The Experience of **being a** Qualified **Female** BME Clinical Psychologist **in a National Health Service**: An Interpretative Phenomenological and Repertory Grid Analysis

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Abstract

This study explores the lived experience of Black and Minority Ethnic (BME) clinical psychologists employed in the UK National Health Service (NHS). A mixed method qualitative approach was employed utilizing repertory grids and interpretative phenomenological analysis. Six female BME clinical psychologists took part. Four master themes emerged from the analysis including standing out as different, negotiating cultural and professional values, sitting with uncertainty, and **feeling proud to be a clinical psychologist**. The repertory grid analysis supported these findings and enriched the study. Implications of the study are discussed, namely the importance of the profession increasing the cultural competency and sensitivity of its members as well as becoming more diverse.

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A valued and diverse workforce has been argued to be beneficial for client care (Kline, 2014). **Specifically, it is recognised that team effectiveness is enhanced due to drawing from larger talent pools, and increased capacity for innovation and for satisfaction of client needs (Dawson, Kaur & West, 2015).** However, in clinical psychology in the UK, there is a poor representation of Black and Minority Ethnic (BME) groups (Daiches, 2010). As of 2014, it was reported that **in England** there are 9.5% qualified[1] BME clinical psychologists, **87.9% White clinical psychologists and 2.5% reported as unknown (Health and Social Care Information Centre, 2014).** Given our knowledge of the benefits of a diverse workforce, it is surprising that little research has been undertaken to explore the experiences of BME **clinical psychologists who work** in a profession that lacks ethnic diversity. **In the UK, the BME population is now 14.1% of the overall total in England and Wales, not including the 'White Other' demographic (Office National Statistics, 2011).** In a society where institutional racism is still a reality, it is important to understand their experiences. **Though some studies have explored the experience of BME therapists (e.g. Rastogi & Wieling, 2004), the potentially unique experiences of BME clinical psychologists in the UK merit further attention.**

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[1] **In the UK, a qualified clinical psychologist has completed a recognized training program and is granted authority to practice.**

The therapy room is one example of where complex dynamics can be played out between individuals. **For example,** Joseph (1995) described her experience of status contradiction whereby a White client is confronted with the presence of a BME clinician who traditionally may be thought of as holding a low status/position. This can have implications for the psychological wellbeing of the clinician who is faced with such encounters in their working life, especially if acted upon by the client. In a study conducted by Patel (1998), the unusual power dynamics arising between White clients and Black therapists were explored. In the therapy room, both held a different kind of power, i.e. membership of the dominant privileged group versus being in a high status professional role.

The supervisory relationship is a further arena where racial and cultural dynamics can come into play. It has been reported that in cross-cultural supervision, there can be a tendency for supervisors to avoid overtly discussing issues of race and culture. In a study by Constantine and Sue (2007), it was found that many Black supervisees felt that their White supervisors either minimized or dismissed discussions about race or cultural issues in supervision. The impact of this may be the silencing of supervisees within this relationship. **Dos Santos and Dallos (2012) found that for BME clients of White psychotherapists, the absence of open discussion about race and culture excluded fundamental aspects of the client's identity from the therapeutic milieu.** Conversely, Wieling and Marshall (1999) found that supervisees reported better supervisory experiences with supervisors of a different racial background to them than with someone of the same background. A study to illuminate these previous research findings may be particularly useful for a profession that has struggled to shed an image of being racist.

Having a professional role arguably provides the holder with power (Goodbody & Burns, 2011), privilege (Slay & Smith, 2011), and a degree of autonomy (Benveniste, 1987). However, it has been argued that stigmatized individuals are afforded less prestige due to their 'tainted' identities (Slay & Smith, 2011). According to Piore and Safford (2006), one's social identity is integral to one's work career. In a predominantly White profession such as clinical psychology, BME clinicians may struggle to integrate the identity of a clinical psychologist with their existing sense of self (Tan & Champion, 2007). To date, published studies have looked at the trainee experience of BME clinical psychologists (e.g. Rajan & Shaw, 2008; Shah, Wood, Nolte & Goodbody, 2012). These have reported on various challenges, including a fear of speaking out due to the risk of becoming isolated or **being negatively labelled as a trouble maker** as well as the dilemma that trainees faced concerning who should carry the burden of raising race and culture issues in a context wherein they were experiencing avoidance from peers and supervisors.

One study that has focused on majority and minority groups within the profession is by Goodbody and Burns (2011). In their qualitative study, they looked at the psychological discourses about personal-professional development and their contribution to maintaining social power inequalities. They found that for BME participants, there were tensions between personal and professional identities, which arose from instances of discrimination. They also found that for all the psychologists who took part in the study, regardless of their ethnic background, tensions between their personal identities and professional culture were managed by them increasingly allowing for an integration of their personal selves in their work. The study was able to highlight how for White participants, "the context marker was the invisible and unquestioned characteristic of privilege as social power and lived knowledge" (p. 306).

The aim of this study is to focus on the entirety of the experience of BME clinical psychologists given that the ethnicity of clinicians is often the overriding factor in how they are positioned within the profession. **In British clinical psychology, the gender imbalance in the profession places males in a minority position, with 81.5% of the profession being female and 18.5% male (Health and Social Care Information Centre, 2014). In order to focus on the experience of being in an ethnic minority position, this study was concerned solely with BME clinical psychologists who are in the majority position in relation to their gender.** Thus, the research aspires to answer the following question: how do **female** BME clinical psychologists experience and make sense of being part of the profession of clinical psychology?

Method

Design

This was a mixed method study combining Repertory Grid and Interpretative Phenomenological Analysis (IPA) methods. The combined use of IPA and repertory grids has been demonstrated to be a successful **and compatible** blend of methodologies **in other studies** (e.g. Blagden *et al.*, 2014; Gerrish, Neimeyer & Bailey, 2014). **With both methods** the focus is on understanding an individual's social world and both methodologies allow for individuals to share their own way of sense making. **However, the methods also each add to the robustness of the study. IPA provides themes drawn from rich, detailed data, that are then generalised across participants, whereas repertory grids offer a more detailed level of analysis into the individual experience and can analyse for experiences that are more defended. Furthermore, this study recognizes that no** one approach on its own can provide the richness

given by the use of more than one methodological approach. According to Mason (2006), when trying to understand the lived experience of individuals in a social reality, one must take a multidimensional approach, as these phenomena are not easily understood along a single dimension. She argues that there is multi-dimensionality to lived experience and in order to make sense of this, researchers should think creatively about the methods that they employ. **Thus, the** strengths of **a mixed-method approach** include the added value of incorporating **such** multiperspectivity. Furthermore, the use of the two methodologies in this study provides a way of triangulating the data to a degree, and therefore enhancing the validity of the study.

Participants

A purposive sample of 6 female BME clinical psychologists took part in the study (M age = 37.2, range 34 to 46 years). All participants had been qualified for at least two years (M qualification period = 7.3, range 3 to 16 years), and had qualified from clinical training programmes in the UK. Three were from a British Asian background and three were from a Black African/Black Caribbean background. Participant details can be found in Table 1.

Procedure

Ethical approval for the study was granted, and participants were recruited from around the country via various recruitment strategies including through a snowballing methodology whereby clinical psychologists known to the researcher were invited to contact other BME clinical psychologists they knew with an invitation email. Other recruitment strategies included identifying clinical psychologists via an online social networking service, the British

Psychological Society (BPS) as well as London-based Clinical Psychology Doctorate training programmes. The majority of the sample were working in major cities in the UK. Each participant was interviewed twice, once for **a** repertory grid interview and once for **an Interpretative Phenomenological Analysis** (IPA) interview, in a location of their choosing. Interviews took place on separate days with the exception of 2 participants whose interviews took place on the same day.

Data collection and Analysis

Repertory Grids

The repertory grid (Kelly, 1955) is a technique that allows us to understand a person's worldview or experience in their own terms rather than using a standard conceptual framework, which may not fit with how the person sees the world. As such, it is a tool that provides a perspective on the way in which an individual views him/herself and the world. Repertory grids were employed as they can tap lower levels of cognitive awareness (Winter, 2003) reducing the effects of social desirability on answers given by participants (Neergaard & Leitch, 2015), and thus possibly allow for a more insightful perspective into the experience of participants. This was particularly important as discussing the experience of being marginalized or oppressed can be very difficult (e.g. Adetimole, Afuape, & Vara, 2005). By moving beyond the descriptions given in a semi-structured interview, the repertory grid technique can promote a more elaborated understanding of what those experiences mean for the individual, particularly with reference to the sense of self. It has been recognized that oppressed individuals in some contexts where they

open up about their experiences feel the need to be careful in how they talk about their experiences due to feelings of guilt (Adetimole *et al*., 2005), an awareness of other people's anxieties (Roy, 2002), anger (Wagner, 2005), or even suspiciousness (Samuel, 2004).

A standard grid technique was employed with elements supplied by the researcher as relevant to the topic:

1. Self as I really am,

2. Self at work,

3. Ideal self,

4. Self as a trainee,

5. Self prior to training,

6. BME Clinical Psychologist,

7. White Clinical Psychologist,

8. Ideal Clinical Psychologist,

9. How my BME clients see me,

10. How my White clients see me,

11. How my BME colleagues see me,

12. How my White colleagues see me.

In line with the central tenets of Personal Construct Theory, all the constructs were elicited from the participants rather than supplied to them. This was to ensure that the constructs were personally meaningful to each participant. The elicitation of the constructs was completed using the triadic method, where participants were shown three element cards and asked how two

of them are alike, but different from the third. Past studies have recommended between 10 and

12 constructs as sufficient to gain an insight into an individual's construing of a particular topic

(Blagden *et al.*, 2014). With each participant, elicitation was ceased once they had provided 12

constructs, with every participant being able to do so. Following elicitation of constructs,

participants were asked to rate the elements on them using a seven point rating scale.

Data from the repertory grid interviews were analysed using the software programme

Idiogrid, version 2.4 (Grice, 2007). The data provided from the grids were analysed to give

information regarding participants' construing of the profession and their own identity within it.

Part of the analysis was a Principal Component Analysis (PCA), which gives an account of the

patterns and spread of variance within a grid (Slater, 1977), the results of which are depicted in a

plot of elements in construct space derived from loadings of the elements and constructs on the

first two principal components. The horizontal axis of the plot derived from this analysis shows

the first principal component, otherwise known as the participant's major dimension of

construing, and this accounts for the largest amount of variability in the grid. The second

principal component is represented by the vertical axis and accounts for the second largest

amount of variability in the grid. Elements are plotted along these axes according to how much

they are represented by the components, whilst the constructs fall around the grid in relation to

their loadings on the components. Also provided by the analysis are element Euclidean distances

(on a scale from 0 to 2) indicating how differently each element is construed from the others. A

distance of 0 indicates that two elements are construed identically, whilst distances rarely go

above 2 (Winter, 1992). A distance of less than 0.5 would indicate that two elements are

construed as very similar whilst a distance of more than 1.5 would indicate that two elements are

construed very differently. Construct correlations are also provided indicating the degree of similarity in the meaning of each construct with each other. An implicative dilemma analysis was also performed. Implicative dilemmas (ID) are types of cognitive conflicts whereby "a personal construct on which change is desired is associated with another construct on which change is undesirable" (Feixas, Montesano, Erazo-Caicedo, Compañ, & Pucurull, 2014, p. 31). An ID is composed of discrepant and congruent constructs. Discrepant constructs indicate some sort of dissatisfaction; whereas congruent constructs can reveal personal qualities that an individual wishes not to change. IDs arise when change as reflected in a discrepant construct is connected to change on a construct for which this change is not desirable (Feixas *et al.*, 2014). IDs are highlighted by examining all correlation coefficients between construct pairs and identifying whether there are any construct pairings that have a different relationship direction than would be expected **by the positioning of the ideal self on the constructs concerned** (Winter, 1992). Employment of such statistical analyses allowed for an insight into any discrepancies between the self at work and the ideal clinical psychologist, for example.

Semi-Structured Interviews

Interpretative Phenomenological Analysis (IPA) is primarily concerned with an examination of an individual's lived experience (Smith, Flowers & Larkin, 2009). The questions in the semi-structured interview were broad, flexible and allowed for the participants to elaborate on their own accounts without being stifled by the interview schedule. The themes covered in the semi-structured interview included the experience of being a BME trainee clinical psychologist, and a qualified BME clinical psychologist, as well as the impact of ethnic identity on therapeutic

relationships and on professional development. **Interviews were transcribed verbatim before being subjected to an analysis following the steps described by Smith (2008) for an IPA study.**

Credibility

To demonstrate the credibility of the themes derived, two supervisors engaged with the coding of two separate transcripts. To further strengthen the credibility of the themes, three independent researchers engaged in an audit involving coding a transcript and subsequently discussing discrepancies that were found and engaging in a process of revision to ensure that various views were utilised in providing a trustworthy account of the data (Elliot, Fischer & Rennie, 1999). A similar process took place with the repertory grid data, with one supervisor analysing the grids independently.

Results

Semi-Structured Interviews

Four master themes emerged from the IPA analysis: standing out as different, negotiating cultural and professional values, sitting with uncertainty, and feeling proud to be a clinical psychologist.

Master Theme 1: Standing out as different

Given the minority position of BME clinical psychologists in the profession, it is not surprising that participants felt that they stood out as different. Although difference is more helpfully understood as something that is between people as opposed to being within an individual, this did not stop participants from feeling as though difference was located within them.

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

This feeling of standing out as different had the implication of participants feeling like outsiders within the profession, particularly at the outset of their careers. It was also the aspect of their minority status that most participants found challenging, as one participant described:

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

Feeling marginalized as a newly qualified psychologist may reflect the challenges that clinical psychology has faced over the years in relation to its lack of ethnic diversity. There was a sense from participants who had been qualified for longer that feeling marginalized changes over

time and one can come to feel more integrated within the profession with time. The desire to belong was echoed in many of the participants' stories of seeking integration in the profession.

Feeling rejected was another way in which participants came to feel as though they were outsiders. The visibility of their minority status meant that even with clients there were experiences of feeling rejected on account of their ethnicity.

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

Standing out on account of one's ethnicity was deemed as having both positive and negative implications for participants. One noted negative aspect of standing out is the **fear of being seen as inferior by the profession because of this visible difference, and therefore psychologists felt the need to constantly work hard and prove that they were good enough**:

> 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. So I'm constantly trying to prove myself and I think that comes back from a script that comes from my mother where she was like 'you're black and you're female you're going to have to work twice as hard as everybody else'
> ***Natasha***

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

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

The desire to be like "everybody else" may speak to the perception of a normative position of being White and not having to account for one's actions, as a BME psychologist might have to do. It seemed that for some, feeling pigeonholed into a particular position was a direct implication of standing out as different. Standing out as different also had positive implications. For example, one participant discussed the possibility of her ethnicity putting her at an advantage in securing a place on a training course and getting assistant psychologist posts:

> I don't know if it was officially sort of they were positively discriminating[2] or sort of off the record but it … certainly did seem to help
> *Saima*

Ultimately, the dilemma that arises from this theme is the uncertainty of whether accomplishments are due to one's background rather than ability. **Participants often have to contend with stereotypes about their ethnicity playing a role in conferring some professional advantage on their success**. Knowledge of this then fuels thoughts in participants as to whether there may be any truth to this, bringing into question their own abilities. In situations where standing out meant that participants were either treated unfairly or experienced something particularly invalidating, participants had to make the choice of whether to address this or not. This was a dilemma, with many suggesting that they often had to make the decision as to which 'battles' they fought and which they left unaddressed. This highlights how daily experiences, encounters, and seemingly harmless interactions often carry with them exhausting

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[2] **Reverse discrimination**

worries which involve participants having to consider thoughtfully what their experiences mean and why they unfold in the way that they do. This theme was an important one from this research that highlights the myriad of ways in which standing out can be experienced both as a benefit and a burden, and the intricacies of participants coming to decide which is the preferred position.

Owing to their BME identities, participants spoke of being positioned as experts on issues of race and culture based solely on their ethnicity. The irritation was clear for some who found it to be a common feature in their clinical practice, yet for others it was seen as a strength to be able to offer a cultural consultation.

> It's almost as though sometimes you're positioned as the expert and it's like I'm not, I can only really talk to what … I've understood or what I know, which can be valuable to the team but I think it's [about] how do we then kind of … think a bit more widely … as a team about difference and diversity?
> *Serena*
>
> Another challenge is this idea that you somehow will have this insight into every ethnic minority experience or every Black person's experience
> *Mary*
>
> There are times when it's really positive … and when people are really interested to find out what you know … or people kind of come to you … almost for cultural consultation
> *Farida*

Being positioned as an expert on cultural matters went as far back as clinical training.

> 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!
> *Mary*

In being positioned as the expert others would sometimes expose their lack of cultural sensitivity. Participants were left with the fall out of trying to understand whether these encounters were due to people's ignorance, misunderstanding, or genuine desire to understand. The common thread for all participants was the need to highlight the caveat that the responsibility of understanding people's cultures lies with everyone as all cultures are different and cannot be assumed to all be the same.

Master theme 2: Negotiating cultural and professional values

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

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

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

This affirmation of dual identity (both being Black and a clinical psychologist) highlights that there may have been a point where being a clinical psychologist was equated to being a

White clinical psychologist and it is taking time not to equate the profession with an ethnic

background. This also suggests that Serena previously felt that 'Black' was seen more negatively

and she had to **'moderate' her cultural identity in order** to function in the profession. These

examples highlight how as BME clinicians within the profession, it **became increasingly**

important for participants to hold on to their sense of self, amidst the professional values that are

taught and expected from clinical psychologists. Furthermore, some participants spoke of the

pressure from the perspective of not just one's personal cultural values but also one's

community.

> You do need to be able to speak up for yourself and you do need to stand up for
> yourself and be able to portray yourself … to the best of your strengths … and that's
> something that, I think actually you know gender wise … that women generally are
> socialized against … particularly from a British Asian point of view … that's
> something that people particularly try to teach out of you … and you do get those …
> other pressures from … cultural community groups and thinking well you know ...
> you're gonna get a doctorate … who's gonna want to marry you?
>
> In terms of the communities that you're … from I think … there are some people
> who see … psychology as a … white western thing … and think that you've sold out
> or become white or a coconut
> ***Farida***

Instead of splitting their professional and cultural identities, it seemed important for the

psychologists in the study to find a way of integrateing in their identities.

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

The above extracts from participants' accounts give a sense of a type of developmental process that they undergo. From starting out as 'split' to coming to a place where they feel more integrated, participants have to navigate this challenge in their own way. The possibility of being seen as rejecting or dismissing one's cultural self was not just important for the participants' sense of self, there was also an indication that it may have had something to do with the perception of them from their friends, families and communities. Maintaining their cultural identity was clearly important to these psychologists, as was feeling as though they were still credible members of the profession, which brings us to the related subordinate theme of being seen as credible.

In their daily lives working as clinical psychologists, there were some reported experiences whereby participants felt as though they were not seen as psychologists. One participant described being mistaken for a student nurse on her first day of work in an inpatient setting.

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

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

'Don't apply to that university', which is where I trained, 'because you won't get on because you're not from an ethnic background because that's what they do in that university - they kind of help people from an ethnic background get ahead'. And there was almost an implication that it's not that you got on that training course because you were good, it's just because it was a PC[3] thing to do, and that's really quite offensive ... so I do wonder that ... whether sometimes people do think that … that's how you got ahead ... which is not the case at all, I don't think I've been handed anything

For one participant, there was a journey from feeling like a fraud to gradually being confident in her role as a psychologist and not worrying about others' perceptions of how she works.

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

Master theme 3: Sitting with uncertainty

This major theme was characterized by a consistent thread throughout participants' accounts whereby many of their experiences within the profession, whether positive or negative, were questioned as having something to do with their ethnicity. There were accounts of feeling frustrated at not knowing whether this was the case or not, and this seemed to reflect a constant struggle to make sense of their experiences.

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[3]Politically correct

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

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

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

The exception to this experience was with BME clients, who often acknowledged the ethnicity of their psychologist. Being able to have colleagues and clients acknowledge their ethnicity when it mattered was important to participants, who described feeling invalidated when this did not happen. Ultimately the responsibility was left to them to bring into discussions issues of race and culture, which in many ways would raise another dilemma for participants, which is that of '*being the person who always brings up race'* as one participant put it.

The experience of cultural issues not being acknowledged in a profession that highlights the importance of practitioners being aware of issues of diversity and which places an emphasis

on cultural competency leaves BME psychologists having to work hard to interpret the unspoken. The complexity of trying to make sense of situations by using a racial lens or not seemed to be a challenging task, with little space in the workplace to think about and process this. Ultimately, there was a sense that for all the participants, every interaction had the possibility of needing to be analyzed through a racial lens. The implication of this was the overwhelming emotional effort of constantly second-guessing the meaning behind their experiences.

Master theme 4: Feeling proud to be a clinical psychologist

Despite the challenges faced by participants, being a clinical psychologist was something that many explicitly described as valuing in that they were able to recognize their professional status or identity as something to be proud of:

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

The struggle and lengthy journey into the profession meant that for many of the participants they held a sense of pride in making it as a clinical psychologist. From participants' stories one can see that there was an 'against all odds' theme around this topic. Considering the lack of ethnic diversity in the profession and claims of clinical psychology being racist **(See Fernando, 2002 for a summarized history),** there was almost disbelief for some that they had indeed made it:

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

Repertory grid results

Rather than presenting at an individual level the results of the six participants, the repertory grid data will be presented at the group level to demonstrate similarities and differences in the experiences of the participants. However, to provide an example of an analyzed grid, one diagram is shown (Figure 1) as well as an implicative dilemma that was found during the comparison between the self and "ideal".

The principal component analysis plot of the relationships between elements and constructs in Figure 1 shows that Serena perceives 'self as trainee' in a more extreme way than the other elements within the grid. This element is situated very close to the construct poles "separated", "unsureness," and "trying to figure out how to be consolidated", suggesting that these constructs define well 'self as trainee'. It can be seen from the plot that she sees her 'self at work' as rather different from 'self as I really am'. The standardized element Euclidean Distance between these two elements is 1.06, which is suggestive of her feeling that whilst at work she does not function as how she thinks an ideal clinical psychologist should. This may speak to the length of time Serena has been qualified as a clinical psychologist.

View of self as a clinical psychologist

With the exception of Serena, all the participants appeared to see themselves as fairly to very similar at work to 'self as I really am'. This would suggest that overall as a sample most of the participants are able to integrate their personal identities into their professional identities. Serena, who sees her 'self at work' and 'self as I really am' as somewhat dissimilar, is interestingly the psychologist in the sample who has been qualified for the shortest amount of time. This may provide some evidence for participants feeling more comfortable in their personal identities within the profession as time goes on. It may also be an indication of why studies have found that BME trainee clinical psychologists within the profession have difficult experiences (e.g. Shah *et al*., 2012) in relation to their identities and positioning within the profession.

For all but one participant, the most meaningful elements for participants interestingly were their identities around the time of them being a trainee (See Table 2). Even for those who had been qualified for a significant length of time this was still a salient element. This is interesting considering the presence of elements that are closer to where they are now in the profession, i.e. 'self at work' or 'self as I really am'. It is possible that this highlights the significance of the self earlier on in their careers within the profession as crucial in their identity formation. It is pertinent to note that for Mary a BME clinical psychologist is the least salient element. Indeed, for all of the participants their idea of a BME clinical psychologist featured very low in the rankings of salience. For all of the participants, their concept of a White clinical psychologist was more salient than their concept of a BME clinical psychologist. This is surprising given their identities as BME clinical psychologists. This may be due to the majority position held within the profession by White clinical psychologists. According to Slay and Smith

(2011), in societies where stigmatized BME individuals have been stereotyped as non-professionals and people with limited prospects or potential, they may possess a restricted awareness of who they may become professionally.

An implicative dilemma highlighted from an analysis of Priya's grid was the following: the 'self at work' is construed as having an "awareness of professional boundaries" whereas the 'ideal self' is construed as being attuned to one's "personal belief systems". The dilemma for Priya is that someone who is attuned to their "personal belief systems" tends to be seen as "not being seen as a professional" person. So if Priya were to move towards her view of her ideal self, she would be attuned to her personal belief systems at the expense of not being seen as professional, which would be undesirable for her. This conflict provides a small glimpse into the inner world of clinicians who may find their personal values at odds with professional ones.

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

Most of the participants construed how they thought their BME clients saw them as closer to the ideal clinical psychologist than how their White clients saw them. Four out of the six participants had standardized element distance between 'How White clients see me' and the 'Ideal clinical psychologist' between 1.10 and 1.34, which suggests that these elements are seen as somewhat dissimilar, whereas the comparable range of distances for how BME clients saw them was 0.31 to 0.96 (with the exception of one participant with a standardized EED of 1.32). This provides some support for the idea that participants construe their BME clients as seeing them in a more positive light than do their White clients.

Discussion

There was a high incidence of convergence between the Repertory Grid and IPA methodologies, supporting their utility in a mixed method study, in particular as a tool for triangulation. The IPA highlighted key experiences of qualified female clinical psychologists in the profession. The repertory grids supported much of these findings and enhanced our insight into what it feels like for practitioners working in a profession where they are in the minority position on account of their ethnicity.

One of the main findings of this study was that clinicians felt a pressure to conform which was compounded by feeling isolated in the profession, particularly early on in their careers. For many, the compromise was to either stay 'different' and be disconnected, or conform and put in the hard work to adapt to a norm that is perceived to be of more intrinsic value. This supports previous studies on the experience of trainee BME clinical psychologists and reinforces the need for the profession to engage with diversifying the profession in a meaningful way.

An interesting finding from the results was that participants were able to integrate their personal identities into their professional identities, particularly if they had been in the profession for a number of years. The ability to integrate a stigmatized cultural identity into a professional context where the majority of one's colleagues are White has been highlighted as challenging. However, the ability to successfully navigate this may be due to participants defining for themselves what it means to be a BME clinical psychologist and constructing a professional identity that fits within their personal narratives of how they

came to their professional roles. Furthermore, valuing their professional roles as clinical psychologists may have been a mediating factor for being able to assimilate the two identities. It is important however, not to discount that for four of the participants there were implicative dilemmas associated with how they viewed a BME clinical psychologist and the ideal clinical psychologist as well as their self at work and their ideal selves.

The importance of participants' trainee selves was an interesting finding from this study. It highlights clinical training as a key historical event in professional identity development as a qualified clinical psychologist. This point in their lives where they begin to construct their identities as clinical psychologists may benefit from the social validation of having role models from which to support this newly constructed professional identity (Kaufmann, Pratt & Rockmann, 2006).

A particularly surprising finding of this study was that a BME clinical psychologist was not a salient element in the repertory grids. Slay and Smith's (2011) assertion is thus supported in that the absence of minority groups in particular roles can hinder an individuals view of themselves as a professional in that context due to a lack of role models. For the psychologists in this study, there will have been few role models to look to in constructing a perception of a BME clinical psychologist, potentially resulting in the lack of salience of this element. It is also probable that given the historical and contextual framework of clinical psychology, Whiteness has been situated in the normative position within the profession as much as within wider society (Nolte, 2007). As the norm, it often goes unchallenged **and as such BME psychologists may be constructing their professional**

identities on the status quo of White clinical psychologists, thus making this element more salient in the study.

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

What is interesting for these female clinical psychologists is that though they hold minority statuses due to their ethnicity, their gender places them in the majority position on account of clinical psychology being a female dominated profession. The male BME experience becomes of interest here as to how their gender and ethnic identities intersect and impact on their experience of the profession.

Recommendations for the profession

Supervisor training should focus on training supervisors to be more confident in being 'clumsy rather than clever' (Burnham & Harris, 1996). In raising issues of race and culture routinely with all supervisees this will ensure that issues are not left to BME practitioners to raise, and may relieve the burden that BME psychologists experience. It may contribute to

clinicians feeling supported in the workplace to consider and reflect on issues that may be impacting on their clinical work and professional development.

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

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

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

Recommendations for Clinicians

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

As the clinical utility of the repertory grid is well established, there may be a place for clinicians to utilize this tool more extensively in clinical practice such as in supervision (e.g. Marrow, Macauley & Crumbie, 1997). As one example, it may be used in supervisory relationships to provide a means of routinely discussing issues of race and culture in a way that is particularly meaningful as it considers the personal and professional dimensions which clinicians are using to make sense of their professional lives. Supervisors and their supervisees can jointly design repertory grids that would serve the purpose of highlighting areas of concern, e.g. through the identification of implicative dilemmas, or alternatively as a way of opening up discussions around the supervisees' experiences within the profession in relation to cultural issues. Alternatively, a tool such as the Cultural Attitudes Repertory Technique (Neimeyer & Fukuyama, 1984), which has been designed and used to explore counseling trainees' cultural attitudes that would have otherwise remained implicit in their clinical work, may be employed as a useful tool in supervision.

Future Research

This study has demonstrated the utility and benefits of combining IPA and repertory

grids. One of the benefits was demonstrating that clinical psychologists are able to talk about their experiences of feeling marginalized within the profession in the same way as is revealed by a less direct method of exploring their construing of these experiences.   The high degree of convergence between the **findings from the two** methodologies further adds strength to the **research** in providing a degree of triangulation to a qualitative study **by incorporating a method, repertory grid technique, which is both qualitative and quantitative**. The use of the repertory grids to elicit constructs was key in giving voice to clinicians' experience of the profession in such a way that gave meaning to their experience rather than the frame which society's dominant discourse may impose. The latter is the concept of epistemic oppression, where the powerful in society have an influence over how our understanding of the social world is structured (Fricker, 1999).

A study that replicates this research would be valuable in order to enhance the validity of the study. Conversely, a study enquiring into the experience of clinical psychologists in the dominant position, i.e. the White female perspective, might further illuminate their experience of working in a profession that lacks ethnic diversity. This would also give voice to trying to understand key issues such as why clinicians do not take more responsibility in doing their own thinking around issues of difference. This study demonstrated the possibility of a developmental journey that psychologists undergo whereby though there are challenges in the early stages of their professional lives, there is also a confidence that emerges and allows for the dilemmas that were present not to be so pertinent. A longitudinal study that can give more understanding to this process would be beneficial. Likewise a study looking at the experience of BME clinical

psychologists who have been qualified for a significant period of time would be a worthwhile endeavor.

A study with a male sample may highlight their experience of the profession and further clarify how the intersection of race and gender impacts on the minority experience.

Limitations

Generalizing the results of this study, which concerned the experiences of a very small number of BME clinicians is problematic, though this was not the aim of the study. The variety of experiences that BME psychologists have should further be explored. Also, an exploration of their personal historical narratives may shed light on how they come to construct their professional identities in the context of their cultural and ethnic identities. The mechanism by which this occurs is of interest as this study showed that the BME clinical psychologist element was one of the least salient elements for the participants. Another drawback of this study was that elements were supplied and not elicited which may have reduced how meaningful they were to participants.

Conclusions

Using a pluralistic research methodology incorporating constructivist data collection methods, this study attempted to explore the experience of BME clinical psychologists working in **a National Health Service setting**. The findings highlight some important issues that appear to be reflective of psychologists' experiences from their time as trainees. Challenges highlighted in previous studies on the experience of BME trainees were indicated as relevant issues,

including being positioned as the expert on issues of race and culture, feeling isolated within the profession, and trying to find a way to integrate their cultural identities with their professional identities. Having been conducted on a small sample, the findings of this study cannot of course be generalized to the experience of all BME clinicians in the profession. However, it gives an insight into a previously understudied group of individuals adding to and enriching existing research in the area.

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Table 1: Demographic Information on Participants

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

In being mindful of helping to preserve the anonymity of participants, no further information about ethnic background is given

Table 2: Participants' most and least salient elements (as defined by the percentage total sum of squares)

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

Figure 1: An illustrative example of one participants' analyzed repertory grid