Using Self-Practice/Self-Reflection to support CBT Therapists from minoritised ethnic backgrounds: A reflexive thematic analysis

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DClinPsy. Thesis (Volume 1) 2024

University College London

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Date: 20/12/2024

OVERVIEW

Psychological therapists from minoritised ethnic backgrounds play a crucial role in patients' wellbeing and clinical outcomes. Evidence shows that having a diverse workforce brings innovation and improved productivity, and can facilitate help-seeking for patients from minoritised racial/ethnic groups within healthcare settings. It can also foster a more supportive, inclusive space for staff from minoritised racial/ethnic backgrounds. The primary aim of this research is to qualitatively explore the experiences of psychological therapists and mental health professionals from minoritised ethnic backgrounds when working therapeutically with patients from minoritised ethnic backgrounds.

Part One is a qualitative synthesis of findings from 16 qualitative studies exploring the experiences of mental health professionals from minoritised ethnic backgrounds when working therapeutically with patients from the same racial/ethnic backgrounds.

Part Two is an empirical paper reporting the findings from a qualitative study, underpinned by the methodological principles of Reflexive Thematic Analysis. The study was part of a joint project evaluating a Self-Practice/Self-Reflection (SP/SR) programme for CBT Therapists from minoritised ethnic backgrounds. Semi-structured interviews were conducted with nine UK-based CBT Therapists. The unique contributions that the present research can offer with regards to improving support systems for psychological therapists is highlighted. Suggestions for further research are made.

Part Three represents a critical appraisal which has considered the potential impact of the author's previous academic and professional experiences on the

present thesis. It mostly outlines the steps that were taken towards maintaining reflexivity throughout the research process.

IMPACT STATEMENT

The present thesis set out to explore the expressed experiences and perceptions of psychological therapists and mental health professionals (MHPs) from minoritised ethnic backgrounds who are working therapeutically with patients. A particular focus of the present research was to examine how MHPs experience working with ethnically similar or ethnically-matched patients in terms of their perceived technical, conceptual and relational skills needed to work within these dyads. This thesis comprises a systematic review and an empirical paper, both of which employed qualitative methods.

To the author's knowledge, this is the first systematic review to have examined the available qualitative evidence in relation to MHPs experiences of working therapeutically with patients of the same ethnic/racial backgrounds. Given that previous reviews have tended to focus on patients' preferences, perceptions and outcomes of therapy in ethnically-matched dyads, the findings presented provide unique, in-depth insights in to how MHP's across a range of professional groups have experienced working with patients from the same racial/ethnic backgrounds. Overall findings showed that MHP's have very little support in managing and navigating the complexity of the therapeutic space within ethnically-matched dyads, and that there are both strengths and challenges in the way that ethnic matching impacts on the therapeutic relationship and therapy outcomes. The review identified that there is a paucity of studies, particularly in UK contexts, that explore how MHPs from minoritised ethnic backgrounds experience their work with patients from the same racial/ethnic background.

The empirical paper aimed to qualitatively explore CBT Therapists experiences of a Self-Practise/Self-Reflection (SP/SR) programme that supported them to reflect on how their ethnic background relates to their clinical role. The present analysis demonstrated that the programme was generally experienced as a safe space where the therapists could share the strengths and challenges of holding a minoritsed ethnic identity within their clinical role. A finding of particular significance was the observed improvements in therapists technical, conceptual, and interpersonal skills in working with patients from minoritised ethnic backgrounds. The themes suggested that this was mostly developed through reflecting on their own ethnic identities using the SP/SR exercises and discussions within the group spaces. The analysis also highlighted systemic issues, such as scant opportunity and a lack of safe spaces to consider their ethnic identity within their clinical role. This impacted their overall workplace satisfaction and colleague relationships, personal wellbeing, and opportunity to work with their patients race/ethnicity in therapy. Taken together, the research provides important insights into the experiences of psychological healthcare professionals working intra-culturally, and how they navigate their racial/ethnic identity in the systems that they work in.

The research is pertinent to how therapists from minoritised ethnic backgrounds are supported moving forwards. The research will be of interest to CBT training providers and other psychological professions that are involved in developing trainees' knowledge and skills in working with patients from diverse sociocultural backgrounds. The research will also be important for those who manage and commission NHS mental health services as there is scope to develop necessary support structures for therapists. These may include peer support spaces and training spaces specifically for MHP's from minoritised ethnic backgrounds, as well

as developing supervisors' skills in supporting therapists from minoritised ethnic backgrounds. Therefore, the present findings have potential to contribute to developing training and working environments where the personal wellbeing and professional skills of these therapists can be prioritised.

TABLE OF CONTENTS

ACKNOWLEDGMENTS

Thank you to my loving mother and father for your wise, caring and inquisitive nature, and to my sister Sophia for all of your understanding and encouragement.

To my Fiancé Daniel, I deeply appreciate the ongoing love, kindness and support you have shown me day-in day-out throughout this process, thank you.

I would like to give special thanks to my research team: Dr. Henry Clements, Dr. Richard Thwaites, Dr. Alasdair Churchard, and to the best research partner I could have asked for, Dr. Sakshi Shetty Chowdhury. The knowledge, guidance, enthusiasm, and commitment you have all dedicated towards such an important research field have been invaluable. I am immensely proud of us all.

Finally, thank you God for walking beside me and hearing my prayers.

PART 1:

A SYSTEMATIC LITERATURE REVIEW

Mental health professionals' experiences of working therapeutically with racially/ethnically matched patients: a systematic review of qualitative studies

Abstract

Aims: Mental Health Professionals (MHPs) from minoritised ethnic backgrounds can incur complex, challenging experiences when working therapeutically with patients from the same race/ethnicity, with little support in navigating these challenges. To understand common experiences and consider relevant support structures for MHP's from minoritised ethnicities, this review synthesises qualitative studies of their experiences of working therapeutically with patients from the same racial/ethnic background.

Methods: The researcher developed the search terms in consultation with the subject librarian and through consulting previous literature on racial/ethnic matching. Searches were conducted within four databases. The titles of the papers were screened and following this, the full-texts of included papers were read. Following this, additional citation searches of the articles included in the review were conducted. Sixteen papers met inclusion criteria. They were methodologically appraised and the findings were synthesised using reflexive thematic analysis.

Results: Three superordinate, interconnected themes were developed in the thematic-synthesis. First, '*Holding knowledge and personal experience of your race, ethnicity and culture'* described the personal and professional impact on MHP's of holding personal knowledge and experiences of their patients' race/ethnicity. Secondly, *'Navigating the therapeutic relationship''* described how MHP's experienced and navigated their relationships with patients from the same racial/ethnic background. Thirdly*, 'Beyond racial, ethnic and cultural identity'*

described factors beyond the MHP and patient that impacted their ability to provide culturally-informed care to their patients.

Conclusions and implications: The review emphasises the need for services to recognise the unique impact that a shared race/ethnicity can have on aspects of MHP's personal and professional lives, and on patient care. The review identifies and discusses appropriate spaces that could be provided to MHP's to navigate the above challenges.

1. Introduction

1.1. The experiences of psychology professionals from minoritised ethnic backgrounds

It is widely understood through research that valuing and striving for a more racially/ethnically inclusive healthcare workforce improves workplace innovation, team communication, decision-making, patient safety and the quality of healthcare (Barak, 2022; Gomez & Bernet, 2019; Hong & Page, 2004). A more accurate racial/ethnic representation in a workforce encourages patients help-seeking behaviours, improves intercultural trust (Eleftheriadou, 2010), and can improve civility amongst the communities a workforce serves (King et al., 2011). Given this, the NHS Equality and Diversity Council within the UK NHS mental health system has attempted to address the lack of representation of staff from minoritised racial/ethnic backgrounds (Kline, 2015; NHS Workforce Race Equality Standard (WRES), 2016; NHS Benckmarking Network, 2021).

However, there has been little focus towards understanding the experiences of Mental Health Professionals (MHP) from minoritised racial/ethnic backgrounds within the UK psychology workforce. Research has found that compared to White British healthcare professionals, racially/ethnically minoritised professionals have lower overall workplace satisfaction (NHS Workforce Race Equality Standard (WRES), 2021). This may be related to structural and systemic factors, such as working in a ‘colonised’ mental health service that disregards indigenous knowledges and idolises Eurocentric models and theories of mental health (Cullen et al., 2020; Dudgeon & Walker, 2015). Additionally, MHPs are more likely to experience workplace racial

discrimination (Rhead et al., 2021; WRES, 2021), less opportunity for professional development (WRES, 2021), and a lack of support with addressing the impact of their race/ethnicity on their work with patients from any ethnic background (Iwamasa, 1996). Although a workforce that reflects the diversity of the community is important, the unaddressed inequalities within MHPs systems and structures is likely to impact on the uptake, retention, and overall professional experience of MHP's from minoritised racial/ethnic backgrounds.

1.2. Definitions: Minoritised, Race, Ethnicity and Culture

There are many definitions and terms that can be used to describe people from minoritised backgrounds. This review follows the definition from The Law Society (2020). It defines 'minoritised' people as those who exist in distinct statistical minorities according to their race, ethnicity, and culture and are treated less equally in society through social processes.

The term '*ethnicity*' can be defined as 'a dynamic, subjective definition of oneself in relation to a range of factors including language, geographical origin, skin colour, political preferences, and religious and cultural practices' (Loue, 2006), which may be passed through generations (Jandt, 2017). '*Culture*' can be understood as a set of attitudes, values, beliefs, and behavioural conventions that are shared by groups of people, and impact on the way individuals understand the meaning of other peoples' behaviours (Matsumoto, 2006; Spencer-Oatey, 2012). The term '*race*' can be understood as a socially constructed concept that classifies individuals by their physical attributes, which do not map on to meaningful and important biological realities (Machery & Faucher, 2005). Racial categories are understood to be malleable over time and in different social contexts (Richeson & Sommers, 2016).

The research into multicultural psychotherapy has used the terms ethnicity, race and culture interchangeably (Cabral & Smith, 2011; Shin et al., 2005). Therefore, like most of the research on race and ethnicity in MHP's, the term 'racial/ethnic' will be used to refer holistically to '*race', 'ethnicity'* and *'culture* within the present review except in instances when these terms are used singularly.

1.3. Implications of race, ethnicity and culture in therapeutic work

Race/ethnicity contribute towards the formation of social realities, experiences, identities, and relationships (Burnham, 2018). They are powerfully influential over the way people think, make decisions, behave, define events and relationships. The salience of an individual's race/ethnicity can be affected by their social context, the visibility of their identity, and how their multiple social identities intersect to form a holistic sense of themselves (Sue, 2001). This is relevant to MHP-patient dyads, as their racial/ethnic identities will have an impact on the therapeutic relationship and may affect the way that concepts of identity and mental wellbeing are explored.

Within psychological therapy, research has shown there are higher dropout rates and lower successful therapy outcomes for patients across racially/ethnically minoritised backgrounds compared to White patients (Crawford et al. 2016; Mercer et al. 2018; Sue et al., 2009). Service providers have attempted to address this by matching MHPs' and patients' racial/ethnic identities, known as '*ethnic matching'* in the literature. There are various constructs of ethnic matching, such as patients and clinicians who share the same racial/ethnic background (Karlsson, 2005; Flaskerud, 1990), perceived physical attributes (Cabral & Smith, 2011) and/or cultural practises (such as holding the same religious identity) (Leung et al., 2002). Evaluating the impact of ethnic matching on the therapeutic experience is challenging, as constructs

of race, ethnicity, and culture are used interchangeably, or not measured, defined, or interpreted within studies (Ertl et al., 2019).

1.4. Patients' experiences of racial/ethnic matching

Multiple systematic reviews have been undertaken to develop an understanding of patients' experiences of ethnic matching (Cabral & Smith., 2011; Karlsson et al., 2005; Wintersteen, Mesinger & Diamond, 2005). Research has found that patients have strong preferences for therapists of their own race/ethnicity (Coleman, Wampold & Casali, 1995; Cabral & Smith, 2011) and attended more sessions with them (Kim & Kang, 2018). This may be explained through a stronger therapeutic relationship in racially/ethnically matched dyads (Sharf, Primavera & Diener., 2010).

However, much of the evidence has shown that a racial/ethnic match has no benefit on treatment outcomes (Cabral & Smith, 2010; Maramba & Nagayama-Hall, 2002; Shin et al., 2005). In fact, it has been hypothesised that matching done purely based on racial group may "*imprison*" MHP's and patients within their own racial/ethnic backgrounds, and "*diminish the human element*" of therapeutic encounters (Sue et al., 1991, Kareem, 1992; Ertl et al., 2019).

1.5. Mental Health Professionals' experiences of racial/ethnic matching

The available research surrounding MHPs' experiences of racial/ethnic matching has highlighted several challenges unique to MHPs when working therapeutically with patients of their own race/ethnicity. Psychological therapists have reported that overidentifying with patients or resonating with patients' difficulties related to their racial/ethnic identity can trigger difficult emotions for them (Evans, 2019). This can leave MHPs feeling emotionally vulnerable in the therapeutic relationship (Maki,

1999; Parhar, 2022; Raja, 2016). This may affect their ability to maintain their preferred professional boundaries, as they may be inclined to form more personal relationships and use self-disclosure more with racially/ethnically matched patients (Goode-Cross & Grim, 2016).

Additional barriers that MHP's may face when working effectively with racially/ethnically matched patients have been more systemic in nature. For example, Eastern Asian clinicians shared that when working in Western mental health settings, their own and their patients' cultural beliefs and practices were labelled and diagnosed using Western mental health disorders and concepts by their colleagues (Nagai, 2013). Racially/ethnically matched clinicians have also reported that their colleagues' have shown resistance towards them for applying non-Western cultural theories and practices within their work where relevant (Ito & Maramba, 2002; Nagai, 2013). This research brings to light the dilemmas and issues racially/ethnically matched MHPs can encounter within their teams and professional systems.

Some research has shown that racial/ethnic matching has benefitted MHPs and they have preferred working in racially/ethnically-matched dyads (Scharff et al., 2021). Black therapists have felt a sense of 'community' when offering group counselling to Black patients (Bartholomew et al., 2021). MHPs have described feelings of being honoured, healed, comfortable, at ease, connected, rewarded, and privileged when they have worked with racially/ethnically matched patients (Bartholomew et al., 2021; Burch, 2018; Evans, 2019; Ito & Maramba, 2002). These preferences have been predominantly identified in research with Black dyads, suggesting that there may be a stronger reciprocal relationship between preferences for matching Black patients and Black therapists.

1.6. Identity and ethnic matching

One of the motivations for matching patients and HCPs by race/ethnicity came through research showing that dyads' of the same racial/ethnic background were likely to share 'worldviews' (Alladin, 2002; Newcombe, 1961). However, Sue (1988) acknowledges that views, attitudes, experiences, lifestyles, and culture can also be shared by people from different ethnic backgrounds. Studies have shown that therapy outcomes are more successful when there is a high level of 'cognitive match' between a patient and therapist. This refers to the dyad being compatible within their understanding of the patient's distress, their worldviews, and ways to approach therapy, irrespective of their race/ethnicity (Messer & Wampold, 2002; Zane et al., 2005). Further to this, there can be vast amounts of heterogeneity in cultural and general worldviews within ethnic groups, (Aymer, 2012; Comas-Díaz & Jacobsen, 1991; Meghani et al., 2009), which further highlights that racial/ethnic similarity does not automatically lead to cognitive matching. Together, this research suggests that focussing solely on racial/ethnic matches may not be the most beneficial approach for MHPs and patient care.

Another important consideration is that people hold multiple identities that intersect and form unique beliefs, values and life experiences that are influenced by dynamic, culturally specific, systems of hierarchy and oppression, known as '*intersectionality*' (Crenshaw, 1989). In the context of therapeutic encounters, Gomez (2015) suggests that all aspects of patients' identities are important (such as race, ethnicity, sexual orientation, gender, age, etc.), and clinicians should not assume that their racial/ethnic identities are the most salient and important identities to them. In fact, research has shown that regardless of race/ethnicity, MHP-patient

relationships can be negatively impacted by the dyad holding different nationalities, languages, and sociodemographic statuses (Blanchard, Nayar & Lurie, 2007), showing the influence of other identities on the therapeutic process. Further, research into African American MHP-patient dyads found that some therapists lacked insight, professional education, and socialisation into how the intersection between patients' race/ethnicity and their other identities may have contributed to their experiences of oppression and marginalisation (Burch, 2018). This relates to the concept of '*cultural humility*' (Tervalon and Murray-Garcia, 1998). Clinicians are encouraged to continuously self-reflect on how their own and their patients' identities hold power and privileges, which can affect how they experience and relate to others in the world (Buchanan, Rios & Case, 2020; Tervalon and Murray-Garcia, 1998).

1.7. Purpose of the review

The available research into patients' experiences of racial/ethnic matching has shown mixed outcomes, and there is very little research focussed on MHPs' experiences of racial/ethnic matching. Therefore, this review aims to synthesise the qualitative literature on MHPs' experiences of working therapeutically with racially/ethnically matched patients. This review will contribute to the development in this field as to the author's knowledge, this is the first systematic review summarising all the available qualitative evidence related to this research question.

2. Method

2.1. Developing the review question

The SPIDER mnemonic was used to structure and define key aspects of the review question (Cooke, Smith, & Booth, 2012) (See Table 2.1). The *Sample* was

MHPs from racially/ethnically minoritised backgrounds working therapeutically with patients from the same ethnic/racial background. The *Phenomenon of interest* was the provision of therapeutic care to patients from the same racial/ethnic background. The *Design* and *Research type* was any qualitative or mixed-methods research study where the qualitative component was reported separately. The *Evaluation* related to participants' views, experiences and perceptions of the aforementioned phenomenon.

Research Question:

What are the expressed experiences of mental health professionals when working therapeutically with racially/ethnically matched patients?

Table 2.1. *Spider Tool*

SPIDER Component	**Review Question**
Sample	Mental health professionals from racially/ethnically minoritised backgrounds working therapeutically with patients from the same racial/ethnic background
Phenomenon of Interest	The provision of therapeutic care to patients from the same racial/ethnic background
Design	Qualitative Design. Empirical, published studies
Evaluation	Views, perceptions, or experiences of participants regarding the phenomenon of interest
Research Type	Any qualitative research including mixed-methods studies (but only when the qualitative component was reported separately).

Inclusion and exclusion criteria (Table 2.2) were developed in collaboration with the research supervisor. The researchers included studies focussed on racial/ethnic matching between patients accessing mental health services and MHPs. Whilst some studies refer to racial/ethnic matching as having the same 'cultural' background (Leung et al., 2002) such as the same native language or religious identity, it was beyond the scope of this review to include these studies.

The research base on racial/ethnic matching in healthcare settings focusses on MHPs and patients from minoritised racial/ethnic backgrounds. This is because matching patients and MHPs by race/ethnicity was developed to mitigate any potential negative impact of ethnic majority (predominantly western) cultural values when working with mental health difficulties (Alladin, 2002). Thus, this review includes any paper with a MHP and patient dyad who shared the same race or ethnicity and who were racially/ethnically minoritised within their social context.

The term 'working therapeutically' has been used as the literature shows that psychologically-informed work is undertaken by a range of mental health professionals (Browne, Cashin & Graham, 2012; Sudbery, 2002). Therefore, to broaden the scope of this review within the limited timeframe provided to conduct the review, all clinicians working in mental health and social care settings were included, and all studies where professionals were working solely with patients' physical health were excluded.

Table 2.2*. Inclusion and exclusion criteria*

Component	Studies were included if:	Studies were excluded if:

Population	Any mental health or social care clinician working therapeutically in a mental health setting with patients of the same racial/ethnic background. Their ethnic or racial background is categorised as 'minoritised' within the country of study.	Clinicians that worked with patients with solely physical health conditions.
Language	English	Any language other than English
Publication Date	Any date	N/A
Papers	Publication status: Peer-reviewed papers; Type: Primary research paper; ethnically or racially matched dyads	Publication Status: Non-peer reviewed papers. Type: Protocols; Reports; Letters; Editorials; Conference papers/abstracts/presentations; Dissertations; Theses; Thought pieces/discussions; Primary focus on culturally matched dyads irrespective of race or ethnicity.
Design	Qualitative; Mixed-methods	Quantitative research

2.2. Search Strategy

Studies were identified through searches in four electronic databases (CINHAL; PsycINFO; Medline; Web of Science). Records were retrieved from these databases from the earliest records available, until 14th December 2022. An initial scoping

search of Google Scholar was conducted to identify key papers and search terms. Search terms focused on the following topics central to the research question: ‘qualitative methodology’, racial/ethnic matching in racially/ethnically minoritised populations’, ‘mental health and/or social care professionals’, and ‘lived experiences’. During the informal literature searches, the researcher noticed racial/ethnic categories were used in the titles, such as ‘African American’. Therefore, the researcher, research supervisor and subject librarian decided to include distinct racial/ethnic categories in the search. The informal scoping search identified that most literature on racial/ethnic matching had been undertaken in the United Kingdom, United States of America, Canada and Australia. The Minority Rights Group (MRG) is an international non-governmental organization that works to defend the rights and gain equal opportunities for disadvantaged, racially/ethnically minoritised and indigenous people. Their resource, titled ‘*World Directory of Minorities and Indigenous Peoples’*, is a directory that holds information by country about minorities and indigenous communities (MRG, 1969). According to the MRG, this information has been “well-researched and verified and provides a unique resource to journalists, governments, UN officials and academics across the globe” (MRG, 1969). Therefore, this directory was used to identify racially/ethnically minoritised groups in these countries that could be included in the search. Additionally, the current literature on racial/ethnic matching has included MHPs that have worked in a range of mental health and social care fields. Therefore, to capture all relevant studies where MHPs worked in these settings, all professional labels that may work in mental health settings were used in the search.

Finally, search terms were finalised (see Appendix 1.1 for the complete set of search terms) and entered into the four research databases. Boolean operators

‘or’,‘and’ and ‘not’ were used to combine specified terms. Truncation symbols (e.g. *) and wildcards were used to search for term variations and for British and American English spellings. Each term was also searched using a ‘subject heading’ appropriate to the database. Appendix 2.1 details the search strategy for each for the four databases.

2.3. Study selection

PRISMA guidelines were used to identify relevant papers (Moher et al., 2015; Figure 2.1). The searches in the four databases conducted on 14th December 2022 yielded a total of 1879 references: 389 results from PsychINFO, 384 from Web of Science, 512 from CINHAL and 594 from Ovid MEDLINE. Forwards and backwards citation searches of the identified articles were conducted. Titles of the papers were screened, and full-texts were read following this. They produced fourteen more references of which two were included in the review.

2.4. Data Extraction

The information extracted from the studies included: research questions; geographical location of study; participant demographic information; participant work settings; participant therapeutic modalities; data collection and analysis methods (See Table 3.1). Only the findings that specifically answered the research question were extracted. The data was retrieved from tables or text from the main body of the findings sections within the papers. Within each paper, the original quotes and the authors’ themes, comments, explanations and interpretations of the findings were included in the analysis. The extracted data was imported in to NVivo for analysis (QSR International Pty Ltd, 2020).

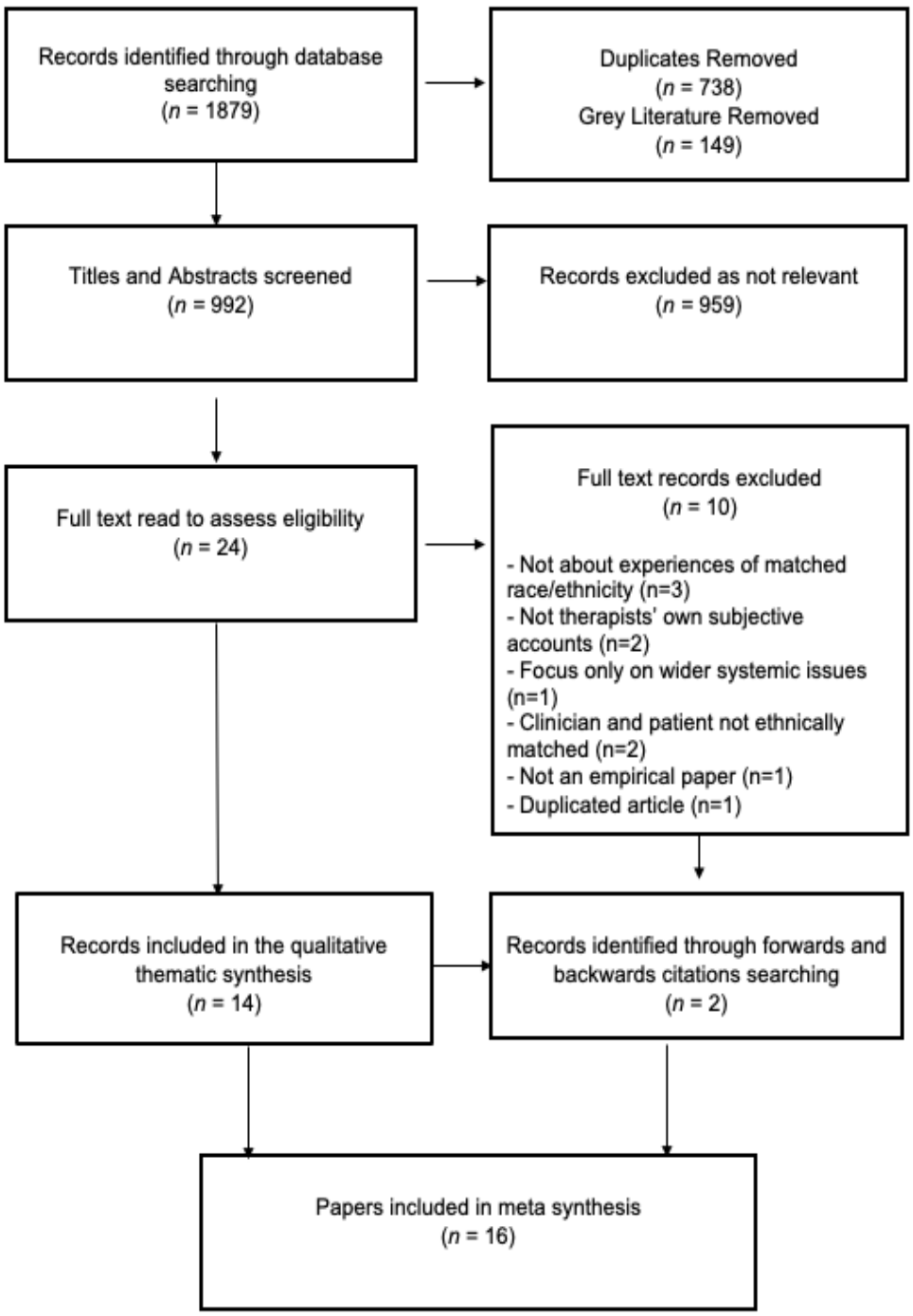

Figure 2.1. *PRISMA Flowchart*

2.5. Data analysis

The Cochrane Group guidance (Noyes et al., 2018; Noyes & Lewin, 2011) and RETREAT Framework (Booth et al., 2018) supported the choice of undertaking a thematic synthesis, as it met the broader objectives of the present review. In line with the guidelines for thematic synthesis, the generated themes reflected the underlying similarities, inconsistencies, and contextual differences in the primary data. The researcher aimed to better understand MHPs knowable reality of working with patients of the same race/ethnicity, which were mediated by their own personal perceptions, beliefs, and context in which they worked (Barnett-Page & Thomas, 2009; Barker, Pistrang & Elliott, 2016). Hence, it fitted with the critical realist yet broad phenomenological epistemological stance.

The thematic synthesis was carried out using an inductive approach (Thomas and Harden, 2008). This involved the following four stages: 1. In-depth reading and note taking of full-text papers, 2. 'line-by-line' coding of study data. This included the original quotes and the author's additional findings, such as their themes and interpretations. 3. Grouping the initial codes into descriptive themes by looking for similarities and differences between codes, and 4. Forming higher order analytical themes by assembling and interpreting descriptive themes so that clinicians' experiences of working in racially/ethnically matched dyads could be captured. Each theme or sub-theme included at least one data extract in the form of a quote from an included study. An experienced qualitative research supervisor provided supervision throughout the process (see 'researcher reflexivity' section for more detail).

Concepts that appeared more frequently (i.e., those which were mentioned by many studies and many participants within those studies); had a high level of

explanatory value (Noyes & Lewin, 2011), or featured in more methodologically robust studies, were given more weight in the analysis. Less weight was given to concepts that appeared infrequently, were poorly explained, or featured in methodologically weaker studies.

2.6. Researcher Reflexivity

Understanding researcher expectations and biases is important in evaluating qualitative research since personal perspectives may influence the collection and interpretation of the data (Kvale, 1996). As a Trainee Clinical Psychologist from a minoritised racial/ethnic background, I have experienced working with patients from the same racial/ethnic backgrounds. Thus, when conducting this review I was conscious of interpreting findings in line with my own experiences of this work, whilst also using these experiences to uphold my interest and curiosity towards the data and the research question.

I have reflected on my experiences of feeling that there may be a greater therapeutic connection and a therapeutic relationship that felt safter for patients that shared my race/ethnicity. However, I recognised the limitations that racial/ethnic matching could have on therapeutic success and outcomes. This reflection enabled me to notice where I aligned with the data during the coding process and where my experiences conflicted with the data. This supported me to apply the coding processes with some reliability, attending to items of data appropriately. During the process of generating analytical themes, I consciously attempted to ensure that I did not over- or under-weight such data. I discussed, in detail, all thematic synthesis themes and how the data represent them with my research supervisor. The

discussions supported me to attend to the data with care and curiosity, developing the analysis further.

3. Results

3.1. Description of included studies

Sixteen papers met the inclusion criteria for the review. It was presumed that Goode-Cross (2011) and Goode-Cross and Grim (2016) partially reported on the same sample as the participants had demographic and contextual similarities in the papers, and they were co-authored by the same person. The studies are referenced separately as an additional sample had been used in Goode-Cross and Grim (2016), as well as there being different study aims and interpretations of the findings between the studies.

Participating therapists and their index patients

Of the 342 participants across the studies, 56 were identified as White European, White American or White Anglo-Australian ethnic background (16%), three identified their ethnicity as 'other', and 283 participants were from ethnically minoritised backgrounds (83%) (as defined by The Minority Rights Group). A total of 253 were female (73.7%), 66 were male (19%), one was non-binary (0.3%) and 23 were unknown (7%). Participant ages ranged between 25-65 years old. Participants' professional backgrounds were in areas of social work (Social Workers, Trainee Social Workers, Child Welfare Case Workers), psychology (Psychologists, Counsellors, Psychotherapists) and psychiatric medicine (Mental Health Nurses, Psychiatrists). Participants practised using a range of interventions, all of which had a therapeutic component.

Some studies considered other aspects of patients' identities that might impact on the experience of clinicians and patients, such as socio-economic status (Goode-Cross and Grim, 2016), immigration status (Ito and Maramba, 2002), and access to services (McMaster et al., 2021), and had attempted to control for these.

Setting and context

Most studies took place in the USA (n = 12; 75%), and one in each of Canada, Australia, New Zealand, and Israel (n=4, 15%). Participants worked in a variety of settings, including ethnic-specific services (n=3, 20%), child and adult services, community and inpatient settings, private, charity and public healthcare services, social services, schools and colleges, and religious institutions.

Data collection and analysis method

The studies' sample sizes ranged from 5 to 102 participants. Data was collected through individual and group semi-structed interviews. The analysis was undertaken using interpretive phenomenological analysis (n=4), thematic analysis (n=5), grounded theory (n=4), case study approaches, (n=2), and unspecified analysis (n=1).

Study aims

Although the studies had different aims, all studies included in the review explored MHP's experiences of working with patients from the same racial/ethnic background. All descriptive information that was extracted from the studies is presented in Table 3.1.

Author and study location	Study Aims	Methodology, method, and data analysis	Sample demographics	Setting and Intervention
Bartholomew et al (2021) USA	To consider the experiences of therapists' cultural comfort when black patients discuss experiencing anti-black racism	Qualitative, 1:1 semi-structured interviews, multiple case study and cross-case analysis	5 Participants: 1.White American Female (Clinical Psychologist) 2.White Male (Masters in Clinical Psychology) 3.Black Male (Masters in Counselling) 4. African American, Creole, Cisgender Woman (Counselling Psychologist) 5. Asian and White (Clinical Psychologist) Gender: 2 females, 2 males, 1 non-binary Age range: 29-39	1.Clinical research, behavioural approach, Northeastern USA 2.College counselling/private practise, existential approach 3.Community mental health/private practise, person-centred therapy, Pacific Coast state 4.State forensic inpatient/private practise, relational-cultural perspective, Southern USA 5. medical centre, CBT, Southern USA
Bayne and Branco (2018) USA	To explore the lived experiences of counselors of color in broaching issues of race	Qualitative, 1:1 semi-structured interview, phenomenological approach	8 Counselors. Ethnic backgrounds: 5 African American 1 Indian American	Settings: Community, private, college, school, jail, military Additional Information:

	and culture with their patients.		Gender: 6 Female, 2 Male Age range: 30-41 years	Participants reported between 10-80% ethnic dissimilarity between them and patients' they work with.
Chenot et al (2019) USA	To investigate what public child welfare workers believe about ethnic matching in the child welfare system	Qualitative, 1:1 structured interview, grounded theory	Sample 1: 70 line workers 58 female, 12 male Self-identified Ethnic backgrounds: 21 Black/African American 27 Hispanic 19 Caucasian/White 3 Asian American Sample 2: 32 Social Worker Students 27 female, 5 male Self-identified Ethnic backgrounds: 2 Black/African American 12 Hispanic 15 White/Caucasian 3 Other Gender: not specified Age range: 25-65 years (1 missing)	Line workers 'worked in some capacity with public child welfare agencies' Student Social workers currently or previously worked in a public child welfare agency. Both samples worked in rural and urban areas of the USA.
Gelman (2004) USA	To understand how psychodynamic	Qualitative, 1:1 semi-structured interviews, grounded theory	15 bilingual Latino psychoanalytic psychotherapists	Provides Psychodynamically-informed treatment to Latino patients

	approaches are being used with Latino patients		Gender: 8 female, 7 male Age range: 29-53 years	in Community Mental Health Teams, hospital clinical, schools and in private practise.
Good Cross (2011) USA	To understand the lived experience of black therapists in same-race dyads in therapy and supervision	Qualitative, 1:1 semi-structured interviews, a thematic analysis method called 'meaning condensation'	12 Black doctoral level psychotherapists 8 Counselling Psychologists, 2 Clinical Psychologists, 1 Humanistic Counsellor, 1 Counsellor Education, 1 Clinical-Community Psychologist Gender: 10 female, 2 male Age range: not specified	Based in rural and urban, private and public college counselling settings. 11 colleges had predominantly White students and 1 college had predominantly Black students Theoretical orientations: Afrocentric, Interpersonal, psychodynamic, Cognitive-behavioural, Gestalt, Existential, Family Systems, Object Relations, Multicultural Frameworks, Humanistic, Person-centred, Integrative/Eclectic
Good-Cross and Grim (2016): USA	To deepen an understanding of the nuances in the relationship between black therapists and black patients in psychotherapy	Qualitative, 1:1 semi-structured interviews, Interpretive Phenomenological Analysis	36 Black clinicians 12 Counselling Psychologists, 10 Clinical Psychologists, 1 Clinical-community Psychologist, 1 School Psychologist, 5 Counsellors, 4 Social Workers, 3 Psychiatrists	Based in college counselling centres, community mental health centres, social services, medical schools, hospitals, schools Practising in California, Georgia, Kentucky, Maryland, New Jersey,

			Gender: 26 females, 10 males Age: not specified	North Carolina, Ohio, Pennsylvania, Texas, Virginia and the District of Columbo Additional Information: Black doctoral students were chosen to study, to lower the socioeconomic gap between therapist and patient
Greenberg (2018) New York, USA	To understand practitioners' subjective experiences related to racial/ethnic similarity and difference in the therapeutic process	Qualitative, 3 focus group interviews, thematic analysis guided by a phenomenological approach	18 Clinicians: 13 Social Workers, 5 Trainee Social Workers Self-identified Ethnic backgrounds: 10 Hispanic (Puerto Rican, Dominican, Ecuadorean) 8 Black (African America, African, Afro Caribbean) 13 Female, 8 Male Age: not specified	Social Workers were funded by the Department of Health and Human Services to be trained to work in a behavioural health capacity with high need, underserved populations.
Ito and Maramba (2002) California, USA	To understand how Asian Americans define the nature of ethno-specific care as they	Qualitative, 1:1 semi-structured interviews, deductive thematic analysis	16 Psychotherapists Self-identified Ethnic backgrounds: 9 Chinese, 2 Korean American, 2 Vietnamese American, 2 Japanese	The organisation provides outpatient services for chronic and severe mental health illnesses, community outreach programmes, child abuse prevention, family enhancement education,

	provided it to Asian Americans		American, 2 Vietnamese Chinese Gender: 12 female, 4 male Average Age: 37.2 years	school-based crisis interventions Cognitive Behavioural Therapy, Psychodynamic Psychotherapy Additional Information: Patients were all first generation immigrants of Chinese and Vietnamese ethnic backgrounds.
Leung et al (2022) Greater Toronto Area, Canada	To understand practitioners' personal and interpersonal experiences working with Chinese immigrants To explore organisational policies regarding ethnic matching To examine intra-community dynamics and their impacts on ethnic matching	Qualitative, 6 focus groups, grounded theory	34 Practitioners: Country of origin: 19 from Mainland China, 9 from Hong Kong, 2 from Taiwan, 1 from Canada, 1 from Vietnam, 2 unknown Gender: 27 female, 7 male Age: not specified	Working with Chinese immigrants in settlement agencies, geriatric care centres, schools, churches, physical health and mental health agencies

	and cultural competence			
Lin et al (2018) New York, USA	To explore the experiences and perceptions of ethnic Chinese immigrant social workers who work with immigrant and non-immigrant families in the child welfare field	Qualitative, 1:1 semi-structured interviews, specific type of data analysis not stated. Analysis involved "repeatedly reading, coding, sorting, as well as identifying and comparing themes".	14 Chinese immigrant Social Workers Country of origin: 9 from China, 4 from Taiwan, 1 from Malaysia Gender: 12 female, 2 male Age range: 26-46	Currently or previously worked in the family supportive service programme Additional Information: The large Asian population in New York mean there were high numbers of ethnic matching between patients and clinicians
McMaster (2021) USA mid-Atlantic region	To understand if cultural competencies are being translated into practice amongst mental health care providers	Qualitative, 1:1 semi-structured interviews, thematic analysis	12 Clinicians: 5 Psychologists, 4 Nurses, 2 Social Workers, 1 'Other' Self-identified Ethnic backgrounds: 5 from minority ethnic backgrounds 7 white clinicians Gender: 10 female, 2 male Age range: 32-61 years	Working in veteran affairs mental healthcare

Reddy (2019) New York, USA	To explore the lived experience of South Asian therapists working in a South Asian women's organisation	Qualitative, 1:1 semi-structured interviews, Interpretive Phenomenological Analysis	8 South Asian Social Workers practising as psychological therapists Self-identified Ethnic backgrounds: 4 Indian, 2 Pakistani, 1 Bangladeshi, 1 Sri Lankan All participants grew up in western societies but were socialized within a family that espouses South Asian cultural values and traditions. Gender: 8 females Age range: 26-49 years	Working in a women's organisation specifically for South Asian women affected by domestic violence
Sawrikar (2013) New South Wales, Australia	To understand the perceived and experienced advantages and disadvantages of ethnic matching caseworkers and patients	Qualitative, 1:1 semi-structured interviews, unknown analysis	17 Child Protection Caseworkers/Case Managers Self-identified Ethnic backgrounds: 3 Anglo Australian, 6 dual-ethnicity (Asian-Australian, Australian of Indian background), 1 'trans-racial'', 7 identified ethnicity in line with culture of origin e.g. African, Latin American	Working in Community Service Centres Patient race/ethnicity: The 29 families that took part in this study came from the following ethnic backgrounds: Arabic-speaking and Middle Eastern countries: Egypt, Iraq, Jordan, Lebanon, Turkey Asian countries:

			Gender: 15 females, 2 males Age range: 23-59 years	Cambodia, Vietnam, Philippines African countries: Sudan, Burundi, Ethiopia, Ghana, Sierra Leone East European countries: Greece, Macedonia, Serbia Pacific Island countries: Māori New Zealand, Samoa South American countries: Argentina West European countries: Netherlands
Weng and Clark (2017) USA	To explore how social service providers address community needs and fight for social justice from emic and etic perspectives	Qualitative, descriptive multiple-case study approach, 1:1 semi-structured interviews	20 Clinicians: 3 Counselling backgrounds 5 social work backgrounds 7 BSc in Psychology/Sociology, 1 master's in psychology 4 qualified in other/unrelated fields Self-identified Ethnic backgrounds: 5 African American, 5 Latino American, 10 European American Gender: 19 female, 1 male Age Range: not specified	Working with African American and Latino American patients in the following settings: mental health, homelessness and housing, health substance abuse, criminal justice, refugee resettlement, child welfare, finance, education, domestic violence

Wilson (2012) New Zealand	To explain the current experiences of Māori mental health nurses	Qualitative, 3 focus groups using a Māori-centred methodology, grounded theory	10 Māori Mental Health Nurses from a range of North Island iwi (tribes) Gender: not specified Age range: 43-55 years	Working in inpatient mental health units, Māori-specific mental health services, community mental health services including patient with serious mental illnesses and substance abuse problems
Zaken & Walsh (2022) Israel	To learn from the art therapists how they experience the two cultures and how they combine them when using art in the therapy they conduct.	Qualitative, 1:1 semi-structured interviews and use of visual and verbal imagery according to the model of 'drawing images as a tool for focused observation of the intra-personal context', thematic content analysed using a phenomenological approach	13 Arab Art Therapists Religious backgrounds: 9 Muslim, 2 Christian, 2 Druze All participants reported that their lifestyle and cultural perception have a 'dual-cultural orientation'. Gender: not specified Age Range: 29-34 years	All worked with children at schools, child and family care institutes, and child psychiatric hospitals.

Table 3.1. *Study characteristics*

Table Notes:
The 12 participants and their data in the Goode-Cross (2011) paper are used within in the study sample and findings in the Goode-Cross and Grim paper (2016).

Methodological Quality of Included Studies

The Critical Appraisal Skills Programme checklist (CASP, 2016) was used to assess the quality of included studies. Given that the present research concerns the experiences of therapists and patients from a given racial/ethnic background, a minimum level of reporting participants' racial/ethnic background was imposed as an additional quality criteria question (question 4b). Each question was answered with responses of 'yes', 'no' or 'unclear/partially', scored 2, 1 or 0 respectively. An aggregate score was provided to classify the overall quality of the studies. Higher scores reflected better methodological quality. In this review, papers have not been excluded based upon this quality assessment, but the assessment has been used to contextualise the data and make decisions about the overall contribution of the findings to the formation of themes for the qualitative review. Table 3.2 summarises the findings of this process for each of the sixteen studies. The average score of the quality of the papers was 18.2 of a maximum of 22 points available, with a minimum score of 13 and a maximum score of 22.

The most common methodological issue that arose was ethical issues. The ethical criterion was partially met in some studies (n=7) where researchers did not explicitly state how they described the study to participants, or the steps they took to manage the potential negative impact of it. One study did not state that ethical approval had been sought.

Some researchers did not explicitly comment on the impact of their personal or professional identity on the research process (n=5). One study (n=1) partially met this criterion as the researcher acknowledged that the interviewers' race/ethnicity may affect participants' responses. However, there was no acknowledgment of how their personal and professional identity could affect research design or analysis. In one study (n=1), minimum ethnic and racial demographic data were not reported.

Study	Bartholomew et al., (2021)	Bayne and Branco (2018)	Chenot t al., (2019)	Gelman (2004)	Goode-Cross (2011)	Goode-Cross and Grim (2016)	Greenberg et al., (2018)	Ito and Maramba (2002)	Leung et al., (2022)	Lin et al., (2018)	McMaster et al., (2021)	Reddy (2019)	Sawrikar (2013)	Weng and Clark (2017)	Wilson & Baker (2012)	Zaken & Walsh (2022)
CASP Questions																
1. Statement of aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Appropriateness of qualitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Appropriateness of design	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
4. Appropriateness of recruitment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4a. Inclusion of racial/ethnic demographic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓
5. Data collected in a way that addressed research issue	✓	✓×	✓	✓×	✓	✓	✓	✓×	✓	✓	✓	✓	✓	✓	✓	✓

6. Consideration of relationship between researcher and participants	✓	✓	×	×	✓	✓	✓	×	✓	✓	✓×	×	✓	✓	×	✓
7. Consideration of ethical issues	✓	✓×	✓×	×	✓×	✓×	✓	×	✓×	✓	✓	✓	✓	✓×	✓	✓
8. Rigor of data analysis	✓	✓	✓	×	✓×	✓	✓	✓	×	✓×	✓	✓×	✓	✓×	×	✓
9. Clear statement of findings	✓	✓	✓	✓	✓	✓	✓	✓×	✓	✓	✓	✓	✓	✓	✓	✓
10. Value of research	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Total CASP score:	22	20	18	13	20	21	22	14	19	21	19	19	22	20	18	22

Table 3.2. *CASP ratings for included studies*

3.3. Synthesis of findings

The data synthesis revealed three interrelated analytical themes: *'Holding knowledge and personal experience of your race, ethnicity and culture', 'Navigating the therapeutic relationship'* and *'Beyond racial, ethnic and cultural identity'*. Figure 3.1 is a visual map of the descriptive and analytical themes, and how they interrelate.

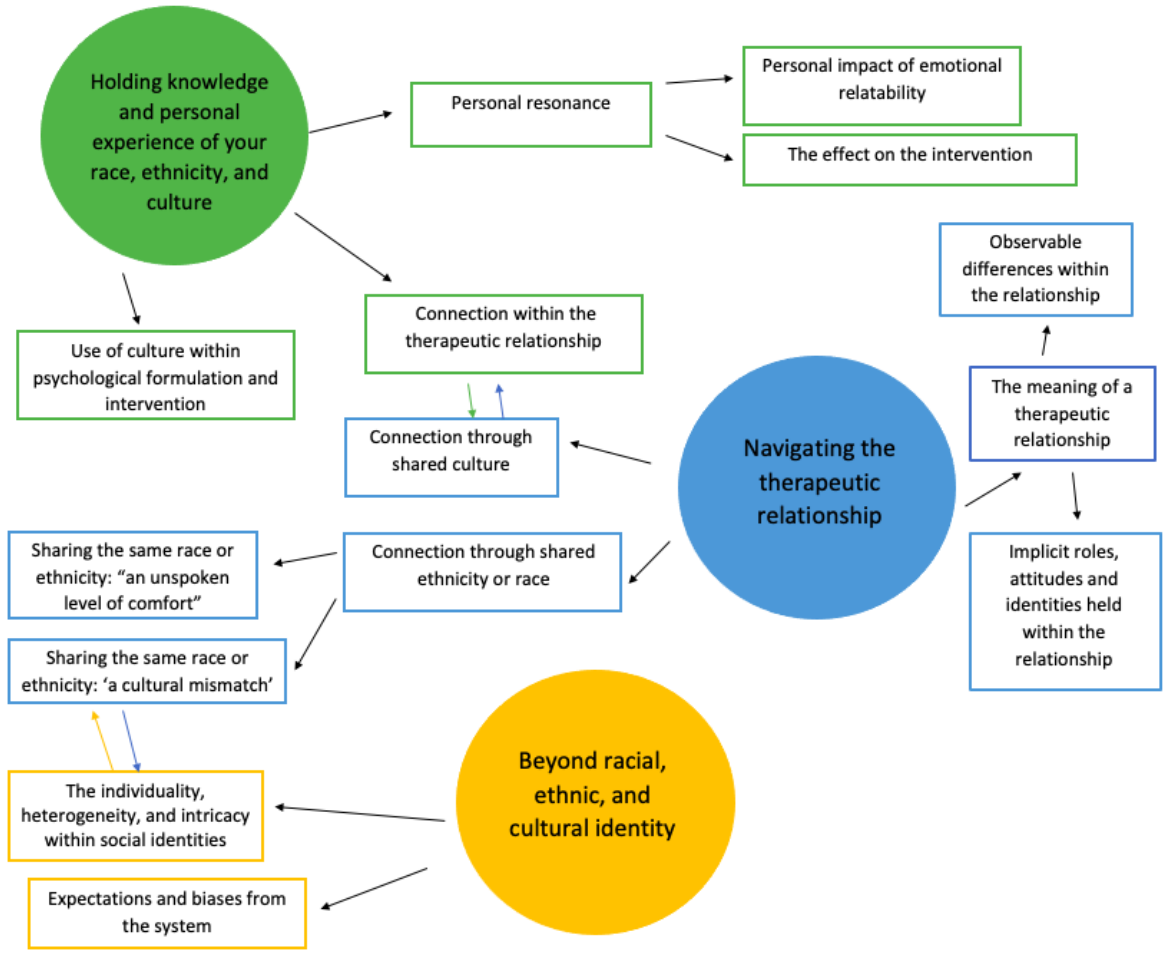

Figure 3.1. *Visual map of themes*

3.3.1. Analytical Theme: Holding knowledge and personal experience of your race, ethnicity and culture

The first analytical theme refers to how clinicians' knowledge and personal experiences related to their ethnicity had implications for them personally and

professionally. Three descriptive themes and two descriptive sub-themes were categorised under this analytical theme.

3.3.1.1 Personal resonance

3.3.1.1.1. Personal Impact of emotional relatability

MHP's found that the therapeutic material brought up difficult past and present experiences related to their ethnicity, race and culture, particularly when their patients had similar identities. There was a sense that this may have felt emotionally difficult for MHP's, even if they had not explicitly stated this:

> *"I think with an African American or Black [patient], because I am African American, Black, I don't have to go to the literature, it's like… I know these experiences, I've had these experiences" (Interview 25);* ***(Paper 1; Bartholomew et al., 2022****).*

The following quote illustrates the extent to which experiencing personal resonance with patients' therapy material affected MHP's wellbeing:

> *Participants specifically drew attention to the difficulties of navigating trauma work. "Work means being triggered all the time, unfortunately. And that's just so tiring. Whenever I have a day off to myself, it's almost as if I have to depart from that world so I can carve out this space of not having to be triggered, not having to be reminded of a client's story. So often I take client stories home with me and I would break down on the train ride home."* ***(Paper 12; Reddy, 2019).***

There was also an alternative narrative that when MHP's worked with patients from the same ethnicity or race, it brought up feelings of fulfilment,

responsibility, duty, motivation to help, and a sense of honour to be able to support them.

> *Marshall, who uses person-centred therapy, identified that he felt honoured and healed himself, which he connected to his own identity as a Black man:*
>
> *"I was honored, as a Black man, to hold space for a Black woman in that way. And I carved a sacred space and have other group members be able to hear and share. So for me, it was very healing. As a therapist, I also get a lot from doing this work.".* ***(Paper 1, Bartholomew et al., 2021).***

3.3.1.1.2. The effect on the intervention

There was a sense that when MHP's resonated with patients' ethnically-related experiences it affected their interactions in the therapy space. Whilst some clinicians used their own experiences to provide thoughtful, considered, and '*compassionate*' responses towards patients experiences **(Bartholomew et al., 2021; paper 1)**, other clinicians described the way they proceeded as '*disadvantageous'* **(Chenot et al., 2019; paper 3).** A clinician describes how they felt that their personal resonance had challenged their ability to remain present in the sessions:

> *Participants acknowledged it was difficult to remain present with clients at times, especially when somatic symptoms, including shortness of breath, heart palpitations, and numbness, arose mid-session. Nightmares were also a common experience for therapists, as well as hypervigilance and feelings of despair. Most connected that their reactions echoed those of their clients.* ***(Paper 12; Reddy, 2019).***

Furthermore, a theme of emotional enmeshment or overidentification was identified across studies, which affected the approach that clinicians' took with their clients in the therapeutic space:

> *One later career psychologist described his earlier experiences working with Black clients: "Sometimes when I had Black clients, I identified with them and invested in them so much that I might not have pushed them in the way they needed to be pushed. Or I might not have helped them develop something they may have needed to develop. Because I was so busy caring about . . . being helpful".* ***(Paper 6; Goode-Cross & Grim, 2016)***

3.3.1.2. Use of culture within psychological formulation and intervention

Clinicians' accounts identified that their familiarity and experience within the normative beliefs, values, and practices of their culture meant they were able to more accurately assess, formulate and appropriately adapt psychological interventions:

> *"The pros are the knowledge base, the sensitivity that they know how to approach that family (Participant 15); If a family has a caseworker that is from the same culture, they are going to have more understanding in terms of language and mannerisms, and how they go about everyday life (Participant 7); At least that caseworker knows, they've grown up in this culture, they know the views of this culture, what their beliefs are, and it would help...*
> ***(Paper 13; Sawrikar, 2013).***

Having this personal knowledge and understanding supported clinicians to adapt their practice to engage therapeutically whilst working with patients' cultural practises and preferences:

The therapists reported using a variety of crafts in their therapy: sewing (pillows, clothes), embroidery, carpentry, making jewellery, creating glass cups and bowls, in order to arouse interest and to adapt the art to the culture. Jaan refers to use of sewing in art therapy: "I combined all sorts of textile and beads, and that speaks to Arab girls. For example, working with threads and collage with fabrics. It has to do with our culture, because every Arab woman sews and does things like that. Even at school I remember that I learned sewing". ***(Paper 16; Zaken & Walsh, 2022).***

Theme 3.3.1.3. Connection within the therapeutic relationship

Clinicians' accounts suggested that they had formed strong therapeutic relationships within matched dyads. They explained being able to easily resonate with their patients' experiences and more readily able to incorporate patients' race/ethnicity into the work:

When this view of the relationship itself as curative is coupled with the value ascribed to personalismo, the respect and cordiality accorded to each individual in Latino culture, it becomes even more powerful. The importance of relationship is compounded by having both clinical and cultural value: "Building a relationship...to learn their stories is very important. You learn a lot about them, and connect with them on a personal level". ***(Paper 4; Gelman, 2004).***

The following analytical theme links to this descriptive theme by further discussing the relationships between shared culture and the clinician-patient relational connection.

3.3.2. Analytical Theme: Navigating the therapeutic relationship

This theme speaks to the nuances in therapeutic relationships that HCP's experienced. Three descriptive themes and five descriptive sub-themes were categorised under the theme.

3.3.2.1. Connection through shared culture

This theme builds on the '*connection within the therapeutic relationship'* descriptive theme, within the first analytical theme. Clinicians' accounts suggested that holding similar cultural beliefs and experiences developed feelings of connection and '*closeness*' within the dyad:

> *Pui explained why similar cultural backgrounds can narrow the gap between practitioners and users:*
>
> *"Beside common language, common culture matters. Most of our clients emigrated from China, Hong Kong, or other Asian countries. Most of our Chinese workers are immigrants too. It makes us feel really close to each other when we talk about experiences back in our home country". (Female, Hong Kong, Cantonese group, event coordinator).* ***(Paper 10; Leung et al., 2022).***

Specifically, a common, clearly defined theme that arose within eight of the studies was sharing the same native language or culturally-related vocabulary. This promoted safety, trust and comfort within the dyad:

> *Participants believe matching of language and culture contributes to a more trusting relationship. According to one participant: "You need to have people who are bilingual and bicultural to help provide those services. Not that all your staff has to be bilingual but you have to have that accessibility so that*

*they have people they can understand and they can trust". **(Paper 15; Weng & Clark, 2017)**.*

Theme 3.3.2.2. Connection through shared ethnicity or race

3.3.2.2.1. Sharing the same race or ethnicity: "an unspoken level of comfort"

Within the Goode-Cross & Grim (2016), a clinician described connection in the dyad as "*an unspoken level of comfort",* which was formed through their shared racial/ethnic background. There was an overall sense amongst clinicians that sharing the same race/ethnicity enabled an immediate connection between themselves and their patients. The following excerpts suggest this may occur through sharing similar perspectives, or similar physical characteristics related to their race and ethnicity:

*Participant 4 noted that clients of color often broached race themselves, which she attributed to a perceived level of understanding and acceptance because she was also a person of color: "I would say that I have found that my African American clients and minority clients seem to be much more willing and ready to bring that topic up . . . because even if they don't know me very well their assumption is I am African American so on some level or degree I can relate." **(Paper 2; Bayne & Branco, 2018).***

Clinicians identified that the shared racial/ethnic background in the dyad meant patients assumed they would share the same racial, ethnic and culturally-related experiences, beliefs, and values:

Providers of color were perceived as having special abilities to understand, build trust with, and communicate with black clients that white providers lacked: "I don't really think I need to make known all my specifics, but I'm [a person of color] […]. And that seems, just because I might be also a person of

color, sometimes I think when they know, that they can relax a little bit and feel more comfortable that I might see some things from their perspective, or understand their perspective better." ***(Paper 11; McMaster et al., 2021).***

3.3.2.2.2. Sharing the same race or ethnicity: 'a cultural mismatch'

An alternative narrative was identified in four of the papers. Some clinicians felt the matched identities contributed to a diminished connection and lowered trust within the relationship. Participants' accounts suggested their patients' held expectations towards individuals from their own ethnic background, and held some resistance towards the therapist when these expectations were unmet:

An African American worker in Sample 1 […] stated "I would prefer not to work with African American clients, because they're suspicious. I don't sound like them. I don't carry myself like that, so they're questioning, 'Who are you, why are you here, why do you sound like that?' It's like I almost have to defend myself first before we can even open a door for communication…" She also, mentioned that African American clients often view her as potentially against them because, "You work for the system, for the man.". ***(Paper 3; Chenot, 2019).***

Theme 3.3.2.3. The meaning of a therapeutic relationship

Clinicians' narratives suggested that the shared race/ethnicity in the dyad meant there were differences in the way they and their patients related to each other compared to non-matched dyads.

3.3.2.3.1. Observable differences within the relationship

Clinicians identified that some of these differences were more overt and easier to recognise. For example, patients would more regularly contact them, come physically closer to them, and regularly give to them or provide for them:

> *One of the Chinese American female therapists stated: "For many Asians, especially the older people, they have no boundaries. They tell me sometimes, "Oh, I will invite you to have dim sum [Chinese dumplings] on a Sunday." . . . They really see me like one of their friends." However, later she noted pointedly: "I think they respect me as a professional. So the relationship is hierarchical." Although this may sound contradictory, it is understandable in an Asian system of hierarchies, which includes family members.* ***(Paper 8; Ito & Maramba, 2002).***

These relational differences affected clinicians' therapeutic approaches, such as using self-disclosure to encourage patients to share their difficulties:

> *"For the Vietnamese population, they are on a more personal level. For example, they would like to tell me their personal problems and family problems [but] they also expect to know from me about my personal problems and family problems. I found out if I disclose a little bit of my life, it helps them to open themselves a little more."* ***(Paper 8; Ito and Maramba, 2002)***

3.3.2.3.2. Implicit roles, attitudes and identities held within the relationship

Clinicians identified that the relationship dynamics were affected by the cultural understandings that themselves and their patients had of their roles in the relationship. For example, clinicians viewed themselves as their patients' mentors, and both parties viewed themselves as each other's family members or friends:

As the therapeutic relationship developed, they remarked that their clients increasingly viewed them as "daughters" or "sisters" as opposed to professional service providers. Although discouraged by mental health mandates, the formation of fictive kinships within South Asian women's organizations was regarded by participants to be paramount for client success since they strengthened the therapeutic alliance. Furthermore, they believed that kinship labels were unique to the South Asian experience and contributed to an increased affinity for their clients. ***(Paper 12; Reddy, 2019)***

Some clinicians were confronted with situations where patients' assumed that their shared race/ethnicity meant the clinician would agree with or allow cultural practices to take place that were against clinicians' professional codes of conduct. In these circumstances, clinicians were concerned about their ability to both maintain professional boundaries and hold therapeutic relationships with patients:

Parents often felt comfortable arguing with immigrant social workers and demanded leniency based on a shared understanding and similar discipline strategies within their shared cultures of origin: "My clients are Chinese, and they do corporal punishment with their children. They would say, 'You can understand. We were disciplined in this way when growing up in China. You know that. Leave me alone." ***(Paper 10; Lin et al., 2018).***

3.3.3. Analytical Theme: Beyond racial, ethnic, and cultural identity

Two descriptive sub-themes were categorised under this analytical theme.

Theme 3.3.3.1. The individuality, heterogeneity, and intricacy within social identities

Clinicians accounts suggested that over time, they acknowledge the heterogeneity within racial, ethnic and cultural groups, with each person making

sense of their race/ethnicity differently. Through reflecting on their relationship to their racial/ethnic identity, clinicians acknowledged that they would often assume the experiences, beliefs, attitudes and values of their patients due to their shared race/ethnicity:

> *Therapists came to appreciate the diversity within the Black community through working with Black clients. One therapist working at an HBCU elaborated on this experience: I think that we all assume there's this inherent level of comfort and understanding, and the reality is, working at [HBCU] we have so many folks of color from varying countries that we still have significant cultural differences that we have to work out. We might look alike, but our interpretation of a lot of stuff can be different.* ***(Paper 5; Goode-Cross et al., 2011).***

Clinicians' accounts also showed that the other aspects of their own and their patients' identities (such as language, age, gender, nationality, social class) influenced how the patient related to the clinician and the shared race/ethnicity within the relationship:

> *Participants discussed the intersection of race, language, and nationality/ethnicity. One participant stated: "When the clients first see me, they see that I'm Hispanic and they're comfortable. Then . . . they start talking Spanish and I'm like "I don't speak Spanish." And they're like what? . . . It kind of strips my identity in their eyes, like "you don't speak Spanish?" I'm like "no." . . . They're like you're kidding me.* ***(Paper 7; Greenberg et al., 2018).***

Theme 3.3.3.2. Expectations and biases from the system

Clinicians accounts showed that the system they worked in were not receptive to adapting their practise to uphold the cultural preferences of patients. The following excerpt denotes a clinician's colleague who had challenged their behaviour in an interaction with a patient that had been informed by their shared race/ethnicity:

> *…Māori nurses were forced to put aside their personal cultural protocols and practices, and those of their patients and their families: "In the past, it [has] always been the clinical, and our tikanga [cultural practices] [have] always [been] left on the side. When we [have tried] to bring or incorporate tikanga into clinical practice, we have been challenged. I remember the day when a non-Māori nurse challenged me. She said that I crossed the [professional] boundaries when I hongied [the pressing of foreheads and noses as a cultural form of greeting] one of the tangata whaiora [person seeking wellness/patient]. I said to her that it is our way of greeting; it is not about boundaries. In fact, it [would be] more ignorant of me if I didn't do it.* ***(Paper 15; Wilson, 2012).***

The above and below excerpts show that the system had challenged their professional skills and capability. The following excerpt demonstrates the effect of this. The clinician became reluctant to share their practise with their team, including and any ethical dilemmas that may have arisen. This would inevitably affect the clinician-patient and clinician-system relationships:

> *"Physical discipline is part of Chinese parenting practice. Some Chinese parents are not aware that this practice is not acceptable in the U.S., and they don't have the intention to harm their children. If you tell them you are going to report them to the police or [the child welfare agency], parents feel there is no*

room for further discussion [and cooperation]." […]. However, while immigrant workers provided such contextual and cultural information to their supervisors and colleagues, they were also concerned that they may have been accused of not following U.S. protocol or maintaining the professional boundaries and ethics to work with these families. One social worker, for example, stated that "I was worried that if I discussed this issue with [supervisor], [supervisor] would question my capability … I was like 'Okay, I am not gonna say anything". ***(Paper 10; Lin et al., 2018).***

4. Discussion

This qualitative review identified 16 articles and used thematic synthesis to explore MHPs' experiences of working therapeutically in racially/ethnically matched dyads.

The analytical theme '*Beyond racial, ethnic and cultural identity'* illustrated that MHPs considered that aspects of their patients' identities held importance to them. These identities intersected with their racial/ethnic background to shape patients' unique beliefs, values, and life experiences. Research into patients' perspectives of multicultural therapy has found that a therapist's ability to be aware of power and differences in therapy dyads is preferred over what was described as a 'narrow and binary' approach of being matched by race/ethnicity (Olaniyan & Hayes, 2022). The salience and importance that a patient ascribes to their race/ethnicity has also been identified as an important factor in the usefulness of ethnic matching (Ertl et al., 2019). Together, the research highlights that ethnic matching may not serve its purpose in some cases, and that a more nuanced approach whereby patients'

multiple identities and what they mean to them should be considered within ethnic matching.

MHPs also identified that the heterogeneity within their racial/ethnic background was another factor that affected the dyad's shared experience of their race/ethnicity. Despite sharing the same race/ethnicity as their patients, they explained that differences in upbringings, ways of cultural identification, acculturation experiences, and belonging to different ethnic subgroups created nuances in the way they and their patients experienced their racial/ethnic identity. Again, this is contrary to the literature that suggests that one of the reasons that ethnic/racial matching increases patient satisfaction and psychological treatment outcomes is because clinicians and patients are likely to share beliefs, attitudes, personality traits, and worldviews (Knipscheer & Kleber, 2004). Therefore, the findings confirm the need to consider the relevance of racial/ethnic matching more carefully in therapeutic work.

Interestingly, the theme '*Navigating the therapeutic relationship'* suggests that some MHPs found that fostering trust within the therapeutic relationship was most challenging if the dyad had recognised that they did not share cultural beliefs, values, and worldviews, despite sharing the same race or ethnic background. This may explain the evidence that shows patients prefer to work with MHPs from their own race/ethnicity from the outset, as they assume that one's cultural beliefs and worldviews would be congruent with one's race/ethnicity (Cabral & Smith, 2011). However, the match does not necessarily improve patients' clinical outcomes compared to non-match dyads (Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002; Meyer et al., 2011; Shin et al., 2005). Thus, it may be that through cognitive heuristics, expectations of one another are formed through sharing the same race or ethnicity, however these are not necessarily met within the actual therapeutic

encounters. These findings may also explain why research on patient-MHP matches have shifted towards examining other identity factors that may influence the therapeutic relationship, such as their worldviews, racial identity status, interracial mistrust, and shared languages (Sue & Zane, 1987; Zane et al., 2005; Cabral & Smith, 2011).

On the other hand, the analytic theme '*Holding knowledge and personal experience of your race, ethnicity, and culture*' showed that MHPs' personal experiences of their race/ethnicity meant they were better able to work with their patients' racial/ethnic identities and preferences. They were more readily able to embed relevant cultural knowledge and understanding into their patients' formulations and interventions. Greene-Moton and Minkler (2019) suggest that many clinicians fail to take the time to learn about the cultural realities of their patients. This can risk forming misunderstandings and distrust within the dyad. Thus, there is a strong narrative within the field of multicultural healthcare to adopt a 'both/and' approach. This means MHPs should aim to be open and unassuming of their patients' worldviews and identities, whilst also holding some background knowledge of their patients' racial/ethnic identities and their associated cultural belief systems (Yancu & Farmer, 2017).

Within this analytic theme, the '*Personal resonance'* theme was developed through acknowledging the challenges MHPs faced when they were confronted with personal experiences of their race/ethnicity within the therapeutic process. It has been long understood that patients and MHPs racial/ethnic backgrounds can have powerful effects on the therapeutic process by touching their deep, unconscious feelings (Comas-Diaz & Jacobsen, 1991; Maki, 1990). To illustrate this, 'intra-ethnic transference and countertransference' theories within the psychodynamic literature

have been developed. They suggest that the analyst's painful, unresolved intrapsychic issues related to their race, ethnicity and cultural identities can be uncovered, which can bring up a range of difficult emotions for the analyst (Comas-Diaz & Jacobsen, 1991). It can affect their ability to attend to their patients' issues, decrease their confidence in working therapeutically, and reduce their overall wellbeing (Comas-Diaz, 1991; Nagai, 2009; Fauth & Hayes, 2006; Lee et al., 2011; Stampley, 2008; Rosenberger & Hayes, 2002; Crawford, 2012). Together, this suggests that working intra-ethnically may have a significant emotional impact on MHPs, and they may benefit from supportive spaces to explore these feelings.

With regards to support spaces, the theme '*Expectations and biases from the system'* showed that there was a lack of appropriate, safe spaces for MHPs to discuss their work. This meant they concealed complex ethical issues and relational experiences from their team, as they were concerned that colleagues would consider their cultural practices and therapeutic relationships to be unskilled. Research into the experiences of MHPs in inter-ethnic supervision and training suggests that these forms of communication are 'racial microaggressions', as they communicate denigrating, negative messages to people from minoritised ethnic backgrounds (Constantine & Sue, 2007; Hays, Dean & Chang, 2007). If appropriate training and supervision is not provided for these issues, it is likely that MHPs will experience emotional exhaustion and burnout (Fauth & Hayes, 2006; Lee et al., 2011). Therefore, it is vital that supportive and safe spaces for MHPs to share these experiences are provided.

Implications for Clinical Practise and Future Research

The findings in this review suggest that MHPs working in mental health services should not automatically assume that racial/ethnic matching would improve the therapeutic process or patient outcomes. It has shown that each person's way of relating to their identities is intricate and unique. Services should adopt a more considered and nuanced approach towards the use of racial/ethnic matching.

Importantly, services should provide MHPs with spaces to develop their skills in working across cultures, reducing the need to rely on MHPs with the same racial/ethnic backgrounds to work with a patients racial/ethnic background. Research suggests that clinical supervision (Hook et al., 2016), peer supervision, reflective practice spaces and group training experiences are effective ways to develop MHPs' skills in providing culturally appropriate care in multicultural psychological services (APA, 2003; 2017; Patallo, 2019).

Most MHPs in the UK are from White western ethnic groups (NHS Digital, 2022). Thus, the research and training that has been provided on multicultural therapy within healthcare settings has mainly focussed on White MHPs dismantling and reflecting on the power and privilege between them and their patients from minoritised ethnic backgrounds (Beck et al., 2019; Sue et al., 2022). However, this review highlights that MHPs identified multiple barriers to finding supportive spaces to navigate challenges related to working with patients who identify as racially/ethnically similar. Clinical training programmes and healthcare services should consider how to provide this support.

Strengths and limitations

The present review has some methodological limitations. Firstly, qualitative research is subjective, which can be viewed as valuable if the researchers are able

to be reflexive, taking responsibility for how their own situatedness within the research effects the research process (Berger, 2015). One third of the studies in the present review did not identify that they had considered this, which may have impacted on the aims, methodological approaches, and analysis of the research.

Secondly, it may be suggested that encompassing the views and experiences of MHPs from multiple different ethnically/racially minoritised backgrounds fails to consider the unique experiences of racial/ethnic groups that may be linked to current and past socio-political events and contexts. Thus, different racial/ethnic groups are likely to hold heterogeneous, nuanced perceptions and attitudes towards themselves and others. However, to the author's knowledge, this is the first systematic review evaluating qualitative studies of MHPs from minoritised racial/ethnic backgrounds experiences working therapeutically with patients of the same racial/ethnic background. Therefore, the present review has made an important and initial step towards identifying common narratives, views and experiences of MHPs working therapeutically in racially/ethnically matched dyads. Future research could focus on how MHPs from specific ethnic/racial backgrounds experience the therapeutic process in racial/ethnic matching.

Finally, despite having a comprehensive database search strategy, included studies were limited to the USA, UK, Canada and Australia. Although studies from other countries were not excluded, and other search terms (such as 'minoritised ethnicity') were used to yield a wider international search, there may be some MHPs' experiences that were unintentionally not identified in the search.

Concluding remarks

For decades, the rationale and effectivity of matching patients and MHPs by race/ethnicity has been heavily researched and debated within mental healthcare literature (Cabral & Smith, 2011). This review indicates that more careful consideration is needed towards the rationale for racial/ethnic matching. Patients' and MHPs' cultural beliefs and multiple intersecting identities should also be considered within the matching process.

Importantly, this review identifies the need for supportive spaces for MHPs to discuss their experiences when working intra-ethnically, which may support their professional practice and personal wellbeing. The following chapter is an empirical study that qualitatively evaluated a self-practice/self-reflection programme for CBT therapists from minoritised ethnic backgrounds.

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PART 2:

EMPIRICAL PAPER

Using Self-Practice/Self-Reflection to support CBT Therapists from minoritised ethnic backgrounds: A reflexive thematic analysis

Abstract

Aims: CBT Therapists from minoritised ethnic backgrounds experience increased work-related difficulties compared to their white counterparts, with little supportive spaces to address these difficulties. This study aims to qualitatively evaluate a novel Self-Practise/Self-Reflection (SP/SR) programme that supports CBT Therapists to reflect on how their ethnic background relates to their clinical role.

Method: Reflexive Thematic Analysis was used to explore eight CBT Therapists experiences of the programme. Interviews were conducted via an online videoconference platform and transcribed verbatim.

Results: The analytical process developed three superordinate themes. Firstly, *'Organisational culture'* provided insights into some of the system-level factors that affected therapists ability to navigate personal and professional issues of race, ethnicity and culture; *secondly, 'A search for understanding'* captured participants' experiences of understanding themselves and feeling understood by others in relation to their ethnic identity; *thirdly, 'Contextualising CBT'* centred participants experience of reflecting on their own and their patients racial, ethnic and cultural backgrounds to improve their culturally-informed CBT skills.

Conclusion: The themes from this novel programme suggest that the SP/SR exercises and the group component had a positive impact on therapist's ethnic identity, and their provision of culturally-competent care. Systemic barriers were identified in the way therapists experienced their ethnicity and accessing support in relation to their ethnicity. System-level changes are discussed in relation to improving employee satisfaction and providing effective psychological services.

1. Introduction

In recent years there has been a drive within the NHS to recruit more ethnically diverse individuals (NHS Workforce Race Equality Standard (WRES), 2014; 2015; NHS Benchmarking Network, 2021). Providing equal employment opportunities and encouraging diversity contributes towards addressing systemic racial prejudice and encourages innovative approaches to developing and improving the quality of healthcare (NHS Workforce Race Equality Standard (WRES), 2014). However, psychological therapists from ethnically minoritised backgrounds experience a significant amount of workplace racial discrimination, bullying and harassment (Kline, Naqvi & Wilhelm, 2017). Additionally, there is a lack of safe and supportive supervision and other spaces to reflect their experience of their ethnicity in the professional role (Iwamasa, 1996; Vekaria et al., 2023). Careful consideration should be devoted to relevant support structures and opportunities for these therapists to address the above challenges. This would directly and indirectly have a positive impact on patient care.

1.1. Definitions and use of language

Multicultural psychological therapy research uses the terms *'ethnicity', 'race'* and *'culture'* interchangeably (Cabral & Smith, 2011; Shin et al., 2005). The term *'ethnicity'* has been used by the research team as it encompasses aspects of one's race (categorisation of distinct physical traits) and culture (shared beliefs, attitudes, and behaviours) in addition to acknowledging an individual's specific geographical origins. It can be understood as *'a dynamic, subjective definition of oneself in relation to a range of factors including language, geographical origin, skin colour, political preferences, and religious and cultural practices'* (Loue, 2006), which may be passed on through generations (Jandt, 2017).

The term *'minoritised'* was chosen by the research team to refer to individuals who have been denigrated through social processes of power, domination and prejudice. The terms *'ethnic' and 'minoritised'* will be used to communicate the above constructs throughout the present study, unless otherwise specified.

1.2. The provision of culturally competent therapy

There is a recognition that culturally competent care in NHS psychological services is essential (Nardi, Waite & Killian, 2012). There is no clear, organised framework for defining the multiple facets of '*cultural competence'* (Ridley, Baker & Hill, 2000; Sue, 2001). Holistically, it refers to individuals and systems devotion towards working effectively and respectfully across cultures (Williams, 2001). It encompasses a clinician's ability to reflect on how cultural influences and experiences affect their own and their patients' belief systems, emotional states, and actions (Chao, Okazaki, & Hong, 2011; Sue, 1998). Most research also suggests that holding some knowledge about the patient's culture values and structures and using these flexibly would support the therapeutic process from engagement through to the end of therapy (Sue & Torino, 2005).

NHS services often consider therapists from minoritised ethnicities to be 'experts' and 'competent' in working with patients from similar minoritised ethnic and racial backgrounds, (Naz, Gregory & Bahu, 2019). However, the heterogeneity within the practices, beliefs, and values within minoritised cultures and communities means that mutual therapist-patient cultural understandings cannot always be assumed (Aymer 2012; Comas-Diaz & Jacobsen, 1991; Meghani et al., 2009). Additionally, working intra-ethnically (meaning within your own ethnic background) can be experienced as challenging and unique for therapists, and likely involves reflecting

upon personal experience. Therefore, they may benefit from supportive spaces to navigate complexities that may arise within this work (Evans, 2019; Maki, 1990).

The concept of '*cultural humility'* (Tervalon and Murray-Garcia, 1998) holds a different approach to working with cultural differences. It encourages therapists to reflect on the power and privileges held within their own and their patients' identities. It involves continuous self-reflection and engaging patients in conversations around the relationships between their identities, experiences, and relationships to themselves, others and the world (Buchanan, Rios & Case, 2020; Tervalon and Murray-Garcia, 1998). Thus, it suggests that it is not possible to reach a level of 'skill' or 'competence' when working with different racial, ethnic or cultural backgrounds.

1.3. Therapists from minoritised ethnicities working intra-ethnically

Research has highlighted specific challenges for therapists from minoritised ethnicities when working intra-ethnically. Patients' experiences of racial oppression have had personal resonance for them, and they described the process of discussing this in therapy as 'tough'. (Bartholomew et al., 2023). Black therapists have reported feeling 'uncomfortable', being emotionally enmeshed and over-identifying with Black patients, particularly when broaching the subject of race and racism (Goode-Cross & Grim, 2016). Models of ethnic identity development suggest that one's beliefs and attitudes towards their own and other dominant/minoritsed ethnic backgrounds have an impact on the way they view themselves, others, and the world (Sue & Sue, 1990; 1999; Cross, 1971; 1995). Therefore, depending on the therapists' and patients' relationships with their own and other ethnic backgrounds, there are likely to be a range of emotional experiences that arise for them when

working inter and intra-ethnically and may have an impact on patients experiences of therapy.

Additional challenges may also arise for therapists from minortisied ethnic backgrounds in the context of the Eurocentric, deficit-oriented psychological therapy models and approaches used in Western healthcare settings. There is minimal focus on acknowledging how historical and current systemic and socially oppressive forces may contribute towards a patients distress (Alemu, Osborn & Wasanga, 2023; Fernando, 2014). Without this recognition, patients can feel blamed, pathologized and disempowered through the subjugation of their own cultural beliefs about distress (Comas-Diaz, 2021). This serves to individualise distress and undervalues non-western approaches towards mental health support (Atayero et al., 2021; Naz, Gregory & Bahu, 2019).

1.4. Support structures for therapists from minoritised ethnic backgrounds

Given the challenges for therapists from minoritised ethnic backgrounds identified above, there remains a paucity of research towards understanding their experiences and support needs when working clinically. Clinical supervision has been identified as a vital space for supervisees to develop and integrate their clinical and cultural competence skills to meet the individual needs of each patient (Fleming & Steen, 2012; Gainsbury, 2017). However, research has shown that supervisees from minoritised ethnicities self-reported significantly lower feelings of safety, trust, and cultural responsiveness in supervision with White supervisors (Constantine & Sue, 2007; Hays, Dean & Chang, 2007; Vekaria et al., 2023), which has created barriers for supervisees to discuss and navigate issues of ethnicity in their professional role (Constantine & Sue, 2007; Shah, 2010). If appropriate training and

supervision is not provided for these issues, it is likely that clinicians will experience emotional exhaustion and burnout (Fauth & Hayes, 2006; Lee et al., 2011).

Recently, mental health educators and providers have considered how to address the challenges and inequalities that psychology professionals have faced (Gomes, 2023; Mena, 2023). Non-White peer support spaces have been developed for clinicians to come together to collectively to resist racial oppression, reclaim and embrace aspects of their identity that have been repressed, and heal from racial traumas and internalised racism (Blackwell, 2018). The methods used in the spaces are co-teaching, deconstructing ethnic similarities differences and group dynamics in peer support groups, and approaching clinical work through an anti-racist/multicultural lens (Watts-Jones et al., 2007; Kadaba, Chow & Briscoe-Smith, 2023).

The available empirical evidence on these spaces have shown mixed outcomes. Some group members reported feeling a sense of empowerment and hope through being validated in their experiences of racism and discrimination (Addai, Birch & Nicholas, 2019; Watts-Jones et al., 2007). Using strengths-based approaches that focus on the value therapists may bring to the psychological workforce, emotions such as such as sadness, pain, hope, and insightfulness were evoked for therapists (Addai, Birch & Nicholas, 2019; Watts-Jones et al., 2007). This suggests this kind of support may provide useful yet challenging spaces for therapists to reflect on their professional experiences related to their minoritised ethnicity.

1.5. Use of race, ethnicity and culture within Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is the most commonly used, '*gold-standard'* psychological therapy approach in the NHS to treat a wide range of mental health difficulties (David, Cristea & Hofmann, 2018; NICE, 2011). It aims to reduce mental health symptomology through the exploration of cognitions, physical and emotional feelings and behaviours (Alford, Beck & Jones, 1997; Beck, Beck & Beck, 2011). Research and clinical practice have focussed on how CBT could be adapted to include the cultural values and religious teachings of specific cultures (Mir et al., 2012; Shabbir et al., 2012). Clinical research and practice have also aimed to develop a more '*culturally-informed'* approach, whereby clinicians aim to understand and incorporate patients' sociocultural contexts and lived experiences of their ethnicity into CBT (Beck, 2016; Naz, Gregory & Bahu, 2019; Steele, 2020).

1.6. Self-Practice/Self-Reflection in Cognitive Behavioural Therapy

Self-Practise/Self-Reflection (SP/SR) is a training method that has aimed to develop multiple facets of CBT therapists' clinical practise (Bennett-Levy et al., 2001; Bennet-Levy, 2006). '*Self-Practise'* (SP) refers to therapists practising CBT techniques on themselves to support them with a personal-professional problem. '*Self-Reflection'* (SR) is the process of therapists asking themselves 'reflective' questions about the experience to observe and clarify the impact of it on themselves. Research has shown that SP/SR has supported the development of therapists' personal wellbeing, interpersonal skills (through increased awareness of their interpersonal beliefs and attitudes), self-reflective skills, and therapy-specific conceptual and technical skills (Bennett-Levy, 2019; Bennett-Levy et al., 2003; Thwaites et al., 2014). Research has also shown that therapists' engagement in SP/SR is dependent on their support networks, individual and group feelings of

safety and relational processes, and their expectations of benefitting from the programme (Bennett-Levy et al., 2001; Bennett-Levy & Lee, 2014).

The importance of SP/SR being 'group-specific' has been highlighted. This refers to SP/SR that is grounded in the therapists and patients' sociocultural contexts. For example, developing therapists cultural competency skills through focussing on their ethnically-related beliefs, values and experiences (Freeston, Thwaites & Bennett-Levy, 2019; Haarhoff & Thwaites, 2016).

1.7. Research aims

The present study aims to evaluate a recently developed SP/SR programme designed for CBT Therapists from minortised ethnic backgrounds to reflect on how their ethnic background relates to their clinical role (Churchard & Thwaites, 2022). It aims to enhance therapists' skills in working with patients from minoritised ethnic backgrounds and offer a safe peer support space consider the strengths and challenges of their role in relation to their ethnic background. Qualitative methods are used to understand therapists overall experience of the programme. This included their experience of engagement in the programme, their ethnic identity development, and the effect on their therapeutic skills in working with patients from minoritised ethnic backgrounds. The research intends to inform future support for therapists and develop the provision of culturally-informed psychological care.

2. Method

2.1. Materials

Programme Development

The programme aims to provide a safe and supportive space for CBT Therapists from minoritised ethnic backgrounds to explore how their ethnic identity may relate to their clinical role. It also aims to develop therapists' CBT cultural competence skills.

The programme uses an SP/SR format (see introduction for details about SP/SR). Therapists completed CBT exercises that have been informed by theory and knowledge of culture and mental health (the programme's SP component). They then made written reflections on their experience of doing the exercises (the programme's SR component). The SR component supported therapists to consider the effect of the exercises on themselves, how it relates to their ethnic identity in their clinical role, and how it may relate to working with patients from minoritised ethnic backgrounds. The programme authors agreed the programme would be suitable for 6-12 participants. They felt this would be a sufficient number to encourage multiple perspectives amongst group members whilst promoting group safety and enabling participants to get to know one another. This was also a similar number of people that participated in previous SP/SR programmes. The programme authors designed the programme for CBT Therapists and uses a CBT framework. The programme contains nine modules. A breakdown of each module can be found in Table 2.1.

Table 2.1. *Programme modules*

Module	Theme
1	Identifying a challenging problem
2	Creating a cross-sectional formulation and goal-setting
3	Creating a genogram
4	Your personal experience of coming from a minoritised ethnicity
5	Developing a longitudinal formulation and returning to goals
6	Developing strengths
7	Exploring challenges and looking after yourself
8	Adapting CBT change techniques to address challenges
9	Reviewing the programme and thinking about next steps

There were nine online fortnightly group sessions, lasting 60-90 minutes. They encouraged deeper reflection, provided peer support, and helped therapists remain orientated to the programme modules (Freeston, Thwaites & Bennett-Levy, 2019).

The development of the programme was led by Dr Alasdair Churchard, a Clinical Psychologist and researcher. He is from a mixed-race background and has drawn on his professional and personal experience when creating the programme content. He developed the programme in conjunction with Dr Richard Thwaites, a White British Clinical Psychologist with extensive experience working in CBT-led NHS services and has honed expertise in researching SP/SR methodology. Myself (Zara Malik) and another Trainee Clinical Psychologist working on this thesis project

(Shetty-Chowdhury, 2023) read a draft of the programme and provided some feedback on it to the authors. The feedback included reflections on the structure and content of the programme, which were informed by aspects of their personal and professional identities (e.g. identifying as an ethnically minoritised, mental health clinician). It was agreed within the research team that participants were not made aware of our contributions to the programme development, as we considered that this may have affected their responses and behaviours when completing the evaluations. A copy of a chapter of the workbook can be found in Appendix 2.1.

The programme facilitators agreed that facilitators would need to be psychological therapists who have been formally trained in delivering CBT. Given this was a new SP/SR programme, the programme developers agreed that it would be preferable to have a clinician trained in delivering SP/SR as a group facilitator. Given both the nature of the programme and previous literature showing the racial prejudices therapists from minoritised ethnicities face from White western clinicians, they also identified the importance of having facilitators from ethnically minoritised backgrounds. Therefore, the programme facilitators were: Dr Alasdair Churchard (Clinical Psychologist, primary programme developer, identifies as being from a 'mixed-race' ethnic background, Dr Richard Thwaites (Co-developed SP/SR and second programme developer, identifies as from a 'White-British' ethnic background), Leila Lawton (CBT Therapist, identifies from a 'Black-African' ethnic background.

Table 2.2. *Study inclusion and exclusion criteria*

Inclusion Criteria	Exclusion Criteria
• Age 18+ years • Self-identifies as coming from a minoritised ethnic background • BABCP Accredited CBT Therapist • Practising using CBT with at least 2 patients per week in the UK • Has the resource capacity to undertake the programme and attend the group sessions	• Undertaking any other self-development work and trainings, including personal therapy • Experiencing high personal stress or feels they do not wish to engage with sensitive material related to race, ethnicity and culture at present

Recruitment

Practising CBT Therapists who self-identified as being from a minoritised ethnic background were recruited on to the programme (see Table 2.1 for study inclusion and exclusion criteria).

An advertisement that included brief study information was shared through social media platforms (Twitter, Linkedin, Whatsapp) (See Appendix 2.2 and 2.3 for study advertisements). Therapists were invited to attend online information sessions where all of the researchers involved in the programme were present. They explained the individual roles they held within the research team, provided more information about the study, and answered any questions. Those who attended these sessions and met the inclusion/exclusion criteria were sent a study information sheet. They were invited to sign up to the programme by emailing the researchers (See Appendix 2.4 for study information sheet). The researcher (ZM) met with each participant to gain informed written consent to participate in the study (See Appendix 2.5 for consent form).

2.2. Ethical Approval

Ethical approval for the study was given by the UCL Research Ethics Committee (see the approval letter in Appendix 2.6).

2.3. Participants

Participants were asked to complete a demographic questionnaire (See Appendix 2.7 for questionnaire). Seven participants identified as female and two identified as male. Their ages ranged from 25-64 years old. Their time practising as a qualified CBT Therapist ranged from 2 months – 12 years. Further demographic information was not collected to preserve anonymity. Eight participants said they had experienced racism or microaggressions within their current workplace to some degree (rarely, occasionally, or frequently). One participant chose not to answer the questions about racism.

Six participants rated the staff team they work with as ‘a little diverse’, and the remaining three participants said it was ‘not at all’, ‘moderately’ and ‘very’ diverse. One participant rated the diversity of their patient group as ‘not at all’, two participants said ‘a little’, four participants said ‘moderately’, and the remaining two participants said ‘very’ and ‘extremely’ diverse. This demographic data is summarised in Table 2.2.

Participant	Age Range	Gender (self-identified)	Ethnicity (self-identified)	Time practicing as CBT Therapist	Diversity of staff team currently working in	Diversity of patient group within current clinical role	Experiences of racism or microaggressions within current workplace	Experiences of racism or microaggressions in therapeutic work with patients
1	25-34	Female	Iranian	10 years	A little diverse	Not at all diverse	Yes, occasionally	Yes, occasionally
2	35-44	Female	Black British - Ghanaian	6 years	A little diverse	Very diverse	Yes, however, rarely.	Yes, however, rarely.
3	25-34	Female	British Pakistani	4 years	A little diverse	Moderately diverse	Yes, however, rarely.	Yes, however, rarely.
4	25-34	Male	Mixed - Filipino and Spanish	2 months.	Very diverse	Moderately diverse	Yes, however, rarely.	Yes, occasionally.
5	35-44	Female	Black British African	4 years	Not at all diverse	Moderately diverse	Yes, very frequently.	Yes, frequently.

6	25-34	Female	Pakistani	2.5 years	A little diverse	Extremely diverse	Yes, occasionally.	Yes, however, rarely.
7	55-64	Female	Black African	12 years	A little diverse	A little diverse	Yes, occasionally.	Yes, occasionally.
8	45-54	Male	African	12 years	A little diverse	A little diverse	Yes, however, rarely.	Yes, however, rarely.
9	35-44	Female	Black British Caribbean	2 years	Moderately diverse	Moderately diverse	-	-

***Table 2.3**. Participant demographic and contextual data*

2.4. Study procedure

An overview of the key steps in the study procedure is set out in Figure 2.1.

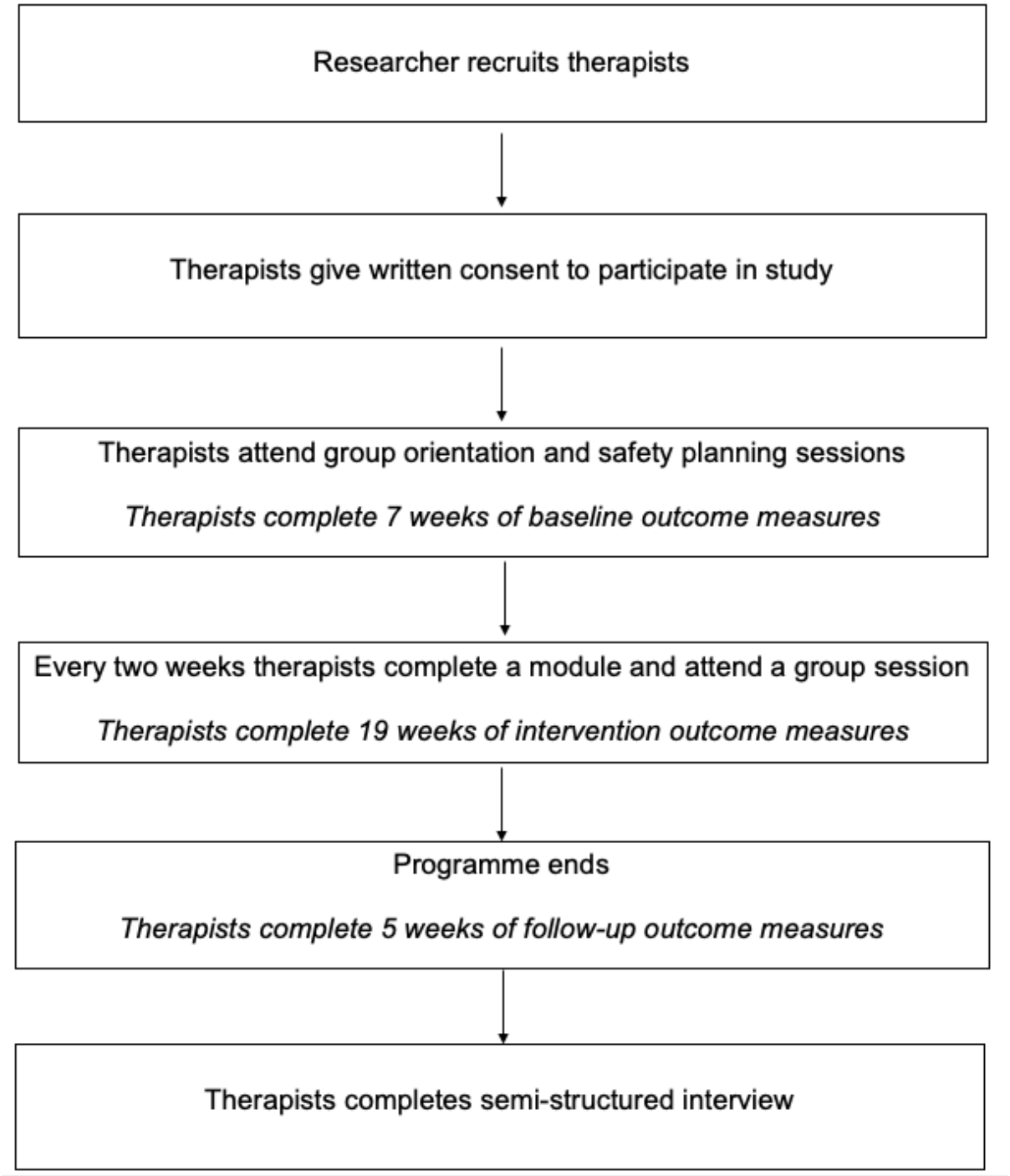

Figure 2.1. *Flow diagram of study procedure*

Measures and Orientation

An orientation session was held to provide an overview of the programme and answered participants' remaining questions. Information was shared about: about the development, aims, and principles; the format and structure of the programme; practicalities of engaging in the programme; keeping oneself safe, and engaging with the self-reflection (SR).

Outcome measures were introduced in this session by a researcher undertaking a quantitative evaluation of the programme. The measures captured constructs of ethnic identity development, CBT skills in working with patients from minoritised ethnic backgrounds, and therapist personal and professional wellbeing (see Appendix 2.8 for measures). Participants were asked to complete the measures weekly, for a total of 19 weeks (7 weeks baseline, 19 weeks intervention and 5 weeks follow-up). This data was made anonymous using a unique code generated by each participant.

Safety Planning

A safety planning session was completed. It aimed to prioritise the overall safety and wellbeing of participants during the programme. A safety strategy document was introduced containing low-grade interventions (e.g. self-care activities), and interventions to manage imminent risk such (e.g. seeking emergency support). This process was designed with the acknowledgment that reflecting on personal and professional experiences related to being from a minoritised ethnic identity could evoke unexpected difficult emotions. A copy of this safety strategy can be found in Appendix 2.9.

Workbook Exercises and Group Sessions

Participants were sent the SP/SR programme workbook prior to the programme starting. Participants were asked to complete the exercises in each module in the workbook before the next group session.

Semi-structured Interview

I (the researcher) developed a semi-structured interview guide (see Appendix 2.10). The questions in the guide were informed by research pertaining to factors that affect SP/SR engagement, ethnic/racial identity development, internalised racism, and cultural competence skills.

Interviews were 1:1 and participants were interviewed and recorded via Zoom up to one month after completion of the follow-up outcome measures. During the interview, the researcher's aim was to elicit information about the therapist's subjective experience of the programme. Following guidelines for semi-structured interviewing in qualitative research (Barker, Pistrang & Elliott., 2016), open-ended questions were used (e.g. 'What was your overall experience of the programme?", followed by more focused questions to encourage elaborating and reflection (e.g. "what did you think the group sessions of the programme achieved?"). The interviewer answered participants' questions and reminded them of their rights to skip questions, pause, or withdraw from the interview at any time.

2.5. Method of analysis

Interviews were audio recorded and transcribed verbatim following pre-established guidelines (Barker, Pistrang & Elliott., 2016). All transcripts were uploaded into QSR International's NVivo qualitative data analysis software (version 12, 2020).

Transcripts were analysed using reflexive thematic analysis as it is a theoretically and epistemologically flexible method of qualitative data analysis that can provide a rich and detailed account of complex data (Braun & Clarke, 2006; Willig, 2013).

The study was to explore the conscious reality of therapists' experiences on the programme. Therefore, a broad experiential stance was adopted. This was underpinned by a critical-realist ontology, as it was also acknowledged that therapists' social contexts, language, and social positionings impact their perceptions, beliefs, and assumptions (Danermark, Ekström & Karlsson, 2019).

2.6 The analytic process

A six-phase reflexive thematic analysis was undertaken to explore patterns across the dataset (Braun & Clarke 2006; 2021). The six phases are distinct yet recursive, meaning that I moved through different phases for interpretation and inquiry into different aspects of the data (Terry et al., 2017). Written text and visual mapping were used as analysis methods. During the process, I shifted between different physical environments, which shaped my thinking processes and the way I interpreted the data. Written excerpts of the journal are referenced within this data analysis section and can be found in Appendix 2.11).

The familiarisation process involved reading the interview transcripts and noting initial ideas, reactions, and perceptions about the data through annotation and making familiarisation notes (See Appendix 2.12). I used a primarily inductive approach to begin to make sense of the data. This was because I chose to adopt a broadly critical realist perspective (Madill, Jordan, & Shirley, 2000; Willig, 1999),

thus, the focus was identifying semantic and latent meanings of the participants lived experiences of the programme.

The coding process primarily involved an inductive orientation to coding, whereby the dataset was the starting point for engaging with meaning. The coding process was completed using NVivo's qualitative data analysis (version 12, 2020), which is an electronic qualitative data analysis software.

Phase three of the analysis involved identifying candidate themes by clustering codes together that represented a category of meaning. Thematic maps to bring the codes together, generate initial themes and consider how themes interrelated.

Phase four involved developing and reviewing candidate themes by re-engaging with the coded data extracts and initial themes. Braun & Clarke (2022) suggested that the focus of the data analyst should not be on developing consistet or precise numbers of themes or subthemes. Instead, they suggest focussing on developing themes that are rich and nuanced, developed to surround a central organising concept, and tell a 'story' across the data. Therefore, I took a recursive approach by re-visiting data codes, tentative themes so that I could develop the depth of the analysis further. I was able to remain reflexive with regards to the analysis process through discussing with my supervisor how codes were interpreted, grouped, named, and organised into candidate themes. During stage five of the analysis, I defined and named each theme. Relevant supporting extracts were chosen from the data to illustrate analytic themes and subthemes. Phase six involved integrating the themes into a coherent analytic narrative to write up the findings.

Data analysis was undertaken solely by the main researcher (I, Zara Malik). Qualitative researchers suggests that researcher subjectivity is essential to the process of a reflexive thematic analysis approach (Braun & Clarke, 2021; Nadar, 2014). A key feature is reflexivity, as knowledge is situated and shaped by the researchers processes and practises of knowledge production. Therefore, a reflexive journal and supervision were used to clarify, explore, and deepen their analytic insights. These reflections were documented in the researcher's reflexive journal, which can be found in Appendix 2.11.

2.6. Validity checks

Validity checks were used to ensure the research was rigorous and transparent, in line with guidance on qualitative analysis (Elliot, Slatick & Urman, 2001).

The researcher engaged in a bracketing interview at the start of the research process and continued to keep a reflexive research journal throughout. The bracketing interview and the reflexive research journal supported the researcher to bring awareness towards the origins of their choices, inconsistencies, overlaps or biases throughout the analysis process. Some of the reflections are shared below.

2.7. Researcher reflexivity

I am a British, female, second-generation immigrant from Pakistani and Irish ethnic backgrounds. I am a Trainee Clinical Psychologist and have my own lived experiences as an employee from minoritised ethnic background of working clinically in NHS services. In teaching and supervision spaces, I have experienced personal benefit from reflecting on how my ethnic identity relates to my clinical role. This has supported me to integrate my personal identity into my professional work and

enhance my skills and self-confidence in the workplace. Therefore, I hold an assumption that this would be beneficial and supportive for other therapists from minoritised ethnic backgrounds.

I have received racial abuse from colleagues and patients within my NHS career. These very difficult, intensely emotional experiences shaped the perception of my own ethnic identity and impacted on my interactions with patients and colleagues. With the support of my research supervisor, I considered how I could remain open and empathic towards participant's accounts of receiving racial prejudice remain curious towards understanding their experiences, and support myself within this process.

Through my training, I have delivered and adapted CBT to consider patients' racial, ethnic and cultural backgrounds. Through this process, I had formed my own views and understandings about the use of CBT across cultures. By bringing awareness to these views, I believe this has reduced the implicit influence they may have had on the analysis process.

3. Results

Three superordinate themes were identified through the analytic process: (1) 'Organisational culture', (2) 'A search for understanding', and (3) 'Contextualising CBT'. These superordinate themes in addition to associated themes and subthemes are presented in table 2.3 below and discussed in the following sections.

Superordinate themes	Themes	Subthemes
Organisational culture	There's no space	
	The system needs to change	
A search for understanding	Finding safety/ experiencing 'safety'	
	Must I fit the mould?	
Contextualising CBT	Is this CBT?	
	The relationship between mental health and holding an ethnically minoritised identity	
	Use of self	Seeing strength in the mirror
		Using my identity

Table 2.4. *Overview of themes*

3.1. Organisational culture

This first super-ordinate theme describes participants challenges and relationships with their workplace systems. The 'system' refers to organisational structures that govern services, and employees working at all levels of participants respective services. Participants accounts showed that navigating personal and professional issues of race, ethnicity and culture within their systems were challenging. Thus, a motivation to engage in the programme was to find a supportive place to consider these issues.

3.1.1. There's no space

Participants described having little 'space' for their ethnic identity within the service. Participants used the word 'space' to describe difficulties finding places to discuss their ethnicity in relation to their professional role. The following participants account illustrates this, describing their experience of their ethnicity being 'dismissed':

> *'There was never any space in any of the training we've done. There's never been any space in supervision to reflect on it [their ethnicity], you know, if there's been discussions around ethnicity or race, or anything like that. It's been kind of dismissed or just not talked about or seen.'* ***(Participant 1)***

Other participants used terms associated with 'space' to describe how they were treated in the service due to their ethnic identity. Phrases such as feeling 'locked out' of their team, or 'opening a door' to their ethnicity refers to creating more space, as if there was now additional physical room for themselves to consider these things:

> *'The kind of scary part of this course was that for so long I've been pushing things to one side and not really giving it attention, thinking I've got a CBT hat on. I'm doing this work now that I've opened the door a little bit, I can't really close it again, because I'm treating myself as a human being who is also doing therapy.* ***(Participant 3)***

The word 'space' refers to having free and unoccupied area to exist and move. Within participants accounts, there was a sense that the stuck feelings that they felt in their workplace with the issues related to their ethnic identity felt as if they were physically trapped and were seeking physical and emotional space to explore

this. In the following excerpt a participant describes needing to ‘make the most’ of the programme. Again, by communicating her need to get the most out of a space that is not present in her workplace:

> *‘I think honestly, I committed myself because I was like, I don't see an opportunity coming up to do this kind of thing in the near future, or maybe it would have been… I don't know, but I felt like I needed to make the most of it for the time that we had.’* ***(Participant 1)***

3.1.2 The system needs to change

This theme spoke to participants views, attitudes, and relationships to their workplace systems. Participants accounts suggested that to fit in to the system/culture, they needed to change their views and tolerate racism towards themselves or others. Participants described being ignored or dismisssed when discussing racial matters with colleagues, leaving them feeling *‘oversensitive’* and worrying that comments they believed were racist were actually insignificant. However, the programme supported them to acknowledge that there are racially unjust aspects of the system. The following account illustrated this. A participant described learning that they did not need to change. They began to acknowledge and value the strengths of their identity within their clinical practise:

> *‘It all comes back to the shrinking or kind of trying to change you to fit into the environment that we find ourselves. But actually, having this opportunity, it's kind of relearning that you don't have to change you to be in this space. But how, you know, the value that you bring as a person from minoritised ethnic background, it's rich in itself, and actually, that richness helps you to be that better therapist within the practice that you are in.’* ***(Participant 5)***

This shift in perspective also gave participants confidence to make changes towards their relationship with the system. The following excerpt is an example of how a participant acknowledged that they had previously tolerated racism directed towards themselves, but was now able to validate their own experiences of racism and address racial injustices in the system:

> *'It did make me question…well… did I just let people get away with lots of stuff [racism], and I probably did, because I didn't speak out much, and by not speaking up… how much had that person then gotten away with other things that they might have done to other people, you know, after me. So that's what was helpful with the confidence, then, where I'm kind of just saying things, I'm just naming things and I'm not letting, like I said before, that doubt creep in and say, 'oh, hang on a sec, you know what if you got the wrong page here?' It's 'no, this is what I saw or heard or witnessed, and that what I'm gonna say'.* ***(Participant 3)***

3.2. 'A search for understanding'

The second superordinate theme predominantly focussed on how the group spaces influenced participants experiences of being understood by others and developing an understanding of themselves in relation to their ethnic identity. Interestingly, there seemed to be a dichotomisation in views; participants felt either a sense of belonging and felt understood or a sense of not belonging and felt misunderstood.

3.2.1. Finding and experiencing 'safety'

Most participants described feeling '*safe'* in the group. '*Safe'* was conceptualised by participants as: not feeling judged, being able to be open and honest, mutual trust, respect, and their experiences being validated by facilitators

other group members. The following participant describes how they gauged the level of safety before sharing their experiences:

> *'All the facilitators made it feel like a safe place, and the other members of the group made it feel like a safe place. And I didn't feel judged when I did say something, which is the reason why I didn't say something in the first session, because I was afraid of being judged. And then I think when I saw that the other people who had been speaking weren't being judged or being looked at in a different way, and they're experiences were being validated, I felt comfortable.'* ***(Participant 6)***

Some participants referred to need to have some facilitators from minoritised ethnic backgrounds for the group spaces to feel safe. Though, there was a strong sense that the feeling safe could be experienced around the White British facilitator in the group because of the way they interacted with the group. Participants had described their White co-workers as '*defensive'* and *'dismissive'* when engaging in conversations about ethnicity, thus there was a sense that this interactional experience felt new and different. The following quote illustrates this:

> *'I really liked [facilitator's name] was there as well, as a, kind of a… White male. Because it helped. It just made it feel like that he was interested, and that he acknowledged his race, and who he was, and he was curious to learn. I think that was so helpful and really important.'* ***(Participant 6)***

3.2.2 Must I fit the mould?

The word *'mould'* is defined as a distinctive, typical style or form that has been developed over time. In this setting, a participant suggested there was a 'mould' that most group members and 'typical' ethnically minoritised people fit in to.

This included those that had experienced or witnessed racism within their professional role, and had been emotionally affected or had felt victimised through this experience. The following participant described how they resisted fitting this mould during their time on the programme, sharing that they did not want current or historical sociopolitical racist events to be part of their *'story'*:

> *'I guess I don't want to just fit a mould because the mould is there. 'Oh, you're a black female you must have experienced racism. Oh, you're this age, so you must have experienced this.' No! That's not the truth. That's not my reality. That's not my lived experience. I've looked for it, um… I haven't found it. I appreciate that other people may have experienced it.'* ***(Participant 9)***
>
> *'I guess I'm not maybe 'typical' as a minoritised person, in that I don't want to be the victim of my life. I don't want to be the person that says, 'oh but slavery' and 'oh, but black people are always treated worse', and 'oh but this, and oh but that'. I appreciate that all of those things may be true, but I don't want that to be my story. I don't want that to be my lived experience, because it's not.'* ***(Participant 9)***

In the above quote, it can be inferred that '*other people'* refers to the programme group members, suggesting they had contributed to the co-construction of this mould. In the following excerpt a participant describes their experiences with the programme exercises. This contributes to the construction of the 'mould', as the participant describes how their ethnic identity did not fit in with the SP/SR exercises:

> *I think maybe there were certain exercises that, you know, I struggled with, which kind of made me feel more like 'oh, yes I don't belong'. […] Some of the questions in the book I found quite hard. Also, like thinking about how to*

identify my identity and things. And yeah, I remember finding them quite like frustrating, because I just didn't really know how to answer it. Because… I guess I've always thought of my ethnic identity as being quite blurred, because my parents both moved here from their own different countries, and almost had to like, assimilate. So, it's always felt like my ethnic identity has been a bit blurred and hard to identify. ***(Participant 4)***

This participant also shared that they had not experienced the kind of racism that other group members had shared in the group. This seemed to further confirm that there was a mould they felt they did not fit in to, perpetuating feelings of not belonging in the group:

'I think people kind of... sharing experiences of quite overt racism that they'd experience, and I guess maybe I felt like I hadn't really experienced enough of that to warrant me being here. I think maybe because of my mix of ethnic identities, sometimes it's not as obvious that I am from a minoritised ethnicity. I felt like maybe I shouldn't be here,' ***(Participant 4)***

3.3. Contextualising CBT

The third super-ordinate theme captured participants perspectives on the principles, aims and components that comprise culturally-informed CBT. Therapists developed an understanding of the relationship between patients' mental health and their ethnic identity, and considered how they could approach this within a CBT framework. They also reflected on how their own ethnic identity may affect the therapeutic process, and how the self-reflection supported their skills in providing culturally-informed CBT.

3.3.1 Is this CBT?

Participants considered how exploring aspects of ethnicity, race and culture with their patients would fit within a CBT framework. Regardless of the amount of experience that the therapists had in practicing CBT, many participants expressed that at some stage during the programme they questioned how the SP/SR exercises would be applicable to working within a CBT model. The following account demonstrates how a participant re-evaluated their understanding of CBT after witnessing the positive effect of opening a conversation about ethnic identity with a patient:

> *'I was like I'm concerned about, you know, is this is still CBT or not, but as I said it was all completely CBT. So, we still were working on the main things he wanted to work on, but then, seeing his confidence increase, also had an effect on my own [confidence]. Like, thinking 'Okay, so it was good idea then to open up this question about ethnic identity, it was a good idea to pinpoint these things and name these things.'* ***(Participant 3)***

Some participants shared that addressing their patients' ethnic backgrounds felt unnecessary and too time intensive, as CBT should focus on the '*here and now*'. The quote below illustrates a participant sharing that they 'struggled' to make sense of how exploring their own and their patient's ethnic background aligned with a CBT model:

> *'We're not doing psychoanalytic, its CBT we are doing. I'm not saying we need to box clients in when doing formulations, but I'm thinking about the time it would take to do these things I'm expected to do in terms of exploring my own backgrounds and where I'm coming from and then explore the clients background and where they are coming from and look for commonalities. I*

struggle with matching that with CBT to be honest in terms of looking at too much details of the background, because it's about the here and now.' ***(Participant 7)***

3.3.2. Appreciation of ethnically minoritised experiences on mental health

Participants accounts showed that they became increasingly aware how holding a minoritised ethnic identity could impact on one's mental health. Participants' accounts showed that they felt therapists were *'better'* or more skilled if were able to incorporate this into their assessments, formulations and interventions. The following excerpt illustrates this:

'I think it's definitely made me into a better therapist, because I'm more aware of how everyone's, like, different parts and little parts of them, different parts of their identity, all connect to their wellbeing, their wellbeing in society, in the workplace, in the family and their relationships, and the setups they're in, in a country where they potentially are an ethnic minority.' ***(Participant 1)***

Specifically, the following participant's account demonstrates how the genogram exercise developed their thinking to consider the effect that societal and socio-political structures might have on their own and their patients belief systems:

'With the genograms I find it helpful just because it helped me think of myself but also my patients, you know, as part of like the bigger system. And also to start to consider other factors that might be impacting their kind of thoughts and beliefs.' ***(Participant 4)***

Participants articulated ways in which their practice had changed. The below excerpt shows a participants experience of the timeline exercise. This deepened their thinking about their father's experiences of racism, and how this may have had an

impact on her family's belief system. They then considered how to approach conversations about generational beliefs and experiences when using CBT with ethnically minoritised patients:

'The timeline, the questions that they asked, some of the questions I thought, 'oh, I hadn't really thought about some of the questions that they asked' about like the challenges. It made me think actually, I know my dad, he came here during that whole time, I think in the sixties, when there was that whole thing about no blacks. But I'd never really spoken to him about it, and he sort of said, 'yeah, it was hard', but we never really had like in depth conversations about it. So, I guess it was just a case of carry on... So I think questions like that helps you. In my practice It makes me think if somebody is bringing those things, maybe finding out a bit more about what it was like or what their family may have gone through, which I think usually do when I've had clients. I always ask about their background, but not necessarily in relation to that level of thinking about generational kind of stuff, which is something that I guess I'm taking away from the program which will be really important for people of BAME and other people as well. If there's relevant kind of stuff that may have happened, if they migrated from different countries, for example.' ***(Participant 2)***

3.3.3. Use of self

This theme contains two subthemes: 1. *'Seeing strength in the mirror'*, and 2. *'Using my identity'*. These subthemes showed the value participants ascribed towards reflecting on their own ethnic identity and how they felt it improved their therapy skills, professional practises and personal lives.

3.3.3.1. Seeing strength in the mirror

The word *‘mirror’* has been used to represent the idea that participants’ beliefs and assumptions towards their ethnicity had been reflected on to their patients who held similar identities, as if the therapists were viewing the patient as a reflection of themselves. Throughout participants accounts, there was a sense that they identified this was a relational position that they were taking with some of their patients. The following excerpt demonstrates this. The participant shared that they became aware that they had viewed their ethnicity negatively. They began to reconnect with aspects of it in a different way:

> *‘I think it's really similar, being really aware of my own biases as well around my own ethnicity, my own country, my own culture. Thinking ‘it's not that simple [participant’s own name]… It's not all bad’, and it's not. […] So, I guess in a way, it's been a long, hard battle to try and get some of it [their culture] back, but also to recognise nothing is perfect. It doesn't need to be perfect. Yes, it's ugly, and it's messy, and there are bad bits to it. But there is also lots of good bits to it, and [I’m] not expecting perfection from it, and that's okay, not being ashamed of it, because it doesn't need to be perfect, because no one else’s is perfect. I think it comes back to that superiority, to white superiority, doesn't it.’* ***(Participant 1)***

The following quotes demonstrate how the SP/SR exercises supported positive changes in a participant’s beliefs related to their ethnic identity. The mirror metaphor can be used here to show that their beliefs about the way they viewed themselves in the context of their ethnicity perhaps changed the way they related to their patient’s ethnicity, approaching their work with ethnically minoritised individuals differently:

‘Something I’m using with my clients now was looking at the strength of identity, something that I hadn't been looking at before within myself, maybe seeing it more as a negative thing. But, through doing that formulation, and looking more at those strengths, that was really useful and something that I started to do with my clients.’ […] With that genogram, I guess it helped me see kind of the strengths that they [the participant and their family] had, and you know, what they did, and what they worked on. […] Then thinking about how you know, I've maybe had to be resilient due to an experience and how my family may have had to be like that, and it's something that has been, I don't know the word but I'm going to say the only way to think of it was ‘driven’ into me. And therefore, how can I consider that with the people that I’m working with? Feelings of empathy… things like that, just really highlighting on that.’ ***(Participant 6)***

3.3.3.2. Using my identity

Participants accounts showed that they identified unique strengths they held through holding a minoritised ethnic identity, which could support their work with patients from minoritised ethnic backgrounds. In the following excerpt, the participant identified their ethnicity as a *‘gift’* that they could bring to their work as a CBT Therapist. The statements *‘I don’t need to change’* and *‘I don’t need to be something else to help’* implied that previously, they assumed that their ethnic background had an unhelpful, negative impact on their work with their patients:

‘Sometimes, in all of this, I thought about not going back to this thing [their role as a therapist]. But actually, this is a gift. This is the gift that I have. There something about my experiences, and who I am as a human being that allows

*me to do my job in a unique way, and that is okay, that that is a blessing, and I don't need to change. I don't need to be something else to be able to help somebody.' **(Participant 5)***

Participants accounts showed that the programme supported them to understand the use of their ethnicity in their relationships with patients differently. In the following extract a participant described how the genogram and timeline exercises meant they had explored their family's Black racial identity, and their identity as a woman. This meant that instead of feeling fearful when working with a Black patient, they were able to empathise and connect with them:

*'I think it took away some of that kind of fear of someone's bringing that, maybe they want to talk about their racism, maybe in my head I was catastrophizing a bit, thinking that's all they're gonna want to talk about, and they might expect me to be able to do something with that, and I can't. But actually after the program, making me realize that maybe, yeah, they do want to share that with somebody who they think will understand, but not necessarily feeling like anything has to change, but just that they just need somebody who understands, that they feel comfortable to share that with somebody who they feel gets it as well.' **(Participant 2)***

4. Discussion

The primary aim of the present study was qualitatively to explore CBT Therapists' experiences of a novel SP/SR programme that aimed to support them to consider how their ethnic identity may relate to their clinical role. Participants' narratives provided insight into approaches that can support their personal and

professional development, and provide therapy that is inclusive of patients' ethnic backgrounds.

The '*Finding Safety'* theme suggests that many participants felt psychologically 'safe' in the group spaces. Safety was developed through sharing an identity (minoritised ethnicity), feeling understood, and being validated by the group in their thoughts and experiences. This corresponds with research showing that non-White spaces have been identified as safer spaces for non-White professionals, as they did not feel they had to minimise their experiences (UCL DClinPsy HEE Action Plan Working Group, 2021; Ragavan, 2018; Tong, Peart & Rennalls, 2019). Therapists have also felt they had to remain hypervigilant towards signs of being misunderstood or judged by their White colleagues (Shah, 2010). Together, these findings help explain the reasons that therapists from minoritised ethnicities particularly value non-White spaces to explore their ethnicity in the context of their professional role.

Within the same superordinate theme, '*Must I fit the mould?*' was a theme to reflect how participants' experiences of 'fitting in' and feeling safe within the group affected their engagement in the programme. This is important, as therapists' psychological safety within SP/SR has shown to mediate their engagement in it (Bennett-Levy & Lee, 2014). A participant shared they struggled with the group as they did not feel like a 'typical' ethnically minoritised person, as they did not want their 'story' to be one of a 'racial victim'. Another participant shared their challenges in relating to group members experiences of racism, and felt frustrated and confused that the structure and content of SP/SR exercises were not representative of their ethnic background. Research has shown that using problem-saturated labels to describe heterogeneous groups of people can create stereotypes and stories about them. This can lead to perceptions that non-White people are homogenous. Thus,

for these participants it may be that they felt they had little control over the stories of their identity, affecting their feelings of safety and their engagement in the programme (Tong, Peart & Reynolds, 2019; White & Epston, 1990).

Interestingly, the '*Finding* Safety' theme suggested that over time, participants developed feelings of safety with the group facilitator who was from a White-British ethnic background. The evidence base shows that psychology professionals from minoritised ethnicities typically hold high levels of mistrust towards their White colleagues, to protect themselves from experiences of racial prejudice (Brown & Grothaus, 2021), being stereotyped (Constantine & Sue, 2007), or having the social impact of their ethnicity ignored, known as '*colour-blindness'* (Shah, 2010). In the present study, participants valued the facilitator's ability to openly acknowledge and discuss how their White British ethnicity may impact on how they understand and relate to participants' experiences. This finding is in line with research showing that that ethnically minoritised supervisees have increased trust towards White supervisors who were able to open conversations about how their ethnicities may affect relational dynamics in supervision (Brown & Grothaus, 2021; Cisneros et al., 2023). This suggests that it would be important to consider both the ethnic backgrounds of future facilitators, and the self-awareness they have of their ethnicity and how it may have an impact on the group interactions.

The theme '*Is this CBT*?' is posed as a question to capture participants ambivalence towards exploring how aspects of patients' ethnicity could fit within a CBT framework. This is perhaps unsurprising, given that research has shown there is low consensus amongst highly skilled CBT professionals regarding the required skills to practise competent CBT (Muse & McManus, 2016). The Muse and McManus (2016) study showed that a therapist's ability to 'adapt and respond' to their patients'

individual personalities and circumstances was identified as a key skill. Thus, consideration may need to be given towards supporting therapists' understandings of working in this way. Moving forwards, focus should be given towards developing therapists' skills to incorporate patients' ethnic backgrounds and addressing their concerns about drifting from a CBT framework.

Nevertheless, the theme '*The relationship between mental health and holding an ethnically minoritised identity*' reflects a process of participants becoming less concerned about drifting from a CBT framework. Through the programme, participants recognised and valued the extent to which wider socio-political contexts, inter-generational beliefs, and personal experiences can influence how they relate to their ethnicity, and the implications this could have for their mental health. This demonstrated developments in their CBT conceptual skills through adapting their work to consider social and systemic contributors to their patients' belief systems. Within SP/SR, this is an example of participants '*bridging the gap'* between personal learning and professional practise (Bennet-Levy & Finlay-Jones, 2018).

The theme *'Use of self'* suggests the programme developed participants' self-awareness and interpersonal skills. These skills are important in addition to CBT-specific skills, as the CBT literature has shown that therapists' belief systems, emotions, and actions have a large impact on their interpersonal skills with patients (Bennett-Levy & Thwaites, 2007; Hayes et al., 2007; MacLaren, 2008). Through completing the strengths-based exercises, a participant developed a more personal understanding of their Black racial background. They considered that their patients request for a Black therapist may be because they considered this to be the safest and most understanding space to discuss their ethnicity. This decreased the therapist's fears and concerns that their patient and team would expect them to 'do

something about' the racism. Other participants identified developments in their empathic communication skills through reflecting on the resilience their family had built through their experiences of racial prejudice. This demonstrates the positive effect that the SP/SR process had on participants' interpersonal CBT skills.

Within this theme, the theme *'Seeing strength in the mirror'* suggests that the self-practice work developed participants' personal relationships with their ethnicity by introducing different perspectives towards their ethnicity into their belief system. This meant that therapists connected to more positive aspects of their ethnicity, such as their resilient nature or the positive aspects of their country of origin. Through this, participants became more curious towards discussing aspects of their patients' ethnicities with them, and could more readily incorporate patients' personal strengths that they had developed through their ethnic background into the therapy. The findings in this study speak to research demonstrating that therapists' personal development and wellbeing is a core outcome of SP/SR (Bennett-Levy & Finlay-Jones, 2018). This is because the value an individual ascribes to themselves is likely to have a positive effect on therapists' overall ability to navigate the complexity of working with patients' mental wellbeing.

Furthermore, the superordinate theme *'Organisational culture'* may relate to participants connection towards the personal strengths within their ethnicity. The theme demonstrates developments in participant's self-confidence as they began to challenge the systems discriminatory actions. This included having less self-doubt with regards to naming racism, and valuing the richness their ethnicity can bring to the work. Sue & Sue's Minority Ethnic Identity Model (1990; 1999) would suggest that participants had encountered '*dissonance*' within their beliefs about their ethnicity. In this stage of the model, individuals develop an appreciation of their own

race, and in some contexts, a depreciation of the White race. This may explain some of the differences in participants' approaches towards their colleagues. Nonetheless, changing the culture of how therapists from minortised ethnicities are treated and supported remains the responsibility of their respective professional teams and systems.

4.1. Clinical and Research Implications

The present study has shown that the group spaces provided feelings of safety and solidarity for participants through collective acknowledgment and validation of how individual and shared experiences of their ethnicity shaped their personal and professional selves. The present study contributes to the findings showing the value of these spaces for therapists overall personal wellbeing and professional skills, and for patient outcomes (UCL DClinPsy HEE Action Plan Working Group, 2021; Ragavan, 2018; Tong, Peart & Rennalls, 2019).

This research also identifies systemic changes needed to support psychological therapists from minoritised ethnicities. First, it is evident that supervisors need to provide a safe, trusting, and non-judgmental supervisor-supervisee relationship to provide therapists with space to share any personal challenges and strengths that the work may have on them, and how those may be affecting them personally or professionally. Training around how to create these spaces with supervisees should be considered within a supervisor's role development.

Secondly, this research implies that CBT conceptual, technical, and interpersonal skills are developed through providing opportunities for therapists to reflect on how their ethnic backgrounds may shape their therapeutic work with patients. Most cultural competency training is delivered didactically, focussing on White clinicians'

skills in broaching conversations about ethnicity (Beck et al., 2019), or learning about specific cultural norms and practices (Maura & Kopelovich, 2019). There are rarely reflective opportunities for therapists to learn how to work with ethnic diversity through linking their personal and professional selves. The present study indicates cultural training should incorporate more reflective methods of teaching and include content that is applicable and relatable to therapists from minoritised ethnicities.

4.2. Limitations

The interviews were conducted up to 8 weeks after the programme finished, with no follow-up data gathered after this time. This means that the long-term impact that the programme had on CBT Therapists personally and professionally is unknown. Collecting longitudinal data may highlight any ongoing support that would be helpful for CBT Therapists from minoritised ethnic backgrounds. It also may shed light on any challenges that they have faced in incorporating some of the learning and understanding gained from the programme into their clinical work.

Another limitation was that this is the first evaluation of this novel programme. Given that we have data from only nine participants, the generated themes can only very tentatively suggest there are relationships between participants' ethnic backgrounds, how they relate to their ethnicity, and the extent to which they benefitted from the programme. It may be that gathering more qualitative data through further evaluations of the programme would develop our understanding of specific factors that may mediate these relationships, enabling the most effective support to be offered to therapists from minoritised ethnic backgrounds.

4.3. Conclusion

This qualitative study evaluated a novel SP/SR programme that aimed to support CBT Therapists to consider how their ethnic background relates to their clinical role. The findings have shown that the programme had a positive impact on the way therapists viewed their ethnicity, and showed developments in their CBT conceptual, technical, and interpersonal skills, both of which improved their work with patients from minoritised ethnic backgrounds. However, therapists will continue to internalise racist messages if systemic racism continues to remain unaddressed, and they remain unsupported (Kline, 2014). The recommendations of support for therapists primarily lie with organisations and institutions in positions of greater power, such as CBT training programmes, NHS trusts and relevant professional registration bodies, such as the BABCP. The action of all these parties is necessary to support the personal and professional lives of therapists and patients from minoritised ethnic backgrounds.

PART 3

CRITICAL APPRAISAL

1. Overview

Within Part Three of the thesis I reflect upon the experience of undertaking the literature review and the empirical study presented in Parts One and Two, from a researchers perspective. The reflections presented here were informed both by the bracketing interview, the reflexive journal I kept throughout the research process (see Appendix 2.11), and reflections and understandings that I had gained through research supervision and research meetings. The reflections presented here focus on three key sections. The *first* section explores my own position throughout the research, including how my personal and professional identities may have influenced my thinking within different stages of the research lifecycle. The *second* section discusses the strengths and weaknesses of the research, particularly related to dilemmas arising from the use of language and how that may serve to include and exclude people and studies from research. The *third* and last section shares the dilemmas of how to appropriately disseminate the research, and learning points I have gained throughout this process. Personal reflections are embedded throughout the various sections.

1.1. Reflexivity and exploring my own position throughout the research

Reflexivity can be understood as routinely reflecting on your assumptions, expectations, choices and actions throughout your research process (Finlay & Gough, 2008). The aim of this process is for the researcher to consider what their position may enable, exclude, and moderate in relation to the creation of knowledge (Wilkinson, 1988). This means developing an awareness of your personal

sociodemographic standpoints and your values and assumptions about the world, because who you are and what you bring will inform the research. Thus, in the present research, I considered how my personal beliefs and experiences influence the reason I pursued this particular research project, and the way they may have influenced the data collection and data analysis processes.

At the time of selecting the research topic, I was engaged in teaching on ‘cultural competence’ and engaging in peer reflective groups where discussions about how our ‘Social GRACES’ (Burnham, 2013) impact on the work we do with patients and systems within NHS settings. This was one of the first opportunities I had to actively reflect on my racial, ethnic and cultural identities. I began to make sense of how my Pakistani and Irish ethnic backgrounds related to how I have experienced my personal and professional life. Due to this, my racial, ethnic and cultural backgrounds became more salient, and I became more curious about myself in relation to coming from a socially minoritised ethnic identity. I believed this may have represented a motivating factor to conduct research in this area.

In addition to this, I reflected on how my professional identity as a Trainee Clinical Psychologist may have influenced my perceptions on the type of support that I believe would be most helpful for therapists from minortised ethnic backgrounds. Through my training and my own personal experiences of having psychological therapy, I have developed beliefs that ‘talking’ about difficulties and reflecting on them using psychological models is of benefit. For myself, it has supported me to make sense of how my ethnic identity and associated experiences may have had an impact on my personal and professional identities. Therefore, when entering into the research, I became aware that an assumption I held was that this will be a beneficial experience for other mental health professionals. Holding this awareness in mind

throughout the research process, and particularly during data collection, has meant I have been able to remain open to differences in opinion and perspective in relation to the structure and content of the programme.

The experiences of undertaking a qualitative methodology for my service-related research project highlighted to me the importance of exploring and understanding how individuals make sense of their experiences and the world around them, and how that can be detailed through dialogue. Additionally, the experience of conducting qualitative methodology in my undergraduate studies showed me the invaluable role that it has in the creation of valid and reliable research evidence that can inform psychological practise. Given that the project employed both qualitative and quantitative methods, I strongly wished to pursue this project for its robust, mixed methods design.

Regarding the data collection process, my reflective research journal supported me to consider how to navigate my role as a research interviewer and my identity as a Trainee Clinical Psychologist. Outside of the research, I was actively working on developing my interpersonal skills in working with a range of different clinical populations. Thus, it was a challenge to resist responding in a curious way whereby I would want to open the space to understand more about what a participant had shared and enable them to be more directive within the conversation. My researcher stance meant that I had to find the balance between being empathetic and validating towards the participants experiences, whilst engaging them in conversation that would be relevant to the research question. The balance between fostering this safe space where participants felt held and acknowledged, whilst focussing on obtaining rich, relevant data, was a challenge throughout the interviews.

A particular difficulty was when participants shared their experiences of racism within their personal and professional lives, and went into detail about this experience. Entries in the reflective journal conveyed that I felt a sense of guilt for bringing focus back to the research topic, such as exploring the implications that those experiences had for them personally and professionally, rather than hearing a detailed account of the racist incident. Active engagement with journaling during this process helped me make sense of my feelings of guilt. I thought about times where I had shared my own experiences of being a victim of racism, and how vulnerable that I felt whilst doing this. Therefore, I wondered whether these personal resonances were implicated in the feelings of guilt I had about not providing an open space for participants to share theirs. This process of journaling and reflecting on how my own experiences may impact on my ability to collect meaningful data helped me keep sight of the key purpose of the research during interviews, whilst also being sensitive and empathic towards participants experiences of racism.

I also wondered whether the participants knowledge of my professional background as a trainee clinical psychologist influenced their way of relating to me. It may have been that they had dual expectations of the interview; to share their experiences of the programme, but also a space to share and process their experiences of racism in a safe space with a professional who has been trained therapeutically to facilitate conversations like these. In addition, I wondered if my identity as an Asian Pakistani, ethnically minoritised individual may have influenced the direction of the interview conversations. It is well understood that people who share a social identity are more likely to feel safe as there is an assumed shared mutual understanding of their experiences related to their identity (LeDoux, 1998; McHarg, Mattick & Knight, 2007; Shah, 2010). Therefore, it may be that participants

felt our shared identity as someone who is ‘minoritised’ meant I would be able to resonate with some of their experiences of racial prejudice, and they were therefore more inclined to share them.

During the data analysis process, my research journal helped me maintain a curious, open stance towards participants accounts of their experiences of the programme. I noticed that my feelings towards a participant, or an excerpt would be dependent on the extent to which the participant felt they had ‘benefitted’ from the programme. I believe this came about through my conflicting roles within the research. I was actively involved in developing the SP/SR programme and believed the programme to be valuable in being able to support therapists from minoritised ethnic backgrounds, but I was also the researcher evaluating the programme. Therefore, I wondered if I had, consciously or unconsciously, a desire for the participants to experience the programme as beneficial. In these circumstances, I found that referring back to entries in my reflective journal helpful. Here, I had reflected on this conflict in role and acknowledged that this was a difficult position to be. This supported me to take a pause during times in the analytic process where I noticed being influenced by my dual positions, and reduced the influence of my own beliefs and assumptions on the data. Through this, I have learnt that it is important to carefully consider each person’s roles within a research team. In the future, I could consider how having roles within both the study/experiment and evaluation sides of the research can create a conflict for a researcher, which could impact on the validity of the research.

1.2. Strengths and limitations of the research: the dilemma of language

A strength of the research relates to the application of CBT to different cultural backgrounds. Within more recent years, CBT has been criticised for not being able

to adapt to incorporate patients racial, ethnic, cultural backgrounds. Whilst there have been some clinical trials that evidence that CBT can be adapted for specific cultural backgrounds experiencing specific mental health difficulties, the content of the SP/SR exercises in the present programme use systemic theory and approaches to consider the impact of an individuals sociocultural backgrounds and contexts on their mental wellbeing. By integrating systemic theory into a CBT framework, this acknowledges the impact of systemic issues on mental health and moves away from solely relying on individual early experiences to make sense of one's mental health difficulties. This demonstrates that CBT can be broadened to acknowledge social and societal impacts on one's mental health. On a personal level, this influenced my own assumptions about the use of CBT in different cultural contexts. At the beginning of my clinical psychology training, I undertook a one-year placement delivering CBT in an IAPT service. At this stage of my training, the focus was on developing knowledge and skills of applying CBT to specific 'disorders' of mental health. Therefore, when joining the present research project, I was both interested and concerned about how the programme authors were going to focus on therapists reflecting on their social and cultural experiences within a CBT framework. From this, my perception of CBT has altered, and I ultimately view the model as more culturally-adaptive and flexible than I had previously thought.

During the stages of developing the programme the research team, including myself, reflected on what it meant to be from a *'minoritised'* ethnic background. We considered our use of language, such as using the word *'minority'* compared to *'minoritised'*. After considerable amounts of reflection and discussion, the consensus was to use the word *'minoritised'*. This term implies that people hold a marginalised status because of active, systemic power dynamics. These dynamics serve to

continuously oppress people currently and in the future. As a research team, we thought about how to identify the ethnic/racial backgrounds of minoritised people. We thought about our own positions of power as academic researchers, and agreed that it would be most fitting to let participants self-identify themselves as coming from a minoritised ethnic background. We believed this meant we were not further excluding and 'doubly marginalising' people that may already feel marginalised in society because of their ethnic/racial backgrounds. Whilst I remain feeling that this was the most satisfactory decision at the time, this came with some challenges throughout the programme, which were made clear through the findings in the present analysis.

One of the significant findings in the present research related to the extent to which participants felt a sense of fitting in or belonging within the programme. Whilst most of the participants reported that they felt a strong sense of safety, other participants felt that the programme did not meet their needs, leaving them feeling excluded. A particularly important account was of a participant who identified their racial background as 'mixed-race'. They shared openly during the interview process that they felt the programme was not designed to meet the needs of people from mixed-race backgrounds, and referred to the SP/SR exercises being confusing and difficult to answer from somebody of a mixed race heritage. Additionally, they felt the group spaces were for people who had experienced racial prejudice, as the group sessions tended to be centred around participants sharing their experiences of racism. I used my reflective journal to revisit on the aims and objectives of the programme, and reflect on whether including all people that 'self-identify' as coming from a minoritised ethnic background was the most beneficial, inclusive way to provide a support space for therapists who have been ethnically minortitised.

My hope is to consult my research team prior to the publication of this research. I hope that we can use the present findings to consider the applicability and suitability of the programme for a range of ethnic backgrounds. Meanwhile, I decided to re-visit the literature on group support spaces for psychological professionals from minoritised ethnic backgrounds. There is a scant evidence base pertaining to this area. However, as previously acknowledged, grouping together non-White people as 'minoritised', irrespective of their ethnic background and experiences has been labelled as problematic. This is because it can cause racial homogeneity and make assumptions that all non-white people have similar problem-saturated stories (Tong, Peart & Reynolds, 2019). This relates to the experiences of this participant, as there may have been underlying assumptions that a group of 'ethnically minortised' therapists would have shared the same challenges related to their ethnic background. It may be that the programme could benefit from acknowledging therapists differences. This may include facilitators taking an active role in opening conversations around how differences in ethnic backgrounds may impact on group dynamics, and mean that aspects of the programme may or may not fit for therapists in the context of their ethnic background and experiences. Indeed, Hardy (2016) suggests that sharing experiences of suffering in these types of cross-racial group contexts generates emotional compassion and builds connection amongst group members. Thus, providing this space may support the group members to hold each other's differences in a respectful, accepting, and curious way.

Whilst considering how we best represent the programme in terms of the language that is used to describe the programme, and the ethnic backgrounds of therapists who joined the programme, I considered if this may have linked to the difficulties myself and the research team experienced when recruiting therapists for

the programme. It is important to acknowledge that within many research studies there can be difficulties with recruitment. Factors that can generally impact study recruitment may be study advertising methods or time resources, which is particularly relevant for this present 9-week programme, which may be considered as time intensive. However, it is important to consider that therapists from minoritised ethnic backgrounds may not have felt that being categorised as 'minoritised' was a way that they identified themselves. There may have been concerns that grouping all non-white people together meant there was an assumption that they shared the same experiences, identities, and problem-saturated stories. This may relate to the participant's account who shared that they did not want to identify themselves as a *'racial victim'* and did not feel that fit their life *'story',* nor their lived experience, leading them to withdraw early from the programme. It may be useful to explore therapists perceptions of a programme that invites such diversity of ethnic backgrounds, and consider if this brings up any barriers or facilitators for therapists deciding to access this support.

Whilst the research team and I were having discussions about the use of language, and how the word 'minoritised' is best used and understood, I was actively working on developing search terms for my systematic review. An aspect of the research question involved capturing all mental healthcare professionals who were from 'minoritised' or 'minority' ethnic backgrounds. The discussions with the research team, with my research supervisor and with the subject librarian (who hold skills in search strategies for psychology literature reviews) supported me to decide how to move forwards. Whilst I acknowledge that it is often the case that people who are socially disadvantaged due to racial/ethnic/cultural systemic prejudice are also a minority in numbers, I decided not to focus my search on people that are a numerical

minority in the population. This is because in the context of this research (in London, UK) there is a growing number of mental health professionals from non-white British racial/ethnic backgrounds that are working in the NHS, and I wanted the research to be applicable and relevant to the experiences of therapists in a UK context. Therefore, I decided to use the word 'minoritised', referring to individuals who have been minoritised through social processes of power and domination rather than groups of individuals who hold identities that exist in distinct statistical minorities.

The next challenge was to decide how to identify those who are ethnically and racially minoritised. This brought up dilemmas in how to research which ethnic/racial backgrounds could be considered minoritised, and in which countries. After informally searching the evidence base, most studies on therapist-patient ethnic/racial matching were completed in the USA, Australia, and Canada. Therefore, I decided to narrow my search to focus on the minoritised ethnic and racial backgrounds within these countries. I included the UK, as it was the country in which the review was conducted and wanted to make the review as relevant to a UK context as possible. In order to define what they were, I also had to extensively research and weigh up which data sources to use that would provide me with the most valid and accurate information on this. In the systematic reviews and meta-analyses on racial/ethnic matching, there was no clear consensus on the search terms used to capture studies on racial/ethnic matching. For example, some reviews used specific ethnic backgrounds in their search strategy (Cabral and Smith, 2011), whist other reviews only used synonyms for the words 'race' and ethnicity' (Shin et al., 2005). Therefore, I attempted to consult the countries respective government/state websites that hold information on equality in relation to race and ethnicity. However, this only provided statistical information about the percentages of

each racial/ethnic category within the country/state. Eventually, I decided to use an online source called the 'Minority Rights Group' (MRG). This is an international, non-governmental organisation that support minorities and indigenous peoples who experience discrimination and strive to defend their rights in full participation of public life within their residing country. MRG has developed a World Directory of Minorities and Indigenous Peoples, where you can find information by country about minorities and indigenous communities. MRG states that the information is *'well-researched and verified and provides a unique resource to journalists, governments, UN officials and academics across the globe'.* Therefore, this directory was used to identify racially/ethnically minoritised groups within the USA, Australia and Canada.

To an extent, this process appeared to be a valid and evidence-based method to identify my search terms. However, it may be likely that some papers on ethnic matching in other countries or within other racial/ethnic groups were not identified through the search. Throughout this process of developing the search terms, I wondered if there was too much ambiguity and subjectivity within the process to be able to create a comprehensive and exhaustive set of search terms that would yield an unbiased and valid search. This concerned me, therefore I reflected on my thoughts and dilemmas related to moving forwards with the research with my research supervisor. We discussed that the dilemmas with a systematic search are that they do not always allow for 'messy' constructs that can be more difficult to define, and that this may deter researchers from conducting systematic reviews on certain types of research for worry that it will be a biased, invalid, and complex process. These reflections meant I could move forward by both owning the limitations of the search, whilst acknowledging the importance of aggregating the research in this area. To my knowledge, this was the first systematic review on

mental health clinicians' experiences of ethnic/racial matching, thus I could see great value in moving forward with the research and developing knowledge and understanding of how best to support clinicians within their work with patients matched by race/ethnicity.

1.3. Disseminating research and its application to practise

The present SP/SR programme has shown to be of benefit in supporting therapists from minoritised ethnic backgrounds in multiple domains of their personal and professional lives. The programme has a great deal of potential to develop therapists CBT skills when working with people from a range of minoritised ethnic backgrounds. It also serves as a peer support space for many therapists to consider the strengths and challenges of being a CBT therapist from a minoritised ethnic background. Through the findings, a number of clinical and service recommendations have been identified. This made me wonder how we navigate moving forwards with these recommendations.

As this was a pilot study, and there is a very limited research base on these kinds of support spaces, the research team felt that this should initially be facilitated within non-working hours. However, there is a growing recognition of the difficulties that NHS staff from minoritised ethnic background experience as a result of the direct and indirect racial discrimination they face. Specifically, mental health professionals from minoritised ethnic backgrounds may experience challenges with using Eurocentric models of mental health. They may have different training and support needs when working intra-ethnically, as this can elicit relational dynamics and emotions that are different to their white counterparts. In order to recognise these therapists needs, creating space and time within therapists working hours to access support would be important. It would demonstrate that NHS mental health

services actively recognise the needs of their workforce, and taking steps to meet these needs. It will be important for myself and other members of the research team to utilise our existing professional links to IAPT management teams to begin to have conversations about their existing support structures for therapists, and how these can be developed by being informed by using existing research such as the present study. Through this, I have recognised the that the final dissemination stages of the research lifecycle are vital to conducting research that develops understanding and creates change in working practises.

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Appendices

PART 1: SYSTEMATIC REVIEW

Appendix 1.1: Identified search terms

Search Terms by Stem Group			
Sample: Mental health clinicians from minoritised ethnic backgrounds and their patients	**Phenomenon of interest:** the provision of therapeutic care to patients of the same racial/ethnic background	**Study design:** qualitative/mixed methods (where the qualitative component is reported separately)	**Evaluation type: participants v**iews, perceptions, or experiences
Therapist Counsellor Clinician Psychologist Mental health professional Healthcare professional Healthcare worker Psychology practitioner Allied health professional Social worker (Mental health) nurse Doctor Physician Medic Medical professional Occupational Therapist Patient	Racial/Ethnic concordance Racial/Ethnic disconcordance Same race Ethnic/Racial dyad Racial/ethnic match Racially/Ethnically similar Racial/ethnic sameness Cultural worldview match Therapy process Therapy alliance Therapy relationship Transference Countertransference	Qualitative methods/design/analysis Thematic analysis Interpretative Phenomenological Analysis (Critical) discourse Analysis Content Analysis Grounded Theory Conversation Analysis Semi-structured interview Sturctured interview Interview guide Unstructured interview Informal interview In-depth interview Discussion Questionnaire	Experience View Perception Attitude Perspective Observation Thought Discourse Preference Feeling Emotion Narrative Opportunity Rewarding

Client Dyad Black African Black Caribbean Asian Indian Pakistani Bangladeshi Arab Middle Eastern Native American Indigenous Aboriginal Alaskan Romanian Roma Latino Chinese Irish Scottish Welsh Minoritised Ethnically minoritised Ethnic Minority Racial minority Racially minoritised Racialised BME/BAME BIPOC MENA/AMENA			

Non-white Foreign			

Appendix 1.2. Review search strategy

Database	Search statement	Search terms	**Notes on strategy**
PsycINFO			
	1	(Rac* concordan* or Ethnic* concordan* or Same-race or Ethnic Dyad or Rac* Dyad or Rac* match* or Ethnic* match* or Rac* same* or Rac sim* or Ethnic* same* or Ethnic* similar* or Cultur* Worldview Match*).ab,ti.	ab,ti. = abstract and title search * = word truncation
	2	(patient* or client* or dyad*).ab,ti.	ab,ti. = abstract and title search * = word truncation
	3	(Therap* process* or Therap* alliance* or Experience* or View* or Attitude* or Perspective* or therap* relationship* or therap* connection* or Observation* or Thought* or relationship* or transference* or countertransference* Narrative* or Discourse* or Theme* or Perception* or Similarit* or Difference* or Reward* or Opportunit* or Comfort* or Preference* or Feeling* or Emotion*).ab,ti.	ab,ti. = abstract and title search * = word truncation
	4	therapeutic processes/ or dual relationships/ or psychotherapeutic processes/	/ = subject heading search
	5	health personnel attitudes/ or therapist attitudes/ or counselor attitudes/ or psychologist attitudes/	/ = subject heading search
	6	4 or 5 or 6	
	7	exp Qualitative Methods/ or exp Semi-Structured Interview/ or exp Thematic Analysis/ or exp Phenomenology/ or exp Grounded Theory/ or exp Discourse Analysis/ or exp Content Analysis/	/ = subject heading search exp = ‘auto-explodes’ term

	8	(thematic coding or narrative analysis or interpretative phenomenological analysis or interpretive phenomenology or discourse analysis or critical discourse analysis or conversation analysis or qualitative analysis).ab,ti.	ab,ti. = abstract and title search
	9	(focus group* or qualitative or ethnograph* or fieldwork or field work or key informant).ab,ti.	ab,ti. = abstract and title search * = word truncation
	10	((semi-structured or semistructured or unstructured or informal or in-depth or in depth or face-to-face or structured or guide or semi structured) adj3 (interview* or discussion* or questionnaire*)).ab,ti.	ab,ti. = abstract and title search * = word truncation Adj3 = proximity operator
	11	8 or 9 or 10 or 11	
	12	((therapist* or counsel?or or clinician* or psychologist* or psychotherapist* or Mental Health Professional* or Psychiatrist* or Allied Health professional* or Healthcare professional* or Psycholog* Practitioner* or Health care worker* or Social work* or Nurse* or Doctor* or Physician* or Medic or medics or medical professional* or Occupational therapist*) adj3 (black* or asian* or pakistani* or indian* or bangladeshi* or roma or romani or latin* or africa* or african american* or afro?carribean* or chinese* or irish* or scottish* or welsh* or arab* or middle east* or haiti* or native american* or alaska* or hispanic* or indig* or aborig* or native* or Ethnic* minorit* or Minorit* ethnic or Rac* minorit or raciali?ed or B?ME or BIPOC or MENA or AMENA or non#white or "non-white" or non white or foreign#born or foreign*)).ab,ti.	ab,ti. = abstract and title search * = word truncation Adj3 = proximity operator # = wildcard ? = character replacement
	13	1 or 12	

	14	2 and 6 and 11 and 13	**Final Search**
Ovid MEDLINE			
	1	(Rac* concordan* or Ethnic* concordan* or Same-race or Ethnic Dyad or Rac* Dyad or Rac* match* or Ethnic* match* or Rac* same* or Rac sim* or Ethnic* same* or Ethnic* similar* or Cultur* Worldview Match*).ab,ti.	ab,ti. = abstract and title search * = word truncation
	2	((therapist* or counsel?or or clinician* or psychologist* or psychotherapist* or psychiatrist* or Mental Health Professional* or Allied Health professional* or Healthcare professional* or Psycholog* Practitioner* or Health care worker* or Social work* or Nurse* or Doctor* or Physician* or Medic or medics or medical professional* or Occupational therapist*) adj3 (black* or asian* or pakistani* or bangladeshi* or indian* or latin* or africa* or african american* or afro?carribean* or chinese* or irish* or scottish* or welsh* or roma or romani or arab* or middle?east* or haiti* or native american* or alaska* or hispanic* or indig* or aborig* or native* or Ethnic* minorit* or Minorit* ethnic or Rac* minorit or raciali?ed or B?ME or BIPOC or MENA or AMENA or non#white or "non-white" or non white or foreign#born or foreign*)).ab,ti.	ab,ti. = abstract and title search * = word truncation Adj3 = proximity operator # = wildcard ? = character replacement
	3	(patient* or client* or dyad*).ab,ti.	ab,ti. = abstract and title search * = word truncation
	4	exp qualitative research/	Exp = ‘auto-explodes’ term / = subject heading search
	5	Interview/ or Focus Groups/	/ = subject heading search

	6	focus group* or qualitative or ethnograph* or narrative analysis or interpretative phenomenological analysis or interpretive phenomenology or discourse analysis or conversation analysis or qualitative analysis or ((interview adj1 semi-structured) or semistructured or unstructured or in-depth or indepth or face-to-face or structured or guide or semi structured)).ab,ti.	ab,ti. = abstract and title search * = word truncation Adj1 = proximity operator
	7	4 or 5 or 6	
	8	(Therap* process* or Therap* alliance* or Experience* or View* or Attitude* or Perspective* or therap* relationship* or therap* connection* or Observation* or Thought or relationship* or transference* or countertransference* or Narrative* or Discourse* or Theme* or Perception* or Similarit* or Difference* or Reward* or Opportunit* or Comfort* or Preference* or Feeling* or Emotion*).ab,ti.	ab,ti. = abstract and title search * = word truncation
	9	1 or 2	
	10	3 and 7 and 8 and 9	**Final Search**
CINHAL			
	1	(MH "Qualitative Studies") OR (MH "Semi-Structured Interview") OR (MH "Unstructured Interview") OR (MH "Interviews") OR (MH "Thematic Analysis") OR (MH "Phenomenology") OR (MH "Phenomenological Research") (MH "Grounded Theory") OR (MH "Content Analysis")	MH = mesh heading AB = abstract
	2	AB ("focus group*" or qualitative or ethnograph* or fieldwork or "field work" or "key informant" or "thematic coding" or "narrative analysis" or "interpretative phenomenological analysis" or "interpretive phenomenology" or "discourse analysis" or "conversation analysis")	AB = abstract * = word truncation

	3	AB (("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guid* or "semi-structured" or "semi structured") n4 (interview* or discussion* or questionnaire*))	AB = abstract * = word truncation N4 = proximity indicator
	4	AB (patient* or client* or dyad*)	AB = abstract * = word truncation
	5	AB (“Rac* concordan*” or “Ethnic* concordan*” or “Same?race” or “same race” or “Ethnic Dyad” or “Rac* Dyad” or “Rac* match*” or “Ethnic* match*” or “Rac* same*” or “Rac sim*” or “Ethnic* same*” or “Ethnic* similar*” or “Cultur* Worldview Match*”)	AB = abstract * = word truncation
	6	AB ((therapist* or counsel?or or clinician* or psychologist* or psychotherapist* or “Mental Health Professional*” or “Allied Health professional”* or “Healthcare professional”* or “Psycholog* Practitioner*” or “psychiatrist*” or “Health care worker*” or “Social work*” or Nurse* or Doctor* or Physician* or Medic or medics or “medical professional*” or “Occupational therapist*”) N3 (black* or asian* or pakistani* or bangladeshi* or indian* or roma or romani or latin* or africa* or "african american*" or "afro?carribean*" or chinese* or irish* or scottish* or welsh* or arab* or "middle east*" or haiti* or "native american*" or alaska* or hispanic* or indig* or aborig* or native* or "Ethnic* minorit*" or "Minorit* ethnic" or "Rac* minorit*" or raciali?ed or B?ME or BIPOC or MENA or AMENA or "non#white" or "non-white" or "non white" or "foreign#born" or foreign*))	AB = abstract * = word truncation # = wildcard ? = character replacement **N3 = proximity indicator**
	7	AB (“Therap* process*” or “Therap* alliance*” or Experience* or View* or Attitude* or Perspective* or “therap* relationship*” or “therap* connection*” or Observation* or Thought* or relationship* or transference*	AB = abstract * = word truncation

		or countertransference* Narrative* or Discourse* or Theme* or Perception* or Similarit* or Difference* or Reward* or Opportunit* or Comfort* or Preference* or Feeling* or Emotion* or thought*)	
	8	(MH "Professional-Client Relations") OR (MH "Professional-Patient Relations") OR (MH "Attitude of Health Personnel") OR (MH "Psychotherapeutic Processes")	MH = mesh heading
	9	7 or 8	
	10	5 or 6	
	11	1 or 2 or 3	
	12	4 and 9 and 10 and 11	**Final Search**
Web of Science	1	AB=("Rac* concordan*" or "Ethnic* concordan*" or "Same$race" or" Ethnic Dyad" or "Rac* Dyad" or "Rac*match*" or "Ethnic* match"* or "Rac* same*" or "Rac sim*" or "Ethnic* same*" or "Ethnic* similar*" or "Cultur* Worldview Match*")	AB = abstract * = word truncation
	2	AB=(patient* or client* or dyad*)	AB = abstract * = word truncation
	3	AB=(qualitative OR "mixed methods" OR "mixed-methods" OR "case study" OR "content analysis" OR "conversation analysis" OR "critical discourse analysis" OR "ethnography" OR" ethnographic content analysis" OR "discourse analysis" OR "grounded theory" OR "interpretive phenomenology" OR" interpretative phenomenological analysis" OR "narrative analysis" OR phenomenology OR "thematic coding" OR "thematic analysis")	AB = abstract * = word truncation
	4	AB=("Therap* process*" or "Therap* alliance*" or Experience* or View* or Attitude* or Perspective* or	AB = abstract * = word truncation

		therap* relationship* or therap* connection* or Observation* or Thought or relationship* or transference* or countertransference* or Narrative* or Discourse* or Theme* or Perception* or Similarit* or Difference* or Reward* or Opportunit* or Comfort* or Preference* or Feeling* or Emotion*)	
	5	AB=((therapist* or counsel$or* or clinician* or psychologist* or psychotherapist* or "Mental Health Professional"* or "Allied Health professional"* or "Healthcare professional*" or "Psycholog* Practitioner*" or "Health care worker*" or" Social work*" or Nurse* or Doctor* or Physician* or Medic or medics or "medical professional*" or "Occupational therapist*") NEAR/3 (black* or asian* or pakistani* or bangladeshi* or indian* or latin* or africa* or "african american*" or "afro$carribean*" or chinese* or irish* or scottish* or welsh* or roma or romani or arab* or "middle$east*" or haiti* or "native american*" or alaska* or hispanic* or indig* or aborig* or native* or "Ethnic* minorit*" or "Minorit* ethnic" or "Rac* minorit*" or raciali$ed or B$ME or BIPOC or MENA or AMENA or "non$white" or "non white" or "foreign$born" or foreign*))	AB = abstract $ = character replacement * = word truncation NEAR/3 = proximity indicator
	6	1 or 5	
		2 and 3 and 4 and 6	**Final Search**

PART 2: EMPIRICAL PAPER

Appendix 2.1: Chapter 3 of SPSR Workbook

Module 3: Creating a Genogram

Introduction

In this module you will begin to explore the specifics of your personal experience of coming from a minoritised ethnicity. In order to do this you will be creating a genogram (more commonly known as a family tree).

You are doing this exercise because we know that our personal experiences of being from a minoritised ethnicity are closely related to being part of a wider family and social network. In the previous module you developed a cross-sectional formulation of the challenging situation you are working on in this programme. As this formulation relates to your ethnic identity, it is important to link the formulation to you and your family's experience of being part of a minoritised ethnicity. We will guide you in creating your own genogram, then look at how this could help further develop the formulation you have already created.

When you create the genogram you may want to speak with family members to get more information. If this is the case we would suggest factoring in the additional time this will take. Many people find doing a genogram an interesting and positive experience. However, it is also important to remember that this can bring up more uncomfortable and difficult material; it may even be that doing this leads to you learning about an aspect of your family history which you had not previously known about. When you are completing your genogram keep an eye on how this is emotionally affecting you, give yourself space to manage any more difficult emotions that come up, and do use your safety strategy if necessary.

Exercise 1: Creating Your Genogram

We form our identities, whether personal or professional, within a family context. Therapists from minoritised ethnicities may particularly benefit from thinking about the specific experiences of their family. You will explore this first by creating a genogram for your family. At its most basic a genogram shows the structure of the family and key relationships. However additional information can be added to give details such as age, ethnicity and other important factors such as place of birth and migration histories. When creating a genogram you should put yourself at or near the bottom, potentially leaving space for children and grandchildren, and then fill out the previous generations. The figure below gives an example of the basic layout of a genogram, based on a fictional family of Jamaican and white Irish descent where some family members have passed away and one couple have divorced.

However when it comes to completing your genogram we would encourage you to add more information than this, based on the questions we ask you in the table below which details how to go about completing the genogram. In particular we would encourage you to include written information around the genogram, such as names, ages, places of birth, and your own reflections on the meaning of the genogram for you.

An example of the basic structure of a genogram:

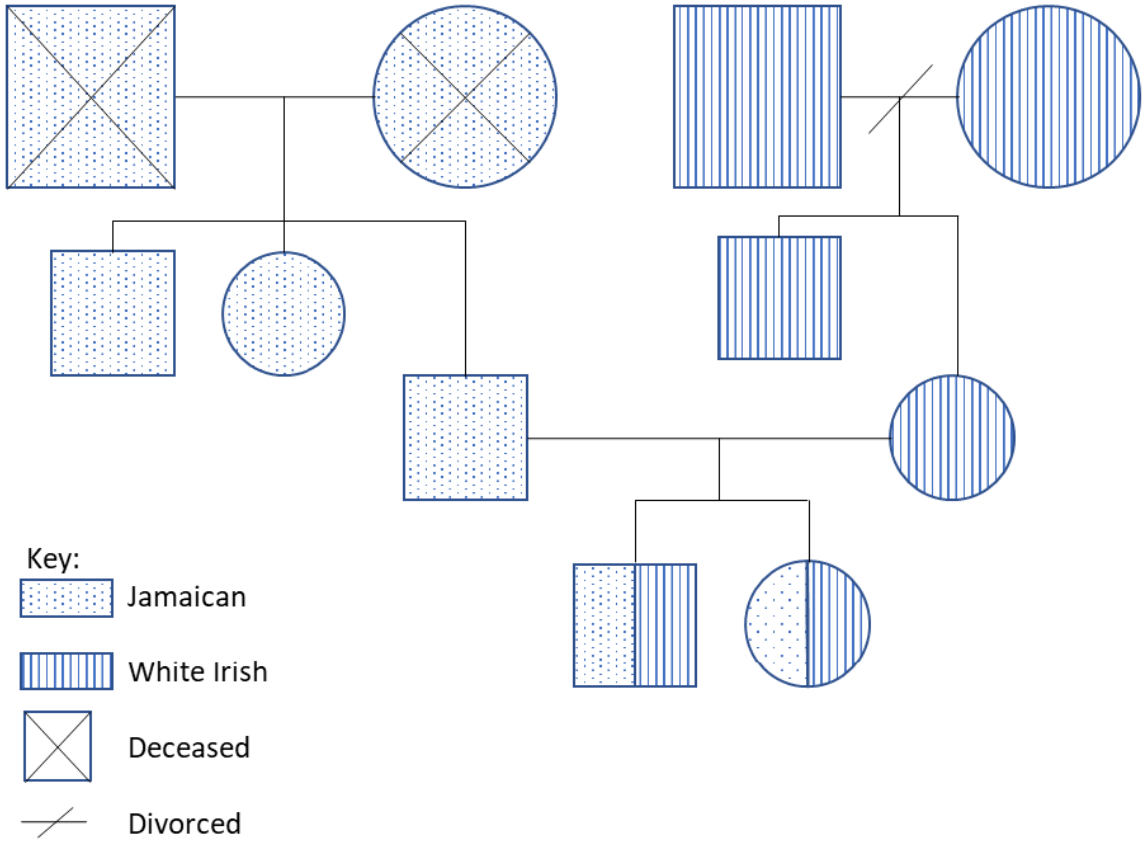


Table: Details of How to Complete Your Genogram

General area	Specific details
The basics of creating the genogram	• Traditionally genograms have had a circle for women and a square for men. There is ongoing debate about what symbols to use to represent other types of gender identification: it would take up too much space to discuss this here, so if you would like more guidance on this please contact the facilitators. • Write the name and age of the person inside or by the side of the shape. • People who are married or in a long-term romantic relationship with each other have a horizontal line connecting them. If they were in a relationship but are now divorced, or the relationship is ended, then the horizontal line has a cross through it.

General area	Specific details
	• Children are connected by vertical lines going downwards from the horizontal lines connecting their parents.
Indicating ethnicity	If family members come from more than one ethnic group then it can be helpful to record this on the genogram. Do this by choosing different colours or patterns to represent different ethnicities.
Considerations specific to minoritised ethnicities Considerations specific to minoritised ethnicities (continued)	• **Migration histories.** As you are completing the genogram think about where you and family members were born and where you and they are currently living. As you do this you may start to think about the 'migration narrative' of your family, that is the story (or stories) your family tells about what happened in and around the move to this country. Who migrated when, and what did you and/or they experience during that migration? You might want to think about positives and negatives, that is both any achievements which occurred as a result of this migration, but also the stressors and losses encountered. What are the remaining links with the country which was migrated from? • **Experiences of belonging or marginalisation.** How have you and your family interacted and fitted in with the various communities they have been part of in the UK? When has your family felt a sense of belonging, and has the family been marginalised (by marginalised we mean experiences of being excluded and having fewer opportunities than the white majority population)? • **Experiences of prejudice and resilience.** Have your family experienced racism? What has your family done to manage the effects of this, and does this show resilience on the part of the family? **Experiences of continued cultural connection or acculturation.** The different cultural background of your family as compared to the white majority population means that you and/or your family may have adopted some cultural practices from the majority culture, but also kept alive cultural practices from your family's ethnic community/communities. This can be a positive experience of continued connection and flexibility in exploring what it is like to be from a different culture, or it can be a more challenging experience of a loss of cultural connection with the culture of your family's original country (or countries). What cultural practices associated with their ethnic background(s) have your family maintained, what have your family lost touch with, and what has your family adopted from the white majority culture? By culture we mean a very wide variety of things, for instance: religion, sport, food, festivals, music, the arts and many more activities beside. You may want to think about the 'visible' aspects of your culture (e.g. food, language, music etc), but also the 'invisible' aspects

General area	Specific details
	such as underlying attitudes and beliefs (i.e. around religious beliefs, communication styles). The culture iceberg model is a helpful way of unpacking this.
Who to include	Depending on the size of the family the genogram can quickly become quite crowded. You do not need to include details of everyone and it is helpful to think about who has played a bigger part in your life. To guide you in this you can think about who has a role in decision making about family issues such as finances and expectations for behaviour as a family. Which relationships are the most important in making decisions as a family? If you have a partner you may also want to think about including some of their genogram.

Now it is time to complete your own genogram. As you are doing this notice if any thoughts or feelings come up particularly strongly and take a note of these in the box by the side of the genogram. Do remember that this can trigger more powerful emotions, so make sure to give yourself sufficient space when you are doing this and to take steps to look after yourself.

Another thing to consider is when to stop. As in any course of CBT there has to be a moment when you decide that you have developed a good enough understanding of the issue at hand. The aim here is not to get a complete picture – which in any case would be impossible given the amount of information the genogram can represent – so think about when you get to the point where you have a genogram that represents the important aspects of your family.

Space for Your Genogram:

Exercise 2: Linking the Genogram to Your Formulation

We have asked you to do a genogram as a first step in reflecting on links between your ethnic identity and your clinical role as a therapist. Similarly to when a genogram is used in therapy, a key step now is to start to think about how the information contained in the genogram might link to a CBT formulation. If it is not linked to the formulation, there is a risk that the genogram will be an interesting reflective exercise but will not actually lead to any change.

Over this and the next three modules we will work towards developing a longitudinal formulation of how your ethnic identity relates to your clinical role. We will build up to this, so the first step is to organise the information in the genogram so it will more easily fit into the longitudinal formulation when we reach that stage. We will organise the information in the following way:

- **Background systemic and contextual factors**. We are thinking here about the type of societal context your family found itself in, and how this led to family members having the experiences they did.
- **Experiences of strength.** As discussed in the introduction a core part of our approach is to not just focus on the challenges that come with being from a minoritised

ethnicity. We also want to think about strengths that come with diverse ethnic identities.

- **Challenging experiences.** It is also important to acknowledge and recognise the challenges that your family have met as a result of being from a minoritised ethnicity.

These areas are listed in the below table. Fill out the table based on the information you have included in the genogram.

Table to Complete as Part of Exercise 2 

General area	Aspects to consider	Your notes
Background factors	• What was the societal context you and/or your family found yourselves within? How were they treated at the time of migrating and as they made their place within the UK? What key experiences did family members have as a result which have had an impact on the family to the present day?	
Experiences of strength	• What strengths have your family shown? • Have your family been able to find a place where they belong in the UK, and if so how have they done that? • What continued connections have there been with the culture of the ethnic group or groups your family come from? • How have your family managed and coped with experiences of prejudice? Does this say anything about resilience within the family or broader ethnic community they are part of? • Are there any metaphors, sayings, stories or images the family draws upon which relate to strength and resilience?	
Challenging experiences	• What challenging experiences have your family been through? • Have your family experienced marginalisation within the UK (that is experiences of being excluded and having fewer opportunities than the white majority population)? • Has acculturation been an issue within your family? By this we mean the loss of cultural connection to the culture of the ethnic group(s) your family comes from. • Has the family been affected by racism?	

The final task in this module is to think about how the information you have already collected might link to the initial formulation you created in the last module. We are doing this to explore whether there are any factors in your family history which make the situation described in the formulation more emotionally 'hot' for you, and also to find out more about the specific meaning this situation has for you.

In the above table you have listed background factors and experiences. According to a CBT model, the link between these background factors and your current experience (as described in the formulation in module 2) is the beliefs that you hold. We will not go into this in great depth now, but to begin with we would ask you to reflect on whether there are any resonances between aspects of your family history and the challenging situation you formulated. We would suggest that you ask yourself the following questions:

QUESTIONS TO CONSIDER 

- When you look at your genogram are there any thoughts or beliefs that you have developed which make more sense as a result of your family background?

- What was the most emotionally 'hot' thought in your initial five-part formulation? Do any of the challenging experiences your family have faced relate to this thought? Think about the experiences you have listed in the above table.

- Are there any strengths your family have demonstrated which you could draw upon to help you to respond to the challenging situation?

Self-reflection 

- What was your experience of creating a genogram? Was it easy or difficult to map out the basic structure of your family? A key part of the genogram is the notes that you make around it (e.g. places people were born, migration histories), so how did you find fitting this information in?

- Has spending time mapping out the genogram led to you seeing yourself or your family differently? Has it led to you having any different conversations with family members?

- Has doing the genogram led to any stronger feelings and thoughts about your family or yourself? It is not uncommon to feel mixed emotions when doing this, so is there anything you need to do to manage any more difficult emotions?

- A genogram can be a useful tool with any client, not just those from minoritised ethnicities. How could you use a genogram with a white client, and what differences might there be to how you would do this with a client from a minoritised ethnicity?

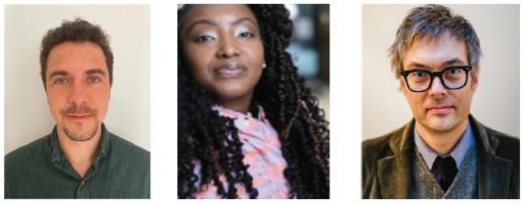
- In this module we have begun to more explicitly bring ethnic identity into a CBT framework. How have you found doing this so far? Does it fit with your understanding of what CBT is?

Appendix 2.2: Study Advertisement

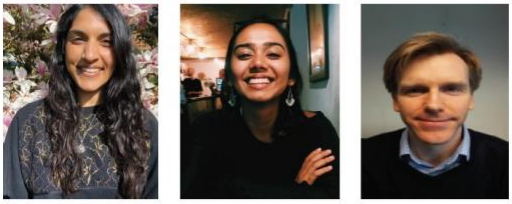
UCL Ethics ID 22167/001

SELF-PRACTICE/SELF-REFLECTION PROGRAMME FOR CBT THERAPISTS FROM MINORITISED ETHNICITIES

We are a group of researchers from psychological professions who believe that more needs to be done to support therapists from minoritised ethnicities. Therefore, we are looking for CBT Therapists from minoritised ethnicities to take part in a new Self-Practice/Self-Reflection programme to explore how their ethnic identity may relate to their clinical practice as a therapist, in a safe and supportive space.



Facilitators: Dr Alasdair Churchard (Clinical Psychologist, Leila Lawton (Cognitive Behavioural Psychotherapist) and Dr Richard Thwaites (Consultant Clinical Psychologist)



Researchers: Zara Malik, Sakshi Shetty Chowdhury (Trainee Clinical Psychologists) and Dr Henry Clements (Clinical Psychologist and Clinical Director, UCL DClinPsy)

What your participation in the programme would involve:

- Working through 9 modules that involve you reflecting on the links between your ethnic identity and your clinical practice, over approximately 18 weeks (estimated May to September 2022)
- Attending an online reflective group space every fortnight with other CBT Therapists from minoritised ethnicities to reflect on your experience of completing the modules.
- Helping us evaluate the programme by answering a short series of questions on a weekly basis and completing one interview after the programme.

You can you get involved if you:

- Identify yourself as being from a minority ethnic background.
- Have provisional or full accreditation with the BABCP.
- Are currently practising as a CBT Therapist in the UK.

Potential benefits of participating:

- We hope this will be a supportive and reflective space for therapists to consider how their specific cultural context and background, as well as the the strengths and challenges of being from a minoritised ethnicity, may relate to their clinical practice.
- We hope that gaining your perspectives of the programme will further an understanding of therapists' experiences of being from a minoritised ethnicity and ways in which they can be supported.

If you would like to find out more about participating in this programme, please attend any one of the three online information sessions that are being hosted on the dates and times below. Please use the below zoom links to access the meeting:

Session 1: Wednesday 30th March at 7.30pm (Zoom Meeting ID: 948 9398 2009 https://ucl.zoom.us/j/94893982009)

Session 2: Wednesday 6th April at 12.30pm (Zoom Meeting ID: 956 7831 6407 https://ucl.zoom.us/j/95678316407)

Session 3: Monday 11th April at 7.30pm (Zoom Meeting ID: 983 8641 1511 https://ucl.zoom.us/j/98386411511)

For further information, please contact Zara Malik (zara.malik.20@ucl.ac.uk).

Any personal infor[illegible]d as part of the research will be processed in accordance with relevant data protection legislation.

Screenshot

Appendix 2.3: Study Recruitment Poster

Appendix 2.4: Participant Information Sheet

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

Participant Information Sheet

UCL Research Ethics Committee Approval ID Number: 22167/001

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Project Title: Self-Practice/Self-Reflection programme for CBT therapists from minoritised ethnicities
Department: Research Department of Clinical, Educational and Health Psychology

Name of the Researchers: Zara Malik and Sakshi Shetty Chowdhury (Trainee Clinical Psychologists)
Name of the Principal Researcher: Dr Henry Clements (Clinical Director and Associate Professor, UCL Doctorate in Clinical Psychology)

Zara Malik: zara.malik.20@ucl.ac.uk
Sakshi Shetty Chowdhury: sakshi.chowdhury.20@ucl.ac.uk

You are being invited to take part in a research study, which is being done as a part of the above researcher's Doctorate in Clinical Psychology thesis project. Before you decide to take part in this study it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. We can be contacted using the above email addresses if there is anything that is not clear or if you would like more information.

Please take time to decide whether you wish to take part.

Purpose of the study

There are a growing number of psychological therapists that identify as being from a minoritised ethnicity as the NHS aims to diversify their workforce. However, being a therapist from a minoritised ethnicity can come with some challenges because there has been historical and ongoing racial and ethnic prejudice, discrimination, and injustice. This novel programme aims to provide a space for therapists to reflect on their experiences, challenges and strengths of being from a minoritised ethnicity and to consider how this may relate to their clinical practice.

The programme follows a Self-Practice/Self-Reflection (SP/SR) format. SP/SR is a programme designed to assist therapists in learning therapeutic techniques 'from the inside', increase therapy skill and importantly give them a chance to engage in self-care. We hope that by adapting traditional SP/SR programmes, we will enable a safe and supportive space for you to explore how your ethnic identity might relate to your clinical role. We also hope that this will give you a chance to further develop your therapeutic skills in working with clients from minoritised ethnicities.

This programme be delivered via a workbook comprising 9 modules of information, self-directed practice and reflective tasks, alongside bi-weekly reflective sessions, led by three experienced facilitators: Dr Alasdair Churchard (Clinical Psychologist), Leila Lawton (Cognitive Behavioural Psychotherapist) and Dr Richard Thwaites (Consultant Clinical Psychologist).

As this is a novel programme, we will evaluate the impact and experience of participating in this programme. Specifically, Zara Malik and Sakshi Shetty Chowdhury (UCL Trainee Clinical Psychologists) will be carrying out this evaluation as a part of their Doctorate in Clinical Psychology (DClinPsy) research.

This project is being supervised by Dr Henry Clements (Associate Professor and Clinical Director, UCL DClinPsy), who is also the named Principal Investigator (PI) for this project.

Can I take part?

As this programme is for CBT therapists from minoritised ethnicities, we ask that people are provisionally or fully accredited as a CBT Therapist from the BABCP and are in regular clinical practice. We ask that people identify themselves as being from a minoritised ethnic background.

It is important that we ensure this programme is as safe and useful as possible for you, therefore we ask you not to participate if you feel you are undergoing a high degree of stress. Additionally, so that we can evaluate the effectiveness of the programme, it is important that we reduce things that may influence people's experiences and outcomes in relation to the programme. Therefore, we also ask you not to participate if you are undergoing psychological therapy or any major professional development courses or formal programmes exploring your ethnic identity.

If we receive high levels of interest in this programme, the first 15 people to contact the researcher Zara Malik via email to express an interest in participating in the programme will be invited to participate and offered an opportunity to ask any further questions they may have about the study or the consent form. A waiting list will be formed after the first 15 participants and ordered on a first come first served basis. If a potential participant decides not to take part, or if Zara does not hear back from them within 1 week, the next person on the waiting list will be contacted. Once 15 people have fully consented to take part, the remaining people that expressed an interest will be emailed to let them know they have not secured a place on the programme and to thank them for their interest in taking part.

Do I have to take part?

You do not have to take part and you can also withdraw at any stage without giving a reason and without any negative consequences. If you wish to withdraw then please speak to the programme facilitators.
However, with your consent (as indicated on the study consent form) you may still be invited to participate in an interview about your experience of the programme. You can choose whether or not you would like to complete this interview when invited.

If you choose to withdraw from the study, all of your data will be subsequently withdrawn from the study.

Facilitator contact details:
Dr Alasdair Churchard: alasdair.churchard@oxfordhealth.nhs.uk
Leila Lawton: leila.lawton@slam.nhs.uk
Dr Richard Thwaites: richard.thwaites@cntw.nhs.uk

What will happen if I take part?
If you take part in the programme, you will be invited to orientation and safety planning sessions where you will meet the programme facilitators, researchers and other participants in the programme. You will also be provided with the SP/SR workbook, which contains nine modules in total. Personal data will be collected as a part of this research. During the orientation session, you will also be invited to complete a questionnaire asking for details of your age group, ethnicity, gender, diversity of your workplaces, as well as number of years qualified as a CBT Therapist. This will be done using Qualtrics, a web-based survey tool.

You will be guided to complete a module every two weeks, following which you will be invited to join a reflective session with the programme facilitators (Dr Alasdair Churchard, Leila Lawton and Dr Richard Thwaites) and other group participants to share experiences of completing the module and reflections noted at the end of it. The group will consist of the same 12-15 people and will take place every two weeks, following each module.
The group sessions will be between May 2022 and October 2022. You are encouraged to attend all of the group sessions. Each group session will last one hour, and we suggest an additional hour and a half each week would be sufficient for you to work on the allocated module between the group sessions.

Throughout the programme, you will be asked to complete a series of questions which are designed to help evaluate the programme. The questions ask about your self-rated skill in working with people from minoritised ethnicities, as well as your own beliefs your ethnicity and your personal and professional wellbeing. These questions are designed for you to complete weekly and take around 5 to 10 minutes to complete. You will also be asked to complete these measures for up to 7 weeks prior to the beginning of the programme (either 5, 6 or 7 weeks, depending on random allocation to baseline condition at orientation session), and for 5 weeks after the end of the programme. All measures will be collected using Qualtrics, and will be collected pseudonymously, using a unique code.

You will also be invited to participate in an interview after the completion of the programme to tell us about your experience of it. Zara Malik will contact you up to 2

weeks after the final session to arrange a suitable time for the interview, which will take place online using Zoom video conferencing. Interviews are expected to last between 60 to 90 minutes and will mark the end of your participation in the research study. If for any reason you do not complete the programme, Zara Malik may contact you to check whether you would still like to be interviewed if you consent to this.

The interview will be audio recorded on a separate encrypted recording device, and the audio recording will be stored on the UCL N drive and will be transcribed by Zara Malik, using an approved transcribing software, Scrintal. Recordings will be identified only by a unique code and they will not be used for any purpose other than for the research study. Your name and any potentially identifying information will not be included anywhere in the transcript. We may quote you directly in the project write up. If this is done your anonymity will be preserved.
The interview data will be transcribed verbatim. The transcribed data will be evaluated using a robust method called 'Reflexive Thematic Analysis'. which aims to analyse and interpret patterns across the data and develop themes from these interpretations.

Safety during the programme:
You will be invited to create a Personal Safety Strategy during the initial orientation and safety planning group session. This plan will outline steps for you to take if you do become distressed during the course of the programme, for any reason.
If you need more help after having used this strategy the facilitators will be available to meet with you individually on up to two occasions. We hope this will be enough to manage any distress you feel, but if it is not then the facilitators may suggest discontinuing the SP/SR programme and think with you about what further support might be helpful. They will be available for a debrief session if you do decide to discontinue the programme.

Are there possible disadvantages and/or risks in taking part?
The programme is focused on your experience as a CBT therapist from a minoritised ethnicity, therefore we think it is inevitable that you will encounter some challenging personal material, for example related to racial prejudice. When more challenging material comes up, we want you to be confident that you will not feel overwhelmed, therefore strategies to manage any understandable distress will be identified in your own personal safeguard strategy. Nevertheless, before you begin the programme, we would encourage you to think about whether you are experiencing, or are likely to experience soon, any periods of high personal stress. If this is the case, then we would advise that now is not the right time to do this programme.
You may also find aspects of completing the questions and the interview distressing as we may ask for your experiences of 'race' and racism in relation to your job role. We encourage you to regularly complete the measures, however if something is too sensitive then you do not have to answer it**.** We want to understand your experience of the programme as much as possible, but you can choose not to discuss something at the interview and will be reminded of this before the interview begins. You will also be directed to your personal safety strategy during the interview, if needed.
This programme will involve around 30 hours of individual and group work over the course of 7 months.

What are the possible benefits of taking part?
There is a growing number of therapists from minoritised ethnic backgrounds in the UK. However, we believe there is a strong need for more support for therapists from minoritised ethnicities to consider how their ethnic identity might relate to their clinical role. Therefore, we hope this programme may provide a supportive and reflective space for you and the other participants to consider your specific cultural context and background, as well as the strengths and challenges of being from a minoritised ethnicity. We also hope that this will help you to develop your CBT skills when working with clients of all ethnicities.
We hope that gaining your perspective of the programme through the questionnaires and interview that you complete will further an understanding of CBT therapists' experiences of being from a minoritised ethnicity, and potentially indicate ways in which such therapists may be supported.

What if something goes wrong?
If you wish to raise a concern about the SP/SR programme, we would encourage you to contact the programme facilitators in the first instance (alasdair.churchard@oxfordhealth.nhs.uk; leila.lawton@slam.nhs.uk; richard.thwaites@cntw.nhs.uk).

However, if for any reason you feel unable to speak to the facilitators, please contact Henry Clements (Principal Investigator for the study) at henry.clements@ucl.ac.uk. He can also be contacted for any complaints related to the evaluation of the programme.

If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk.

Will my taking part in this project be kept confidential?
The facilitators and participants in the group sessions of the programme will consent to keeping everything confidential to the group. The groups will be set up in a way that you will not have access to other participants' contact information unless you wish to share it. If you prefer, you may also choose an alternative name to display when you join the online group sessions via Zoom.

Contact information, including email addresses and home addresses (used to post a copy of the workbook) will be held securely by Zara Malik on an encrypted file on a secure UCL drive. Address information will be deleted as soon as the workbooks are sent in April before the programme starts. Email addresses will be held until the submission of the researchers' DClinPsy theses, anticipated to be in September 2023. You may also consent to your email being held for a further three years (September 2026), if you wish to receive copies of any publications resulting from this research.

All data collected during the programme, including demographic information, questionnaire and interview data will all be held against a unique code, thereby pseudonymising the data.
A key containing the code and the above demographic information will be stored securely as an encrypted zip file on the researcher's secure UCL drive. The

quantitative questionnaires will be collated using this code via Qualtrics and all responses will be stored in an encrypted folder on secure UCL drives. The interviews will be recorded using an encrypted audio recording device and the recordings will be immediately transferred to Zara Malik's UCL N drive in an encrypted folder. The recordings will be deleted from the recording device following this. Zara will transcribe the recordings using an approved transcription software, Scrintal, and the recording of each interview will be destroyed as soon as the interview has been transcribed which will be within three weeks of the interview. All recordings will be deleted by June 2023. Any identifying or potentially identifying information will so far as possible be removed at the time of transcription.

Your personal identifiable information will be deleted once the researchers have passed the Doctorate in Clinical Psychology course (anticipated to be September 2023), such that the data is then fully anonymised. This data will be stored until we have written up and disseminated study findings which will be a maximum of 3 years (September 2026).

All personally identifiable information will be kept confidential within the research team.

Limits to confidentiality
If the programme facilitators or researchers have concerns that you are a risk to yourself or others, then the safety plan that you will have created at the beginning of the programme needs to be followed, which includes information about the relevant support services. In the unlikely event they may have to break confidentiality and let relevant others know, they will inform you if they are going to do this, unless they believe it will increase the risk or it is not possible to inform you.

What will happen to the results of the research project?
The write-up of this project will be part of our theses and published online. The project may be published in an academic journal. You will not be identifiable in any way from the write-up of the project. If you wish to receive a copy of any publications resulting from this research, please indicate your consent and provide us with a preferred email in the consent form.

Local Data Protection Privacy Notice
This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in the UCL General Participant Privacy Notice which is available here.

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

Personal data will be sought in this research. As stated above, if you disclose identifying or potentially identifying information which constitutes personal data in your interview, this identifying or potentially identifying information will so far as possible be removed at the time of transcription.

The controller for this project will be University College London (UCL). UCL has appointed a Data Protection Officer who has oversight of UCL activities involving the processing of personal data. If you are concerned about how your personal data is being processed, or if you would like to discuss your rights in relation to personal data, please contact the UCL Data Protection Officer at data-protection@ucl.ac.uk. The UCL Data Protection Officer can also be contacted by telephoning +44 (0)20 7679 2000 or by writing to: University College London, Gower Street, London WC1E 6BT.

Personal data, or personal information, mean any information about an individual from which that person can be identified. It does not include data where an individual's identity has been removed (anonymous data). In this study, the lawful basis that will be used to process your personal data is 'Public task' for personal data. Personal data will be sought in this study for the purposes of the research.

Special category personal data means any personal data that reveal racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health (the physical or mental), sex life or sexual orientation, genetic or biometric data. In this study, the lawful basis for processing any special category personal data is for scientific and historical research or statistical purposes. Special category personal data will be sought in this study for the purposes of the research.

As stated above, you have the right to withdraw from the study at any time and to request that all your data are immediately destroyed.

The retention periods for data have been set out above.

Complaints
If you wish to complain about our use of personal data, please send an email with the details of your complaint to the UCL Data Protection Officer so that they can look into the issue and respond to you. Their email address is data-protection@ucl.ac.uk.

You also have the right to lodge a complaint with the Information Commissioner's Office (ICO) (the UK data protection regulator). For further information on your rights and how to complain to the ICO, please refer to the ICO website: https://ico.org.uk/

Ethical review of the study
The project has received ethical approval from …… (to be completed once ethics have been granted)

Thank you for reading this information sheet and for considering taking part in this research study.

Appendix 2.5: Participant Consent Form

RESEARCH DEPARTMENT OF
CLINICAL, EDUCATIONAL AND
HEALTH PSYCHOLOGY

UCL

Participant Consent Form

CONSENT FORM FOR CBT THERAPISTS FROM MINORITISED ETHNIC BACKGROUNDS

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Self-Practice/Self-Reflection programme for CBT therapists from minoritised ethnicities

Department: Research Department of Clinical, Educational and Health Psychology

Name and Contact Details of the Researcher(s):
Zara Malik: zara.malik.20@ucl.ac.uk
Sakshi Shetty Chowdhury: sakshi.chowdhury.20@ucl.ac.uk

Name and Contact Details of the Principal Researcher:
Henry Clements: henry.clements@ucl.ac.uk

Name and Contact Details of the UCL Data Protection Officer:
Alexandra Potts: data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee: TBC

Project ID number: 22167/001

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am

consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction. I consent to participating in the SP/SR group programme for therapists from minoritised ethnic backgrounds. I consent to participating in the quantitative evaluation of the programme, which would involve completing weekly outcome measures. I consent to participating in post-programme interviews for the qualitative evaluation of the programme.	
2.	I understand that I can withdraw from the programme and evaluations at any point during the programme and without needing to provide any reason. If I wish to withdraw from the programme, I am aware that I will need to contact the SP/SR group facilitators (Richard Thwaites - richard.thwaites@cntw.nhs.uk, Alasdair Churchard - alasdair.churchard@oxfordhealth.nhs.uk) to inform them of this. I understand that if I withdraw from the programme, I may be contacted by the researchers to check whether I would still like to be interviewed about my experience of the programme.	
3.	I understand that my personal information *(gender, ethnicity, area of work, diversity of workplace, number of years qualified)* will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing. I understand that according to data protection legislation,	

	‘research purposes’ will be the lawful basis for processing special category data.	
4.	I understand that all personal information will remain confidential outside of the research team and that all efforts will be made to ensure I cannot be identified. I understand that my personal data gathered in this study will be encrypted and stored securely on the UCL N: drive, which will be destroyed when the researchers have passed their Doctorate in Clinical Psychology course which is anticipated to be in September 2023. I understand that quantitative data that is collected weekly using Qualtrics will be pseudonymised using a unique identification number and this data will be destroyed by September 2023. It will not be possible to identify me in any publications.	
5.	I consent to my interview being audio recorded and understand that the recordings will be stored on an encrypted folder in the UCL N: drive and destroyed within three weeks following transcription. All recordings will be deleted by June 2023. Any potentially identifiable information will so far as possible be removed at the time of transcription. The transcripts will also be destroyed when the researchers have passed their Doctorate in Clinical Psychology course which is anticipated to be in September 2023. I consent to audio recording of my interview.	
6.	I understand that an element of my participation in the SP/SR programme would be to take part in a reflective group session which will be every two weeks. As the group session will involve myself and other group members sharing their reflections on the SP/SR process, I am aware of the importance of confidentiality within the space, which will be set out during the initial sessions of the programme. I understand that confidentiality will be maintained by the facilitators as far as possible, unless they become concerned for mine or someone else’s welfare during the programme, in which case they might need to inform relevant agencies. I will be made aware of this by the facilitators unless this is not possible, or it is deemed this might raise any risk.	

7.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the research. I understand that a safety plan will be drawn up at the beginning of the programme and that I will make use of this when needed. I am also aware that I can contact the group facilitators for up to two one-to-one sessions, if needed.	
8.	I understand the direct/indirect benefits of participating.	
9.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
10.	I understand that the information I have submitted may be published as a research study within an academic journal, as well as the findings being disseminated in other forums.	
11.	I understand that if I would like to receive a copy of any publications, my email address will be held by the researchers for up to three years after the end of the programme (September 2026) I wish to receive a copy of any written publications. Yes/No I would like any publications to be sent to this email address:	
12.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
13.	I hereby confirm that: understand the exclusion criteria as detailed in the Information Sheet d explained to me by the researcher; and meet the inclusion criteria; and lo not fall under the exclusion criteria.	
14.	I am aware of who I should contact if I wish to lodge a complaint.	

_____	_____	_____
Name of participant	Date	Signature
Zara Malik	**6.04.2022**	[redacted]

Appendix 2.6: Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

9th March 2022

Dr Henry Clements
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: Zara Malik & Sakshi Chowdhury

Dear Dr Clements

Notification of Ethics Approval with Provisos
Project ID/Title: 22167/001: Self-Practice/Self-Reflection programme for CBT Therapists from minoritised ethnicities

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **9th September 2023.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' https://www.ucl.ac.uk/research-ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol.

The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email:ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research;
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Lynn Ang
Joint Chair, UCL Research Ethics Committee

Appendix 2.7: Participant Demographic Questionnaire

Full Demographic and Weekly Outcome Questionnaire

Demographic/Contextual information questionnaire

Thank you so much for completing the following questions as a part of the evaluation of the SP/SR programme for therapists from minoritised ethnic backgrounds. This initial questionnaire is for us to get some helpful demographic and contextual information.

Please create a unique ID code using the first three letters of the city in which you were born and the last four digits of your phone number. For example, for someone born in London with a phone number of 123456789, their unique ID would be LON6789.

This code will be used to collect all subsequent data in this study and all questionnaire and interview data will also be stored pseudonymously against this code.

Some definitions…

Throughout this programme and its evaluation, we will be using the terms ‘ethnicity’ and ‘minoritised ethnicity’.

Where we use the term ethnicity, we mean a group of people who share similar cultural experiences, religious practices, traditions, ancestry, language, dialect or national origins (for example, African-Caribbean, Indian, Irish). We use this term here instead of race, as this captures a broader range of shared identities as well as allows for greater nuance within this, however, we do understand that there will be multiples experiences within ethnic groups.

This programme and its evaluation are also particularly focussed on the experiences of individuals from minoritised ethnicities or people from minoritised ethnic backgrounds. By this, we mean people who are in an ethnic or racial minority within the UK, that is, people from ethnic groups other than White British. We are using the term “minoritised” as opposed to minority as we think that this acknowledges how people from backgrounds other than White British are made into a minority by social processes, such as racism. Other terms that are also used to refer to people of non-White British ethnicities are 'BAME' (Black, Asian and minority ethnic) and 'BME' (Black and minority ethnic).

Please answer the following demographic questions:

What age bracket are you in?
18-24
25-34
35-44
45-54

55-64
65 and over

What is your gender identity? (Free text box)

What is your ethnicity? (Free text box)

How many years have you been working as a CBT therapist for? (Free text box)
How would you rate the ethnic diversity within the staff team that you currently work in? Please answer this question based on the team(s) you work with directly/most closely.

Not at all diverse
A little diverse
Moderately diverse
Very diverse
Extremely diverse
I do not work in a team

How would you rate the ethnic diversity of the client group you have worked with in your current clinical role?

Not at all diverse
A little diverse
Moderately diverse
Very diverse
Extremely diverse

Unfortunately, we find ourselves in a society where issues of systemic racism are pervasive and individuals from minoritised ethnicities are often faced with experiences of racism and microaggressions.

We would like to understand a little more about your individual experiences of this, if any, within your clinical work as one of the central hopes of this programme is to offer a supportive and reflective space for therapists from minoritised ethnicities to make sense of some of these experiences within a safe group environment.

We do understand that this may be difficult information to share, so you may choose not to answer the following questions if you would prefer not to.

Have you experienced racism or microaggressions in your current workplace? If yes, how frequent would you say these experiences have been?

Yes, very frequently
Yes, frequently

Yes, occasionally
Yes, however, rarely
No, never

Have you experienced racism or microaggressions in your therapeutic work with clients? If yes, how frequent would you say these experiences have been?

Yes, very frequently
Yes, frequently
Yes, occasionally
Yes, however, rarely
No, never

Appendix 2.8: Participant weekly quantitative measures

Weekly questionnaire

Please enter the unique ID code that you generated at the beginning of the programme. This code was created using the first three letters of the city in which you were born and the last four digits of your phone number. For example, for someone born in London with a phone number of 123456789, their unique ID would be LON6789.

How many clients, if any, have you worked with this week who are from a minoritised ethnic background? (Free text)

How much time have you spent on the SP/SR programme this week? Please give an estimate in minutes.

Therapist Skill

We would like to ask you some questions in relation to your clinical work over the last week, both as a therapist and as a supervisor and/or supervisee.

All the responses that you provide will be used solely for the evaluation of this SP/SR programme and will not be used for other purposes, for example, to rate your skills as a clinician.

Please rate the following statements from 0 to 100, in relation to your perceived level of skill in considering ethnicity within your clinical role. While the following anchor points are given, please do use the whole scale from 0 to 100 to provide your self-rating.

Note: If you have not worked in a supervisory capacity, please mark "Not Applicable" for Question 10.

0----------25----------50----------75----------100

No skills Novice Competent Proficient Highly Expert

1. I have the skills to talk about and explore my client's ethnic identity in sessions
2. I have the skills to incorporate my client's ethnic identity and cultural context into formulations
3. I have the skills to adapt CBT interventions in a culturally sensitive way (e.g. thought challenging, behavioural activation)
4. In sessions, I have the skills needed to explicitly address difficulties related to my client's minoritised ethnic identity (e.g., microaggressions, experiences of discrimination)
5. I have the skills to identify, sit with and manage personal resonances that conversations around my clients' ethnicity bring up for me.

6. I have the skills to elicit and integrate my client's strengths that are related to their ethnic identity.
7. I have the skills to identify and address my own ethnic differences and/or similarities with my client in sessions
8. I have been aware of/been able to identify my own biases about my client's ethnic identity
9. As a supervisee, I have the skills to bring discussions and issues related to my own or my clients' ethnicity to supervision.
10. As a supervisor, I have the skills to create a space where my supervisee can bring in discussions and issues around their own or their client's ethnicity (NA option included)

Ethnic Identity Development
We would also like to ask you some questions in relation to your ethnic identity.

Please rate the following statements from 0 to 100, in relation to the following areas. While the following anchor points are given, please do use the whole scale from 0 to 100 to provide your self-rating.

In relation to the last week, how well do the following statements describe you:

I have explored aspects of my ethnic identity

I have a clear sense of what my ethnicity means to me

0----------25----------50----------75----------100

Not well at all Slightly well Moderately well Very well Extremely well

Over the last week, how have you felt in relation to your ethnic identity:

In relation to my ethnic identity, I have felt

0----------25----------50----------75----------100

Completely negative Quite negative Neutral Quite positive Completely positive

Wellbeing

Finally, we would like to ask you a few questions about your perceived wellbeing, both personally and as a therapist.

While there are a number of ways to understand and define wellbeing, we would consider wellbeing here to mean both how people feel (e.g. feeling happy and

content) and how they function (e.g. having agency over their lives, having a sense of purpose and experiencing positive relationships).

Please rate the following statements from 0 to 100. While the following anchor points are given, please do use the whole scale from 0 to 100 to provide your self-rating.

Over the last week, how would you rate:

Your personal wellbeing

Your therapist wellbeing

0----------25----------50----------75----------100

Poor Wellbeing Fair Wellbeing Good Wellbeing Very Good Wellbeing Excellent Wellbeing

Is there any other information that you would like to provide that would help us to contextualise the ratings you have provided for this week (e.g. illness)? (Free text box).

Appendix 2.9: Safety strategy

SP/SR Participant Safety Strategy

Why we feel a safety strategy is important

Within this pilot of a novel SP/SR programme for CBT therapists of a minoritized ethnicity, we will be asking you to work towards your own personal goals in an area of your choosing. Whilst we will be suggesting that you pick an issue that is moderately emotionally hot, we are aware that reflecting on issues and experiences can lead to thinking about other experiences and in the case of an individual's own ethnic identity, for some individuals this can be extremely powerful, often unexpectedly.

We know that many minoritized therapists regularly report experiences of day-to-day racism or microaggressions and deal with this on an ongoing basis, so we don't want to avoid reflection on this within this programme but at the same time we do not want it to become overwhelming or destabilizing. We will only be asking you to share your reflections on the **process** of SP/SR and how this has helped your learning and development, we will not be asking you to share the **content.**

Best practice in SP/SR programmes is to establish an individual plan for what to do if the emotion becomes too hot or feels overwhelming. This is even more necessary when the focus is on the experience of being from a minoritised ethnic identity, in a context where the individual may still be experiencing such incidents in their day-to-day lives and the cumulative impact may grow. Therefore, the steps below are processes that you and we as facilitators may consider so that you remain safe during the programme.

This form does not need to be submitted, but we suggest you complete it either electronically or on paper and store it safely, making a commitment to yourself that you will prioritise your own wellbeing and needs should the course raise too much emotion.

My Safety Strategy"

Possibly a note about identifying own warning signs for things being too difficult? Not sure if necessary.

1. The usual activities and experiences that I would usually engage in and that help me maintain a balance in my life are:

(Consider what ways you cope, calm or soothe yourself)

It is important that I maintain these during the programme.

2. If the impact of taking part in the programme becomes too much for me to handle, I will talk to _____ [*name friends, family, colleagues, mentors*] about my experience and whether it is right for me to continue with the programme.

3. If the impact of the programme becomes overwhelming and I am finding it difficult to engage with it, I will contact the programme facilitators and discuss whether it is right for me to continue. The facilitators will be able to provide up to two individual meetings.

4. If the programme facilitators become concerned about the immediate safety of myself or others, they will ask me to stay behind at the end of the group session. At this point they may encourage me to seek immediate emergency support, for example using the services identified below:

- My GP
- The Samaritans helpline: 116 123
- The NHS confidential staff support line, operated by the Samaritans and free to access seven days a week from 7:00am – 11:00pm: 0800 069 6222.
- Attending an A& E department
- Emergency Services: 999
- Other services that I know may be helpful for me to contact are:

  _____

  We would also encourage you to use these resources, if they feel necessary, in between group sessions.

5. I am aware that in very rare circumstances, the group facilitators may have to break confidentiality and let relevant others know. This would only be in situations where there is immediate risk to my safety and I may be finding it difficult to reach out to support services, or where discussing it with me may increase the risk.
6. I know that I can discontinue the programme at any time and will do what is right for my own wellbeing. Facilitators would be available for a debrief if I need to leave the programme early.
Signed: Date:

Appendix 2.10: Interview guide

Post-programme Interview Guide

Questions informed by SP/SR Engagement model:

- **What led you to sign up to the programme?**

- **How did you experience being on the programme?**

Personally
Professionally

- **What did you expect to get out of the programme?** Personally and professionally
- Did you feel that was met?

Was there anything about the programme that you did not expect? (e.g. content, group dynamics, your feelings towards the programme, the structure of the programme)

- **What were the most/least important parts of the programme to you?** Personally and professionally

- **What did you think about the relationship between different aspects/exercises/sections of the programme?**

- Is there anything you would have liked to add to the programme?

- **Did you have any concerns before or during the programme?**
- Were the concerns dealt with in an appropriate way?
- **How did the group experiences feel for you?**
- What did you think the group work achieved?
- How was engaging in the group work?
- Did you feel safe when engaging in the group work?
- How did you experience others on the programme?
- **How did you experience the facilitators of the programme?**
- Do you think the ethnic identity of the facilitators is important for a programme like this?
- What about your experiences of engaging in the programme overall?

Questions informed by theories of Internalized Racism and Racial Salience:

Has the programme made any difference to how you work with race and racism in your clinical role?

- Patients bringing own experiences/others experiences of racism, you receiving racism from patients/from colleagues/systems.
- Could you tell me more about what that looks like?

Has the programme, if at all, had an impact on your relationship to experiences of racism, or prejudice in relation to your ethnicity or race?

- Personally
- In your clinical role

Do you have any ideas, thoughts or feelings about why that might be? (a follow up question for both of the above questions)

Questions informed by models of cultural Identity, personal self and therapist self:

Could you tell me about your experience of exploring your ethnic/racial identity as part of the programme?

In what ways has your sense of your ethnic/racial identity changed or stayed the same in relation to:
Yourself as a therapist
People of a similar/different [ethnic] background?

How did you make sense of that change/no change?

Has the programme impacted, in any way, the way you notice your ethnic/racial identity in your clinical role?

What have you noticed about the programme in relation to your work with your clients?
Have you noticed any differences or similarities in how you work with minoritised clients?

Has the programme had any impact on your personal wellbeing?
How do you make sense of what you have noticed?

What experience in this meant the most to you?
Personally and Professionally

Are there other parts/aspects of your identity that we have not spoken about so far today?
Is there anything we haven't discussed in relation to your experience of the programme which you think is important?

Appendix 2.11: Researcher reflexive journal excerpts

NB. This is not the full research journal. The below excerpts have been chosen to demonstrate the researchers reflections during different stages of the research lifecycle.

Reflecting on my personal identity and social context in relation to the research topic, with my supervisor – 18/06/22

Being from a minoritized ethnic background myself, I was immediately drawn to the project. I have found experiences at school, work, and in the communities I have lived in really challenging, as they have often been white dominant spaces, and/or ones where I have experienced direct or indirect racial discrimination. Within the DClinPsy course I am on now, I can also see that models, theories and practices are dominated by a western mentality and way of thinking, and it is a challenge to practise authentically using the 'evidence' whilst remaining aligned within your own cultural worldview and values. I felt immediately excited that support for minority ethnic therapists was even being considered, and felt I had to back and support the project due to my own ethnic and cultural backgrounds. I also felt a sense of nervousness – what if I am not the 'ethnic minority' that the research team want – I am not aligned with the typical religion of my ethnicity, and I do not fluently speak the language. I felt a sense of having one foot in, and one foot out of the project and being the 'model' researcher.

Reflecting on my feelings after my first few participant interviews – December 2022

The interviews with therapists have made me think about how difficult it is to hold and validate the therapists emotions that come up whilst sharing their experiences, whilst attempting to collect meaningful data for my research question. I have found that some therapists are expressing their grief related to their own personal experiences of racial prejudice, which means they are sharing detailed stories about these experiences. It feels really difficult to know how to navigate this – it feels wrong redirect the conversation when they're sharing such difficult, personal experiences? I'm also wondering about the impact of them repeating these stories and whether it feels helpful for them to do this in this space. I wonder whether my shared characteristics of being a woman from a minoritized ethnic background makes them feel safer, or more aligned to me, and therefore they feel I would understand them? I think this would be something to bring to my research and clinical-research supervisors to consider how to manage this.

Experiences of coding – February 2023

I am surprised by how many different, and contradictory codes that have come up during the coding process. I'm also surprised by how long my codes are, some of them are like sentences. I think because I am in the early coding stages, I am making more semantic codes, taking the data literally, rather than using latent meaning to interpret any underlying, unconscious meaning in the data. This might be because I feel quite overwhelmed by the amount of data, and I am worried about misinterpreting what a participant has said.

I have to try to remember that this type of research design heavily involves the researchers own subjective interpretation, and that critically interrogating myself and the research process will enable me to hold my views, assumptions and position in mind when interpreting the data. Also, latent codes may be useful for depth within the analysis, and I should not be scared to use latent meanings.

Moving on to theme development – April 2023
I feel good that I have decided to finish coding and move on to considering making patterns of meaning from my codes. Looking back, there are so many ways that the therapists have experienced the programme, and it is interesting that whilst there are similarities within what the therapists have shared, they have all experienced similar things, yet slightly differently. Two things have come up frequently: self-esteem/confidence, and feelings of safety and belonging. Each have been said and experienced in a slightly different way by each therapist. I am looking forward to looking across the codes to find patterns and begin to conceptualise the data!

Theme generation – July 2023
Because there are so many different ways the therapists have experienced the programme, I have found it hard to zoom out of looking at individual aspects of the data and start looking across the dataset. It is a really different way of looking at data and I have been so immersed in coding line-by-line for a long(ish) period of time. It has also been quite hard to let go of the initial pattern I noticed in the coding stage of 'belonging and safety', which I keep noticing when looking at the codes in this stage. Perhaps this is because it clearly is something a number of participants experienced and expressed using similar words, so it is easier to see within the data. Or, is it also something that I expected to find, as from personal experience I know that I can tend to feel a sense of safety with others who are from minoritized ethnic backgrounds, in my personal and professional life.

Meeting with my research supervisor: theme development – July 2023
Today I met my research supervisor to share my initial themes and patterns of meaning that I have formed from the dataset. We talked about the sense of 'belonging and safety' that I noticed amongst therapists accounts, and when articulating this further with him using data extracts and codes to illustrate it, we noticed that therapists had multiple unmet needs/feelings within their role as a CBT therapist from a minoritized ethnicity: needing to belong/fit in, needing to feel safe, longing for fulfilment, feelings of emptiness, searching for identity. This conversation enabled me to zoom out of those two feelings of 'belonging' and 'safety' and consider the unmet needs of therapists, shedding light on the reasons they chose to engage with the programme. It was a really helpful conversation to enable me to develop this theme further.

Theme development: Two or Three themes?! – 1st August 2023
I am quite far along the analysis process now and it feels like I am gaining a bit more confidence in my themes and how I have represented the data within them. One theme represents how the application of CBT has been contextualised through the programme, and the other one refers to participants experiences of understanding themselves and feeling understood, and the impact of that. I am keen to use my third theme, which captures participants experiences of how their workplace culture

brought up challenges for their role as a CBT therapist from a minoritised ethnic background. I have considered how relevant this is, and thought about whether I am keen to develop this theme due to my anger and upset towards how NHS services treat professionals from minoritised ethnicities (and therefore am keen to have it as an overarching theme), or whether this theme really does helpfully represent the challenges with their work in their respective workplaces. I wonder if it might be a bit of both of these reasons? I feel it is so important for the readers to understand that the systems in which therapists work in have a huge impact on the way they/their workplaces relate to their ethnic identity and how this impacts on their work with patients. Without this, I feel it would be difficult for readers to understand how NHS services need to make changes to best support therapists from minoritised ethnic backgrounds.

Selecting and writing up my themes – August 2023

I am almost at the end of writing up my themes, which has been a really enjoyable process. I have been able to see how much richness each participant has brough to the data and analysis process, and each participant has been key in developing the analysis. I think something to be mindful about when selecting the extracts to use in the write up is the way in which the meaning is communicated. For example, some participants communicate things more indirectly, or I may have made an interpretation of something that a participant has said, whereas other participants say things more 'matter of fact', which I feel is sometimes a 'better' extract to demonstrate a theme – but not necessarily! I think it is important to remain confident yet tentative within the write up. It relates back to the idea that knowledge and meaning within qualitative data analysis stands at the intersection between the researchers own beliefs/biases/perceptions, the data, and the researchers social context.

Appendix 2.12 : Data familiarisation notes

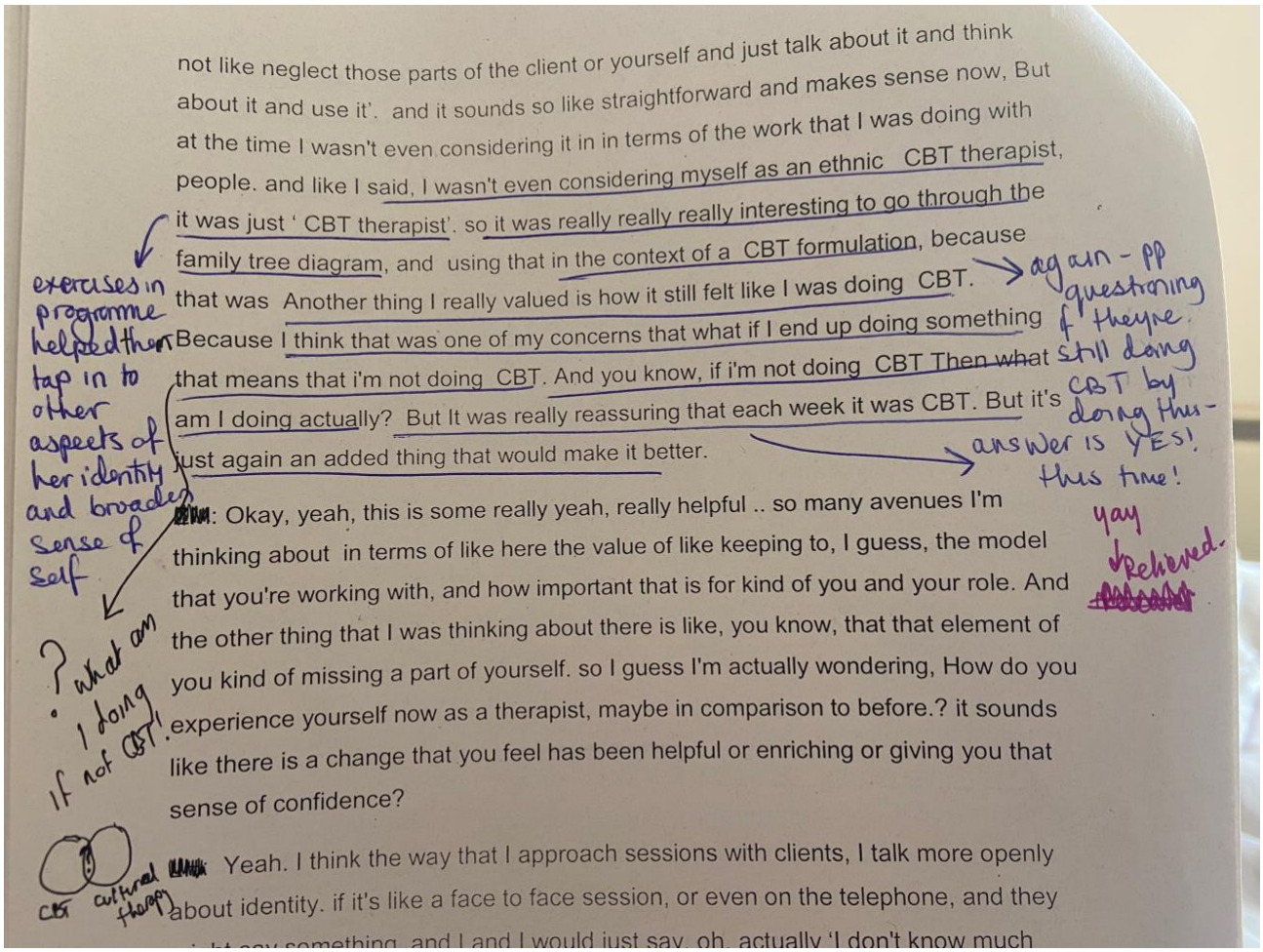
NB. This is not all of the researcher's data familiarisation notes. Examples have been selected to demonstrate some of the researchers methods, processes and content of data familiarisation.

What I bring to the familiarisation process:

- I have limited experiences of engaging with qualitative research prior to my Doctoral training. However, I have always thought qualitative research was rich, interesting, and meaningful, allowing for deeper exploration of the research subject. Being a Trainee Clinical Psychologist I have had some teaching on qualitative methods, and I have completed two projects (SRRP and thematic synthesis) which enabled me to experience engaging with data through a subjective and interpretative lens, considering my own position within the research such as considering my own identity and how that shapes my beliefs and values about the research, but also considering the research paradigm and my own views about objectivity-subjectivity of knowledge, and therefore how I situate myself in the research.
- Experience with subject areas: I joined this project in February 2021, and have since been learning about the themes of this research project: Self-Practise/Self-Reflection, therapists from ethnic minority backgrounds experiences of working as a therapist, therapist wellbeing, cultural competency skills. I have particularly taken an interest in therapists experiences of providing therapy to patients of similar and different ethnic backgrounds, and what common themes arise in their work when working with these differences and similarities. My systematic review focussed on the concept of 'ethnic matching', and particularly used Social GRACES and intersectionality theory and frameworks to understand therapists experiences. Therefore, when looking at this dataset and doing the analysis, I will inevitably be considering these findings and theories from my literature review, in this work, which is a programme focussing primarily on race/ethnicity and cultural identities. I am also particularly interested in the use of language and how that creates certain meanings. For example, the use of words such as 'minoritised/minority' and how the programme I am evaluating uses that term consistently to describe that participants and also the patients that they see that are from non-white western racial and/or ethnic backgrounds. It makes me wonder how the participants might understand themselves and others from different racial categories, and the impact of how they then engaged with the programme material.

- Familiarisation methods: I usually interact with material best when I can write/draw/use pen and paper rather than online. Therefore I decided initially annotating the transcripts would enable me to work more flexibly and find it more accessible to add notes. Initially I did not plan on drawing or using colour during this process, however I noticed my initial reactions to the data arose in emotions and sometimes doodles/images came to mind. The emotions were helpful indicators of understand more about what the data meant to me, and allowed me to think about what parts of my own worldview, beliefs and attitudes were informing these emotions. Therefore, I decided to note these in a different colour, and also note down my more considered thoughts that arose from exploring these feelings. Some thoughts were also quick, alike the emotions, and those were also noted. The written emotions/thoughts and pictures also enabled me to begin to spot patterns in the data, answer the above reflective familiarisation questions, and also enabled me to reflect on whether I felt/thought/reacted in the same way when I re-visited the data at a different day/time.

Participant 3: Transcript familiarisation notes



not like neglect those parts of the client or yourself and just talk about it and think about it and use it'. and it sounds so like straightforward and makes sense now, But at the time I wasn't even considering it in in terms of the work that I was doing with people. and like I said, I wasn't even considering myself as an ethnic CBT therapist, it was just ' CBT therapist'. so it was really really really interesting to go through the family tree diagram, and using that in the context of a CBT formulation, because that was Another thing I really valued is how it still felt like I was doing CBT. Because I think that was one of my concerns that what if I end up doing something that means that i'm not doing CBT. And you know, if i'm not doing CBT Then what am I doing actually? But It was really reassuring that each week it was CBT. But it's just again an added thing that would make it better.

[redacted]: Okay, yeah, this is some really yeah, really helpful .. so many avenues I'm thinking about in terms of like here the value of like keeping to, I guess, the model that you're working with, and how important that is for kind of you and your role. And the other thing that I was thinking about there is like, you know, that that element of you kind of missing a part of yourself. so I guess I'm actually wondering, How do you experience yourself now as a therapist, maybe in comparison to before.? it sounds like there is a change that you feel has been helpful or enriching or giving you that sense of confidence?

[redacted] Yeah. I think the way that I approach sessions with clients, I talk more openly about identity. if it's like a face to face session, or even on the telephone, and they might say something, and I and I would just say, oh, actually 'I don't know much

exercises in programme helped them tap in to other aspects of her identity and broader sense of self

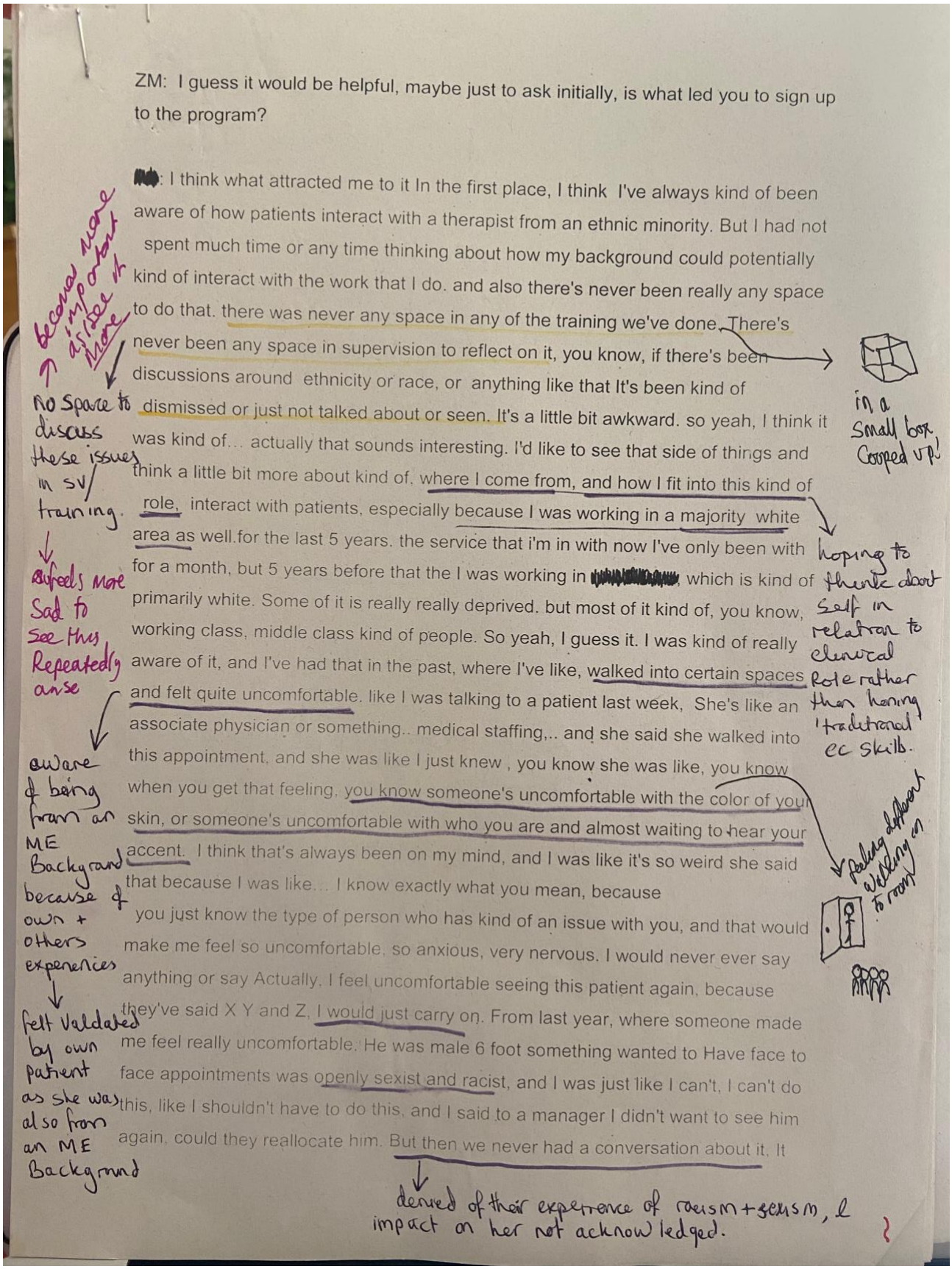
again - PP questioning if they're still doing CBT by doing this - answer is YES! this time!

yay achieved.

? what am I doing if not CBT!

CBT cultural therapy

Participant 1: Transcript familiarisation notes



ZM: I guess it would be helpful, maybe just to ask initially, is what led you to sign up to the program?

[redacted]: I think what attracted me to it In the first place, I think I've always kind of been aware of how patients interact with a therapist from an ethnic minority. But I had not spent much time or any time thinking about how my background could potentially kind of interact with the work that I do. and also there's never been really any space to do that. there was never any space in any of the training we've done. There's never been any space in supervision to reflect on it, you know, if there's been discussions around ethnicity or race, or anything like that It's been kind of dismissed or just not talked about or seen. It's a little bit awkward. so yeah, I think it was kind of... actually that sounds interesting. I'd like to see that side of things and think a little bit more about kind of, where I come from, and how I fit into this kind of role, interact with patients, especially because I was working in a majority white area as well.for the last 5 years. the service that i'm in with now I've only been with for a month, but 5 years before that the I was working in [redacted], which is kind of primarily white. Some of it is really really deprived. but most of it kind of, you know, working class, middle class kind of people. So yeah, I guess it. I was kind of really aware of it, and I've had that in the past, where I've like, walked into certain spaces and felt quite uncomfortable. like I was talking to a patient last week, She's like an associate physician or something.. medical staffing,.. and she said she walked into this appointment, and she was like I just knew , you know she was like, you know when you get that feeling, you know someone's uncomfortable with the color of your skin, or someone's uncomfortable with who you are and almost waiting to hear your accent. I think that's always been on my mind, and I was like it's so weird she said that because I was like... I know exactly what you mean, because you just know the type of person who has kind of an issue with you, and that would make me feel so uncomfortable, so anxious, very nervous. I would never ever say anything or say Actually, I feel uncomfortable seeing this patient again, because they've said X Y and Z, I would just carry on. From last year, where someone made me feel really uncomfortable. He was male 6 foot something wanted to Have face to face appointments was openly sexist and racist, and I was just like I can't, I can't do this, like I shouldn't have to do this, and I said to a manager I didn't want to see him again, could they reallocate him. But then we never had a conversation about it, It

becoming more important as I see it more

No space to discuss these issues in SV/ training.

↓

suffers more sad to see this Repeatedly arise

aware of being from an ME Background because of own + others experiences

↓

felt Validated by own patient as she was also from an ME Background

in a small box Cooped up!

hoping to think about self in relation to clinical Role rather than having traditional cc skills.

feeling different walking in room

↓

denied of their experience of racism + sexism, & impact on her not acknowledged.

?

Participant **4:** reflections from familiarisation of transcript

Dates that researcher engaged in data familiarisation: 13/02/2023 – 23/02/23

This interview made me feel really sad and I held a lot of empathy towards them. It seemed like he made sense of the programme through the lens of not 'fitting in' ,being an 'anomaly' or not belonging to the group space, but also not belonging outside of the group space. They explained this through having a mixed heritage, XXX and XXX. I sensed that the fact he assumed he hadn't experienced racism/discrimination in the same way/as much as other pp had, which made him feel it didn't warrant them being on the programme and he couldn't meet its aims. Their struggles with engaging in some of the exercises and feeling their identity was blurred when engaging with them also perpetuated this belief that they did not fit in to the programme. It was interesting that initially, they interpreted the programme as being beneficial in reducing these feelings of difference, and as time went on he realised that that might not be true, as he found it hard to justify what enabled them to feel more connected with others from EM backgrounds.

This feeling of not belonging in relation to ethnicity/race/culture really resonated with me – being of a mixed heritage with 2 religions, 2 cultures (+the third British one), but also not fully identifying with either of those three.

I also found it interesting that they spoke a lot about how they thought the programme would be helpful for their cultural competency skills, but not so much for themselves…. did/do they see themselves from a minority ethnic background? Is that a helpful way to categorise people or does it further marginalise people?

As well as not identifying with racist experiences , they also mentioned feeling 'guilty' for not engaging with the programme themes/materials/thinking related to diversity sooner – I sensed when he said that he identified with not being minoritized – white guilt around not thinking about racial discrimination. But then, at times they identified with their parents/grandparents migration and assimilation experiences and the systems they were brought up in, and how that impacted them all – more thinking via a minoritized identity lens?

Participant 2: reflections from familiarisation of transcript

Dates that researcher engaged in data familiarisation: 18/02/23 – 22/02/23

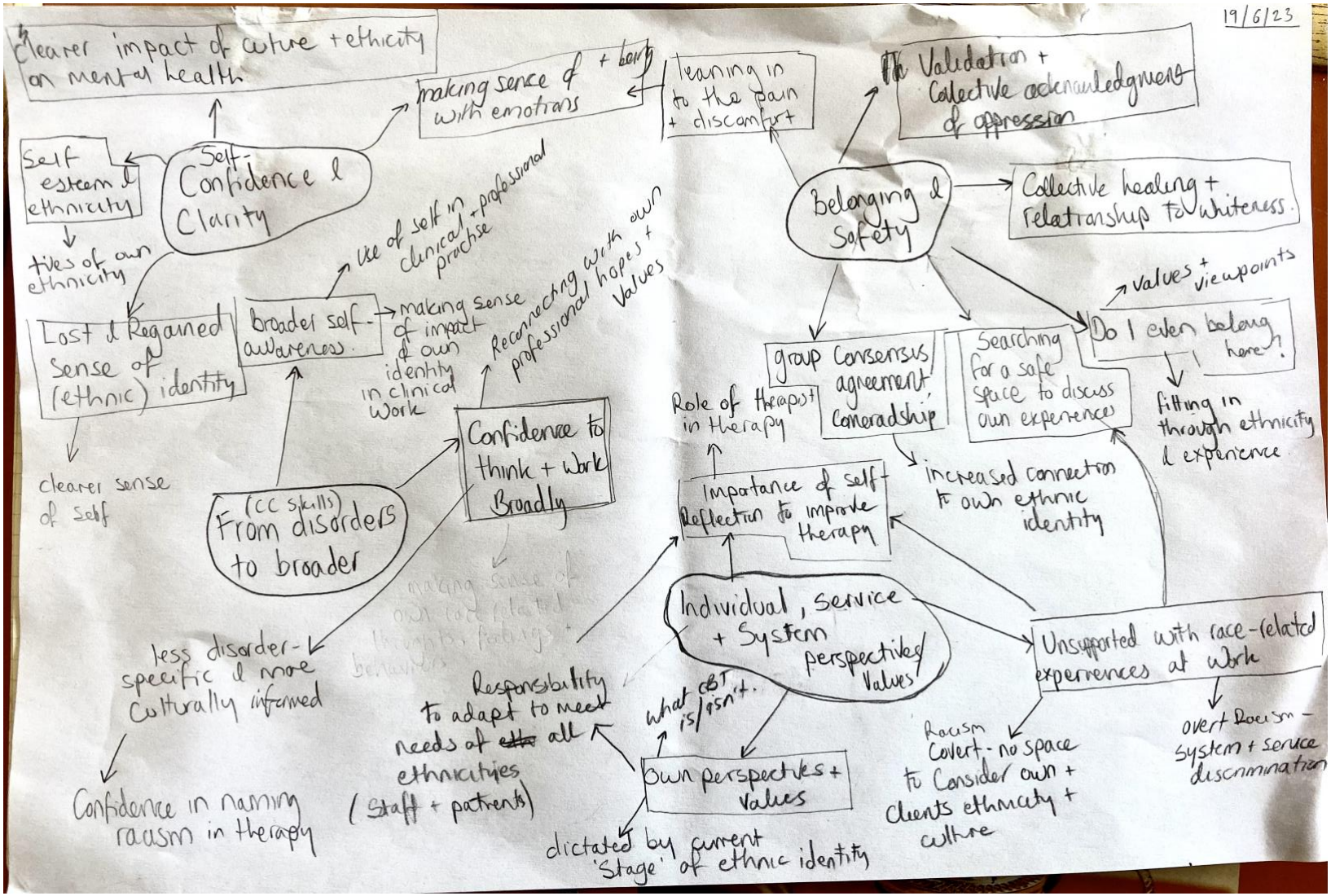
I noticed that they had been deeply affected by the murder of George Floyd as they referenced back to his murder and the impact it had on them, their work with colleagues/in their service, and their work with clients. They seemed to make sense of their colleagues and workplace dealing with issues of race 'performatively', e.g. through the black lives matter + George Floyd team discussions, making it hard for them to connect with these conversations and instead, understandably avoiding them.

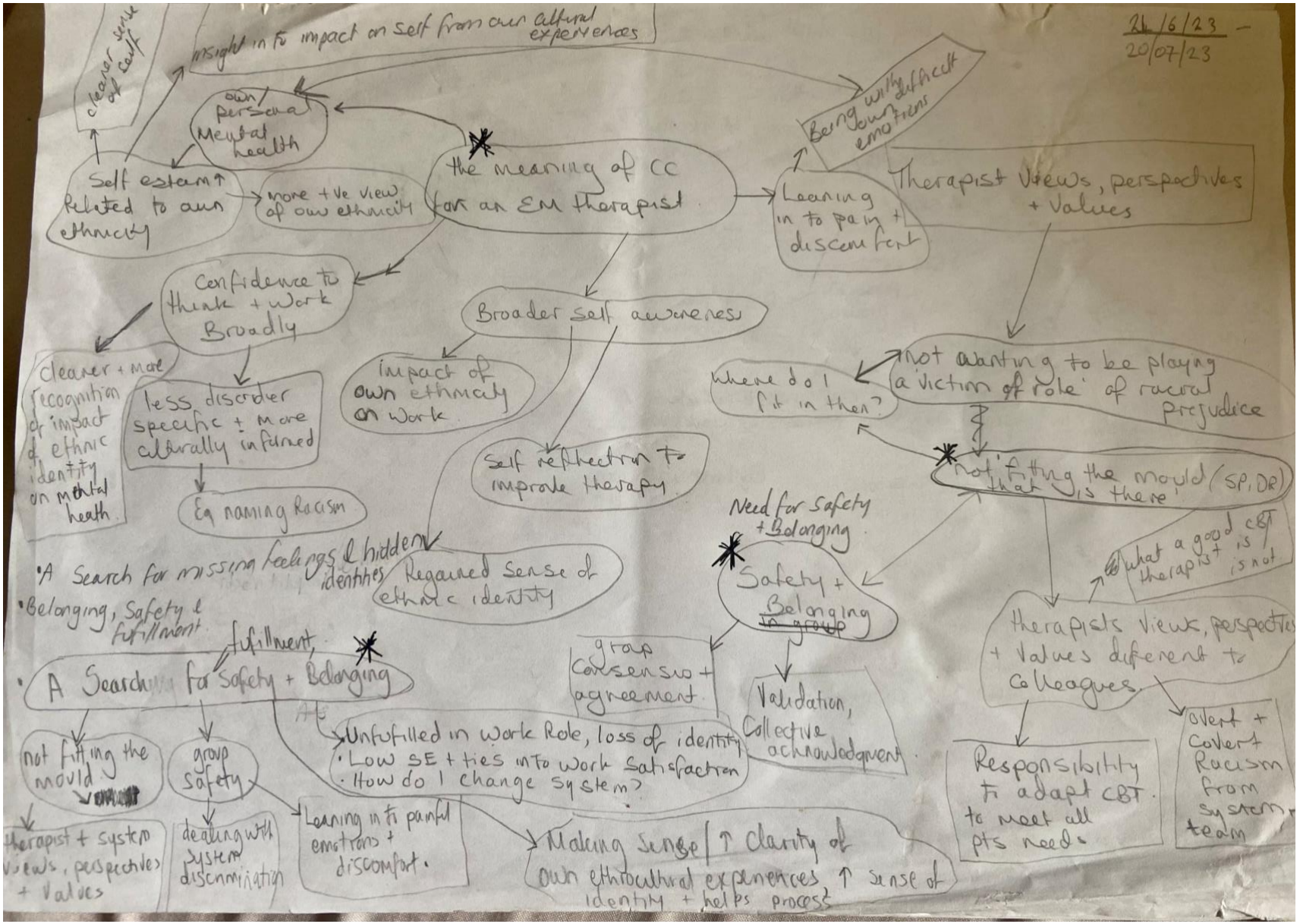
I also noticed a big life transition for them – the birth of their child and what it meant for them as a black parent having to share and teach their children about race and racial injustice.

I really resonated with their sense of people dealing with issues of race/racism and the BLM movement 'performatively' – everyone just acknowledging it happened and no helpful actions actually coming of it, e.g. she referred to decolonising childrens educational curriculum as a helpful step that has been acknowledged as important, but they have seen no action from their childrens school with this. I felt quite connected to them throughout the interview and my resonation with what their was saying made me do lots of 'nodding' in their responses.

I also wondered if they were, through her speech, resisting people and systems that whilst may seem they are doing 'good' they are actually doing more damage. E.g. managers telling them that they are 'resilient' and what that means about them having to always be resilient to issues that arise related to her experiences of racism. Also them colleagues talking about the George Floyd incident, but not doing anything to make changes in the service, and them not wanting to engage with that. That could be both protective but also empowering for them?

Appendix 2.13: Thematic Maps




24/6/23 – 20/07/23
clearer sense of self
insight in to impact on self from our cultural experiences
own personal Mental health
Self esteem ↑ related to own ethnicity
more +ve view of own ethnicity
the meaning of CC for an EM therapist
Being with your difficult emotions
Leaning in to pain + discomfort
Therapist Views, perspectives + Values
Confidence to think + work Broadly
Broader self awareness
clearer + more recognition of impact of ethnic identity on mental health
less disorder specific + more culturally informed
Eg naming Racism
impact of own ethnicity on work
Self reflection to improve therapy
where do I fit in then?
Not wanting to be playing a 'victim of role' of racial prejudice
Not fitting the mould (SP, DR) that is there
what a good CBT therapist is / is not
Need for Safety + Belonging
Safety + Belonging in group
group consensus + agreement
Validation, Collective acknowledgment
Therapists views, perspectives + values different to colleagues
Responsibility to adapt CBT to meet all pts needs
Overt + Covert Racism from system, team
*A Search for missing feelings & hidden identities
Regained sense of ethnic identity
*Belonging, Safety & fulfillment
A Search for Safety + Belonging
fulfillment
Unfulfilled in Work Role, loss of identity
• Low SE + ties into work satisfaction
• How do I change system?
not fitting the mould
group Safety
Therapist + system views, perspectives + Values
dealing with system discrimination
Leaning in to painful emotions + discomfort.
Making Sense / ↑ Clarity of own ethnocultural experiences, ↑ sense of identity + helps process

Appendix 2.14: Joint Project Contributions

Development of the programme: Joint development through separately revising the programme module drafts and discussing them in research meetings with the programme developers.

Ethics: we Jointly completed the UCL ethics process within research meetings.

Recruitment: Joint responsibilities in the study advertising and recruitment processes. We both facilitated the recruitment information sessions. We took turns to meet individually with participants to go through the consent process.

Data collection: Separately collected data. Sakshi Shetty Chowdhury created the outcome measures and collected the quantitative data independently. I (Zara Malik) independently devised the interview guide and collected the qualitative data through post-programme interviews. We jointly agreed to keep the data on the UCL OneDrive.

Data analysis: Separately analysed the data. I (Zara Malik) analysed the qualitative data independently.