choosing this path meant to them and their families. Many participants faced dilemmas merging their personal and professional values, which was made more complex, as these value systems continued to evolve and change throughout their journeys to becoming aspiring clinical psychologists.

3.1.1 The meaning of choosing a career in mental health.

Participants spoke about how their cultural backgrounds had shaped their views on mental health, as well as the internal and external influences on their choice to pursue a career in mental health.

A number of participants spoke about their backgrounds and how this tied in with their understanding of mental health. Below, Monica describes not receiving any messages in relation to mental health from her family. However, her emphasis on speaking about the lack of messages could imply that perhaps this is something she would have liked to learn more about from her family. Not receiving messages about mental health may have implied to Monica that one shouldn't speak about mental health.

> I think a lot of it does come from sort of the messages that you're brought up with and
> the kind of messages that you get about mental health, or the lack of messages
> actually. My own knowledge about mental health doesn't come from my family
> background, I sourced that information because I was interested in it. (Monica)

This was echoed by Priya, who mentions the absence of speaking about mental health within her family. Throughout this extract, Priya explains that she has observed a change within her grandfather's behaviour and hypothesises that this change is in relation to him experiencing chronic pain. However, she appears to be finding it difficult to raise awareness about his experiences to him as he interprets his experience very differently.

> I guess because for them mental health is just not even a thing, for example, right now I'm working in a chronic pain service and I'm sure my grandad's got chronic pain, but it's not that he'd ever identify with that... he's stopped doing a lot of things that he used to do, he's literally so lonely and quiet, not depressed, but he's a lot quieter than he used to be, but he'd never see that as like anything wrong with him, he just thinks of it like "that's the way life is" type of thing. (Priya)

These examples may mean that there is a dichotomy of views on health and illness, dependent on the cultural backgrounds that people come from and their own personal views. Here, both Monica and Priya have sought information regarding mental health and have had thoughts surrounding different clinical presentations, however, their families' opinions and understanding of psychology may influence what choosing this career path would mean for them.

There were also accounts from participants explaining more about their internal motivation for this career and what choosing clinical psychology meant to them. Charlene speaks about the silence that her community has around mental health. However, there appears to an urgency in her language and in wanting to share her knowledge and experience with her community.

> I needed to tell people about it. I needed to tell people about it because it's something that shouldn't be unknown. (Charlene)

This silence was also mentioned by Fatima. Fatima uses the term "ignorant" here, perhaps indicating her impression that there is a lack of mental health awareness and acceptance within her community. However, it could also be indicative of her frustration around her community's views on mental health and the stigma associated with it. Stigma around mental health is a topic which many participants spoke about.

> We need Bengali, Muslim, British individuals in this field to make us aware of what it's about, rather than being ignorant to it. (Fatima)

Related to Fatima's extract of wanting to break down these stigmas that people may hold, Elizabeth and Kim allude to the stigma of mental health within their communities. This was something that was spoken about by all of the participants.

> So, in certain countries, especially Nigeria, you can really identify people who have mental health issues. She [Kim's mother] was telling me, "I know this person is mad because they're going around naked, screaming and shouting off their heads." I'm like, "But that's not, certainly, true here." And she was like, "Because they don't have a mental health problem". (Kim)

> There's a lot of sort of derogatory terms that are used to describe people who do suffer from mental health problems. (Elizabeth)

> It also appeared that the participants were eager to be agents of change for their communities and to change the narrative of mental health. When Monica speaks about actively resolving the problems in her culture, she may be speaking about being an advocate for her community and bridging the gap between communities and Services.

> So I want to look at the problems that people in my culture are facing and work to actively resolve them (Monica)

Participants also spoke about wanting to change the conversations around western ways of conceptualising mental health.

> It was like cultural differences was an extra little slide at the end, like an add-on. Whatever we were talking about that week. It would just be like a little thing at the

end like, "Oh and there- there are culture differences. The end." So I made a point of

always being like actually I'm taking it from that angle to begin with. (Charlene)

There appeared to be a variety of factors which contributed to the internal struggle of

choosing clinical psychology as a career. On one hand, participants felt drawn to learning

more about mental health which was their internal motivation. Additionally, they desired to

be agents of change for their communities and to spread awareness as well as acceptance

around the stigma of mental health. However, internal conflict seemed to be instigated when

considering how their families did not view or recognise value in talking about mental health.

3.1.2 Negotiating personal and professional values.

Once participants had made a decision to pursue a career in clinical psychology, they

spoke about having to negotiate between their personal values and their professional values.

This included trying to blend the expectations of being a psychologist, the cultural views of

clinical psychology as a profession and their personal and family values together.

Fatima's quote below indicates that there may be times where expectations of being a

psychologist may not mesh well with someone's personal values.

> As a psychologist, you're going to kind of like adopt an open and curious stance but
>
> when it interferes with your values; it's going to cause a friction between two parties
>
> (Fatima)

Charlene takes this a step further to illustrate why marrying her personal attributes, coming

from a BAME background and her professional skills may not mesh well.

> On the one hand you wanna be seen for like your skill set and the fact that you are an
>
> intelligent person that's capable of doing the doctorate, and on the other hand, you

wanna show how your own background can benefit the field, and I think it's hard to

marry the two without having some sort of, like, controversy. (Charlene)

Here, Charlene speaks about the difficulties in blending her professional knowledge and

skills with her personal knowledge of being from a BAME background. It appears that

participants may feel they need to choose between the two aspects of themselves. This can be

seen in Charlene's description of "controversy" being present when people do try to blend

these aspects.

In addition to trying to navigate and blend both their personal and their professional

values and skills; participants also spoke about the difficulties in relation to maintaining a

professional demeanor, whilst discussing areas within mental health that they felt passionate

about. Monica describes the difficulties she has faced in trying to balance her personal

interests in mental health, which were culturally bound, whilst trying to be professional.

I think sometimes I become quite heavily invested in my own experiences and

become very protective over my own culture. But I think I'm very wary of how other

people speak on issues like this and I think I can become quite defensive. But if my

passion is from a personal point, I think sometimes that can be quite difficult because

I need to be more level-headed. (Monica)

It seems that this was a struggle for her as she is viewed as being defensive instead of

passionate. Her dilemma is highlighted in her self-evaluation that she "needs to be more

level-headed". The term "level headed" could refer to her not wanting to be defensive against

alternative views. However, this phrase could also imply that she perhaps felt she wasn't

level-headed when speaking about topics she was passionate about. The quote below shows

how Monica felt external pressure from her senior management to fit into the team. This may

have also contributed to her difficulties balancing the personal and professional values she

holds.

> I'm the only Black member of staff, and I think my views are so contrasting to certain
>
> members of staff (Monica).

I wondered if this was related to a developmental stage in her career, rather than her feeling

like she couldn't balance out being passionate and level headed. As psychologists, do we all

not feel passionate about certain topics over others? And if so, then is it more about how we

express that passion that is key, rather than feeling we should dim our passion?

Another key topic which nearly all of the participants spoke about in relation to

navigating their personal and professional values; was trying to blend and navigate their

personal goals and the expectations which were placed upon them by family. This also

included navigating their roles as women within society. Fatima explained what she knew

about her community's expectations of her as a woman.

> So, it may be that for a female, they need to stay home, they need to take care of their
>
> elderly or their family and that might interfere with the work they do. It might
>
> interfere with the role that they have to play in society. (Fatima)

In this quote, Fatima gives an example of how it may be difficult to navigate between these

value bases. It could be that Fatima's description of a female could be in relation to herself

and perhaps she may feel that she has to play a role within society and within the profession

of clinical psychology; which may not be true to her personal values. Jasmine also spoke

about the particular pressures of being a woman from a BAME background and how she feels

pressure from her mother to get married and start a family. Jasmine may feel pressured to

forego working towards this career in order to pacify her mother's ambitions for her.

> So, I'm 30 now and my mum is a very traditional Ghanian and so for instance, for her, she was married off to my dad and had me by the time she was 26. So her idea is that, yeah you need to get a job and you need to work, but you also need to make sure that you have a family first and that needs to be your priority. So, she's just very very traditional and she hasn't moved with the times and that's fine. My mum's a little bit like "whatever, just have children and stop studying". That's her approach. (Jasmine)

These quotes, again, indicate the hard work in negotiating the multiple identities and the different societal expectations of being a woman, a person from a BAME group and a psychologist.

Mary also speaks about the difficulties she has experienced in trying to remain true to her personal goals, whilst on this journey to pursuing a place on a clinical program.

> I got to a point where I was either going to have to break my relationship because then I was ready to go anywhere in England where I would get an assistant psychologist job. Or then if the same thing happened with training, do the same thing. I felt like at some point, I had to stop and just think about actually how my life also mattered, and the things that mattered to me were important. (Mary)

It seems that Mary was perhaps allowing her professional values and dreams to take precedent over her personal life. However, when she realised she was doing this, she decided to put forward her personal goals. This highlights the difficulty that participants faced. Although Mary had changed what goals were prioritised- personal or professional; she still struggled to balance these goals in a way that felt comfortable for her.

Some participants described perceiving the DClinPsy course as unattainable to them and that it was a career which was renowned for being uncertain and creating instability in applicants' lives. The feeling of having to put their lives on hold and having to dedicate years

to the process, was interwoven with pressure to progress through the process at a quicker pace. This pressure sometimes came from an internal ambition, but also some participants described that the pressure came from external sources, namely family members. Below, Elizabeth describes not feeling strong enough to go through potential rejections. However, there is also a subtle implication of her possibly feeling guilty about continuing down this path because in doing so, this may affect those around her.

> I know most people say that you have to wait an average length of three years, but even after this year. I don't know whether I'm going to be strong enough to go through kind of potential rejection for so many years before thinking of what to do next with my life because it's not fair on anyone else that's around you when you're experiencing that. And I am starting to be aware of that as well. (Elizabeth)

This was a similar account to others who described feeling that decisions became harder to justify to friends and family who were unfamiliar with the somewhat lengthy and uncertain journey to gaining a place on a clinical doctorate programme.

In making a choice to pursue a career in clinical psychology, participants spoke of the influence their families assert upon them and the impact of these opinions. Jasmine describes the idea of her choosing this career to be a joke to her family as they do not consider it to be a traditionally professional career. This may make it more difficult for Jasmine to maintain motivation in pursuing this career, if she feels that her family do not support her.

> So, my family are originally from Ghana and so in my culture, it's like you either become a doctor, a real doctor, a lawyer, an accountant or you can do something in business as long as you have an MBA. So, this whole psychology thing is like a big joke, especially to my dad. (Jasmine)

She references that a culturally acceptable and traditional role would be to become a "real" doctor; thus making the implication of a difference between different Dr titles.

With regards to other family queries, Priya speaks about how her father had more concerns around the salary within this profession.

At first, the question was "Oh do you get paid a lot? Are you sure you want to be doing that? Will it affect your mental health?" so there was a lot of that (Priya)

This ties in with Jasmine's family's ideas around what is a culturally acceptable career. However, Priya goes on to say that:

I think less Asians know about psychology or go down the psychology route because you need to make money when you're older to support a family and be a doctor, be a dentist, do banking and because of that, it's never been psychology or healthcare, so I think less Asians apply because of that. (Priya)

Priya not only makes reference to being a doctor which is suggestive of a medical doctor, but she also provides a financial rationale for why these professions are viewed in higher regard over other professions. This is echoed by Mary's quote below, where she describes the importance of looking after family.

You don't just come in and you earn money and that's your money. It's kind of like whenever your family is in need, you're putting out as well because there's that whole culture of looking after each other. (Mary)

Although participants gave accounts of the difficulties in blending their personal and professional selves, some gave accounts of ways in which they did manage to balance and blend these identities. Jasmine describes her ability to see things from different perspectives.

She appears to show how this ability may aid her in working within mental health which has an array of service users from a variety of different backgrounds.

> I have my culture as being Ghanaian and I was raised in the states so I have that culture as an American and then obviously living in the UK for however many years, so it's like being able to look at things from different perspectives, understanding how different cultures may interpret and filter different information. (Jasmine)

These subthemes within the first super ordinate theme highlight how participants had to negotiate their professional and personal values through different layers and contexts. This negotiation, in addition to what it meant to participants to choose a career in this field presented the challenges of negotiating multiple identities and narratives.

3.2 Grappling with white privilege

Whilst the first super ordinate theme referred to difficulties participants may have faced internally and within their families or communities; in this super ordinate theme refers to the difficulties participants faced within the systems and teams that they were working. Throughout the interviews, participants spoke of experiencing and facing challenges with regards to White privilege. This was a term which was used by the majority of participants in reference to the inequalities they experienced on their pursuit of training. Participants spoke about the difficulties in grappling with these inequalities and how this impacted on them. This super ordinate theme encompassed three sub-themes: participants' experiences of racism, having to pay "black tax" (i.e. working harder) and contending with fitting in. Participants spoke about the hardship of dealing with overt racism and micro aggressions within the workplace, but also how these experiences made them feel silenced. They shared experiences of being on the receiving end of unconscious bias and the difficulties they faced in relation to positive discrimination. With regards to "black tax", participants spoke about

the constant comparisons they made between themselves and white peers and how these comparisons made them feel that they had to work harder. Finally, participants spoke of the dilemmas of not fitting in with the majority White British workforce and impact this has had on them.

3.2.1 The hardship of dealing with racism.

Participants described two different variations of the racism they had experienced. There were accounts of overt racism from service users, and there were also accounts of being on the receiving end of people's unconscious or unspoken bias.

Jasmine provided a detailed account of observing her supervisor carry out a neuropsychological assessment with a service user. During the assessment, the service user spoke about two Nigerian nurses who were previously caring for him:

> He [the service user] starts saying how they weren't intelligent and just starts going on about Black people and I was just sitting there thinking, "Okay, I've got to hold my mouth. I have to keep my mouth shut." And he turned to me and was like, "Um, do you mind me making jokes about black people?"(Jasmine)

By Jasmine saying she felt she had to "hold her mouth", may indicate a feeling of being silenced. This may have been a particularly difficult scenario for Jasmine as she was with her supervisor at the time and was just starting within a new post. Being in this position may have meant that Jasmine felt that she had to tolerate this perceived racial abuse.

It is a topic which can be very contentious and controversial and I wondered whether participants felt that they couldn't talk about these experiences and if this was especially true for those with White British supervisors.

Feeling silenced is something which other participants had also experienced and seemed to relate to the idea that one shouldn't talk about racial abuse. As Fatima described, she felt unable to discuss her experiences and issues around race because she felt she shouldn't be speaking about it.

> I didn't speak about it to him either because I thought "you know it's nothing. We shouldn't be talking about it". (Fatima)

Elizabeth described other experiences of overt racism and having to tolerate being called derogatory names. She explains here that she believes service users dislike her just because she is Black. This may indicate an institutional racism which is entrenched within the system.

> Like, I've been called everything under the sun. So, I've had to work with service users who actively dislike me because I'm Black, for no other reason, and kind of have to push that thing aside. (Elizabeth)

In this quote, Elizabeth minimises her experiences by saying that she has to "push that aside". This implies that Elizabeth may not have had the opportunity to discuss these incidents or to reflect on them in supervision or in any other domain. What Elizabeth reflects on in this excerpt highlights how this minimisation of racism may be more widespread. This tolerance of racial abuse, including feeling silenced was experienced by others whilst some participants discussed feeling as though their experiences were minimised by other White British professionals, including supervisors. Participants described racism being so entrenched within the system, that it became difficult for some of those within the majority, i.e. White British, to recognise and be open to participant's experiences. The quote below from Kim highlights how her supervisor was perhaps minimising a situation which occurred and in doing so may have left Kim feeling invalidated and angry.

Because they're obviously White and they don't see like how rude that was. She was like "oh I don't think he meant it like that", and I said, "Regardless of how he meant it as a joke, he offended my skin tone." And then she was like, "Well, I've never had anybody say that to me". And I said, "Yeah because you're White like you don't understand." (Kim)

Kim's statement at the end of this quote sheds light on the contrasting experiences of professionals from a White British background, in comparison to professionals from a BAME background. Fatima also described a similar experience with White British professionals she worked with. However she alludes to the concept of White privilege here by questioning White British professionals' beliefs about their superiority.

It may be something that they are ignorant of, or it may be something that they deny. Because they want their rights, they think they're superior. I don't know, this is just my thinking (Fatima)

Both Fatima and Kim's quotes are controversial in their content. It may be important to recognise the anger that these participants may have felt after experiencing racism (both overt and covert) or in relation to feeling unsupported by colleagues within these experiences of racism.

I thought about the idea of minimisation of racism especially when thinking about institutional racism. The idea of being a professional came to mind and I wondered whether participants were eager to be seen as being professional and therefore didn't want to raise these incidents as incidents. I wondered whether at this stage of their career, they were more willing to showcase their resilience, rather than reflecting on these incidents and how it made them feel. Additionally, I thought about how participants, in particular Fatima, viewed professionals who were naïve to their experiences of racism or may not have experienced

racial abuse themselves. Would this mean that these professionals were blind to the potential impact of these experiences on people from BAME backgrounds? If so, how would this impact on participants' connections with these individuals? I also speculated that if racism has been so embedded within the system, maybe it is viewed as being acceptable.

Although, the majority of participants spoke of overt racist experiences, Priya appeared hesitant to label an experience she had as racism.

This wasn't racism, but the patient didn't want to see me because I was Asian, but that's because she had a previous husband who was Asian and she was white and so she didn't feel comfortable seeing me (Priya)

Whilst these may be unique circumstances, perhaps there was some discomfort in labelling something as "racist" because of the negative connotations associated with this. Charlene also spoke of racism as being uncomfortable as a label.

It's really hard cause I don't really like to…Its weird, it's uncomfortable to talk about, but could be racism (Charlene)

Although at the time, I didn't consider the implications of this discomfort, I wonder if in Priya's case, there was an avoidance presenting itself as naivety. Perhaps it was too difficult, and as Charlene described, uncomfortable labelling an experience as a racist experience. This links back to minimisation of experiences- both from participants' perspectives and other perspectives. There also may be the additional layer of trying to make sense of these experiences and the hard work it may take participants to determine whether an interaction or a conversation has racist connotations within it.

Along with specific incidents of overt racism, participants also spoke about the entrenchment of racism within systems and referred to this as institutional racism. When considering the idea of institutional racism, participants' descriptions indicated a feeling of

being let down by the system and feeling that there was an institutional injustice. This related to them feeling as though they were being underestimated and undervalued. Being a part of the system in this instance relates to being a professional within the arena of clinical psychology, but also being an individual in the societal systems within the UK. Charlene's quote below, portrays her anxiety around feeling accepted and being taken seriously within her role. This also refers back to the institutional racism whereby people from BAME backgrounds were traditionally working within certain roles. Therefore, seeing someone from a BAME community within a different role can be unexpected for some individuals.

> So for example, you see more people from BAME communities more like in nursing, social work those sort of fields and so you hear now, "Oh what are you doing here?" And it's like, "Oh, yeah I'm here to sort of work" And then I think "am I even going to be accepted, am I ever going to be taken seriously." (Charlene).

Participants also spoke about experiences and thoughts relating to the institutional biases of clinical training, including micro aggressions, unconscious biases and the tokenism of diversity. Below, Charlene describes meeting other people who hold prejudices against people from BAME backgrounds. She talks about how people from BAME backgrounds may not be perceived as good enough and this could also relate to thoughts around not being smart enough to pursue clinical training.

> People might be racist, not outwardly, but where they might have beliefs, that people from those backgrounds, are not good enough or things like that. (Charlene)

Other participants went on to describe the impact of their physical appearances and how other people related to this. Fatima describes how in making the decision to wear her head scarf which is customary in her religion (where she previously hadn't), she was struck by how people interacted with her.

> I didn't know how much of an impact your physical appearance can affect your interactions with others. (Fatima)

This was also echoed by Jasmine who expressed her anxiety on how she would be perceived by interviewers because she is Black.

> I do feel very nervous about going to an interview and wondering "is the fact that I'm Black going to be a problem". It is a fear in the back of my mind (Jasmine)

Elizabeth had explained this same anxiety, and as a result withheld her ethnic identity on application forms for the clinical doctorate and did not mention this in her supporting statement.

> It wasn't so much that I'm not doing it because I feel ashamed of myself, but more so because implicit racism and implicit bias is a real thing and if I can remove that as much as possible, then I will do that. (Elizabeth)

> Participants spoke of the unconscious bias they experienced and also expressed the huge emotional impact this had on them, such as experiencing anxiety or fear of implicit racism. These interactions may form the basis of participants wanting to hide their ethnicities and to try not to appear different from those in more senior positions. However, this was not a shared experience amongst all participants. Monica shared her desire to demonstrate her ethnic identity and show pride in doing so.

> Because I think some people are, "Oh I wouldn't, like oh that's a bit like risky." And I'm like, "That's who you are. That shouldn't be risky." Like I'm writing that all over (Monica)

Although she describes how other people may find it risky, perhaps because of similar reasons as Jasmine and Elizabeth; Monica felt the opposite in fact. The difference in these

positions may be in relation to experiences of racism. As mentioned earlier, both Jasmin and

Elizabeth have encountered experiences of overt racism from service users. However, this

was not the same for Monica. Her experiences which she shared during the interview were

slanted more towards being on the receiving end of unconscious and unspoken bias.

The final point of consideration within the hardship of dealing with racism was the

notion of positive discrimination, which refers to favouring individuals who belong to groups

which experience discrimination, i.e. BAME groups. As mentioned in the introductory

chapter, there have been major developments in clinical psychology doctorate courses in the

UK trying to increase the number of BAME applicants they attract and accept. Although this

was welcomed by some of the participants, other participants felt frustrated and angry about

this process and the assumptions that come with the push for increasing diversity. Priya

related her BAME status with enhancing her clinical application.

> I guess one of the main strengths is the whole shift of them trying to make their
>
> cohorts more ethnically diverse. So, me coming from an Asian background means that
>
> that's a strength for me getting on. (Priya)

However, for others this shift has created anxiety around the numbers of places available,

what this meant for BAME applicants and also questioned whether they will be offered

interviews based on their merit or because of their skin colour. The excerpts from Mary and

Monica below, show how the increased push for diversity within the profession may have left

BAME applicants feeling that it is a 'campaign', which continues to make them feel different

from those who have been traditionally accepted to this program.

> I'm also aware that they would want to have a certain amount of people from BAME
>
> backgrounds. So, I feel like that's even more challenging that I'm from that
>
> background because then I wonder sometimes whether they'll look at it and say,

"Right, we've got three people from the BAME background, and we've got two disabled people, and we've met our criteria, so then we need more people to kind of represent"(Mary)

But I also am like, is this just a tick- box exercise, to be like, yeah we're being diverse. I don't know. (Monica)

Below, Fatima echoes their sentiment, however, she begins to question the authenticity of the process and whether universities are aiming to complete quotas, as opposed to choosing the best candidates for their cohorts.

Because it's one thing saying it and encouraging people to apply because that would increase your rating. But in a way, I feel they want to increase the number of applicants, BME applicants to kind of like make the university look good. Instead of looking out for the best of the applicants. (Fatima)

Whilst some participants saw the positive, or negative consequences of universities increasing diversity, Elizabeth expressed ambivalence and confusion about this process.

I'm thinking if I got an interview, would there then be some bias because I am Black? Um, and that could be biased in either way. Maybe they're like, "Well, it'd be good to have ethnic minorities on the course" or the fact that they might discriminate because I am Black. (Elizabeth)

This ambivalence and confusion may have been a result of conversations with other peers. As Monica's quote suggests, BAME applicants may be left questioning their own skills and abilities from their own experiences, but this may also be reinforced by others around them.

Some people have said things like, "oh, don't you think that they just let ethnic minorities in because they need to, because of this whole new diversity thing. (Monica)

The components of this sub theme highlight the difficulty that participants experience when dealing with racism. Participants spoke of overt racism, unspoken bias and positive discrimination. However, within each area, there was still confusion as to how to manage this well in a way that doesn't alienate them from their teams, but allows them to stand up for themselves and not tolerate discrimination.

In writing this section, I have become engrossed in the nuances of participants' experiences and it has left me speculating on the confusion that participants have articulated. I have become more curious to know how they have managed to navigate this and whether they have- essentially, what are they meant to do? And who are they meant to be? It makes me think of the concept of gaslighting, which is a tactic a person may use in order to gain more power and make others question their reality and the meaning behind interactions. Due to previous, ongoing and recurrent incidents of racism- be that overt or less overt; participants may be more vigilant to the possibility of bias or racism. This may be incredibly hard emotional work for participants and will add to the complexities of being a minority in this profession. Additionally, the anticipation of racially fueled interactions may have a huge emotional impact on participants in navigating these experiences and trying to make sense of them. However, when these racist interactions are subtle and difficult to name and describe, this may leave participants questioning the motives behind them.

3.2.2 "Black tax" and the struggle of not being white.

The term *"black tax"* was mentioned by Mary in her interview. This phrase suggests there is a price to pay for being from a BAME background, and sums up the sense that many

participants had of there being an uneven playing field, where they were having to do more and work harder to have the same chances and opportunities as their White colleagues.

> There's that continuous assumption that if you're from a BME background, you kind of have to do something called "Black tax", where you work more to get the same result as someone else. (Mary)

Throughout the interviews, participants referred to this idea of feeling as though they had to work harder, to be viewed as good enough and to achieve the same accolades as their "white counterparts" (Fatima). Participants would often compare themselves to others. Mary described how she would compare herself to other peers who were from White British backgrounds.

> Because first of all I can't speak the way they do. I can't argue my points very well. And I knew that was probably one of my biggest struggles, expressing myself in a way that sounds extremely professional and convincing. And they were good at that, and they also had everything to their kit in terms of also they had really good experience, like research experience. I didn't have that. (Mary)

In this statement, there is a sense of Mary perhaps second- guessing herself and her own abilities. It seems that she minimises her own experiences and skills such as being able to articulate herself, whilst simultaneously assuming that people from White British backgrounds will be efficient in these areas.

The comparisons described here not only highlight the narrative of people from BAME backgrounds needing to work harder, but also highlight the struggle of not being White. These narratives appeared to be somewhat unconscious for some participants, with them perhaps not recognising where this need to work harder had come from. As Monica describes here, she felt that she had to be on her "A game", but was not sure why this was.

This could be a result of the narrative that she has been accustomed to- of having to work harder than her peers.

> I don't know what it was, but just as soon as I got there, I was just like on my A game. I was like, I'm gonna do everything that I can to like show that I'm capable. (Monica)

The basis of the comparisons mentioned above could be linked with participants' descriptions of social injustice. Fatima alludes to her social circumstances in this extract and how she feels her lack of opportunity may have an influence on her educational achievements and how the lack of support in her community meant she had to be self-reliant.

> From my background living in one of the most deprived boroughs in England, we didn't have great education. We didn't have great developmental initiatives. You do try your best, but we didn't get that opportunity (Fatima)

Several of the participants mentioned speaking a different language at home and with family originating from a different country. This may mean that for some BAME applicants, English is not their mother tongue and in some instances, may not be their first language. Therefore, this may make it harder for them to articulate themselves in the same manner as someone who has had greater educational opportunities and advantages.

> The way your application is, can determine your social economic status let's say, so my language compared to my White counterparts who's probably gone to private schooling is going to be different. They may be more eloquent or they've had more opportunities that I haven't had. (Fatima)

Jasmine also described the struggle of not coming from a White middle-class background and how this meant it was more difficult for her to gain relevant experience. Honorary contracts may be an important factor in the length of time it takes for one to gain the relevant

experience for the clinical course. Nevertheless, it is dependent on applicants' means to be able to undertake an unpaid position.

> I'm not going to lie, it freaking annoyed me. This girl had one year's experience post masters and then she got an interview for two courses and I'm thinking "but I've got more years' experience than you", but one thing we were talking about was that she has the privilege of not working because she's middle class, so she was able to go an volunteer and stuff like that. But for me, I needed to work. I don't come from money like that (Jasmine)

Within both of these quotes, Fatima and Jasmine speak to the assumptions that White applicants may come from a higher socio-economic background to themselves.

This subtheme of "Black tax" and the struggle of not being White and from a higher socio-economic background, highlights another layer of grappling with white privilege and participants feeling they need to work harder in comparison to those who may be more traditionally "suited" for this career.

All but one participant spoke to socio-economic status and it made me wonder about the interaction of class and the BAME status. For example, if the majority of BAME applicants consider themselves to come from lower socio-economic groups, then isn't there an institutional level problem present, regarding the rewarding of unpaid work and thus favouring those with more private funds?

3.2.3 The dilemma of not fitting in.

In addition to managing racism and working harder, participants also spoke of the dilemma of not fitting in. This subtheme refers to participants' struggle with fitting in with the "status quo" (Monica). There were some accounts whereby participants reported being

the only person from an ethnic minority background within the early stages of their pursuit of

clinical psychology such as at undergraduate stages, the teams that they were working in and

what impact this had on them. This included feeling isolated within their pursuit of clinical

training. Fatima's description of walking into her first undergraduate psychology lecture

emphasises the shock she felt by only seeing a handful of people from BAME backgrounds.

> I walked in and instantly noticed that there were two other Asian people, three other
>
> black people, and one Chinese guy. I was just really kind of surprised, speechless… I
>
> think for the whole three years of my undergraduate, I kind of very much felt like a
>
> minority in psychology from the start. (Fatima)

This is similar to some of the other participants' experiences of not seeing role models and

aspirational figures who looked similar to them. The impact of this could have resulted in

participants feeling somewhat isolated in their pursuit of clinical training and not having role

models to look up to.

> I'm assuming from what I've seen, other people had those relationships with people
>
> that were able to mould them, and could always kind of see themselves in that person
>
> to bring them up and make them feel confident. When you don't have someone that
>
> sees you as a previous version of them, like, um, "Oh yeah, I remember when I was
>
> like you, trying to get there." When no one connects with you like that, then how-
>
> who really do you find that is going to mould you and tell you what you need to
>
> know, and kind of give you the little everyday tips?. (Mary)

Here Mary describes not having a role model who could "mould" her as she did not have

supervisors or role models who saw themselves as being similar to her. This lack of

representation within psychology, particularly clinical psychology, may have inadvertently

indicated that there is no place for people from BAME backgrounds within this field. Jasmine

described how she believed courses did not want to diversify their cohorts and felt that this would mean that she would be unsuccessful in her pursuit of clinical training.

> I've just felt convinced that people don't want diversity on the programme, so why should I bother doing this? I'm not going to get on because I'm not this White middle class person with less than half a year's experience, you know what I mean. (Jasmine)

This may have been a frustrating dilemma which Jasmine has had to work through and may have left her wondering about whether she should continue this pursuit. This can be seen by her statement of "why should I bother doing this?"

In line with this inadvertent indication that there is no place for people from BAME backgrounds within this profession, all of the participants expressed anxiety with regards to statistics of BAME applicants being accepted on clinical doctoral programmes within the UK. There appeared to be a sense of hopelessness that the odds were against them.

> Because when you read statistics, there's only one or two and it gets a bit scary. For example, all the trainees who have come here have been white and all the trainees I've seen in the trust have been White (Priya).

This feeling of hopelessness and anticipation of failure, was combined with the thought that one needed luck to get onto the course. This was described by Fatima as "winning the lottery".

With regards to the dilemma of fitting in within teams, Elizabeth describes being the only Black person within her role and refers to this impacting her experience, by being a minority. This highlights the dilemma that comes with having a BAME background. Being visibly different from other people may have made it difficult for Elizabeth to feel a sense of belonging with her team and may have left her feeling isolated.

> I tend to usually be the only black person in my role. Whether that is an honorary
>
> Assistant Psychologist or the Associate, the one that I'm doing now, I am the only
>
> black person in my role. So, I think it has kind of impacted my experiences because I
>
> tend to always be that minority. I tend to always be that one. (Elizabeth)

Charlene echoes what Elizabeth mentioned about being the only BAME person, however, Charlene goes on to say that this can make her feel intimidated. This intimidation may refer to feeling as if she stands out and feeling perhaps out of place within these meetings. It appears that there was a desire from participants to feel accepted by the teams they were working in.

> because there's times where you can go to into like meetings and things and you
>
> might be the only person from that kind of ethnic group or from any ethnic group and
>
> sometimes it can be quite intimidating. (Charlene)

Acceptance was also applicable to different levels such as desiring acceptance on a societal level and within the world of clinical psychology. The perceived lack of acceptance that Fatima mentions below, may mean that it is more difficult for her to fit in with other people who are from different backgrounds to her. She also mentions the connection between society and clinical psychology.

> With what's going around in the media, society, individuals that you come across, it
>
> makes it quite challenging for you to feel accepted in society. And if you feel like
>
> you're not accepted in society, how can you feel like you could be accepted in a field
>
> where it is 85% White? (Fatima)

This was echoed by other participants in that they felt the profession would reject them purely on the basis of their background. Jasmine explained her thoughts around the

profession not looking for someone like her as she does not appear to be the norm of who is accepted onto the courses.

> I genuinely just thought "it's because I'm Black and because these people are White and they come from middle class backgrounds" and when you look at the programme and you look at those who get on, when you look at the psychologists who come out of it are usually White, middle class people. Not to say all of them are, but typically, and I was just like "well I'm clearly not what these people are looking for" and that's what I thought. (Jasmine)

This posed a dilemma for participants in terms of navigating their authenticity, whilst trying not to be too different. For most participants, this dilemma caused confusion and they felt they did not know how to balance these two sides. As Mary describes here, she felt she had to change key characteristics which made her who she was, i.e. changing the way she spoke. It may have been that Mary thought she had to do these things in order to fit in, however, this may have taken her further away from her authentic self.

> I changed the way I spoke. I changed the things I said. I completely lost my London slang 'cause people looked at me like I was crazy when I said some things to fit in, I had to speak like some people as well. (Mary)

I wondered how often participants and other BAME applicants felt they had to do this and reflected on their different identities and how much of each identity we let other professionals bear witness to. I also wondered about the emotional impact of toning oneself down or changing oneself to feel accepted- would participants and other people from BAME backgrounds feel frustrated and angry at the profession for creating this narrative? Or would they feel saddened and confused that they had to change and filter who they were to fit in?

Whilst Mary changed certain things about herself in order to fit in and feel more connected to her colleagues, Monica chose not to change how she interacted with her colleagues and remained as true to herself as she could within a professional capacity. However, this was often interpreted in stereotypical ways, leaving Monica feeling frustrated.

> I think actually at my workplace, like people call me like you know, sassy and things like that. And it's just always what the Black girls get known for… I feel like I'm not taken seriously because it's just "we knew that she was gonna react in this way, you know, she's getting hyped up", so it can just become a stereotype. So I think "Where is this coming from? And why is it that just because I'm speaking out on this and I happen to be a Black girl, like I'm the angry Black girl?" There's just always this stereotypical view of it. (Monica)

Monica's quote explicates the biases and assumptions her colleagues may hold of her. Within this stereotype, Monica has found it difficult to be taken seriously and may leave her feeling further disconnected. This may also have left Monica feeling frustrated that she is being seen as an "angry black girl", but also upset if she feels she is not being taken seriously by her colleagues and seniors.

I was left thinking about the language used in different contexts and how society may play a role in which descriptive terms are more regularly used with different ethnic groups. This also made me think about the role of social media which has been mentioned earlier and how with the rise of social media, certain terms are used more frequently in everyday language such as the term "sassy".

Whilst many participants kept these experiences to themselves, Kim's experience of sharing her feelings of isolation with her supervisor seemed to leave her feeling misunderstood and perhaps more isolated. It could be that her supervisor couldn't identify

with Kim's experiences, however it appears that Kim was left feeling unsupported in managing this dilemma of fitting in.

> I told her that I've struggled socially with the other staff members, and I said, "You know, I don't really feel like I'm clicking with these people". And she just didn't get it, she didn't understand the pressure and I understand she's White, but I just felt that these people don't want to talk to me, and I just was like "as a clinical psychologist-- how are you that naive of what's going on around you?" (Kim)

This experience may have left Kim feeling unheard and possibly rejected at the lack of support she felt she received, but also disappointed as she expected more from a senior member of the team and a clinical psychologist and these expectations were not met.

This subtheme looked at the dilemmas participants faced in trying to fit in to their teams and how these dilemmas have impacted their journeys towards clinical training, but possibly, also their views on the profession.

3.3 Finding value in being a BAME applicant

This final super ordinate theme refers to the value participants found in being a BAME applicant. Participants spoke of the comfort they found in connections with other BAME applicants and colleagues; but also the comfort service users found in connections with participants. The positive aspects of diversity were mentioned by all participants and how this can enhance the profession. Finally, despite the hardship and difficulties they had experienced thus far in their journey, participants spoke of having developed resilience and continued to be driven and motivated to succeed.

3.3.1 Comfort in connections.

Although participants described difficulties in fitting in with the White majority, they also spoke of the connections they found with other BAME colleagues. Once participants found these connections, a void was filled. In meeting like-minded individuals who were also on the same journey, or working within similar career fields; participants were able to find a sense of belonging and support. Monica's quote below illustrates the position that many participants found themselves in, where finding likeminded people who were also from BAME backgrounds was supportive and reassuring.

> I think that there's a lot of support out there, and it's nice to have a network of people that actually share my views, and have similar experiences. Because then it makes me think, if I come home one day and I think "Was I too much today?" I have those days a lot where I just think am I too much, do I need to stop advocating for these issues? And then I like talk to people in my position and I'm like, no, like this is a real thing like. So that's been really helpful. So I think where I am at the moment is actually quite supportive (Monica)

Many of the participants referred to this experience as being part of a community. Being part of a community may involve being emotionally supportive of each other which may take isolation away from their experiences. This may be particularly true for those who have shared similar experiences and have engaged in the constant hard work of trying make sense of these experiences through a racial lens. This mutual understanding, validation and connection may have strengthened the bonds that BAME applicants hold with each other within these professional communities. Below, Mary describes the encouragement and support she receives from other BAME professionals, which may enhance her connections with these individuals.

but people from BME backgrounds, when they see me and they see what I'm trying to

achieve, they're very willing to kind of come and support me and encourage me and

say that we know it's not easy. If you need any help we're here. (Mary)

I wondered whether this description of community was similar to that feeling of being part of

a wider family. Many of the participants shared that they were close with extended family and

some lived with extended family. This sense of being part of a wider network may have felt

familiar to the participants and therefore be seen as a positive aspect of being a BAME

applicant.

As mentioned earlier, some participants struggled to find role models who looked like

them or who were from BAME backgrounds. However some participants did have

supervisors who were from BAME backgrounds. Charlene's experience of having a

supervisor from a similar background to herself enabled her to develop self-confidence and

pride in being a person from a BAME background, working within clinical psychology.

Perhaps having someone who she could aspire to be like, allowed her flourish and embrace

her cultural differences.

I've spoken about it in like supervision and things like that and that's really helped,

because my supervisor was able to kind of relate with me and talk to me about her

own experience and how she's managed it. (Charlene)

It appeared that having supervisors from BAME backgrounds almost gave participants

permission to be themselves and gave them space to reflect on their experiences of being

from a BAME background.

So, when I did my first draft [of my doctorate application], my supervisor sent it back

and she was like "this isn't you, you're trying to be who you think they want you to

> be as opposed to being yourself and you didn't mention anywhere about your
>
> experience of being a Black woman". (Jasmine)

In having this space to reflect on their positions and experiences, some participants were able to recognize the strengths of coming from a BAME background.

> She taught me to kind of just be confident and be more assertive, because there's
>
> going to be things that others may not know or have insight into and you will be
>
> valuable, because you'll be able to give that to the team. (Charlene)

These two extracts both were in relation to BAME supervisors, and within both, there was a sense of their supervisors encouraging Jasmine and Charlene to have pride in their differences from the traditions of clinical psychology and to recognise the strengths that come with these differences.

In addition to feeling more connected to other BAME professionals, participants also described feeling more connected and relatable to service users from all backgrounds. There was a sense that participants saw themselves as bridging the gap between service users and other professionals. Jasmine's experiences of speaking with service users highlights what was seen across all of participants' accounts- the concept of feeling more relatable and allowing service users to feel more understood.

> I remember one of them, he was saying that he was so happy that in our service, all
>
> the psychologists were from somewhere else…I was Black, the placement student
>
> was from an Asian background, one of the other psychologists was Black, the other
>
> psychologist was from Bulgaria and he loved that because what he struggles with is
>
> that often he meets psychologists that are White British and he's like "they can't
>
> relate to me at all and I mean obviously your experience is not going to be my
>
> experience, but even you as someone who's a Black person, I'm sure you know what

it feels like sometimes to be marginalised. These guys, they talk to me out of a

textbook, they don't talk to me from a place of empathy or experience". (Jasmine)

The idea that people from BAME backgrounds and service users may have faced similar

experiences of adversity and marginalisation is a contentious topic. However, it is important

to recognise that this assumed relatedness may present a platform for BAME applicants to

access and interact with service users on a more personal and perhaps more meaningful level.

3.3.2 Strengths in diversity.

When thinking about this relatability and connectivity between service users and

BAME applicants, participants made associations with their cultural backgrounds. All of the

participants articulated that there could be links between coming from a BAME background

and having cultural awareness. As Mary described, coming from a BAME background may

allow her to see things from a different perspective. This was especially true for service users

from BAME backgrounds.

I do have an insight onto some issues that someone else may not necessarily have.

Um, and I do also feel that coming from a BAME background, I might be able to nit-

pick and-and see things from a different picture. (Mary)

Participants recounted being the bridge between BAME service users and White British

professionals as they were able to recognise and "translate" the different views on mental

health. This can be indicated in Mary's quote below.

I can at least understand the experiences of the minorities, and I think that I'll be better

able to treat them or support them. I don't think you can treat really anything you don't

understand. (Mary)

Other participants had a similar narrative. Monica spoke of the value in coming from a BAME background and how this can help to diversify the workforce and moreover share cultural knowledge with other psychologists and colleagues. This sharing of knowledge may promote different ways of conceptualising mental health and thus enabling psychology as a profession to connect with service users (of similar BAME backgrounds) who have negative views or feel stigmatised when usually engaging with psychology teams and services.

> I'm not saying that I'll understand everybody's cultural background but I think having the diversity means that, I mean you can all educate each other. If you've just got room full of White psychologists, you are only going to be able to educate each other on, like, to a certain degree, but the more diversity you've got, you can teach each other and you can have that. (Monica).

I wondered about the impact of coming from a BAME background and growing up in the UK. This blending of cultures may mean that people from BAME backgrounds are more aligned with social constructionist ways of thinking as they may be frequently managing different ways of being and thinking, including multiple truths.

3.3.3 The gift of resilience.

Throughout the accounts, participants spoke about the hardship they had experienced on their pursuit of clinical training. However, between these stories and narratives was an emerging sense of resilience within the participants. It appeared that scenarios and events related to "Black tax and the struggle of not being White" had been a motivating factor in enabling them to be the best versions of themselves as clinicians.

In the extract below, Charlene explicitly states feeling that she will be judged for being Black. However, this judgement may have spurred her to be even better and in essence, prove people wrong about the stereotypes they may hold for her as a Black woman.

> Being underestimated allows you to sort of work harder because you're going to be
>
> judged because you're Black basically or from a BME community anyway. They're
>
> not going to sort of expect you to have these sorts of skills or qualities. (Charlene)

Kim spoke about working harder and how she will be a better clinician for this and through the adversity she has faced. She speaks of the resilience she has developed and views her experiences through a more positive lens.

> Some of us have faced some level of adversity and I think that adversity again builds
>
> character. Just in general and I think having that, I will be able to tackle the
>
> challenging situations that come my way as a potential aspiring therapist. (Kim)

Other participants took this concept further, to suggest that they wanted to keep fighting these judgements and experiences of adversity in order to be motivation for other people and to make changes within the profession.

> It's kind of made me want to be a clinical psychologist even more. So, for that reason,
>
> hopefully one day I inspire someone. (Mary)

> I just have to keep fighting it and I think just, the more I keep fighting it, the more I
>
> keep pushing and saying that I can actually make a change and that somebody like
>
> me, just a normal person, I could actually get there and help people. (Kim)

Mary and Kim describe wanting to be role models for other BAME applicants and how this is a motivating factor for them. Kim also refers to herself as "a normal person", which goes back to previous themes of not feeling good enough and feeling that this career may be unattainable for BAME applicants, but that this enhances her motivation to succeed.

Additionally, working harder meant that participants may have been more motivated and proactive within their pursuit of clinical training. Priya explained how she was consistent and persistent in her applications for assistant psychologist jobs.

I'm quite proactive in that, I knew assistant jobs are hard to find, so I was applying every single day, like I wasn't laid back about it, I was applying a lot. (Priya)

Jasmine also echoed this proactivity, but went on to explain why she had to be proactive and resourceful and how this enhanced her resilience working within this profession.

so when I was working on the ward, I was finding places to volunteer on top of my masters, I would finish work, then go and volunteer, then go to the library and the next day I had class, so I had to be very very resilient and I think it's because I didn't come from money. I had to literally create my opportunities and actually find a way to be resourceful and not bank on the fact that "oh it's ok if I can't work, I can go and volunteer because my parents can look after me". I don't have that luxury. (Jasmine)

Here, Jasmine describes the additional responsibilities she felt she had to take on in order to gain relevant experience. However, she explains how this fuelled her resilience and motivation to succeed.

These sub themes showcase how despite facing personal challenges in relation to navigating values as well as professional challenges, such as grappling with White privilege; participants were motivated to do more. They felt that they were better clinicians as a result of these experiences and have developed immense resilience throughout their journeys to becoming clinical psychologists.

4. Discussion

This study's findings will now be considered in the context of the original research question. The chapter will begin with a summary of the key findings addressing this question which will encompass how these findings expand on past research looking at the experiences of BAME clinical psychology professionals, in addition to the novel contributions of this study to the evidence base. The clinical implications of the findings, as well as reflections on the strengths and limitations of this study will be discussed. Finally, recommendations for further research within this area will be presented, prior to a concluding summary.

4.1 Summary of findings

As previously indicated, the main research question was:

What are the experiences of Black, Asian and minority ethnic (BAME) clinical psychology doctorate applicants within the UK?

The study's findings in relation to participants' experiences of racism and management of their BAME identities, whilst pursuing a highly competitive career path will be discussed below. The findings will be discussed in relation to the sub questions which were outlined in Chapter 1. These were:

- What are the implications of being a BAME clinical psychology applicant?

- What are the issues related to being from a BAME background within clinical practice?

- What are the issues concerning identity development for BAME applicants?

- What are the barriers and enablers for BAME applicants getting onto clinical training?

- What are the available and desired support systems for BAME applicants?

4.1.1 Implications of being a BAME clinical psychology doctorate applicant.

4.1.1.1 Fitting in with the "status quo".

The majority of participants spoke about the need to abide by the status quo and feeling that they needed to hide or filter their identity. As mentioned in previous chapters, it can be argued that the status quo and normative position of clinical psychology is an individual who is female and from a White British middle class background (Baker & Nash, 2013). Therefore, as the norm, this position can often be unchallenged and people coming into the clinical psychology profession are therefore referred to in relation to this normative position (Adetimole et al., 2005). In the current study, the dominance of Whiteness within the profession meant that participants often felt that they needed to moderate or scaffold themselves in order to "fit in". This created an internal battle and dissonance for participants where they felt they either had to conform to the status quo, or remain different and feel disconnected from colleagues. This pressure to conform to the status quo was also reinforced by participants feeling isolated within the profession, something which was echoed by BAME trainee clinical psychologists (Rajan & Shaw, 2008; Shah et al., 2012). This isolation related to standing out as different and the difficulties of being visibly different to the majority of their White colleagues.

Some participants also spoke about not wanting to perpetuate cultural stereotypes which could be explained by "stereotype threat". Stereotype threat (Steele & Aronson, 1995) occurs when people believe they are at risk of confirming the negative stereotypes of their social group. An example of this was given by Monica where she commented on not wanting to become the "angry black girl" within a team at work. These stereotypes may also reflect on the historical stereotypes and representation of BAME groups as mentioned in the introductory chapter. An example being Black men being perceived as being aggressive and dangerous (Francis, 2002).

This was also reported as occurring to other aspiring clinical psychologists during the interview process (Kinouani et al., 2016). The emotional experience of standing out as different has been documented by previous research (Shah et al., 2012) and was echoed within this research. Participants may have had to engage in emotionally hard work to manage these experiences and to moderate themselves. This can be seen within Monica's example and others'.

4.1.1.2 Not feeling good enough.

In addition to feeling that they needed to abide by the status quo, participants spoke about their experiences of not feeling good enough. This was in reference to an internal state of mind, but also in relation to how their experiences of being in the profession had shaped this view of themselves. Participants felt that by not being the traditional image of what a clinical psychologist looks like, they had to work harder in their roles in order to feel worthy of the pursuit of clinical psychology training. This is similar to previous findings whereby people from BAME backgrounds felt like outsiders of the profession (Odusanya et al., 2017).

Interestingly, participants spoke about how courses stating they wanted more ethnic diversity in their cohorts; maintained and reinforced their feelings of needing to work harder. In doing this, participants reported concerns that there was a narrative that people from BAME backgrounds were not offered places on training courses because they deserved it, but because they needed to meet a quota. This narrative has been mentioned in research since 2005 (Adetimole et al., 2005) and has resulted in BAME applicants questioning their own abilities and White applicants questioning BAME applicants' abilities (Rajan & Shaw, 2008). This speaks to how the wider society's minority-majority power relations may be reproduced in the microcosm of clinical psychology. These power imbalances may maintain the status

quo of White as being of more intrinsic value, as well as being implicitly normative and

hierarchically superior in terms of power (Patel, 2004).

4.1.1.3 Difference and racism.

The experience of racism was a challenge that participants faced and another

implication of being a BAME applicant. Participants spoke of instances where overt racism

occurred, predominantly when interacting with service users. However, throughout their

interviews, participants spoke about the difficulties they faced when managing more subtle

and covert forms of racism. This referred to instances where supervisors or other

psychologists would minimise racist experiences or when participants felt they were being

responded to differently because of their visible differences, such as wearing traditional

Islamic attire. These responses to visible differences may be highlighted more to participants

or participants may have felt more sensitive to these issues, due to the rise in cultural hate

crime (ONS, 2017). These interactions were difficult to name. This aligns with Sue et al's.,

(2007) description of "racial micro aggressions" and may explain why some participants

questioned their interactions more so than others; depending on their previous experiences in

relation to race. In navigating these experiences and in attempts to ascertain whether

interactions had racial connotations or not, participants had to undertake tough emotional

work (Hochschild, 2003) to avoid being seen as a victim. This involved having to question,

rationalise or dismiss these experiences. These experiences resonated with other BAME

trainees (Shah et al., 2012) and qualified BAME psychologists (Odusanya et al., 2017) and

was also echoed by Adetimole et al., (2005), where participants wanted to avoid being seen

as victims within their own reflections of their experiences of being trainee clinical

psychologists.

Critical race theory may be used to explain how these dynamics which were occurring between participants and White colleagues or service users. Critical race theory proposes that White supremacy and White privilege and power are maintained over time, despite laws being implemented to promote equality. This theory also proposes the influence and role that law plays in this process (Crenshaw, Gotanda & Peller 1995). It is also suggested that White people may not be aware of the racist encounters or every micro aggressions that occur for BAME individuals and that racism in engrained within society, rather than being the fault of any one individual (Delgado & Stefancic, 2017). This could be seen within participants' experiences whereby they found White supervisors did not always acknowledge or recognise racist encounters participants were facing. Within the same vein as this was White fragility (DiAngelo, 2011). White fragility refers to the idea that a minimum amount of racial stress can become intolerable and uncomfortable. This can often result in White people feeling anger, fear and guilt and may result in behaviours such as silence, argumentation leaving the situation. The functions of these behaviours may reinstate the White racial equilibrium (Di Angelo, 2011). It could be argued that participants' experiences of White colleagues and supervisors tapped into their White fragility and therefore these experiences were not reflected on or explored in the presence of White people.

4.1.1.4 Intersectionality.

In line with critical race theory and White fragility is intersectionality. As mentioned in the introductory chapter, intersectionality refers to the overlapping of different aspects of one's identity which are related to feeling oppressed and are embedded within different contexts which give them power. Within this research, interactions between gender, socio-economic status and race were highlighted. Participants within the study spoke about the hardships they faced in relation to being a BAME applicant, with respects to different aspects

of their identity. With regards to gender, participants spoke about the expectations which were placed upon them by family members in relation to getting married and starting families vs careers. This issue may intersect with the age of participants in that they were all in their mid-20s to early 30s and this issue may be more prominent for these participants in comparison with trainees and qualified psychologists. This may because of the uncertainty of the pursuit of clinical training which participants spoke about. Participants also spoke about the issues in relation to being women in addition to being from a BAME background, such as being labelled as an "angry black girl". This speaks to the additional complexities participants had to navigate in terms of being women and from a BAME background. By speaking out about issues important to them, participants may have felt as though they were placed within stereotypical categories. Socio-economic status was raised by two participants and was another aspect where participants may have felt oppressed or marginalised. Fatima described the impact coming from a lower socio economic background may have had on her pursuit of clinical training.

These examples highlight how participants experienced hardship within different facets of their identities. By isolating one aspect of one's identity, such as being from a BAME background, this may overlook the experience of participants who fall within other groups of marginalisation, such as lower socio-economic groups. This relates to the "double jeopardy" that occurs with multiple subordinate group identities (Cortina, 2001). "Double jeopardy" (Beale, 1979) was used to characterise the dual discrimination of racism and sexism. In line with this, it is argued that women from ethnic minority backgrounds suffer the effects of gender and ethnic prejudice. This theory continued to develop to incorporate a third "jeopardy" based on class (Purdie-Vaughns & Eibach, 2008). This model suggests that people who have multiple subordinate identities may be faced with more discrimination and prejudice than those with a single subordinate identity. An example could be the participants

who identified as coming from a lower socio-economic background may have faced more discrimination by having more than one subordinate identity (i.e. being from a BAME background and a lower socio-economic background).

4.1.2 Issues relating to being from a BAME background within clinical practice.

4.1.2.1 Working relationships.

Participants spoke about their working relationships with colleagues and supervisors and how being from a BAME background had an impact on these relationships. The majority of participants reflected on feeling more connected to other senior BAME professionals and how they were able to gain more support from these relationships than supervisory relationships, which tended to be with White British individuals. This may have been in relation to the power imbalance present in terms of differing histories, privileges and oppression which is experienced by both parties (Patel, 2004). In addition to feeling more connected to BAME professionals, participants also spoke of how they felt little or no connection with their White peers, which has also been documented previously (Rajan & Shaw, 2008). This lack of connection may affect the way participants interacted with colleagues and may be linked to participants feeling isolated within the profession. These issues arose in varying degrees for participants and correspond with previous research (Shah et al., 2012) where trainees felt disconnected and isolated within the profession. These findings may suggest that current policies may not be effective in the way the profession attempts to attract and integrate BAME applicants. Therefore, these are important issues to consider if the profession wishes to diversify and attract more applicants from BAME backgrounds.

Some participants raised instances of not feeling comfortable raising issues related to "race" with their White supervisors. It could be argued that White supervisors may avoid

these topics with BAME supervisees for fear of being viewed or labelled as being racist, fears

around recognition and realisation of their own racism, fears around acknowledging and

managing their White privilege or a fear to take more responsibility to end racism (Sue,

2013). However, avoiding these conversations within a politeness or academic protocol (Sue,

2013), may perpetuate and maintain the colour-blindness and silence which people from

BAME groups often experience (Sullivan, 2014). This silence is then internalised by BAME

groups who then sit with the uncertainty of knowing whether interactions are racially charged

and thus making them more susceptible to micro-aggressions within working relationships

(Sue, 2013).

Whilst these ideas may provide some understanding to why participants felt less

connection with their White superiors, the stronger connection with BAME superiors may be

explained by social psychology theories such as the "homophily" principle (Lazarsfeld &

Merton, 1954), which suggests that connections are formed between those who are alike,

which in this instance would be people who are from BAME backgrounds. It could be argued

that people from BAME backgrounds feel more connection to those, with whom they identify

their social identities and are able to feel safer within these relationships (LeDoux, 1998;

McHarg, Mattick & Knight, 2007).

The "optimal distinctiveness model" (Brewer, 1991) may also provide an explanation

for why participants felt more connected to BAME colleagues and less connected to White

colleagues. This model posits that individuals seek two opposing needs- assimilation and

inclusion in social groups, but also differentiation from others. The model suggests that there

needs to be a balance between inclusion and differentiation in order to meet one's social

needs within groups. Within this study, participants found they were more different to the

majority group, and therefore the need for inclusion was activated and the differentiation

need was reduced. Thus, perhaps participants sought out groups in which they felt more included.

Interestingly, some participants made assumptions about "a room full of White psychologists" being a homogeneous group. Social identity theory and Tajfel's In and Out groups theory (Tajfel, 1979) can be used to explain this. Social identity theory suggests that groups provide a sense of belonging to the social world. It is hypothesised that people divide the world into social groups and create in-groups and out-groups. Tajfel also proposed that by creating these groups, people tend to exaggerate the differences between groups and the similarities of things in the same group (Tajfel & Turner, 1979). Participants in this study tended to make assumptions that all White psychologists were from middle class backgrounds and that they would think about things from the same perspective. Social identity theory may explain these exaggerated similarities.

4.1.2.2 Relationships with service users.

In addition to describing their relationships with colleagues and supervisors, participants also spoke about the working relationships they had with service users. They spoke about how service users often felt more connected to them because they assumed that people from BAME backgrounds would have experienced adversity and marginalisation, similarly to what some people with mental health difficulties may have experienced. Research has also indicated that service users from BAME communities may feel "safer" with professionals who are able to identify better with their cultural background and beliefs (Jones & Devlin, 2009). Although power differences still remained within these relationships, common ground may have been accessed via different aspects of the Social Graces (Burnham, 2012). The Social Graces is an acronym which represents facets of difference in beliefs, power, lifestyle, voiced and unvoiced, visible and invisible. Participants

and service users may have shared similarities in relation to one of these aspects which

created space to develop meaningful relationships, which participants spoke about.

Participants spoke about how this connection with service users allowed them to be better

clinicians. The above experience is one which has not previously been detailed within the

literature and this study therefore adds to the knowledge base in this area. Although

participants spoke of feeling connected to service users, it is also important to note that some

White service users were experienced as racist. This was also highlighted within the 2016

Workforce Race Equality Data Standard Report (Kline et al., 2017), whereby BME staff are

still more likely to experience bullying and harassment from patients.

4.1.3 Issues concerning identity development for BAME applicants.

With regards to participants' identities, almost all of the participants spoke of their

professional identities being influenced by their culture of origin and the British and Western

culture in which they live. This was viewed as a fluid process which tended to change and

vary and was dependent on the context they found themselves in. This was further influenced

by being a part of a profession which is predominantly made up of White professionals.

Therefore, participants spoke of experiencing dilemmas in choosing how much of their

culture of origin to bring in. This experience is known as biculturalism within the literature

(Benet-Martinez & Haritatos, 2005) and refers to the internalisation of more than one culture.

Negotiating this biculturalism may have meant that participants had to adopt more of the

Western British values in order to be seen as worthy and competent clinicians. Additionally,

as previously mentioned, participants spoke about not wanting to portray certain stereotypes.

Therefore, by stepping away from their culture of origin, they may have believed that others

would not judge them according to the stereotypes attached to their minority groups

(Roberson & Kulik, 2007). This also relates to Alleyne's work (2004) whereby participants

may have adopted these values of the dominant culture and dismissed the values from their

cultures of origin. However, some participants did bring in their culture of origin within their

clinical work with service users which was considered a strength and resource within these

instances. Additionally, some participants chose to actively bring their culture of origin

within their professional arena. Hence, this indicates the complexities within participants'

cultural identity developments.

There appeared to be some dissonance for some participants with regards to the

integration of their identities. Through balancing their experiences of feeling included and

differentiated, it was evident that participants were in every stage of the "racial/cultural

identity development model" (Sue & Sue, 2012), including conformity, dissonance, resistance

and awareness. As postulated by Lee (2005), this process was not linear and participants

found themselves moving between stages depending on their changing contexts.

4.1.4 Barriers and enablers for BAME applicants.

4.1.4.1 Cultural views of profession.

Throughout the interviews, participants spoke about the difficulties of pursuing a

career which their families did not consider appropriate or adequate. Examples were given of

comparisons being made between the clinical psychology profession and a career in

medicine, law or business. The main basis of these comparisons were salary and prestige

within the careers. This interestingly differs from how the clinical psychological profession

within a White British UK context is viewed, whereby it is perceived as having a reputable

status (Goodbody & Burns, 2011). This made it more challenging for some participants to

continue to pursue a career which did not align with what their families approved of. These

findings are similar to that of previous studies (Smith, 2017; Turpin & Fensom, 2004).

Additionally, participants spoke of how mental health was conceptualised within their

families and within teaching sessions at university. Participants tended to experience the conceptualisation of mental health within a Western context, with cultural aspects being added on. This is similar to the historical perspective of psychology being developed within a Western context (Fernando, 2017).

4.1.4.2 Cultural views of women's roles.

Participants reflected on the dilemmas of pursuing a career within clinical psychology in relation to feeling that their professional goals did not align with the goals placed upon them by their families. As an example, Priya, Fatima and Jasmine talked about how their families were expecting them to be married and thinking about starting families by this stage in their lives. They commented on how this was difficult to achieve when their professional goal was so uncertain. This also relates to the "inner turmoil" (Meredith & Baker, 2007) that may occur by pursuing a career which may be laced with fear of being rejected by their families and communities. It could be that these issues were more prominent for the pre-qualification group, as opposed to trainees and qualified psychologists as the future remained more uncertain. This is important to consider as the uncertainty of the career path may be a particular deterrent for people from BAME backgrounds.

4.1.4.3 Advocating for BAME communities.

When speaking about their motivation for pursuing this career path, many participants spoke about the desire to help and be an advocate for people from BAME communities who may not access mental health services, but may need to. This was interconnected with constructions people from BAME communities had about mental health and the psychology profession. It seemed important for some participants to explain the importance of mental wellbeing to people from their communities and to try and reduce the stigma attached with

having certain diagnoses. This was a novel finding and has not been mentioned in previous literature within this area.

4.1.4.4 Resilience.

Although participants spoke about the hardships and implications of being a BAME applicant, they also spoke about the resilience they developed whilst working within this profession. Participants felt that their experiences of subtle racism and not fitting in with the status quo enabled them to develop thicker skin when working within clinical psychology. Previous studies have commented on the positive aspects of being from a BAME background (Adetimole et al., 2005; Shah et al., 2012; Odusanya et al., 2017). However, the current study adds to the knowledge by highlighting the resilience participants had developed as a result of feeling they had to face additional challenges of subtle racism, cultural factors such as those mentioned above (cultural views of the profession and of women's roles in society) and not feeling good enough. Participants also felt their resilience enabled them to become better clinicians and allowed them to identify more with service users. Thus, they felt that they were more relatable to service users than their White counterparts and would benefit the clinical psychology profession.

4.1.5 Available and desired support systems.

With regards to available support systems, participants spoke of developing relationships with people from BAME backgrounds as key in feeling supported within their workplaces. Two of the participants spoke about their experiences of having supervisors from BAME backgrounds and how these supervisory relationships allowed them to show more of their personalities and feel "safer" within these relationships (Mason, 2015). Additionally, they found that these supervisors raised issues around culture and race more confidently and openly than those from White backgrounds. This aligns with research suggesting that BAME

supervisors are more likely to spend time discussing multicultural issues than White

supervisors (Hird et al., 2004). Findings from this study indicated that a helpful aspect of

these supervisory relationships was the acknowledgement and addressing of White privilege

and issues around power in relationships.

In line with this idea, participants spoke about wishing there were more role models

from BAME backgrounds. In particular, Mary spoke about how she felt she didn't have

anyone she could aspire to be like and wasn't able to access people who could help to

"mould" her. She spoke about how her White peers were able to easily find aspirational

models and how she felt that this enabled them to gain more confidence in their roles. This is

similar to previous papers which highlight the lack of BAME representation in higher paid

jobs within the NHS (Kline, 2014).

Participants also spoke about the support they gained from peer support networks.

Participants described these networks as being a community where they felt that their journey

towards clinical training was validated and enhanced. Therefore, by finding a safe space with

other BAME applicants and trainees, it could be suggested that there is an assumed implicit

and non-judgemental understanding around issues of race and culture. Therefore, participants

may have felt able to step away from the difficult emotional work of being within a White

dominant profession where they may have felt concerned about being judged as being

different. These findings also align with previous trainee experiences of feeling more

comfortable and able to relax around other BAME trainees, in comparison with White

trainees (Shah et al., 2012).

Interestingly, when thinking about the available and desired support systems,

participants did not mention wanting this support from White colleagues or supervisors. It is

important to acknowledge that no participants described any positive aspects to working with White colleagues and supervisors in regards to BAME issues.

This may have been a result of some participants feeling that some of their experiences with White supervisors was not supportive. However, it is important to recognise that the majority of the clinical psychology profession remains to be from a White background. Therefore, whilst it is important to continue to increase the diversity within the profession, it will also be important to consider how White supervisors and colleagues can best support supervisees from BAME backgrounds.

When participants mentioned wanting to see more role models within the profession, all of those who spoke about role models mentioned feeling excited and happy to see me and how this gave them hope that people from BAME communities do succeed in this pursuit. I couldn't help but feel an array of different emotions by these statements. On one hand, I felt glad that I was able to be that person for someone wanting to go down this career path, but on the other end, I felt frustrated and disappointed that the profession of clinical psychology was still at a premature stage of cultural integration.

4.2 Clinical Implications

I will now note the clinical implications of this study and suggest some recommendations for the profession and for UK clinical psychology training courses.

4.2.1 Sharing knowledge about the profession.

Within this study, participants spoke about how they had to actively seek out knowledge about the profession and how to get onto clinical training. This could imply that the lack of awareness of the profession and the route to becoming a clinical psychologist may not be as clear as other professional routes which are more common for people from BAME

backgrounds, such as medicine. Some initiatives which have looked at attracting people from BAME backgrounds into the profession, have begun to reach out to these communities from an earlier stage at high school (Scior et al., 2016). This is something which should continue to be done throughout the UK, including in lower socio-economic status areas. These initiatives may also benefit from being explicit about the stigma around mental health within BAME communities and how this can often be hidden or not spoken about. Discussion around some of these issues with students from BAME backgrounds may help to facilitate decision making around choosing this career path.

4.2.2 Implications for Undergraduate Psychology Courses.

It appeared that over half of the participants were able to gain initial clinical experience via a sandwich placement year, which was embedded within their undergraduate course. Therefore, having a year where they can gain more understanding and experience within the profession may be a helpful way to attract more BAME applicants into the profession. The heart of this issue may be related to socio-economic status. By having a placement year as part of the course, may provide the opportunity for people who don't have the finances to volunteer to gain important clinical experience.

Additionally, participants spoke about how issues related to difference and diversity tended to be treated as an "add-on" at the end of lectures, rather than being seen as a key concept within their teaching. An implication of this could be to include issues of difference and diversity at an undergraduate stage as a meaningful part of the curriculum. This may help BAME students to feel more comfortable raising these issues and may show them that White lecturers and supervisors are able to take responsibility in raising these issues too.

4.2.3 Implications for the pursuit of clinical training.

Participants raised concerns in relation to not feeling they were able to raise issues of race and culture. Thus, an implication of this could be the suggestion that training could be offered and provided to supervisors which should highlight the necessity of raising issues around culture and race routinely with all supervisees. This will aid in applicants from BAME backgrounds to feel validated and understood by their supervisors, irrespective if their supervisor is from a BAME background or not. This will also ensure that issues around race and culture are not solely left to BAME professionals to address and thus may alleviate some of the perceived burden. This may also allow BAME applicants opportunities to feel supported by senior colleagues. Furthermore, this could allow them to reflect on their experiences and how this impacts their clinical work and professional development. In turn, they may be better prepared for other challenges they may face throughout their training experience. By engaging with supervisor training which addresses these difficult issues, there may be opportunity for practitioners to engage with issues related to difference in a fruitful and meaningful manner. It would be important that this is not achieved in a tokenistic manner, which may defeat its purpose, but in a thoughtful manner that is inclusive (Nolte & Nel, 2012). Additionally, this endeavour can be achieved by CPD courses which highlight issues around difference and provide examples of best practice when working in a culturally sensitive manner with colleagues and service users from BAME backgrounds.

Furthermore, with regards to the development of their professional identity, participants spoke about the difficulties they experienced in relation to being different to the White norm. With further training, supervisors may better able to support BAME applicants to consider and develop their professional identities, whilst acknowledging the White norm and finding ways to move beyond this.

Participants within this study also spoke about the importance of having role models. Therefore, these initiatives and schemes speak to this importance. As previously mentioned, research has highlighted the low rates of ethnic diversity within the clinical psychology profession (Smith, 2016; Turpin & Coleman, 2010; Turpin & Fensom, 2004). Initiatives have been implemented to attract people from BAME groups and backgrounds into the profession (Scior et al., 2016), and should continue to be an on-going focus for the profession. Having mentors from different stages of clinical psychology, e.g. trainee clinical psychologists and qualified clinical psychologists, would allow the support to be maintained for potential BAME applicants. In line with this, is the introduction and implementation of social/ online groups which are founded and run by people from BAME backgrounds. Groups such as the Minorities Group, which is part of the Division of Clinical Psychology Pre-Qualification Group provide a platform and opportunity for people who consider themselves to be minorities in this profession, to make connections and alleviate the feeling of loneliness which was described by many participants in this study and in previous studies (Odusanya et al., 2017; Shah et al., 2012; Rajan & Shaw, 2008). Additionally, having mentors from BAME backgrounds may allow a safe space for reflection in order to consider issues around the navigation and integration of personal and professional values, in a way that feels true and authentic to themselves (Daniel, 2009). It may also be important to consider White mentors in addition to BAME mentors. This may highlight that the responsibility of integration lies with all psychologists and not just those from BAME backgrounds.

4.2.4 Implications for clinical doctorate courses.

The findings from this study show that participants found it difficult to initially find relevant jobs and spoke about not being able to take on honorary positions as they needed to have paid jobs. This speaks to the somewhat inflexible route to gaining a place on doctorate

programmes. It may therefore be useful for doctorate courses to be more explicit in terms of their flexibility in relation to relevant experience. This however, may tie in with an earlier implication of offering placement years within undergraduate study in order for applicants to begin gaining relevant clinical experience.

Participants spoke of being more attracted to courses which placed emphasis on cultural diversity in teaching and research as it allowed them to feel heard and understood. In order to attract BAME applicants, training courses should be more explicit about their commitment to supporting applicants and trainees from these backgrounds (Patel et al., 2000). It may be helpful to provide clarity around why BAME applicants are encouraged and to explicitly state that courses are looking to diversify cohorts in order to diversify the profession; and perhaps highlighting why there is a need to diversify the profession. This may aid in BAME applicants feeling worthy of gaining places, rather than believing they are meeting course quotas (Adetimole et al., 2005).

There are some doctorate courses who offer specific open days for BAME applicants. This may be helpful if it was systematically done across all courses in order to attract BAME applicants across the UK and to encourage diversity as a profession, rather than be limited to certain areas within the UK.

Finally, it has been mentioned in the introductory chapter that proportionally fewer BAME applicants are accepted than those who apply. Therefore, it will be important to consider the interview process and the biases that may exist at this stage, which has been suggested in this research. It may be likely that the majority of those conducting interviews are representative of the profession norm, i.e. White British women. It may be possible that the "homophily" principle could apply here in that they are looking for qualities in candidates that are more similar to them. An implication of this could be to include more BAME

psychologists in selection procedures. Additionally, training could be provided to psychologists who are involved in selection procedures on how to recognise their own biases.

4.3 Strengths and limitations of the study

4.3.1 Strengths.

The main strength of this study is that it focuses on a group of individuals who are often spoken about in relation to their lack of presence within the clinical psychology profession. There has been little research thus far, which allows their voices to be heard and their experiences to be shared. By shedding light on this group, I hope to have empowered my participants by providing a platform for them to be heard in a profession where they feel silenced. This research has also built on the previous studies related to the experiences of BAME professionals within clinical psychology and added novel findings to the evidence base. The novel findings include participants feeling they were able to connect more with service users, because both parties may have had experiences of being discriminated against (i.e. as people from minority backgrounds or as people with mental health diagnoses). Additionally, participants felt motivated to pursue this profession in order to be advocates for BAME communities and wanting to create change in perceptions of psychology and mental health within their communities. Finally, the resilience of BAME applicants was highlighted as a strength of coming from a BAME background, which has not previously been explicitly mentioned.

Although when discussing qualitative research, caution should be maintained as small sample sizes lead to limited transferability, this study has a sample size on the higher end for an initial IPA study (Smith et al., 2009). Each interview was also analysed individually, rather than conducting in-depth analysis on one transcript and using the emergent themes

from this transcript to analyse the rest of the dataset. Thus, this has allowed for more confidence within the results. This speaks to the sincerity of the study (Tracy, 2010).

It should also be acknowledged, that whilst the findings of this study are co-constructed between myself and the participants of this study, several measures were taken to ensure that the results of this study were sincere and credible (Tracy, 2010). For example, my personal and epistemological positions were made explicit in Chapter 1 and personal reflections about the research process can be found in Appendix A. Direct quotes are used throughout the results chapter and an audit trail of analyses can be found in Appendix K which demonstrate the transparency of the research process. Triangulation was achieved by the collaboration of independent researchers to assist with the coding of some interview transcripts. Researchers from different ethnic backgrounds were involved in this process, thus allowing for a broader perspective of the data.

4.3.2 Limitations.

One of the main limitations may come from the recruitment strategy. All participants were recruited from the same "aspiring clinical psychologists" pre-qualification group. The interest in the project was overwhelming with many people wanting to take part in the study and thus due to restricted time, other recruitment strategies were not employed. It could be that BAME applicants from different areas of the UK may have had different experiences.

I wondered at the time about why people were so eager to take part. Was it that they were keen for their voices to be heard? Or was it that they were hoping for any "insider knowledge" of the training course and how to get on it. By being explicit about the research and asking about their expectations, I was able to understand that participants felt this research was important to undertake in order to shed light on some of the issues within the profession and were eager to have their voices heard.

It is also important to consider that those who volunteered for this research may have had more time and opportunity to reflect on their experiences and felt more comfortable talking about their experiences. Thus, this may limit the transferability of these findings to all BAME applicants as people will enter their journey toward clinical psychology training at different stages and with varying degrees of understanding about themselves and the context to which they are entering.

Research has looked at the advantages and disadvantages of interviewing peers (Miller, Glassner & Silverman 2004), however within this research, I was interviewing people who were currently in a position that I used to be in. This provided an additional layer of complexity in that my previous shared membership of this group may have led to a degree of assumed knowledge on my part (Platt, 1981).

I often wondered throughout my data collection and analysis if the data I collected would have been different to that collected from someone from an "outsider position" (Platt, 1981). Was it because participants saw similarities between myself and them and assumed I would understand their experiences and thus felt more comfortable talking about contentious and difficult topics such as racism, or would they have still spoken about these things if the person interviewing them had been from the White British majority?

The requirements of IPA in terms of having a homogenous sample were adhered to by recruiting participants who identified as being from a BAME background. However, a limitation with regards to this could be the variation of BAME backgrounds participants came from. Due to high levels of variation of defining BAME groups (Vivero & Jenkins, 1999), this may have implications towards the transferability of the findings. However, despite this, the convergences and divergences within the data were both presented to show the nuances of the dataset (Smith et al., 2009). The sample maintained homogeneity

by interviewing only female participants. However, this poses another limitation to the study. The representation of males within clinical psychology is low (Caswell & Baker, 2007) and this is even lower for males who identify as being from BAME backgrounds. Thus, the lack of representation within the study may reflect the lack of males from non-White British ethnic groups. This has meant that intersectional issues regarding males from BAME backgrounds were not able to be considered within this study. It is important to note that no men were at the Aspiring Psychologists meeting where I recruited from and therefore I was unable to interview men.

Another potential intersecting issue which could impact on participant experience is socio-economic status. As this was raised throughout the interviews, it would have been helpful to consider this at the recruitment stage. It could be argued that the results may have been different if participants had been from different socioeconomic backgrounds. All but one participant spoke about coming from a lower socioeconomic background.

4.4 Suggestions for further research

As mentioned, a study which could build upon this one could focus on the experience of male BAME aspiring clinical psychologists within the profession. This is a group of individuals who are arguably more of a minority group than females from BAME backgrounds. As suggested by Dodzro (2016), there may also be other issues related to gender differences within this profession, in addition to cultural differences of "appropriate male profession" which warrant further research.

Additionally, in order to enhance the validity of the current study, a replication of this study in other areas of the UK will be valuable and may shed more light on the divergences and convergences of experiences. This research was conducted and recruited within London which has a high multicultural population. It could be that other BAME aspiring clinical

psychologists in other predominantly White British areas of the UK may have varying experiences.

In addition to ethnic diversity, although there have been studies to look at trainee experiences (Butler, 2004), there have been limited studies looking at other marginalised experiences, such as Lesbian, Gay and Bisexual individuals who are pursuing clinical training. Research in relation to being an aspiring clinical psychologist would provide a voice for people who identify as being part of these groups.

Another interesting study could look at the trajectory of BAME clinical psychologists and whether their experiences change or remain the same throughout their journey of pursuing a place on a clinical doctoral programme, to being on the training programme, to life working as a newly qualified clinician and those further along their career path.

4.5 Conclusions

This study provides insight into the experiences of an under researched group of individuals working within the NHS. It speaks to barriers which may be in place for people from BAME backgrounds who are pursuing clinical training. One of the pertinent reasons for diversifying the clinical psychology workforce is so our profession can reflect the BAME population which the NHS serves.

This study used an IPA methodology in order to explore the experiences of aspiring clinical psychologists from BAME backgrounds on their journey towards clinical psychology training. Although the findings provide a rich account of participants' experiences, it is important to note that these accounts are not necessarily reflective of all BAME aspiring psychologists.

The findings of this study have built upon previous findings of BAME trainees and qualified BAME clinical psychologists which show that all experience racism and marginalisation, can feel isolated within the profession and are trying to navigate and integrate their cultural and professional identities. Participants within this study spoke about the difficulties of these experiences, working towards a career where they felt unwelcomed. There was continual reflection in order to ascertain whether experiences and interactions were "innocent" or whether racial connotations were attached.

Participants spoke about the support and encouragement they found from meeting other professionals from BAME backgrounds and how this enabled them to continue to move forwards on their journey. This was in contrast to the sense of competition they felt in relation to White counterparts and how this competition made them feel they had to work harder to achieve the same goals.

Cultural identity was experienced as being complex as there was a dual cultural identity present for all participants. Some participants spoke of the difficulties in blending their culturally traditional views of mental health and psychology with their professional views, whilst others spoke about the isolation in pursuing a career that their families did not understand or approve of.

This study provides insight into an understudied group of individuals and adds to the existing evidence base within this area. The implications and limitations of this research have been discussed, in addition to suggestions for future studies within this area.

4.6 Final reflections

Throughout this research, I have felt pressure to do the research and my participants, justice. At times, I recognised my own experiences in my participants words and thus this may have hindered the research process, by my not wanting to let anything go and striving to

capture all of my participants' experience. I tried to remain aware of these feelings and thoughts throughout my reflective diary and through supervisory meetings.

This research has taken me on a journey through recognising and reflecting on my previous experiences, as well as my current experiences. I constantly found myself feeling grateful for having gained a place on a doctoral course. In listening to participants' experiences, I was reminded of myself prior to training. Perhaps I was so thankful for getting onto training that I unconsciously never looked back at the struggles that I, myself had experienced. By carrying out this research, I was able to recognise my previous experiences and recognise the growth I have made throughout training. I hope I will hold onto these learning experiences and reflections and continue to grow throughout the duration of my career.

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Appendices

Appendix A: Reflective research diary

July 2017

I have finally decided on a project which I am interested in and one which I think is important to do. It's interesting how I never considered this project before. It's almost like I've had tunnel vision and have struggled to see other options beyond working with client groups that I am interested in carrying out research with. I feel so strongly about giving a voice to unheard groups or "hard to reach" groups, yet I seem to have forgotten about unheard professional groups. I'm not quite sure why, but I feel somewhat guilty for not considering this project before. I'm really glad I'm doing it now though because I think it really is a necessary project.

August/September 2017

So, I really feel like I have to play catch up. I've spent the whole Summer trying to think of a project and feel like I need to get a move on now. I've submitted my proposal, which came back ok-ish and now have submitted ethics. I'm really hoping it comes through soon because I won't be able to do any more practical work on it until I get ethical approval.

October 2017

So the talk went really well and so many people were interested in taking part in the project. Although, I need to be realistic in that some people may decide not to do it.

So, I've received positive responses from the follow up emails I've sent out. I've arranged dates and places to meet with people. Everything is happening really fast though. I don't think I realised how other people have been wanting their voices to be heard and their experiences to be listened to. I also feel less stressed now that I have a viable project which will work in the timescale I have left.

November 2017

I had my first interview today and it was such a strange, yet empowering experience. I think I've just forgotten how hard I worked to get onto the course because once I was on, there was a different level of hard work to engage in. Listening to what Fatima was saying just reminds me of how difficult this journey can be. I could sense her anger and frustration in what she was saying and how she felt a connection with me because I was from a BAME background too. I really don't think she would have said half of the things she said to me if I was White, or maybe it would have been toned down. It's just made me think though- how we all scaffold ourselves in different ways when we're around different people.

December 2017

I am so glad I am transcribing some of the interviews myself! If I had more time, I would have definitely done all of them. I just feel like it is helping so much with getting to know the data and really understanding what participants have been saying. I'm feeling quite anxious about the analysis stage though.

January 2018

I feel like there is so much going on in my mind around this project and everywhere I turn or every conversation I have brings me back to this project in terms of race inequality and White privilege. I also went to a book launch the other day on Institutional Racism in psychology and psychiatry. It was so refreshing to hear the author's thoughts and hear what other people were saying. I also saw one of my participants there too. This is the second time I've bumped into a participant and it's strange because I feel such a connection to them now. I've spoken about this with my supervisors to be aware of this whilst I'm analysing the data. I sometimes feel like I owe them something and therefore every theme is important and I'm struggling to let things go. I've also decided to analyse each transcript individually, rather than doing 3 and then mapping the others onto it. I just think there's so much richness in the data that I really want to do it justice.

March 2018

So, I've had feedback from both of my supervisors on the results section and one of the quotes I included was raised as being too controversial and bordering being racist too. It made me think more about what was said in the interviews and how participants may have said things to me that they wouldn't, had I been White. I also had a conversation with my supervisors around the vulnerability of the participants, in that they spoke in a safe context. Whilst consent was provided by all participants, my supervisor reflected how sharing some quotes may question or threaten this safety. I feel stuck if I'm honest- I feel really strongly about including all facets of experiences in order to shed light on these experiences, but at the same time, I may risk other people reading certain quotes and ultimately dismissing the research because they may view certain quotes as being racist to White British people. I need to be mindful on how I present information so that there is enough context to situate the quotes. I have heard the interviews a number of times now and know the events that have led up to participants saying certain things, but I need to be aware that other people won't have this background knowledge.

Appendix B: Summary of papers used in the systematic literature review

Author and Date	Participants / Sample details	Research methodology	Summary of study and key findings	Strengths and limitations
Adetimole, Afuape & Vara, 2015	Three female BAME trainees- reflective piece	Reflective piece	• Insidious racism-covert racism • Negative associations with being Black e.g being disadvantaged, struggling or needing additional help- reinforced by BME schemes • Identity development- cyclic processes of identity development- conformity, disagreement and re-establishment • Assumption that Black trainees were lucky instead of hard working • Positive racism and tokenism of diversity in DClinPsy • Lack of acknowledgement of White privilege • Lack of acknowledgement of positive aspects of being Black • Avoidance of race discussions in supervisory relationships	+ Focuses on the Black female experience + Considers the nuances of institutional racism and the implications of this -Based on personal experience and therefore may not be generalizable to other Black trainees' experiences

| Alleyne, 2004 | Thirty Black NHS employees- 18 from educational services (psychology departments, college or university settings), six from social services and six from NHS | Qualitative phenomenological study looking at the experience of being Black in the workplace and the impact of this experience on the wellbeing of the worker | Covert racism by subtle comments and behaviours about individual's race or cultural identity, e.g. failure to notice their presence, meeting silence when a supportive response would normally be expected, white colleagues not making appropriate eye contact when it mattered, repeated instances of isolation, over use of adjectives such as aggressive, scary, angry, frightening. Cultural jokes and offensive remarks, such as being called uncivilised because a Black female psychologist chose not to go to pub lunches. Collusive management in relation to workplace oppression Black workers experiencing more severe disciplinary action than White counterparts Negative effects on physical and mental wellbeing- hypertension, clinical depression Internal and external factors- | +Looks at different professional groups within different contexts

+Adds to evidence base by considering impact of slavery and how this influences relationships

-Difficulties in extracting psychologists' experiences

-Doesn't focus on pre-qualification

-Limited male perspective and limited Asian perspective

-difficult to know how data was analysed |

			internal is feelings, external is management • Identity development • NHS group had poorer outcomes • The legacy of slavery and colonialism shapes Black people's attachments and relationships with White people	
Dodzro, 2016	Reflective piece	Reflective piece	• Provides statistics on underrepresentation of males within ClinPsy, but also underrepresentation of people from BME backgrounds. • Mentions the need for having a workforce which is representative of service users and clients in receipt of psychological services in terms of cultural diversity and gender • Mentions importance of DCP BME mentoring scheme- lack of understanding and awareness around route to clinpsy	+Gives a male BAME perspective -Only focuses on one person's experience, therefore cannot be generalised to other male BAME aspiring clinical psychologists

Kinouani, Tserpeli, Nicholas, Neumann-May, Stamatopoulou & Ibrahim, 2014	Members of the DCP minorities group- 17 members out of group of 70 at the time of publication	Survey about demographic data, open questions about reasons for joining the group, questions about potential obstacles faced on professional pathway, motivation and views about how access to profession could be improved -Descriptive statistics looking at minority characteristics of members -Content analysis on quantitative data	• BME group was largest subgroup, followed by disabilities and then members who identify as LGBT • People joined the group in order to network and raise issues of diversity • Main obstacles included lack of awareness of diversity issues and difference within the profession, low paying jobs and lack of relevant experience • Respondents wanted to continue this profession to make a difference, they enjoyed the job and the sense that clinpsy was one's vocation. • Considers issues around power	+Considers other minority groups such as those who identify as LGBT and those with disabilities -Small sample group so results may not be generalizable -Only 1 male included in study
Kinouani, Ibrahim, Wallace, Nicholas, Baah, Hasham & Stamatopoulou, 2016	Reflective piece	Reflective piece on experiences of selection process for DClinPsy	• Considers theoretical links to application process • Provides suggestions and implications for interviews and support for interviewees	+Offers insight into the lived experience of minority applicants -Subjective experiences and therefore not generalizable to all minority applicants

Odusanya, Winter, Nolte & Shah, 2017	6 female BME qualified clinical psychologists. Qualified for at least 2 years. 3 from Asian backgrounds, 3 from Black British backgrounds	Mixed methods study- IPA and repertory grids	• Feeling like outsiders in the profession- including the positives and negatives of this • Change of feeling less marginalised over time • Having to work harder • Being positioned as an expert • Integration of personal and professional identities and how this became easier the longer into qualification • Feeling proud to be a clinical psychologist • Training as a key time point in professional identity development • Onus on supervisors to raise issues of race	+Credibility checks and triangulation explicitly mentioned -Supplied elements in rep grid may have made it less meaningful for ppts -Small sample size
Patel & Fatimiliehein, 2005	Reflective piece	Reflective Piece	• Struggle against racism with BME clients, participants and professionals • Lack of diversity in psychological ways of working • Being positioned as an expert • Lack of acknowledgement of racism from some professionals and resistance to change within practice and	+Provides a view 15 years after qualification -Subjective experiences and therefore not generalizable to all minority professionals

			Services	
Rajan & Shaw, 2008	8 trainees from UK courses- all female, 2 were Black British, 5 were British Asian and 1 was dual heritage	-Semi structured interviews -IPA analysis	• Experience of BME trainees • Professional issues • Eurocentric ways of conceptualising mental health • Challenges around challenging dominant discourses • Being positioned as experts • Personal/ Professional identities • Issues around racism-institutionalised racism	+Transparency by use of quotations - Little known about male experience
Shah, Wood, Nolte & Goodbody, 2012	Nine trainees- 4 from Black British background, 4 from Asian background and 1 from Chinese background	-Semi structured interviews -IPA analysis from critical psychology perspective	• Power dynamics around conversations about race and difference • Feeling isolated in training • Strengths of being from BME backgrounds • Integration of personal and professional identities • Safe spaces to be authentic and find support	+Builds on previous studies +Emphasises positive experiences of being from BME background

Appendix C: Evaluation of papers from systematic literature review

Guideline Paper	Worthy Topic	Rich rigor	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence
Alleyne, 2004	Yes	The study outlines that interviews took place over a 6 month period. Data is collected from 30 people and used a combined phenomenological approach to analyse data- reasons are provided for why each aspect was chosen, however it is not clear how this approach was used to analyse the data- it would be difficult to replicate the study due to lack of information.	-Self reflexivity is evident throughout the study and the author makes her theoretical position clear. -No data extracts inserted, therefore lack of transparency	-no evidence of triangulation checks or member checks - it doesn't show thick description of how the themes emerged or whether there was divergence between experiences.	The paper was difficult to read as the findings start off by suggesting there are two themes, but then goes on to discuss initial findings and then subsequent findings.	The study provides significant contribution by providing a lens onto workplace oppression.	No mention of ethical considerations throughout the paper	The study uses a qualitative methodology which is appropriate when people's experiences

Kinouani, Tserpeli, Nicholas, Neumann-May, Stamatopoulou & Ibrahim, 2014	Yes	The study states how many participants have taken part, however recognise that it is a small proportion of the members of the group. Some data is gathered via online self-disclosures and therefore may not be accurate.	The authors state they are part of the Minorities group, however do not clarify whether their data has been included in the study. Therefore, the study lacks sincerity.	Both descriptive statistics and content analysis are used to analyse data, however, it is not made clear how this is done or how many participants aligned with the comments reported.	The study is a small one which is very idiosyncratic to the group, therefore transferability is limited.	The study is one of the few which looks at experiences from the pre-qualification group.	Little is provided around ethical information. It is also unclear whether participants knew their self-disclosures on an online forum were being used as data for a public paper.	The aims of the study are not made clear, therefore it is not possible to say if the goals are achieved.
Odusanya, Winter, Nolte & Shah, 2017	Yes	The authors interview 6 individuals which is on the slightly lower end of numbers of participants. However, an appropriate sample was chosen for the goals of the study.	The author's theoretical position is not mentioned throughout the paper which shows no evidence of self-reflexivity. Data extracts were present throughout	Credibility checks are explicitly mentioned and showcase how these were achieved- by other researchers engaging with coding transcripts and	The paper was clear and concise to read and was written in a way that was easy to follow. The findings could also be transferable to other professionals from BAME	The paper is unique in it's combination of repertory grids and IPA and allows an insight into spoken and unspoken views of themselves (participants).	The paper specifically mentions their ethical approval.	The study does achieve its goals and aims and uses appropriate methods to achieve this.

				the paper which indicates transparency.	discussions about any discrepancies.	backgrounds working within health settings.			
Rajan & Shaw, 2008	Yes	The authors interview 8 participants from various training courses throughout the UK which was appropriate for the study. Data is also present to support claims and themes.	Self reflexivity is not present throughout the paper. Data extracts are presented throughout which indicates transparency.	Thick description is provided throughout the paper and context is given throughout the results section in particular. Triangulation is not noted to be present in this paper.	The paper is easy to read and navigate through and transferability to other BAME trainees may be transferred due to study recruiting from different courses across the UK.	The study makes a significant contribution to hearing the reflections of an unheard group.	Ethical considerations are not made explicit, however anonymity is upheld by not using any identifying information throughout the results.	The paper achieves its aims of looking at the experience of trainees from BAME backgrounds.
Shah, Wood, Nolte & Goodbody, 2012	Yes	Nine participants were chosen which is on the higher end for an IPA study and indicates rich rigor was attained by the data. Appropriate procedures were	Data extracts are used to support the themes and claims made in this paper. Self-reflexivity is not present throughout	Thick description is provided throughout the paper and context is given throughout the results section in	Due to limitations of space, not all results are shown in this paper, however the authors choose to highlight new	The study makes explicit reference to the new knowledge gained from this research.	Ethical considerations are not made explicit, however there is no identifiable information in the paper which	Meaningful coherence is achieved in this study by achieving its original aims by using appropriate methodology.

		also in place in terms of interviewing participants.	this paper.	particular. Triangulation is not noted to be present in this paper.	findings to the evidence base.		protects participants from being identified.	

Quality criteria were not used to evaluate the remaining papers (Dodzro, 2016; Kinouani et al., 2016; Adetimole et al., 2005 and Patel & Fatimilehin, 2005) as these were reflective pieces, rather than empirical studies.

Appendix D: Participant Information Sheet

INFORMATION SHEET
University of Hertfordshire

University *of*
Hertfordshire

Doctorate in Clinical Psychology
PARTICIPANT INFORMATION SHEET

(LMS/PGT/UH/02983)

Title of study: Looking at the experience of people from black and minority
ethnic backgrounds (BME) on their journey to applying for Clinical Psychology training in the UK.

Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link:

http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Who is carrying out the study?

The study is being carried out by Romila Ragaven, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Dr Helen Ellis-Caird (Research Tutor at the University of Hertfordshire) and Dr Snehal Shah (Clinical Psychologist working within Hertfordshire Partnership Foundation Trust).

The study has received full ethical approval by The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority.

What is the purpose of this study?

This study will be exploring the experiences of people from Black and Minority Ethnic (BME) backgrounds on their journey to gaining a place on a Clinical Psychology Doctorate programme. Previous research has looked at the experience of BME trainees and also the experience of BME qualified psychologists. To date, there have been statistics published, looking at the percentage of

applicants there are from BME backgrounds and how many are accepted. However, there is no known research looking at the experiences of people from these backgrounds on gaining a place.

My project will aim to develop some understanding of how this experience is interpreted from an individual and systemic perspective. For my project, I am looking to recruit 6-8 people from Black and Minority Ethnic backgrounds who are looking to gain a place onto a Clinical Psychology Doctorate programme within the UK.

Do I have to take part?

It is wholly your choice as to whether you decide to participate or not. If you do decide to participate you will be asked to sign a form recording your consent.

If you do decide to take part you are still free to withdraw at any time and without giving a reason. If you decide to withdraw from the study at a later time, your data will be destroyed.

How long will my part in the study take?

If you decide to take part you would be asked to take part in one audio-recorded meeting lasting around 1 - 1½ hours in a comfortable setting, which could be your own home. The meeting will involve talking to me about your experiences of applying for Clinical Psychology Training. It is fully acknowledged that telling your story may mean that some questions I may ask you might feel sensitive. If any of the questions are found to be particularly upsetting you do not have to answer them.

What happens if I am interested in taking part?

If you are willing to consider participation, please feel free to contact me on the email address below or telephone me on 07800 543 779/ 01707 286322, for further discussion and information about this project.

What are the possible disadvantages, risks or side effects of taking part?

The possible disadvantages, risks or side effects to all participants have been considered. It is unlikely, but it may be possible, that you find the interview process distressing, for example, if you are recalling a specific professional incident relating to your ethnic identity.

Also, if you were to reveal information involving risk to you or to others deemed to be of serious concern, it would be necessary for the principal investigator to make contact with an appropriate third party. This step would only be taken following discussion with you in the first instance.

What are the possible benefits of taking part?

The study provides an opportunity for being provided with the time and space to reflect on often unheard experiences. It is hoped that this research may help those who provide training course, clinical supervisors and other Clinical Psychologists to make sense of, and gain a deeper understanding of the experience, perspectives and needs of people from BME backgrounds hoping to get onto clinical psychology training. In turn, this may facilitate support systems to help this particular group to manage their experiences. Additionally, through reading the findings, other people from BME backgrounds hoping to get onto clinical psychology training, who may have had similar experiences to participants in this study; may experience a sense that they are not alone.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any harm you might suffer 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 (Telephone number: 01707 286322). If you remain unhappy and wish to complain formally you can do so by contacting the project's Research Supervisor, Dr Helen Ellis-Caird (Telephone number: 01707 286322).

How will my taking part in this study be kept confidential?

You will be assigned an anonymous code which will be attached to your interview data, and your identity will be known only to members of the research team. Details of your place of work will not be stated in any reports related to the research. The project may be published in a research paper and to protect your identity, all data will be anonymised by changing your name and other details that would identify you.

What will happen to the data collected within this study?

All data collected will be anonymised and stored electronically, in a password-protected environment, for a period of 10 years, after which time it will be destroyed under secure conditions. Data will also be stored in hard copy format, and destroyed under secure conditions after 10 years. It is possible that data may be re-used or further analysed in future ethically-approved studies.

The study findings will be written in a thesis for doctoral-level research. An article will then be written and submitted to a relevant academic psychology journal for publication. There will be no identifying features or names written in the thesis or academic journal.

Who has reviewed this study?

This study has been reviewed by The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGT/UH/02983

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details, please get in touch with me, in writing, by phone or by email.

Address: Clinical Psychology Doctoral Training College. College Lane Campus, University of Hertfordshire, Hatfield, Hertfordshire, AL10 9AB.

Email: r.ragaven@herts.ac.uk. Tel: 01707 286322.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Thank you very much for reading this information.

Appendix E: Participant Demographic Form

PARTICIPANT SCREENING
STRICTLY CONFIDENTIAL:
Participant Screening.
All participants will be asked the following questions to screen for inclusion and exclusion criteria of the study. Please complete questions 1 - 5.

Was verbal consent obtained from the potential participant before asking the questions below?
Yes/No

1) What is your ethnic group?
Choose ONE section from A to E, then ☐☐the appropriate box to indicate your ethnic group.
A White
☐☐British
☐☐Any Other White background, *please write in*
_____

B Mixed
☐☐White and Black Caribbean
☐☐White and Black African
☐☐White and Asian
☐☐Any Other Mixed background, *please write in*
_____

C Asian or Asian British
☐☐Indian
☐☐Pakistani
☐☐Bangladeshi
☐☐Any Other Asian background, *please write in*
_____

D Black or Black British
☐☐Caribbean
☐☐African
☐☐Any Other Black background, *please write in*
_____

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: _____

Appendix F: Ethical Approval

University of Hertfordshire **UH**

HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO: Romila Ragaven

CC: Dr Helen Ellis-Caird

FROM: Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chairman

DATE: 30/10/17

Protocol number: LMS/PGT/UH/02983

Title of study: Looking at the experience of people from a black and minority ethnic (BME) background on their journey to applying for Clinical Psychology training in the UK.

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 30/10/17

To: 30/09/18

Additional workers: no additional workers named

Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. 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 (if you are a student) and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A 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 G: Consent Form

University of Hertfordshire

University of Hertfordshire

UH

Doctorate in Clinical Psychology

Participant Consent Form

Title of Project: Exploring the experiences of the BME population when applying for the Clinical Psychology Doctorate (**Protocol Number: LMS/PGT/UH/02983**)

Researcher: Romila Ragaven: Trainee Clinical Psychologist

Please initial box

1) I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered.

2) I understand that participation is voluntary and that I am free to withdraw at any time until the point that the research is written up (approximately April 2018), without giving any reason.

3) I understand that the information I provide will be audio recorded and transcribed and will be anonymised for the use of the study.

4) I have been informed that I have the right to a de-brief following completion of the research study.

5) I agree to take part in the above study

………………………………….. …………….. …………………………

Name of participant   Date   Signature

………………………………….. …………….. …………………………

Name of researcher   Date   Signature

Appendix H: Debrief Sheet

DEBRIEF SHEET
University of Hertfordshire

Doctorate in Clinical Psychology
DEBRIEFING INFORMATION SHEET
(LMS/PGT/UH/02983)

Thank you very much for making this study possible.

You have now completed your interview where I asked you about your experiences of applying for a Doctorate in Clinical Psychology course. I particularly asked you about your journey on applying for the course. I asked you about a range of experiences that you may have encountered on this journey and how you have dealt with issues that might have arose involving difference. I also asked about how you feel you have been supported when considering diversity.

The purpose of this study was to explore the experiences of applicants from BME backgrounds on their route to gaining a place on a Clinical Psychology Doctorate Course. This study aimed to explore the support this group experiences with the hope that changes, if needed, can be made by Doctorate in Clinical Psychology courses. There has been little research detailing the experiences of these applicants whose diversity and difference may be not spoken about and it may be that a better understanding of this group experience has potential implications across all areas of clinical psychology training. This study aimed to explore these implications.

If you have any questions about the study you can contact me on:
Email address: r.ragaven@herts.ac.uk
Telephone number: 07800 543 779
Postal address: Doctorate in Clinical Psychology Training Course
                         University of Hertfordshire
                         Hatfield, Herts., AL10 9AB

Sometimes talking about your experiences can stir up emotions. If you need to talk to somebody about any difficulties, or worries that you might have, some of the information below might be useful for you. Please also think about contacting your supervisor, if you have one, and/or your GP.

***Mind*info*line:** *0845 766 0163* info@mind.org.uk*
          Mindinfoline PO Box 277 Manchester M60 3XN
SANEline: 0845 767 8000
Samaritans: 08457 90 90 90

Appendix I: Interview Schedule

INTERVIEW SCHEDULE

Career Choice

1. Why did you choose to study psychology?

2. What made you choose clinical psychology as a career? Why choose clinical psychology over other options (e.g. counselling psychology)

   Prompts:

   a. How does your family view your career choice?

   b. Can you tell me about any challenges and dilemmas you might have faced in making a choice to do clinical psychology training? [e.g. family commitments and obligations, cultural beliefs about women working, family's view of psychological distress or working with certain client groups e.g. LD?

Experience applying to doctorate

3. How did you find out about the route to becoming a clinical psychologist and about the doctorate?

4. How long have you been thinking of/ actively applying for the clinical psychology doctorate?

5. What has been your experience thus far of applying for the doctorate?

   Prompts:

   a. How have your experiences being from a BME background affected your decision to apply for the doctorate?

   b. Do you think being from a BME background has impacted your journey to getting onto the doctorate? How?

   c. Can you tell me about any specific strengths/resources that come with being from a BME background when applying for the doctorate?

   d. Can you tell me about any specific limitations/dilemmas that come with being from a BME background when applying for the doctorate?

   e. What considerations do you have when choosing which DClinPsy course to apply for?

Support

6. Can you tell me about ways in which you tend to manage any difficulties or dilemmas related to ethnicity that might arise in relation to pursuing clinical psychology training?

7. Are you aware of any relevant support structures available to you e.g. via workplace, other organisations?

8. What kind of support structures do you think would be helpful for other aspiring clinical psychologists from BME backgrounds?

Experience of interview

9. What has the experience of being interviewed for this research been like for you?

Final question

10. As we are coming to the end of our interview, is there anything else that you feel would be important for me to know about your experience?

Appendix J: Transcription Confidentiality Agreement

Doctorate in Clinical Psychology

University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

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

Romila Ragaven ('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.

Should the recipient recognise the interviewee in the recording, they agree to return or destroy any copies of the recordings and will not transcribe the interview to ensure confidentiality.

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 L: Quality assurance for current study (using Tracy's big eight criteria, 2010)

Quality Criteria	Evidence of meeting criteria
Worthy topic	Tracy (2010) describes a worthy topic being one that is timely, relevant, significant, interesting or evocative. The literature review in the introductory chapter highlights the paucity of literature in the experience of the BAME pre- qualification group. Although there have been accounts highlighting the need for increasing diversity within the clinical psychology profession, very little research has highlighted what people's experiences are and how the profession can help to support these individuals in an effort to diversify the workforce.
Rich rigor	Rich rigor is defined as having a rich complexity of abundance that provides face validity. The current study employed the use of semi structured interviews which allowed the use of quotations throughout the results section of this report to illustrate the themes which emerged from the data. Additionally, throughout the analysis phase, close line-by-line analyses were carried out in order to ascertain the pertinent elements of the data; in addition to the convergence and divergence across the dataset. Further details about the procedures used within this research can be found in the method chapter.
Sincerity	Sincerity refers to the transparency about the researcher's biases and goals. I have outlined my personal and epistemological positions in the introduction chapter and have demonstrated my personal reflections

	about the process, my expectations and thoughts throughout the report. Additionally, the use of a reflective diary (Appendix A) allowed me to remain reflexive throughout the research process.
	The transparency of the research process can be seen by the use of quotes from interview transcripts throughout the results chapter. Additionally, an "audit trail" is included in Appendix K, which provides the process of the analysed transcript and the process by which emergent themes were derived. The self-reflexivity and transparency methods I have utilised throughout this research process, allow the reader to hold this in mind whilst engaging with my interpretation of the data.
Credibility	Credibility refers to the trustworthiness and plausibility of the research findings. Thick description is achieved in this research by explicitly defining key terms in the introductory chapter, by being transparent about the methodological processes and procedures employed in this study, and also by the use of quotations throughout the results chapter. By doing this, the reader is provided with the context of the study and is provided with detail so that they may arrive at their own conclusions.
	Triangulation was achieved by the collaboration of independent researchers to assist with the coding of some interview transcripts. Where divergent codes were indicated, discussions allowed further analysis to take place and provided me with an opportunity to review my codes and to ensure my final codes were grounded within the data. Researchers from different backgrounds were involved in this process,

	thus allowing for a broader perspective of the data and enabled me to become more aware of my own biases. Supervision was also used as a reflective space to think about these potential biases, of which further description can be found about my bracketing interview in the method chapter.
Resonance	Resonance refers to the researcher's ability to meaningfully affect the reader. I have written this study with the aim that it is thought provoking to read, whilst also broadening the reader's understanding of the subject matter and appreciation of the participants' experiences.
Significant contribution	As shown in the literature review, there is limited research to show and highlight the experiences of this particular group of individuals. Thus, the present study adds to the evidence base by highlighting the implications of this study. By shedding light on this population, I hope to have empowered my participants by providing a platform for them to be heard in a profession where they feel silenced. This research has also built on the previous studies related to the experiences of BAME professionals within clinical psychology.
Ethical	Ethical approval for this study was sought and granted by the University of Hertfordshire (Appendix F). Informed consent was gained from all participants and all personal information was kept securely as outlined by the ethics form. Further details about the ethical considerations and process of this study can be found in the method chapter.

Meaningful coherence	Meaningful coherence is known as a clear interconnection of the research design, data collection, analysis and theoretical framework. I have outlined my epistemological position at the beginning of this project and have shown how this position (critical realist) has informed the study design as being qualitative, the data collection by means of semi structured interviews in order to gain insight into participants' lived experiences, and the analysis employing IPA.