

**Exploring How Aspiring Clinical Psychologists from  
Different Racial Groups Experience and Make Sense of  
their NHS Career Trajectory**

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## **Dedication**

I would like to dedicate this body of work to my mother, Mary Mosunmola Mesimo, who is a constant reminder that it is never too late to learn, and that kindness is free.

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# 1 Lay Summary

**Paper 1:** What do Black British and White British hopeful therapists think of working in the NHS?

## **What is the problem?**

A therapist is someone that helps people to cope with their emotions and relationships. The majority of therapists in the UK are White women. People who are not White women find it difficult to become a therapist. People that train and employ therapists want to increase the number of therapists from different racial backgrounds. Earlier studies spoke with people from different racial backgrounds who were:

- Training to become a therapist
- Already a therapist

We do not know much about people from different racial backgrounds that want to become therapists. However, research has shown that having people with different racial backgrounds working in the NHS improves patient care. So in my study, I wanted to explore ‘What do Black British and White British hopeful therapists think about working in the NHS?’

## **What did I do?**

When planning my study, I asked another hopeful therapist to help me think about what to do. To collect information, I helped five White British hopeful therapists talk to each other about getting a job/working in the NHS. I also helped five Black British hopeful therapists to have the same conversation. I decided to use this way of collecting information so that the hopeful therapists would feel comfortable.

## **What did I find?**

I found that the experience of hopeful therapists were different based on the therapist’s racial background.

White British hopeful therapists:

- Enjoyed their jobs
- Felt accepted and supported by people they work with

Black British hopeful therapists felt:

- People treated them differently because of their race
- They had to change how they acted to become therapists
- Wished that more people who looked like them were therapists

### **What does this mean?**

Hopeful therapists working in the NHS have different experiences based on their race. Black British individuals aspiring to become therapist need more support because people treat them more negatively than White British hopeful therapists. People responsible for training and hiring therapists should be aware of these findings and work to change this. I have shared this information with therapists and other people researching this topic. I also plan to share this information with hopeful therapists and the people that train them.

**Paper 2:** What do NHS staff with different racial backgrounds think of working in the NHS?

### **What is the problem?**

The NHS has staff from different countries and racial backgrounds. There is evidence that people with different racial backgrounds who work in the NHS are treated differently by colleagues. Research shows that if NHS staff are happy at work, they provide good care to patients. I read and summarised evidence on the experience of NHS staff that work directly with patients. I wanted to understand if the experiences of these staff members were different based on their race. I also wanted to understand the experiences of White NHS staff because this had not been looked at before.

### **What did I do?**



I wanted to find studies that had asked NHS staff about their experiences through interviews, focus groups, or questionnaires. I created a list of words related to my topic. I put these words into three different research databases (CINAHL, APA PsychInfo, MEDLINE). This helped me to find 1,866 research papers, but not all of them were related to my topic. Another researcher helped me to go through the papers and pick studies related to my topic. This left us with 23 studies related to my topic. After reading all 23 studies, we decided that only 16 were relevant. We then used a tool called the 'Critical Appraisal Skills Programme' checklist to understand how well each study was run. We removed one study because it was not as good as the others. I then used a method called 'thematic synthesis' to examine the results from the 15 studies.

### **What did I find?**

321 NHS staff were included across the 15 studies. Staff described their experiences of:

- Applying for NHS jobs
- Working in the NHS
- Applying for promotions in the NHS

My understanding of what NHS staff shared in these studies was that:

- Staff across the NHS were treated negatively if their race was not White
- Being White was a benefit in the NHS
- NHS managers treated people who were not White differently, and because of this other staff did too
- People who were not White found different ways of coping with negative treatment including:
  - Working harder
  - Leaving their job or the NHS

- Changing who they were at work
- Fighting against the negative treatment

### **What does this mean?**

Managers and other leaders in the NHS need to act to change the negative experiences that NHS staff who are not White have at work. Making experiences at work more positive and fairer for all staff will make patient care better.

### **Paper 3: Bringing it all together**

In this paper I summarised how Paper 1 and 2 go together. I described how the findings of these two papers can help:

- Hopeful therapists with different racial backgrounds
- Other staff working in the NHS with different racial backgrounds
- NHS Managers understand how to help staff with different racial backgrounds
- People that create guidelines on how to employ and promote NHS staff
- Create more research to understand this topic

I also talked about the ups and downs of doing this research and how I felt doing it. I described my plan for how I will share my research with others.

## **2 Paper 1: Exploring How Aspiring Clinical Psychologists from Different Racial Groups Experience and Make Sense of their NHS Career Trajectory**

## Abstract

Racial diversity in the clinical psychology workforce has increased in recent years. However, the profession is situated within a broader National Health Service (NHS) context where there is evidence of workforce racial inequity in staff recruitment, career development, and progression. Previous studies have focused on the experiences of trainee and qualified clinical psychologists from underrepresented racial backgrounds, and there exists little research on the experience of those racialised as White. Therefore, in this study I aimed to gain an insight into the lived experiences of aspiring clinical psychologists (ACPs) from different racial backgrounds working in the NHS, and how they made sense of their pre-qualification career trajectory. I conducted two racially homogenous online focus groups with Black British ( $n=5$ ) and White British ( $n=5$ ) ACPs with at least 6 months' experience of working in NHS mental health services. I transcribed and analysed the focus groups using interpretative phenomenological analysis. My analysis yielded three whole-group themes. ACPs experienced and made sense of their pre-qualification career trajectories in relation to 1) the profession, 2) interpersonal relationships, and 3) sense of self. Stark differences emerged across racial groups, highlighting how ACPs experiences within the NHS are shaped by power in relation to race, institutional racism, and Whiteness. White British ACP group experiential themes (GETs) included 'Whiteness as the norm in clinical psychology', 'I feel confident and supported', and 'Luck vs. Merit'. Black British ACPs GETs included 'Being Black: An asset vs. Racism', 'Support: A luxury vs. A right', and 'Racism costs me energy'. I explored these findings in relation to existing literature, as well as the implications for policy and practice within clinical psychology.

Key words: clinical psychology, racism, interpretative phenomenological analysis, qualitative, Whiteness, NHS staff, focus groups

## Introduction

### Terminology

I begin this paper by defining the key concepts used across my research. By providing a brief historical overview of the use of these terms in the NHS and United Kingdom (UK), I highlight how these concepts manifest within the clinical psychology profession and my own positionality whilst undertaking this study.

‘Race’ is often used to categorise groups of people based on features such as skin colour and hair type (Omi & Wynant, 2014). The hierarchical categorisation of people based on physical features developed historically from colonialism and eugenics to provide justification for the subjugation and disempowerment of ‘non-White’ people (Rao et al., 2020; Smedley & Smedley, 2005). There is now widespread agreement among scientists that race is not biological, but a social construct that precisely captures the impact of racism (Jones, 2000; Smedley & Smedley, 2005; Umek & Fischer, 2020). In the UK ‘ethnicity’ is incorrectly used to define race/nationality (e.g., ‘Black British’; Ong, 2021). Instead, ethnicity reflects the social characteristics that people have in common, such as language, regional background, traditions, and culture (Smedley & Smedley, 2005). Therefore, across my research I use the term ‘race’ rather than ‘ethnicity’ when discussing the phenotypic features of individuals and their experiences of racism.

Racism is a system where opportunities and value are based on race, which unfairly advantages certain racial groups and systematically disadvantages others (Jones, 2020). Racism can take different forms and occurs across different levels. Most commonly acknowledged are instances of overt racism at an interpersonally-mediated level; a classic example is one person directing a racial slur at another person. Other more subtle, but equally harmful, forms of racism include microaggressions. Microaggression are commonplace slights that, whether intentional or not, communicate hostile or derogatory messages towards

marginalised racial groups (Rollock, 2012; Sue, 2010). However, focusing on racism as isolated acts of ignorance perpetrated by *individuals* removes the *societal* context in which racism occurs (Salter & Adams, 2013). It is therefore crucial to consider institutional racism, which is defined as the involvement of institutional systems in the discrimination and oppression of people based on their skin colour, ethnicity, or culture (Braveman et al., 2022; Home Office, 1999).

Whiteness refers to a social system of racism that ensures the dominance and privilege of people racialised as White (DiAngelo, 2011; Kinouani, 2021). Among Western cultures, Whiteness is considered as the norm and neutral, with those deviating from this seen as ‘other’ (Malherbe et al., 2021; Salter & Adams, 2013). This is reflected in the common grouping together of ‘non-White’ individuals as ‘ethnic minorities’ or ‘Black Asian and Minority Ethnic’ (i.e., BAME, BME).

Global majority refers to racial groups that are classed as minorities within Western contexts, despite representing the majority of the human population (Campbell-Stephens, 2020). I use this in place of terms such as ‘BAME’, ‘ethnic minority’, and ‘racialised minority’ as these terms centre Whiteness as the norm, can be experienced as stigmatising, and minimise the active process of racism (Ahsan, 2020; Campbell-Stephens, 2020; Hatch et al., 2021). In order to disrupt the deficit narrative applied to ‘othered’ groups, I opt to use empowering language that has been created by those the term seeks to define, challenges marginalisation, and undermines White power structures (Campbell-Stephens, 2020).

### **Racial Diversity in Clinical Psychology**

Clinical psychologists are trained to reduce psychological distress and promote wellbeing through the application of knowledge derived from psychological theory and research (British Psychological Society [BPS], 2019). The doctorate in clinical psychology (DClinPsy) is a three-year professional training programme and the main route to becoming a

clinical psychologist in the UK. The clinical psychology workforce has been criticised for being predominantly White, middle class, and female (Jameel et al., 2022). Historically, White applicants were more likely to be accepted onto a DClinPsy course than global majority applicants. This is evident in the case of DClinPsy admissions statistics between 2017-2019 that show the overall acceptance rate was 15%, but the percentage of successful White applicants was 17%, compared to 9% for Black applicants (Clearing House for Postgraduate Courses in Clinical Psychology [CHPCCP], 2017; 2018; 2019). This resulted in a clinical psychology workforce that does not reflect the population it serves and created racial equity issues in the accessibility and cultural sensitivity of mental health services (Odusanya et al., 2017; Williams et al., 2006).

### **Racial Inequity in Mental Health Services**

Global majority communities, compared to White British groups, are less likely to access talking therapies but are overrepresented in forensic and psychiatric services (Clark, 2011; Williams et al., 2006). Furthermore, when global majority individuals access mental health services, they experience poorer care and clinical outcomes compared to White individuals (Beck et al., 2019; Roche, 2017). For example, global majority patients are less likely than White patients to complete psychological treatment, reliably improve, or fully recover (Baker 2018).

The dominant narrative within the profession is that global majority groups are “hard to reach”, not “psychologically minded”, and engage poorly with psychological services (Ong, 2021; Rao et al., 2020; Roche, 2017). Yet, psychological services are not culturally sensitive and continue to be dominated by Eurocentric models of psychological distress impacting patient experience (Brady et al., 2018; Farooq et al., 2022; Williams et al., 2006). Furthermore, ‘culturally adapted’ models of psychological distress locate the problem within global majority groups, ignoring their cultural and socio-political contexts, including

experiences of racism (Ong, 2021). Many White psychologists are uncomfortable discussing race with patients, even when central to the patients' experience (Beck, 2019). This further perpetuates the silence around race, not only in the therapy room but in teaching and supervisory relationships across the profession (Shah, 2010). Knowledge of historical and sociocultural factors that impact global majority communities is essential when attempting to understand and treat mental health difficulties in these communities, which is enhanced by a diverse workforce (Atayero, 2020).

To accomplish this, in 2020 Health Education England (HEE) ringfenced funding for DCLinPsy courses to improve racial diversity. This was achieved through revised contextual admissions and mentoring schemes (HEE, 2020; Gourley, 2022). Contextual admissions aim to examine wider systemic factors that may have obscured or hindered a candidate's progress (Gourley, 2022). This, coupled with the recent increase in number of funded DCLinPsy places, has led to drastic improvements in the profession's racial diversity. For example, 22% of applicants accepted onto the DCLinPsy in 2021 identified as from a global majority background, compared to only 10% in 2017 (CHPCCP, 2017; 2021). Despite increased racial diversity, global majority clinicians' voices remain marginalised within clinical psychology, and very little is known about their experiences (Farooq et al., 2022).

### **Unheard Global Majority Voices**

There is a growing body of literature that highlights the racism, marginalisation, and isolation experienced by global majority trainee- and qualified- clinical psychologists both within the profession and wider NHS (Adetimole et al., 2005; Edeh et al., 2022; Odusanya et al., 2018; Paulraj, 2016; Ragan & Shaw, 2008; Shah, 2010). However, there remains a paucity of research on the experience of aspiring clinical psychologists (ACPs) from global majority backgrounds. ACPs are considered paraprofessionals, defined as those "to whom a particular aspect of a professional task is delegated, but who [are] not licensed to practice as a



fully qualified professional” (Woodley-Hume & Woods, 2019). ACP pre-qualification roles include clinical support worker, assistant psychologist, graduate mental health worker, and trainee psychological wellbeing practitioner (PWP), among others. ACPs work alongside qualified psychologists to extend psychological input, yet they experience job uncertainty, temporary short fixed-term or voluntary contracts, and a lack of consistency in the remit of their roles (Farooq et al., 2022; Snell et al., 2022; Woodley-Hume & Woods, 2019).

Furthermore, ACPs typically work within an NHS context where there is evidence of workforce racial inequity (see Paper 2, pg.60). Consistent with this, the few studies that have explored global majority ACPs’ experience in clinical psychology report anticipated discrimination in recruitment, struggles to fit in, experiences of racism, and the negative impact of White privilege (Farooq et al., 2022; Jameel et al., 2022; Ragaven, 2018). In a recent study by Farooq and colleagues (2022), global majority ACPs described experiencing self-doubt, internalised oppression, and stereotype threat that any incompetence would be perceived as being due to their race. Similarly, Jameel et al., (2022) found that ACPs felt othered, tension between hope and cynicism for the future of the profession, and frustration with the status quo of racial inequity. Such findings emphasise the need to focus on the lived experiences of ACPs from global majority backgrounds, with a specific focus on issues of Whiteness, power and privilege, and how these factors impact access, resources, opportunities, and relationships (Farooq et al., 2022).

Existing research treats global majority applicants as a homogenous group despite high levels of variation in defining this population (Tong et al., 2019; Vivero & Jenkins, 1999). Such methodological issues not only limit the generalisability of findings but hinder the applicability of findings to inform DClinPsy admissions criteria, widening access schemes, and further support for ACPs. Widening access schemes in clinical psychology predominantly focus on increasing racial diversity. However, they do not acknowledge the

wider context of structural experiences of power in relation to race, ethnicity, and culture within the NHS that global majority aspiring clinical psychologists (ACPs) are likely to face (Shah, 2010). This will impact their chances of progression onto DclinPsy training, as well as the quality of care they deliver (Dawson, 2018; Kline, 2022). Thus, there is a strong rationale for investigating the experiences of global majority ACPs working in the NHS.

### **Whiteness in the Profession**

Whilst the dominance of Whiteness is a recurring theme from studies of global majority ACPs, studies rarely sample White ACPs. There exists a small literature base on Whiteness in clinical psychology, primarily from the perspective of qualified clinical psychologists. These studies highlight that White clinical psychologists recognise the dominance of Whiteness in the profession and the benefit of White privilege but find it difficult to contend with their unearned advantage of being White (Ahsan, 2020; Williams, 2022). White privilege refers to the unearned rewards afforded to White individuals based on their skin colour (McIntosh, 1988) and has been posited to contribute to the overrepresentation of White clinical psychologists in the profession (Ragaven, 2018; Odunsanya et al., 2017).

White psychologists also recognise issues with Whiteness in therapy, but report feeling too ashamed, anxious, and uncomfortable to address race with patients or supervisees (Ahsan, 2020; Ong, 2021; Williams, 2022). In addition, White clinical psychologists in Ong's (2021) study recognised that Whiteness was not discussed in supervision with White supervisees, and only discussed when global majority supervisees raised it. This further highlights the invisibility of Whiteness for White people, as well as the burden placed on global majority clinicians in the profession to champion discussions on race and racial equity (Eddo-Lodge, 2017; Wood & Patel, 2019). Racism is relational as it involves the unfair advantaging of those racialised as White and the systemic disadvantage of global majority

groups (Jones, 2000). Therefore, when studying racial inequity, attention should not only focus on those harmed by racism, but those who benefit from inequities (Lipsitz, 2018). Thus, there is a strong rationale for understanding the experience of White ACPs, whose voices remain unheard within the literature.

### **Underpinning Theories and Epistemological Position**

I conceptualised and conducted my research within a constructivism-interpretivism research paradigm. Central tenets of constructivism-interpretivism include (1) reality is constructed through an individual's mind (Hansen, 2004), (2) the meaning of experiences is hidden and can be accessed through reflection (Ponterotto, 2005), and (3) the researcher is a co-constructor of findings alongside participants (Ponterotto, 2005). The purpose of interpretation is to reveal the meaning hidden in the data obtained through scientific investigation; however a researcher's lived experiences "cannot be divorced from the research process" (Barrett, 2009; Ponterotto, 2005). Thus, I recognise my influence, as a Black African trainee clinical psychologist and previous ACP attempting to understand ACPs' experiences, on the joint co-construction of findings in this research (Kirkpatrick, 2020).

Consistent with constructivism-interpretivism, I used interpretative phenomenological analysis (IPA) to design, conduct, and analyse my study findings. IPA is an existential phenomenological approach that focuses on understanding how individuals make sense of their lived experience and attempts to gain an "insider's perspective" (Smith et al., 2022; van Manen, 1997). IPA engages in a double hermeneutic where the researcher attempts to understand the participants' attempts at meaning-making (Smith et al., 2022). In this study, participants' stories, accessed through language and meaning-making activities, formed the basis for learning about their relationship to their NHS career trajectory and lived world (Smith et al., 2022).

Within constructivism-interpretivism, a researcher attempts to understand the world of human experience not only through their own view, but through the assumptions within their underlying theoretical framework (van der Walt, 2020). My work calls upon critical race theory (CRT), which is a set of theories that acknowledge the multifaceted nature of discrimination and promote an intersectional approach by seeking to understand how gender, race, and class together impact the experiences of global majority groups (Donnor & Ladson-Billings, 2018).

The term intersectionality refers to how individuals exist along multiple dimensions of identity and social systems which interact with one another to produce inequity (APA, 2020; Crenshaw, 1989). Whilst the main axis of difference considered in this study is race, I adopted an intersectional approach by also considering how gender, class, nationality, and ethnicity interacted to shape participants' experiences. Furthermore, CRT considers racism as a systemic force embedded in everyday society, rather than a problem of individual bias, and proposes the practice of counter-storytelling to highlight racialised bases of everyday experiences (Salter & Adams, 2013). Counter-storytelling is where marginalised groups' stories are platformed to expose, analyse, and challenge the dominant race discourse (Solórzano & Yosso, 2002). I applied these principles in my attempt to understand participants' experiences of applying to prequalification roles and working in the NHS.

### **Summary**

As evidenced in the literature presented, racial inequity exists both within the clinical psychology profession and the broader NHS. Whilst racial diversity within the clinical psychology profession has increased in recent years, the voices of global majority ACPs remain unheard. The few studies that have explored the experiences of global majority ACPs highlighted how the NHS context gave rise to issues of racism, discrimination and Whiteness which has a negative impact on global majority ACPs. The BPS (2019) states that clinical

psychologists are trained to deliver interventions that “aim to minimise exclusion and inequalities and enable patients to engage in meaningful interpersonal relationships and commonly valued social activities such as work”. To better the quality of mental health services for patients, the workforce must be able to meet patients’ needs, both in representation and cultural sensitivity. To achieve this, we must examine the employment and experiences of ACPs who are embedded in the NHS, including both those who benefit and those who are disadvantaged by the Whiteness that dominates the profession.

### **Aims and Research Question**

This study sought to utilise a phenomenological and CRT framework to understand the experiences of Black British ACPs and their White British counterparts, as respectively underrepresented and overrepresented racial groups within the profession. Using information gleaned from this study, I aimed to identify targets for change within the clinical psychology profession and broader NHS. To address these study aims, I investigated the research question “How do ACPs working in the NHS experience and make sense of their pre-qualification career trajectory, and how does this vary by race?”

### **Study Overview**

I designed a qualitative study and conducted two racially homogenous online focus groups, with each group consisting of five ACPs (i.e., either White British or Black British). I aimed to start a discussion on participants’ experience of recruitment to ACP roles in the NHS, their current role, and their experience of actual and desired support for progressing onto the DclinPsy. I video-recorded and transcribed the focus groups, and analysed data using IPA adapted for focus groups (Love et al., 2020; Palmer et al., 2010; Smith et al. 2022).

## **Method**

### **Ethics**

Royal Holloway, University of London Research Ethics Committee granted ethical approval for this study (REC Number: 3084, see [Appendix A](#)).

## **Design**

I employed a qualitative design in order to understand participants' experiences. I ran two racially homogenous online semi-structured focus groups with ACPs from Black British and White British backgrounds. I decided to conduct focus groups to reduce the power imbalance often present in individual interviews, and help participants feel psychologically safe when discussing sensitive topics such as race (Daniel et al., 2001; Love et al., 2020). This was important given the global majority status of one of my groups, as well as my position as a trainee clinical psychologist, meaning that I occupied the position that participants were working towards.

## **Participants**

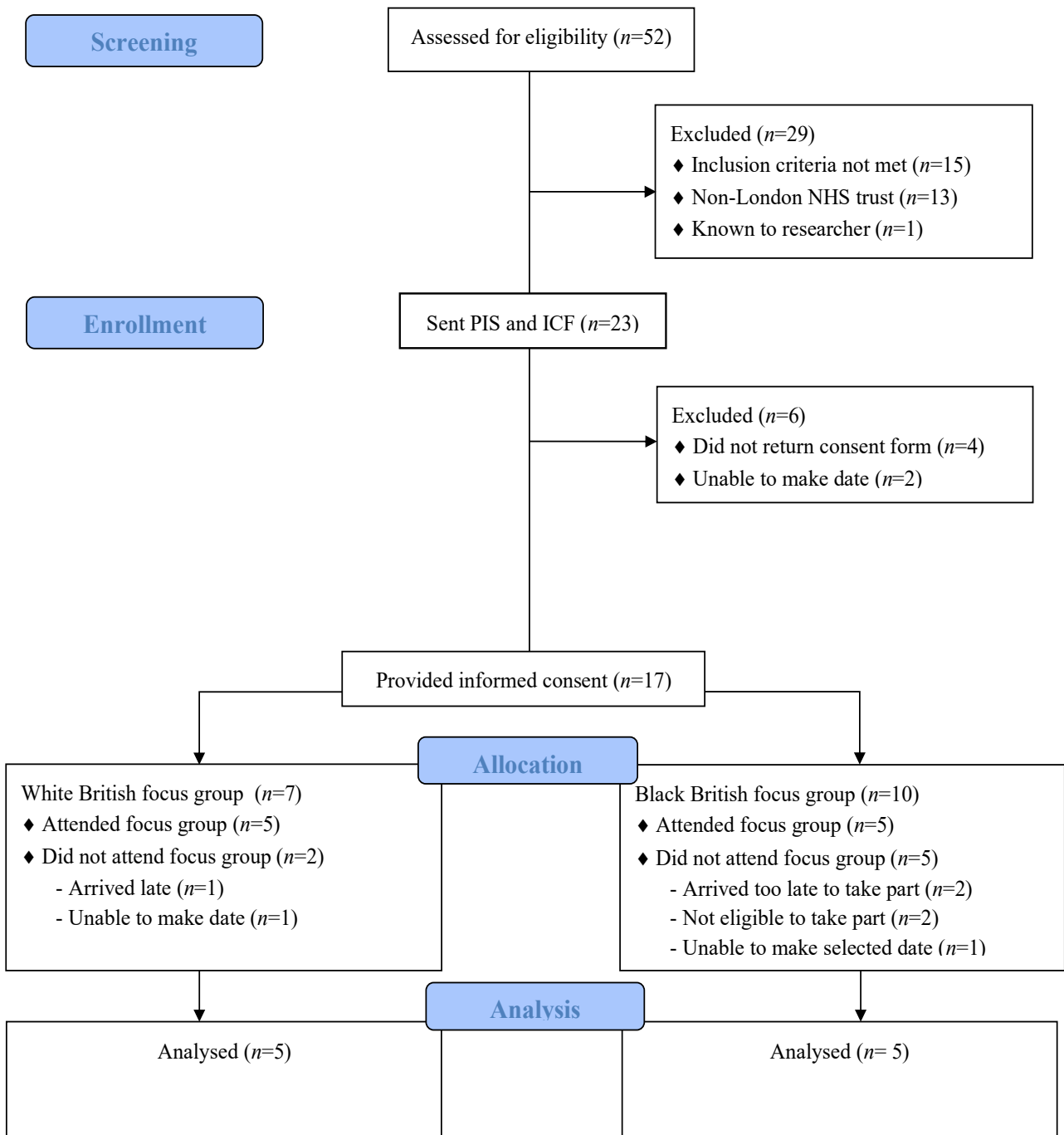
I aimed to recruit 4-5 participants per group, based on recommendations for group size in IPA (Smith et al., 2022). I used purposive sampling with predetermined eligibility criteria (see [Figure 1](#)), which were selected to ensure that participants had sufficient lived experience to engage in a group discussion. I recruited participants by sharing the study poster and advertisement across social media and professional networks ([Appendix B](#)). I used this method rather than recruiting directly through NHS Trusts (i.e., participants' employers), to encourage participation without concern of impact on employment.

## Figure 1

### *Empirical Study Eligibility Criteria*

<p><u>Inclusion criteria</u></p> <ul style="list-style-type: none"> <li>▪ Self-identify as Black British or White British</li> <li>▪ Can be of Mixed heritage as long as they identify as Black</li> <li>▪ Aged 21 years or older</li> <li>▪ Has at least 6 months' experience of working in a relevant NHS pre-qualification role</li> <li>▪ Currently pursuing a career in clinical psychology via entry onto a UK DClinPsy course</li> <li>▪ Holds Graduate Basis for Chartered Membership status</li> </ul> <p><u>Exclusion criteria</u></p> <ul style="list-style-type: none"> <li>▪ Does not self-identify as Black British or White British</li> <li>▪ Currently undertaking or has recently graduated from a DClinPsy programme</li> </ul>
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Individuals interested in participating contacted me via email; I sent them the participant information sheet ([Appendix C](#)) and a link to the online screening questionnaire ([Appendix D](#)). Based on responses, I invited eligible participants to complete the informed consent form ([Appendix E](#)). I created two racially homogenous focus groups from participants who provided informed consent. I considered participants' availability and group homogeneity when selecting participants. For example, I selected participants that worked in London due to the region's racial diversity, which provided participants with a context for discussing race in clinical psychology (Ross et al., 2020). I aimed for a gender distribution representative of the clinical psychology profession. I over-recruited by 75% for each focus group to pre-empt last minute unavailability. [Figure 2](#) shows the full flow of study participants.

**Figure 2***Recruitment Flowchart*

Ten ACPs from Black British ( $n=5$ ) and White British ( $n=5$ ) backgrounds participated in the study. Participants' average age across both groups was between 25-29 years and representative of DclinPsy applicants (CHPCCP, 2021). Across both groups, four out of five participants identified as female, representative of the gender distribution within clinical



psychology (HPCC, 2021). All participants were currently working in a London NHS Trust.

[Table 1](#) shows participants' sociodemographic characteristics and prequalification experience.

**Table 1**

*Participant Demographic and Questionnaire Data*

Pseudonym	Race	Gender	Age (Years)	Role	Time in Role (Months)
Amarachi	Black	Female	20-24	Assistant Psychologist	6
Campbell	Black	Male	25-29	Trainee Psychological Wellbeing Practitioner	11
Isioma	Black	Female	25-29	Trainee Psychological Wellbeing Practitioner	12
Tolani	Black	Female	20-24	Assistant Psychologist	12
Whitney	Black	Female	35-39	Assistant Psychologist	10
Imogen	White	Female	25-29	Assistant Psychologist	10
Josh	White	Male	30-34	Assistant Psychologist	18
Nancy	White	Female	20-24	Assistant Psychologist	12
Rachel	White	Female	25-29	Assistant Psychologist	6
Vicky	White	Female	35-39	Assistant Psychologist	4

*Note.* Time in role reflects time in current job at only, all participants had at least 6 month's prequalification experience in the NHS.

### Procedure

I developed a focus group topic guide (see [Figure 3](#)) through consultation with an ACP expert-by-experience (EBE) and an assistant moderator (N.S.) who was a qualitative researcher with experience conducting focus groups. We worded questions to prompt discussion of experiences throughout participants' career trajectory, from NHS recruitment to prequalification roles and desired DclinPsy progression. Follow-up prompts were only used in response to experiences shared and where relevant.

### Figure 3

#### *Focus Group Topic Guide*

**Framing Question (1) What do you think of when you hear the phrase ‘pre-qualification roles’ and what has been your experience of applying for such roles in the NHS?**

Prompts:

- What support, if any, did you receive during the application process and from who?
- In what way, if at all, did you consider your ethnic background when applying for these positions?

**Framing Question (2) What was your experience of the NHS recruitment process for your current role?**

Prompts:

- In what way has your ethnic background and/or gender been a strength or a limitation in the recruitment process?
- What potential barriers do you feel applicants from different ethnic backgrounds and/or gender groups may face during recruitment?

**Framing Question (3) What has been your experience of your current pre-qualification role?**

Prompts:

- How do you think your response might differ if you belonged to another ethnic background or gender group?

**Framing Question (4) What forms of support, if any, for progressing onto DClInPsy training are there in your workplace?**

Prompts:

- How did you find out about the forms of support available?
- What challenges, if any, have you experienced with this form of support?

**Framing Question (5) What forms of support for progressing onto DClInPsy training would you like to see in your workplace?**

Prompts:

- What one thing would help people from your ethnic background and/or gender group progress onto DClInPsy training?
- Are there any support structures you think would be helpful for aspiring clinical psychologists from other backgrounds?

**Framing Question (6) Of all the different things we discussed, which is the most important to you?**

I facilitated the focus groups with the support of N.S. (i.e., assistant moderator). Prior to the focus groups, I asked participants to find a space where they felt comfortable and would not be interrupted, and to keep their cameras on during the discussion to promote a sense of safety and to allow for accurate transcription. At the start of each focus group, I informed participants that N.S. would be available to talk privately to anyone that experienced distress during the discussion. I hosted and recorded the focus groups on Microsoft Teams and allocated 2 hours for each group: 90 minutes for discussion, a 10-minute comfort break, and 15 minutes for debrief. During the debrief, I provided participants with a space to reflect on their experience taking part and raise any concerns about the study. Following the focus groups, I emailed participants the participant debrief sheet (see [Appendix F](#)) and a secure payment link for £15. Participants signed and returned the payment receipt to me via email (see [Appendix G](#)).

### **Analysis**

I transcribed and analysed the data using IPA adapted for focus groups (Love et al., 2020; Palmer et al., 2010; Smith et al. 2022). IPA is underpinned by a strong idiographic philosophy as it focuses on how individuals experience and understand phenomena in their everyday lives (Smith, 2011, Smith et al., 2012). Focusing on the individual is essential in my study to ensure that I am privileging individual accounts rather than simply homogenising experiences based on race as done in previous studies. Furthermore, the hermeneutic circle ascribed to in IPA argues that to understand the part, one must examine the whole, and to understand the whole one must examine parts (Kirkpatrick, 2020; Smith et al., 2012). Thus, IPA balances the need to amplify individual voices whilst simultaneously find meaning and patterns across a sample. This contrasts with other qualitative methods which were considered but not selected for this analysis, such as Thematic analysis, which aims to identify patterns across a dataset (Braun & Clarke, 2006). IPA also recognises that human

experiences are informed and shaped by social processes, which is in line with the constructivism-interpretivism and CRT framework underpinning this study (Salter & Adams, 2013). I followed standard IPA procedures including a) immersion in the data through reading and rereading transcripts, b) making initial exploratory notes on transcripts, c) analysing exploratory comments to construct experiential statements, and d) identifying group experiential themes by analysing connections across statements (Smith et al., 2022; Tomkins & Eatough, 2010). These processes were not followed step-by-step because IPA is an iterative process (see , Analysis Plan). Furthermore, due to the study's multi-perspective design (i.e., two racially different groups), I adapted my analysis so that the focus group discussion, as opposed to the individual participant, formed the unit of analysis (Tomkins & Eatough, 2010). I conducted the analysis for each group separately until step seven, where I made cross-group comparisons (see , Audit Trail).

Using IPA to analyse focus group data can help to enhance individual accounts through shared dialogue between group members (Love et al., 2020; Smith, 2011). However, the use of IPA with focus group data has been criticised due to challenges with privileging individual accounts, which can be overshadowed by the dominant group narrative (Palmer et al., 2010; Tomkins & Eatough, 2010). To account for this, I incorporated additional iterative steps into my analysis plan to ensure that the idiographic accounts were privileged. This included rereading each participant's involvement in their focus group as a unified whole, and noting which elements of themes participants' accounts emphasised and what was not represented (Tomkins & Eatough, 2010). I also created matrices for the level of group consensus for each theme (Onwuegbuzie et al., 2009; Sandelowski, 2001).

### **Methodological Integrity**

To elicit strong data, I ensured good interviewing by utilising my clinical skills of confidentiality, a non-judgemental stance, and using friendly nonverbal communication

(Smith, 2011). I also ensured rigour in my reporting by presenting information on convergence and divergence, representativeness, and variability both within and between focus groups (Nizza et al., 2021; Smith, 2011). A researcher (I.N.) with no involvement in the study reviewed the initial noting, group experiential statements (GES), and GETs from a section of one transcript. Whilst there was broad agreement, based on I.N.'s feedback, I reviewed both transcripts and conducted further reading to ensure greater depth in my interpretative comments. I also discussed the development and interpretation of themes with other qualitative researchers, the assistant moderator (N.S.), and EBE<sup>1</sup>.

### **Positionality**

As acknowledged in the underlying epistemological framework and selected methodology for this study, my perspective as a researcher forms part of the study design, data analysis and interpretation (Ponterotto, 2005; Smith et al., 2012). Thus, it is essential that my positionality is acknowledged at this stage to help readers understand how my different positions have influenced the nature and outcomes of this study. I identify as Black British Nigerian woman from a working-class background. I grew up and went to school in predominantly White neighbourhoods in the UK. I also witnessed and experienced the impact gentrification, and the difficulties of living in multi-ethnic towns where racial tension is high. Unsurprisingly, this means I have experienced racism both within my personal and professional life. My motivation to undertake this research was born out of my own experience of bullying and racial discrimination whilst working in the NHS as an aspiring clinical psychologist.

My own experiences mean that I have been in a similar position to my research participants (i.e., an aspiring clinical psychologist at pre-qualification stage), and thus need to

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<sup>1</sup> Participant validity checks were not conducted based on strong epistemological arguments for not doing so when conducting IPA (Smith, 2004).

exert caution in facilitating and interpreting findings from focus groups. It is important that I am able to take a step back, remembering that this is not about me, but is about amplifying voices that are often marginalised within the profession in order to create positive change. My position also means that I have my own understanding of how race plays a part in recruitment and work experiences within clinical psychology and the wider NHS. As outlined in the introduction, my understanding of race, Whiteness and the different intersecting identities is influenced by critical race theory.

### **Reflexivity**

I completed a self-reflexive interview before the first focus group (see [Appendix J](#)). These questions, posed by N.S., allowed me to engage with, acknowledge, and put aside my preconceptions about the data (Love et al., 2020; McCormack & Joseph, 2018; Shaw, 2010). I reviewed the self-reflexive interview again before data analysis and monitored my field notes after each group. I incorporated any identified biases or changes in perception into my analysis, for example acknowledging how my own experiences meant that I anticipated racial identity would be experienced as a challenge, rather than positive, among Black British participants.

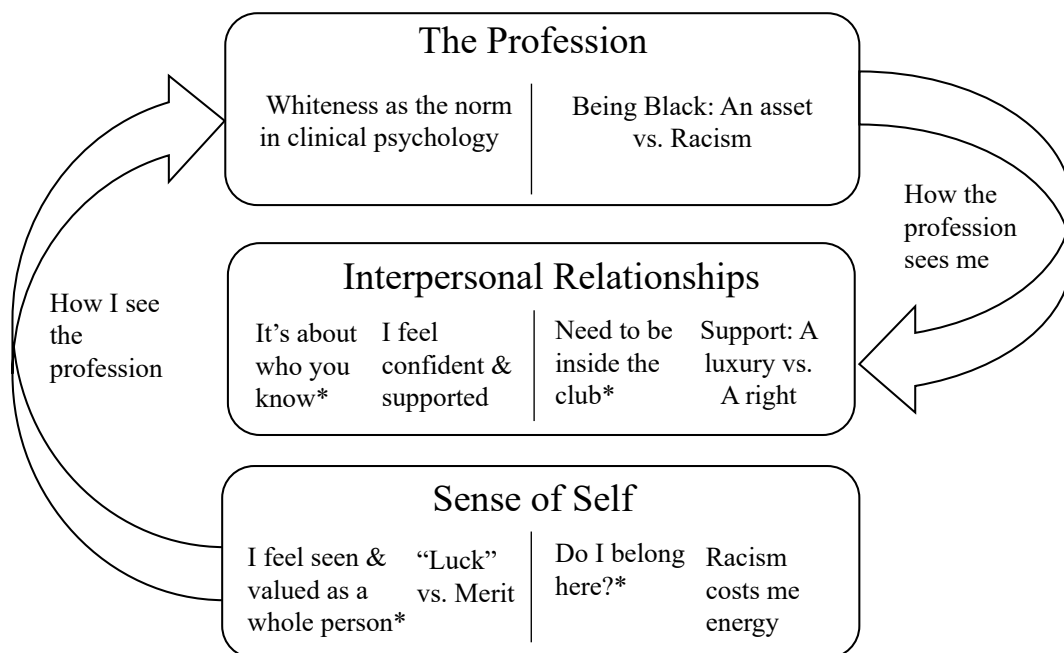
I kept a reflexive journal throughout the research process to engage in metacognition and process my emotions from conducting the study (Etherington, 2004; Randall, 2019). This was an important way to reflect on my own positionality as a Black British Nigerian, female, trainee clinical psychologist facilitating focus groups for ACPs. My positionality was acknowledged and incorporated throughout all stages of the research process from the study design, data collection, through to analysis and reporting. I met with a range of peer and experienced qualitative researchers throughout the research process to engage in further reflexive thought and gain diverse perspectives on the research.

## Results

I identified five group experiential themes (GETs) in both the Black British and White British focus groups (see [Figure 4](#)). Only a subset of GETs are presented to allow sufficient elaboration on each theme (Smith, 2011). The level of consensus for each GET is presented in [Appendix K](#). Three whole-group themes emerged, as participants described and made sense of their pre-qualification career trajectory in relation to 1) the profession, 2) interpersonal relationships and 3) sense of self. Additional illustrative quotes and supplementary GETs appear in [Appendix L](#).

**Figure 4**

*Diagrammatic Formulation of Focus Group Themes*



*Note.* \*Supplementary GETs (see [Appendix L](#))

### Group Process

Group cohesion formed quickly across both focus groups, evidenced through turn-taking and identification with each other's experience, based on participants' shared identity as ACPs working towards the DClInPsy. For Black British participants, part of this group cohesion was due to race, and participants made explicit references to the group's racial

identity. In the Black British group, Isioma spoke the most, followed by Amarachi, often initiating the discussion. Whitney spoke in response to other participants' contributions and rarely initiated discussion. Tolani was a quieter member of the group, developing other participants' narratives with her own perspective. In the White British group, Imogen spoke the least and appeared more to be actively listening to other participants. Rachel, Nancy, and Vicky spoke a similar amount, often building on each other's accounts.

Male participants across groups adopted different roles. Campbell, in the Black British group, spoke the least and always allowed other participants to talk first; whereas Josh in the White British group dominated the discussion. It is difficult to gauge how much of this is due to personality, race, or gender as males within a female-dominated profession. Further comparisons between male participants across groups is beyond the scope of this study. As the focus groups were hosted online, information on eye-contact, gesticulation, and other non-verbal communication was limited, but I recorded them in the transcript where relevant. During the debrief, participants across both groups reported valuing taking part in the study, as it provided them with an opportunity to connect and reflect with other ACPs on a similar journey.

### **Theme 1 – The Profession**

Whilst both groups discussed racial disparities in the workforce, these discussions manifested in different ways. White British participants focused on the dominance of 'Whiteness' in the profession in relation to their sense of belonging. In contrast, Black British participants navigated the conflict in perceiving their race as an asset to the profession but experiencing racism at work.

#### ***White British GET: Whiteness as the Norm in Clinical Psychology***



White British participants were upfront in naming that clinical psychology is dominated by White women. Participants also highlighted their sense of belonging, as their racial identity meant that they “match” (Vicky, 232) other psychologists.

All of the other people I was working with in the psychology departments there were [pause] White and either British or European [Nancy, Rachel, and Imogen nod]. But all of the staff outside of the psychology department are all Black or of colour [Nancy, Rachel, and Imogen nod]...you seem to stand out as the psychology department, it's quite obvious when you're in an MDT [multidisciplinary team] who the psychology staff are and who isn't psychology staff. (Vicky, 221-227)

Vicky experiences a sense of racial cohesion within her psychology team, but the stark contrast to other members of the MDT makes her uncomfortable. Vicky could be alluding to the idea that ‘Whiteness’ is not just about race, but other markers such as nationality, language, and culture. Participants noticed patterns across intersections of race and gender, and the types of roles people occupied.

If you come in for an interview and all you see in staff is just purely White, staff is pretty bloody off putting to be honest...it's always myself and my colleagues on reception. So it's either...just two White faces or the clinical administrator who's Black, who's band 3 and we're band 4. And it also just sends immediately a message without even speaking a word. (Josh, 283-285)

Josh's account suggests racial segregation and hierarchy exists in the NHS, and he discusses banding, which reflects seniority and pay. Rachel echoed this in describing a racial split in clinical and non-clinical roles “so it sometimes you sit in team meetings and the split is literally White women, Black man” (Rachel, 351-357). Josh appears to imply that this “unspoken message” about who belongs in the profession might influence global majority

applicants during recruitment. An undercurrent in participants' narratives was that global majority ACPs were actively self-selecting out of the profession, as implied by Imogen.

I might even be disenfranchised with the whole process because I'm like, 'well, I'm not seeing people [pause] you know that that look like me from the same background as me. What's the point of me maybe trying?' And maybe that's partly one of the reasons why some people, well, pretty much all the people that I work with in psychologist, roles are White. (Imogen, 843-847)

The word "disenfranchised" suggests that Imogen acknowledges the systemic barriers faced by global majority ACPs, yet simultaneously she demonstrates her unconscious bias as she believes global majority ACPs are self-selecting out of the profession. In contrast, other participants appeared to understand that being "non-White" (Nancy, 760) was an additional barrier for global majority ACPs and explicitly recognised the impact of Whiteness in the profession.

If you were male as well and if you were kind of not White, actually if you went into a session with somebody and was working with somebody and they brought something up about the fact you were male, or about the fact you weren't White, or about the fact you were LGBTQ plus. It's it's actually who would you go to for support? Because no one supervising you would be of the same gender or ethnicity or kind of background...so I guess that would be quite hard (Rachel, 499-506).

Rachel hypothesises how provision of support might be based on supervisor's racial identification with supervisees, thus global majority ACPs are unlikely to receive support following racism. Rachel seemingly recognises the intersection of gender and how men are a minority in psychology.

***Black British GET: Being Black - An Asset Versus Racism***

Black British participants appeared to experience conflict in trying to make sense of their place within clinical psychology. When asked whether their racial background was a strength or limitation, participants unanimously named their race as a strength.

Just like identifying as say a um Black male, it seems like I mean, people recognise that like...there's not that many like Black males going into like psychology, so people seem pretty willing to help me [Isioma and Whitney nod], so I consider that as like more of a strength than anything. I'm like grateful for that. (Campbell, 239-243)

Campbell describes being grateful towards the profession almost as if he is finally being seen and let “in the club” (Amarachi, 725) of clinical psychology (see [Appendix L](#), theme: ‘Need to be inside the club’). I interpreted this as resulting from the profession’s messages about the need for greater racial diversity, as described by Isioma.

There's a lot of conversation about like, outreach work [Amarachi nods] and what can we do to diversify um the not just the staff, but how can we attract, you know more, people from diverse backgrounds to actually access um IAPT [Improving Access to Psychological Therapies]. And it is a bit like frustrating to see, just like if you're whenever they're recruiting a new group of people...and it's like it's *still* not representative of the people that they are trying to serve. (Isioma, 317-322)

Isioma demonstrates conflict in feeling part of her team, evidenced by her hesitancy and shifting use of language, as she states “we” then quickly corrects herself to say “they”, positioning herself outside of the team. Isioma highlighted how the profession’s declarations of a desire for a diverse workforce differed from actual recruitment practices. This was experienced as “frustrating” (Isioma, 319) by all participants as they recognised that as Black British ACPs they brought unique skills and value to the profession.

I found that now in the room... I'm able to bring those nuances of their culture to like MDT [multidisciplinary] discussions when it might be people of different races that

might not understand, like someone from like a Nigerian background or maybe a West African background, which I'll be quite privy to as being a West African woman from Nigeria. (Amarachi, 251-256)

During the discussion, Amarachi made repeated references to the profession as a physical space that was difficult to gain access to “when you got into your position then you have access to information, but before that it's like there's a barrier like you have to kind of be in the club to kind of get all the information” (Amarachi, 723-725). Yet, once entry was gained participants experienced microaggressions, racism, and isolation and felt that they stood out like “a sore thumb” (Tolani, 370), which appeared to create conflict.

One of the psychologists actually, unfortunately is a clinical psychologist, was a bit racist towards me [Tolani nods] and I thought that that team have provided the right support [Amarachi and Isioma nod] and I feel *really, really* supported [Amarachi, Isioma and Tolani nod]. (Whitney, 409-412)

On one hand, Whitney experienced a distressing racist incident, which appeared to be significant for her as she mentioned it multiple times. On the other hand, Whitney described feeling supported and valued by her team following this incident. Feeling supported was not a shared experience by the group (see GET ‘Support: A luxury versus A right’ below). Other participants however, described how working in diverse teams was a protective factor as this reduced worries about racism and enhanced their confidence in their clinical competencies (see [Appendix L](#), ‘Do I belong here?’).

## **Theme 2 – Interpersonal Relationships**

Participants’ experience of interpersonal relationships impacted their NHS career trajectory. White British participants felt connected to and supported by a network, whereas most Black British participants felt excluded and found support hard to access.

### ***White British GET - I Feel Confident and Supported***

A collective narrative developed among White British participants that they received high levels of support from peers, colleagues, and supervisors. Supervisors were an important source of support:

We'll have supervision and I'll reflect on something she'll be like, 'Yes! Put that in your application...That sounds great'. And also looking out for opportunities to do research stuff. She's always doing that...actively looking out for things for me to help with that she knows will help my doctorate. (Imogen, 631-636)

Imogen emphasises how proactive her supervisor is in supporting her to apply for the DClinPsy. Imogen's tone indicates excitement, her emphasis on the word "knows" and describing this as an "opportunity" suggests confidence that this support will be instrumental in her successfully gaining admission to the DClinPsy. Imogen valued mentorship, and provided multiple examples of being mentored, for example, meeting an Assistant Psychologist who "taught" her how to apply for different pre-qualification roles (Imogen, 68). Peer support also increased participants' confidence.

[I] have four other APs [Assistant Psychologists] that I work with. So we have like peer support sessions, which I find really useful just to kind of decompress and also talk about kind of where we're at with our applications...we have a really nice like kind of relationship together so it doesn't feel, it feels more that we're helping each other out rather than there being an element of competition. (Nancy, 566-571)

Nancy uses the word "decompress" suggesting that the work environment is experienced as pressurised and the opportunity to meet with peers is a space where she can be closer to her true self. In an almost identical narrative, Vicky described having harmonious peer support and emphasised a lack of competition.

We do a journal club to upskill us and it's there's no competition between us. We just all want to help each other to get onto the training and it feels really good...which makes

a huge difference I think, having support from people that are trainees or qualified already, but also from peers that that combination is really really, beneficial and helpful. (Vicky, 585-590)

Similar to other participants, Vicky describes receiving support from different parts of her professional network. In contrast, participants also described support as fragile and limited “I've just felt so lucky to be there, but I didn't want to like not really rock the boat, but I didn't want to ask too much of the people around me” (Nancy, 110-111). This fragility was particularly evident in relationships with supervisors. For example, Rachel describes feeling uneasy asking her supervisor for time off to attend a trust-wide ACP group.

My manager's not wild on let me kind of leave early... I definitely found that in my first sort of couple of months when I was still a bit new, didn't really want to ask not to be on the rota that day...I was a bit like, ‘Ohh, I won't go to this one’...you know when you're in that first, like starting bit [All other participants nod]. So yeah, that was probably a barrier initially [Josh & Vicky nod]. (Rachel, 670-677)

Thus, despite expansive networks and support described by participants, support appeared to be understood as a finite resource. This view was only shared by female members of the group, as Josh was explicit in stating “I can't see anyone in my service not feeling able to go and ask for help because it is a very tight knit service” (Josh, 613-614). This could potentially reflect a workplace gender stereotype in which assertiveness and ambition are seen as more acceptable in men compared to women (Heilman, 2001). Similarly, despite being a gender minority among both focus group participants and the clinical psychology profession, Josh appeared confident in navigating prequalification roles and interpersonal relationships.

***Black British GET - Support: A Luxury Versus A Right***

Black British participants felt that instrumental support for DCLinPsy progression was hard to access, and participants placed responsibility on themselves to be proactive.

I've had to go outside of my role [Isioma and Tolani nod]. So like I have to go to a clinical psychologist from my old trust to ask her for support... I've tried asking like clinical psychologist in my current role and um all they can tell me is, 'Oh, just keep trying. You'll get on one day.' [Tolani curls her bottom lip, Isioma and Whitney smile] and I'm just like that does not help me right now [Amarachi, Whitney, and Isioma laugh]. (Campbell, 543-549)

Campbell's repeated use of the phrase "had to" potentially reflects his feeling that this was his only option. The other participants' reactions suggested annoyance and identification with being dismissed by supervisors. For example, Amarachi described support for DCLinPsy progression as ad hoc and limited "when I first started, my supervisor let me know like how much she can help. And then just signposted me to the AP [Assistant Psychologist] like peer supervision group" (Amarachi, 617-618). Whitney is not represented in this GET (see [Appendix K](#), Consensus Matrix) as she described her supervisor as "responsive" (Whitney, 233) in supporting her to prepare for DCLinPsy applications.

Similarly, participants, with the exception of Whitney, felt unsupported after experiencing racism at work, as they were left to process this alone. This is related to the GET 'Racism costs me energy' explored in Theme 3. Participants may have attempted to resolve their conflicting experiences of support by a desire for mandatory support structures.

So kind of similar to what Amarachi just said, just kind of having like a like a formal structured scheme where it involves clinical psychologists and like to maybe meet up like once a month to kind of discuss any personal issues they kind of encourage you to reflect. And yeah, they just kind of that one to one support to kind of guide you in that process. (Tolani, 745-749)

In detailing her desired support for DCLinPsy, Tolani alludes to the lack of guidance and challenges she has experienced along her career trajectory. The desire for formal support and connection highlights the isolating experience of participants' journey. This may have led to the overwhelming responsibility participants placed on themselves to advocate for, mentor, and "bring up" (Whitney, 140) other Black ACPs, because they understood that no-one else would. Similarly, participants looked for support from other Black clinicians where possible.

It's been clear to me, obviously maybe I shouldn't do this visually, I can see and usually predict whether there's going to be support from someone [inflection] who's in, in, in a position. So if they look like, you know, they come from a similar background, I found that they've usually been quite *willing* to provide that support or that advice. (Isioma, 196-200)

Isioma appears to be expressing two beliefs: she anticipates discrimination from White clinicians, and she finds safety and support among those that look like "you" in reference to the shared racial identity of the group (i.e., including both moderators). Isioma's emphasis on the word "willing" suggests that she feels like a burden when asking for support, hence when received it feels like a luxury.

### **Theme 3 – My Sense of Self**

This theme captures participants' sense of belonging and competency as psychological practitioners. Both groups experienced challenges in relation to their professional identity. Black British participants experienced an erosion of their sense of self as experiences of racism cost them "mental energy" (Isioma, 458), whereas White British participants battled with the influence of race on their career trajectory so far.

#### ***White British GET - "Luck" Versus Merit***

Participants acknowledged that the profession was dominated by Whiteness but found it difficult to acknowledge that *their* being White conferred an advantage. Rachel



demonstrates this in response to the question “In what way do you feel either your ethnic background or your gender identity has influenced your recruitment process?”.

So my job at the moment, I think I probably *did* have more experience than anyone else applying because I've done a very similar job before...but at some point I think the fact that I'm a White woman has probably benefited me getting into psychology. (Rachel, 208-214)

Rachel could be experiencing threat caused by the idea that anything other than her hard work played a part in getting her role, as this could bring into question her merit as a clinician. It appeared important to participants that they had independently earned their place within the profession without White privilege. Participants appeared to use different strategies to resolve this conflict including highlighting “really difficult” (Vicky, 49) recruitment experiences.

My experience of applying for particularly assistant psychologist roles has been tough and lengthy...um, it definitely took a long time to hear anything back, ended up getting one interview, and then luckily got that job. So I'd say it's quite an exhausting process...it does kind of get easier over time, but especially that initial like getting your foot through the door is really, really tricky. (Nancy, 13-20)

Nancy uses the metaphor “getting your foot through the door” and repetition of “really” to emphasise how challenging she found recruitment. However, once entry was gained, participants appeared to easily navigate professional relationships, build support networks, and progress. Nancy uses “luck” to describe being successful. Throughout the discussion, participants used the word “luck” almost as a synonym for privilege “I'm really lucky to be able to finance that” (Imogen, 124).

Another potential strategy was rationalising that there were not many “diverse” (Josh, 828) applicants to begin with “the issues around [inhales] ethnic diversity and gender stem

way before the DClin. Um, and way before even being APs [assistant psychologists] or...other kind of like entry level positions” (Josh, 823-826). Nancy echoes this and mocks clinical psychology’s declared intentions of diversifying.

It's all well and good and saying ‘Oh yeah we should recruit more people from diverse backgrounds’. But if 80% of the psychology graduates in the UK are White then your pool of diversity is pretty small already. Umm but yeah doesn't mean we shouldn't try, but just a thought [laughs]. (Nancy, 852-863)

Nancy laughs nervously as she identifies as part of the profession, thus potentially part of the problem. Other participants appeared uneasy discussing race; they were less coherent “but that's that's quite a roundabout answer [chuckles]” (Rachel, 214-215), unsure of themselves “I'm not sure how relevant it is to the to the conversation” (Vicky, 229-230), and used humour/sarcasm “the majority of the psychologists I work with are White women. Um. Yeah, I'd agree [Nancy and Rachel laugh and smile at each other]” (Nancy, 217-218). During the focus group, Vicky was the first participant to reflect on her White privilege.

It's struck me as something I've noticed before, but when we we're talking about identity. I think being a White female probably has helped because everyone else in my current team and my current role is is White female. So I match, but that that shouldn't be how it is [pause] hmm. (Vicky, 230-233)

Vicky uses the word “struck” to potentially illustrate a sudden awareness as she engages in live reflection and comes to the realisation of her privilege as a White woman in psychology. Towards the end of the focus group, the narrative began to change. By reflecting on the discussion and each other’s contributions, participants began to recognise their own position of privilege “I've never really thought of it like that, I guess” (Rachel, 764). Imogen illustrates this point clearly.

I applied for the DClin first time last year, but I wouldn't have done that until getting the experience I have. And I've most likely *got* the experience I have because I'm a White woman. I'm sure that's definitely come into it. (Imogen, 836-839)

There is a sadness in Imogen's tone as she shares this reflection, this could be associated with the realisation that we live in a society whose structures uphold and maintain racism, or could that for Imogen recognising her privilege may call into question her merit as a clinician.

### ***Black British GET – Racism Costs Me Energy***

Black British participants reported that anticipating and experiencing racism in their workplace added an additional layer of anxiety “If I were White like perhaps like, I feel like. I'd feel less self-conscious” (Campbell, 519-520). Participants were explicit in that experiences of racism were draining and impacted their ability to be their authentic selves at work.

I'm always changing my hair, this is something that I always do...one of my newer supervisors' like ‘Oh my God, you keep changing your hair!’ and even that is it's just a small comment. But then that's like I'm like, ‘Oh, should I say something? Oh does she does she know what she means? Is this something I need to pay attention to in the future?’ (Isioma, 460-465)

Isioma relays the intrusive cognitions that were triggered after experiencing a microaggression from her supervisor. Isioma may have shared this incident to highlight the importance of her hair in relation to her identity, and how this microaggression potentially created a sense of being policed. Similarly, anticipating racism also cost participants energy, as described by Tolani.

I was working on an older adult ward and all the patients were White there and kind of, yeah, just worrying about oh you know, ‘How am I gonna work with these people? Are

they going to have some of the like outdated views?' [Whitney, Isioma and Amarachi nod] and sometimes some of them have been and been like, 'Oh, I don't wanna work with you' and haven't explicitly stated why. But like I kind of know why. (Tolani, 508-513)

As Tolani describes the different thoughts she had during this encounter, she creates a sense of exhaustion. This experience may have also caused Tolani to question her legitimacy as a psychological professional - what does it mean about *you* if a patient does not want to be treated by you? This could have caused self-doubt. In contrast, participants' common status as the only Black clinician in the room made them feel responsible for advocating on behalf of global majority service users. In this way, their unique ethnic and racial identities were lost.

I've had to sort of jump in and sort of if like a clinician is using maybe a derogatory term [Isioma nods] about a client...and having to challenge that [Campbell nods]. I sometimes feel like, 'Oh my God, did I overstep my boundaries?' but at the same time, sometimes you feel like you have to advocate for people look like you, and then that also can be draining at times and also being a Black woman as well I know it's being very conscious of that when you're doing that. (Whitney, 497-503)

Whitney uses the phrase "had to" to suggest that speaking up was her duty as the only Black clinician in the room. Whitney also uses the idiom "jump in" which creates an image of physical exertion of energy that racism costs. Whitney's worry about speaking-up and challenging racism from staff could be due to her 'lower' position in the NHS hierarchy as an assistant psychologist, or due to a fear that she will be positioned as an 'angry Black woman' (Jones, 2023). Such worries left participants feeling they had to act a certain way to progress within their careers and/or avoid confirming racial stereotypes.

People telling me to like, ‘speak proper English’ before and like it's just made me more aware of, like, my accent and stuff like that [Isioma nods, Whitney nods and rolls her eyes]. So I try to umm just speak really like clearly and I find myself just trying to like, I guess, change a little bits of who I am to just like, accommodate other people [Amarachi, Whitney and Isioma nod]...it does become like frustrating for me when some days when I have to, like, constantly do this because I don't feel like I'm fully being myself. (Campbell, 521-527)

Campbell’s use of the phrase “change little bits” suggests that racism was consistent, pervasive, and suggests an erosion of his sense of self. Tolani echoes this in describing “having to like act a certain way to kind of like fit in with the team”, which suggests that the erosion of their sense of self was related to the conflict of whether they belong in the profession (see [Appendix L](#), GET ‘Do I belong here?’).

## **Discussion**

This study sought to gain an insight into the experiences of ACPs working in the NHS and how they made sense of their career trajectory. This study was novel in its use of a multi-perspective design to understand how the experiences and meaning-making of ACPs differed by racial group, and is the first to investigate the experiences of White British ACPs. By conducting two racially homogenous focus groups and analysing data using IPA, I found that ACPs experienced and made sense of their NHS career trajectory in relation to 1) the profession, 2) interpersonal relationships, and 3) their sense of self. These themes manifested differently both within and across focus groups, reflecting the unique idiographic accounts of ACPs in this study.

### **Recognising the Dominance of Whiteness**

Diversifying the profession to reflect the communities we serve is the current zeitgeist in clinical psychology (Atayero & Dozdro, 2021). Thus, it is understandable that racial

diversity was central to how ACPs across both groups made sense of the profession. For White British ACPs, racial homogeneity led to a sense of belonging as they fit the prototype of what a clinical psychologist looks like. However, this homogeneity made some participants uncomfortable, as they noticed the startling Whiteness of clinical psychology compared to other mental health professions. Sue (2015) argues that 'race talk' is uncomfortable for White people and leads to cognitive, emotional, and behavioural avoidance, including thinking of alternative explanations that absolve White people of the impact of racism on global majority communities.

One way White British ACPs in this study dealt with this discomfort was to locate the problem in global majority ACPs. They posited that the lack of racial diversity in undergraduate psychology courses resulted in a lack of potential global majority ACPs, and also suggested that global majority ACPs self-selected out of the profession. This reasoning allowed White British ACPs to place themselves outside of the problem and is consistent with many clinical psychology widening access initiatives that argue global majority groups are not attracted to the profession (Wood & Patel, 2019).

Black British ACPs, on the other hand, battled with contradicting messages from the profession about the need for racial diversity, whilst simultaneously experiencing racism at work. Consistent with previous studies, participants described how microaggressions about their appearance and accents contributed to feeling hyper visible, yet they also felt invisible due to the lack of racial representation in the profession (Farooq et al., 2022; Ragaven, 2018). In contrast to previous studies, the majority of Black British ACPs reported experiencing racism from colleagues and supervisors, rather than patients (Ragaven, 2018).

As a result, some Black British ACPs felt unwelcome, unable to be their authentic selves at work, and questioned their sense of belonging in clinical psychology. This can make the journey into training exhausting, demoralising, and can negatively impact global majority

ACPs' mental health (Bawa et al., 2019), as captured in the GETs 'Racism costs me energy' and 'Do I belong here?' (see [Appendix L](#)). Direct racial discrimination, microaggressions, and structural racism are all forms of racial trauma, which significantly impact mental health including reduced self-esteem, increased feelings of powerlessness, hopelessness, and depression (Edwards, 2006; UK Trauma Council, 2022; Wallace et al., 2016).

### **Racialised Hierarchy in Clinical Psychology**

White British ACPs alluded to the unspoken rule that White people belonged in certain positions and noticed this in their workplaces. Black British ACPs also confirmed this, as they struggled to see themselves reflected in clinical psychology, which represents a higher-banding roles compared to other mental health professions (e.g., nursing). As explored in [Paper 2](#), evidence suggests that the NHS is a racialised institution, as researchers have argued organisations inherently are, with global majority staff overrepresented at lower bands and underrepresented at higher bands (Avent-holt & Tomaskovic-Devey, 2019; Ray, 2019). A racialised hierarchy in the NHS not only represents pay grade and seniority, but also the unequal distribution of power among the workforce.

Clinical psychologists are considered leaders within the NHS and hold power in multiple contexts including supervision, teaching-training, recruitment, commissioning of services, consultation, and policymaking (Bawa et al., 2019; Williams, 2022). Williams (2022) found that senior White clinical psychologists avoided conflict rather than using their positions of power to challenge Whiteness, due to fear of loss of power or exclusion by White peers (Helms, 1990). Senior White clinical psychologists also hypothesised that their position and power meant that colleagues felt unable to call them out on racist actions, consistent with narratives from global majority ACPs feeling powerless or fearful of challenging racism both in this study and previous studies (Shah, 2010; Paulraj, 2016; Williams, 2022). This further emphasises the importance of studying and understanding Whiteness and institutional racism.

Seeking to diversify the profession without simultaneous recognition of these factors, and systemic action to address the negative experiences of global majority ACPs is ineffective and unethical (Daiches, 2010; Jameel et al., 2022; Wood & Patel, 2019).

### **Interpersonal Relationships Essential for Progression**

Individuals' workplace relationships and networks influence how included they feel, how others view them, and how they progress (Kandola, 2018). Across both groups in this study, ACPs recognised the importance of networks and support to progress onto the DClinPsy. White British ACPs experienced support from peers, trainees, supervisors, and other clinical psychologists, which helped them to navigate their career trajectories. There was a direct contrast in White British ACPs' experience of supervisors as encouraging, proactive, and invested in their career progression, compared to the majority of Black British ACPs feeling dismissed and unsupported by supervisors. Kandola (2018) argues that race impacts the level of comfort with and support for a person. This relates to the experiences of Black British ACPs' limited support from White supervisors. This, combined with experiences of racism from White supervisors and colleagues, meant that Black ACPs moved between being extremely grateful for the little support they received and desiring formalised mandatory support structures. Black British ACPs described being able to identify which clinical psychologists were more likely to support them based on the psychologist's race, in line with evidence that global majority clinicians are more likely to feel safer and seek support from other global majority clinicians (Paulraj, 2016; Williams, 2022).

This is consistent with findings from Ahsan (2020), where White clinical psychologists explicitly stated that they did not want increased racial diversity "at the expense of really good White psychologists". This rhetoric is damaging as ACPs applying for the DClinPsy require a strong clinical reference, which will most likely be from a supervising White clinical psychologist. Consequently, global majority ACPs supervised by White



clinical psychologists might be denied support to progress onto DClInPsy training. This is not simply in-group favouritism but reflects the dominance of Whiteness and White privilege within the profession. Critical race theory (CRT) highlights how despite the equality legislation embedded within the NHS, White privilege and power are maintained within practices (Crenshaw et al., 1995).

### **Black ACPs Left to Deal with Racism Alone**

The power dynamics associated with racial difference in the supervisory relationship can make it difficult for global majority ACPs to address issues of race (Patel, 2004). Consistent with this, Black ACPs did not feel able to discuss experiences of workplace racism with their supervisors. This was also commented on by White British ACPs, who imagined that the dominance of Whiteness within the profession would leave global majority ACPs without support following experiences of racism. Supervision is an important part of clinical psychology, and being able to reflect on personal experiences in supervision is an essential part of training (Bennett-Levy & Thwaites, 2007). There is evidence to suggest that highlighting and discussing racial issues in supervision can positively impact supervisory relationships and supervisee satisfaction (Roche, 2017). However, research suggests that global majority supervisors are more likely to spend time talking about race in supervision than White supervisors (Hird et al., 2005; Ong, 2021; Williams, 2022). Pendry (2012) argues that the patient-psychologist-supervisor triad is important when working with Whiteness, and it is the supervisor's ethical responsibility to prioritise this. Good practice examples of this include the three North London DClInPsy training courses which provide training on racism and power for supervisors of DClInPsy trainees (Berg et al., 2019). However, there is a lack of such training for supervisors of ACPs working in the wider NHS.

Being left alone to navigate support for progression and following racism meant that many Black British ACPs felt the need to reach back and support other Black British ACPs.

The multiple barriers that Black ACPs face in gaining access to support and networks in the profession has resulted in the setting up of their own community-based networks (e.g., the Black Aspiring Clinical Psychologists' Network; Farooq et al., 2022). This provides connection and safe spaces to discuss experiences and to connect with other global majority trainees and qualified clinical psychologists (Tong et al., 2019; Farooq et al., 2022). Similar networks exist for Asian and international ACPs (e.g., the Collective for Asian Psychological Therapists, DClinPsy-International), reinforcing the importance of disaggregating global majority, whilst also taking an intersectional approach by considering other forms of difference, such as migration status and nationality.

### **Influence of Experiences on Sense of Self**

ACPs' sense of belonging and professional competency was influenced by their experience of interpersonal relationships and perception of the profession. White British ACPs felt seen, valued, and able to be their authentic selves at work. However, when discussing their experience of recruitment to prequalification roles, some White British ACPs challenged the notion that their race played a part in their success. As discussed in Paper 2 (pg.101), the invisibility of Whiteness to White people can lead to a belief that the advantages of White privilege (e.g., favouritism at recruitment, instrumental support for progression) are not related to race, and so benefits are interpreted as deserved (Fernando, 2017). White people's emotional response and defensiveness at the mention of racism and their complicity, can be referred to as 'White fragility' (DiAngelo, 2011), although not directly measured, this may have been present among White British ACPs.

Most individuals racialised as White see racism as a problem of a "few bad apples", and to be associated with racism challenges their self-perception of being good and forces them to take accountability for perpetuating racism (Akala, 2019; Eddo-Lodge, 2017). Therefore, despite White British ACPs' ability to recognise the dominance of Whiteness in

clinical psychology, they struggled to engage with what this meant regarding their own White privilege, consistent with findings from previous studies (Ahsan, 2020). This contrasts with findings from Williams (2022), who found that senior White clinical psychologists recognised that Whiteness within the profession meant that they must be racist and enact Whiteness within their roles. These differences may reflect years of experience or a different stage of racial identity development.

The White Awareness Model (WAM; Ryde, 2009) posits that White people move through five different stages in relation to recognition of Whiteness and racism including: denial, establishing a new openness to engaging, guilt and shame, acknowledgement of one's own role in racism, and integration where Whiteness and its impact is fully explored. This model is helpful to understand where different White British ACPs were in their ability to acknowledge their own Whiteness. For example, Vicky was the most able to reflect, recognise, and own her White privilege, which may have been due to her self-declared low socioeconomic status as this provided her with a different perspective to that of the typical White, middle class, female clinician in clinical psychology (Jameel et al., 2022). Other White British ACPs appeared unable to recognise their Whiteness and located the problem with global majority groups. However, towards the end of the discussion, they gained new insight into their own privilege, potentially moving from the stage of denial to establishing a new openness to engaging with Whiteness.

Black British ACPs battled with questioning their belonging in the profession, and experiences of racism impacted their wellbeing and sense of self. Consistent with previous studies, Black British ACPs' experience of working in services dominated by Whiteness resulted in incongruence between their racial identities and their professional identities (Farooq et al. 2022; Prajapati et al., 2019). Black British ACPs described feeling that they needed to change and mould themselves to fit into the profession, almost having to distance

themselves from their racial identity to be accepted within the traditionally White, middle class, clinical psychology profession (Farooq et al., 2022). Furthermore, Black British ACPs described how experiences of racism cost them mental energy by anticipating, challenging, and processing racism. Similarly, Ragaven (2018) found that global majority ACPs found it difficult to navigate subtle forms of racism, as questioning whether their experience was due to race was emotionally draining.

Black British female ACPs also experienced stereotype threat when attempting to challenge racism in their workplaces, as they feared they would be labelled as ‘angry Black women’ (Jones, 2023). This stereotype has negative consequences on Black women’s mental health, including lower self-esteem, anxiety, and depression (Ashley, 2014). This is a real threat, as women from global majority backgrounds experience the most harassment, abuse, and bullying from patients and staff in the NHS (WRES, 2022), thus emphasising the importance of considering intersectionality when exploring experiences of racism (Crenshaw, 1989; Williams, 2022). Working in racially diverse teams appeared to be protective factor for Black British ACPs as they felt that they could be themselves and this increased their professional confidence.

### **Strengths and Limitations**

This study was grounded in the current socioeconomic and political climate within the UK, NHS, and clinical psychology profession. This was a strength as these contexts influenced participants’ understanding of their experiences and my interpretations (Ong, 2021). The research team (i.e., supervisors, N.S., EBE) had a mixture of racial and ethnic backgrounds, qualitative research experience, and knowledge of NHS racial inequity. This brought different perspectives to the study design and conduct, and was crucial during analysis to engage with and reflect on different positions in the hermeneutic circle (Smith,

2022). Furthermore, engaging in co-production with an EBE (an ACP from a Mixed Other background) helped to design a study that was more acceptable and meaningful to participants (Ennis & Wykes, 2013).

The use of racially homogenous focus groups provided a safe reflective space for ACPs, contributed to consciousness-raising for White British ACPs, and provided peer support and validation for Black British ACPs (Ahsan, 2020; Williams, 2022). Previous studies highlight that when discussing race in individual interviews, the presence of a global majority interviewer can influence White participants' responses (Desai, 2018; Ong, 2021). Focus groups made it easier for White British participants to discuss race openly as they were amongst peers. However, racial homogeneity in the Black British group meant that my identity as a Black British woman occasionally led to overfamiliarity and a lack of clarity in ACPs' explanations due to assumed shared experiences.

During recruitment, interested ACPs provided feedback that the screening question about Graduate Basis for Chartered Membership was unclear (see [Appendix D](#)), as some thought this referred to BPS membership. This might have excluded participants from low socioeconomic backgrounds due to membership costs. The online nature of my study automatically excluded those without access to the internet and/or a device with a camera/microphone. Furthermore, the inclusion of only one male ACP in both focus groups created gender homogeneity issues, however I decided to include male ACPs as they are underrepresented within the profession (HCPC, 2021) and this was consistent with the intersectional CRT framework underpinning the study.

This was my first time conducting IPA and I adopted a complex design with multiple hermeneutics, as I attempted to understand participants' meaning-making who were also trying to understand each other's meaning-making (Tomkins & Eatough, 2010). I found it challenging to avoid making causal explanations, which is not the aim of IPA (McCormack

& Joseph, 2018). I addressed this through supervision, consulting expert and peer IPA researchers, and engaging in self-reflexivity (see [Appendix J](#)). From this, I was able to understand the context that each group provided to the other's experiences and put aside my own assumption about the data.

### **Implications and Recommendations for Practice**

This study was centred on the experiences of ACPs working in the NHS and has important implications for clinical practice. As discussed in [Paper 2](#), the treatment of NHS global majority staff is a key determinant of NHS patient experience (Dawson, 2018). By exploring the experiences of both White British and Black British ACPs, this study helped to identify tangible targets for addressing racial inequity within the profession. Anti-racism is (1) the continual practice of unlearning internalised belief systems dictated by White supremacy, (2) redistributing power, resources, and privilege to populations directly disproportionately harmed by White supremacy, and (3) redressing historical and contemporary injustices enacted under White supremacy (Lett, 2023).

Anti-racism within clinical psychology will aid better support and retention of global majority clinicians and train White clinicians that feel competent and confident working with racial equity in mind; ultimately leading to the improved accessibility, quality, and acceptability of mental health services for global majority communities (Rao et al., 2020). This requires commitment and accountability from DCLinPsy course and admissions tutors, clinical psychology leaders, and governing bodies (e.g., BPS, Health & Care Professions Council, HEE), as well as systemic change within the wider NHS. Based on the experiences shared by ACPs in this study and in line with previous studies on racial inequity in clinical psychology, I make the following recommendations:

1. ***Address Racism as a Structural Issue*** –It is essential that the NHS context of workforce racial inequity and institutional racism is acknowledged and addressed in

all anti-racism efforts within the clinical psychology profession. Furthermore, it is important that White clinical psychologists, academics, and DClinPsy trainers take responsibility for addressing Whiteness and White privilege in the profession.

2. ***Change the Aim of Widening Access Schemes*** – Most increasing/widening access schemes within clinical psychology simply aim to increase racial diversity among ACPs and DClinPsy trainees, but this does not address the challenges global majority ACPs face when they enter the profession. Increasing access schemes should aim to work alongside global majority ACPs to better understand their needs and effectively utilise their cultural knowledge/expertise to shape accessible and equitable mental health services for everyone.
3. ***Protected Reflective Practice Spaces for ACPs*** – Both groups in this study reported experiencing the focus groups as safe and reflective spaces. Previous studies have highlighted the importance of reflective spaces for solidarity, connection, and validation, which are invaluable when navigating the NHS, clinical psychology, and racial identities (Farooq et al., 2022). For White British ACPs committed to developing as anti-racism practitioners, supportive reflective spaces focused on anti-racism, diversity, and decolonisation are required to help guide reflection and negotiate boundaries between the personal and professional (Wood & Patel, 2019). Good practice examples of such spaces include Wood and Patel's (2019) 'Decolonising White Psychology' workshop for University of East London DClinPsy trainees.
4. ***Regulations and Guidance for the Employment of ACPs*** – Currently, no up-to-date guidance exists on the employment of ACPs from the governing or representative bodies (i.e., BPS, Health and Care Professions Council) for clinical psychologists in the UK. This is required to avoid the exploitation of ACPs and to ensure that

necessary support structures are built-into prequalification roles (Snell et al., 2022). This includes the provision of formalised support structures for progressing onto the DClinPsy or other psychological training programmes. This is to safeguard against instrumental support only being accessible to those with professional interpersonal relationships and networks in the profession, as global majority ACPs are typically disadvantaged by this due to institutional racism.

5. *Disaggregate Global Majority, Move Towards Intersectionality* – It is essential to stop homogenising global majority groups and acknowledge the unique challenges individual racial communities and intersecting identities face to create support structures that adequately meet staff’s needs and lead to more culturally sensitive services.

### **Future Research**

This study highlighted the importance of studying the experiences of advantaged groups in clinical psychology (i.e., White clinicians) as this helped to explore how Whiteness and racism are perceived among those that benefit from these systems. However, due to sample limitations, the intersection of gender was not fully explored in this study. Future studies could examine the experiences of White men in psychology, as despite being a gender minority within the profession, they are often overrepresented in leadership roles (i.e. DClinPsy course directors, service-leads, consultant psychologists; Gourley, 2022; Williams, 2022). This could help to better understand how gender and White privilege intersect within the clinical psychology profession (Williams, 2022). Similarly, there is scope to explore how gender and race intersect to shape the experiences of global majority men in clinical psychology who are a minority within a minority.

Another area for future research is cross-racial supervisory dyads in order to explore the indirect impact of Whiteness and racism on patient therapeutic care. Previous evidence



has shown that White clinical psychologists are less likely, compared to global majority clinical psychologists, to initiate discussions on race in supervision with ACPs and trainees (Desai, 2018; Williams, 2022). A future study could explore global majority patient outcomes for ACPs supervised by White clinical psychologists compared to those supervised by a global majority clinical psychologists.

### **Conclusion**

This study highlighted that ACPs' experience and understanding of their pre-qualification career trajectory, including recruitment to and working in NHS roles, was related to their perception of the clinical psychology profession, experience of interpersonal relationships at work, and the impact of these factors on their sense of self. However, findings reflect the stark differences in these experiences based on race. White British ACPs described a sense of belong in the profession, felt that they had access to various support structures and felt confident in their identities as psychological practitioners, compared to Black British ACPs whose understanding and experiences of clinical psychology created several internal conflicts. This was reflected in Black British ACPs' experience of racism, poor support for progression and development and lack of representation at senior levels in clinical psychology. At a time when racial diversity within the clinical psychology workforce is rapidly growing, it is essential that leaders within the profession work towards addressing Whiteness and champion anti-racism practice in order to support global majority clinicians throughout their career trajectory. This will lead to improved, culturally responsive and equitable mental health services for the communities we serve.

### **3 Paper 2: Exploring Clinical Staff from Different Racial Backgrounds' Experience of Recruitment to and Roles in the NHS: A Systematic Review of Qualitative Research**

## Abstract

The National Health Service (NHS) has a racially diverse workforce, however racial inequities exist in relation to recruitment, career development, and progression. This systematic review aimed to critically review and synthesise findings from qualitative studies on the experience of NHS clinical staff, in order to investigate whether recruitment experiences and working in the NHS differed across racial groups. I aimed to explore the experiences of a range of professions and disaggregate global majority. I expanded on the remit of previous reviews by including the perspectives of those racialised as White. I systematically searched three databases (CINAHL, APA PsychInfo, MEDLINE) and identified eligible studies by screening the 1,866 search results using eligibility criteria that included: published and unpublished literature, qualitative methods of data collection, aims/research question focused on experiences related to racialised identities, and studies conducted with clinical staff working in the NHS. I conducted an initial screening of search results with a second reviewer. Following the removal of duplicates and ineligible records, we each independently conducted a quality review of the remaining 16 studies using the Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative studies and removed one study. I used thematic synthesis to analyse data from 321 NHS clinical staff across the 15 studies included in the review. I identified six analytic themes based on staff's descriptions and researchers' interpretations of their experiences in the NHS: 'Institutional racism', 'Whiteness as beneficial', 'Management as agents of racism', 'Ways of coping', 'Protective factors', and 'Reduction of self'. I explored these findings in relation to relevant theoretical models and empirical literature and discussed the implications of findings for NHS policy and practice.

Key terms: thematic synthesis, NHS, healthcare professionals, lived experience, qualitative, racial inequality, racism, discrimination

## Introduction

The NHS has the most racially diverse workforce in the UK, with global majority<sup>2</sup> staff representation currently at 24% (Archibong & Darr, 2010; WRES, 2023). This is unsurprising given the long history of international recruitment in the NHS, dating back to its inception in 1948, when nurses and midwives were recruited from British colonies (Likupe, 2006; Snow & Jones, 2011). Furthermore, the expansion of the European Union in 2004 led to many European citizens coming to work in the NHS (Edeh et al., 2019; Dalingwater, 2019; Blanchflower et al., 2007). Consequently, free movement, increased globalisation, and continued international recruitment has resulted in an NHS workforce that is currently more diverse than at any point in its 75-year history (NHS England, 2021).

The racial and ethnic diversity of the NHS' workforce is often presented as evidence that structural racial inequities do not exist (Fernando, 2017; Manthorpe & Moriarty, 2021). However, long-standing issues of institutional racism in the NHS received renewed attention in the wake of the COVID-19 pandemic, and the resurgence of the Black Lives Matter movement following the murder of George Floyd in the US (Manthorpe & Moriarty, 2021; NHS Confederation, 2022). Institutional racism can be defined as the way in which institutional systems discriminate and oppress people based on their race, ethnicity, or culture (Braveman et al., 2022; Home Office, 1999). Evidence suggests that structural experiences of power in relation to race, ethnicity, and culture impact NHS staff from global majority backgrounds more so than their White counterparts (Patel, 2004; Shah, 2010). For example, global majority staff are more likely to experience discrimination from colleagues, with Black staff reporting the highest level of discrimination in the NHS (Kline et al., 2017).

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<sup>2</sup> The term 'global majority' refers to racial groups that are labelled as minorities within Western contexts (Campbell-Stevens, 2020). See [Paper 1](#), pg. 13-14 for a detailed definition.

The ‘Snowy White Peaks of the NHS’ report highlighted the existence of a racialised hierarchy in the NHS regarding banding, which reflects seniority and pay: staff from global majority backgrounds are over-represented in lower bands and under-represented at senior levels (Kline et al., 2014; Stevenson & Rao, 2014). This structural inequity is more pronounced in areas of high racial diversity such as London, where despite global majority communities making up 45% of the population and 45% of NHS staff, they represent only 8% of London NHS trust board members and 2.5% of chief executives (Limb, 2014; Ross et al., 2020). Such examples of workplace racial inequity led to the introduction of the Workforce Race Equality Standard (WRES) in 2014. WRES collects data on the race-related experiences of global majority staff and requires NHS trusts to demonstrate, record, and report improvement in staff race equity. This is based on nine indicators including access to non-mandatory training, likelihood of being shortlisted for positions, experiences of racial discrimination, and bullying and harassment at work (WRES, 2023).

Despite progress since 2014 in the recording of this data, the 2022 WRES report shows that global majority NHS staff continue to face inequalities in recruitment, discrimination from colleagues, and overrepresentation within formal disciplinary proceedings (WRES, 2023). For example, White applicants were 1.54 times more likely to be appointed to NHS roles after shortlisting compared to global majority applicants, with no significant improvement on this indicator over the seven-year history of WRES reporting. Furthermore, staff from global majority backgrounds were 1.14 times more likely to be involved in formal disciplinary proceedings compared to White staff, reflecting no change from 2021. Worryingly, 17.0% of global majority staff had experienced discrimination from a manager, team leader, or other colleagues, representing the highest in WRES history (WRES, 2023). Conversely, data show a 38.1% increase in the number of global majority board members in NHS trusts since 2020 (WRES, 2023). However, the methodological

limitations of WRES data such as the inclusion of staff whose race is unknown, the use of unweighted data for regional breakdowns comparing trusts of different sizes, and the use of 'Black and Minority Ethnic' which obscures differences between racial groups (Naqvi & Coghill, 2018; Norrie, 2021) should be kept in mind.

Nevertheless, the racial inequity highlighted by WRES data has consequences not only for global majority staff but NHS patients too. The treatment of global majority NHS staff is related to patient outcomes, experiences, and safety of care (Kline, 2022, Limb, 2014). Research examining NHS staff and patient surveys revealed that the bullying, harassment, and abuse of global majority staff is related to poorer patient experience (Dawson, 2009; 2018). Specifically, staff's experience of workplace discrimination and beliefs that their trust provides equal opportunities for career progression predicted patient care (Dawson, 2018). Additionally, a culture of fear where staff are unable to admit mistakes or raise concerns further jeopardises patient safety (Kline, 2022; Limb, 2014). Thus, racial inequity in the NHS is not simply an equal opportunities issue, but a public health issue (Limb, 2014; Stevenson & Rao, 2014). Understanding the experiences of NHS staff from different racial backgrounds has the potential to improve patient outcomes.

The racism, discrimination, bullying, and harassment experienced by global majority staff are social processes that take place within a given context. Therefore, to address these issues, it is essential to understand how the NHS context gives rise to such phenomena (Woodhead et al., 2022). Existing reviews have focused on understanding the experiences of global majority NHS staff. For example, Alexis and Vydellingum (2005) examined the experiences of global majority NHS nurses and found that they were denied opportunities for promotion and professional development as a result of racism. A subsequent review by Likupe (2006) investigated the experiences of African nurses, who reported negative experiences of working in the UK, which raises ethical questions about the practice of

international recruitment from economically developing countries. More recently, Pendleton (2017) reviewed qualitative studies on global majority nurses' experience working in the NHS and concluded that they are underemployed, experience excessive scrutiny from managers, and reduced self-confidence. Pendleton (2017) described racism from both White and global majority staff, an example of 'horizontal racism' between global majority staff from different races.

Existing reviews leave an important knowledge gap. For example, the focus on specific staff groups (e.g., nurses/midwives) makes it possible that the racial inequities highlighted may be profession-specific, rather than reflecting institutional racism in the NHS. A further limitation of existing reviews is the aggregation of different racial groups. This is a common issue within health inequalities research, further exacerbated by use of terms such as 'Black, Asian and Minority Ethnic' and 'BME' that group all 'non-White' individuals together. This limits our ability to understand the needs of different racial groups, the inequalities that exist, and how to develop targeted interventions (Hatch et al., 2021). Lastly, existing reviews on racial inequities among NHS staff exclude the experiences of staff racialised as White, although researchers have argued that studying the experience of advantaged groups is necessary, as racism is a system that not only disadvantages global majority populations but confers advantages for White people (Pendleton, 2017; Woodhead et al., 2022). Understanding systemic inequalities necessitates the understanding of the experiences of both those harmed by inequity and those who may benefit from such systems (Lipsitz, 2006). Inclusion of White staff's experiences also sheds light on witnessing racism and how the status quo is upheld in the NHS (Ahsan, 2020; Likupe et al., 2014; Woodhead et al., 2022).

Therefore, this review aimed to identify, critically review, and synthesise findings from qualitative studies exploring clinical staff's experience of applying to and working in

the NHS. I sought to answer the following research question “What is the experience of clinical staff in recruitment to and during roles in the NHS, and how does this vary by race?” Building on the work of previous reviews, I sought to include the experience of clinicians across a range of disciplines and races, including those racialised as White. By broadening the scope of this review compared to previous literature, I aimed to provide a holistic picture of the NHS as an organisation and how it is experienced by staff. The findings from this review informed the development of my associated empirical study ([Paper 1](#)).

## **Method**

### **Literature Search**

I identified relevant studies by systematically searching three electronic databases: CINAHL, MEDLINE, and APA PsycInfo. I chose these databases due to their wide coverage of healthcare and psychological research, including unpublished and grey literature. I aimed to include unpublished and grey literature to help reduce publication bias and create a balanced view of the evidence (Paez, 2017; Thomas & Harden, 2008). I conducted the search in September 2022 and set up search alerts for additional studies that met my criteria until study completion in December 2022. I used the SPIDER framework (Cooke et al., 2012) to help identify search terms and form the search strategy to answer my research question ([see Table 2](#)). I included these search terms based on the language used in previous reviews on the same topic (e.g., Pendleton et al., 2017) as they are the most commonly used terms to describe clinical staff and race within the NHS. I combined search terms using Boolean operators and truncation. Initial searches revealed that the search terms under ‘Study Design’ ‘Evaluation’ and ‘Research type’ reduced the sensitivity of search results so I removed them from the final search, and instead used them at the screening stage.



**Table 2***Search Terms Entered into Electronic Databases*

(S)ample	clinical staff OR healthcare staff OR healthcare worker* OR nurse* OR “midwi* OR doctor* or psychologist*
(P)henomenon of (I)nterest	bme OR black minority ethnic* OR ethnic group* OR bame OR ethnic minorit* OR racial minorit*
	AND
	nhs OR national health service
Study (D)esign*	survey* OR questionnaire* OR interview* OR focus group* OR case stud* OR observ
(E)valuation*	view* OR experience* OR opinion OR attitude* OR perce* OR belie* OR feel* OR know* OR understand*
(R)esearch type*	qualitative OR mixed method*

*Note.* \*Terms excluded from final search to increase relevance of results and used for study screening.

**Eligibility Criteria**

In line with good practice for systematic reviews in health research I applied inclusion and exclusion criteria to identify relevant studies (see [Figure 5](#); Morton et al., 2011; Smith et al., 2011). In qualitative evidence, the phenomenon of interest is the experience, event or process under study which can include cultural factors such as race, geographical location and the setting (Munn et al., 2018), as highlighted in my search terms (see [Table 2](#)). Another key feature of qualitative evidence is the richness of stories shared through participants’ words that provide deeper insight into their attitudes, beliefs and perspectives (Lockwood et al., 2015). Therefore, I decided to only include qualitative studies, as they are the most appropriate to capture the lived experiences of staff working in the NHS in detail and how this varies by race (Denzin & Lincoln, 2017). Studies were also limited to those conducted in

the UK due to the desired NHS context, but excluded COVID-19 studies that were not centred on racialised experiences. Both the second reviewer (M.K.) and I used these criteria when screening the search results.

## Figure 5

### *Systematic Review Eligibility Criteria*

<p><u>Inclusion criteria</u></p> <ul style="list-style-type: none"> <li>▪ Published and unpublished literature (e.g. digital Doctoral thesis)</li> <li>▪ Qualitative methods of data collection (interviews, focus groups, open-ended surveys), including mixed method studies with qualitative excerpts</li> <li>▪ Aims or research questions specify a focus on racialised experiences</li> <li>▪ Conducted in the context of NHS services</li> <li>▪ Study participants must be clinical staff working within an NHS service - examples include, but are not limited to, support worker, nurse, doctor, psychiatrist and psychologist</li> </ul> <p><u>Exclusion criteria</u></p> <ul style="list-style-type: none"> <li>▪ Systematic reviews, literature reviews, opinion pieces, books, secondary data analyses, review articles, study protocols, conference abstracts</li> <li>▪ Studies conducted outside of the United Kingdom</li> <li>▪ Studies on COVID-19 vaccination hesitancy/opinions</li> <li>▪ Studies on clinical populations/patient experience</li> <li>▪ Studies only using quantitative methods</li> </ul>
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## Search Results

A total of 1,866 studies were identified from database searches (see [Figure 6](#)). Adding language (i.e., English) and location (i.e., United Kingdom) limiters to my search removed 1,020 records. I removed a further 126 records as they were duplicates or inappropriate (e.g., opinion piece), leaving 720 records to be screened. Prior to screening, M.K. and I conducted a pilot on 10 studies so that there was shared understanding and application of the eligibility criteria. I then screened the remaining records and M.K. screened 25% of randomly selected records by title and abstract. We achieved perfect inter-rater reliability ( $k=1.00$ ) for pilot and initial screening, indicating that we were applying the eligibility criteria in a similar manner.

Together we removed 709 records due to incorrect publication type, study design, population, or outcomes.

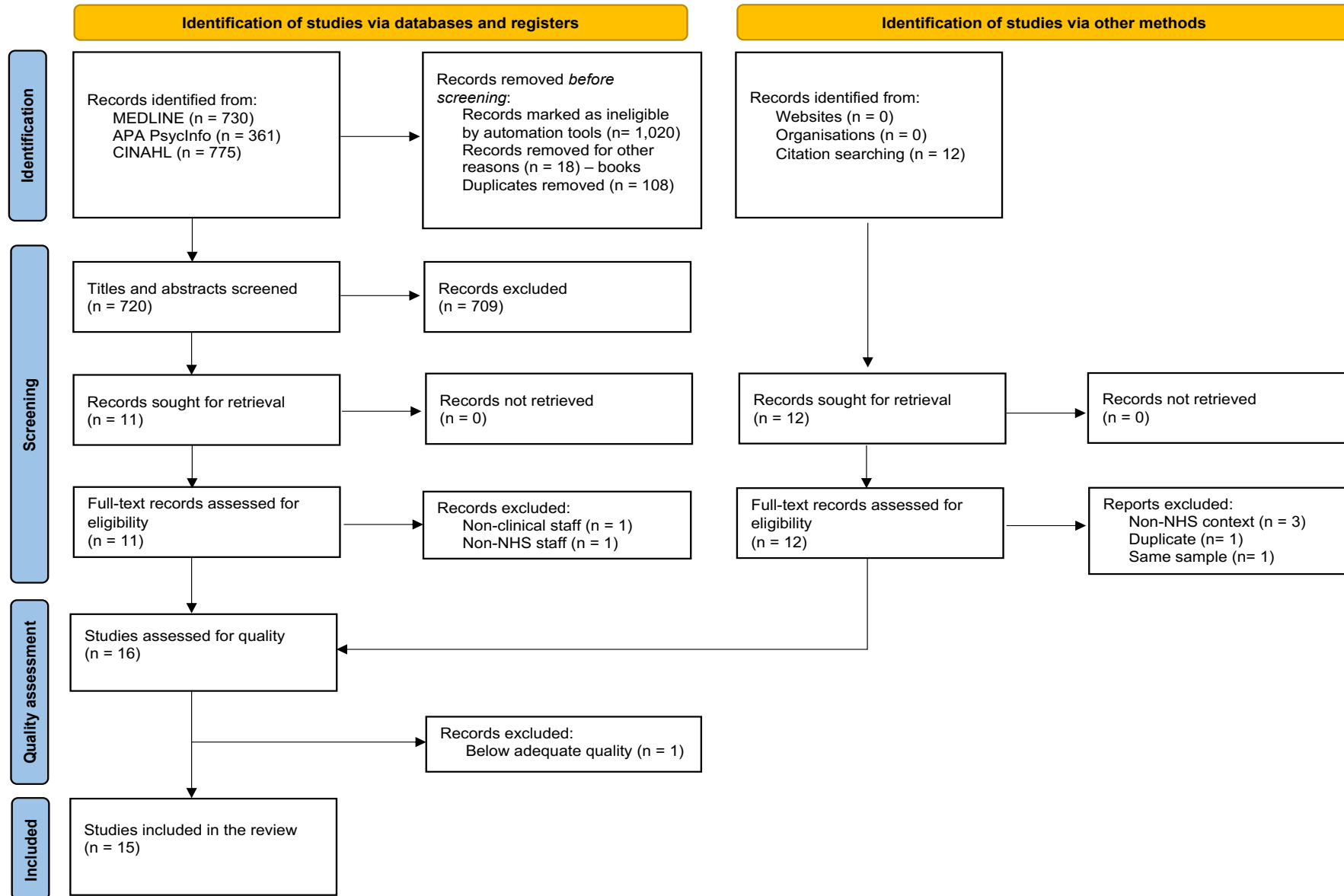
M.K. and I conducted a full-screen of all 23 retrieved full-text records and achieved high agreement ( $k=0.77$ , 95% CI= 0.18, 1.00). We recorded and tracked all remaining review decisions, keeping an accurate audit trail of inclusion and exclusion decisions in an excel spreadsheet. We resolved discrepancies in decisions through discussion and re-reading where necessary. A third reviewer (T.B.) made the final decision for one paper. Reasons for exclusion at this stage included studies with a non-clinical sample ( $n=1$ ), non-NHS context or staff ( $n=4$ ), and duplicate records ( $n=1$ ). I removed one study that reported on the same sample as an already included study, as it did not make an independent contribution to the research question.

### **Quality Assessment**

Following recommendations that the dataset be read through at least once before initial coding (Braun & Clarke, 2006), the quality review was conducted prior to data synthesis. We assessed the methodological quality of the 16 included studies using the Critical Appraisal Skills Programme (CASP; 2018) checklist for qualitative research. The CASP (2018) checklist is the most used quality appraisal tool for healthcare-related qualitative evidence synthesis and has been used in previous systematic reviews of the experience of healthcare staff (Hannes & Macaitis, 2012; Long et al., 2020; Pendleton et al., 2017), which enabled comparison to other systematic reviews within this field of research.

Figure 6

## PRISMA Flow Diagram



We assessed the 16 included studies using a scoring system adapted from Adams et al., (2019) against the CASP checklist's 10 criteria, awarding each study a total quality rating out of 10. Studies received a score of 1 for each 'Yes' on a criterion met, and 0 for each 'No' on a criterion not met or 'Can't tell' if the reviewer was unable to conclude whether the criterion was met from the publication alone. Studies were classified as weak if up to four CASP criterion were fulfilled, adequate if five to six items were fulfilled, moderate if seven to eight items were fulfilled, and strong if nine to ten items were fulfilled. This process was blinded, and we achieved moderate agreement between reviewers ( $k=0.48$ , 95% CI=0.28, 0.69). We resolved discrepancies in ratings through discussion, which led to rating revisions. The third reviewer (T.B.) settled the three remaining discrepancies between reviewers.

Based on the agreed ratings, I removed one study (Garcha, 2022) which received a CASP rating of 2 due to the lack of information on methodology, ethical approval, informed consent procedure, data analysis, and consideration of relationship between author and participants, reported in the publication. We included the remaining 15 studies, which each scored an adequate rating (5) or above in the final review. Whilst there is general consensus that quality appraisal results should be used to inform qualitative evidence synthesis (Carroll & Booth, 2015; Dixon-Woods et al., 2007; Garside, 2014), there is still wide debate and poor consensus on what is considered 'quality' in qualitative research as this is not always synonymous with methodological rigour (Long et al., 2020). However, I made the decision to use CASP ratings to inform which studies would be included in the review to ensure that a high standard of papers were included.

### **Data Synthesis**

I synthesised findings using Thomas and Harden's (2008) three-stage method of thematic synthesis, as my research question focused on staff's lived experiences and perspectives (Ralph et al., 2014). For each study, I coded all data labelled as 'Findings' or

‘Results’ and gave each line at least one code (see [Appendix M](#)). This included authors’ explanation of findings, which was essential to include as researchers play an active role in identifying themes and selecting what is of interest to report (Braun & Clarke, 2006). Line-by-line coding supports the reciprocal translation of concepts from one study to another, which began when I coded the second study (Britten et al., 2002; Fisher et al., 2006). The software program NVivo 12 was used to create, cluster, and manage codes in this review. In line with best practice, the qualitative researcher (N.S.) involved in my empirical study (see Paper 1, pg. 24) secondary coded 25% of the included studies and there was good agreement (O’Connor & Joffe, 2020). N.S. also conducted validity checking of my resulting themes, based on their feedback I separated one theme into two to better capture the concepts explored.

Next, I developed descriptive themes by grouping codes based on similarity, and created new codes to capture the meaning of these groupings. I checked the draft themes with other members of the review team before finalising (Thomas & Harden, 2008). I then generated analytic themes, an interpretative stage, by considering how the descriptive themes applied to my research question. I discussed themes with relevant experts (e.g., NHS professionals, qualitative researchers), considered existing literature, and relevant theoretical frameworks such as intersectionality (Crenshaw, 1991) and relational inequality theory (Avent-holt & Tomaskovic-Devey, 2019) to make sense of my data. This resulted in themes that were contextualised and sufficiently explained all the initial descriptive themes (Thomas & Harden, 2008).

## **Results**

### **Study Characteristics**

The characteristics of included studies are presented in [Table 3](#). In total 15 qualitative studies published between 2001-2022 were included in this review. Twelve studies were

conducted in England and three UK-wide. All studies used purposive sampling, recruiting participants from hospitals<sup>1,3,5,8-10,13-15</sup>, and a mixture of professional and informal networks<sup>6,11</sup>, snowball sampling<sup>6,9,11</sup>, community centres and places of worship<sup>12</sup>. Study sample sizes ranged from five to 48 participants, with a median sample size of 20 (IQR=12.0), totalling 321 NHS staff. Of the studies that reported gender<sup>1,2,4-15</sup>, 84% of participants were female. Most studies only sampled nurses<sup>1-5,9,10,12-14</sup>, one study only sampled psychologists<sup>11</sup>, and the remaining included a mixture of professionals, such as trainee and recently graduated healthcare students, healthcare assistants, doctors, nurses and midwives, and physiotherapists.

Three studies<sup>1,7,9</sup> reported participants' age, which ranged from 20-48 years old. Only four studies<sup>7,9,13,15</sup> included White participants (i.e., White British, White European, White Other), with the remaining studies exclusively sampling global majority participants including Black Caribbean, Black African, Southeast Asian, and South Asian. Most included studies only sampled migrants to the UK, with few studies exclusively sampling British nationals<sup>11,12</sup>, or a mixture of migrants and non-migrants<sup>15</sup>, and one study<sup>7</sup> did not report participants' migration status. In studies that only sampled migrant staff<sup>1-6,8-10,12-14</sup>, time in the UK ranged from 2 weeks to 56 years.

Seven studies focused on the expectations and experiences of international nurses in the NHS<sup>1-3,5,10,13,14</sup>, and others focused on; experiences of racism, discrimination, bullying and harassment<sup>4,9,15</sup>, career progression<sup>7,8</sup>, barriers into the profession<sup>12</sup>, and general experiences of staff working in the NHS<sup>6,11</sup>, comparing this across racial groups. Multiple theoretical underpinnings were adopted across studies including phenomenology<sup>2,3,6,7,10,11,14</sup>, constructivism-interpretivism<sup>13</sup>, critical race theory<sup>15</sup>, feminism<sup>6</sup>, and Marxism<sup>4</sup>. Data were collected via interviews (i.e., mainly semi-structured)<sup>1,2,4,6-8,10-12,14,15</sup>, focus groups<sup>3,5</sup>, and interviews mixed with another method such as repertory grids<sup>11</sup>, observations<sup>13</sup>, focus

groups<sup>9</sup> or a questionnaire<sup>14</sup>. Phenomenological analysis was most commonly used to analyse data<sup>2,6,7,10,11</sup>, followed by thematic analysis<sup>3,15</sup>, and other methods such as grounded theory<sup>5</sup>, framework analysis<sup>12</sup>, and inductive analysis<sup>13</sup>. Some studies simply described using “qualitative analysis”<sup>1,4,9,14</sup> and one study<sup>8</sup> did not state the analytic method used.

### **Quality Assessment**

Eight studies received a CASP (2018) rating of 9 and were classified as strong<sup>2,3,5,6,8,11,13,14</sup>, six studies moderate<sup>1,4,10,12,14,15</sup>, and one study<sup>8</sup> adequate. Overall, the average CASP rating across studies was 8.33 ( $SD=0.90$ ) indicating moderate methodological quality. All studies, except one<sup>6</sup>, provided a clear statement of research aims and a qualitative approach was deemed appropriate by the review team. All but four studies<sup>1,8,12,15</sup> were able to justify their selected research design, and all but one study<sup>3</sup> provided justification for why the recruitment and sampling strategy were appropriate for study aims.

Most studies explained the sampling frame and limitations. All studies provided a clear statement of research findings, although not all studies provided details of data triangulation<sup>3,9</sup> or an adequate discussion of evidence for and against the researcher’s argument<sup>6</sup> - exclusions which could be due to limited journal word-counts rather than author oversight (Walsh & Downe, 2006). The weakest area in reporting across studies was on CASP criterion six, which assessed the extent to which the relationship between the researcher and participants has been considered. Only three studies<sup>2,6,12</sup> adequately explored the influence of the researcher’s positionality on formulation of the research question and data collection. This is a considerable limitation given the potential influence of a researcher’s own identity on how they view and interpret racialised experiences (Braun & Clarke, 2019; Palmer et al., 2010). For further details on CASP scoring on each criterion for included studies see [Appendix N](#).



**Table 3***Study Characteristics*

	Author(s)	Publication Type & Source	Aim	Participants & Sampling	Method	Theoretical Position	Analysis	CASP Rating
1	Alexis & Shillingford (2015)	Journal article, APA PsycInfo	To explore internationally recruited neonatal nurses' perception of their experiences of working in the NHS.	Purposive sample from two neonatal units across two London hospitals. <ul style="list-style-type: none"> <li>• 13 female neonatal nurses</li> <li>• From the Philippines and Jamaica</li> <li>• Aged 24-55 years</li> <li>• 1-10 years' experience working in the NHS</li> </ul>	Semi-structured interviews, tape recorded	Not stated	Qualitative analysis, Pope et al.'s five-stage framework	7

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2	Alexis & Vydelingum (2004)	Journal article, Citation mining	To explore and understand the experiences of internationally recruited global majority nurses working in the NHS.	<p>Purposive sample recruited via wards across NHS trusts in the South of England.</p> <ul style="list-style-type: none"> <li>• 12 nurses</li> <li>• 5 Male, 7 Female</li> <li>• From the Philippines, South Africa, the Caribbean, and sub-Saharan Africa</li> <li>• <math>\geq 1</math> year's NHS experience</li> <li>• 1-20 years' nursing experience in home countries</li> </ul>	Semi-structured interviews, tape recorded	Phenomenological approach, using Heidegger's (1962) perspective on hermeneutics	Phenomenological analysis, Van Manen's (1990) seven-step analytical framework	9
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3	Alexis et al., (2007)	Journal article, CINAHL	To understand the experiences of recently recruited international global majority nurses working in the NHS.	<p>Purposive sample from a hospital in the South of England.</p> <ul style="list-style-type: none"> <li>• 24 nurses</li> <li>• Gender not reported</li> <li>• 8 different countries across Asia, Africa, and the Caribbean</li> <li>• <math>\geq 1</math> year experience in NHS, average of 3 years' NHS experience</li> <li>• Range of seniority in roles in their home countries (e.g., nurse lecturer, head nurse)</li> </ul>	Focus groups, 6 participants per group	Phenomenological approach	Thematic analysis	9
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4	Batnitzky & McDowell (2011)	Journal article, Citation mining	To show how migrant nurses in the post-war decades were recruited to less prestigious and shorter nurse training course, and how this influenced their career trajectories in the NHS.	<p>Purposive sample recruited via advertisement in Royal College of Nursing newsletter, a subset from of UK-wide study</p> <ul style="list-style-type: none"> <li>• 21 female nurses</li> <li>• Black Caribbean (<math>n=11</math>) and South Asian descent (<math>n=10</math>)</li> <li>• Arrived in the UK for nursing training between 1955-1980</li> </ul>	Interviews, tape recorded	Different epistemological approaches including sociology, feminist theory, Marxism, law and politics	‘Qualitative analysis’, using the notion of interpellation to structure findings	7
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5	Daniel et al., (2001)	Journal article, Citation mining	To identify expectations and experiences of new migrant nurses to support their adjustment and retention.	<p>Purposive sample recruited from a Filipino staff forum in a London hospital.</p> <p>Two groups:</p> <p>Group 1</p> <ul style="list-style-type: none"> <li>• 15 nurses</li> <li>• 1 Male, 14 Female</li> <li>• 3 months in the UK and experience working in NHS.</li> </ul> <p>Group 2</p> <ul style="list-style-type: none"> <li>• 9 Female nurses</li> <li>• On the hospital 2-week orientation programme</li> </ul>	Focus groups, responses recorded on flipchart paper	Pilette's (1989) theory of adjustment	Grounded Theory, Grounded focus group processes (Bulmer 1998)	9
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6	Edeh et al., (2022)	Journal article, APA PsycInfo	To examine the experiences of female Nigerian doctors and nurses working in the NHS.	Purposive sample recruited through churches and professional networks across UK (mainly London). Used snowball sampling.	Unstructured interviews	Phenomenological psychology, feminism, and Hall (1990, 1992, 1997a, 1997b 2017) on migration, racism, and identity	Phenomenological psychological analysis	9	
				<ul style="list-style-type: none"> <li>• 24 Female staff members (12 doctors, 12 nurses)</li> <li>• Nigerian</li> <li>• Subset of 8 participants interviewed again</li> <li>• 5-34 years in UK</li> </ul>					

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7	Hammond et al., (2017)	Journal article, CINAHL	To explore the experiences of student nurses and physiotherapists throughout their education and during the first 6-months post-qualification to identify key experiences and milestones relating to successful employment particularly from different ethnic groups.	<p>Purposive sample recruited from a London university by delivering a presentation to all students.</p> <ul style="list-style-type: none"> <li>• 18 recently graduated nurses (<math>n=12</math>) and physiotherapists (<math>n=6</math>)</li> <li>• 10 Female, 2 Male</li> <li>• White British (<math>n=2</math>), White Other (<math>n=3</math>), Black African (<math>n=7</math>), Asian (<math>n=3</math>), Mixed Other (<math>n=3</math>)</li> <li>• Aged 21+</li> </ul>	Semi-structured interviews, tape-recorded	Phenomenological approach, using Heidegger's (1962) perspective on hermeneutics	Interpretative Phenomenological Analysis (Smith et al., 1999)	9
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8	Henry (2007)	Journal article, Citation mining	To explore the perceptions of career progression in the NHS of a group of midwives and nurses trained in Ghana and working in the UK.	<p>Purposive sample of nurses working in NHS hospital in London and the Home Counties recruited via the Ghana Nurses Association.</p> <ul style="list-style-type: none"> <li>• 20 nurses and midwives</li> <li>• All female</li> <li>• Ghanaian</li> <li>• Half of participants had been in the UK for 15+ years</li> </ul>	Semi-structured interviews, tape-recorded	Turner's (1960) description of modalities of exclusion in the process of social advancement	Not stated, however described data transcription, coding framework, and data validation	6
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9	Likupe (2015)	Journal article, APA PsycInfo	To explore experiences of racism, discrimination, and equality of opportunity among black African nurses and their managers' perspective on these issues.	<p>Purposive sample from hospital wards across four NHS trusts in the Northeast of England. Used snowball sampling.</p> <p>Two groups:</p> <p>Group 1:</p> <ul style="list-style-type: none"> <li>• 30 nurses</li> <li>• 26 Female, 4 Male</li> <li>• Aged 25-48 years</li> <li>• Sub-Saharan African countries</li> <li>• 2-5 years in UK</li> <li>• 5-20 years' nursing experience in home countries</li> </ul> <p>Group 2:</p> <ul style="list-style-type: none"> <li>• 10 managers</li> <li>• 1 male, 1 Black female, 8 White female</li> <li>• 1-6 years' experience of managing</li> </ul>	15 individual semi-structured interviews, and 4 focus groups across 15 participants, tape-recorded	Richmond (1994) on power, and Hall (1999) on stereotyping	Van Manen's (1990) selective approach to highlight themes, Spencer et al (2003) analytic hierarchy to order data	8
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10	Matiti & Taylor (2005)	Journal article, Citation mining	To investigate the cultural experiences of internationally recruited nurses in the UK.	Purposive sample recruited via letters sent to three hospitals across Trent. <ul style="list-style-type: none"><li>• 12 nurses</li><li>• 7 Female, 5 Male</li><li>• From Mauritius, the Philippines, India, and Nigeria</li><li>• 9 months-2 years in the UK</li><li>• 3-12 years' nursing experience</li></ul>	Semi-structured interviews, tape-recorded	Phenomenology	Phenomenological approach (Colaizzi, 1978)	9
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11	Odusanya et al., (2018)	Journal article, APA PsycInfo	To understand how female global majority clinical psychologists experience and make sense of being part of the profession of clinical psychology.	<p>Purposive sample recruited from around the UK. Used personal networks, social media, and snowball sampling.</p> <ul style="list-style-type: none"> <li>• 6 female clinical psychologists</li> <li>• British Asian (<math>n=3</math>), Black African/Black Caribbean (<math>n=3</math>)</li> <li>• Qualified for at least 2 years (range 3-16 years) and qualified in the UK</li> </ul>	Interviews (each participant interviewed twice)	Phenomenology, Multidimensional approach	Mixed method qualitative approach using repertory grids and interpretative phenomenological analysis	8
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12	Qureshi et al., (2020)	Journal article, CINAHL	To understand British South Asian male nurses' views on the barriers and enablers to entering the nursing profession.	Purposive sampling from NHS trusts community centres and places of worship across England <ul style="list-style-type: none"> <li>• 5 Male nurses</li> <li>• British South Asian backgrounds</li> <li>• Bangladeshi (<i>n</i>=1), Pakistani (<i>n</i>=1), Indian (<i>n</i>=3)</li> </ul>	Semi-structured interviews, tape-recorded	Interpretative intersectional approach	Framework analysis	9
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13	Taylor (2005)	Journal article, Citation mining	To explore the experiences of nurses who have trained overseas and travelled to work in the NHS.	<p>Purposive sample recruited by contact ward managers from four Oxfordshire hospitals to share study advert.</p> <ul style="list-style-type: none"> <li>• 11 nurses</li> <li>• 9 Female, 2 Male</li> <li>• From the Philippines (<i>n</i>=5), China (<i>n</i>=2), Finland (<i>n</i>=1), New Zealand (<i>n</i>=1), Nigeria (<i>n</i>=1), and South Africa (<i>n</i>=1)</li> <li>• 3 White staff</li> <li>• 7 months- 6 years working in the UK</li> </ul>	Participant observation, focus group and informal interviews	Constructivist methodology within interpretivist approach	Inductive analysis	9
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14	Withers & Snowball (2003)	Journal article, Citation mining	To explore whether the experiences of Filipino nurses match their expectations of working in the UK	Purposive sample recruited from hospital wards across Oxford Radcliffe Hospitals NHS trust.	<ul style="list-style-type: none"> <li>• 43 Filipino nurses</li> <li>• 31 Female, 12 Male</li> <li>• Qualified on average 6 years ago in the Philippines</li> <li>• 3-18 months (average 7 months) working in Oxford</li> </ul>	Questionnaire with closed and open-ended questions	Semi-structured interviews ( $n=8$ )	Interpretative, phenomenological and Culturalist approach, Pilette's (1989) theory of adjustment	Qualitative data analysis (Miles & Huberman, 1994)	9
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15	Woodhead et al., (2022)	Journal article, CINAHL	To examine the processes through which institutional and workplace context shape discrimination, bullying and harassment to inform approaches to intervention.	Purposive sampling of participants from the TIDES who agreed to be recontacted for research from London NHS trusts <ul style="list-style-type: none"> <li>• 48 healthcare staff including students, nurses, midwives, healthcare assistants</li> <li>• 41 Female, 7 Male</li> <li>• Asian (<i>n</i>=5), Black (<i>n</i>=13), White British (<i>n</i>=19), White Other (<i>n</i>=7), Any other group (<i>n</i>=4)</li> <li>• 31 non-migrants, 17 migrants</li> <li>• Majority were student nurses/midwives (<i>n</i>=21)</li> </ul>	Semi-structured interviews, tape recorded	Critical Race Theory, Intersectionality, Workplace diversity and inclusion	Thematic Analysis (Braun & Clarke, 2012)	8
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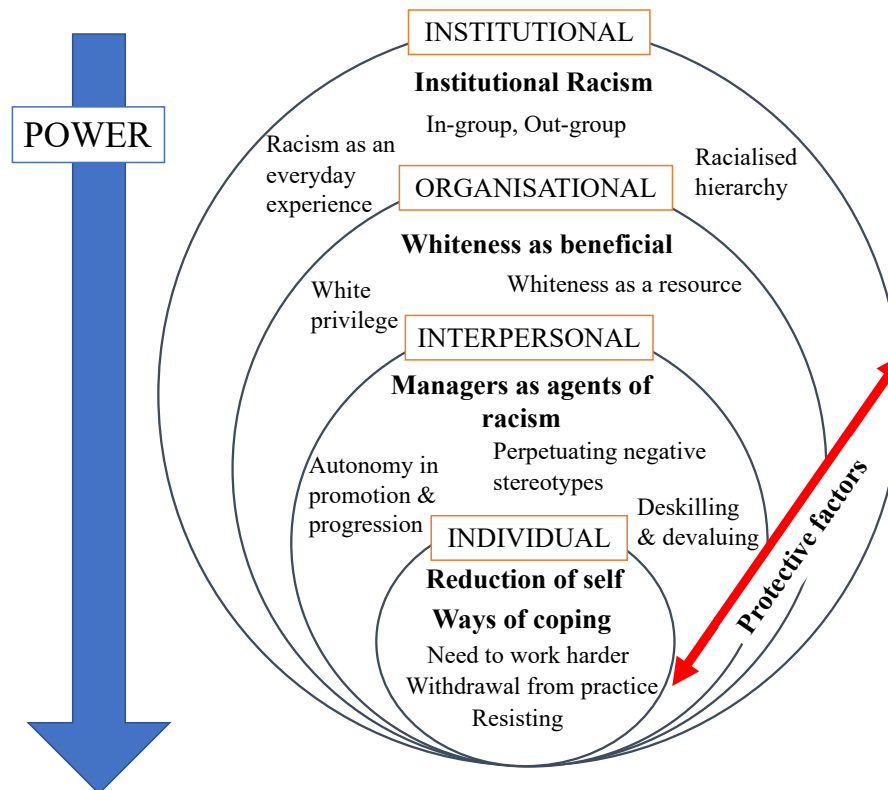
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## Thematic Synthesis

Despite heterogeneity in underpinning theory, sample, methods, and racial groups across studies, six key analytic themes emerged: Institutional racism, Whiteness as beneficial, Management as agents of racism, Ways of coping, Reduction of self, and Protective factors (see [Figure 7](#)). Differences in NHS staff's experience across racial groups emerged. Additional illustrative quotes for each theme and subtheme appear in [Appendix O](#).

### Figure 7

*Diagrammatic Formulation of Clinical Staff from Different Racial Backgrounds' Experience of Recruitment to and Working in the NHS*



### Theme 1 – Institutional Racism

Across all 15 included studies, the NHS was experienced as institutionally racist<sup>1-15</sup> – that is, a system where racism is embedded into the organisation's structure from recruitment to progression (Braveman et al., 2022). For global majority staff, racism was an everyday



experience<sup>1,2,4,6-15</sup> and was reflected in the racial stratification of staff across the NHS<sup>1-6,8-9,11-15</sup>.

### ***Subtheme 1: Racialised Hierarchy***

A narrative developed across studies that higher-band roles were meant for White British staff, whereas staff from global majority backgrounds were associated with and restricted to lower-banded roles<sup>2-6, 8,9,12,13,15</sup>. This racialised hierarchy was maintained through different mechanisms, and the most commonly reported strategy was through barriers to career progression for global majority staff<sup>4,6,8,9,14</sup>. Despite additional training<sup>4,8,9</sup> and years of experience<sup>2,4,8,9,12</sup> global majority staff remained at lower bands and witnessed their less-experienced White colleagues progress<sup>2,4,6,8,9,12</sup> “people less deserving get higher post than us for example a new White staff nurse was promoted within a month of being here” (Southeast Asian nurse)<sup>7</sup>.

This led to a reduction of hope among global majority staff of progressing in the NHS<sup>2-6,8,9,12,15</sup> “we’ve seen too many people go through it and not get there, so we can’t be bothered...we know we’re never going to get this, we know what’s going to happen, so what’s the point?” (Black, non-migrant, senior qualified nurse/midwife)<sup>15</sup>.

Global majority staff that *did* occupy senior positions represented an incongruence to the racialised hierarchy and were met with resistance from staff<sup>3,11,13,15</sup> “some White nurses do not regard some Black doctors and I have had that in the past” (Black African, migrant, doctor)<sup>6</sup> and patients “some relatives would by-pass me and look for a White nurse to enquire about their family member although I am the one caring for that patient” (Black African, migrant, nurse)<sup>3</sup>. For international nurses this racialised hierarchy resulted in a loss of status after migrating to the UK<sup>6,13</sup>.

Jennifer (Black African, migrant, doctor) described her move from Nigeria to the UK as one of going from being ‘a pretty young doctor’ to a ‘statistic where nobody notices

you.’ This shift was more than just a loss of status but the development of a new identity of being Black in the UK<sup>6</sup>.

In the racial hierarchy Asian staff were placed higher up than Black staff, which some staff explained was due to recruitment<sup>4,9</sup>.

When the Indian nurses were recruited there was this thing [policy] about recruitment and retention so...that’s why they came up with this attitude that they are better than you because they were given the impression that they were needed more than you are (Black African, migrant, nurse)<sup>9</sup>.

Consistent with this, Asian staff reported more positive experiences in relation to career progression<sup>1</sup>, less discrimination in the UK compared to other countries<sup>5</sup>, and feeling supported by colleagues<sup>5,14</sup> “it’s perfect, because they have done a lot of things for us. They encourage us and they motivate us to work hard... they are very supportive; appreciative also” (Southeast Asian, migrant, nurse)<sup>14</sup>.

### ***Subtheme 2: Racism as an Everyday Experience***

Systemic racism within the NHS was demonstrated in global majority staff’s reports of racism from patients<sup>4,6,9,11,13</sup>, colleagues<sup>9,13</sup>, and managers<sup>1-15</sup>. They experienced different forms of racism from overt racial abuse<sup>4,7,9,11,13,15</sup> “when I first started coming in the country and was nursing, the older patient was not used to Black people so they were very nasty, they will take their poo [faeces] and throw at you or call you Black (Black Caribbean, migrant, nurse<sup>4</sup>); to more insidious forms of racism that left the victim questioning whether what they experienced was due to race<sup>2,4,6,11,13,15</sup> “this surgeon may be racist, I am not sure. I felt upset. He made me feel as though I knew nothing” (Global majority, migrant, nurse)<sup>2</sup>.

Racism from colleagues and managers was more commonly reported compared to racism from patients<sup>4,9,13,15</sup>. This sometimes took the form of humour and workplace ‘banter’ aimed at global majority staff, particularly internationally recruited staff.

On one occasion, a UK member of staff joked: ‘We’re not having any more like her here.’ (White British, non-migrant, nurse) This was said whilst catching the eye of an overseas nurse, who laughed loudly in response. On another occasion, a UK nurse joked, referring to ‘your Filipino ways’ (White British, non-migrant, nurse)<sup>13</sup>.

### ***Subtheme 3: In-group, Out-group***

Global majority staff understood that due their race they were seen as inferior<sup>4,6,10,11,13</sup> and members of the out-group<sup>2-11,13,15</sup> “since I came here I have never experienced such open discrimination. White nurses have treated me as stupid and they will not include me as part of the nursing team” (Southeast Asian, migrant, nurse)<sup>3</sup>, “the best word I can use is racism or discrimination, as long as you come from Africa you are not one of them, you are not a White person, you are looked down upon in every way” (Black African, migrant, nurse)<sup>9</sup>.

Global majority staff described how any deviation from the in-group culture of White British was treated as a problem<sup>2,6,11,13,15</sup>. Global majority staff who were British citizens or educated in the UK also experienced exclusion from the in-group<sup>4,6,7,11,15</sup> “even if you are British and you say you are British, people want to know where your parents are from... there is a sense of we are different, a sense of division that is already created in such queries” (Black African, migrant, doctor)<sup>6</sup>.

Additional markers of difference that led to exclusion included international qualifications<sup>4,6,9,13</sup>, migration status<sup>15</sup>, and cultural dress<sup>7,15</sup>. However, cultural challenges between global majority staff and White British staff were experienced both ways<sup>5,13,14</sup>. For example, issues understanding accents<sup>2,10</sup>, the role<sup>2,5</sup>, and general practice<sup>13,14</sup>.

One respondent observed that the Filipinos' attitude to nursing as being a 24-hour occupation could be a cause of conflict with those UK nurses who believed that some unfinished tasks could be handed over to the next shift as long as patient care was not compromised<sup>14</sup>.

## **Theme 2 – Whiteness as Beneficial**

Whiteness is a social system that ensures the dominance and privilege of people racialised as White (Kinouani, 2021). This theme, present across 12 of 15 studies, highlighted the advantage afforded to White staff across banding<sup>7,9,15</sup> including increased access to social relationships<sup>15</sup>, support<sup>6,15</sup>, and career progression<sup>2-4,6,9,12</sup>. Global majority staff also utilised Whiteness as a resource to fit in and improve their chances of being promoted.

### ***Subtheme 1: White Privilege***

A central feature of Whiteness is its ability to bestow White privilege upon its beneficiary (Bhattacharyya et al., 2002). Across studies, a narrative developed that White staff were advantaged in the NHS<sup>2-4,6,9,11-13,15</sup>. Global majority staff described experiences of White staff being offered patronage for promotion<sup>6,7</sup> and White staff being able to access different spaces regardless of their banding<sup>7,9,15</sup>.

When you went into the staff room, it was really tiny anyway but...all the White nurses and the HCA [Health care assistant] was fine. There was another two admin staff that were, um, of White English background and they were in there. And everything was fine. But all the cleaners, any admin, like, other HCAs, the housekeeper, it felt like we weren't allowed in there... Like, you guys don't belong here in the staff room. (Asian, non-migrant, student nurse/midwife)<sup>15</sup>

White privilege appeared to transcend migration status as White migrant staff were accepted as part of the in-group in contrast to migrants from global majority backgrounds<sup>13,15</sup>. For example, UK staff referred to the nurses from global majority backgrounds, but not White nurses from New Zealand and South Africa, as “overseas nurses”<sup>13</sup>. White privilege allowed White staff a lack of accountability<sup>9,13</sup> “we had one Hungarian lady...we were saying the work she was doing wasn't the right thing but she was treated like...you know because of the colour as if she knows what she is doing” (Black African, migrant, nurse)<sup>9</sup>. This theme is

closely related to the theme ‘Management as agents of racism’, which highlights the autonomy with which White managers exercised nepotism in recruitment processes<sup>1-4,6,7,9,15</sup>.

***Subtheme 2: Whiteness as a Resource for Global Majority Staff***

Whiteness represented not only White staff, but proximity to Whiteness through skin colour and accent<sup>15</sup>. Staff and researchers described how Whiteness conferred advantage for global majority staff when utilised to support career progression or assimilation into NHS culture<sup>5,7,8,11,15</sup>. Global majority staff modified aspects of their identity (e.g., clothing, cultural markers) in the workplace to reduce difference and increase proximity to Whiteness<sup>7,15</sup>. For example, “a nursing graduate discussed with her husband “not wearing a headscarf to interviews” and “not showing [her] passport” because her Muslim culture and place of birth might lead to bias at interview (Asian, migration status unknown, nurse)<sup>7</sup>. Where there were multiple markers of difference (e.g., race, ethnicity, religion, migration status) staff explicitly sought the help of White colleagues<sup>8</sup>. For example, after consulting a White colleague, a Black African migrant nurse was successful after eight years of applying for a promotion<sup>8</sup>.

However, efforts of global majority staff to gain proximity to Whiteness did not come without a cost. Modifying aspects of their cultural identity caused global majority psychologists’ internal conflict and criticism from their own communities<sup>11</sup>.

I think the challenge is how do you integrate yourself into all the different teams without necessarily compromising who you are and your identity... [I]t’s one of those things that’s always difficult, or people look at you selling out or you’re sort of trying to be White. (Black British, non-migrant, psychologist)<sup>11</sup>

**Theme 3 – Management as Agents of Racism**

This theme, present across all 15 studies, captured how racism was enacted by those with power: managers. The racialised hierarchy within the NHS meant that managers were often White. Managers acted as agents of racism through perpetuation of negative racial

stereotypes<sup>3-6,8,9,11,13,15</sup>, deskilling and devaluing global majority staff<sup>1-4,6,8-11,13-15</sup>, and favouring White staff in recruitment and promotion<sup>2,4,6-9,14,15</sup>.

### ***Subtheme 1: Perpetuating Negative Racial Stereotypes***

Managers hold power and influence within the NHS hierarchy<sup>4,3,15</sup>. Across studies that sampled managers and other senior NHS staff<sup>3,9,13,15</sup>, direct quotes from managers demonstrated negative racial stereotypes and prejudice towards global majority staff<sup>9,15</sup>.

That's either cultural, either their schooling, either their country of origin...we have a real problem with Filipinos...in the Philippines it's [unequal progression] much wider apart, so women already are feeling less valued. And also, they, they are much more, um, subservient. And especially in, they have a pecking order in things. They'll always back down if someone is more senior. (White British, non- migrant, senior qualified nurse/midwife)<sup>15</sup>

The NHS recruitment and promotion system appeared to be based on manager's judgements about candidates' ability<sup>4,6-8</sup>, which are open to racial stereotypes and prejudice<sup>8</sup>. Negative racial stereotypes about the attributes of global majority staff from managers affected career progression<sup>4</sup> and led to differential treatment of different races<sup>3,4,8,9,13,15</sup> "I mean if you look at Filipino nurses are pretty quick and they are quite good. African nurses are not bothered about developing themselves, honestly they just want to go back to Africa" (Ethnicity and migration status unknown, charge nurse)<sup>9</sup>. Racial stereotyping from managers reinforced the position of Black staff at the bottom of the NHS' racialised hierarchy<sup>9</sup>. This, in turn, increased inter-ethnic group conflict<sup>4,9,15</sup> "even if you search on YouTube and you see, like, women harassing Muslim women or like, most, 90 percent they are Black women" (Other ethnic group, migrant, nurse/midwife)<sup>15</sup>.

### ***Subtheme 2: Deskillling and Devaluing Global Majority Staff***

Global majority staff, especially international staff, described a process of deskillling and devaluing by managers<sup>1-4,6,8-11,13-15</sup>. Managers restricted international staff from carrying out routine procedures that they were used to doing in their home countries<sup>1-4,10,13</sup> “when one graduates you do everything. Here you have to undergo certain training. You are not allowed. Anyway it is quite amusing” (Southeast Asian, migrant, nurse)<sup>10</sup>, “you can’t suggest using your skills. You can’t really suggest because they will tell you forget about your past experience, this is a different place, this is UK. I mean it was quite frustrating because... you are treated like students” (Global majority staff, migrant, nurse)<sup>1</sup>.

International recruits were asked to do menial jobs such as patient personal care<sup>2,4,9,13</sup> “shocking to say the least. We have health carers who will give patients baths” (Global majority, migrant, nurse)<sup>2</sup>. This often left international staff feeling frustrated as they were worried that they would lose their skills<sup>1,4,9,13,14</sup> “they treated us as newly qualified. Yet we were experienced nurses. I’d been working in this country for a year and a half (in a different trust) yet when I came here I was still treated as nothing” (Race unknown; migrant, nurse)<sup>13</sup>.

Staff from global majority backgrounds also experienced being watched closely by managers<sup>3,9,13</sup> “in this country you are followed so much you are looked at so much, you are watched so much and you are put down so much and you are not allowed to do anything” (South Asian, migrant, nurse)<sup>3</sup>. This close observation of global majority staff was corroborated by managers<sup>9</sup>.

I still observe because they could fib to me. They might say yes I can do this but I’ve still got to be aware that they could be telling me a few mistruths. So I still watch. It’s not only my eyes but somebody’s eyes as well, and they are monitoring as well. (Race and migration status unknown, Charge nurse)<sup>9</sup>

### ***Subtheme 3: Autonomy in Promotion and Progression***

Staff consistently described how systems of promotion were based on managers' favouritism<sup>6-9,15</sup>. Global majority staff reported that managers gave White staff additional interview support<sup>6-8</sup> "they would call people to their offices and show them, tell them everything." (Black African, dual UK/Ghanaian, nurse)<sup>7</sup>. Whereas global majority staff experienced a lack of interview support from managers and in some cases were given misleading information<sup>4,8</sup>.

I tell them my version and they tell me it is alright. So I go away thinking that what I know is alright and is enough to go through the interview. So I go to the interview I get asked the questions and I tell them what I know and then it's like I make a fool of myself. (Black African, dual UK/other West African, nurse)<sup>7</sup>

Both staff and managers recalled that White staff were invited to apply for certain positions regardless of experience<sup>7</sup> "in one example, a student recalled being invited to apply for a job by a manager, despite the fact that she did not have the six months experience requested on the job description"<sup>7</sup>. This favouritism was not only extended to White staff, but to particular global majority ethnic groups<sup>9</sup>, further reinforcing a racialised hierarchy that placed Black staff at the bottom.

Like Filipino, there was one that was there for three years and was extremely good... but it took a good two years of bullying in a nice way, saying there is an E grade coming up; I want to see you go for it. But like I said for (Black African nurse) there hasn't been an opportunity on this ward, but there have been on other wards. I know she likes it here, she likes the people, she likes the work, and it works out well within her home life. (Race and migration status unknown, Charge nurse)<sup>9</sup>

Whilst Likupe (2015) did not provide the ethnicities or migration status of managers alongside quotes, most managers interviewed identified as White (see [Table 3](#)). This system



of manager autonomy in promotion and unequal opportunity extended beyond White managers, as global majority managers were complicit in providing unsolicited advantage to support White applicants<sup>6</sup> “...if a White, Caucasian applies for a job, and if a Black sister or brother applies for the same job, you have a duty to make sure you support the Caucasian to get it” (Black African, migrant, nurse)<sup>6</sup>. This was due to feeling pressured to conform to the status quo and not wanting to show in-group favouritism<sup>6</sup>.

#### **Theme 4 – Reduction of Self**

These experiences of racism from patients, colleagues, and managers slowly chipped away at global majority staff’s sense of professional and personal identities<sup>2-4,6-11,13,15</sup>. For example, requests for help from managers that were ignored, and excessive scrutiny left global majority staff feeling like failures<sup>2,3</sup>. This impacted global majority staff’s sense of self as well as professional competency<sup>2,3</sup>. Global majority staff described a loss of confidence and reduced self-esteem in their professional ability due to negative experiences with colleagues and managers<sup>2,3,9</sup> “when I do my sentences, my grammar. It is like they do check me right there and then, they don’t wait for....they say let’s talk about how you should say it. I felt embarrassed and humiliated (Global majority, migrant, nurse)<sup>2</sup>.”

For some global majority staff these experiences led to the internalisation of racist beliefs, and they began to think there was something wrong with them<sup>3,4,7,9,10,15</sup> “I could have moved on at a greater pace than I did really... I think of it as positive not negative. I don’t think I would make a good manager. I’m more of a hands-on person anyway” (South Asian, migrant, nurse)<sup>4</sup> and “he states he was “not ready” and goes on to say that he was: “very lucky to get a Band 4 [physiotherapy technician, not a qualified post], on rotation and gaining necessary experience along the way” (Black African, physiotherapist)<sup>7</sup>.

Unique to Black staff were descriptions of how their cultural identities were reduced and they were seen as a monolith<sup>6,11</sup>.

Sometimes in lectures someone would turn to me and go, ‘So, what’s the opinion of, you know, the Caribbean community? And I’m like, ‘I don’t know. I’m not Caribbean’ [laughs], and even if I was, doesn’t mean I speak for every single Caribbean person you know! (Black British, non-migrant, psychologist)<sup>11</sup>

Our respondents described leaving Nigeria with multiple identities based on, for example, gender, ethnic and occupational identities, but they ‘became Black’ when they came to the UK, an identity that, as Rose (Black African, migrant, doctor) said, created ‘worries’ that did not exist ‘back home’<sup>6</sup>.

### **Theme 5 – Ways of Coping**

This theme, present across all 15 studies, illustrates how staff attempted to cope with racism in the NHS. Some staff placed responsibility on themselves to change their circumstances through hard work<sup>4,6,9</sup>, proactiveness<sup>2,7,10</sup>, and resilience<sup>1-3,5,8,10</sup>, whereas others withdrew from professional practice<sup>1-3,5-9,15</sup>. A minority of staff reported resisting and challenging the status quo within their teams and wider NHS culture<sup>4,5,7-9,11,13-15</sup>. Many global majority staff coped using a combination of often contradictory strategies, resulting in internal conflict and emotional exhaustion.

#### ***Subtheme 1: Need to Work Hard, be Proactive and Resilient***

Due to a lack of support received from colleagues and managers, a narrative developed among all staff that “it’s up to me”<sup>7</sup>. This self-reliance and proactiveness was present in both White and global majority staff<sup>7,10,14</sup> “If I ask, I then do it myself” (White Other, nurse) and “I had to go there... Just to get an idea of what they do so that I can get prepared for the job... You wouldn’t get a job unless you’re proactive, yes, yes very proactive” (Black African, migration status unknown, nurse)<sup>7</sup>. However, global majority staff understood that they needed to work harder than their White counterparts as their experiences would be more difficult due to their race<sup>4,6,7,9</sup>.

For global majority staff this anticipated discrimination meant staying later<sup>6</sup>, attending additional training<sup>9</sup>, and going above and beyond to progress and combat racial stereotypes<sup>4,6,11</sup>. This way of coping highlighted an emphasis on an internal locus of control, rather than placing responsibility in an inequitable system<sup>6,7,11</sup> “it’s something that I still carry today. That I still have to constantly prove myself, and so I’m the person that will get there early and leave later...my reports will be of probably more detail than they need to be” (Black British, non-migrant, psychologist)<sup>11</sup>, “It is more likely that if I make a mistake at work, there will be higher litigation for me, do you understand? Because I am not from here, because I don't speak like them, so I have to be excellent” (Black African, migrant, doctor)<sup>6</sup>.

International staff described a lack of support from colleagues and managers in adjusting to their new work environment and culture<sup>2,5,6</sup> “I felt I was an alien at times. Nobody seemed to bother” (Southeast Asian, migrant, nurse)<sup>5</sup>. Instead staff described having to find their own ways and build resilience to working in such pressurised environments<sup>1-3,5,8,10</sup> “I sometimes feel it’s difficult to be honest to be comfortable here. I think if you are a softie and don’t have enough strength to survive it can be quite difficult here” (South Asian, migrant, nurse)<sup>3</sup>. Part of this resilience was by reminding themselves of their motivation to migrate which included ability to financially support family back home, experience a new culture, and develop professionally<sup>1,3,5</sup>.

### ***Subtheme 2: Withdrawal from Practice***

Another way global majority staff coped with their negative experiences in the NHS was to withdraw from practice<sup>1-3,5-9,15</sup>. This included withdrawal from recruitment and promotion processes<sup>7,12</sup>, increased sick leave<sup>2,15</sup>, moving teams<sup>6,15</sup>, leaving their job and NHS<sup>2,7,9,15</sup>, or leaving the UK altogether<sup>1,3,5</sup>. Global majority staff felt hopeless and despondent in the realisation that recruitment processes were biased towards White staff<sup>12</sup>.

The next time it was advertised there was a much more junior English nurse who only worked part-time and she has currently got that job but I actually withdrew from the interview process because it was evident no matter how bad she could have been that she would have got it. (South Asian, non-migrant, nurse)<sup>12</sup>

In addition to negative recruitment experiences, the racist and discriminatory treatment staff faced in their workplaces also led to wanting to leave their job, team, or the UK<sup>1-3, 5-9, 12, 15</sup>.

Whenever you make mistakes you are made to feel awful. This made me lose my confidence and I felt so low that I was on the verge of going back because I never thought I would be able to live up to their expectations. (South Asian, migrant, nurse)<sup>3</sup>

Global majority staff also described how despite additional training, their careers stagnated to the point that their only option was to leave the role<sup>4,9</sup>.

I had to do a lot of courses, did everything and then when I applied for the job I realised that am just banging myself against a brick wall then I thought I am going to leave. (Black African, migrant, charge nurse)<sup>9</sup>

### ***Subtheme 3: Resisting the Status Quo***

Global majority staff described individual and collective strategies used to resist their positioned status as inferior<sup>4,5,7-9,11,13-15</sup>. Individual resistance involved staff speaking up against unfair treatment<sup>4,9,14</sup>, challenging attempts to restrict access to appropriate training<sup>4</sup>, and bringing their cultural identity into their work<sup>11</sup>.

Nobody recognises any Black [nurse] no matter how intelligent you are. If you are intelligent they would rather prove you to be too confrontational. So I tell you I cannot hide, I told my manager last week I said I'm not happy. (Black African, migrant, nurse)<sup>9</sup>

However, individual resistance was difficult, and few staff felt able to challenge their inferior status "you're doing State Enrolled Nurse training'. And they have no choice, they

accepted it. But somebody like me, I knew I had a choice; I didn't have to do it" (Black Caribbean, migrant, nurse)<sup>4</sup>. More commonly staff reported coping using mutual support from other global majority staff<sup>4,7,11,13-15</sup>.

Black people, we were treated differently, the White ones would go to the kitchen and have their cup of tea and we were sent to the sluice, to wash the bed pans and to do all the work and to be on the ward looking after the patients, but we didn't worry because we know what we wanted to achieve and what we had to do and we did it, and we did it by making jokes with each other and laughing and doing our work properly. (Black Caribbean, migrant, nurse)<sup>4</sup>

This was especially prominent among international nurses that were recruited in cohorts<sup>5,14</sup>. They would provide mutual support for each other by preparing for interviews together<sup>13</sup>, speaking shared language<sup>5,14,15</sup>, and socialising with each other inside and outside work<sup>4,13,14</sup> "there is a strong network of nurses from the Philippines, so we share things together" (Southeast Asian, migrant, nurse)<sup>14</sup>.

### **Theme 6 – Protective Factors**

Whilst the majority of experiences of recruitment to and working in the NHS described by global majority staff were negative, some reports of positive experiences helped them to cope with working in the NHS<sup>1,2,5,10,13-15</sup>. This theme captures the experiences of internationally recruited global majority staff and what helped them to adjust to their new environment. The adjustment was aided through a supportive induction programme that considered cultural issues and access to social support<sup>5,10,13</sup>. This helped international staff to feel welcome and valued by existing staff<sup>5,10,13</sup>.

A party was also organised with Filipino nurses already working for the trust. The fact that they were recruited as part of a group and arrived together was also helpful.<sup>5</sup>

I had a chance to be in a ward where everybody now I can say is my family. I have got somebody I can talk to and also some took me out for a meal. Which was nice of them.

They sometimes talk about UK life. (Black African, migrant, nurse)<sup>10</sup>

Induction programmes that slowly prepared international global majority for their duties were greatly appreciated by staff<sup>2,5,13</sup>. Staff described follow-up support in the form of mentors, buddy-systems, and dedicated internationally recruited staff coordinators<sup>1,2,10,13</sup>.

I think they are treating me fairly well. They tend to give me responsibility. If I want to learn something they give me a mentor whom I can turn to for support. (Global majority, migrant, nurse)<sup>2</sup>

Positive team dynamics strongly influenced staff wellbeing for both international and British global majority staff<sup>13,15</sup>. This led to increased confidence and self-esteem for global majority staff<sup>5,13</sup>.

My confidence in working as a nurse has already increased as the weeks go by. This is not only because of the helpful study days that we have had but also because of the warmth of the other staff members, acceptance of our presence and capabilities as nurses. (Southeast Asian, migrant, nurse)<sup>5</sup>

## **Discussion**

This systematic review aimed to synthesise findings on clinical staff from different racial backgrounds' experience of recruitment to and during roles in the NHS. Fifteen qualitative studies were found that met my eligibility criteria. Clinical staff's experience of recruitment to and working in the NHS fell into the following six themes: Institutional racism, Whiteness as beneficial, Management as agents of racism, Reduction of self, Ways of coping, and Protective factors. The included studies sampled a total of 321 clinical staff from different racial backgrounds and across a range of professions. All studies were conducted in

the UK, with many studies drawing on London-based samples. However, included studies were heterogenous in underpinning theory, study design, sample size, and analysis.

In contrast, previous systematic reviews on this topic were relatively homogenous, focusing exclusively on the experiences of global majority nurses (Alexis & Vydelingum, 2005; Likupe, 2006; Pendleton, 2017). Furthermore, previous reviews aggregated experiences of staff from different racial groups (Alexis & Vydelingum, 2005; Pendleton, 2017), whereas in the current review, where possible, I disaggregated 'global majority' to highlight the unique experiences of different racial groups. This was limited, however, by the way in which studies categorised and reported participants' race. Nevertheless, this review was novel in its inclusion of multiple clinical professions and in its attempt to understand the experience of different racial groups – including White staff. By considering the perspectives of those that benefit from and those disadvantaged by a racialised system, this review provided a multi-perspective view on the issue of NHS workforce racial inequity.

The current review highlighted that institutional racism represented the overarching system in the NHS, within which power and opportunities were distributed based on a racialised hierarchy (see [Figure 7](#)). Staff from the included studies described a culture where Whiteness was beneficial regarding access to training, social relationships, and career progression. This is consistent with evidence that has identified the NHS as an institutionally racist organisation (Gould, 2004; Iacobucci, 2021; Kline, 2014; Lintern, 2021). Across studies, staff described the existence of a racialised hierarchy whereby global majority staff were overrepresented at lower bands and White staff were more likely to occupy higher bands. These findings align with literature from organisational psychology and sociology that argue organisations are inherently racialised structures (Avent-holt & Tomaskovic-Devey, 2019; Ray, 2019). Indeed, Avent-holt and Tomaskovic-Devey (2019) posit that inequalities present within modern society are established and solidified through organisations. When

external categories, such as race, map onto internal categories within an organisation, such as NHS banding, these inequalities become more extreme and durable (Blau, 1977; Tilly, 1998; Avent-holt & Tomaskovic-Devey, 2019).

The impact of the COVID-19 global pandemic is a recent example of the existence and impact of a racialised hierarchy in the NHS. Whilst most of the included studies ( $n=12$ ) pre-dated the COVID-19 global pandemic, this review helped to provide a context for the disproportionate impact of COVID-19 on global majority NHS staff. Of the first 100 healthcare staff to die from COVID-19 in 2020, 63% were from a global majority background, despite at the time only representing 20% of the NHS workforce (Cook et al., 2020). Consistent with this review's findings, the NHS's racialised hierarchy meant that global majority staff had an increased likelihood of COVID-19 patient contact compared to their White counterparts, due to working in lower-banded roles (Chisnall & Vindrola-Padros, 2021). Previous studies have highlighted that high frontline prevalence, combined with inequity in redeployment to COVID-19 wards and lack of access to training and fit-testing for PPE, resulted in increased viral exposure and subsequently high mortality rates for global majority NHS staff (Chisnall & Vindrola-Padros, 2021; Ford, 2020; Moorthy & Sankar, 2020; WRES, 2021). In accordance, this review's findings emphasise the importance of conceptualising racism as a systemic force embedded within the structure of the NHS rather than a problem of individual prejudice (Salter & Adams, 2013).

Also embedded within the structure of the NHS was a culture of Whiteness, which represented racism at an organisational level (see [Figure 7](#)). Although only 20% of included studies in this review sampled White staff, the theme of 'Whiteness as beneficial' emerged across studies. The concept of Whiteness reflected the normative culture and conferred advantages in the NHS. This review demonstrated how Whiteness impacted global majority staff's access to jobs and progression, as staff frequently reported being passed over for a



position by a White member of staff. Global majority staff described attempting to gain proximity to Whiteness by modifying their accents, clothes, and asking White colleagues to help them with applications to access promotions.

Whilst global majority staff across studies described clearly that White privilege existed in the NHS, not everyone may recognise this advantage. Fernando (2017) argues that White people believe the advantages of White privilege are not related to race and so are interpreted as deserved. Hence White staff are absolved from reflecting on their unearned advantage, their smooth accession to positions of power, and their high status (Kandola, 2018). Similarly, Jones (2020) argues that one of the routes to racism is the myth of meritocracy: the idea that those who work hard will be successful, ignoring the uneven playing field (i.e., institutional racism) which means that many global majority individuals fail to succeed despite their hard work. This belief among White staff can make discussing racism within the workplace challenging. Moorley et al. (2020) argue that simply mentioning ‘White people’ violates the narrative that clinical professions such as nursing are ‘colour blind’ and treat everyone equally, resulting in meaningful discussions on racism treated as “taboo” (Barbee, 1993).

In this review, White privilege also provided White international staff in-group membership, whereas global majority international staff were excluded. However, following Brexit, research has shown that White NHS staff from EU countries such as Spain and Greece have reported increased discrimination and negative treatment from their colleagues (Johnson, 2020; Spiliopoulos & Timmons, 2019). This further highlights the need to take an intersectional approach when studying racialised experiences, for example understanding the interplay between race and migration status.

Despite this evidence, the predominantly White leadership in the NHS who maintain the culture of Whiteness have failed to recognise institutional racism exists (Moorely et al.,

2020). Staff across studies described how institutional racism in the NHS was upheld and perpetuated by managers, whose negative racial stereotyping and discrimination created a system based on White favouritism, as captured in the theme 'Management as agents of racism'. One of the earliest studies to highlight racial inequity in NHS recruitment revealed British-trained doctors with 'foreign' names were less likely to be shortlisted compared to those with English names (Esmail & Everington, 1993). Almost two decades later, evidence exists that NHS recruitment processes continue to favour White over global majority applicants: WRES data shows White applicants are 1.54 times more likely to be successful after shortlisting compared to global majority staff (WRES, 2023).

Staff across this review reported witnessing managers' negative stereotyping, bullying, and harassment of global majority staff, and their simultaneous support and favouritism for White staff. This is in line with a report by the NHS Confederation which highlighted that racism from colleagues, leaders, and managers occurred more frequently than racism from the general public (NHS Confederation, 2022). This reflects an interpersonally-mediated level of racism (Jones, 2000). NHS managers positioned Black staff as confident but incompetent, and Asian staff as submissive and culturally oppressed. Such negative racial stereotypes were directly and indirectly spread across staff members and teams, and these stereotypes were also present among junior staff and students. An implication of this finding is the possibility that negative stigma is used by managers in the NHS to exploit and excluded global majority staff from social positions and relationships (Link and Garcia, 2021; Phelan et al., 2008).

This review also highlighted the complex position of global majority managers in the NHS as both victims and perpetrators of racism. To progress within their career or protect their jobs, some global majority managers in the NHS uphold racial inequities rather than challenging them (Kar, 2021). However, in this review, global majority managers also

reported overt resistance to their authority from White colleagues and witnessing unfair advantage in favour of White staff during recruitment and promotion. Only 10% of global majority managers surveyed were confident in the NHS's ability to tackle institutional racism, and 51% of leaders considered leaving the NHS due to experiences of racism whilst performing their role (NHS Confederation, 2022).

Leaving their job, the NHS, or the UK altogether was a commonly reported strategy by global majority staff in the analytic theme 'Ways of coping'. Whilst this way a way of coping for global majority staff, it also led to the internalisation of racist beliefs. Internalised racism is acceptance by global majority groups of negative messages about their own ability or intrinsic worth (Jones, 2000). For example, following multiple failed attempts to progress onto higher bands, some staff reported that they were not suited to managerial roles. These experiences led to feelings of resignation and helplessness, which while captured in the subtheme 'Reduction of self' was a consistent narrative across all themes.

Previous research has shown that staff wellbeing predicts the quality of patient care. At a time when the NHS faces increased staff shortages post-Brexit (Hervey, 2022; The King's Fund, 2018), high numbers of staff leaving (General Medical Council, 2022), and an overreliance on internationally recruited staff to meet this shortfall (Siddique, 2017; Walker, 2023), an increased investment in global majority staff's personal wellbeing and professional development through anti-racism practice is essential. Anti-racism is defined as "the continual practice of unlearning internalised belief systems dictated by White supremacy, redistributing power, resources and privilege to populations directly disproportionately harmed by White supremacy, and redressing historical and contemporary biological, mental, spiritual and social injustices enacted under White supremacy" (Lett, 2023).

Consistent with this idea, the current review found global majority staff reported that resisting their racialised treatment was one way of coping with experiences of racism. Forms

of resistance to the status quo captured in this review included speaking up against racism and mutual support within global majority groups. This is consistent with good-practice examples of anti-racism and have been viewed positively by global majority NHS staff (Hatch et al., 2021; Ross et al., 2020; Jieman et al., 2022). For example, a recent report by Ross and colleagues (2020) based on interviews from staff across three NHS trusts showed that establishing staff networks and psychologically safe routes for raising concerns (e.g., Freedom to Speak Up Guardians) helped global majority staff feel their organisation was committed to anti-racism.

### **Implications and Recommendations**

The inclusion of clinical staff from a variety of clinical professions builds on previous reviews by highlighting that the challenges of racial inequity are not specific to certain professions but represent an institutional and systemic issue across the entire NHS. Thus, the findings from this systematic review emphasise the need of structural efforts to work towards an NHS that is equitable and practices anti-racism.

The findings of this review also highlight the distressing narratives of global majority clinical staff; these experiences should be used to inform the creation of anti-racism interventions to support the psychological wellbeing of global majority NHS staff in order to promote safer working environments where staff feel valued and able to progress. This could also help to retain more global majority staff and create more ethical international recruitment programmes. For example, the findings of this review could be used to inform the next quarterly review of the NHS' International Recruitment toolkit (NHS Employers, 2023), which is an interactive guide to support good practice and ethical international recruitment across the NHS.

At a more local level, the findings from this review could support NHS managers to review their practice, acknowledge their biases, and change recruitment and promotion

practices within their services. Furthermore, for staff from global majority backgrounds that access this paper, it could help to affirm and validate their workplace experiences and motivate them to seek mutual support from colleagues with shared identities (e.g., setting up of global majority staff networks). Based on the experiences shared by the NHS clinical staff from the studies included in this systematic review, and in line with previous reviews and research on this topic, I make the following recommendations for policy and practice:

### **1. *Addressing Whiteness within the NHS***

The dominant culture of Whiteness in the NHS needs to be addressed at a top-down level through policy, practice, and organisational priorities. This requires systematically interrogating the policies, processes, procedures, norms, and attitudes operating within and across the NHS that disadvantage global majority groups (Hatch et al., 2021). Recognition of White privilege and reflection on the meaning of Whiteness can help NHS staff and services to recognise racist behaviour (Jieman et al., 2022). A step to doing so is removal of the use of terms such as ‘BAME’ and ‘ethnic minority’ in NHS policy, communications, material, and other outputs to recognise difference within these groups and to de-centre Whiteness (Ahsan, 2020; Hatch et al., 2021). Another step is to offer meaningful learning spaces for White staff to discuss the tensions and transformations in relation to the NHS’ move towards anti-racism (Jieman et al., 2022).

### **2. *Equitable recruitment practices and implementation of safeguards***

Managers should not have unwavering autonomy in recruitment processes, as this leaves room for biases to influence the procedures. There should be tighter safeguards, racially diverse recruitment panels, and clear processes for staff to raise concerns following negative experiences of applying for roles/promotions (Hatch et al., 2021). Furthermore, the NHS is responsible for the ethical recruitment and successful adaptation of internationally recruited staff (Ugiagbe et al., 2023). Thus, previous experience and

competencies of internationally recruited staff must be acknowledged and valued during the recruitment process.

### ***3. Training and Support for Managers***

'Unconscious bias' training aims to make individuals aware of their implicit biases in order to change behaviour, and is often hailed as a quick-fix solution to addressing racism in workplaces. Evidence has shown that it is not sufficient and ineffective without wider systemic change or additional anti-racism initiatives (Atewologun et al., 2018; Bezrukova et al., 2016; Noon, 2018). Both Whiteness and anti-racism need to be addressed through a multi-faceted, interactive training programme that is mandatory for anyone who manages staff. These issues should also be addressed in managers' line-management and appraisal meetings, and managers/leaders should be held accountable for reporting and recording improvements towards staff racial equity (Jieman et al., 2022).

### ***4. Listening to the Voices of Global Majority Staff***

Global majority staff should feel heard and valued; their unique cultural capital and skills are essential to support the racially diverse communities that the NHS serves. Leaders within NHS trusts should include global majority staff, from across all bandings, in key decision-making processes (Jieman et al., 2022). NHS board members should engage and consult with global majority staff networks, for example through facilitated events at which staff raise concerns and share experiences (Hatch et al., 2021). Global majority staff should feel psychologically safe at work, thus should be a clear and consistent protocol for protecting staff against racism from both staff and patients (Spiliopoulos & Timmons, 2019). Global majority staff should also feel empowered in the workplace, for example through multicultural staff networks, awards ceremonies, cultural spaces (e.g., prayer rooms), and events (e.g., Black History Month, South Asian

Heritage Month) to promote racial equity issues, as well as exemplary practice and contributions.

### **Strengths and Limitations**

A strength of this review was that a second reviewer independently screened 25% of the initial search results, 100% of the full text-records, and conducted a quality appraisal of the included papers. Prior to starting the review, I provided the second reviewer an information sheet to orient them to the study and we conducted a pilot study for both screening and the quality review. This ensured methodological rigour and increased the inter-rater reliability, as evidenced by high agreement across screening and the quality review. An additional strength was having a qualitative researcher, who assisted with my empirical study, review the codes and themes from my thematic synthesis. This provided continuity across studies in the reflective questioning and positionality of the researchers involved.

The current review is limited in several ways. First, the review included multiple studies from the same authors, with 27% of included papers from the same author, which opens the review up to potential researcher bias. Although my eligibility criteria allowed for the inclusion of unpublished literature, none was included the final review, potentially excluding specific types of information and increasing the risk of publication bias (Petticrew et al., 2008). However, given that the context of this review is within a governmental organisation (i.e., the NHS), it is a strength that the included studies are all peer-reviewed publications, as a high methodological standard is required for research that may be used to inform policy and practice (Long et al., 2020).

The methodological quality of included studies was moderate and captured well the limited literature available on this topic (Pendleton, 2017). However, most studies failed to explore the researcher's own positionality in relation to participants. This was important to consider when interpreting study findings as the researchers' own identities are likely to

influence their interpretation of participants' experiences (Braun & Clarke, 2019; Palmer et al., 2010).

Furthermore, it is important to acknowledge the date of the included studies. They were published between 2001-2022, spanning more than two decades, during which both the NHS and socioeconomic climate have changed significantly (e.g., changes in both legislation and demand for internationally recruited nurses, the impact of Brexit on European staff), which may impact the reported experiences of clinical staff (Clews, 2022; Department of Health & Social Care, 2023; Simpkin & Mossialos, 2017; Ugiagbe et al., 2023). The 321 clinical NHS staff represented across this review's findings represent less than 1% of the 1.2 million staff working in the NHS, thus limiting the applicability of findings and recommendations to the entire NHS workforce (NHS Digital, 2022). Furthermore, the majority of the participants across studies were from global majority backgrounds, which is not representative of the NHS workforce. However, the findings from this review are consistent with previous literature, increasing the validity of the findings (Pendleton, 2017; Alexis & Vydelingum, 2005).

### **Future Research**

There are opportunities for future research to build on the work presented here by continuing to explore the experiences of White staff and/or White managers and leaders that benefit from the dominance of Whiteness in the NHS. This will allow a thorough interrogation of how racism and Whiteness are upheld by those with privilege and power, and provide targets for anti-racism intervention. Furthermore, future research is needed on the experiences of staff from specific racial groups in the NHS (e.g. Black, Asian), as this will provide information on the unique needs of these populations and how the NHS system can work to better support, include and champion these staff groups. Related to this, it is important that future research adopts an intersectional approach by exploring the interplay



between multiple factors such as staff's race, gender, ethnicity, migration status and nationality.

### **Conclusion**

An inclusive workplace values and utilises diversity within its workforce (Atayero, 2020), yet the findings from this systematic review suggest that this is not the case in the NHS. This review highlighted that institutional racism, a dominant culture of Whiteness, and NHS managers that perpetuate racially prejudiced discriminatory practice pose a threat to a safe, effective, and valued NHS clinical workforce. Findings also demonstrate how global majority clinical staff's experience of racism in the NHS plays out across institutional, organisational, interpersonally-mediated, and internalised levels. Furthermore, this review highlighted the importance of studying those that benefit from a racialised system in order to tackle systemic racism within the NHS.

The whole NHS language has to change. It is not blame, it is not bullying, it is not inspection, it is not. It is working together. It is putting patients at the heart of everything we do, it is about good leadership, it is about a sense of belonging, it is about fair and open culture, supportive learning culture. (Dr. Umesh Prabhu, Medical Director; Stevenson & Rar, 2014).

## **4 Paper 3: Integration, Impact and Dissemination**

This paper provides a critical review of the extent to which (1) my empirical study and systematic review (i.e. Paper 1 and Paper 2) form a unified whole, (2) the potential impact of my research findings and how they can be maximised, and (3) an overview of my dissemination activities to-date, as well as future dissemination plans.

## **Integration**

My motivation to undertake research on workforce racial inequity in clinical psychology and the wider NHS was born out of the context of my Doctorate in Clinical Psychology (DClinPsy) training. I began my doctorate in 2020, a unique and complex time due to the ongoing challenges of the COVID-19 pandemic and the simultaneous resurgence of the Black Lives Matter movement. These events in tandem shone a light on the racial inequity that exists within the NHS, as staff from global majority backgrounds were disproportionately impacted by COVID-19 despite only representing 20% of the workforce at the time (Cook et al., 2020; WRES, 2021). In 2020, conversations on racial inequality in recruitment to the DClinPsy and the negative experiences of global majority trainee and qualified clinical psychologists dominated within the clinical psychology profession (Atayero, 2020; Bell, 2020; Wood, 2020). This was in the context of increased government investment to expand the mental health workforce, which included a 25% increase in DClinPsy places (HEE, 2020).

However, existing research had neglected aspiring clinical psychologists (ACPs), who are an unprotected category due to their paraprofessional status and often fixed-term/voluntary contracts (Farooq et al., 2022; Snell et al., 2022; Woodley-Hume & Woods, 2019). The lack of regulation and standardisation regarding what consists of an ‘assistant psychologist’ role among other prequalification roles, allows room for inequity to flourish (Ellerton & Gains, 2022; Hughes et al., 2015; Snell & Ramsden, 2020; Wilkinson & Chin, 2022), as both support and opportunities for progression within these roles are dependent on

ACPs' relationships with their supervising clinical psychologist (Ellerton & Gains, 2022; Snell & Ramsden, 2020; Snell et al., 2022).

Combined, these factors contributed to the aim of my thesis as a unified whole, which was to better understand the experiences and perspectives of an underrepresented workforce in the clinical psychology literature (i.e., ACPs), and how their experiences are shaped by the NHS context within which they work. Consequently, the purpose of my systematic review was to set the conceptual basis for my empirical study. By critically reviewing and synthesising qualitative studies on the experience of clinical staff in recruitment to and during roles in the NHS, and how this varied by race, I was able to provide a holistic picture of the NHS as an organisation. Building on previous reviews, I broadened the scope of my review to include a range of professionals, disaggregate global majority, and explore the experiences of individual racial groups - including White staff.

The findings from my systematic review helped to situate my target sample (i.e., ACPs) in the context within which they worked. My empirical study was subsequently designed to explore a similar topic but focused exclusively within the clinical psychology profession. My empirical study sought to gain a better understanding of the lived experiences of ACPs from different racial backgrounds working in the NHS, and how they made sense of their pre-qualification career trajectory. This study added to the findings of my systematic review by focusing on specific racial groups (i.e., Black British, White British) and a specific staff population (i.e., ACPs), whereas the majority of included studies in my systematic review explored the experiences of nurses and aggregated global majority groups together.

There are further key differences and similarities between my systematic review and empirical study including analysis method used and overlap in resulting themes. Whilst both papers were underpinned by a critical race theory (CRT) framework, a further distinction between the two papers was the epistemological position and analysis method used. In my

systematic review, I adopted thematic synthesis – a method rooted in thematic analysis which seeks to find themes within data (Braun & Clarke, 2006). Braun and Clarke (2019) describe themes as patterns of shared meaning underpinned or united by a core concept. I felt this was the most appropriate method to synthesise data from several heterogeneous studies. In contrast, I used interpretative phenomenological analysis (IPA) to analyse my empirical study findings. IPA is rooted in three core philosophies: phenomenology, hermeneutics, and idiography (see Paper 1, pg. 26; Smith et al., 2022; Love et al., 2020). This meant that central to my empirical study, the data analysis was uncovering the hidden meaning in participant's accounts of significant experiences (Smith, Flowers, & Larkin, 2012), as well as considering the individual narratives, positionalities, biases, and assumptions of both my study participants and myself as the interpreting researcher (Smith et al., 2022).

I felt the underlying theory of IPA was the most suited to my empirical study as my research question was concerned with how ACPs made sense of their experiences within the NHS in relation to their identities – namely race. Furthermore, the idiographic nature of IPA aligned with intersectionality within CRT as I was able to consider the heterogeneity in multiple identities that participants held within racially homogenous focus groups. This included gender, class, ethnicity, and migration status. Despite these differences in underlying epistemology and analysis method used, there are similarities in findings across the two papers.

Notably, there was overlap in the conceptual ideas behind the themes from each paper. The themes of workplace racism and racial inequity that emerged from both my systematic review and empirical study findings represented the different levels of racism: institutional, interpersonally-mediated, and internalised (Jones, 2000). For example, in my systematic review the themes Institutional racism, Managers as Agents of Racism, and Reduction of Self represent experiences and the impact of racism at the institutional,

interpersonal, and internalised level, respectively. Similarly, in my empirical study, the three whole-group experiential themes (i.e., The Profession, Interpersonal Relationships, and Sense of Self) that emerged from the data also represent three levels of racism, demonstrating consistency in global majority clinical staff's experiences of racism working within an NHS context. It is important to note that I completed the synthesis of my systematic review findings before I conducted the IPA analysis for my empirical study, thus it is possible that this conceptualisation of the different levels of racism influenced my empirical study analysis. However, as evidenced in my empirical study analysis audit trail (see [Appendix I](#), Figure I4) I went through several iterations and organisations of my empirical study themes before I settled on a final version, which I felt best represented the data.

Other conceptual overlaps revealed in the themes from both papers included: the existence of a racialised hierarchy in the NHS, the concept of Whiteness transcending just race, and that managers treated staff from different racial backgrounds differently which perpetuated racism and upheld Whiteness in the NHS. For example, 'Racialised hierarchy' emerged as a subtheme under 'Institutional Racism' in my systematic review. This reflected clinical staff's experience of opportunities and progression in the NHS being allocated according to race. Across the different professions represented in my systematic review (e.g., nursing, medicine, physiotherapy, psychology), clinical staff consistently reported a lack of global majority representation at senior levels. Similarly, in my empirical study, both Black British and White British participants described the lack of qualified clinical psychologists from global majority and Black British backgrounds. This was encapsulated within the whole-group experiential theme 'The Profession' which represented ACPs' understanding and experience of workforce racial inequity in the clinical psychology profession.

Furthermore, both my systematic review and empirical study had themes that spoke to a culture of Whiteness and White privilege within their NHS workplaces, which further

represented institutional/organisational levels of racism. Interestingly, only a minority of clinical staff sampled within the 15 included studies in my systematic review were White, whereas 50% of my empirical study sample were White British, and yet the dominance of Whiteness in the NHS and impact of White privilege on staff's experiences were present in staff's narratives across the two papers. Across both papers, the idea that Whiteness was not only skin colour but specific (i.e., typically Western/European) ethnicities, nationalities, and languages was present in staff's narratives across racial groups.

White privilege across both papers was described to positively impact White clinical staff in recruitment, social and instrumental support, promotion, and progression within the NHS. The dominance of Whiteness was upheld, and racism perpetuated by managers in the NHS across both papers, including supervising clinical psychologists in my empirical study, which represented racism at an interpersonal level. In line with this, some of the clinical staff in my systematic review described how they modified their behaviour, visible differences, and accents to gain proximity to Whiteness and reap the advantages (e.g., successfully gaining a promotion). In my empirical study, Black British ACPs described the pain and energy that having to modify aspects of their identity to fit into a White profession caused them, demonstrated in the theme 'Racism costs me energy'. In contrast, Black British ACPs, captured in the theme 'Being Black: An Asset vs. Racism', emulated pride in their racial identities and what that meant about their competencies as culturally sensitive clinicians that were able to advocate for global majority patients.

### **Challenges and Reflections**

The process of undertaking a systematic review raised two key challenges: novelty of conducting a systematic review, and the upsetting and distressing nature of having to read countless articles on experiences of racism. This was my first time undertaking a systematic review, which meant I spent a significant amount of time familiarising myself with different

component parts of the review process. However, what I learnt from this process was the importance of collaborating and engaging with other researchers. I utilised both peer researchers and more experienced researchers to help orient myself to the process of conducting a systematic review. I built a network of peer researchers, secondary reviewers and coders, supervisors, and experts-by-experience who signposted me to key texts and resources, reviewed my proposals and themes, and overall helped me to feel embedded in a community whilst undergoing the isolating journey of a PhD programme.

However, this did not protect me from the distressing nature of my research topic. In order to conduct my systematic review, I read many papers for screening and background literature on global majority staff's experiences of racism within the NHS. The negative impact on my mental wellbeing was not simply due to the masses of papers I had to read, but also the triggering nature of some of the reported experiences. I dealt with this by utilising both research and clinical supervision, by discussing with colleagues and friends, tweeting key findings to spread awareness, and most importantly taking time away from the review when it became too overwhelming. Similar, often more difficult, emotions were raised in designing and conducting my empirical study, as these experiences were directly embedded within the profession I am a part of (i.e., clinical psychology).

Though, the more central challenges I experienced in relation to my empirical study were recruitment challenges and the complexity of intersecting identities. Regarding the latter, whilst my study was underpinned by CRT and intersectionality, in order to adhere to best practice IPA principles, I aimed to recruit a homogenous sample of ACPs from the same racial backgrounds. The issues this raised were twofold. In researching a specific global majority group (i.e., Black British), my study excluded other global majority ACPs whose voices are often marginalised. Furthermore, whilst I accounted for gender diversity in my study, by only privileging gender and race, and recruiting a subset of racial groups, I was in



danger of accidentally introducing new forms of exclusion within a study designed to promote inclusion and anti-racism (Kandola, 2018). I can only hope that my study paves the way for future studies on the experiences of specific racial groups within clinical psychology and champions the importance of disaggregating global majority.

In relation to recruitment difficulties, I experienced challenges with recruiting male participants across racial groups, participant availability, last-minute dropouts, and participant eligibility. I used purposive sample to recruit participants for my study, however very few male participants initially expressed an interest. I used social media and specific closed groups (e.g., BPS Minorities in Clinical Psychology Facebook page) to recruit further male participants. However, linked to the challenge of participant availability challenge, 50% of participants scheduled to take part in the first scheduled focus group did not attend, both of whom identified as male. Due to the design of my study, this meant the first focus group I organised could not go ahead due to insufficient participants numbers. In order to ensure this did not continue to happen, I over-recruited for each focus group to ensure a minimum of attendees (see Paper 1, Method, pg. 22).

## **Impact**

The findings of both my systematic review and empirical study have the potential to impact ACPs, supervising qualified clinical psychologists, DClinPsy course staff, HEE, and other NHS policymakers. I also reflect on the personal impact that undertaking this research had on me.

### ***Aspiring Clinical Psychologists***

First and foremost, the participants that took part in my empirical study were directly positively impacted by this research. Conducting a qualitative study meant that ACPs were given a chance to share their lived experiences in their own words. By utilising focus groups, ACPs in my study were also able to connect with others on the same journey. In the debrief,

participants reported that taking part provided them with a positive space to share and reflect on their journey, which they valued. For other ACPs with similar experiences to those that took part, the illustrative quotes presented in Paper 1 may help to affirm and validate their own experiences. I hope that the recommendations made lead to direct benefits for Black British ACPs in their experiences of recruitment to and during prequalification roles, and future progression onto a DClinPsy course. I also hope that in reviewing the experiences of their Black British counterparts, White British ACPs will feel motivated to address their own Whiteness, embed anti-racism into their work, and advocate for equality and inclusion in their workplace.

### ***Supervisors of ACPs***

As discussed in my empirical study, supervision is essential for ACPs' development and progression within clinical psychology. My study findings highlight that Black British ACPs anticipate discrimination and a lack of support from supervisors, and that White British ACPs feel that they cannot ask for certain forms of support in clinical supervision. I hope that in reviewing the findings this research, supervising clinical psychologists become aware of and feel able to address the challenges faced by ACPs and how their needs differ based on race in relation to power, Whiteness, and potential experiences of racism.

### ***DClinPsy Course Staff***

The experiences of ACPs prior to clinical training impacts their feelings of readiness to apply, the strength of their clinical references, and ultimately their ability to progress onto DClinPsy training (Ragaven, 2018). I hope that DClinPsy course leaders, lecturers, and tutors listen to the narratives of Black British ACPs presented in my empirical study to better understand the needs and desires of this group, and support them prior to training through widening participation schemes, as well as on training once they become trainee clinical psychologists. In order to maximise the benefits of this research, DClinPsy course staff must

work alongside and led by those with lived experiences of workforce racial inequity to design and implement sustained change.

### ***Policymakers***

The recommendations provided in my empirical study and systematic review have the potential to impact profession-specific guidance and NHS policy. ACPs emphasised the challenges of the temporary/unpaid nature of some pre-qualification roles, as well as desire for more formal support for progression. Whilst the Association of Clinical Psychologists' guidance for the employment and supervising of assistant psychologists recommends that ACPs receive a minimum of 3.75 hours of continuing professional development allowance, this would enable ACPs to attend reflective practice and workshops related to skills development and DClinPsy progression, yet there are no consequences for supervisors that do not follow this guidance. Thus, the results of my study could be incorporated into future guidance for ACPs and help to inform policy to ensure that such guidance is followed.

In a wider NHS context, my systematic review and empirical study findings could be used to support the work of NHS policymakers in their desire to engage in more ethical international recruitment, retain global majority staff and implement anti-racism strategies. For example, the narratives in the theme 'Protective Factors' from my systematic review (see Paper 2, pg. 98) could help to identify strategies to support the transition of internationally recruited staff. I hope that my research findings support all those with decision-making power in relation to all NHS staff recruitment and retention policy to move beyond simply diversifying and towards actively promoting and embodying anti-racism practice.

### ***Personal Impact***

I cannot overemphasise the impact that undertaking this research had on me both personally and professionally, as a Black British Nigerian, female, trainee clinical psychologist. As is common, my own personal experiences of racism led me to this research

topic. Some might view this as being “too close” to the research topic and thus my potential for bias increased, others will say this gives me greater access to an “insider’s perspective” (Smith et al., 2022). However, this insider’s perspective made it difficult and emotionally taxing to read countless papers on global majority NHS clinicians’ experiences of bullying, harassment, stagnated career progression, microaggressions, and other consequences of the racism and Whiteness that exists within the NHS.

I also recognise the bravery required to call out and challenge racism in one’s own profession (Atayero & Dodzro, 2021). I was particularly taken aback by Esmail and Everington’s (2020) descriptions of being continuously threatened with legal action after publishing their monumental research highlighting racial discrimination in NHS recruitment of doctors (Esmail & Everington, 1993). I too have concerns about the potential consequences on me professionally following the reporting and dissemination of my research findings. Nevertheless, I feel honoured to have been trusted with the stories of the ACPs that took part in my study and to have been able to amplify the voices of clinical staff from the studies in my systematic review. My hope is that I can continue to produce research that motivates continued and sustained anti-racism action, that promotes better mental wellbeing among global majority NHS staff, and that indirectly improves mental health care for global majority communities.

## **Dissemination**

The dissemination of my systematic review and empirical paper are essential to ensure that new insights gained are shared with those who it affects and those who have the power to implement change.

### ***Clinical Community***

I have presented my study findings to trainees and qualified clinical psychologists at Royal Holloway, University of London. Current trainees and qualified clinical psychologists

work alongside/supervise ACPs, thus I hope my findings support them to consider the challenges Black British ACPs experience and support them through anti-racism. I aim to further share my research findings with relevant clinical psychology stakeholders, including study participants, DClinPsy applicants, trainee and qualified clinical psychologists, mental health patients, and clinical and research supervisors. In addition to this, I will email a summary of key findings and plans for dissemination to participants who consented to be informed. I will also write a summary blog post and submit it to the Black and Minority Ethnicities in Psychiatry and Psychology (BiPP) Network, a community-led organisation that works to advance the representation of students and professionals from global majority backgrounds in psychiatry and psychology.

I am scheduled to present the findings of my systematic review to the Staff Wellbeing Psychology team at Guy's and St Thomas' (GSTT) NHS trust, which has the largest staff psychology wellbeing team and support offer. My study findings are relevant to GSTT practice and organisational goals as the organisation is actively recruiting international staff and has made anti-racism one of its top priorities for 2023.

### ***Research Community***

I presented my empirical study findings to the Health Inequalities Research Group (HIRG) at King's College London. I hope that my findings inspired future collaboration and research on this topic to address the workforce racial inequity that exists within clinical psychology which subsequently impacts mental health care.

In writing my thesis, I adhered to the COREQ checklist for qualitative studies (Tong et al., 2007) and the CASP checklist for qualitative research and systematic reviews (CASP, 2020), ensuring my research is in line with published quality standards. I plan to submit my empirical study into a peer-reviewed journal that publishes qualitative work, has previously published research on workforce equity, and is open access (e.g., Psychological Medicine,

Cultural Diversity and Ethnic Minority Psychology). Open access is important as it allows for rapid and wider dispersal of new knowledge and removes barriers that may be in place for many ACPs who are not connected to an academic institution (Greussing et al., 2020). I also plan to present my findings at the next Association of Clinical Psychologists conference, this will be a good opportunity to share findings and connect with relevant clinicians in the field.

### ***Policymakers***

In line with the research aims, I aim to present my empirical study findings to leaders, directors and staff in DClinPsy courses, and the HEE Mental Health Workforce Equalities Subgroup, who are working on this pressing issue on a national scale. I also plan to present my empirical study findings during the Psychological Professions Week in November 2023, hosted by the Psychological Professions Network, a network for psychological professionals who advise policymakers, workforce planners, and commissioners of NHS commissioned healthcare to support the development of psychological professions and excellence in practice.

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## **6 Appendices**

**Appendix A**  
**RHUL Ethics Approval**

21/05/2023, 17:50

Mail - Atayero, Sarah (2020) - Outlook

**Result of your application to the Research Ethics Committee (application ID 3084)**

Ethics Application System &lt;ethics@rhul.ac.uk&gt;

Tue 3/1/2022 2:28 PM

To: Atayero, Sarah (2020) &lt;Sarah.Atayero.2020@live.rhul.ac.uk&gt;; Lau, Tatiana &lt;Tatiana.Lau@rhul.ac.uk&gt;; Ethics &lt;Ethics@rhul.ac.uk&gt;

PI: Dr Tatiana Lau

Project title: Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS

REC ProjectID: 3084

Your application has been approved by the Research Ethics Committee.

Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

This email, its contents and any attachments are intended solely for the addressee and may contain confidential information. In certain circumstances, it may also be subject to legal privilege. Any unauthorised use, disclosure, or copying is not permitted. If you have received this email in error, please notify us and immediately and permanently delete it. Any views or opinions expressed in personal emails are solely those of the author and do not necessarily represent those of Royal Holloway, University of London. It is your responsibility to ensure that this email and any attachments are virus free.

<https://outlook.office.com/mail/AAMkAGNkNjViNzkyLTNhMDYtNDAXNS05MTU5LWY2NTQyZDgwMGFmYQAUAAAAABJI5MnfBm0QYYLP010Sxi...> 1/1

## Appendix B

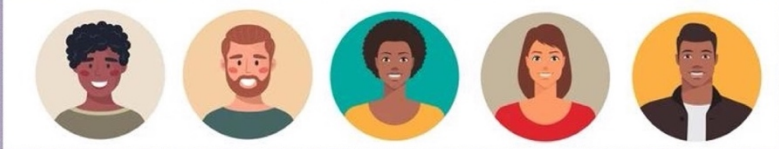
### Recruitment Materials

Figure B1

*Study Recruitment Poster*

The Career Trajectory of

# ASPIRING CLINICAL PSYCHOLOGISTS



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**What is the research about?** This research aims to explore the pre-qualification career paths of aspiring clinical psychologists working in the NHS and to understand differences across the most and least represented ethnic groups.

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<p><b>What will I be asked to do?</b> You will be invited to take part in an online focus group with other aspiring clinical psychologists from a similar ethnic background to you. The focus group will be video recorded and last up to 90-minutes. You will receive £15 cash as a thank you for participating.</p>	<p><b>Who can take part?</b> You must</p> <ul style="list-style-type: none"> <li>• Self-identify as Black British or White British</li> <li>• Be 21 years or older</li> <li>• Have at least 6 months' experience of working in a pre-qualification role within the NHS</li> <li>• Be pursuing a career in clinical psychology</li> <li>• Have Graduate Basis for Chartered Membership status</li> </ul>
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**If you would like to take part or want more information please contact:**  
Sarah Atayero (Trainee Clinical Psychologist)  
[sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk)



This study has received ethical approval from Royal Holloway, University of London Research Ethics Committee.

Figure B2

*Recruitment Email to Professional Networks*

**Email to NHS trust and other selected organisations (see section 6.1.1):**

Dear [XX],

My name is Sarah Atayero, and I am a PhD researcher at Royal Holloway, University of London. I am currently recruiting participants for my research project titled 'Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS'.

The aim of this study is to explore the pre-qualification career paths of aspiring clinical psychologists working in the NHS and to understand differences across the most and least represented ethnic groups. Participation will involve taking part in an online focus group with other aspiring clinical psychologists from a similar ethnic background. The focus group will be video recorded and last up to 90 minutes. Participants will receive £15 cash as a thank-you for participating.

The study is looking to recruit aspiring clinical psychologists from Black British and White British backgrounds. If you know anyone who may be interested in taking part, please feel free to forward this email to them or circulate this among your network/organisation. Interested participants can contact me via email [sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk) for a more detailed information sheet about the project that describes what participation would involve.

Best wishes,  
Sarah Atayero

Supervised by

Prof Stephani Hatch (KCL), Dr Tatiana Lau & Dr Thora Bjornsdottir (RHUL)

Version 1.0  
Version Date 26.01.22

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**Figure B3**

*Social Media Advert Template*

**Social Media posts:**

Are you an aspiring clinical psychologist from a Black British or White British background?

My name is Sarah Atayero, and I am a PhD researcher at Royal Holloway, University of London. I am currently recruiting participants for my research project titled 'Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS'.

The aim of this study is to explore the pre-qualification career paths of aspiring clinical psychologists working in the NHS and to understand differences across the most and least represented ethnic groups. Participation will involve taking part in an online focus group with other aspiring clinical psychologists from a similar ethnic background to you. The focus group will be video recorded and last up to 90 minutes. You will receive £15 cash as a thank-you for participating.

If you are interested in taking part, please let me know by contacting me via email [sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk). I would be very pleased to provide you with a more detailed information sheet about the project that describes what your participation would involve.

## **Appendix C**

### **Participant Information Sheet**





## Participant Information Sheet

**Study Title:** Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS

My name is Sarah Atayero, and I am a second year doctoral student in the Psychology department at Royal Holloway, University of London. I invite you to take part in this research study, which forms part of my course. Before deciding whether or not you would like to take part, it is important for you to understand the purpose of this research and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if you have any questions, anything is unclear or if you would like further information.

### What is the purpose of the study?

The aim of this study is to explore the pre-qualification career paths of aspiring clinical psychologists working in the NHS and to understand differences across the most and least represented ethnic groups. This study acknowledges the multifaceted nature of discrimination, and promotes an intersectional approach by seeking to understand how gender and race together impact the experiences aspiring clinical psychologists hoping to progress onto a professional Doctorate in Clinical Psychology course.

- 1) Understand how aspiring clinical psychologists navigate the recruitment process for pre-qualification roles.
- 2) Understand how systems and structures within the NHS influence pre-qualification roles.
- 3) Explore the available and desired support systems for progressing onto DClinPsy training.

### Why have I been invited to take part?

You have been invited to take part in the study because:

- You self-identify as Black British or White British
- You are aged 21 years or older
- You have at least 6 months' experience of working in a relevant clinical psychology pre-qualification role within the NHS (e.g. support worker, assistant psychologist, psychological wellbeing practitioner)
- You are currently pursuing a career in clinical psychology via entry onto a UK Doctorate in Clinical Psychology programme
- You have Graduate Basis for Chartered Membership status (GBC)

### What will happen if I take part?

You will complete a brief screening questionnaire to ensure that you meet the eligibility criteria for this study. Following this, you will be invited to take part in a focus group with three other aspiring clinical psychologists. During the focus group, you will be prompted to discuss your experience of the recruitment

process for pre-qualification roles in the NHS, your experience working in the NHS and support for applying for the Doctorate in Clinical Psychology. This focus group will take approximately 90 minutes and will take place online via Microsoft Teams. Participation in the focus group will require you to have access to a microphone as well as a camera or webcam and have your camera turned on and facing you for the duration of the focus group.

After the focus group, you will be invited to reflect on your experience of participating in the study and will be offered information on relevant support groups if required. You will also be provided with further information about the study and asked for consent to be informed of the key findings of the completed study via email. After the debrief, you will be provided with £15 via electronic bank transfer for taking part in the focus group. You will be required to digitally sign a participant payment receipt which will also be digitally signed by me.

The focus group will be video recorded and transcribed. The data will be used in my doctoral thesis.

### **Do I have to take part?**

You do not have to take part in this study if you do not want to. If you decide to take part, you may withdraw at any time without having to give a reason. Your decision whether or not to take part will not affect your NHS employment in any way. If you do decide to take part in the study, you will be asked to electronically sign a consent form, and you will be given a copy to keep.

### **What are the possible risks of taking part?**

The focus group discussion will include discussion of potentially distressing issues around discrimination and other adversities at work. The focus group will be set up as a supportive space that attempts to foster peer support and minimise any distress. Sensitive issues to do with identity will be managed respectfully.

If at any point during the focus group you feel distress, you should message the assistant moderator. You can withdraw from the focus group if you are finding it distressing, and the assistant moderator will be on standby to discuss this with you.

There will be a space during the debrief to reflect on your experience of taking part in the focus group and raise any concerns. We can also provide you with information on culturally sensitive mental health organisations, resources and groups.

### **What are the possible benefits of taking part?**

There are no direct benefits for participants in this study. However, some may find the focus group a good chance to reflect on their pre-qualification career journeys so far and may find peer support from other participants. By highlighting difficulties faced by aspiring clinical psychologists in their pre-qualification careers, we can improve these experiences and increase ethnic representation within the field of clinical psychology.

### **Data handling and confidentiality**

The focus group will be video recorded and transcribed. Nobody except myself, my supervisors, and other members of the research team will see the video recording. An examiner will be allowed to see the transcription of the recording, but in the study, you will be known by a pseudonym. Copies of the

anonymised information may be made available to other researchers for further secondary research. The information will not be available to your employing NHS trust.

Confidentiality will only be breached if you share information that leads us to believe that you are at risk to yourself or others, or at risk from others, in which case we may contact your GP with the details you provide.

#### **Data protection statement**

The data controllers for the study will be Royal Holloway, University of London. The university will act in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act (2018) when controlling and processing your personal data for the purpose of the research outlined in this Participant Information Sheet. The legal basis for collecting and processing your personal data for research purposes is considered 'a task in the public interest' as a university. You can provide your consent for the use of your personal data in this study by completing the Participant Informed Consent form that has been provided to you. You are not obliged in any way to provide me with your personal data for the purposes of research, but you may not be able to participate in a study if you do not. I will only collect the minimal amount of data necessary for their project.

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Royal Holloway, University of London Data Protection Officer by email at [dataprotection@royalholloway.ac.uk](mailto:dataprotection@royalholloway.ac.uk). You also have the right to complain to the Information Commissioner's Office and you can find more information on their website – [www.ico.org.uk](http://www.ico.org.uk)

#### **GDPR statement**

Important General Data Protection Information (GDPR) Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted on servers within the European Economic Area'. Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your personal data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed.

Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally-identifiable information possible (i.e., the email address you provide us). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to provide a summary of the study results if requested and/or for

the prize draw). The lead researcher will keep information about you and data gathered from the study, the duration of which will depend on the study. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting <https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/> and if you wish to exercise your rights, please contact [dataprotection@royalholloway.ac.uk](mailto:dataprotection@royalholloway.ac.uk)

#### **What if I change my mind about taking part?**

You are free to decline study participation, or can withdraw your consent at any point during the study for any reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until the point of taking part in the focus group. After taking part in the focus group, withdrawal of your data will no longer be possible due the fact that it forms part of a group dataset. If you choose to withdraw from the study we will not retain any information that you have provided us.

#### **How is the study being funded?**

As this study forms part of my professional Doctorate in Clinical Psychology programme, the study is funded by Health Education England.

#### **What will happen to the results of the study?**

The results of the study will form part of a Doctorate in Clinical Psychology thesis. The research team plan to publish the study in peer-reviewed journals, as well as share the findings with relevant clinical psychology stakeholders. Thus, it is likely that the results of the study will be publicly available. All results will be anonymised; you will not be identifiable in any reports written as a result of the study.

#### **Who should I contact for further information?**

If you have any questions or would like more information about this study, please contact me via email at [sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk).

#### **What if I have further questions, or if something goes wrong?**

If this study has harmed you in any way or if you wish to make a complaint please contact me using the details above, and I will try my best to resolve the matter.

If you are experiencing difficulties related to your participation in the study and would prefer to discuss this with someone other than me please contact Dr Thora Bjornsdottir (Research Supervisor) at [thora.bjornsdottir@rhul.ac.uk](mailto:thora.bjornsdottir@rhul.ac.uk).

Alternatively you may wish to contact the Royal Holloway Research Ethics Committee for further advice ([ethics@rhul.ac.uk](mailto:ethics@rhul.ac.uk)) or to make a complaint ([integrity@rhul.ac.uk](mailto:integrity@rhul.ac.uk)).

**Who has reviewed this study?**

This study has been reviewed and approved by the College Ethics Committee at Royal Holloway, University of London.

**I would like to take part, what do I do next?**

- Please keep a copy of this for reference.
- Please feel free to ask any questions before you complete the Participant Informed Consent form.
- Please email the electronically completed Participant Informed Consent form to me at [sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk).

**Thank you for taking the time to read this information sheet and for considering taking part in this study.**

## Appendix D

### Screening Questionnaire

This appendix provides details of the screening questionnaires used in my study to assess interested participants' eligibility to take part. The questionnaire was hosted on Qualtrics ([www.qualtrics.com](http://www.qualtrics.com)). The ethnicity categories listed are based on UK 2021 census categories.

**Study Title:** Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS

Thank you for your interest in taking part in the above study. In order to ensure that you are eligible to take part in the study, please complete the following questionnaire.

If you are eligible to take part, you will be contacted by the researcher and provided with further information about the study and a consent form. If you are not eligible to take part you will be notified by the researcher and your information will be deleted.

1. What is your full name?
2. What is your email address?
3. What is your mobile telephone number?
4. What is your date of birth?
5. What is your ethnicity? (select one)
  - Any other Asian background
  - Any other Black, African or Caribbean background
  - Any other ethnic group
  - Any other White background
  - Arab
  - Bangladeshi
  - Black African, Caribbean or Black British
  - Chinese
  - Indian
  - Mixed Any other Mixed or Multiple ethnic background
  - Mixed White and Asian
  - Mixed White and Black African
  - Mixed White and Black Caribbean
  - Pakistani
  - White English, Welsh, Scottish, Northern Irish or British
  - White Gypsy or Irish Traveller
  - White Irish
6. Who is your employing NHS Foundation Trust?
7. What is your current job title?
8. How long have you worked in your current role? (if less than 6 months, please provide details of your previous position)
9. Do you have Graduate Basis for Chartered Membership status (GBC)?
10. Do you have access to a microphone as well as a webcam or camera?
11. Are you pursuing a career in clinical psychology via entry onto a UK doctorate programme?
12. Are you currently undertaking a professional Doctorate in Clinical Psychology?
13. Please provide the name and practice of your GP

## Appendix E

### Informed Consent Form

Department of Psychology  
Royal Holloway University of London  
Egham, Surrey, TW20 0EX  
www.royalholloway.ac.uk/psychology



#### Research Participant Informed Consent Form

**Study Title:** Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS

**Name and email address of researcher:** Sarah Atayero ([sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk))

**Name and email address of supervisor:** Dr Thora Bjornsdottir ([thora.bjornsdottir@rhul.ac.uk](mailto:thora.bjornsdottir@rhul.ac.uk))

**Research Participant** - please read the following statements and indicate your response to each statement.

I have read and understood the Participant Information Sheet [Version 1.0, Dated 14.01.22] and understand what this study involves.	Yes/No
I agree to participate in this study.	Yes/No
I had the opportunity to ask questions and they have been answered fully to my satisfaction.	Yes/No
I understand that my participation in the study is entirely voluntary and that I am free to withdraw at any time without giving a reason.	Yes/No
I understand that if I decide to withdraw from the study then the researchers can continue to use the data and information, I have already given them unless I ask for this to be destroyed.	Yes/No
I understand that data provided during and following the focus groups cannot be destroyed as it is shared data.	Yes/No
I agree to being video recorded during the focus group for the purposes of the study. I understand that the video recordings will be stored securely and deleted at the end of the study.	Yes/No
I agree to an anonymised transcription of the focus group recording being made. I understand that the transcripts will be stored securely and kept for up to ten years after the study ends.	Yes/No
I understand that confidentiality may be breached in circumstances as detailed in the information sheet.	Yes/No
I understand that any personal information that can identify me – such as my name or address, will be kept confidential and not shared with anyone other than the researcher. The researcher will only use these details to contact me in relation to my participation in the study.	Yes/No
I understand that only the study researchers and authorised representatives from the Royal Holloway will have direct access to the study data and documentation. I understand that all data and documentation will also be available to external auditors when required, and inspectors in the event of regulatory inspection.	Yes/No
I agree to copies of my anonymised information being made available to other researchers for further secondary research.	Yes/No
I understand that my words may be anonymously quoted in publications, reports, web pages, and in other research outputs.	Yes/No
I agree for the data I provide to be archived at Royal Holloway, University of London.	Yes/No

Version 1.1

Version Date 20.01.2022

**Department of Psychology**  
Royal Holloway University of London  
Egham, Surrey, TW20 0EX  
[www.royalholloway.ac.uk/psychology](http://www.royalholloway.ac.uk/psychology)



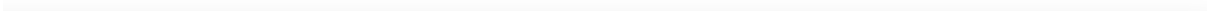
Participant signature.....

Participant Name .....

Date .....

Please note that this Consent form will be stored separately from the responses you provide.

If you have any concerns about this research, please email [ethics@rhul.ac.uk](mailto:ethics@rhul.ac.uk).





## Appendix F

### Participant Debrief Sheet

Department of Psychology  
Royal Holloway, University of London  
Egham, Surrey TW20 0EX  
[www.royalholloway.ac.uk/psychology](http://www.royalholloway.ac.uk/psychology)



#### Participant Debrief

**Study Title:** Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS

Thank you for taking the time to take part in the above study. The aim of the study is to explore how aspiring clinical psychologists working in the NHS experience their pre-qualification career paths, and to understand differences across the most and least represented ethnic groups. The study acknowledges the multifaceted nature of discrimination, and promotes an intersectional approach by seeking to understand how gender and race together impact the experiences of aspiring clinical psychologists hoping to progress onto a professional Doctorate in Clinical Psychology course.

You took part in a focus group with aspiring clinical psychologists from a similar ethnic background to yourself. Over the course of the focus group, you were asked questions about your experience of the recruitment process for pre-qualification roles in the NHS, your experience working in the NHS and support for applying for the Doctorate in Clinical Psychology.

We understand that some of the topics covered and stories shared may have caused you distress; this is understandable given the sensitive nature of the topics discussed. We have included a list of helpful services at the end of this sheet. If you feel you are at risk to yourself, to others, or require immediate support, please contact your GP to book an emergency GP appointment or go to A&E.

The focus group recording will now be transcribed and analysed to help better understand how participants made sense of their pre-qualification experiences and career trajectory within the NHS. The results of the study will form part of a Doctorate in Clinical Psychology thesis. The research team plan to publish the study in peer-reviewed journals, as well as share the findings with relevant clinical psychology stakeholders. Thus, it is likely that the results of the study will be publicly available. All results will be anonymised; you will not be identifiable in any reports written as a result of the study and no NHS services or trusts will be named in any reports to ensure complete anonymity. Please let the researcher know if you would like to be informed of the key findings of the completed study via email.

**Who should I contact for further information?**

If you have any questions or would like more information about this study, please contact Sarah Atayero via email at [sarah.atayero.2020@live.rhul.ac.uk](mailto:sarah.atayero.2020@live.rhul.ac.uk).

**What if I have further questions, or if something goes wrong?**

If this study has harmed you in any way or if you wish to make a complaint, please contact me using the details above, and I will try my best to resolve the matter.

## Appendix G

### Participant Payment Receipt



**Study Title:** Exploring ethnic differences in aspiring clinical psychologists' experience of their pre-qualification career trajectory in the NHS

#### Receipt of Payment

I confirm I have received a payment of £15 for participating in the above research study, conducted by Sarah Atayero, Trainee Clinical Psychologist, Doctorate in Clinical Psychology, Royal Holloway University of London.

Date	Name	Amount	Signature
		£15	

Trainee Signature .....

Supervisor Signature .....

## Appendix H

### IPA for Focus Groups Analysis Plan

- 1. *Identify the Researcher's Orientation and Bias.*** Prior to the first focus group, I completed a self-reflexive interview (see [Appendix J](#)). This was a set of questions posed by the assistant moderator, in order to for me to engage with, acknowledge and put aside any pre-conceptions, assumptions and hypothesis about the data that could prevent access to an “insider's perspective” (Love et al., 2020; McCormack & Joseph, 2018). I reviewed the self-reflexive interview again before I started data analysis, and monitored my field notes after each group. I have incorporated any identified biases or changes in perception into my analysis.
- 2. *Immersion in the Data.*** I transcribed the video recordings verbatim and included depiction of participants' tone, pitch, and gesticulations, and group dynamics where relevant. I read the transcripts several times to better focus on the participants' accounts attempting to gain an ‘insider's perspective’ (Smith et al., 2022).
- 3. *Exploratory Noting.*** Using a hard-copy of the transcripts with wide margins, I made interpretative, linguistic, and conceptual comments of the transcripts, this helped to identify the main group experiential claims (see [Appendix I](#), Figure I1).
- 4. *Constructing Group Experiential Statements.*** Working from my initial notes, I wrote down statements that spoke to the core experiences of the group (Group Experiential statements, GES) on pieces of paper, ensuring that the statements were both grounded in data and abstract enough to reflect a concept (Smith et al., 2022). In order to get an ‘insider's perspective’, I found it helpful to use ‘I’ statements when constructing experiential statements.

5. ***Develop Group Experiential Themes.*** I scattered the written statements across a table in no particular order, then began clustering them into group experiential themes (GETs). See [Appendix I](#), Figure I2 and Figure I3.
6. ***Checking Themes.*** In order to privilege the representation of idiographic accounts, I reread each participant's involvement in the focus group as a whole and noted thoughts about which elements of the GETs the participant's account emphasised and which elements were not represented (Dunne & Quayle, 2001; Tomkins & Eatough, 2010). I systematically examined each participant's account on different levels including 1) individual, 2) evident influence by group, 3) dialogue, and 4) collective group voice, in order to highlight the context in which idiographic account arose.
7. ***Cluster Themes and Identify Whole-group Experiential Themes.*** Using PowerPoint, I mapped the connections and patterns across GETs and through this process was able to identify whole-group experiential themes (see [Appendix L](#)).
8. ***Identify Patterns Across Focus Groups.*** At this stage, I wrote out the GETs for each focus group, on a flash card and spread them on a table. This helped to build an overview of what was happening in across the entire dataset. From this, I identified commonalities and differences, revisited transcripts, and considered analysis in context of CRT, phenomenological psychology, the research questions and aims.
9. ***Data Validation.*** I discussed the development and interpretation of themes with other qualitative researchers, the study assistant moderator (N.S.), and EBE who was an ACP from a global majority background. Participant validity checks were not conducted based on strong epistemological arguments for not doing so when conducting IPA (Smith, 2004).

**10. Organise Superordinate Themes into a Hierarchy.** I ordered the final themes into a logical sequence in the context of the data and wrote up my analysis (see [Appendix I](#), Figure I5).

## Appendix I

### Audit Trail

This appendix provides details of the different stages of interpretative phenomenological analysis conducted on focus group data from my empirical study. I present examples of transcription, initial exploratory notes, and clustering group experiential themes (GETs) to create an overall formulation of my study results. IPA is an iterative process which is demonstrated by the different versions and iterations of themes presented in this appendix.

#### Figure I1

##### *A Sample Section of Annotated Transcript*

White British Focus Group: Transcript (04.10.22)

<p>low socioeconomic status significant barrier</p> <p>acknowledges ethnicity as 'additional layer'</p> <p>Turn-taking</p> <p>Whiteness as the norm</p> <p>what does culture mean to me?</p> <p>Acknowledging that clinicians from GPs more likely to bring culture, religion into formulation / client work</p>	<p>are really underpaid [nodding from other female participants] and also assistant psychologist roles have not well paid either, especially if you live in London they I think for a huge amount of all kind of pre-qualification roles are inaccessible because of financial difficulty. Let alone even thinking about like other intersections of identity and ethnicity and other background. Err yeah. So that would be my kind of best thought, let alone kind of what's services look like and kind of how you feel in the space is you're entering into there majority white. And people don't really understand your kind of lived experience aswell.</p> <p>[Silence]</p> <p>Rachel: Erm yeah.</p> <p>Josh: I think when you're in. Oh sorry go on, Rachel. Go.</p> <p>Rachel: Oh no you go, you go ohh. Erm I guess it's kind of the care you're delivering as well. So we're doing a lot at the moment about bringing culture into formulations and thinking about race, ethnicity, but I guess if you're kind of not of a white background and actually culture is, or even if you are of kind of a white background and culture is really important to you, but you're working in a service where it's not really considered. When you're working with people, it must be quite difficult erm to kind of do even do that work without thinking actually, what does your religion mean? What does your culture mean? What does your race mean as I suppose that's that must be really hard.</p> <p>[Silence]</p> <p>Sarah: Josh any final thoughts?</p> <p>Josh: Well, mine is just really simple. It's just for people from, you know various diverse backgrounds, if you come in for an interview and all you see in staff is just</p>	<p>If you're not white, there's an additional layer of things you have to think about</p> <p>no part of psychology?</p>
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Figure I2

Initial Scattering of White British Group Experiential Statements in No Particular Order

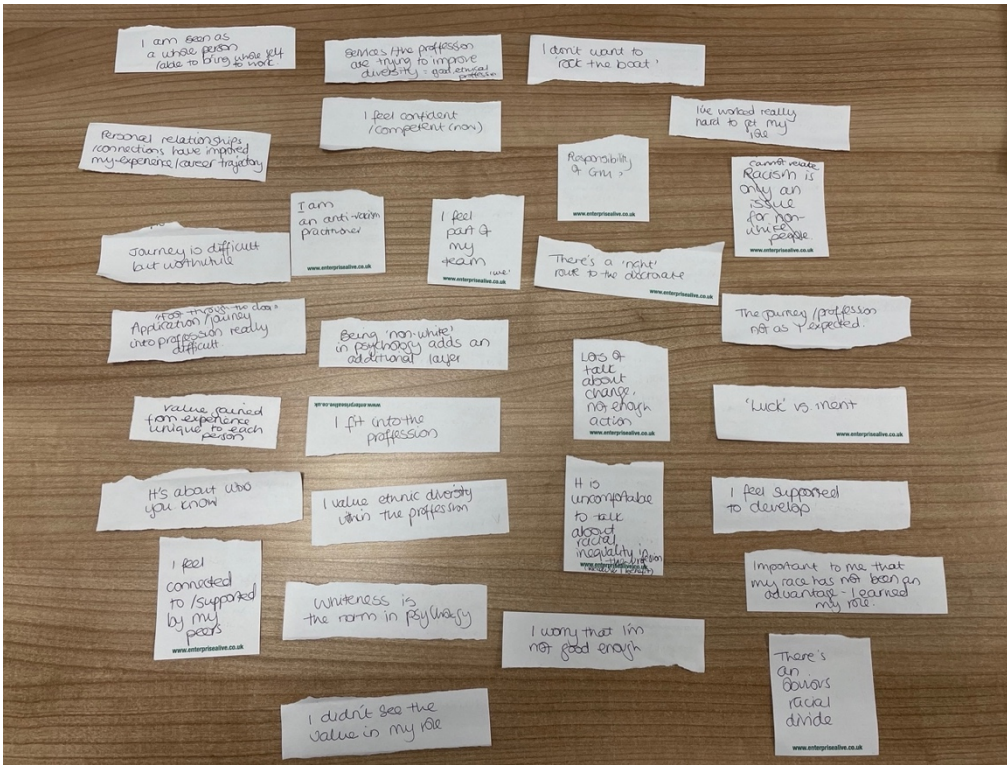
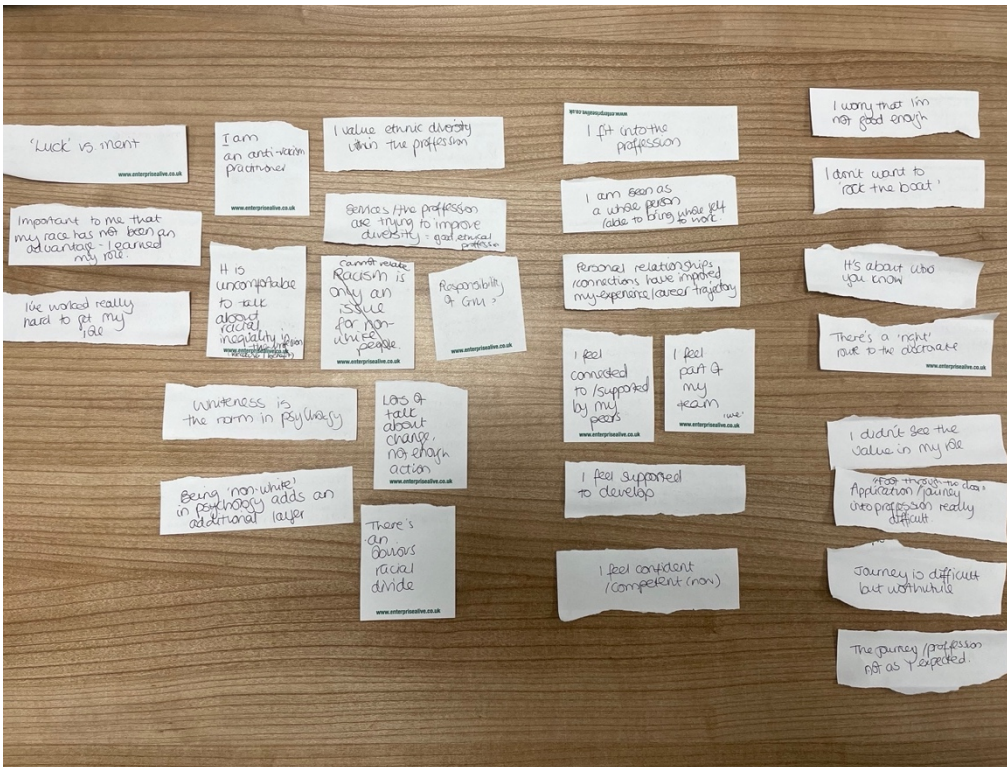


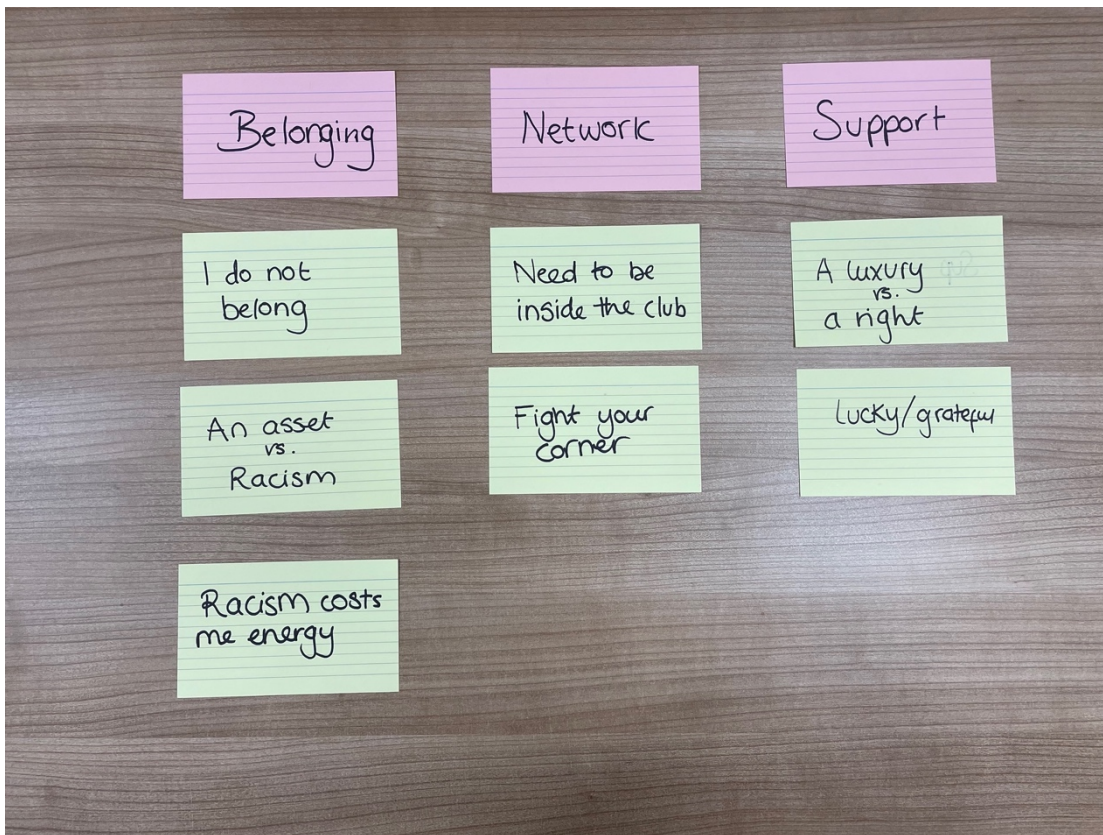
Figure I3

Initial Clustering of White British Group Experiential Statements

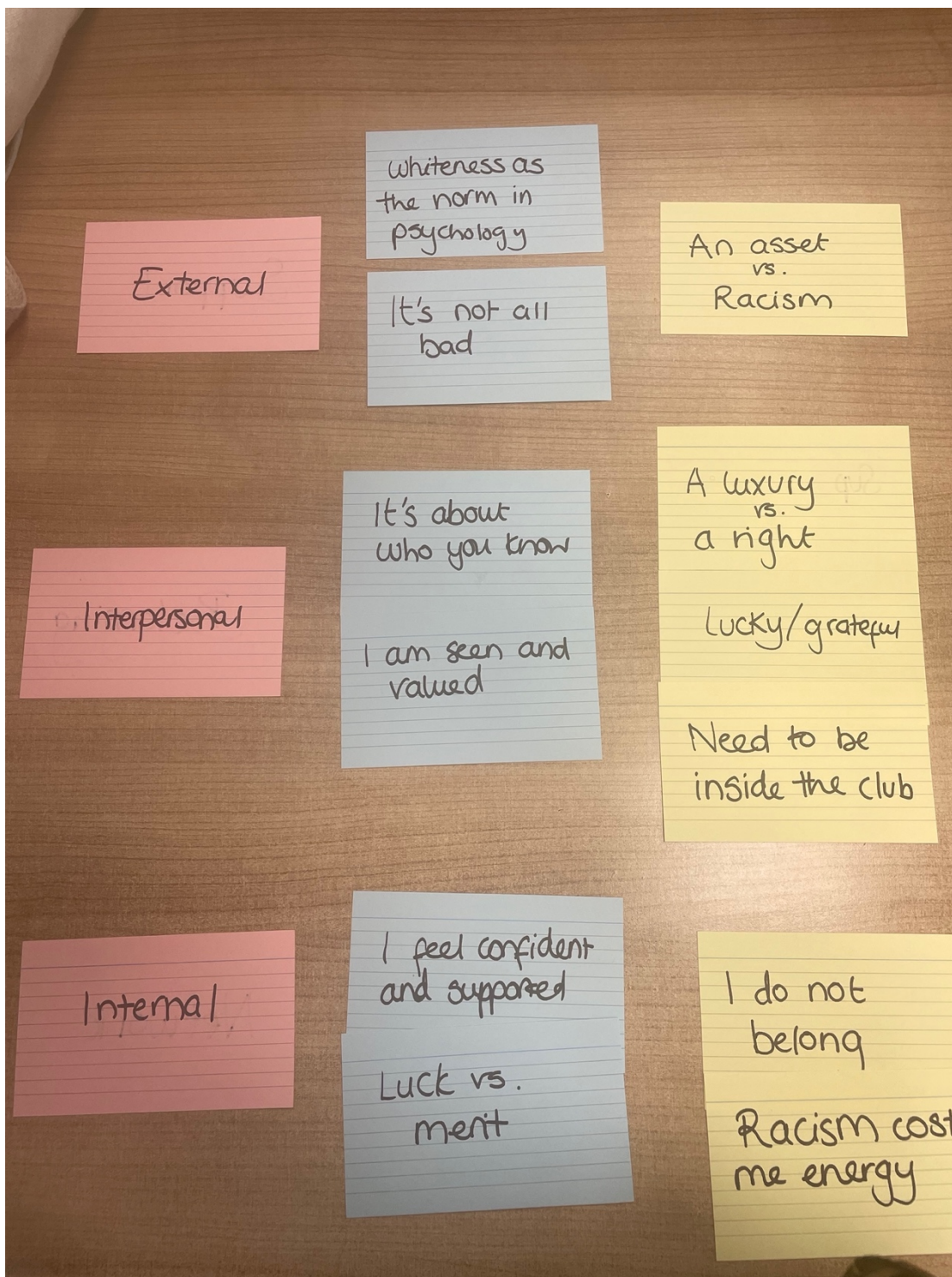


**Figure I4**

*Organisation of Initial Black British Group GETs According to Initial Whole-group Themes*





**Figure I5***Cross-group Comparisons in Second Iteration of Whole-group Themes*

*Note.* Black British group experiential themes are represented by the yellow cards, White British group experiential themes are represented by blue cards, and whole-group themes represented as pink cards.

## Appendix J

### Self-reflexive Interview Schedule

**Reflexive questions posed by Nkasi Stoll for Sarah Atayero as part of the study titled ‘Exploring ethnic differences in aspiring clinical psychologists’ experience of their pre-qualification career trajectory in the NHS’**

**31.08.22**

1. What does your personal story **tell you** about why you want to conduct research on ethnic differences in aspiring clinical psychologists’ experience of their pre-qualification career trajectory in the NHS?
2. What have you learned from your experiences that might facilitate your research process?
3. What might it be like for an aspiring psychologist to talk to you, a visibly Black female trainee clinical psychologist, about their career journey? Depending on their visible identities (e.g. gender, race, ability, colour, nationality, accent etc.)
4. What types of personalities and stories are you drawn to, and which do you find harder to listen to/engage with?
5. What themes do you assume will come out of the focus group?
6. How will you be able to tell in the moment whether your personal pre-qualification experiences are impacting your research process (e.g. interview, data interpretation, choosing quotes)?

## Appendix K

### Consensus Matrices for Focus Groups

These consensus matrices represent the level of convergence and divergence on group experiential themes within each focus. The key is taken from (Onwuegbuzie et al., 2009).

#### **Key**

A = Indicated agreement (i.e., verbal or nonverbal)

D = Indicated dissent (i.e., verbal or nonverbal)

SE = Provided significant statement or example suggesting agreement

SD = Provided significant statement or example suggesting dissent

NR = Did not indicate agreement or dissent (i.e. nonresponse)

**Table K1**

*White British Focus Group Themes Consensus Matrix*

Whole-group Theme	Group Experiential Theme	Participant				
		Imogen	Josh	Nancy	Rachel	Vicky
Profession	Whiteness as the norm in psychology	A	SE	SE	SE	SE
Interpersonal	It's about who you know	SE	SE	SE	SE	NR
	I feel supported and confident	SE	SE	SE	A	SE
Internal	"Luck" vs. merit	SE	SE	SE	SE	SE
	I am seen and valued as a whole person	SE	A	SE	D	A

**Table K2***Black British Focus Group Themes Consensus Matrix*

Whole-group Theme	Group Experiential Theme	Participant				
		Amarachi	Campbell	Isioma	Tolani	Whitney
Profession	An asset vs. Racism	SE	SE	SE	SE	SE
Interpersonal	Need to be inside the club	SE	SE	SE	A	A
	A luxury vs. A right	SE	SE	SE	SE	D
Internal	Racism costs me energy	SE	SE	SE	SE	SE
	Do I belong here?	SE	SE	SE	SE	A

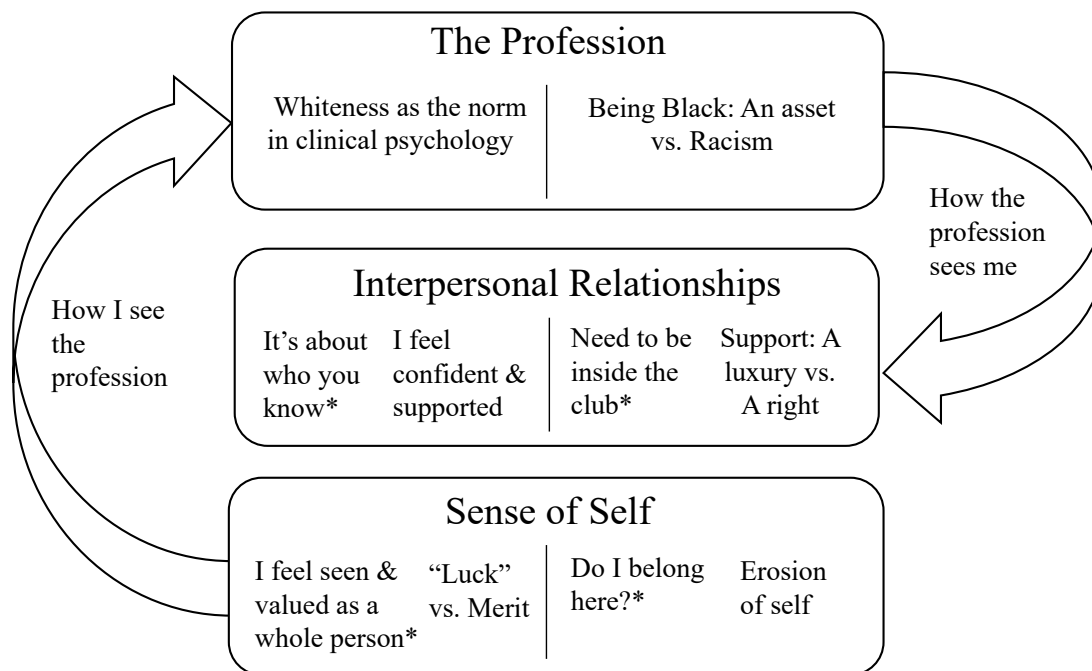
## Appendix L

### Additional Group Experiential Themes and Quotes

This appendix includes a brief write-up of the four remaining GETs that were not presented as part of the main write-up, as well as additional supporting quotes for all themes.

#### Figure J1

*Diagrammatic Formulation of Focus Group Themes*



**Table J1***Additional Supporting Quotes for Themes*

Whole-group theme	Racial Group	Group Experiential Theme	Illustrative Quotes
The Profession	White British	Whiteness as the norm in clinical psychology	<p>“I remember kind of sitting there and thinking actually like my Uni course like if you even go back to kind of Uni course is my Uni course was not diverse <i>at all</i>. Like it was full of kind of like White females, who will basically look the same as me.” (Rachel, 203-206).</p> <p>“And we've just had that when we've umm recruited an administrator and she is Black Portuguese. And she was. She was, she was very daunted when she came in and she realised that all of the rest of us as staff, the me as the assistant, the trainee the, the two qualifieds [clinical psychologists] that everyone is White...Must be an extra layer of something to deal with that is on top of what you would normally deal with in a new role when you're settling in. Another level difficulty.” (Vicky, 476-486)</p> <p>“Especially if you live in London I think for a huge amount of all kind of pre-qualification roles are inaccessible because of financial difficulty. Let alone even thinking about like other intersections of identity and ethnicity...let alone kind of what's services look like and kind of how you feel in the space is you're entering into they're majority White. And people don't really understand your kind of lived experience.” (Nancy, 260-265)</p>

	<p>Black British</p> <p>Being Black: An asset versus. Racism</p>	<p>“I’m someone who always liked vocalises to people who are interviewing me about lack of more aware of like disparity between like black female psychologists and white female psychologists and how that’s something like, I would like to kind of change. And I think the people who are interviewing are kind of aware of that as well and that kind of puts a question into the mind of considering like, “OK, maybe like who are the previous like people we’ve had for this role and this this, you know, this is a person who we should maybe kind of take under our wing as well to kind of like challenge that disparity that’s going on”. [Isioma nods] So I think it’s something that has been a strength.” (Tolani, 205-213)</p> <p>“I remember for my current role, one of the questions was like an EDI question and they explained that um like where I’m working now is really like multicultural and they kind of asked, “OK, how how would that affect your work? Do you think you’ll be able to relate?” and things like that, and I was able to explain that as a Black woman, I feel like being a minority will help me clinic to be clinically, to be able to actually relate to like the clients that we have [Campbell nods].” (Amarachi, 246-251)</p>
<p>Interpersonal Relationships</p>	<p>White British</p> <p>It’s about who you know</p>	<p>“And we’ve got a psychology network across the Trust that’s been set up well, it has been set up, it’s been in place for a few months now. So there’s a lot of psychologists that when we last had a whole meet up in person that they are also really invested in helping the assistants with their</p>

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applications and so that would be really useful.” (Vicky, 578-582)

“So my supervisors in this job are really helpful. And it's kind of not just my supervisor, but the kind of the lead psychologist and then the the lead for the service. They're kind of all really invested and they they're all helping.” (Rachel, 593-595)

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I feel confident and supported

“I didn't really know what I should be asking and there wasn't a kind of formal procedure to kind of supervision in that space... I just felt really like happy that I had the opportunity. Um and I feel like having spoken to other people who have done a similar thing, they kind of feel the same sometimes, just like you feel so lucky to be even there that you're kind of overwhelmed. Don't really know what to ask, don't know whether you should ask. Er which is not the most helpful dynamics I would say.” (Nancy, 108-116)

“you definitely don't really know what to expect unless someone is prepared to create a mock entry for you, which is then asking quite a lot [Nancy and Rachel nod] of someone who is a clinician and is already supervising other clinicians or APs. It feels a bit daunting to ask for that, but that is something I would really love, and I think the other APs that are in my Trust would probably also really like but also don't want to ask for. It's, it's tricky one” (Vicky, 726-731)

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Black British	Need to be inside the club	<p>“It was just kind of seeing the same people. And you felt kind of, well, I felt kind of washed out, but I tried to keep like networking and speaking to people regardless” (Tolani, 355-357)</p> <p>“When I was first doing research into trying to do that PWP [Psychological Wellbeing Practitioner] umm role, I found a like it was quite difficult to find people who were willing to give like, a certain amount of information...but I found that information a bit more difficult to to reach, and then once I've taken that step within that, that system within IAPT, there was a lot easier to negotiate to talk to, I guess, to discuss with the people who were directly related to me.” (Isioma, 151-159)</p>
Support: A luxury versus A Right		<p>“I went on Twitter and I just put out a call for anyone who was willing [Tolani nods] to be like a mentor for me, any trainee or qualified clinical psychologist. And that was something that I really like, I really had to psych myself up to do that [Campbell, Whitney and Amarachi nod]. And I found that there are people out there who are willing to help. There's a lot of people who are willing to, like, reach back umm and share that knowledge that they've accumulated. But it's not that you have to, you have to look for it. And that's something I really had to have to learn, it's not just going to arrive [laughs] on your on your doorstep.” (Isioma, 113-117)</p>

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			<p>“And yeah, being more, I don't wanna say being more free with information but. Yeah, be more free with information. So letting someone know, like how you got to where you are [Tolani nods] or give them advice about maybe how you structure interview questions as much as you can.” (Amarachi, 719-722)</p>
Sense of Self	White British	I am seen and valued as a whole person	<p>“Erm but it's actually nice to hear err everyone's AP roles are enjoyable, mine's mine's the same to be honest. Err, very supportive. They massively erm protect space for thinking [nods from Imogen and Rachel] err in the service... you get your individual clinical supervision and we have a team supervision for the whole service.” (Josh, 368-372)</p> <p>“So for me, I think there's a couple of forms of support. So first is, my supervisors, so there's a space there for kind of reflection, thinking about kind of why I want to write in my applications, but also thinking about what's skills they need to develop [increase in pitch] in order to kind of meet the competencies for the Dclin.” (Nancy, 556-559)</p>
		“Luck” versus. Merit	<p>“Kind of actively sought out pretty much all of the psychologists in my Trust and then managed to get a um kind of honorary AP position for a while...I guess er for a lot of people that isn't an option. I think honorary positions are should not really be allowed, but I was in quite privileged position...I guess in that sense that really helped with some of my application.” (Nancy, 100-107).</p>

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“Yeah, it's difficult question. What would you feel if you were different gender or ethnicity? It almost feels too uncomfortable to answer in a way, but um and I definitely agree, I think Imogen was saying about “my service holds service user’s ethnicities and genders more more in mind than the staff on the team.” (Josh, 510-513)

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Black British      Do I belong here?

“Um when I was a support worker, I saw a lot of like a lot of people who did look like me in that in that position. But then the more experience I'm gaining [Whitney smiles and nods] and and the, the more I'm kind of progressing towards my end goal. I'm seeing that like fade a bit, so that has been an experience I've had” (Isioma, 326-329)

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Racism costs me energy

“Yeah, I think I can relate to sort of having that in like feeling like you have to, you're spending a lot of your energy trying to figure out what someone meant. “Was it intentional? Are they being nasty?” Um I think I can relate to that kind of experience” (Whitney, 494-496)

“I've had a treatment session where I've had a client say something use a word that's quite outdated and it's not aware that we use in in er *I* would use personally and then me having the ugh and then that affecting the the session as it goes on and me wondering, “oh, should I say something?” Is this beneficial to our like our therapeutic relationship? Should I bring this up and *that* energy, those kinds of things, those little things that are a part of existing as a Black

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woman in a majority White country and that those things that turn up when you're at work.” (Isioma, 486-492)

“Whilst working on the ward just kind of experiencing racism from patients who are unwell and kind of having to navigate that as well um even sometimes in group settings, maybe having like all White um patients. And then there's one unwell patient who's quite racist and having to kind of handle that [Whitney and Isioma nod] in the room can be quite difficult.” (Tolani, 504-508)

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## Theme 2: Interpersonal Relationships

### *White British GET: It's About Who You Know*

White British participants understood that in order to progress within clinical psychology, connections with other professionals within the profession was essential. Participants described the different ways in which they built their networks, through both personal and professional connections.

I worked in a pub for a while...I actually ended up working with someone who was also working part time and as an assistant psych...so she was a real source of support for me. She kind of taught me about the doctorate process and suggested some jobs to go for, like research jobs or support worker jobs. Erm help me write applications as well, she's she's been absolutely amazing.  
(Imogen, 63-70)

This experience was significant for Imogen as she described it as her very first experience of having a connection within the profession. Imogen used the phrase “ended up” to emphasise the serendipitous nature of this personal connection. Another example of how a personal connection was used to gain entry to the field of clinical psychology comes from Josh.

I didn't know much about I I was a career changer, changed during COVID... I got some of my support from word of mouth, my partner's sister's a psychologist in [redacted], so I spoke to her about the doctorate. Didn't know anything about it. (Josh, 80-82)

Josh uses the phrase “word of mouth” to create imagery of information being passed, almost as if secrets are being shared. This highlights a sense of exclusivity and difficulty of accessing the clinical psychology profession. Consistent with this, successfully gaining a pre-qualification role was described as challenging by all

participants, however once entry was gained, participants appeared to easily navigate professional relationships to build networks to progress.

I've worked with APs [Assistant Psychologists] before, so kind of still got APs that I used to work with and a trainee who's just qualified that I used to work with is also kind of helping as well. So I think you do build up almost a network of people as you go through jobs. You almost find people who are really, really helpful. So I think, yeah, you just add them to your collection of people [Vicky, Nancy and Imogen smile] that have helped [laughs]. (Rachel, 600-605)

Rachel, in a casual tone, lists members of her professional networks suggesting a quiet confidence that she has the support she needs. The language used by Rachel (e.g., “build up” and “go through”) echoes the idea of their career trajectory as a physical endeavour, “going through” different doors toward destination of the DCLinPsy. Most participants explicitly described the importance of networks to them; however, this did not appear important to Vicky. This could have been due to Vicky identifying as coming from a low socioeconomic background, thus feeling she does not have the same access networks as other participants had from personal connections, experience of multiple ACP roles or paid memberships “I've now signed up to like a paid membership where I pay each month to meet with the psychologist and other aspiring psychologists to like share tips” (Imogen, 120-122).

However, Vicky described communicating with her interviewer (i.e. now her supervisor) prior to her interview, which she believes contributed to her interview success through increased confidence and feeling at ease.

I had quite a lot of communication with my now supervisor, the consultant like who. So I felt like I had a bit of a connection with the recruiter. Who would then be my supervisor as it felt. So, I felt more at ease, by time it came to interview

and then when I got the role the next day, it felt really [pause] it felt really great.  
(Vicky, 148-151)

Vicky implies that familiarity and a personal “connection” with those that are interviewer you, increases your chance of success within the profession.

***Black British GET: Need to Be Inside the Club***

Black British participants experienced a sense of exclusion in trying to access career-relevant information, navigate professional relationships, and progress within clinical psychology. Participants positioned themselves as existing outside of “the club” (Amarachi, 725) of clinical psychology, and struggled to find peers, mentors, and supervisors who were “willing” (Isioma, 114) to help them to gain entry.

And yeah, being more, I don't wanna say being more free with information about. Yeah, be more free with information... I think like Isioma was saying earlier, I think you were talking about how when you got into your position then you have access to information, but before that it's like there's a barrier like you have to kind of be in the club to kind of get all the information. [Whitney, Isioma and Tolani nod] (Amarachi, 719-725)

Amarachi describes a process of information restriction and gatekeeping.

Amarachi feels as though information is purposefully being withheld, an experience shared by other members of the group “when I was first doing research into trying to do that PWP umm role, I found like it was quite difficult to find people who were willing to give like, a certain amount of information” (Isioma, 151-153). Amarachi’s uses the word “free” implying that accessing information comes at a cost and in order to access the club you (i.e., Black British ACP) must mould and contort yourself to fit through the door.

I told myself to start doing things a bit differently, so putting myself out there, being more proactive, asking questions, asking, asking, even when I thought these are quite stupid questions and from that I've been able to sort of always come across people to support me [Isioma nods]... Umm I and just really working on that as well. I'm still working on it [Laughs]. (Whitney, 134-138)

Whitney relays an internal pep-talk that she gave herself when trying to build a network of support. The idea of “doing things differently” suggests that previous ways of working were not enough to access and feel comfortable within the profession. Whitney’s laughter suggests an uneasiness with her reflection of not being good enough. For example, Whitney describes asking “stupid questions” and that she is still “working on it”, working on developing, or changing herself to fit within the mould of what she has been told how an ACP should be. Other participants described seeking the support of mentors to gain entry into “the club”.

Just like even getting into IAPT [Improving Access to Psychological Therapies], you it's about like what you know and like it's also like very helpful to have like other people in your corner. So like mentoring so you can [Isioma nods in agreement], like, tell you like what you need to get because it can be hard when you're coming from, like, backgrounds like, what we're come from really.” (Campbell, 187-191)

Campbell’s use of the phrase “getting into IAPT” produces an image of IAPT as a closed door/space, a narrative shared by Isioma, as she states “a lot of doors opened for me” once she started training as a psychological wellbeing practitioner (PWP). Campbell also refers to the group’s shared racial identity without explicitly naming racism. This mimics the discourse, or lack of, on racial inequity within the clinical psychology profession. The importance of coming from “backgrounds we’re



coming from” is a nod to participants’ understanding that it is harder for Black ACPs to progress within psychology.

### **Theme 3: My Sense of Self**

#### ***White British GET: I Am Seen and Valued as a Whole Person***

The majority of White British participants felt seen and valued as psychological practitioners within their roles, contributing to a sense of belonging. This was demonstrated in a variety of ways, including feeling understood by supervisors, having opportunities to showcase different skills and overall enjoyment of their current roles. This theme was closely related to the GET ‘Whiteness as the norm in psychology’ which depicts how White British participants understood that to be White means that “I match” (Vicky, 232) other psychologists.

I've had a really good experience. Erm in general, err it's been a lot more er my supervisors have been really nurturing and very understanding of personal circumstances... So I felt like seen as much more of a whole person in this role than I have in other roles. (Imogen, 304-308)

Imogen is explicit in how her personal context is considered and accepted within her role, allowing her to bring her “whole” self to work, encouraging a strong sense of cohesion across her personal and professional identities. Imogen describes her supervisor using warm adjectives such as “nurturing” and “supportive”, almost describing a parental figure. Feeling mentored and guided along her career path is of great importance to Imogen as she repeatedly provides examples of support via personal networks “I actually ended up working [in the pub] with someone who was also working part time and as an assistant psych” (64-65), peers “the PWP [Psychological Wellbeing Practitioners] in my service are really lovely and I can talk

to them about that [the doctorate]” (639) and supervisors “we'll have supervision and I'll reflect on something she'll be like, “Yes! Put that in your application” (631-637).

Feeling accepted and social integration appears to provide access to increase self-esteem, as echoed by Nancy.

I think I really agree with you there in kind of thinking about how kind of excited you've been about going to work, that being related to how supported you feel like. I think I have a similar experience in that the role I'm in at the moment I feel so supported and like very understood. (Nancy, 332-335).

Nancy's comments demonstrate the relationship between feeling understood and sense of self in the workplace. Similar to Imogen, Nancy feels that her relationships with colleagues contribute to her esteem as a psychological professional. Nancy being “excited” to go to work highlights how being understood at work produces feelings of confidence, competence and belonging.

There were variations in how participants individually indicated a sense of belonging, there was consistency across all participants in linguistic indicators of belonging. In describing their experience of current roles, participants commonly positioned themselves as part of the team and belonging through use of the word “we”: “we're working in a national service (Vicky, 321), “we have a team supervision for the whole service” (Josh 372), and “something that we're thinking about a lot” (Nancy. 464).

As indicated in the consensus matrix ([Appendix K](#)), Rachel is not represented within this GET as she feels she is being deskilled in her current role and is moving to a different role in search of more clinical experience “I'm I feel like I'm losing my skills” (Rachel, 418). However, Rachel is represented in a closely related GET ‘I feel

supported and confident' which reflects participants' experience of support and help with career progression/development.

***Black British GET: Do I Belong Here?***

This GET represents how Black British participants tried to make sense of their belonging in the profession. For example, Amarachi and Tolani describe how in previous roles they felt like they “stood out like a sore thumb”, a simile that evokes vivid imagery of the painfulness of being the only Black face in a White space.

And so I would stand out. I felt like I'd always stand out like a sore thumb [Isioma and Campbell nod] except from when it was like maybe night shifts. And then you would see more people that look like you [Isioma smiles and nods] but also in the same like position. So support worker. (Amarachi, 350-353)

Amarachi repeatedly uses the phrase “stood out” to highlight how persistent and frustrating this experience was. Within this narrative, Amarachi demonstrates the tumultuous nature of this experience, the way that hope is built through seeing “more people that look like you”, and hope falls as the realisation that within the NHS progression for certain racial groups appears capped at a certain band, potentially reflecting a racialised hierarchy. Amarachi refers to the group as a collective where she says “people that look like you”, in reference to her own experience of being Black within clinical psychology, but also her understanding that other participants have experienced a similar feeling.

This is demonstrated by Tolani who explicitly identifies with Amarachi's experience, almost in excitement that she is not alone in feeling this way.

I actually had the like exact same experience as Amarachi, so I was also working um in [redacted]... and all the services user there were all White and all my

colleagues are like again like feel like I'm kind of a sore thumb there and just sometimes feeling like having to like act a certain way to kind of like fit in with the team. (Tolani, 368-371)

Tolani expands on this experience by describing having to become someone else in order to “fit in” with her White team. The word ‘White’ is used here not necessarily to refer to the race of patients and her team, but could be interpreted as the normalcy of ‘Whiteness’ within psychology and that in order to progress, Black British ACPs need to gain proximity to Whiteness. This relates closely to another GET ‘Racism costs me energy’ which depicts participants’ experience of racism, having to “change little bits” of themselves (Campbell, 522-524) and how much the process cost them (see [Paper 1](#), pg. 42).

Participants described not initially seeing themselves as competent or knowledgeable, particularly when working in settings that were not racially diverse “it did feel like I was just like grasping at straws in a way...you constantly have to, like, prove yourself [Isioma and Whitney nod in agreement] as to why you deserve to be like where you are.” (Campbell, 183-186). However, participants’ sense of belonging in the profession and self-confidence in their abilities increased when working in diverse teams.

I think that's why I'm really enjoying my current role and I feel like I've come out of the impostor syndrome feeling a lot quicker than I thought I would [Isioma, Campbell and Whitney nod], and I think that's because I feel represented in the team representing and the service users and that's really coming out in my work as well so I'm really enjoying that [Isioma, Tolani and Whitney nod] and just growing in my confidence. (Amarachi, 361-366)

Amarachi repeatedly describes “coming out” to indicate growth and development. Working in a team with racial diversity at all levels bolstered Amarachi’s confidence, she felt seen “I feel represented” which was a positive experience in contrast to her previous account of standing out “like a sore thumb” (Amarachi, 351). Furthermore, Amarachi recognised her cultural capital and skills as she felt better able to support the service users in the local area.

## Appendix M

### Example of Line-by-Line Coding in NVivo

re Layout View

Stripes Highlight Node Node Matrix Classification

Coding Detail View

Edeh et al 2021 The production of difference

Selection Mode Aa Zoom 100% Recognize Text

Our respondents described how they were produced as different in a variety of interactions with patients and colleagues. Being read as different was demonstrated in questions from patients such as "where you are from" (Mary, doctor – London) and "How long have you been in this country?" (Nina, nurse – Scotland). Such questions were directed to both doctors and nurse respondents. The production of difference was described as immediate and ubiquitous, and often in response to visual signifiers of difference, occurring "as soon as people saw you" (Mary, Doctor – London). But other markers of difference were mobilized, including accent, so that being seen or heard had the potential to be positioned as "other" in their work based interactions.

Such interactions produced the respondents as different and lesser. Questions of origin were frequently followed by questions about respondents' ability. So that what followed from "how long have you been in this country?" was "are you sure you are good for the job?" (Nina, Nurse – Scotland). Similarly, Beverley (Doctor – Scotland) said "it's just that idea of one coming from Africa, I am Black, you know, they think I don't know anything." As Hall (1997a, 1997b, 2017) argued, race is read through markers of difference in relation to colonial ideas of whiteness, classifying and positioning people who are not white as inferior through racist regimes of representation. We see this in Beverley's description of how Africa, Black and ignorance were synonymous or in the many stories respondents told of patients asking for a white or "British" doctor or requests for a "second opinion" that our respondents read as coded requests for a white practitioner. These experiences were not limited to interactions with patients, as Pippa (Doctor – London) said "sometimes ... some white nurses do not regard some Black doctors and I have had that in the past." The production of difference thus positioned our respondents as illegitimately holding office at work, work that they had trained hard for, and which might be expected to bestow them with the valued status usually associated with their professions, especially since professional training is a route for migrants to acquire status, albeit complicated from a race and gender perspective (Zwysen, 2019; also see Witz, 1992 on the relation between the professions and in- and exclusion).

Our respondents' experiences also mapped onto Hall's argument that multiple markers of difference are used in racist regimes of representation. For example, in the extract below, Karen describes how work interactions were structured through the mutually constituted dis-preferred categories of her as "migrant," "foreign," and with an "accent." An accent that positioned Karen as lesser, since she is unintelligible "oh I can't understand you," echoing both Hall's argument that racist regimes of representation link difference to inferiority and Charteris-Black's (2006) discussion of migrants as "unwanted outsiders."

*being a migrant at work, sometimes you have the patients, you get the awkward patients, and they just tell you I don't want to see you, a foreign doctor, and sometimes some of the elderly patients make comments on your accent, like, oh you sound very foreign, where are you from? Or they are like, oh I can't understand you, you don't speak English (Karen, Doctor – North England)*

Other respondents also described how their accent was used as a signifier of difference that positioned them as

seen as inferior  
discriminatory action  
system of promotion in NHS having to prove yourself  
reduced identity  
Whiteness as preferred  
resistance to senior ethnic minority staff  
loss of status in new country  
difference is a problem  
Black  
seen as inferior  
racialis'd hierarchy  
Black, Migrant, Nurse  
Black, Migrant, Doctor

Coding Density

DATA > Files > Edeh et al 2021 The production of difference

## Appendix N

### CASP Checklist for Included Studies

**Table N1**

*Critical Appraisal Skills Programme (CASP) Checklist for Included Articles*

	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	11. Total CASP rating
1. Alexis & Shillingford (2014)	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No	7 (Moderate)
2. Alexis & Vydelingum (2004)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Valuable	9 (Strong)
3. Alexis et al., (2007)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable	9 (Strong)
4. Batnitzky & McDowell (2011)	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Valuable	7 (Moderate)
5. Daniel et al., (2001)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable	9 (Strong)

6. Edeh et al., (2022)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable	9 (Strong)
7. Garcha et al. (2022)	Yes	Can't tell	No	Yes	No	No	No	No	No	No	2 (Weak)
8. Hammond et al., (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable	9 (Strong)
9. Henry (2007)	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	No	6 (Adequate)
10. Likupe (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Valuable	8 (Moderate)
11. Matiti & Taylor (2005)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable	9 (Strong)
12. Odusanya et al., (2018)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Valuable	8 (Moderate)
13. Qureshi et al., (2020)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Valuable	9 (Strong)
14. Taylor (2005)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Valuable	9 (Strong)
15. Withers & Snowball (2003)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable	8 (Moderate)
16. Woodhead et al., (2022)	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Valuable	8 (Moderate)



## Appendix O

### Detailed Table of Themes

**Table O1**

*Systematic Review Resulting Themes, Example Coding and Contributing Studies*

Analytic Theme	Descriptive Theme	Participants' Quotes and/or Authors' Explanation	Example of Initial Codes	Contributing Studies
Institutional racism	Racialised hierarchy	<p>Like some patients, because you're Black, they don't think you are as qualified or have the same experience, so when you go to do something they doubt you (Black Caribbean, migrant, nurse)<sup>4</sup></p> <p>The production of difference thus positioned our respondents as illegitimately holding office at work, work that they had trained hard for.<sup>6</sup></p> <p>I have been there more than a year now, but there was a White nurse who came to work there after finishing her training, she just worked for six months and now she has been promoted to E grade. And you can imagine what impact it has on us" (Black African, migrant, nurse)<sup>9</sup></p>	doctors and consultants top of hierarchy, hierarchical organisation, resistance to senior ethnic minority staff, non-clinical staff ignored, lower-band jobs perceived as menial, poor progression for global majority staff	1-6, 8, 9, 11-15

Racism as an  
everyday experience

There was just some back biting by other nurses and that, I don't know whether that's classed as discrimination or not because that can happen anywhere but it just makes you feel as if it is because you're a different colour. (South Asian, migrant, nurse)<sup>4</sup>

racism everyday experience,  
racism from patients, racism  
from senior staff, racism from  
White colleagues, unable to  
speak up, ethnic minority staff  
feeling resigned to the status  
quo, unmet needs at work,  
racism denial

1-15

Being a migrant at work, sometimes you have the patients, you get the awkward patients, and they just tell you 'I don't want to see you, a foreign doctor.' (Black African, migrant, doctor)<sup>6</sup>

You were very frightened because how many thousands miles away from home so you have to accept what is put in front of you, but you were very disappointed because you were doing two years wasted instead of doing three years with everything. (Black Caribbean, migrant, nurse)<sup>4</sup>

You could say that there was a sort of anger or something like that, but I didn't know if it was just...but it didn't only happen to me, it happened to other overseas colleagues as well. (Global majority, migrant, nurse)<sup>2</sup>

In-group, Out-group	<p>They were seen as the ‘other’ mainly because their cultural identity was different from that of their predominantly White British counterparts.<sup>2</sup></p>	<p>cultural difference, different from dominant culture, differential support, seen as inferior, opportunities based on skin colour, discrimination, seen as ‘other’, ethnic minority excluded from social events, difference is a problem</p>	2-15
	<p>Many overseas nurses perceived that being of the wrong colour was a contributory factor in the way they were treated and wondered whether their treatment would have been any different had they been of similar racial features to that of their White UK counterparts.<sup>3</sup></p>		
	<p>‘The production of difference was described as immediate and ubiquitous, and often in response to visual signifiers of difference, occurring “as soon as people saw you’ (Black African, migrant, doctor). But other markers of difference were mobilized, including accent, so that being seen or heard had the potential to be positioned as ‘other’ in their work based interactions.<sup>6</sup></p>		

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Whiteness as a benefit	White privilege	<p>Because I know they want to educate people but only the Whites. (Global majority, migrant, nurse)<sup>2</sup></p>	<p>White staff won’t lose anything, access for White staff across banding, Whiteness as preferred, underserving of promotion</p>	2-4, 6, 7, 9, 11-13, 15
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They'd go out after work with the White English, like, they'd include her in as well. Like, they'd go out for drinks whatever. But the Black student nurse was never... wouldn't be invited. (Asian, non-migrant, student nurse/midwife)<sup>15</sup>

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Whiteness as a resource for global majority staff

Most common sources of support in developing promotion skills were friends, White colleagues and voluntary ethnic organisations.<sup>8</sup>

Asking advice from White colleagues, desire to fit in, conflict with primary culture

5, 7, 8, 11, 15

There are times when I feel like I am or I have done, moderated myself in order to be in certain groups. And I think that goes across my lifetime ... in some ways [I'm] now learning to do that less. So actually, yes, I am a Black clinical psychologist, but that doesn't take away anything [from] me. (Black British, non-migrant, clinical psychologist)<sup>11</sup>

[W]ho's gonna want to marry you? In terms of the communities that you're ... from, I think ... there are some people who see ... psychology as a ... White Western thing ... and think that you've sold out or become White or a coconut. (British Asian, non-migrant, clinical psychologist)<sup>11</sup>

Management as agents of racism	Perpetuating negative racial stereotypes	Stereotypical and normative assumptions about their attributes and skills from colleagues, managers and patients that affect their opportunities to progress within the National Health Service. <sup>4</sup>	confidence seen as arrogant, differential treatment of different ethnic groups, inter-ethnic group tension, management do not trust ethnic minority staff, denied support, racism from other global majority groups,	3-6, 8, 9, 11, 13, 15
		<p>She is Filipino and she is an excellent staff nurse and I think she would be excellent as a junior sister but she is not interested, she doesn't want the aggravation, doesn't want the responsibility. I would probably say that [name of Black African nurse] knowledge of hospital policies it is probably very limited, because again they focus on patients. (Charge Nurse)<sup>9</sup></p>		
		<p>Sometimes, like, based on, based on stereotypes, some of my colleagues, when we have healthcare assistants, they have, like, there's a stereotype that the healthcare assistant, the Black healthcare assistant are lazy." (White Other, non-migrant, qualified nurse/midwife)<sup>15</sup></p>		

Deskilling and devaluing global majority staff

I feel that the manager's role should be to confront the doctor and tell them that this nurse is qualified to carry out orders. (Black Caribbean, migrant nurse)<sup>3</sup>

With my senior colleagues there was of course that feeling that I was under scrutiny all the time and it took time for them to understand that I can do the same things they do just as well as they do'." (Black African, migrant, nurse)<sup>9</sup>

Sometimes, if you have for example a dressing to remove, or something like that, simple things, 'no I will do it' as if they don't want you to touch the patient. They are not confident with you. (Black African, migrant, nurse)<sup>10</sup>

It was difficult because in the first week, I had a mentor who was younger than me and according to me I have been working for 12 years as a nurse. So I know a lot of things. So many things, that you are not allowed to do here. I think I have more experience than she has [mentor] and so many things she was teaching me I already knew but I had to listen to her. Be very patient and act as a student." (Black African, migrant, nurses)<sup>10</sup>

asked to do menial tasks, lack of skills recognition, role restrictions, tasks not seen as appropriate for role, feel like 'one of a number, feeling degraded by duties given 1-4, 6, 8-11, 13-15

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Autonomy in promotion and progression	This is intensified when the unsuccessful candidates regard the entire process of promotion as characterized by a lack of transparency and unfairness and a perception that few Blacks and especially African nurses and midwives are promoted. <sup>8</sup>	Nepotism helped with progression, interpersonal skills key for career development, system of promotion in the NHS, training does not guarantee access to promotion, patronage for promotion, withholding information, not putting policy into practice	2, 4, 6-9, 14, 15
	Usually if you say that you are underdeveloped they will send you on a billion courses, not because they are particularly interested in helping you to get anywhere but because it is seen to do something.(Black British, non-migrant, nurse) <sup>8</sup>		
	Like Filipino, there was one that was there for three years and was extremely good... But it took a good two years of bullying in a nice way, saying there is an E grade coming up; I want to see you go for it. But like I said for [name of Black African nurse] there hasn't been an opportunity on this ward, but there have been on other wards. I know she likes it here, she likes the people, she likes the work, and it works out well within her home life" (Race and migration status unknown, Charge nurse) <sup>9</sup>		

Reduction of Self	<p>We found that many of the twenty-one nurses included in this analysis accepted, adapted to and internalised both managerial and patient beliefs about which training, which nursing specialism and which ward-based tasks were deemed appropriate for them.<sup>4</sup></p> <p>Some nurses appeared to have lost confidence in their abilities because they were told that they were not good enough, and some even internalised this and accepted that there must be something wrong with them<sup>9</sup></p> <p>Another challenge is this idea that you somehow will have this insight into every ethnic minority experience or every Black person's experience. (Black British, clinical psychologist)<sup>11</sup></p>	<p>feeling demoralised, feeling isolated and lonely, humiliated, lack of support impacted confidence, reduced ethnic identity, feeling like a fraud, not feeling valued, something wrong with me, racism denial, reduced self-esteem, embarrassed by treatment, invisible but visible</p>	2-4, 6-11, 13, 15	
Ways of coping within the system	<p>Need to work harder, be proactive and resilient</p>	<p>Nevertheless, Jasmine told us that throughout her career, she felt that she had to be 'smarter and quicker than the White nurses' as 'they would be given a higher post over you, no matter what, but</p>	<p>Going above and beyond, need strength to survive, need to be independent, not relying on others, own responsibility to access information, had to learn by watching, work culture didn't</p>	1-11, 13, 14



you had to be quicker’(Black Caribbean, migrant, nurse)<sup>4</sup> support adjustment, anxiety in new environment

Because I am an immigrant. It is more likely that if I make a mistake at work, there will be higher litigation for me, do you understand? Because I am not from here, because I don't speak like them, so I have to be excellent. (Black African, migrant, doctor)<sup>6</sup>

Other examples of participants' reflections on preparation being self-directed include: 'If I ask, I then do it myself' (White other, nurse). Another suggested: 'I had to go there... Just to get an idea of what they do so that I can get prepared for the job'... You wouldn't get a job unless you're proactive, yes, yes very proactive, you had to...' (Black African, nurse)<sup>7</sup>

I need to adjust to the culture. You have a different culture. It takes time ... I'm not putting it as a had experience but a learning experience. (Southeast Asian, migrant, nurse)<sup>14</sup>

“I think [about] all the things ... I had to develop in order to get here ... being kind of determined and ... strong-willed

Withdrawal from practice	<p>and focused and all of those things that got ... me through that journey. So I'm quite proud of having developed that range of skills." (Asian British, non-migrant, clinical psychologist)<sup>11</sup></p> <p>A nurse participant stated that she 'wanted to quit' due to a racist remark made by an employee on her clinical placement. She recalled what the employee said: 'I find it difficult to work with Africans...Black people' and discussed how this made her question whether she belonged in the profession." (Black African, migration status unknown, nurse)<sup>7</sup></p> <p>I was accused of random stuff which was not true, and I which I knew wasn't true and I should have fought a bit more but at the time I was broken and I just didn't want to work there anymore. (Black, migrant, senior qualified nurse/midwife)<sup>15</sup></p> <p>Furthermore, several nurses also reported that they were so traumatized or demoralized by the experience that they felt unable to seek feedback from the people they believed discriminated against them. This process of demoralization has led many nurses and</p>	<p>wanting to leave, left the job, move to a different team, time off sick, wanting to go back to home country,</p>	<p>1-3, 5-9, 12, 15</p>
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midwives to withdraw from career development, cease applying for promotion and their careers have stagnated<sup>8</sup>.

Resistance to the racialised status quo	<p>‘I think people do apply for jobs where they are more likely to fit in...That’s where you start off’ (Mixed Other, nurse) and a notion that it is important to apply: ‘where there are more ethnic minority [groups] because we feel that is where we will be comfortable but also the issue of understanding’. (Black African, nurse)<sup>7</sup></p> <p>The Ghanaian nurses and midwives discuss them among themselves and in certain circumstances with other Black nurses.<sup>8</sup></p> <p>Respondents who had been employed for more than six months appeared to conform to Pilette's theory: they were more assertive and tended to speak out about the conflicts.<sup>14</sup></p>	<p>wanting to work with people like you, commonality between ethnic groups, reversal of dominant ethnic group, resistance to positioning, mutual support</p>	4, 5, 7-9, 11, 13-15
Protective factors	<p>This individual felt comfortable and she found support to be available whenever</p>	<p>get on with team, independence increased confidence, made to feel welcome, patients</p>	1, 2, 5, 10, 13-15

she needed it. (Global majority, migrant, nurse)<sup>2</sup>

appreciate my care, support available, treated well by colleagues

They've encouraged us to take the 405 course, so I did. There is always something going on here. (Global majority, migrant, nurse)<sup>1</sup>

For some nurses in the study, the ability to adapt culturally was sustained through the support from other nurses. 'First thing I would say is that I had a chance to be in a ward where everybody now I can say is my family. I have got somebody I can talk to and also some took me out for a meal. Which was nice of them. They sometimes talk about UK life.' (Black African, Migrant, Nurse)<sup>10</sup>

If ever I'm going to transfer, I will transfer within the Oxford trust, because I'm very happy here. There is always somebody there if I have a problem. (Southeast Asian, migrant, nurse)<sup>14</sup>

Other overseas nurses felt valued by other members of the multiprofessional team and that UK colleagues did not treat them any differently: 'As a nurse, I'm the main focal point of everything. Everyone talks to you. Physios talk to you. OTs

[occupational therapists] talk to you.  
Everyone talks to you. Especially  
doctors talk to you.' (Global majority,  
migrant, nurse)<sup>13</sup>