

**The Experience of Black Trainee Clinical Psychologists with Lived Experiences of
Mental Health Problems Navigating Mental Health Support in the NHS** 1

Portfolio Volume 1: Major Research Project

**The Experience of Black Trainee Clinical Psychologists with Lived Experiences of
Mental Health Problems Navigating Mental Health Support in the NHS**

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Submitted to the University of Hertfordshire in partial fulfilment of the requirements of the
degree of Doctor of Clinical Psychology

May 2026

Word count: 36,565

(Excluding title page, contents page, acknowledgements, abstract, tables, figures, reference list and appendices)

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Acknowledgements

To my participants:

First and foremost, I would like to express my deepest gratitude to the eight participants who gave their time and trusted me with their experiences. It is an honour I do not take lightly. Allowing a researcher into a small but deeply significant part of one's life requires courage and generosity, and I am profoundly humbled by each of you. This research exists because of you, and I hope it does justice to what you shared.

To my supervisors:

Thank you both for walking this journey with me.

Natalie, your passion for this work was felt from the very beginning and carried through to the final word of this write-up. Your unwavering confidence in me and in my work meant more than I can express. Thank you for helping me grow. I have grown from our conversations alone, and I feel glad and grateful to have shared this journey with you.

Krystina, thank you for your time and for the thoughtful perspectives you brought to our supervisory meetings. Your contributions shaped this work in ways that will stay with me.

To Barbara:

Thank you for your continuous support throughout my training. The relationship we have built over the past three years is one I will always hold with gratitude. There have been countless moments where you came through for me, and I want you to know that each one mattered more than I was able to say at the time. I cannot express enough how much your presence and support have shaped my DClinPsy experience. You have made a lasting impact.

To my family and friends:

Thank you for your love, your support, and for never once doubting my ability to complete this doctorate. I promise, this is the last time I will go to university.

To Lovie:

Thank you for your sacrifice. There are no words adequate enough to capture what your love and care have meant throughout this journey. I could not have done this without you. You held me up in ways that went unseen by everyone else, and for that I am endlessly grateful.

To myself:

Thank you for continuing to push, even when we were tired, even when it felt impossible, even when life was fighting against us. You did it. Never doubt yourself again. There is nothing you cannot do.

And finally, to God:

All glory.

"The Lord has done great things for us; we are glad." — Psalm 126:3

List of Abbreviations

CRT	Critical Race Theory
TCPs	Trainee Clinical Psychologists
IPA	Interpretative Phenomenological Analysis
PETs	Personal Experiential Themes
GETs	Group Experiential Themes

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Abstract

Background: Black trainee clinical psychologists (TCPs) with lived experience of mental health problems occupy a distinctive position within the NHS, providing and potentially receiving care within institutions shaped by structural racism. Their experiences of navigating mental health support during doctoral training remain largely undocumented. This study explores how race, professional identity, and lived experience intersect to shape help-seeking within NHS Trust-based training contexts.

Methodology: Eight Black female TCPs enrolled on clinical psychology doctoral programmes in England, each with lived experience of mental health problems and who had sought or considered seeking support during training, took part in semi-structured interviews. Data were analysed using Interpretative Phenomenological Analysis (IPA), with interpretation informed by intersectionality and Critical Race Theory. Ethical approval was granted by the University of Hertfordshire.

Findings: Analysis generated five Group Experiential Themes: (1) distress emerges through cultural silencing, delayed recognition, and cumulative pressure; (2) performing wellness and competence under racialised scrutiny; (3) training and university structures as failing to contain distress; (4) NHS and trust-based support is constructed as risky due to power, proximity, racism, and permanence; and (5) safety is pursued outside formal systems through culturally attuned care, religion, peer solidarity, and values-based recommitment. Together, they describe institutional exposure that renders formal help-seeking structurally unsafe.

Implications: Findings indicate the need for genuinely independent pastoral support within training programmes, redesigned NHS pathways that decouple trainee care from professional proximity, and structural rather than representational change across the profession. Future research should include Black male-identifying and non-binary trainees and adopt longitudinal and participatory designs.

Keywords: Black trainee clinical psychologists; lived experience of mental health; Interpretative Phenomenological Analysis; intersectionality; Critical Race Theory; NHS mental health services; help-seeking; racialised experience.

1.0 Introduction

1.1 Overview

This chapter introduces the conceptual, social, and institutional contexts that underpin this empirical study. It is structured to move from the broadest contextual landscape toward the specific focus of the research, functioning as an analytical funnel that locates the experiences of Black trainee clinical psychologists (TCPs) within wider systems of inequality. The chapter begins by outlining the racialised landscape of mental health in the United Kingdom, situating racial disparities in mental health access and outcomes within frameworks of structural racism. It then examines the NHS as an institution in which staff simultaneously provide and receive care and considers the particular vulnerabilities this dual positioning creates. The discussion then narrows to clinical psychology training, exploring diversity, inclusion, and the racialised experiences of Black trainees within doctoral programmes. From there, the chapter turns to the role of lived experience of mental health problems within the profession, attending to the stigma that has historically silenced it and the more recent, incomplete shift toward its recognition. Finally, it brings these threads together to consider the specific and compounded challenges facing Black TCPs who hold lived experience of mental health problems, before articulating the rationale for the systematic literature review that follows.

Two core theoretical frameworks organise the interpretation of these contexts throughout the chapter: intersectionality (Crenshaw, 1989, 1991) and Critical Race Theory (Delgado & Stefancic, 2017). Intersectionality illuminates how race, professional identity, and lived mental health experience interact to produce compounded forms of marginalisation for Black TCPs. Critical Race Theory provides a structural lens, positioning racism not as incidental but as embedded within healthcare and training systems. These frameworks are introduced in Section 1.4 and inform the analysis that follows.

1.2 Researcher Positionality

I approach this research as a Black trainee clinical psychologist with lived experience of mental health problems who has sought support within the NHS during training. My personal and professional experiences form a central part of the motivation for this study and have shaped the research questions and the interpretative lens through which data are understood, alongside the input of my supervisory team and the existing literature. Acknowledging this position is both an ethical and epistemological necessity, as it affirms that research cannot be separated from the identity and standpoint of the researcher (Finlay, 2021).

My position within the research is reflexive rather than detached. I recognise that my experiences provide unique insight into the phenomena under investigation, while also introducing potential biases and assumptions that must be critically examined throughout the research process. Reflexivity is central to maintaining transparency and integrity, requiring continuous reflection on how my values, emotions, and experiences influence the generation and interpretation of knowledge (Berger, 2015). Rather than attempting to eliminate subjectivity, this study embraces it as a resource that deepens understanding of the topic.

Declaring my positionality is an act of accountability to participants and to the wider academic community. It acknowledges that my personal experiences with mental health and my identity as a Black trainee within the NHS are integral to this research, shaping how I engage with participants, interpret their narratives, and contribute to the collective understanding of race and mental health in clinical psychology training. This study is therefore both an academic and personal undertaking, one that seeks to honour the voices of others while remaining critically aware of my own.

1.3 Ontological and Epistemological Position

This research is grounded in a constructivist ontological and epistemological stance. Ontologically, it assumes that reality is not fixed or objective but is multiple, relational, and socially constructed. Individual experiences are understood as products of historical, cultural, and institutional contexts that shape how people make meaning of their lives and environments (Lincoln & Guba, 1985; Pope, 2022). Within this framework, the experiences of Black TCPs who live with mental health problems are understood as co-constructed through their interactions with the NHS, both as an institution that provides professional training and as a system offering mental health support.

Epistemologically, the constructivist perspective holds that knowledge is not discovered but created through human engagement, dialogue, and reflection. Knowledge is therefore subjective and shaped by social interaction, power relations, and the researcher's own standpoint (Lincoln & Guba, 1985; Willig, 2013). The relationship between researcher and participant is collaborative, with understanding emerging through shared exploration rather than objective measurement. This approach rejects positivist assumptions of detached observation and instead recognises that meaning is context-dependent and influenced by the identities, histories, and emotions of those involved in the research process.

In adopting this stance, the study centres the voices and lived realities of Black TCPs, positioning their narratives as essential to understanding the intersections of race, mental health, and professional identity within the NHS. The focus is not on establishing universal truths but on illuminating the diversity, complexity, and situated nature of lived experience. By framing knowledge as co-constructed, the research acknowledges that researcher and participants are active agents in meaning-making, and that individual and systemic structures intersect to shape the mental health journeys of Black TCPs within the professional and institutional landscape of the NHS.

1.4 Theoretical Frameworks

1.4.1 Intersectionality

Intersectionality, originally developed by Crenshaw (1989, 1991), provides a framework for analysing how multiple social identities: such as race, gender, class, and mental health status interact to shape individuals' experiences within systems of power. In the context of this study, intersectionality highlights how Black trainee clinical psychologists occupy a position where racialisation, professional identity formation, and lived mental health experience converge. Rather than treating these identity dimensions as discrete variables, the framework conceptualises them as interlocking structures that jointly produce advantage and disadvantage (Bowleg, 2012; Collins, 2000). For Black TCPs, this means that navigating NHS training and support structures cannot be understood outside of the simultaneous racialised, professional, and psychological pressures that shape their lived realities.

1.4.2 Critical Race Theory

Critical Race Theory (CRT) complements this focus by asserting that racism is normalised and embedded within social institutions, including the NHS and the psychological professions (Delgado & Stefancic, 2017). CRT rejects colour-blind approaches and instead centres the voices and counter-narratives of racially minoritised individuals as essential to understanding how structural racism is reproduced in everyday practices (Ladson-Billings, 1998). In this study, CRT provides an analytic lens for examining how clinical training cultures, supervisory structures, and institutional norms can marginalise Black trainees and undermine their help-seeking. CRT therefore strengthens the interpretive grounding for understanding Black TCPs' experiences not as isolated personal challenges but as reflections of broader racialised systems.

Although intersectionality and CRT are introduced separately above for clarity, they are not treated as parallel or competing explanations in this study; rather, they are understood as mutually reinforcing. Intersectionality specifies which identities matter and how they combine, demonstrating that race, professional identity, and lived mental health experience cannot be disaggregated into separate, additive effects but instead produce a qualitatively distinct experience at their intersection (Crenshaw, 1989; Collins, 2000). CRT specifies where that intersection becomes consequential, locating it within the structural and institutional arrangements of clinical training and the NHS, rather than treating it as a property of individuals alone (Delgado & Stefancic, 2017).

In this sense, intersectionality provides the analytic unit, the compounded identity position of the Black TCP with lived experience, while CRT provides the structural account of why that position carries professional risk within a specific institutional field. Used together, the two frameworks allow the analysis that follows to move between the experiential and the structural: attending to how participants describe their individual experience of navigating mental health support, while simultaneously situating that experience within the racialised institutional structures that CRT identifies as normalised rather than exceptional.

Intersectionality is not without conceptual tensions that are relevant to how it is applied in this study. Bowleg (2012) highlights a persistent methodological difficulty: research drawing on intersectionality risks reverting to an additive logic, in which race and another identity dimension are analysed as separable variables, even though the framework's central claim is that such dimensions are mutually constitutive and cannot be meaningfully isolated from one another. This tension is particularly salient for a study combining race, professional identity, and mental health status, where there is a risk of describing these as three separate "barriers" rather than as a single, compounded position. A further critique concerns the breadth and conceptual looseness of intersectionality as it has travelled beyond its original legal context

(Crenshaw, 1989), which can make its application to a new population, such as Black TCPs with lived experience of mental health problems, more interpretive than determinate. This study addresses these tensions by grounding the analysis in participants' own accounts of how their identities were experienced as combined and inseparable, rather than imposing an a priori additive structure on the data.

CRT, in turn, carries its own contested assumptions. Its central claim that racism is a permanent and normalised feature of social institutions (Delgado & Stefancic, 2017) has been criticised for risking a deterministic account of institutional behaviour, in which racialised outcomes are treated as structurally guaranteed regardless of context or individual agency. Applied uncritically, this could foreclose attention to variation in participants' experiences, including instances of support, allyship, or institutional change. CRT has also faced critique for the risk of essentialism, namely, the tendency to treat racially minoritised groups as internally homogenous, which sits in tension with this study's recognition that Black TCPs are not a uniform group and that their experiences will be shaped by additional, intersecting factors such as gender, immigration history, and class (Delgado & Stefancic, 2017; Ladson-Billings, 1998). In this study, CRT is therefore applied as a lens for understanding structural pattern rather than individual predetermination, used alongside, rather than in place of, close attention to the specific and varied accounts given by participants.

1.5 Terminology and Language

1.5.1 Lived Experience of Mental Health Problems

In this research, the term lived experience refers to the direct, first-hand experience of mental health problems, including the processes of seeking support, receiving treatment, and engaging in recovery. It distinguishes the personal, experiential knowledge of those who have encountered mental distress from the professional, clinical, or theoretical knowledge produced

by practitioners and researchers without such experiences (Faulkner, 2017; Sweeney et al., 2016). Within this study, lived experience is recognised as a legitimate and valuable form of knowledge that offers unique insights into the complexities of mental health systems and the personal meanings attached to recovery and support (Repper & Perkins, 2013).

The concept of valuing lived experience aligns with participatory and emancipatory traditions in mental health research, which seek to challenge traditional hierarchies of expertise that privilege professional knowledge over service user perspectives (Minkler & Wallerstein, 2011). By positioning lived experience as central to understanding the realities faced by Black TCPs, this research acknowledges the epistemic authority of those who have navigated mental health problems within personal and professional contexts. This perspective reflects a broader commitment to co-production and to valuing the voices of those often marginalised in mental health discourse (Sweeney et al., 2016).

1.5.2 Black

The term Black is used in this research to refer to individuals of African, Caribbean, or mixed Black heritage, consistent with contemporary sociological and demographic understandings within the United Kingdom (Office for National Statistics, 2023). The choice to use "Black" rather than broader collective terms such as "BAME" reflects an intentional effort to resist homogenising racialised groups and to recognise the specific historical and socio-political experiences associated with Black identity in Britain (Crenshaw, 1989; Showunmi et al., 2016). Using the term "Black" also acknowledges the collective experiences of anti-Black racism and systemic marginalisation within social and institutional contexts, including healthcare and higher education. This terminological choice is both descriptive and political, foregrounding race as a critical analytic category rather than merely a demographic

variable. This research recognises the diversity that exists within Black communities and does not assume uniformity of experience.

1.5.3 Trainee Clinical Psychologist

Within the context of this study, a Trainee Clinical Psychologist refers to an individual enrolled in a Doctorate in Clinical Psychology (DClinPsy) programme in the United Kingdom. These programmes are accredited by the British Psychological Society (BPS) and regulated by the Health and Care Professions Council (HCPC). Trainees hold a dual status as both postgraduate students within academic institutions and employees of the NHS, engaging in clinical placements across different services while undertaking doctoral-level academic and research work (BPS, 2023; HCPC, 2023). This dual positioning situates trainees at a unique intersection of learning, professional development, and service delivery. For Black TCPs with lived experience of mental health problems, this intersection is particularly complex, as it means navigating multiple identities as service user, professional, and minoritised individual within systems that are often hierarchical and racialised.

1.6 The Racialised Landscape of Mental Health in the UK

To understand the specific experiences of Black TCPs, it is first necessary to situate them within the broader racialised landscape of mental health in the United Kingdom. Racial disparities in mental health outcomes are a well-established and persistent feature of the UK's mental health system. Black people are statistically more likely to experience severe mental health conditions such as schizophrenia and other psychotic disorders, and are more frequently subjected to coercive treatments, including compulsory detention under the Mental Health Act (Barnett et al., 2019; Bhui et al., 2022). These disparities are not simply the result of individual or cultural factors but are rooted in social determinants of health such as deprivation,

discrimination, and exclusion, as well as in the structural racism embedded within health and social care systems (Nazroo et al., 2020).

Structural racism manifests in multiple ways, including diagnostic bias, disproportionate use of restrictive interventions, and underrepresentation in preventative and talking therapies. These inequities extend beyond service delivery into the organisational cultures of both the NHS and higher education, where Black staff and students often report experiences of marginalisation, microaggression, and limited progression opportunities (Kapadia et al., 2022). The NHS Workforce Race Equality Standard consistently documents racial inequity in workforce experience and career progression (NHS England, 2020b). Such structural imbalances raise critical questions about how Black individuals including Black TCPs who have personal mental health problems navigate their dual roles as both professionals and service users within an organisation that continues to reflect broader societal inequities.

Cultural stigma surrounding mental health further compounds these structural dynamics. Within many Black communities, mental health problems may be understood through frameworks of strength and spiritual resilience, with distress sometimes interpreted as weakness or spiritual imbalance, discouraging open discussion and early intervention (Bhui et al., 2015b; Mantovani et al., 2017). This stigma operates as a powerful deterrent to help-seeking, leading to delayed or crisis-driven engagement with services. Norms emphasising self-reliance and emotional control can exacerbate shame and isolation among those experiencing distress (Mantovani et al., 2017).

It is important, however, that this emphasis on barriers, stigma, and structural racism does not obscure the resilience, resistance, and agency that Black individuals, including Black TCPs, continue to exercise within these constrained circumstances. Wade (1997) argues that wherever people are subject to mistreatment or oppression, they respond with acts of resistance, even when those acts are small, covert, or easily overlooked by services and institutions;

reframing apparent passivity or silence not as an absence of agency but as a deliberate, often strategic, response to risk.

Applied to the present context, this suggests that practices sometimes read by services as disengagement, such as selective disclosure, delayed help-seeking, or reliance on informal community and faith-based support, may themselves constitute forms of resistance, dignity-preservation, and self-protection rather than simple deficits in help-seeking behaviour. At the same time, care is needed not to overcorrect into an uncritical celebration of resilience: Sims-Schouten and Gilbert (2022) caution that resilience, when imposed on Black and minoritised communities from a White-normative standpoint, can itself become a subtly pathologising discourse, one that quietly shifts responsibility for managing the effects of structural racism onto the individuals and communities experiencing it, while leaving the structures themselves unexamined.

Read together, the contribution of Wade (1997) and the caution of Sims-Schouten and Gilbert (2022) point toward a balanced position adopted in this thesis: resilience and resistance are recognised as genuine and meaningful features of Black TCPs experiences, without using that recognition to minimise, or shift responsibility away from, the structural and institutional racism that makes such resistance necessary in the first place.

Taken together, structural racism and cultural stigmas lead to Black individuals reporting mistrust of statutory services and disengagement from care, perpetuating cycles of crisis intervention and reinforcing health inequities (Nazroo et al., 2020).

1.7 Accessing Mental Health Support within the NHS

1.7.1 General Barriers and Facilitators

Access to mental health support in the United Kingdom is shaped by a complex interplay of individual, cultural, and systemic factors. The NHS aims to provide equitable, universal access to psychological care; however, longstanding disparities persist, particularly for racially minoritised populations (Nazroo et al., 2020; Memon et al., 2016). Studies have identified several general barriers to help-seeking, including stigma, lack of awareness, limited availability of culturally appropriate services, and structural inequities embedded within healthcare systems (Clement et al., 2015; Bhui et al., 2015a). Conversely, facilitators of access include positive therapeutic relationships, culturally adapted interventions, representation among clinicians, and early community-based engagement initiatives (Mantovani et al., 2017; Memon et al., 2016). Service models that foreground trust, collaboration, and cultural humility are shown to promote engagement and reduce disengagement among Black and other racially minoritised service users (Williams et al., 2021). Despite this, such approaches remain inconsistently embedded across NHS services.

1.7.2 The NHS as a Site of Work and Care for Clinical Trainees

The NHS occupies a distinctive position in the lives of clinical psychology trainees because it is simultaneously their employer, their training context, and the provider of any mental health support they may seek. Trainee clinical psychologists are NHS employees from the outset of their training, receiving a salary and undertaking clinical placements across NHS Trusts. This means that any mental health support accessed through NHS occupational health services or employee assistance programmes operates within the same institutional setting in which they are being evaluated, assessed, and professionally formed. For NHS staff more broadly, research indicates that help-seeking is often inhibited by concerns about confidentiality, career implications, and the perception that mental health problems are incompatible with professional practice (Kinman & Teoh, 2018; West et al., 2020).

These concerns are heightened within clinical psychology training, where professional standards emphasise competence, resilience, and ethical practice (BPS, 2023; HCPC, 2023). For trainees who experience mental health problems during training, the dual position of being both a trainee practitioner and a potential service user within the same institutional context creates particular tensions. They must navigate questions of disclosure, trust, and professional risk in an environment where the boundaries between personal vulnerability and professional assessment are often unclear. These dynamics disproportionately affect Black trainees, for whom racialised scrutiny adds an additional layer of risk to any disclosure of difficulty, as discussed further below.

1.8 Diversity and Inclusion in Clinical Psychology Training

1.8.1 The Profession and Structural Inequity

The clinical psychology profession has historically struggled to reflect the ethnic diversity of the UK population, with Black trainees continuing to be underrepresented in both application and acceptance rates for DClinPsy programmes (Faheem et al., 2024). Efforts to improve diversity and inclusion have grown in recent years, with Health Education England (HEE) and individual DClinPsy programmes introducing widening participation schemes, contextual recruitment, and targeted mentorship programmes to address the underrepresentation of minoritised groups (Health Education England, 2023). Despite these steps, progress remains slow and structural inequities persist throughout the training pipeline (Daloye, 2022; Shah et al., 2012a). Research indicates that mentoring and outreach initiatives, while beneficial, often do not sufficiently address the systemic power imbalances and racialised experiences embedded in training institutions (Faheem et al., 2024).

1.8.2 Racialised Experiences, Representation, and Belonging

Across UK clinical psychology training programmes, Black and other racially minoritised trainees consistently report experiences of marginalisation, tokenism, and racialised expectations (Daloye, 2022; Shah et al., 2012a; Faheem et al., 2024). These dynamics manifest in supervision, cohort interactions, and assessment contexts, contributing to fragile senses of belonging and heightened self-surveillance. Black and Minority Ethnic (BME) trainees frequently describe being in environments that are "White spaces" where racial awareness is limited, and cultural competence is inconsistently embedded across teaching, supervision, and placement settings (Daloye, 2022; Shah et al., 2012a). These dynamics contribute to heightened emotional labour among Black trainees as they navigate predominantly White professional cultures (Metrustay & Hodge, 2025). For Black TCPs, these systemic barriers are compounded by the dual positioning inherent in their training: they occupy a liminal space between student and professional, often navigating institutions where their racial identity and lived experience of mental health intersect in complex ways.

1.9 Lived Experience of Mental Health Problems in Clinical Psychology

1.9.1 Conceptualising Lived Experience within Professional Training

The phenomenon of lived experience has gained increasing recognition within the mental health field, particularly in the context of service-user involvement, co-production, and recovery-oriented practice (Faulkner, 2017; Gillard et al., 2021). Within clinical psychology, however, the integration of lived experience remains contested and further stigmatised. Historically, the profession has been rooted in a medicalised and diagnostic framework that privileges expert knowledge and professional objectivity (Harper & Cromby, 2022). This orientation has often positioned psychologists as detached observers or providers of care, rather than as individuals who might themselves experience psychological distress. Lived experience has always been present within the profession; it has been hidden rather

than absent, concealed because it has been stigmatised. Stigmatisation has played a central role in this, acting as a key disruptor to the possibility of openly acknowledging or integrating these experiences within professional identities and training cultures (Scior et al., 2018).

This stigmatisation is usefully framed through the concept of sanism, an irrational and largely invisible prejudice against people with mental health problems that infects institutional practices and renders disclosure professionally dangerous (Perlin, 1993, 2000, 2013). For Black trainees who also experience racialised scrutiny, this generalised sanist stigma is compounded by racial prejudice: the risk of disclosing mental health problems carries the additional threat of confirming negative racial stereotypes about one's professional capability, making the intersection of sanism and racism qualitatively distinct from either prejudice operating alone.

In recent years, there has been a gradual shift toward valuing and destigmatising lived experience as a form of legitimate professional and epistemic knowledge (Speyer, 2025). This shift reflects broader cultural and institutional movements to democratise knowledge production in mental health and to acknowledge the experiential expertise of those who have navigated psychological difficulties (Byrne et al., 2021). Within training contexts, lived experience offers unique insight into empathy, therapeutic alliance, and reflective practice, contributing to more humanised and relational models of care (Huggett et al., 2023). For trainee clinical psychologists, personal experience of mental health problems can deepen understanding of distress and recovery while challenging normative assumptions about professional identity and resilience (Victor et al., 2022).

It is also important to distinguish lived experience from the concept of clinical neutrality as used within the profession. Neutrality in clinical psychology does not imply the absence of personal history; rather, it refers to the clinician's capacity to hold the client's

needs at the centre while critically managing the influence of their own experiences and assumptions (Gelso, 2011). Contemporary scholarship emphasises that lived experience, when approached reflexively, can enhance empathy, therapeutic attunement, and cultural humility rather than compromising professional practice (Knight et al., 2022; Huggett et al., 2023). Neutrality, in this sense, is an active process of self-awareness and boundary management, and lived experience, approached with reflexivity, is entirely compatible with it.

1.9.2 The Tension Between Personal and Professional Identities

The relationship between personal and professional identities in clinical psychology has long been characterised by ambivalence and negotiation. Trainees are encouraged to be reflexive practitioners self-aware, empathic, and open to personal exploration, yet are simultaneously expected to embody the professionalism, competence, and reflective objectivity associated with clinical practice (Knight et al., 2022). Importantly, dominant conceptualisations of professionalism and competence within mental health training have historically been constructed around ideals of emotional restraint, self-containment, and the subordination of personal experience to professional role framing the practitioner's inner life as something to be managed rather than meaningfully integrated (Kaslow et al., 2007). This understanding, while not universal, remains influential within training and evaluation cultures, and stands in contrast to perspectives that position the embrace of lived experience as central to ethical, relationally attuned practice (Huggett et al., 2023). Professional "norms" of composure and stability represent an idealised standard that in reality no practitioner fully inhabits; yet these norms carry particular weight within training evaluation contexts, where they can inadvertently pathologise the visible expression of distress. For those with lived experience of mental health problems, this dual expectation creates a profound sense of

tension. Personal experience may enhance therapeutic insight, yet it may be perceived as a potential vulnerability or risk within professional settings.

This tension reflects broader cultural narratives within the mental health professions that associate wellness with professional credibility and distress with impairment (Rothschild, 2021). Such narratives are deeply embedded in training cultures where performance evaluation, academic assessment, and clinical supervision converge. For Black trainees in particular, these dynamics are further complicated by racialised expectations and the historical marginalisation of Black voices within psychology (Williams, 2022). The result is that trainees with lived experience may feel compelled to manage or conceal aspects of their identities to align with professional norms. Negotiating this dual identity requires ongoing reflexivity and support, and training institutions that fail to provide psychologically safe spaces for such reflection risk reinforcing silence and self-stigma among those they train to foster openness and empathy in others.

1.9.3 Stigma and Disclosure within Professional Training Contexts

Stigma surrounding mental health within clinical psychology remains a significant barrier to inclusion and authenticity in training environments. Despite increasing awareness of the importance of wellbeing in the profession, trainees and qualified psychologists alike often fear negative consequences if they disclose their own experiences of mental health problems (McCormack et al., 2021). This fear is shaped by professional cultures that equate distress with incompetence and by organisational systems that prioritise risk management and public accountability over personal transparency (Davies, 2020).

Disclosure of lived experience in training contexts is therefore a complex act. While openness may promote authenticity, peer understanding, and a more compassionate training culture, it can also expose trainees to judgement, pathologisation, or exclusion (Huggett et al.,

2023). Research suggests that trainees often engage in selective or strategic disclosure choosing when and to whom to reveal personal experiences based on perceptions of psychological safety and anticipated reactions from others (Knight et al., 2022). This balancing act highlights the enduring power of stigma and the institutional ambivalence toward lived experience within psychology.

In recognition of this gap, the Division of Clinical Psychology (DCP) published guidance in 2020 on Supporting and Valuing Lived Experience of Mental health problems in Clinical Psychology Training, which provides a framework for disclosure and support within training contexts (DCP, 2020). Complementing this, the DCP position statement on clinical psychologists with lived experience of mental health problems (DCP, 2022) signals the profession's commitment to acknowledging lived experience as a legitimate aspect of professional identity. While formal research evaluating their impact is limited partly due to the timing of their release during the COVID-19 pandemic these documents represent a significant step toward normalising discussions of lived experience and reducing the perceived professional risk associated with disclosure.

1.10 Intersectionality, Race, and Lived Experience for Black Trainee Clinical Psychologists

For Black trainee clinical psychologists who also live with mental health problems, the challenges outlined above compound in distinctive ways. Applying an intersectional lens (Crenshaw, 1991) reveals how race, professional identity, and lived experience of mental health interact to produce multilayered experiences of marginalisation that cannot be understood by examining any single dimension in isolation. Black trainees may experience overlapping stigmas, including cultural expectations around strength and emotional restraint within Black communities, and racialised stereotypes within professional contexts that link expressions of emotional difficulty to broader deficit narratives about Black people. These pressures are

further compounded by professional training cultures that associate psychological distress with impaired competence (Tay et al., 2018; Clement et al., 2015).

Within both Black communities and the clinical psychology profession, disclosure of mental health problems can be heavily stigmatised. Research by Tay et al. (2018) found that a substantial proportion of UK clinical psychologists reported experiencing mental health problems, with many describing stigma, fear of judgement, and concerns about career repercussions as key factors inhibiting disclosure or help-seeking within professional contexts. For Black TCPs, these professional dynamics intersect with racialised scrutiny within training cohorts and supervisory relationships, intensifying the sense that disclosure carries asymmetric risk. The very qualities visible distress, help-seeking, vulnerability that White trainees may also struggle to display, carry additional representational weight for Black trainees who are aware that their actions may be read as reflective of Black trainees as a group.

Black TCPs therefore occupy a paradoxical position. On one hand, their dual standpoint as both clinician and service user positions them to bring distinctive empathy, cultural competence, and experiential insight to clinical work. On the other hand, this same duality exposes them to compounded structural risks being simultaneously racialised as "other" within the profession, stigmatised for any visible mental health problems, and dependent for support on systems embedded within the very institution evaluating their professional competence. Their intersecting identities being both providers and potential service users heighten the tension between professional expectations of resilience and personal vulnerability, making the navigation of mental health support a qualitatively distinct and under-examined experience.

To clarify the precise nature of this gap, it is useful to distinguish between what existing research has established and what remains unexamined. A body of UK literature, beginning with Adetimole et al. (2005) and continuing through Shah et al. (2012a), Daloye (2022), Faheem et al. (2024), and Metrustry and Hodge (2025), has documented the racialised

dynamics of clinical and counselling psychology training, including marginalisation, tokenism, hypervisibility, and the emotional labour of navigating predominantly White training cultures. More recently, Sobogun and Nkansa-Dwamena (2025) examined the identity-related and systemic challenges faced by Black trainee counselling psychologists on UK doctoral courses, while McRae et al. (2025) explored how Black qualified clinical psychologists experience racialised barriers and facilitators to career progression once in post. Collectively, these studies establish that race and professional belonging within psychology training and practice have received sustained empirical attention.

What this literature has not examined, however, is how Black trainees who are also living with their own mental health problems navigate disclosure and support specifically within the NHS, where they occupy the dual position of employee and potential service user. The studies above focus on racialised experience in training or career progression broadly, rather than on the intersection of that racialised experience with personal mental health difficulty and help-seeking. Separately, research on lived experience within clinical psychology more broadly (e.g., Victor et al., 2022; Tay et al., 2018) has examined disclosure, stigma, and professional risk for trainees and qualified psychologists as a whole, but without attention to how race reconfigures these dynamics. No identified study has yet brought these two literatures together to examine Black TCPs' lived experience of mental health problems as it intersects with their position as both clinician and potential NHS service user.

Several factors may help explain why this specific gap persists. First, much of the diversity and inclusion literature in clinical psychology has, to date, prioritised entry-point inequities, such as recruitment, selection, and underrepresentation, over the lived, ongoing experience of trainees once on programmes (Health Education England, 2023), which may have directed research attention away from in-training mental health disclosure. Second, the dual stigma described above, that of mental illness within Black communities and professional

contexts, and that of race within majority-White training institutions, may make this population both harder to recruit for research and more cautious about disclosing experiences that could be professionally consequential, potentially suppressing the visibility of these experiences within the evidence base. Third, much of the existing literature on lived experience in psychology has been conducted with predominantly White samples, implicitly treating race as a background characteristic rather than as a factor that fundamentally reshapes how disclosure, risk, and support are experienced (Williams, 2022). Together, these factors may explain why, despite growing attention to both racial equity and lived experience separately within the profession, their intersection for Black trainees specifically has remained largely unexamined, underscoring the contribution of the present study.

Understanding this experience requires attending to both systemic racism and the stigma surrounding mental health within and beyond the profession. Critically, it also requires engaging with the NHS as a specific institutional context in which these dynamics are enacted. This is the focus of the systematic literature review that follows.

1.11 Rationale for the Systematic Literature Review

The evidence outlined above points to a critical gap in the literature. While the barriers facing Black individuals in accessing NHS mental health services have been documented across multiple studies, the evidence base remains fragmented, with studies differing in their conceptualisation of "access," "engagement," and "barriers" across service contexts. Existing literature also varies significantly in methodological rigour, focus, and population characteristics, which obscures a coherent understanding of the factors that meaningfully shape help-seeking trajectories among Black individuals in the UK. Much of the existing research also privileges deficit-oriented explanations such as cultural stigma or lack of mental health literacy without equal consideration of structural inequities, institutional racism, or the

facilitators that enable engagement (Mantovani et al., 2017; Memon et al., 2016; Williams et al., 2021).

Furthermore, the specific experiences of Black clinical psychology trainees who hold lived experience of mental health problems and who must navigate support within the NHS as both employees and potential service users have not been systematically examined. These individuals occupy a uniquely complex position that the general literature on Black mental health access does not adequately capture. Before this experience can be understood with the depth and specificity the research question demands, it is essential to have a robust and up-to-date synthesis of what is known about the broader barriers and facilitators that Black individuals face when accessing NHS mental health services.

A systematic literature review is therefore both timely and methodologically necessary. Increasing public and policy attention to racial inequities in mental health care including the ongoing reform of the Mental Health Act and the NHS Workforce Race Equality Standard has created urgent demand for an evidence base that can guide anti-racist practice and service redesign (NHS England, 2020b). The systematic review that follows synthesises empirical evidence, examining the cultural, structural, relational, and institutional factors that shape how Black individuals navigate mental health services in the UK. Its findings provide the broader contextual foundation upon which the empirical study, with its focus on the specific sub-group of Black TCPs with lived experience, is then built.

2.0 Systematic Literature Review

Facilitators and barriers faced by Black people when accessing mental health support in the UK

2.1 Introduction

2.1.1 Background and Context

Mental health disparities among racially minoritised groups, particularly Black individuals in the United Kingdom, have persisted for decades despite concerted policy efforts (Halvorsrud et al., 2018). Black individuals are disproportionately subject to compulsory admissions under the Mental Health Act (Care Quality Commission, 2021), overrepresented in psychosis diagnoses (Morgan et al., 2020), and less likely to engage with voluntary or preventative services (Bhui et al., 2003; Memon et al., 2016). Contact with services more frequently occurs through coercive pathways such as police referrals or crisis interventions rather than through community or primary care routes (Keating & Robertson, 2004). These patterns reflect not individual-level barriers alone but systemic inequities embedded in the structure and delivery of NHS mental health services (Nazroo et al., 2020).

Structural racism, cultural stigma, institutional mistrust, and socioeconomic disadvantage collectively shape these disparities, intersecting to produce cycles of delayed help-seeking, negative service encounters, and long-term disengagement (Edge & MacKian, 2010; Sewell, 2012). The long-standing failure of services to effectively engage Black communities has prompted calls for transformation of care models towards anti-racist practice, cultural humility, and the meaningful inclusion of lived experience (Fernando, 2017; Kline, 2020).

Several systematic reviews have already synthesised evidence on barriers to mental health support for racially minoritised populations in the UK, and it is useful to situate the present review against them. Halvorsrud et al. (2018) conducted a systematic review and meta-analysis of ethnic inequalities in access to and outcomes of NHS mental health services, finding consistently poorer access and outcomes for Black service users, though their review was outcomes-focused and drew primarily on quantitative epidemiological data rather than first-hand accounts of the help-seeking process itself. Similarly, Barnett et al.'s (2019) systematic review and meta-analysis of international data demonstrated markedly higher rates of compulsory detention among Black service users, a finding that is now well-established, but, like Halvorsrud et al. (2018), this review addressed a downstream outcome of service contact rather than the upstream barriers and facilitators that shape whether and how Black individuals come to engage with services at all.

More directly relevant qualitative evidence is offered by Alam et al. (2024), whose systematic review and thematic synthesis of racially minoritised people's barriers to mental health support in the UK identified stigma, differing understandings of distress, perceived professional competence, and accessibility as recurring barriers; however, their review aggregated experiences across racially minoritised groups broadly rather than focusing specifically on Black populations, for whom particular histories of coercive psychiatric contact and structural racism may produce a distinct configuration of barriers. Bassey and Zaka's (2024) systematic review of barriers to mental health service utilisation among African immigrants in the UK offers a more population-specific account, identifying stigma, residential instability, cultural influences, discrimination, and accessibility as key barriers, though this review was restricted to African immigrant populations and did not include UK-born Black British individuals, who may experience the same systems differently.

Facilitators have received comparatively less systematic attention. Codjoe et al. (2021) conducted a systematic review of interventions to promote mental health and reduce stigma in Black faith communities, identifying community-based, bottom-up approaches and the role of trusted "champions" as effective ingredients of engagement; however, the majority of included studies originated from the United States, and the review's focus on formally evaluated interventions means it offers limited insight into the everyday, informal facilitators that shape individual help-seeking decisions in the UK context specifically.

Taken together, these reviews establish that barriers to accessing mental health support for Black people in the UK are relatively well-documented at the level of broad themes (stigma, discrimination, service accessibility), while UK-specific facilitators remain comparatively underexamined, and existing reviews tend to either aggregate Black participants within broader racially minoritised samples (Alam et al., 2024) or focus on a single sub-population, intervention type, or outcome (Halvorsrud et al., 2018; Barnett et al., 2019; Bassey & Zaka, 2024; Codjoe et al., 2021). No identified systematic review has synthesised qualitative evidence on both barriers and facilitators together, specifically for Black people accessing mental health support in the UK, across the full range of community, cultural, and institutional contexts in which that access takes place. The present review addresses this gap by synthesising both sides of this picture, barriers and facilitators, drawing only on UK-based, Black-specific evidence, in order to provide a more complete and contemporary account that can directly inform the empirical focus of this thesis on Black trainee clinical psychologists.

2.1.2 Aim and Scope of the Review

This systematic literature review synthesises empirical evidence on the cultural, structural, and relational factors that influence help-seeking, treatment engagement, and

service outcomes for Black individuals accessing mental health services in the UK. It considers how these factors intersect with broader systems of racial and socioeconomic inequality and what this means for the lived experiences of Black individuals within healthcare systems.

The review is situated in a specific socio-political moment. The COVID-19 pandemic disproportionately affected Black and minority ethnic communities in terms of both infection rates and mental health outcomes, exposing the vulnerabilities produced by longstanding health inequities (Mathur et al., 2021; Public Health England, 2021). The resurgence of the Black Lives Matter movement amplified calls for institutional accountability and the dismantling of systemic racism in public services including mental health care (Onwumere et al., 2022; Adebawale, 2020). These developments have intensified scrutiny of the NHS and produced increased demand for synthesised, contemporary evidence (Bastos et al., 2021).

The literature identifies several overlapping barriers. Cultural stigma operates as a powerful deterrent to early help-seeking, with mental illness frequently associated with shame or spiritual failure in many Black communities, and cultural norms of strength and self-reliance compounding concealment of distress (Bhui et al., 2015b; Mantovani et al., 2017). Institutional barriers are equally significant: Black individuals are more likely to receive risk-focused assessments, coercive treatment, and involuntary hospitalisation, and less likely to receive talking therapies or culturally sensitive care (Morgan et al., 2020; Memon et al., 2016; Nazroo et al., 2020; Kline, 2020). Socioeconomic disadvantage, including higher rates of poverty, unemployment, and housing insecurity, further shapes the contexts in which help-seeking decisions are made and renders services inaccessible or irrelevant to many Black service users (Kapadia et al., 2022).

Facilitators identified in the literature include culturally responsive care, the presence of Black staff, faith-informed interventions, peer-led programmes, and community-based support services, all of which have been shown to increase trust, reduce stigma, and foster therapeutic engagement (Sewell, 2012; Memon et al., 2016). Despite growing recognition of these dynamics, synthesised evidence on contemporary barriers and facilitators, particularly in the post-2020 context, remains limited. This review addresses that gap by drawing on empirical research published between 2020 and 2024.

2.1.3 Research Question

"What are the barriers and facilitators to accessing and engaging with mental health services for Black individuals in the United Kingdom?"

2.2 Reflexivity and Positionality Statement

As a Black trainee clinical psychologist with lived experience of mental health problems, I occupy a dual position in relation to this review. My personal navigation of mental health services has been shaped by systemic and cultural barriers, including misrecognition by predominantly White practitioners who may lack the cultural frameworks necessary to fully understand my experience. Simultaneously, my training positions me within systems that often reproduce these very exclusions. This intersection of insider-outsider status informs both my motivation for this review and my interpretive stance throughout the analysis. In line with best practices in qualitative research, I acknowledge that my positionality shapes the selection, interpretation, and synthesis of evidence (Berger, 2015; Holmes, 2020). I have therefore sought to engage reflexively and critically with the literature to ensure that marginalised voices are centred and institutional assumptions interrogated.

2.3 Methodology

This chapter adopts a systematic literature review (SLR) design to synthesise empirical evidence on the barriers and facilitators that Black individuals encounter when accessing mental health services in the United Kingdom. The SLR method was chosen due to its structured and replicable approach to identifying, appraising, and synthesising existing research across diverse methodologies (Gough et al., 2017). Given the complex and intersectional nature of the topic spanning culture, race, psychology, and social inequality a systematic approach allows for both rigour and transparency in tracing how evidence has evolved and where knowledge gaps remain.

The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al., 2021). PRISMA was selected for its widespread use and its ability to enhance clarity and replicability by providing a standardised approach to literature identification, screening, eligibility, and inclusion. The PRISMA flow diagram was used to illustrate the screening process, from initial database searches to the final selection of included studies.

This review is underpinned by a constructivist epistemological stance. Constructivism posits that knowledge is not objective or neutral but is socially constructed through language, culture, and context (Lincoln & Guba, 1985). This perspective is particularly relevant to the present review, which explores the lived realities of Black individuals navigating mental health services shaped by histories of exclusion and racism. The constructivist lens recognises that meaning is created through interaction between people and their environments, and that research should account for multiple perspectives and contextual variability. This epistemology informs both the selection of predominantly qualitative and mixed methods studies and the thematic synthesis approach used for analysis. This was chosen to enable the integration of findings from diverse qualitative designs. The process

involved line-by-line coding of primary data, generation of descriptive themes, and development of higher-order analytical themes that cut across the studies. Thematic synthesis is well suited to reviews informed by constructivist thinking, as it acknowledges the interpretive role of the researcher in identifying patterns and making meaning from diverse narratives.

This methodology section lays the foundation for a review that not only collates empirical evidence but critically engages with the social realities underlying the data, making it especially appropriate for exploring the experiences of marginalised groups in healthcare.

2.4 Search Strategy

A comprehensive and systematic literature search was conducted across five major academic databases: PsycINFO, MEDLINE (via PubMed), CINAHL, Scopus, and Web of Science. These databases were selected to ensure broad interdisciplinary coverage spanning psychology, psychiatry, public health, and social science, and to maximise the likelihood of identifying empirical evidence specifically pertaining to Black individuals in UK mental health settings. Searches were conducted by the primary researcher and refined through an iterative scoping process prior to the formal review.

Search terms were developed in accordance with the review's conceptual framework and organised into six conceptual clusters. Terms within each cluster were combined using OR to capture variant and synonymous concepts, and clusters were linked using AND to ensure returned results addressed all key concepts. Population terms included: Black, Black British, Black African, Black Caribbean, African, Caribbean, Afro-Caribbean, ethnic minority, BAME, and BME. Mental health terms included: mental health, mental illness, psychological distress, mental disorder, depression, anxiety, PTSD, trauma, severe mental illness (SMI), psychosis, wellbeing, and well-being. Access terms included: access, accessibility, help-seeking, help

seeking, service use, utilisation, referral, and pathways to care. Engagement terms included: engagement, uptake, adherence, attendance, retention, dropout, and attrition. Barrier and facilitator terms included: barrier, facilitator, obstacle, challenge, enabler, determinant, experience, perception, and attitude. Setting terms included: United Kingdom, UK, England, Wales, Scotland, NHS, and National Health Service.

MeSH subject headings were applied in MEDLINE and PsycINFO to supplement free-text searching. Reference lists of relevant studies were hand-searched, and citation-chaining was employed to identify studies not captured through database searches. The search was restricted to peer-reviewed journal articles published in English between January 2020 and December 2024. The rationale for this timeframe is provided in Section 2.1.3: this period captures the intensified body of empirical research produced in response to the Black Lives Matter movement, the racialised impact of the COVID-19 pandemic, and renewed NHS scrutiny following the government's Race and Health Observatory reports.

Searches were documented using a PRISMA 2020-compliant tracking spreadsheet (Page et al., 2021) to ensure transparency and replicability. Grey literature including NHS Digital reports and guidance from mental health charities was reviewed for contextual triangulation but was not included in the final synthesis unless independently peer reviewed.

2.5 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were established a priori, prior to the commencement of screening. These criteria were designed to operationalise the review question with methodological precision and to ensure that the synthesis was anchored in evidence specifically and separately reporting the experiences of Black individuals in UK mental health service contexts.

2.5.1 Inclusion Criteria

The following criteria were applied to determine study inclusion:

1. Empirical studies using qualitative, quantitative, or mixed methods designs, reporting primary data on barriers and/or facilitators to accessing or engaging with mental health services.
2. Studies conducted within the United Kingdom, addressing statutory or community-based NHS mental health services, primary care mental health provision, or voluntary sector mental health settings.
3. Participants identified as Black African, Black Caribbean, Black British, or of mixed Black heritage, where Black participants were separately identifiable within the sample and their experiences reported distinctly.
4. Studies addressing barriers or facilitators to accessing or engaging with mental health services, broadly defined to include help-seeking, service use, referral, uptake, adherence, retention, or therapeutic engagement.
5. Peer-reviewed journal articles published in English between January 2020 and December 2024.

Rationale for key criteria: The requirement for separately identifiable Black participants reflects the critical methodological position, shared by the NHS Race and Health Observatory and other leading scholars, that aggregated BAME data obscures the specific and often more severe disparities experienced by Black communities (Bhopal, 2021; Kapadia et al., 2022). The 2020–2024 timeframe was selected to capture the contemporary evidence base produced in the wake of the Black Lives Matter movement and COVID-19 pandemic, which both generated renewed research attention to racial inequities in NHS service delivery.

2.5.2 Exclusion Criteria

The following criteria resulted in study exclusion:

1. Studies that used BAME or other aggregate ethnic groupings without disaggregating findings to present data specific to Black participants. Rationale: Such studies cannot reliably inform conclusions about barriers and facilitators for Black individuals specifically, and risk conflating distinct communities with different histories, cultural frameworks, and structural positions.
2. Studies where Black participants were present, but their experiences were not reported separately from other ethnic groups. Rationale: To preserve the integrity of the synthesis and avoid generalising from composite findings to a specific community.
3. Theoretical, editorial, commentary, or opinion pieces without primary empirical data. Rationale: Methodological rigour requires empirically grounded foundations for a thematic synthesis making knowledge claims about community experiences.
4. Studies conducted outside the United Kingdom. Rationale: Cross-national differences in healthcare structures, ethnic classification systems, welfare provision, and historical relationships between Black communities and psychiatric services limit direct transferability to NHS contexts.
5. Studies focused solely on physical health, substance use, or social care services unrelated to mental health. Rationale: These fall outside the scope of the review question.
6. Duplicate publications reporting on the same sample without new data.
7. Studies published prior to January 2020 or after December 2024.

In line with the review's constructivist epistemology, exclusion decisions were treated as interpretive judgements rather than purely mechanical operations. Where borderline cases

arose; for example, where a study used broad BAME sampling but included a separate, identifiable, and substantively reported Black subsample the lead researcher documented the rationale and discussed the decision with a second reviewer. This process is consistent with quality standards for systematic and meta-ethnographic review (Gough et al., 2017).

2.6 Screening and Selection Process

A total of 1,679 records were retrieved following application of the search strategy. Records from all five databases were exported into EndNote, where automated and manual duplicate-checking was used to remove 389 duplicates, leaving 1,252 titles and abstracts for screening. Title and abstract screening, and subsequent full-text screening, were conducted manually by the primary researcher using a structured Excel tracking spreadsheet, in which each record was logged against the inclusion and exclusion criteria (Section 2.5) with reasons for exclusion recorded at the full-text stage; this approach was chosen, in preference to a dedicated screening platform such as Rayyan or Covidence, to maintain full visibility and control over decision-making within the resources available for a doctoral thesis. Of the 1,252 records screened, 94 full-text articles were retrieved for eligibility assessment. Following full-text review and quality appraisal, 10 studies were included in the final synthesis. A second reviewer, a fellow trainee clinical psychologist independent of the research, independently screened 25% of records at both the title/abstract and full-text stages, selected at random from the tracking spreadsheet; inter-rater agreement was high, and disagreements were resolved through discussion and, where necessary, consultation with the research supervisor. Full details of the screening and selection process are presented in the PRISMA 2020 flow diagram (Figure 1). A summary of studies included in the SLR are outlined in Table 1 below.

Figure 1. PRISMA 2020 Flow Diagram

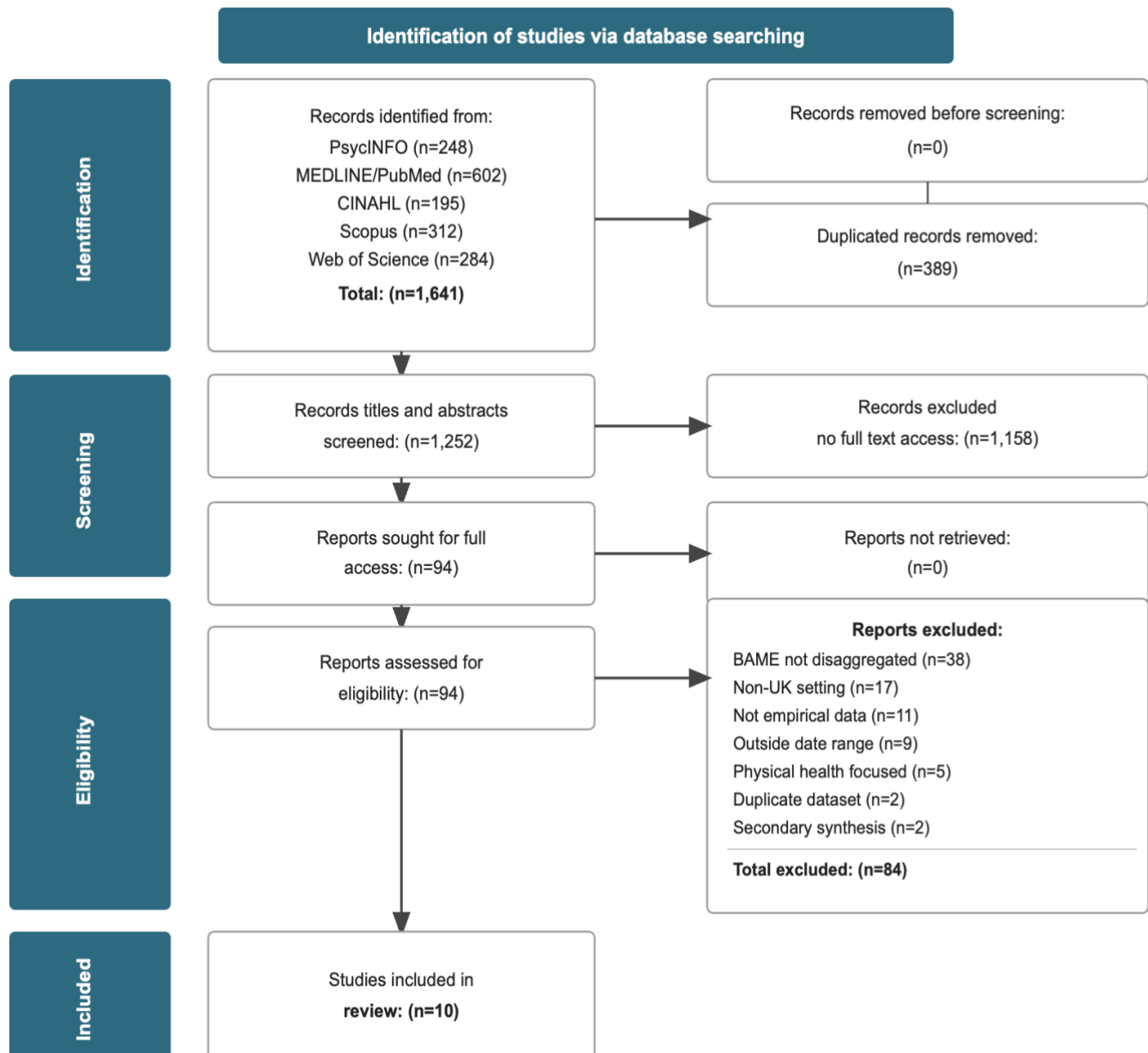


Table 1.
Summary and Characteristics of Studies Selected

Author(s) and Year	Title, Journal & DOI	Sample	Design	Method of Analysis	Summary of Key Findings	Strengths and Limitations
Bailey & Tribe (2021)	A qualitative study to explore the help-seeking views relating to depression among older Black Caribbean adults living in the UK. <i>International Review of Psychiatry</i> , 33(1–2), 113–118. https://doi.org/10.1080/09540261.2020.1761138	n = 8 older Black Caribbean adults (5 women, 3 men), aged 65–79; purposive community recruitment, London.	Qualitative (IPA)	Semi-structured interviews; case-by-case and cross-case IPA.	Three master themes: (1) limited mental health literacy shaped by migration histories; (2) recognition of depression but distancing from pathological framing; (3) help-seeking decisions shaped by intergenerational NHS mistrust, fear of over-medication and detention, and preference for faith and familial coping. Cultural and religious beliefs operated as both buffers and barriers.	Strengths: phenomenological depth; under-researched older Black Caribbean group; disaggregated findings. Limitations: very small sample (n = 8); London-centric; no clinician perspectives.
Harwood et al. (2021)	Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. <i>Psychological Medicine</i> , 53(3), 1084–1095. https://doi.org/10.1017/S0033291721002518	n = 85,800 individuals referred to SLaM NHS Foundation Trust IAPT services, 2013–2016; includes Black African, Black Caribbean, Black Other, and White British groups.	Quantitative (retrospective cohort using NHS routine data)	Multinomial and binary logistic regression; adjusted for demographic and clinical covariates; multiple imputation for missing ethnicity.	Compared with White British: Black African, Asian, and Mixed groups were significantly less likely to self-refer; Black Caribbean and Black Other more likely to enter via community services. All ethnic minority groups less likely to receive assessment; among those assessed, less likely to receive treatment. Differences not explained	Strengths: very large real-world NHS sample; robust adjusted analyses; disaggregated Black African, Black Caribbean, Black Other; open access PMC. Limitations: restricted to South London IAPT; routine data limits granularity; no service-user voice.

Ogueji & Okoloba (2022)	Seeking professional help for mental illness: a mixed methods study of Black family members in the UK and Nigeria. <i>Journal of Public Mental Health</i> , 21(3), 189–199. https://doi.org/10.1007/s12646-022-00650-1	n = 105 Black family members (aged 19–64) of people with diagnosed mental illness; UK subsample via community networks; low-to-middle SES.	Mixed methods (convergent design)	Structured questionnaire with open-ended items; descriptive and inferential statistics (SPSS); thematic analysis.	by clinical need, confirming systematic service-level inequity. Six interlocking barriers: perceived inaccessibility (financial/geographic), stigmatisation and socio-cultural factors (gender norms equating disclosure with weakness), confidentiality concerns, limited-service knowledge, long waiting times, and COVID-19 infection fears. SES shaped barrier salience but not presence. Community and familial attitudes actively discouraged professional help-seeking.	Strengths: combines quantitative and qualitative strands; UK Black participants; addresses COVID-19 era; peer reviewed. Limitations: transnational sample (UK and Nigeria) limits UK-specific inference; integration at interpretation stage; reflexivity under-described.
Degnan et al. (2022)	Engagement with services in Black African and Caribbean people with psychosis: The role of social networks, illness perceptions, internalised stigma, and perceived discrimination. <i>British Journal of</i>	n = 51 Black African and Caribbean individuals with psychosis; NHS community mental health teams, Greater Manchester; predominantly male (67%), mean age 39.4 years.	Quantitative (cross-sectional survey)	Multivariate regression; validated measures (Staff Engagement Scale, Service User Outcome Scale); social network mapping interviews.	Greater perceived racial/ethnic discrimination was significantly associated with poorer service engagement. Ethnically homogenous social networks predicted better engagement. Illness perceptions (personal control, treatment beliefs) were associated with engagement outcomes.	Strengths: first study to directly measure social network characteristics in a Black psychosis sample; validated measures; disaggregated; open access PMC. Limitations: cross-sectional; single region; predominantly male.

Clinical Psychology,
61(4), 1134–1153.
<https://doi.org/10.1111/bjc.12385>

Lawrence et al. (2021)

Ethnicity and power in the mental health system: experiences of White British and black Caribbean people with psychosis. *Epidemiology and Psychiatric Sciences*, 30, e12.
<https://doi.org/10.1017/S2045796020001043>

n = 35 (17 Black Caribbean, 15 White British, 3 non-British White) people with psychosis; purposively sampled from the AESOP-10 longitudinal cohort (a 10-year follow-up of 532 individuals with first-episode psychosis in the UK); diverse age range; community and inpatient settings across England.

Qualitative (narrative inquiry; embedded within AESOP-10 longitudinal cohort)

Thematic narrative analysis; in-depth semi-structured interviews; experience-centred approach prioritising the meaning mental health services held for participants; analysis conducted within and then across individual accounts.

Internalised stigma was not independently significant in multivariate analysis but interacted with discrimination. Disengagement is structurally mediated, not an individual deficit. Experiences of powerlessness dominated the accounts of Black Caribbean participants and, to a lesser extent, White British participants. Black Caribbean participants were more likely to enter services via police involvement and compulsory detention, and less likely to experience shared decision-making around medication and diagnosis. Negative experiences compounded over time, creating a vicious cycle of disempowerment, mistrust, and alienation from services. Cultural and spiritual frameworks of distress were frequently incongruent with clinical models, and structural disadvantage, including

Strengths: large qualitative sample for this type of study; Black Caribbean findings clearly disaggregated and reported separately throughout; narrative inquiry epistemologically coherent for long-term experiential accounts; AESOP-10 provides a well-characterised cohort; open access. Limitations: select sample, breadth of views may not be fully captured; interviews conducted by a White male academic, which may have shaped participant disclosure; findings primarily reflect experiences of Black Caribbean individuals with psychosis, limiting transferability to other presentations or heritage groups.

					poverty, housing instability, and social isolation, both contributed to and was sustained by inequitable service experiences.	
Codjoe et al. (2023)	Pilot study of a manualised mental health awareness and stigma reduction intervention for Black faith communities in the UK: ON TRAC project. Social Psychiatry and Psychiatric Epidemiology, 58(5), 731–742. https://doi.org/10.1007/s00127-023-02492-2	Adult members of Black Christian faith communities, Southwark and Lambeth, London; recruited through Black Majority Churches; small self-selected pilot sample.	Mixed methods (pre–post pilot; MRC Complex Interventions framework)	Pre/post standardised measures (CAMI, MAKs, RIBS, willingness-to-disclose scale); post-group qualitative focus groups; thematic analysis.	ON TRAC was feasible and acceptable. Statistically significant improvements in community attitudes to mental illness (CAMI) and increased willingness to disclose. Qualitative themes highlighted cultural resonance, faith leader gatekeeping, and need for stronger NHS referral capacity. Co-production was itself identified as a facilitator of engagement. Proof-of-concept that community-led faith-based interventions can shift stigma and increase help-seeking intent.	Strengths: co-produced; MRC-based pilot; integrates quantitative outcomes with qualitative process data; open access. Limitations: pilot-scale; no control arm; self-selected faith community sample; limited evidence on downstream NHS pathway outcomes.
Solanki et al. (2023)	Experiences of adults from a Black ethnic background detained as inpatients under the Mental Health Act (1983). Psychiatric	n = 12 self-identified adults from a Black ethnic background currently detained as inpatients under the MHA; acute	Qualitative (semi-structured interviews)	Thematic analysis; semi-structured interviews conducted on acute inpatient wards.	People from a Black ethnic background reported inpatient detention as a racist and racialised experience, inseparable from a wider context of systemic racism, inequality,	Strengths: fills a significant evidence gap on inpatient detention experiences for Black patients; rigorous qualitative methodology; clear disaggregation; open access. Limitations: small

	Rehabilitation Journal, 46(1), 14–20. https://doi.org/10.1037/prj0000537	mental health inpatient wards, England.			and stigma within families and communities. Participants reported feeling unheard, neglected, and without agency. Ethnicity was perceived as relevant to every aspect of their care. Social support outside hospital was experienced as lacking. Systemic racism must be addressed across mental health care, led by the lived experiences of Black patients.	sample (n = 12); single time-point; recruited from specific inpatient settings, limiting transferability across service types.
Mayers & Gordon (2024)	Exploring the experiences of Black men through the decision-making process in secure settings: A qualitative study. Journal of Black Psychology, 50(2), 135–165. https://doi.org/10.1177/00957984231221277	n = 5 Black men aged 33–40 with experience of NHS mental health inpatient provisions within the last 10 years, now discharged; recruited via purposive sampling in England.	Qualitative (IPA)	Semi-structured interviews; Interpretative Phenomenological Analysis (IPA); eight Group Experiential Themes (GETs) and nine sub-themes identified.	Eight GETs identified: role and significance of medication in care; family involvement in decision-making; compliance and concordance with treatment; experience of restraint and use of force; power imbalances within clinical relationships; cultural and racial identity in care contexts; absence of shared decision-making; and barriers to discharge and community reintegration. Black men consistently experienced exclusion from key clinical decisions,	Strengths: directly centres Black men's voices in inpatient decision-making a highly under-researched area; IPA methodology provides idiographic depth; clearly disaggregated Black male sample; UK NHS inpatient settings. Limitations: very small sample (n = 5); retrospective recall; all males; limited to participants who had been discharged, excluding those still detained.

					described a culture of enforcement over therapeutic engagement, and identified race as shaping how their behaviour and distress were interpreted. Participants expressed strong desire for culturally informed, collaborative care and representation among clinical staff.	
Ocloo et al. (2024)	Living less safely through the pandemic in England for people with serious mental and physical health conditions: qualitative interviews with service users and carers of Black African, Caribbean, and South-Asian descent. BMC Public Health, 24(1), Article 2718. https://doi.org/10.1186/s12889-024-20107-6	Purposively sampled adults with serious mental illness (SMI) and comorbid physical health conditions from Black African, Black Caribbean, Indian, Pakistani, and Bangladeshi backgrounds, plus carers; three geographically distinct NHS PCREF pilot sites (Birmingham, Manchester, South London); n = total qualitative sample from interviews.	Qualitative (participatory action research; thematic analysis)	Semi-structured interviews conducted by experts-by-experience and university researchers; inductive and deductive coding; thematic analysis; framework analysis to develop a logic model.	Identified multiple points along primary and secondary health pathways where ethnic inequalities were exacerbated during the pandemic. Black African and Caribbean participants reported abrupt withdrawal of community support, rapid shift to digital/remote services intensifying existing digital inequalities, fear of coercion and detention increased by reduced community oversight, experiences of racism and discrimination in clinical encounters, reduced access to trusted community and voluntary organisations, and inadequate culturally	Strengths: participatory action research design; experts-by-experience co-researchers; multi-site England-wide; NIHR-funded; clearly disaggregates Black African and Caribbean findings; real-world policy relevance to PCREF and MHA reform; open access PMC. Limitations: multi-ethnic sample requires careful extraction of Black-specific findings; pandemic period may limit generalisability to non-crisis service contexts; published October 2024.

					adapted communication. Pre-pandemic structural racism, compounded by pandemic conditions, produced acute deterioration in access and care quality for Black communities. Participants called for NHS reform of the Mental Health Act and investment in community-centred culturally safe care.	
Winsper et al. (2024)	The impact of reduced routine community mental healthcare on people from minority ethnic groups during the COVID-19 pandemic: qualitative study of stakeholder perspectives. British Journal of Psychiatry, 224(5), 150–156. https://doi.org/10.1192/bjp.2024.11	n = 34 patients, 15 carers, and 39 NHS and community organisation mental health professionals across four NHS Trust sites in England (Coventry and Warwickshire, Greater Manchester, East London, Sheffield); includes Black African and Caribbean participants separately identifiable in analysis.	Qualitative (semi-structured interviews; framework analysis)	Semi-structured interviews (n = 88 total); framework analysis to develop a logic model of pre-pandemic barriers and COVID-19 impacts; multi-site experience-based co-design (EBCD) study.	Pre-pandemic barriers institutional mistrust, cultural misattunement, restricted access to community and voluntary organisations, and digital exclusion were significantly exacerbated by COVID-19. For Black participants specifically, community service closures during lockdown removed trusted alternative pathways to care, increasing crisis-level presentations. The transition to remote delivery was particularly harmful for communities already experiencing digital exclusion and who valued	Strengths: large multi-site UK study; includes NHS professionals, service users, and carers; directly addresses both pre-pandemic barriers and COVID-19 impacts; NIHR-funded; open access PMC; Black participants identifiable within analysis. Limitations: mixed ethnic minority sample requires careful extraction of Black-specific findings; pandemic context; stakeholder perspectives on service-level issues may not fully capture individual service-user experiences.

face-to-face, relational care. Stakeholders noted that inequalities were created and sustained by the interaction of structural racism, service design failures, and pandemic disruption. Black service users and carers reported feeling even less heard and less safe during the pandemic, with reduced ability to access culturally competent support.

The final selection of 10 studies from the 94 full-text articles assessed reflects substantive eligibility and quality judgements documented here in the interest of transparency. Two studies that met the formal inclusion criteria were excluded following full-text review: one on methodological quality grounds, and one because its primary focus on longitudinal clinical outcome trajectories placed it outside the boundary of the review question as defined in Section 2.4. Both decisions were reviewed with the supervisory team and are consistent with the a priori quality appraisal criteria documented in Section 2.5.

2.6.1 Summary Statistics of Appraised Studies

A total of 10 studies met all eligibility and quality criteria and were included in the final synthesis. The included studies span four methodological traditions: primary qualitative inquiry (n = 6, 60%); mixed methods primary studies (n = 2, 20%); retrospective quantitative cohort (n = 1, 10%); and cross-sectional quantitative survey (n = 1, 10%). Of the ten studies, nine (90%) were rated as high quality and one (10%) as moderate quality following CASP and MMAT appraisal. No study was rated as low quality. Moderate-quality studies were retained in the synthesis, with their findings interpreted with appropriate caution and weighted accordingly in the analytical commentary. A full breakdown of appraisal characteristics is presented in Table 2 below.

Table 2.

Appraisal Characteristic of Studies Included

Characteristic	Number	%
High quality (CASP/MMAT $\geq$ 80% criteria met)	9	90%
Moderate quality (CASP/MMAT partial criteria met)	1	10%
Qualitative — primary empirical	6	60%
Mixed methods — primary empirical	2	20%

Quantitative — retrospective cohort	1	10%
Quantitative — cross-sectional survey	1	10%
Published 2021	3	30%
Published 2022	2	20%
Published 2023	2	20%
Published 2024	3	30%
Total included studies	10	100%

2.7 Data Extraction and Quality Appraisal

Data extraction was conducted using a structured template developed in Microsoft Excel. For each included study, the following data were recorded: author(s), year of publication, study design and methodology, sample size and participant characteristics, geographical setting, key findings pertaining to barriers or facilitators, and theoretically relevant concepts. The template and the selection of these data items were developed with reference to the Cochrane Handbook for Systematic Reviews of Interventions (Li et al., 2024) and Büchter et al.'s (2020) methodological review of data extraction form development, both of which recommend that extraction forms capture, at minimum, study identification, design and methodological characteristics, participant and setting information, and findings relevant to the review question; this is consistent with the data items specified in Items 9 and 10 of the PRISMA 2020 statement (Page et al., 2021), already adopted for this review's reporting (see Section 2.4). The explicit division of findings into barriers and facilitators reflects the review's research question and was informed by the structure used in comparable prior systematic reviews of access to mental health support for racially minoritised populations (e.g., Alam et

al., 2024). This ensured consistent comparison across studies of varying methodological designs and populations.

To assess methodological quality, three complementary appraisal tools were employed in alignment with the mixed methods nature of the evidence base. The CASP Qualitative Studies Checklist (10 questions; CASP, 2022) was applied to all primary qualitative studies (Table 3). As CASP does not provide a single checklist appropriate to all quantitative designs included in this review, separate design-matched CASP tools were used for the two quantitative primary studies: the CASP Cohort Study Checklist (CASP, 2024a) was applied to the retrospective routine-data cohort study (Harwood et al., 2021; Table 4), and the CASP Descriptive/Cross-Sectional Studies Checklist (CASP, 2024b) was applied to the cross-sectional study (Degnan et al., 2022; Table 5), ensuring that items specific to each design (for example, confounding and follow-up for the cohort study; sample size and power for the cross-sectional study) were appraised using the criteria appropriate to that design rather than a single blended tool. The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was applied to studies employing a mixed methods design (Table 6). Each study was appraised by the primary researcher, with a proportion of appraisals reviewed by a second rater to check consistency of application of the criteria. Ratings of high, moderate, or low quality were assigned based on criteria including: clarity of research aims, appropriateness of design, rigour of sampling and recruitment, suitability of analysis, consideration of researcher positionality, and transparency of ethical reporting.

No included study was rated as low quality. Moderate-quality studies were retained in the synthesis, but their findings were interpreted with greater caution, and this weighting is reflected in the analytical commentary. The results of the quality appraisal are presented in Tables 3, 4, 5 and 6 below.

Table 3.

CASP Qualitative Studies Checklist (10-Question) Appraisal of Included Qualitative Studies

Study	Q1. Clear aims?	Q2. Qualitative methodology appropriate?	Q3. Research design appropriate?	Q4. Recruitment strategy appropriate?	Q5. Data collection addressed research issue?	Q6. Researcher–participant relationship considered?	Q7. Ethical issues considered ?	Q8. Data analysis sufficiently rigorous?	Q9. Clear statement of findings?	Q10. Value of the research?
Bailey & Tribe (2021) (IPA)	Yes – explores help-seeking for depression among older Black Caribbean adults	Yes – IPA fits exploration of meaning-making	Yes – idiographic design fits aim	Yes – purposive, homogeneous sample (n = 8)	Yes – semi-structured interviews	Yes – reflexive account; researcher positioning acknowledged	Yes – ethical approval and consent reported	Yes – transparent case-by-case and cross-case IPA analysis	Yes – themes illustrated with verbatim quotations	High – fills gap; small n and London-centric sample are limitations
Lawrence et al. (2021) (Narrative inquiry; AESOP-10 cohort)	Yes – generates long-term experiential accounts of service pathways	Yes – narrative inquiry coherent for biographical accounts	Yes – longitudinal narrative design fits aim	Yes – purposive sampling from well-characterised cohort	Yes – in-depth narrative interviews within cohort follow-up	Yes – reflexivity and institutional positioning discussed	Yes – ethical approval; longitudinal consent documented	Yes – thematic narrative analysis; verbatim data	Yes – three categories clearly defined and illustrated	High – psychosis-specific sample limits generalisability
Solanki et al. (2023) (Semi-structured)	Yes – explores lived experience	Yes – thematic analysis fits exploration of	Yes – semi-structured design fits aim	Yes – purposive sample of	Yes – semi-structured interviews in	Yes – reflexive journal kept; lead author's	Yes – ethical approval and	Yes – transparent inductive coding; themes checked with a BE	Yes – four themes clearly stated and	High – fills gap in detention literature; small n, single time-

interviews; thematic analysis)	e of Black patients detained under MHA	subjective detention experience		inpatients (n = 12)	inpatient settings	differing ethnic background and lack of lived experience of detention explicitly discussed as a power disparity	inpatient safeguarding documented	service-user and a participant; supported by verbatim quotations	illustrated with verbatim quotations	point, and underrepresentation of men in the sample are limitations
Mayers & Gordon (2024) (IPA)	Yes – explores Black men’s experiences of decision-making in NHS inpatient care	Yes – IPA fits idiographic focus on meaning-making	Yes – small-sample IPA design fits aim	Yes – purposive sample of Black men (n = 5)	Yes – semi-structured interviews	Yes – dual-heritage insider–outsider positionality discussed	Yes – ethics, consent, safeguarding documented	Yes – eight GETs supported by verbatim quotations	Yes – GETs clearly stated and illustrated	High – rare insight; very small, all-male sample is a limitation
Ocloo et al. (2024) (Participatory action research; thematic analysis)	Yes – understands ethnic inequalities in service use during	Yes – PAR with co-researchers fits aim	Yes – multi-site co-produced design fits aim	Yes – purposive sampling across three NHS sites	Yes – co-produced data collection with expert-by-experience researchers	Yes – reflexivity of academic–community team discussed	Yes – NIHR-funded; NHS REC approval documented	Yes – inductive/deductive coding plus framework analysis	Yes – logic model of barriers clearly presented	High – needs careful extraction of Black-specific findings from multi-ethnic sample

COVID-19										
Winsper et al. (2024) (Semi-structured interviews; framework analysis)	Yes – examines how COVID-19 exacerbated ethnic inequalities in care	Yes – framework analysis fits multi-site comparative data	Yes – multi-site, multi-perspective design fits aim	Yes – purposive sampling across four Trusts (n = 88)	Yes – semi-structured interviews with patients, carers, professionals	Yes – LEAP involvement; positionality briefly discussed	Yes – NIHR-funded; PPI in design documented	Yes – systematic framework analysis; logic model developed	Yes – logic model and categories clearly reported	High – needs careful extraction of Black-specific findings from mixed sample

Table 4.

CASP Cohort Study Checklist Appraisal of Harwood et al. (2021)

Study	Q1. Clearly focused issue?	Q2. Cohort recruited acceptably?	Q3. Exposure accurately measured?	Q4. Outcome accurately measured?	Q5a/b. Confounding factors identified & accounted for?	Q6a/b. Follow-up complete & long enough?	Q7. What are the results?	Q8. How precise are the results?	Q9. Do you believe the results?	Q10. Applied to local population?	Q11. Fit with other evidence?	Q12. Implications for practice?
Harwood et al. (2021) (Retrospective routine-data cohort)	Yes – clearly focused on examining ethnic variation in (i) referral source, (ii) receipt of assessment, and (iii) receipt of treatment within IAPT services across four South London	Yes – very large sample drawn from routine IAPTus electronic records for all individuals referred to SLaM IAPT services over a 4-year period; restricted	Yes, with caveats – ethnicity recoded from 17 census categories into 8 groups (disaggregating Black Caribbean/African/Other); 18.5% missing ethnicity data addressed	Yes – referral source, assessment receipt, and treatment receipt extracted from structured IAPTus fields (objective routine service-contact data); missing data on	Yes – multinomial and logistic regression models adjusted for age, gender, year of referral, and borough of service; borough significantly moderated the ethnicity–assessment relationship ($p < .01$).	Not directly applicable – routine-data analysis of first treatment episodes (2013–2016) rather than a prospective follow-up cohort; not a follow-up/attrition design in	Yes – e.g., vs. White British, Black African group significantly less likely to self-refer (OR 0.67, 95% CI 0.63–0.71); most minority groups significantly less likely to receive assessment (e.g., Black	Yes – 95% CIs reported throughout and are narrow given the very large sample ($n = 85,800$), supporting precise effect estimates.	Yes – very large sample, routine administrative data, and convergence of findings across three missing-data approaches (complete case, weighted MI, MICE) strengthens	Yes, for South London IAPT – boroughs are ethnically diverse with substantial Black Caribbean representation; may not generalise to services with different demograph	Yes – consistent with prior literature on ethnic inequalities in psychological therapy access/outcomes (e.g., Cooper et al., 2013; McManus et al., 2016); extends earlier IAPT	Yes – differences not explained by clinical need, indicating systematic service-level inequity; supports targeted review of referral/assessment pathways, though one study cannot

boroughs (SLaM, 2013–2016, n = 85,800).	to one NHS Trust (four South London boroughs).	via weighted multiple imputation, complete-case analysis, and MICE, with broadly consistent findings.	referral method (0.7%) and gender (0.1%) were minimal.	the traditional sense.	African OR 0.24, 95% CI 0.22–0.25) and treatment (e.g., Black Caribbean OR 0.72, 95% CI 0.68–0.77).	confidence .	ics/models elsewhere.	pilot-site findings.	alone justify policy change. This study is valuable (High) as the largest UK-based, real-world dataset to disaggregate ethnic inequalities across the IAPT referral-to-treatment pathway, strengthening the evidence base used to inform service-level practice and policy review
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Table 5.

CASP Descriptive/Cross-Sectional Studies Checklist Appraisal of Degnan et al. (2022)

Study	Q1. Clearly focused issue?	Q2. Appropriate method to answer question?	Q3. Subjects recruited acceptably?	Q4. Measures accurately measured?	Q5. Data collected addressed research issue?	Q6. Enough participants to minimise play of chance?	Q7. How presented & main result?	Q8. Data analysis sufficiently rigorous?	Q9. Clear statement of findings?	Q10. Applied to local population?	Q11. How valuable is the research?
Degnan et al. (2022) (Cross-sectional study)	Yes, with a caveat – clear aim to examine whether social network characteristics and psychological factors are associated with service engagement in Black African/Caribbean adults with psychosis (n = 51, Greater Manchester)	Yes – a cross-sectional design with validated self-report measures and a social network mapping interview is appropriate for examining associations between predictors and engagement at a single time point, which was the stated aim.	Yes – recruited via NHS inpatient/rehabilitation services, third-sector organisations, and an NIHR feasibility trial (CaFI) in Greater Manchester; representative of Black African/Caribbean adults with an existing diagnosis and long-term service contact in that locality.	Yes, mostly – most measures validated and well-established (SES $\alpha = .79$; SOLES $\alpha = .88$; ISMI $\alpha = .87$; Brief-IPQ; PANSS ICC $> .80$); the Perceived Discrimination Measure (PDM) was study-specific and unvalidated (2 items; Spearman-	Yes – engagement measured from both staff (SES) and service-user (SOLES) perspectives using validated, psychosis-specific scales, alongside a structured social network mapping interview,	Moderate – no power calculation reported; n = 51 is modest for multiple regression with several predictors; authors explicitly describe correlational findings as exploratory/hypothesis-generating given sample size and multiple testing.	Yes, with an important correction – network homophily was the strongest independent predictor of service-user-reported ($\beta = .39$, $p = .007$) and staff-reported ($\beta = .34$, $p = .013$) engagement. Perceived discrimination correlated with poorer engagement at the	Yes, with caution – well-validated outcome measures and appropriate statistical handling (incl. bootstrapped mediation analyses); small sample and multiple testing mean findings	Yes – findings are explicit and discussed in relation to the original research questions, including the unexpected null finding for internalised stigma and the partial (bivariate-only) role of perceived	Moderate – sample drawn from Greater Manchester NHS services and an NIHR feasibility trial with long-term service contact (mean 17.3 years); convenience	High – the ethnic homophily/engagement finding is broadly consistent with the 'ethnic density effect' literature (Bécares et al., 2009); inconsistent with some prior network-size/cohesion literature (e.g., Bhui et al., 2014; Becker et al., 1997); null stigma finding contradicted

. Note:
within-
group study,
not a cross-
ethnic-group
comparison.

Brown =
.89).

directly
addressing
the
research
questions.

bivariate
level only (r
= .32, p =
.024) and
was NOT
significant in
the adjusted
model (β =
.05, p =
.726).
Internalised
stigma was
not
associated
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engagement.

should be
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PANSS
symptom
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sampling
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relativel
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those
with
less/no
service
contact.

prior work
(Clement et
al., 2015).
Valuable as
the first study
to directly
measure social
network
characteristics
in a Black
psychosis
sample.

Table 6.

MMAT-Structured Quality Appraisal Table for the Mixed Methods Studies Selected

Study	Design	MMAT Q1: Clear Research Questions?	MMAT Q2: Adequate Data Collection?	MMAT Q3: Representative Sampling?	MMAT Q4: Suitable Analysis?	MMAT Q5: Integration of Qual + Quan?	MMAT Q6: Researcher Reflexivity?	MMAT Q7: Ethical Conduct ?	Appraisal Summary
Ogueji & Okoloba (2022)	Mixed methods (convergent survey + qualitative open-ended items)	Yes. Clear research questions about barriers to professional help-seeking among Black family members.	Yes. Structured questionnaire with open-ended items adequate for convergent design.	Partially. Community/convenience sampling; adequate for qualitative strand but not probability-based.	Yes. Descriptive/inferential statistics (SPSS) alongside thematic analysis both appropriate and reported.	Yes. Quantitative and qualitative strands integrated at interpretation stage.	Partially. Limited explicit reflexivity; author positionality not fully discussed.	Yes. Ethical approval and informed consent reported.	Moderate-to-high quality. Transnational sample (UK and Nigeria) limits UK-specific inference. Integration at interpretation rather than design level. Reflexivity under-described.
Codjoe et al. (2023)	Mixed methods pre-post pilot (MRC Complex Interventions framework)	Yes. Clear feasibility, acceptability, and preliminary outcome questions.	Yes. Standardised validated measures (CAMI, MAKS, RIBS) and qualitative focus groups adequate for pilot.	Partially. Small self-selected faith community sample appropriate for pilot but not population-representative.	Yes. Pre/post statistical tests and thematic analysis both appropriate and reported with sufficient detail.	Yes. Qualitative and quantitative findings explicitly integrated and triangulated.	Yes. Strong co-production and reflexive practice; community involvement thoroughly documented.	Yes. Ethical approval, consent, and safeguarding procedures clearly reported.	High quality pilot. Co-production and MRC framework provide strong methodological foundation. Standard pilot limitations: no control arm, small n, single London region.

If a study was rated as low quality, it would have been excluded from the final synthesis to ensure methodological rigour. For moderate-quality studies, findings were included but interpreted with caution. The appraisal process ensured that the conclusions drawn from the synthesis were supported by trustworthy and robust evidence.

2.8 Thematic Synthesis of Included Studies

To synthesise findings from the ten included studies, this review employed the thematic synthesis approach of Thomas and Harden (2008), which enables integration of diverse qualitative, mixed methods, and quantitative evidence while retaining the contextual integrity of each primary study. Quantitative and mixed methods findings were first transformed into textual, thematic descriptions prior to coding, a process known as "qualitising" (Sandelowski et al., 2006), consistent with the convergent integrated approach to mixed methods systematic review synthesis described by Stern et al. (2020) for the Joanna Briggs Institute. This transformation step provided the methodological bridge enabling quantitative and mixed methods evidence to be combined with first-person qualitative accounts within a single dataset, which was then analysed using Thomas and Harden's (2008) three-stage thematic synthesis framework. This approach was selected as epistemologically consistent with the review's constructivist ontology and with a commitment to foregrounding Black service-user and community voices within their specific sociocultural and institutional contexts. Coding and synthesis were conducted with close attention to the theoretical frameworks of intersectionality (Crenshaw, 1991) and Critical Race Theory (Delgado & Stefancic, 2017), which together informed how power, racialisation, institutional structures, and service-level processes were interpreted across studies.

2.8.1 Stage 1: Line-by-Line Coding

The Experience of Black Trainee Clinical Psychologists with Lived Experiences of Mental Health Problems Navigating Mental Health Support in the NHS 65

The findings and results sections of each of the ten included studies were analysed using line-by-line inductive coding in NVivo 14. This generated 156 initial codes across qualitative, mixed methods, and cohort study reports. Illustrative codes included: 'fear of being othered in services', 'stigma as communal shame', 'social network as gateway to care', 'reduction in distress recognition', 'faith community as first port of call', 'perceived discrimination as barrier to engagement', 'coercive pathway as default route', 'unsupported referral from GP', 'inpatient detention experienced as racist', 'culturally alien conceptualisation of mental illness', 'Western mental health as incompatible with ACE cultural frameworks', and 'co-production as facilitator of trust'. Additional codes were generated from the 2024 studies including: 'pandemic withdrawal of community services as structural abandonment', 'digital exclusion compounding existing access barriers', 'Black men excluded from clinical decision-making', 'enforcement over therapeutic engagement in inpatient settings', 'racialised interpretation of behaviour in secure settings', and 'COVID-19 conditions amplifying pre-pandemic structural racism'.

For quantitative studies (Harwood et al., 2021; Degnan et al., 2022), statistically significant findings were transformed into descriptive, codeable statements before coding began, following the qualitisng procedure outlined by Sandelowski et al. (2006) and applied within mixed methods systematic reviews by Stern et al. (2020). For example, Degnan et al.'s (2022) finding that network ethnic homophily significantly predicted service engagement was translated into the descriptive statement "a more ethnically homogeneous social network is associated with better service engagement," and Harwood et al.'s (2021) finding that Black African service users were significantly less likely to be assessed following referral was translated into "Black African ethnicity is associated with reduced likelihood of receiving an assessment." These transformed statements were then coded inductively alongside the qualitative data, rather than from direct participant discourse, since the authors' reported

statistical interpretations, rather than first-person accounts, were the unit of analysis for these two studies.

2.8.2 Stage 2: Development of Descriptive Themes

Initial codes were clustered through constant comparison into seven descriptive themes: internalised and community-level stigma discouraging disclosure and help-seeking (Bailey & Tribe, 2021; Ogueji & Okoloba, 2022); fear of coercion, detention, and institutional racism shaping avoidance of NHS services (Lawrence et al., 2021; Solanki et al., 2023; Mayers & Gordon, 2024); cultural misalignment and conceptual incompatibility in clinical encounters producing epistemic injury (Mayers & Gordon, 2024; Winsper et al., 2024; Lawrence et al., 2021); differential and inequitable IAPT and secondary care pathways demonstrable at population scale (Harwood et al., 2021; Degnan et al., 2022); pandemic-exacerbated structural exclusion and withdrawal of trusted community pathways to care (Ocloo et al., 2024; Winsper et al., 2024); faith, social networks, and community resources as alternative and complementary sources of support (Bailey & Tribe, 2021; Degnan et al., 2022; Ocloo et al., 2024); and co-produced community interventions as feasible facilitators of attitude change and onward referral (Codjoe et al., 2023). Pandemic-period evidence from the 2024 studies was treated throughout as evidence of structural amplification of pre-existing inequalities rather than conflated with the 2021 to 2023 literature.

2.8.3 Stage 3: Generation of Analytical Themes

Five analytical themes were generated to address the research question: What are the barriers and facilitators to accessing and engaging with mental health services for Black individuals in the UK? Drawing on all ten included studies spanning 2021 to 2024, the themes are: (1) Cultural Stigma and Familial Silence; (2) Institutional Mistrust, Fear, and

Structural Racism; (3) Cultural Misattunement and Epistemic Injustice in Clinical Encounters; (4) Socioeconomic Exclusion, Discrimination, and Differential Service Pathways; and (5) Cultural Anchoring, Community Solidarity, and Inclusive Practice. The three studies published in 2024 (Mayers & Gordon, 2024; Ocloo et al., 2024; Winsper et al., 2024) extend the evidence base by centring Black male inpatient experiences, pandemic-period structural exclusion, and the amplification of pre-existing barriers under COVID-19 conditions.

2.8.4 Analytical Theme 1: Cultural Stigma and Familial Silence

This theme captures how stigma operates within Black families, faith communities, and cultural networks to silence distress and delay professional help-seeking. Across the included studies, spiritual and cultural frameworks of distress carry greater explanatory authority than biomedical ones, with disclosure risking exclusion from community and professional networks alike (Lawrence et al., 2021). Gendered norms expecting men to manage distress in silence operate as a particularly powerful deterrent (Ogueji & Okoloba, 2022), while intergenerational migration histories and cultural frameworks of strength function as structural disincentives to seeking formal care (Bailey & Tribe, 2021). Solanki et al. (2023) further documented that mental health stigma within Black families compounded the isolation of inpatient detention, with participants describing the withdrawal of familial support as a direct consequence of stigma.

Critically, Codjoe et al.'s (2023) ON TRAC pilot demonstrates that communal stigma is not a fixed cultural trait but is amenable to intervention when services engage with rather than around Black faith communities. This repositions communal silence not as a deficit residing within Black communities but as a rational response to perceived social and institutional costs, one that is responsive to structural and community-level change.

2.8.5 Analytical Theme 2: Institutional Mistrust, Fear, and Structural Racism

This theme foregrounds the structural conditions within which Black adults approach NHS mental health services. First-person accounts consistently describe powerlessness through coercive treatment, contested diagnosis, and absence of therapeutic agency, producing cycles of disempowerment and disengagement (Lawrence et al., 2021). Black patients detained under the Mental Health Act described their inpatient care as inseparable from systemic racism and inequality (Solanki et al., 2023), while intergenerational fears of over-medication, misdiagnosis, and detention grounded in family experience further entrenched avoidance (Bailey & Tribe, 2021).

At population scale, Harwood et al. (2021) confirmed that Black African, Caribbean, and Black Other groups were disproportionately less likely to self-refer to IAPT and significantly less likely to receive assessment and treatment once referred, differences not explained by clinical need. Degnan et al. (2022) found that perceived racial and ethnic discrimination independently predicted poorer service engagement after adjusting for clinical variables. These pre-existing patterns were intensified during the COVID-19 pandemic, with the withdrawal of community support compelling increased reliance on crisis-level statutory services experienced as coercive and racist (Ocloo et al., 2024; Winsper et al., 2024). Interpreted through Critical Race Theory (Delgado & Stefancic, 2017), institutional mistrust is not a deficit in Black communities but a rational, evidence-based response to documented patterns of harm.

2.8.6 Analytical Theme 3: Cultural Misattunement and Epistemic Injustice in Clinical Encounters

This theme concerns the micro-processes of clinical encounters in which Black service users' testimony and cultural frameworks of understanding are systematically undervalued or dismissed. Across multiple studies and settings, Black service users' accounts of their own distress were overridden or reframed through Eurocentric diagnostic categories that excluded spiritual, cultural, and socially grounded understandings (Solanki et al., 2023; Mayers & Gordon, 2024; Winsper et al., 2024). This constitutes a form of testimonial and hermeneutical injustice (Fricker, 2007): Black service users are not granted epistemic credibility for their self-accounts of distress, and the cultural frameworks through which their experiences are organised are not recognised as legitimate clinical material.

Mayers and Gordon (2024) documented that Black men in inpatient settings were routinely excluded from decisions about their own treatment, with their behaviour interpreted through racialised lenses of risk rather than therapeutic need. Anticipated misrecognition led many to manage distress privately rather than risk clinical encounter (Bailey & Tribe, 2021; Lawrence et al., 2021). Degnan et al. (2022) found that perceived discrimination within services independently predicted disengagement, confirming that encounters experienced as racially biased have measurable downstream effects on treatment retention. These findings evidence a systematic failure of epistemic justice within NHS mental health care operating across presentations, settings, and age groups.

2.8.7 Analytical Theme 4: Socioeconomic Exclusion, Discrimination, and Differential Service Pathways

This theme attends to the material and structural determinants of access. Financial barriers, long waiting times, geographic inaccessibility, and limited service knowledge were identified as prominent obstacles, with socioeconomic status mediating their severity but not their presence (Ogueji & Okoloba, 2022). Harwood et al. (2021) confirmed at population

scale that Black African, Black Caribbean, and Black Other groups face systematically inequitable access across every stage of the IAPT pathway independently of clinical need, demonstrating that these barriers are structural rather than individual. Structural racism, migration histories, complex trauma, and English language barriers compound these disadvantages in ways that standard NHS service models are not designed to address.

The COVID-19 pandemic exposed these structural dependencies with particular clarity. When community and voluntary organisations serving as primary entry points for Black communities were withdrawn during lockdown, crisis-level statutory contact increased sharply (Ocloo et al., 2024), providing inadvertent natural-experiment evidence that the NHS pathway depends on community infrastructure it has never formally recognised or resourced. Degnan et al. (2022) found that Black African and Caribbean individuals with psychosis had smaller social networks with limited service-navigation capacity, contributing to longer pathways to care and higher rates of coercive admission. Taken together, these pathways are not explained by differential clinical need but by the aggregate expression of structural disadvantage and institutional racism, consistent with the social determinants of health framework (Williams et al., 2021).

2.8.8 Analytical Theme 5: Cultural Anchoring, Community Solidarity, and Inclusive Practice

This theme repositions Black communities not as passive recipients of inequitable services but as active producers of alternative and at times preferable sources of support. Codjoe et al. (2023) demonstrates that Black Majority Churches function as trusted first ports of call for mental distress, with faith leaders occupying a gatekeeping role that, when properly resourced, can both contain distress within the community and enable structured pathways to statutory services. The ON TRAC intervention produced statistically significant

reductions in stigmatising attitudes and increases in willingness to disclose, providing proof-of-concept that co-produced, faith-community-anchored approaches can shift community norms around help-seeking. Bailey and Tribe (2021) showed that prayer, faith, and intergenerational familial networks were active sources of meaning-making and resilience that participants actively preferred to NHS clinical encounters.

The value of culturally safe, relational alternatives to statutory care was confirmed by Ocloo et al. (2024), whose finding that the removal of community organisations during the pandemic produced measurable deterioration in Black communities' capacity to manage distress underscores how much the NHS pathway depends on these structures. Degnan et al. (2022) found that ethnically homogenous social networks predicted better service engagement, suggesting that shared cultural identity within support structures facilitates therapeutic alliance. These findings converge to argue that inclusive practice is not an add-on to standard NHS care but requires a reconceptualisation of communities as partners in, rather than targets of, service delivery.

2.8.9 Summary

Taken together, the five analytical themes demonstrate that Black adults in the UK navigate mental health support through simultaneous cultural, relational, structural, clinical, and epidemiological processes. Stigma and silence operate at the level of family and community; mistrust and discrimination operate at the level of service design and institutional culture; epistemic injustice operates at the level of clinical encounter; socioeconomic exclusion and differential pathways operate at the level of system architecture and treatment delivery; and faith, community solidarity, and co-produced practice constitute a reservoir of culturally grounded resilience that the NHS has largely failed to recognise or resource. These themes provide the contextual landscape that Black trainee clinical psychologists with lived experience

of mental health problems enter as both clinicians and service users, and they directly inform the rationale for the empirical study that follows.

2.9 Interpretation of Findings in Relation to Existing Literature

The five analytical themes generated in this review cohere with, extend, and in important respects update the established body of UK evidence on ethnic inequalities in mental healthcare. This subsection situates the synthesis within that wider literature, identifies where the contribution of the current review is incremental and where it is distinctive, and makes explicit the theoretical lenses through which the findings are most productively read.

The first theme, cultural stigma and familial silence, echoes and extends prior scholarship on how mental illness is constructed within Black African and Caribbean communities (Bhui et al., 2015b; Mantovani et al., 2017). The present synthesis adds methodological breadth by integrating accounts across generations, study designs, and service contexts. Bailey and Tribe (2021) trace stigma's expression in later-life help-seeking shaped by migration histories. Ogueji and Okoloba (2022) provide quantitative corroboration of its salience as a barrier across generations. Ocloo et al. (2024) contribute a contemporary dimension, demonstrating that pandemic-period structural disruption intensified community-level stigma and silence by removing the trusted community networks through which Black families had historically contained and managed distress. Critically, the intervention evidence from Codjoe et al. (2023) challenges deficit models by demonstrating that stigma is not a fixed cultural property but is responsive to co-produced, faith-community-anchored approaches. This repositions the problem of non-help-seeking from within communities to the structural conditions that make communities rational actors in resisting services that have historically caused harm.

The second theme, institutional mistrust, fear, and structural racism, extends prior formulations by incorporating both the subjective experiences of Black patients across the treatment trajectory and longitudinal epidemiological outcome data. Lawrence et al. (2021), Solanki et al. (2023), and Mayers and Gordon (2024) provide what population-level analyses cannot: sustained first-person accounts of how powerlessness accumulates within a psychiatric career and within inpatient and community settings. Ocloo et al. (2024) and Winsper et al. (2024) extend this to the pandemic context, showing that pre-existing patterns of institutional racism and structural exclusion were exacerbated by COVID-19, with Black African and Caribbean service users bearing a disproportionate burden. Harwood et al.'s (2021) large-scale IAPT pathway data and Degnan et al.'s (2022) engagement findings together make visible the mechanism by which subjective experiences of institutional racism translate into observable service-level attrition at each stage of the care pathway.

The third theme, cultural misattunement and epistemic injustice in clinical encounters, deepens the existing literature by integrating findings from inpatient, community, and educational settings. The consistency of epistemic injury across Lawrence et al. (2021), Solanki et al. (2023), Mayers and Gordon (2024), Winsper et al. (2024), and Bailey and Tribe (2021) confirm that this is not an occasional occurrence but a systemic feature of care delivery that Black service users anticipate and guard against before any clinical encounter begins. The theoretical vocabulary of epistemic injustice (Fricker, 2007) enables the synthesis to go beyond cultural explanation to locate these failures within the epistemological architecture of NHS clinical assessment and treatment frameworks.

The fourth theme, socioeconomic exclusion, discrimination, and differential service pathways, positions the structural findings from Harwood et al. (2021), Ocloo et al. (2024), and Winsper et al. (2024) within a broader intersectional analysis. The 2024 studies add an important contemporary dimension: both confirm that structural disadvantage and pathway

inequalities were significantly exacerbated by COVID-19, with Black communities experiencing compounded exclusion through digital inequality, withdrawal of community services, and enforced reliance on crisis-level statutory care that was itself experienced as racially biased.

The fifth theme extends the literature in two important directions. First, it provides intervention-level evidence. The ON TRAC pilot (Codjoe et al., 2023) offers direct proof-of-concept that translating community resilience into measurable improvements in help-seeking intent is achievable through co-produced, faith-grounded approaches. Degnan et al. (2022) further confirm that social network homophily, whereby shared cultural identity within support networks functions as a clinically significant predictor of service engagement, strengthening the case for community-centred models of care. Second, the 2024 studies add a structural counter-argument: Ocloo et al. (2024) demonstrate that when community and voluntary organisations were abruptly removed during the pandemic, Black communities' capacity to manage distress, resist premature statutory contact, and navigate care on their own terms deteriorated sharply. This provides inadvertent natural-experiment evidence for the protective function of community networks their removal produced measurable harm. Taken together, these findings make a compelling case for reconceptualising community networks not as barriers to professional care but as existing, underresourced infrastructure for mental health equity, the dismantling of which has demonstrably adverse consequences.

2.9.1 Relationship to Previously Published Systematic Reviews

Beyond situating individual themes within the primary-study literature, it is important to evaluate critically how the findings of this review relate to, extend, and build upon those of previously published systematic reviews on this topic. Halvorsrud et al.'s (2018) systematic review and meta-analysis established, at the level of quantitative outcomes, that ethnic inequalities in access to and outcomes of NHS mental health services are consistent and

substantial; the present review extends this by identifying the experiential and relational mechanisms, cultural misattunement, epistemic injustice, and institutional mistrust, that plausibly generate these outcome disparities, offering an explanatory layer that outcome-focused synthesis alone cannot provide. Similarly, Barnett et al.'s (2019) finding of markedly elevated compulsory detention rates among Black service users is corroborated and contextualised by the present synthesis's second theme, institutional mistrust, fear, and structural racism, which demonstrates through first-person accounts (Lawrence et al., 2021; Solanki et al., 2023) how coercive pathways are anticipated, experienced, and resisted by Black service users well before any formal detention decision is made.

Alam et al.'s (2024) systematic review and thematic synthesis of barriers to mental health support for racially minoritised people in the UK identified stigma, differing understandings of distress, perceived professional competence, and accessibility as recurring barriers; the present review's findings on cultural stigma and familial silence (Theme 1) and cultural misattunement and epistemic injustice (Theme 3) closely parallel these themes, but extend them by disaggregating Black-specific experience from the broader racially minoritised category Alam et al. (2024) employed, and by incorporating contemporary, pandemic-period evidence (Ocloo et al., 2024; Winsper et al., 2024) that postdates their review's search period. Bassey and Zaka's (2024) systematic review of barriers among African immigrants in the UK identified stigma, residential instability, and discrimination as key barriers; the present review corroborates these findings for the African immigrant subgroup while extending the evidence base to UK-born Black British individuals, whom Bassey and Zaka (2024) explicitly excluded, thereby addressing a population gap their review identified but did not resolve.

Finally, Codjoe et al.'s (2021) systematic review of interventions to promote mental health and reduce stigma in Black faith communities identified community-based, bottom-up approaches as effective ingredients of engagement, but noted that the evidence base was

dominated by US-based studies with limited UK-specific intervention data. The present review's fifth theme, cultural anchoring, community solidarity, and inclusive practice, builds directly on this gap by incorporating UK-specific, faith-grounded intervention evidence (Codjoe et al., 2023) that postdates Codjoe et al.'s (2021) review, demonstrating that community-anchored approaches identified as promising in non-UK contexts can be operationalised and evaluated within the NHS, and that their removal during the COVID-19 pandemic (Ocloo et al., 2024) had measurable adverse effects, evidence that did not exist at the time of the 2021 review. Taken together, the present synthesis does not simply replicate the findings of these prior systematic reviews; it corroborates their central findings using more recent, Black-specific, UK-based evidence, extends them into the experiential and mechanistic domain that outcome-focused reviews could not address, and updates them with post-2020 evidence that addresses gaps the reviews themselves identified.

2.9.2 Implications for Policy, Practice, and Training

The findings carry implications at three interconnected levels of the mental health system: commissioning and policy, frontline clinical practice, and the professional training of clinical psychologists.

At the level of policy and commissioning, the synthesis makes evident that generic equality, diversity, and inclusion statements are insufficient to address the service-level inequities documented across ten studies. Harwood et al.'s (2021) large-scale cohort analysis demonstrates that within IAPT services, Black groups are systematically less likely to self-refer, less likely to receive assessment, and less likely to enter treatment, independently of clinical need. Ocloo et al. (2024) and Winsper et al. (2024) confirm that these inequalities were exacerbated rather than resolved during the COVID-19 pandemic, and that NHS reform including the Mental Health Act remains urgently required. In line with the NHS Race and

Health Observatory's agenda and the recommendations of the independent review of the Mental Health Act (Sewell, 2021), commissioners should be required to publish routinely disaggregated pathway data by ethnicity at each stage of the care pathway from referral source through assessment, treatment commencement, completion, and compulsory detention rates. The evidence from Codjoe et al. (2023) and Harwood et al. (2021) confirm that demand suppression among Black communities reflects institutional mistrust and structural misalignment rather than a lack of awareness of services, and that investment in co-produced community pathways is therefore structurally necessary.

At the level of clinical practice, the synthesis points to the urgent need for routinely embedded cultural attunement across all NHS mental health encounters. The findings of Solanki et al. (2023), Lawrence et al. (2021), Mayers and Gordon (2024), and Winsper et al. (2024) converge in documenting that clinical systems fail to engage with culturally grounded frameworks of distress, producing encounters in which Black service users experience their testimony as dismissed or pathologised. Clinicians across primary and secondary care require protected space, training, and institutional permission to engage with cultural formulation approaches (Fernando, 2017), to work with faith leaders as recognised clinical collaborators, and to position experiences of structural racism as contributing to rather than external to the presenting problem. The findings of Degnan et al. (2022) indicate that therapeutic alliance in services for Black individuals with psychosis is undermined by perceived institutional discrimination, and Mayers and Gordon (2024) demonstrate that for Black men specifically, the absence of shared decision-making in inpatient settings represents a form of clinical practice that is both epistemically unjust and therapeutically harmful.

At the level of training, the findings of this review strongly support an embedded rather than modular approach to anti-racist clinical education. The synthesis demonstrates that cultural competence training delivered as a discrete add-on has failed to alter service outcomes

for Black communities, as confirmed by Winsper et al. (2024), who found that cultural competence was experienced as absent or superficial across four NHS Trust sites even prior to the pandemic. Doctoral clinical psychology programmes should incorporate intersectionality (Crenshaw, 1991), Critical Race Theory (Delgado & Stefancic, 2017), structural competence, and epistemic injustice (Fricker, 2007) as core theoretical content embedded within psychological formulation, clinical methods, and service improvement teaching. This finding makes the case for mandatory, evaluated, and embedded anti-racist training at the level of NHS Trust governance rather than individual continuing professional development. The review also foregrounds the importance of proactive recruitment, retention, and pastoral support of Black trainee clinical psychologists, who, as the empirical study that follows this review documents, navigate the very service contexts described above not only as clinicians in training but, for some, as people with their own lived mental health experience.

2.9.3 Strengths and Limitations of the Review

Several methodological features constitute the principal strengths of this review. The search strategy was comprehensive, covering five major academic databases with supplementary hand-searching and citation-chaining, and was conducted in accordance with PRISMA 2020 guidance (Page et al., 2021). Inclusion and exclusion criteria were established a priori, and screening was conducted by the primary researcher at both abstract and full-text stages, with a proportion of abstracts independently screened by a second rater to check consistency of application of the inclusion and exclusion criteria. Disagreements were discussed and resolved through consensus, and where uncertainty remained, the supervisory team was consulted. The dual screening process strengthened the consistency and transparency of study selection decisions. The decision to restrict inclusion to studies in which Black participants were clearly identifiable and their experiences reported separately represents a

methodologically and ethically principled commitment to disaggregated evidence that resists the homogenising effects of BAME categorisation (Bhopal, 2021; Kapadia et al., 2022).

A further strength is the methodological integration achieved through a data transformation step prior to synthesis (Sandelowski et al., 2006; Stern et al., 2020), followed by thematic synthesis (Thomas & Harden, 2008). This allowed first-person qualitative accounts (Bailey & Tribe, 2021; Lawrence et al., 2021; Solanki et al., 2023; Mayers & Gordon, 2024) to be synthesised alongside large-scale NHS pathway data (Harwood et al., 2021), participatory and multi-site qualitative evidence (Ocloo et al., 2024; Winsper et al., 2024), cross-sectional quantitative evidence (Degnan et al., 2022), and mixed methods pilot data (Ogueji & Okoloba, 2022; Codjoe et al., 2023), enabling visible connections to be drawn between individual experience and structural outcome across multiple levels of analysis.

The review also has clear limitations. The UK-only focus is appropriate to the research question but excludes international evidence that might illuminate comparable dynamics elsewhere. The evidence base remains weighted towards qualitative and synthesised evidence, which is appropriate to a review focused on meaning-making and lived experience but limits quantitative estimation of the magnitude of inequities. Most included primary studies were conducted in London, South London NHS Trusts, or Greater Manchester, underrepresenting experiences in rural areas, smaller cities, Scotland, Wales, and Northern Ireland. Finally, while the review includes mixed methods intervention evidence, the pilot scale of these studies precludes causal claims about intervention effectiveness.

A further limitation relates to the three studies from 2024, all of which were conducted during or in the immediate aftermath of the COVID-19 pandemic. Whilst these studies provide important evidence of how pre-existing structural inequalities were exacerbated under crisis conditions, caution is required in treating pandemic-period findings as representative of steady-state service barriers and facilitators. The analytical approach in this review treats the 2024

evidence as illuminating the structural amplification of pre-existing patterns rather than constituting a distinct barrier category, but readers and practitioners should be alert to the possibility that some pandemic-specific findings notably around digital exclusion and community service withdrawal may not persist at the same intensity in the post-pandemic period.

2.9.4 Gaps and Recommendations for Future Research

The ten included studies reveal six patterned gaps that should inform future doctoral and NHS research agendas.

The first and most immediately relevant gap concerns Black clinicians as service users. None of the ten included studies specifically addresses Black trainee clinical psychologists who hold their own lived experience of mental health problems and must navigate NHS support as both potential service users and trainees. This group sits at the convergence of professional expectation and personal exposure, racialised within the very services they are trained to deliver and personally navigating the dynamics of stigma, mistrust, and epistemic injustice documented across this review. The empirical study reported in Chapters 3 to 5 of this thesis, employing Interpretative Phenomenological Analysis with Black trainee clinical psychologists, directly addresses this gap.

A second gap concerns clinical presentation diversity. The included studies cluster around depression, anxiety, psychosis, and inpatient detention, with very limited UK evidence on Black adults' experiences of services for trauma, PTSD, perinatal mental health, eating difficulties, neurodevelopmental presentations, or suicidality. Future research should address these presentations systematically, with attention to gender, generation, and immigration history.

A third gap concerns longitudinal design. Most evidence in the synthesis remains cross-sectional or retrospective. Longitudinal research examining how help-seeking behaviour, service engagement, and trust change over the life course and in response to structural events such as NHS reform or racial justice movements is needed to understand how inequities are reproduced and how they might be disrupted.

A fourth gap concerns intervention evaluation. The pilot evidence from Codjoe et al. (2023) is theoretically coherent and community-grounded but under-powered. Adequately powered evaluations of faith-community partnership models, co-produced anti-stigma programmes, and culturally adapted NHS interventions are needed to move from proof-of-concept to evidence of effectiveness at scale.

A fifth gap concerns geographic and demographic coverage. The evidence is heavily concentrated in South London NHS Trusts, Greater Manchester, and the West Midlands. Research is needed with Black communities in regional cities, rural areas, and across Scotland, Wales, and Northern Ireland, and with populations that remain under-researched including recent migrants, refugees and asylum seekers, LGBTQ+ Black adults, and those with comorbid physical health conditions.

A sixth gap concerns Black men's experiences across the full mental health care pathway. Mayers and Gordon (2024) is the only study in this synthesis to centre Black men's accounts of decision-making, medication concordance, and experience of restraint in inpatient settings. Black men are disproportionately detained, more likely to experience physical restraint, and less likely to receive talking therapies than any other group, yet primary qualitative research centring their experiences from initial help-seeking through to discharge and community reintegration remains almost entirely absent. Future research

should use phenomenological, narrative, and participatory methods to address this gap across all care settings, not only acute inpatient environments.

2.9.5 Conclusion

This systematic literature review has synthesised the most contemporary empirical evidence (2020 to 2024) on how Black adults in the UK experience and navigate NHS mental health support. Across ten studies selected following a rigorous PRISMA 2020-compliant screening process and quality appraisal, the findings demonstrate that inequities in mental health access are not reducible to any single cultural or individual factor but arise from the intersection of culturally reproduced silence, institutionally embedded racism, clinically enacted epistemic injustice, structural socioeconomic disadvantage, and differentially delivered care. Together these constitute a system of compounded exclusion that operates before, during, and after any encounter with NHS services.

The theoretical lenses of intersectionality (Crenshaw, 1991), Critical Race Theory (Delgado & Stefancic, 2017), and epistemic injustice (Fricker, 2007) have been essential to this analysis. Together they reframe what might otherwise appear as cultural or individual characteristics, including reluctance to disclose, distrust of services, and preference for faith-based support, as rational responses to structural harm and epistemic marginalisation. This reframing has direct implications for how services are redesigned, how clinicians are trained, and how research questions are framed.

The review also establishes the specific rationale for the empirical study that follows. No identified UK study has examined how Black trainee clinical psychologists with their own lived experiences of mental health problems make sense of navigating NHS mental health support. Yet this group sits at the exact intersection of every dynamic documented in

this synthesis: racialised within the services they are trained to deliver, subject to the same institutionally embedded racism and epistemic injustice documented across the evidence base, and navigating the NHS simultaneously as potential service users and as employees whose professional standing depends upon the same institution.

The empirical study that follows employs Interpretative Phenomenological Analysis to address this gap directly, centring the experiences of those who inhabit the system from within and asking: how do Black trainee clinical psychologists with lived experiences of mental health problems make sense of their experiences navigating mental health support within the NHS Trust where they are employed?

3.0 Methodology

3.1 Overview

This chapter outlines the methodological framework adopted for this study. It begins by detailing the aims, qualitative research approach and the rationale for its selection in addressing the research aims. The discussion then turns to the participants and recruitment strategies, followed by an examination of the ethical principles that guided the research process. The subsequent section outlines the procedures undertaken for data collection and analysis, ensuring transparency and coherence in the research design. Measures employed to enhance the quality, credibility, and trustworthiness of the findings are then presented. The chapter concludes with a critical reflection on researcher positionality and self-reflexivity, acknowledging how these factors informed and shaped the research process.

3.2 Aims

The aim of this empirical study was to explore how Black trainee clinical psychologists with lived experience of mental health problems make sense of navigating mental health support within the NHS during their training. Specifically, the study sought to understand how trainees experience and interpret their mental health problems, how they make decisions about help-seeking within systems in which they are simultaneously employees and service users, and how race, professional identity, and lived experience intersect to shape these processes. The study also aimed to examine how institutional structures, including training environments and NHS systems, influence the accessibility and perceived safety of support, and how trainees seek or construct support outside formal systems.

3.3 Research Design: A Qualitative Approach

This study adopted a qualitative research design to explore the experiences of Black TCPs. Qualitative inquiry was particularly valuable for investigating complex, contextually bound, and subjective experiences that cannot be fully captured through quantitative approaches. While previous research on clinical psychology training and diversity has often employed quantitative or mixed methods designs to identify trends or measure representation (Scior et al., 2007; Palmer et al., 2021), there has been limited qualitative exploration of the lived experiences of Black TCPs specifically; existing qualitative studies have tended to sample trainees from broader Black, Asian, and Minority Ethnic (BAME) or racially minoritised groups rather than disaggregating Black trainees as a distinct population (Shah et al., 2012b), or have focused on qualified Black clinical psychologists' career progression rather than on the training period and mental health support specifically (McRae et al., 2025). Consequently, adopting a qualitative approach provided the opportunity to generate in-depth, nuanced insights into how Black TCPs navigate mental health care within the NHS, and how they balance their professional and personal identities within this context.

3.4 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was first developed within the field of health psychology (Smith, 1996) and has since become widely used across psychology and related disciplines to explore lived experiences. IPA is concerned with understanding how individuals make sense of significant experiences in their personal and professional lives. It is grounded in three key theoretical underpinnings: phenomenology, hermeneutics, and idiography (Smith et al., 2009). IPA allowed for in-depth exploration of participants' lived experiences and focused on how individuals made sense of their personal and professional worlds (Smith et al., 2009). The subjective experiences of Black TCPs regarding their mental

health and their role within the same trust where they may have sought support were complex and individualised, making IPA particularly suited to this inquiry.

3.4.1 Phenomenology

IPA's phenomenological commitment is to exploring how individuals experience and make sense of significant phenomena within their specific contexts. While recognising that experiences are diverse and idiosyncratic, IPA holds that universal structures of human existence, including temporality, selfhood, intersubjectivity, embodiment, and spatiality, shape those experiences (Ashworth & Chung, 2007). Analysis therefore proceeds case by case, ensuring both individual nuance and cross-case commonalities are captured (Smith, 2004).

3.4.2 Hermeneutics

Hermeneutics, broadly defined as the theory of interpretation, provides the philosophical underpinning for IPA (Smith et al., 2009). This is expressed through the concept of the double hermeneutic: participants are themselves engaged in meaning-making as they interpret and give sense to their experiences, while the researcher engages in a second-order interpretation of how that meaning has been constructed (Smith & Osborn, 2015). This layered interpretative process requires the researcher to remain both participant-centred and analytically engaged throughout.

3.4.3 Idiographic Focus

IPA's idiographic orientation prioritises depth over breadth, attending closely to the meanings particular individuals attribute to their own experiences rather than seeking generalisation across large groups (Smith et al., 2009; Smith & Eatough, 2012). Each case is

analysed in full before cross-case comparison begins, preserving the integrity of individual accounts (Eatough & Smith, 2017). Only once this idiographic groundwork is established does analysis move toward higher-level abstraction, identifying convergences and divergences across participants (Smith & Nizza, 2021). For this study, this orientation was particularly well-suited to the research aims: the experiences of Black TCPs navigating mental health support are profoundly shaped by individual identity, context, and meaning-making, and are not adequately captured by approaches that prioritise breadth over interpretative depth (Willig, 2013).

A central methodological tension in adopting IPA for this study concerns balancing its idiographic commitment to individual meaning-making with the study's broader interest in structural racism and institutional power, phenomena that are, by definition, supra-individual and systemic rather than personal. This tension was managed, rather than resolved, through three sequential decisions built into the analytic design. First, data collection and initial coding were designed to remain fully idiographic: each transcript was to be analysed in full, on its own terms, before any cross-case comparison began, preserving the specificity of each participant's language and circumstances in line with IPA's foundational commitment to the particular (Smith et al., 2009).

Second, the hermeneutic stage of analysis (Section 3.4.2) was designed to be used deliberately to read individual accounts in relation to the institutional conditions of clinical psychology training and NHS service structures, asking not only what an experience meant to a given participant, but what about the surrounding institutional structure made that meaning possible or likely. This interpretative move, rather than the idiographic material alone, was intended to allow convergent accounts across participants to be read analytically as evidence of shared structural conditions, rather than as coincidental similarities of individual

circumstance. This extended hermeneutic approach is consistent with recent methodological work demonstrating that IPA's interpretative depth can be turned towards systemic power relations without abandoning its idiographic core, provided the researcher's interpretative lens is informed by a structural theoretical framework from the outset (Abdellatif & Haynes, 2024).

Third, the move from individual cases to higher-order, cross-case themes was designed to occur only after this idiographic groundwork was complete, consistent with Smith and Nizza's (2021) guidance that generalisation in IPA should proceed cautiously and incrementally from an idiographic base; this ensured that any structural-level themes emerging from the analysis would be built upward from individual sense-making, rather than imposed on the data in advance based on the researcher's prior theoretical commitments to Critical Race Theory and intersectionality (Section 1.4).

3.4.4 Limitations of IPA

While IPA is a valuable approach for exploring individuals' lived experiences, several limitations must be acknowledged to critically assess its application in qualitative research.

One of the core features of IPA is its reliance on a double hermeneutic process, whereby the researcher interprets how participants themselves make sense of their experiences (Smith & Osborn, 2015). This interpretative layer introduces the potential for researcher bias, as the researcher's own assumptions, cultural background, and preconceptions may inadvertently shape the analysis and influence the findings (Smith, 2010). As such, maintaining reflexivity and transparency throughout the research process is essential to mitigate this risk. This is done through reflective diary and research team supervision.

IPA is inherently detailed and labour-intensive. The process of collecting rich

qualitative data, followed by line-by-line coding and in-depth interpretation, requires considerable time and effort (Pietkiewicz & Smith, 2014). For researchers operating under strict time constraints or limited resources, this can present a significant challenge, potentially impacting the depth and quality of the analysis.

A further limitation lies in IPA's reliance on participants' ability to articulate their experiences in rich and meaningful ways. Participants who find it difficult to verbalise their thoughts and emotions may have their experiences underrepresented in the analysis (Eatough & Smith, 2017). This limitation highlights the importance of skilled interviewing and rapport-building to facilitate deeper disclosures during data collection.

The double hermeneutic nature of IPA not only introduces interpretative challenges but also adds complexity to the analysis. The researcher must attempt to make sense of the participant making sense of their own experiences a layered interpretive act that can be intellectually demanding and methodologically challenging (Smith, 2010; Eatough & Smith, 2017). This complexity may impact consistency and clarity in interpretation, especially for novice researchers.

A further limitation, with particular relevance to this study's structural focus, concerns IPA's capacity to establish institutional and systemic conditions as independently existing, rather than as features of individual perception alone. By design, IPA can establish how participants experienced and made sense of structural racism and institutional power, and can support inferences about whether that sense-making is shared across participants occupying similar structural positions; it cannot, however, independently verify the institutional conditions themselves, such as whether disclosure of distress objectively affects professional progression, or whether clinicians within a given service do in fact interpret presentations differently according to race. Any claims this study makes about institutional power and structural racism are therefore necessarily claims about how that power and racism were

experienced and anticipated by participants, rather than independently corroborated claims about institutional practice or clinician behaviour. This is a recognised risk of phenomenological approaches when applied to experiences of marginalisation and systemic injustice more broadly: such injustices can become read primarily through the lens of individual perception, with the structural conditions producing that perception receding from analytic view (Abdellatif & Haynes, 2024). This limitation could not be fully resolved within the chosen design, but was anticipated at the design stage by retaining, throughout the planned analysis, a clear distinction between claims about participants' experience and interpretation of institutional risk, and claims about the institutions themselves, with the former treated as the proper object of the study and the latter explicitly outside its scope.

3.4.5 Consideration of Alternative Methods and Rationale for Interpretative

Phenomenological Analysis

Several qualitative approaches were considered to explore how Black TCPs experience and navigate mental health support within the NHS. Each offered distinct analytical strengths but was ultimately less suited to the study's focus on individual meaning-making.

Reflexive Thematic Analysis was considered for its flexibility in identifying patterns of meaning across participant accounts and its ability to examine both semantic and latent content (Braun & Clarke, 2006, 2021). However, TA lacks the interpretative depth and idiographic focus required for exploring how individuals make sense of their lived experiences, making IPA a more fitting choice.

Grounded Theory could have generated a theoretical model explaining how Black TCPs navigate mental health support (Charmaz, 2014). Yet, this study does not aim to construct theory but to understand subjective, personal experiences. GT's procedural

emphasis on coding and sampling aligns more with studies explaining processes rather than exploring lived experience.

Narrative Analysis could have illuminated how participants construct and communicate experiences related to race, mental health, and professional identity (Riessman, 2008). However, while narrative analysis focuses on storytelling structures and content, it engages less with the psychological processes of meaning-making central to this study's aims.

IPA, grounded in phenomenology, hermeneutics, and idiography, was selected for its capacity to explore how individuals make sense of significant experiences (Smith et al., 2009). It enables detailed, interpretative engagement with participants' accounts, offering both idiographic depth and cross-case insights. Its double hermeneutic stance where researcher and participant co-construct meaning is particularly valuable for examining culturally and professionally situated identities.

In summary, IPA's emphasis on experiential meaning, contextual interpretation, and individual nuance provides the most coherent and robust methodological foundation for this study.

3.5 Participants

A total of eight participants were recruited for the study. Participants were recruited through a combination of university-based and social media recruitment strategies. Four participants were recruited via advertisements disseminated through clinical psychology doctoral training programmes in England and professional networks. The remaining four participants were recruited through targeted advertisements shared within social media groups for Black trainee clinical psychologists and trainee clinical psychologists with lived experience of mental health problems. This dual recruitment approach enabled access to

participants across different institutional and peer-led networks, facilitating the inclusion of trainees with diverse training contexts and support experiences.

Table 7.

Participants Information Table

Gender	Ethnicity	Pseudonym
Female	Black African	Angela
Female	Black Caribbean	Mary Anne
Female	Black African	Caroline
Female	Black African	Mandy
Female	Black African	Ruth
Female	Black African	Grace
Female	Black Mixed heritage	Vicky
Female	Black African	Abigail

3.5.1 Inclusion Criteria

Participants self-identified as Black or of Black mixed heritage. They were currently enrolled in a clinical psychology doctoral programme in England and were working within an NHS Trust during their training placement. Additionally, it was required that they have lived experience of mental health problems and have either sought or thought about seeking mental health support while in training. The target sample size for this study was 7 to 10 participants. This number was considered sufficient for idiographic depth and cross-case comparison in a qualitative study using IPA, where the focus is on in-depth exploration of personal experiences (Smith et al., 2009).

3.5.2 Exclusion Criteria

Participants were excluded from the study if they were not from a Black or Black mixed background who are employed as a trainee clinical psychologist. Furthermore, trainees who had not experienced mental health problems or had not sought or considered seeking mental health support were also excluded.

3.6 Ethical Considerations

Ethical approval for this study was obtained from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (protocol number: 0569 2025 May HSET; see Appendix A). The study adhered to ethical guidelines established by the British Psychological Society (BPS, 2021a) and was designed to protect participants' rights, dignity, and wellbeing throughout (Wiles, 2013; Orb et al., 2001). The ethics application addressed the study's aims, methodology, recruitment, informed consent, data confidentiality, and provisions for managing distress or withdrawal, in accordance with the principles of respect, beneficence, and justice (BPS, 2021a).

3.6.1 Informed Consent

Informed consent is a cornerstone of ethical research, ensuring participants are adequately informed about the study, their involvement, and their right to withdraw (Beauchamp & Childress, 2019; Wiles, 2013). Participants were provided with a Participant Information Sheet (see Appendix B) and, following the opportunity to ask questions, completed a written Consent Form prior to taking part (see Appendix C). At the start of each interview, participants were reminded of their right to decline any question or withdraw at any point without consequence, in line with BPS standards for psychological research (BPS, 2021a).

3.6.2 Confidentiality and Data Protection

Participant confidentiality was protected throughout. Participants chose their own pseudonyms, which were used across all transcripts, field notes, and outputs. Interviews were audio-recorded on encrypted devices and stored on the University of Hertfordshire's OneDrive system, compliant with GDPR and the UK Data Protection Act 2018. Transcripts were anonymised prior to analysis, with identifying information removed or replaced with generalised descriptors, and audio files were stored separately from consent forms. Access to data was restricted to the primary researcher, and all materials will be permanently deleted following completion of the study in line with university policy (Sieber, 1992; ICO, 2021; BPS, 2021a).

3.6.3 Potential Distress

Given the sensitive nature of the topic, participation had the potential to evoke emotional discomfort or vulnerability. Interview questions focused on general reflections on support-seeking, identity, and professional experiences rather than directly probing past traumas, and participants were reminded at all times of their right to decline any question or withdraw without penalty. Following each interview, a debrief sheet was provided (see Appendix D) containing information about the study's purpose, normalisation of emotional responses, and signposting to support services including Mind, Samaritans, NHS Staff Support Hubs, and university wellbeing services. Participants were also encouraged to contact their course tutor, supervisor, or GP if any concerns arose. The researcher remained attentive to signs of distress throughout, offering breaks or ending sessions if needed.

3.7 Procedure

3.7.1 Recruitment Pathway

Participants for the study were recruited through poster advertisements that were distributed via various channels (see Appendix E). These channels included clinical psychology training programmes at universities across England, where posters were emailed to reach current trainees. Furthermore, professional networks, including social media groups, the Division of Clinical Psychology (DCP) and the Black, African, and Asian Therapy Network (BAATN) and in2gr8mentalhealth CIC, were also utilised to disseminate the recruitment poster and attract potential participants.

The recruitment poster included a brief description of the study, eligibility criteria, and contact information for the researcher.

3.7.2 Potential Recruitment Challenges

Recruitment through academic and professional networks could have introduced challenges related to gatekeeping. Some institutions or supervisors may have been reluctant to distribute materials they perceived as sensitive or stigmatising. To mitigate this, efforts were made to ensure clear communication about the study's purpose and its potential benefits to improving understanding of experiences in order to make recommendations for training courses and services with an emphasis on the protection of participants' confidentiality. Furthermore, there were some concerns about participants' anonymity within their professional community, was addressed by offering assurances about the secure handling of personal data, pseudonyms and anonymising transcripts.

3.8 Data Collection

Semi-structured interviews were the primary method of data collection. This approach was selected for its capacity to facilitate in-depth exploration of lived experience while

allowing flexibility in how individual narratives unfolded, making it particularly well-suited to IPA (Smith et al., 2009). Follow-up questions could be tailored to experiences that were personally significant to each participant, supporting the idiographic depth required by the methodology (Smith et al., 2009).

Interviews were conducted online via Microsoft Teams for practical and ethical reasons (BPS, 2021b). Participants were geographically dispersed across the UK, and remote delivery allowed individuals to engage from their own environments, which may have enhanced privacy and psychological comfort given the sensitive nature of the topics discussed (Salmons, 2015). Each interview lasted approximately 60 to 90 minutes and was audio-recorded with informed consent. Recordings were stored securely on the University of Hertfordshire's encrypted OneDrive system in compliance with data protection policies. All interviews were transcribed verbatim to preserve the accuracy and integrity of participants' language and narrative, and any identifying information was anonymised.

3.8.1 Interview Guide

The interview schedule (see Appendix F) covered four main areas aligned with the research aims: (1) participants' lived experience of mental health problems during training, including coping and formal support sought; (2) their experience of being a Black person working as a TCP and how racial identity intersects with professional role and lived experience; (3) the challenges and dilemmas of considering or accessing mental health support within their own NHS Trust, including conflicts of interest and perceived risks; and (4) the impact of that support, or its absence, on personal and professional identity. These areas were designed to capture the socio-cultural, institutional, and psychological dimensions of participants' experiences.

3.9 Data Analysis

1. Initial Case Engagement

Each transcript was read and re-read to promote immersion in the participant's account.

Detailed exploratory notes were made, attending to descriptive, linguistic, and conceptual aspects, including tone, embodied expression, and use of metaphor (Smith et al., 2022). This stage deepened familiarity with the data and initiated interpretative engagement.

2. Development of Experiential Statements

Exploratory notes were transformed into concise experiential statements that articulated the psychological essence of the participant's meaning-making. These statements remained grounded in the participant's words and context while beginning to reflect interpretative insight (Smith et al., 2022).

3. Formation of Personal Experiential Themes (PETs)

Experiential statements were clustered into PETs, representing key experiential patterns within each individual case. PETs were continually refined to ensure they captured depth, nuance, and fidelity to the participant's lived experience (Smith et al., 2022).

4. Case-by-Case Iteration

Steps 1–3 were repeated for each subsequent case, treating every transcript as a unique account. This idiographic commitment ensured that each participant's meaning-making was explored in its own terms before considering cross-case connections.

5. Identification of Group Experiential Themes (GETs)

After all cases were analysed individually, patterns of convergence and divergence were

examined across cases. Related PETs were integrated into GETs that captured shared experiential meanings while preserving individual variation (Smith et al., 2022).

6. Refinement and Interpretation

The final stage involved iterative reflection on the relationship between PETs and GETs, the study's research questions, and the broader theoretical context. This stage maintained IPA's double hermeneutic, acknowledging the interpretative role of the researcher in making sense of participants' meaning-making (Smith et al., 2022).

In practice, analysis was conducted manually rather than using qualitative data analysis software, consistent with IPA's emphasis on close, sustained immersion in each individual transcript (Smith et al., 2009). Transcripts were annotated directly on-screen, with exploratory notes and emerging experiential statements recorded alongside the relevant text (see Appendix G for an example transcript format).

Personal Experiential Themes were developed and refined using physical clustering methods: experiential statements were transferred onto individual sticky notes, allowing them to be physically grouped, re-grouped, and labelled as patterns within each case were identified and revised (see Appendix P for an example of participant ES to PETs with final clusters and appendix Q for an example of participant ES to PETs with final clusters with quotes).

Cross-case analysis, in which PETs from each individual case were brought together to identify shared Group Experiential Themes, was conducted using the same physical clustering approach, with sticky notes from each case laid out and reorganised on a larger working surface to allow patterns of convergence and divergence across the full data set to be identified and reviewed iteratively (see Appendix L for an example of this clustering process

for an individual participant, and Appendix M for an example of cross-case clustering into GETs).

This hands-on, physical approach was chosen over software-based coding to maintain close, tactile engagement with the data throughout the analytic process, consistent with recommendations that IPA analysis benefit from methods that keep the researcher in sustained, direct contact with participants' own words rather than mediating that contact through software interfaces (Smith et al., 2009; Smith & Nizza, 2021).

Once GETs were finalised, summary tables were constructed to organise and present the relationship between PETs, GETs, and supporting quotations (see Appendix I, Appendix N, Appendix P, and Appendix Q), and a structured reflection on the analytic process as a whole was completed following analysis (see Appendix O).

3.10 Quality assurance

The CASP tool for quality appraisal was used to assess the quality of this study. The CASP includes 11 questions assessing the quality of qualitative research. These questions enquire about the following: aims of the research, methodological rigour, ethical considerations and the value of the research. In addition, Yardley's (2000) qualitative research principles for quality were applied as a complementary framework, attending to four core principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The quality appraisal of this study are in Tables 8 and 9 below.

Table 8.

Quality Appraisal of Current Study Using the CASP Qualitative Checklist Tool (Long et al., 2020)

The Experience of Black Trainee Clinical Psychologists with Lived Experiences of Mental Health Problems Navigating Mental Health Support in the NHS

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Quality criteria	Appraisal
Was there a clear statement of the aims of the research?	The study clearly aimed to explore the lived experiences of Black trainee clinical psychologists with mental health problems, to understand the unique challenges and conflicts faced when seeking support within the NHS trust where they work, and to examine how race and professional identity intersect with mental health service use. These aims were explicitly justified as filling gaps in the literature and giving voice to an underrepresented group.
2. Is a qualitative methodology appropriate?	A qualitative approach was entirely appropriate given the exploratory, experiential focus of the research. IPA was selected to capture participants' personal meaning-making and subjective lived experiences. This aligns with the study's constructivist ontology and epistemology.
3. Was the research design appropriate to address the aims of the research?	The use of semi-structured interviews and IPA's idiographic, case-by-case analysis provided depth and flexibility to explore complex personal and cultural meanings. The design was consistent with the aim of understanding individual and collective experiences of Black TCPs within the NHS.
4. Was the recruitment strategy appropriate to the aims of the research?	Opportunity sampling was used via university training programmes, NHS networks, and professional associations such as, social media, the DCP and BAATN. Inclusion criteria ensured participants self-identified as Black or of Black mixed heritage, were enrolled in UK clinical psychology programmes, and had lived experience of mental health problems. Recruitment challenges and mitigation strategies were acknowledged
5. Was the data collected in a way that addressed the research issue?	Data were collected using in-depth semi-structured interviews, a method aligned with IPA's requirement for rich, detailed accounts. The interview guide explored mental health problems, racialised experiences, and navigating dual roles within the NHS. The approach allowed participants

to reflect deeply on identity, stigma, and help-seeking.

6. Has the relationship between researcher and participants been adequately considered?

Reflexivity was central throughout. The researcher explicitly stated their positionality as a Black trainee clinical psychologist with lived experience of mental health problems. Reflexive journaling, research team supervision and acknowledgement of insider status were used to ensure transparency and manage bias. The study embraced subjectivity as a resource rather than a limitation.

7. Have ethical issues been taken into consideration?

The study followed the British Psychological Society (2021a) ethical guidelines and obtained formal ethical approval from the University of Hertfordshire (Protocol 0569 2025 May HSET). Procedures for informed consent, confidentiality, right to withdraw, and data protection under GDPR were clearly described. Measures to manage potential distress (e.g., debrief sheets, support resources) were included.

8. Was the data analysis sufficiently rigorous?

IPA framework outlined by Smith et al. (2022). Each transcript was read and re-read to ensure immersion, followed by exploratory noting that captured descriptive, linguistic, and conceptual aspects of meaning-making. From these notes, experiential statements were developed to articulate key psychological insights grounded in participants' language and context.

These statements were then clustered into PETs for each individual case, maintaining IPA's idiographic focus. Once all cases were analysed, patterns of convergence and divergence were examined to form GETs, representing shared meanings while preserving individual nuance.

Throughout, reflexivity and theoretical coherence were upheld to enhance interpretative depth and transparency within the double hermeneutic process. Recognised limitations included potential interpretative bias and reliance on participants' expressiveness.

9. Is there a clear statement of findings?	Yes. Findings are clearly presented through well-defined themes supported by participant quotes, demonstrating coherence and transparency. Interpretations are grounded in the data, with consideration of complexity and relevance, aligning with CASP criteria and Yardley's principles of rigour and impact.
10. How valuable is the research?	High value. The study contributes significantly to understanding how race, identity, and mental health intersect in clinical psychology training. It highlights systemic inequities, informs culturally competent training support, and amplifies the voices of marginalised trainees. Dissemination plans include sharing findings with professional bodies and publishing in equity-focused journals
11. Was there a consideration of the researcher's role and influence (reflexivity)?	The researcher's insider perspective was critically examined through reflexive journaling and acknowledgement of positionality. This reflexive stance strengthened transparency, credibility, and trustworthiness, aligning with constructivist epistemology and IPA principles.

Table 9.

Yardley (2000) Qualitative Research Principles for Quality

Principle	Appraisal
Sensitivity to context	This study demonstrates a high level of sensitivity to context across theoretical, methodological, and interpersonal domains. The research is grounded in a comprehensive engagement with literature on racialised mental health inequalities in the UK, clinical psychology training cultures, and the role of lived experience within professional identity. The integration of intersectionality and Critical Race Theory ensures that participants' accounts are interpreted within broader socio-historical and institutional power structures, rather than decontextualised individual experiences.

Sensitivity to context is further reflected in the study's clear articulation of researcher positionality. The researcher's identity as a Black trainee clinical psychologist with lived experience is explicitly acknowledged as shaping the research process, allowing for both insider insight and critical reflexivity. This is particularly important given the cultural and professional sensitivities surrounding disclosure, stigma, and power within NHS settings.

At the level of data collection, the use of semi-structured interviews enabled participants to express culturally situated meanings of distress, help-seeking, and identity. The interview design allowed flexibility to explore issues such as racialised experiences, cultural stigma, and institutional mistrust in a way that respected participants' perspectives and priorities. Overall, the study demonstrates strong attunement to the layered cultural, institutional, and relational contexts in which participants' experiences are embedded.

Commitment and rigour

Commitment is evidenced through the depth of engagement with both the research topic and the participants' accounts. The study addresses a complex and under-researched area, requiring sustained attention to nuanced and potentially sensitive material. The researcher demonstrates commitment through careful recruitment of a specific and information-rich sample (Black trainee clinical psychologists with lived experience), ensuring alignment with the research aims.

Rigour is reflected in the systematic and transparent application of Interpretative Phenomenological Analysis. The analytic process followed established IPA procedures, including repeated immersion in transcripts, detailed exploratory noting (descriptive, linguistic, and conceptual), and the development of experiential statements grounded in participants' accounts. These were then organised into Personal Experiential Themes (PETs) before being integrated into Group Experiential Themes (GETs), preserving IPA's idiographic commitment while enabling cross-case analysis.

The iterative and reflexive nature of the analytic process further strengthens rigour. Each case was treated independently before identifying patterns of convergence and divergence, ensuring that individual meaning-making was not prematurely subsumed into group-level

interpretations. The use of reflexive journaling and supervisory discussions also contributed to analytic depth by supporting critical examination of assumptions and interpretations.

While IPA inherently involves interpretative subjectivity, the study enhances rigour by maintaining close grounding in participants' language and by providing transparent links between data and interpretation. Acknowledged limitations, such as potential interpretative bias and reliance on participants' articulateness, further demonstrate critical engagement with the analytic process.

Transparency and coherence

Transparency is demonstrated through clear and detailed documentation of all stages of the research process. The methodology section provides a coherent account of the study's epistemological position, design, recruitment strategy, data collection procedures, and analytic approach. The rationale for using IPA is explicitly linked to the research aims and theoretical framework, ensuring methodological congruence.

The analytic process is described step-by-step, allowing the reader to understand how raw data were transformed into experiential statements, PETs, and ultimately GETs. This level of detail supports the credibility and traceability of the findings. The inclusion of examples (e.g. in appendices such as transcripts, PETs, and PET-to-GET mapping) further strengthens transparency by demonstrating how interpretations were developed.

Coherence is evident in the alignment between the study's theoretical frameworks (intersectionality and Critical Race Theory), epistemological stance (constructivist), and methodological approach (IPA). The findings and discussion chapters maintain this coherence by consistently interpreting participants' experiences through these lenses, avoiding conceptual fragmentation.

Reflexivity also contributes to transparency, as the researcher explicitly acknowledges their influence on the research process. Rather than attempting to eliminate subjectivity, the study integrates it in a theoretically consistent manner, aligning with IPA's double hermeneutic. Overall, the research presents a logically structured and internally consistent account from research question through to interpretation.

Impact and importance

The study makes a significant and original contribution to the clinical psychology and mental health literature by focusing on a previously underexplored population: Black trainee clinical psychologists with lived experience of mental health problems navigating support within the NHS. This focus addresses a critical gap at the intersection of race, professional identity, and help-seeking within institutional contexts.

The findings have clear applied relevance. They highlight structural and relational barriers within both clinical training programmes and NHS services, including issues of confidentiality, power, racialised misinterpretation, and the perceived risks of accessing support within one's own employing institution. These insights have direct implications for the design of trainee support systems, suggesting the need for independent, culturally attuned, and psychologically safe pathways.

The study also contributes conceptually by extending intersectionality and Critical Race Theory into the domain of clinical psychology training and professional help-seeking, offering a more nuanced understanding of how institutional contexts shape lived experience. By foregrounding participants' voices, the research amplifies marginalised perspectives and challenges dominant assumptions about resilience, professionalism, and mental health within the profession.

In terms of broader impact, the study has the potential to inform policy, training curricula, and service development, particularly in relation to anti-racist practice and workforce wellbeing within the NHS. Its relevance extends beyond academia to clinical, organisational, and policy contexts, demonstrating strong impact and importance in line with Yardley's criteria.

3.11 Self-reflexivity

Reflexivity was central to this research, consistent with its constructivist and interpretative phenomenological framework. It involved a continuous process of examining my own assumptions, beliefs, and potential biases as a Black trainee clinical psychologist with lived experience of mental health problems. A reflective diary was maintained

throughout to document personal reflections, emotional responses, and the influence of my positionality on data collection and interpretation, and regular reflexive discussions were held with my supervisory team to enhance critical reflection and transparency.

During the analytic process itself, the reflective diary surfaced at least one assumption that required active reconsideration. Entering analysis, I held an implicit expectation, shaped by my own experience of training, that university-based support structures such as personal tutoring and pastoral care would be experienced by participants as broadly helpful, since I had found these structures helpful during my own training. As case-by-case analysis proceeded, this assumption was challenged by participants' accounts, which more often described university and training structures as procedurally present but experientially insufficient, reactive, or disconnected from the realities of being a Black trainee clinical psychologist, rather than as a source of meaningful containment for distress.

Recognising that my own positive experience of university support had shaped an initial expectation that did not match what was emerging from the data prompted closer, more deliberate attention during subsequent case analysis to participants' own framing of these structures, rather than reading their accounts through the lens of my own experience. This moment was documented in the reflective diary and discussed in supervision, and is consistent with IPA's requirement that the researcher's preconceptions be made visible and held in check rather than allowed to silently shape interpretation (Smith et al., 2009; Finlay, 2008).

My identity as a Black trainee clinical psychologist with lived experience of mental health problems was also likely to have shaped the interview encounter itself, not only my later interpretation of the data. As an insider to the population being studied, sharing racial identity, professional role, and direct experience of the phenomena under investigation with

participants, I occupied what Dwyer and Buckle (2009) describe as "the space between" insider and outsider positions: close enough to participants' experience to be trusted with disclosures about race and institutional risk that might not have been offered to a researcher without this shared background, yet still positioned as a researcher asking questions within a formal university process. Existing methodological literature on race-matched interviewing suggests that shared racial identity between researcher and participant can enhance comfort and depth of disclosure on sensitive topics such as racism and institutional mistrust, with Black researcher-Black participant dyads associated with richer dialogue on these issues than cross-racial dyads (Mizock et al., 2011). It is plausible that this shared identity contributed to participants speaking openly about experiences of racialised risk within their own NHS Trusts and training programmes during the interviews for this study.

This insider positioning also carried risks that required active management during data collection. Shared identity and professional role could have created an assumption of common ground between myself and participants, potentially leading me to under-probe experiences I believed I already understood, or leading participants to leave certain experiences unspoken on the assumption that, as a fellow Black trainee, I would already know what they meant. Equally, my position as a fellow trainee, rather than an external academic researcher, may have introduced a subtle power dynamic of its own, with participants potentially moderating disclosures in ways shaped by perceived professional proximity within a small and identifiable professional community. These possibilities were addressed during data collection by deliberately asking participants to elaborate on points that might otherwise have been left as shared assumption, and were addressed afterwards through the reflective diary and supervisory discussions described above, in which moments where shared identity may have shaped the direction or depth of a given interview were specifically considered.

A separate instance in the reflective diary concerned how an initial reading of participants' accounts of "performing wellness" during training was revised. On first analysing these accounts, my initial coding leaned toward reading this performance primarily as a familiar form of professional coping and resilience, partly because I recognised this pattern from my own training experience and had previously made sense of it in those terms. Returning to the data after a period of distance, and discussing this coding in supervision, I reconsidered this interpretation: rather than treating the performance of wellness as evidence of effective coping, the accounts were re-read as describing a costly, protective adaptation to racialised scrutiny and the perceived risks of appearing unwell within evaluative training environments. This shift in interpretation, from competence to protective performance, is reflected in how GET 2 (Performing Wellness and Competence Under Racialised Scrutiny) was ultimately framed and is documented in the reflective diary as an example of how my own positive identification with a pattern in the data initially constrained, rather than enriched, its interpretation.

Reflecting on the research process as a whole, my insider position as a Black trainee clinical psychologist with lived experience of mental health problems carried distinct advantages and disadvantages. Advantages included ease of access to a hard-to-reach and historically under-researched population, an interpretative vocabulary already attuned to the institutional and racialised dynamics participants described, and a credibility with participants that plausibly supported the depth and candour of the accounts gathered, consistent with literature on the benefits of insider research with marginalised groups (Dwyer & Buckle, 2009). Disadvantages included the risk, illustrated by the two examples above, that my own experience could be projected onto participants' accounts, either by assuming shared meaning where none was confirmed, or by interpreting unfamiliar or divergent accounts through an unexamined frame drawn from my own experience rather than from the data itself. A further

disadvantage was the difficulty of achieving full distance from data that frequently mirrored my own professional and personal circumstances, requiring deliberate, effortful bracketing rather than the more natural distance available to a researcher without this shared background. These disadvantages were managed, though not eliminated, through the reflective diary, regular supervision, and the iterative return to participants' own data described in Section 3.9, consistent with IPA's view that the researcher's perspective should be made visible and accountable rather than suppressed (Finlay, 2008).

Consistent with IPA's phenomenological foundations, bracketing was employed as an ongoing reflexive practice rather than a single act of suspension prior to data collection (Smith et al., 2009). Preconceptions, emotional responses, and interpretative assumptions were actively identified and documented within the reflective diary and explored within supervisory discussions. This process did not aim to eliminate the researcher's perspective, recognised within IPA as neither possible nor desirable, but to make it visible and accountable so that insider knowledge could inform rather than unduly constrain interpretation (Finlay, 2008).

4.0 Results

4.1 Overview

This Results section presents an interpretative phenomenological analysis of how Black trainee clinical psychologists with lived experience of mental health problems make sense of navigating mental health support within the NHS Trusts and universities in which they are employed and trained. Five GETs were developed through cross-case analysis, capturing shared patterns of meaning while preserving the nuance and variation of individual accounts. An overview of the five GETs and subthemes are in Table 10 below.

Table 10.

Group Experiential Themes and Correlating Subthemes

Group experiential themes	Subthemes
GET 1: Distress Emerges Through Cultural Silencing, Delayed Recognition, and Cumulative Pressure	Distress Initially Hidden by Cultural Scripts of Strength and Coping Academic Transitions and Training as Catalysts for Escalating Distress Reaching a Threshold Where Distress Can No Longer Be Held
GET 2: Performing Wellness and Competence Under Racialised Scrutiny	Hypervisibility and the Burden of Representation Fear of Stereotype Confirmation and Constrained Emotional Expression Performing Wellness as a Strategy for Survival
GET 3: Training and University Structures as Failing to Contain Distress	Personal Tutoring and Course Responses Feel Procedural Rather Than Containing Cohort Culture and Reduced Psychological Safety

Structural Support Gaps Shift Responsibility onto the Trainee

GET 4: NHS and Trust-Based Support Is Constructed as Risky Due to Power, Proximity, Racism, and Permanence

Proximity and Boundary Blurring Between Trainee and Service User

NHS Records and Permanence Transform Care into Exposure

Racialised Misinterpretation and Lack of Choice of Clinician

Professional Consequences and Reputational Risk

GET 5: Safety Is Pursued Outside Formal Systems Through Culturally Attuned Care, Religion, Peer Solidarity, and Values-Based Recommitment

Private Therapy as Safety Through Separation from Professional Identity

Cultural Attunement Reducing the Emotional Labour of Explanation

Peer Solidarity as Containment and Validation

Lived Experience as Ethical Grounding and Professional Recommitment

Faith and Spirituality as an Unrecognised Anchor

4.2 Overview of GET 1: Distress Emerges Through Cultural Silencing, Delayed Recognition, and Cumulative Pressure

This Group Experiential Theme (GET) captures participants' accounts of how early mental health distress was often rendered invisible, minimised, or normalised within cultural, familial, and relational contexts. Across cases, participants described learning to interpret distress through cultural scripts that emphasised strength, endurance, and self-reliance. Within these frameworks, emotional suffering was not immediately recognised as a psychological difficulty requiring support, but instead reframed as something to be tolerated, managed privately, or pushed through.

Participants' narratives suggest that distress was not absent, but rather made liveable through silence, often until academic transitions, professional training demands, or cumulative pressure academic or training pressure made this strategy untenable. In this sense, distress only became recognisable as "needing support" when existing coping mechanisms were exhausted. This GET therefore reflects not only the presence of distress, but the conditions under which it becomes visible and legitimate, both to participants themselves and within institutional contexts. Running beneath this GET and throughout the results section that follows is the underexamined role of mental health stigma, which associates psychological distress with weakness, unreliability, or unsuitability and shapes how help-seeking is imagined even before any formal system is approached. This stigma is pervasive in wider society, but it does not disappear inside mental health professions or healthcare institutions; if anything, it intensifies there, compounded for these participants by racial stereotypes that rendered vulnerability doubly dangerous.

4.2.1 Subtheme 1: Distress Initially Hidden by Cultural Scripts of Strength and Coping

A central feature of participants' accounts was the way early distress was managed, contained, minimised, or obscured by culturally embedded expectations of strength and resilience. Participants described growing up in environments where emotional vulnerability was either unnamed or implicitly discouraged, shaping how they initially made sense of their internal experiences. Rather than interpreting distress as something warranting care, participants often understood it as a normal part of life that should be endured.

Ruth explicitly articulated how cultural expectations shaped their early relationship with distress:

"In my family there wasn't really room for talking about feelings. Growing up... you're strong, you don't break down... you get through it. If something upset you, the message was

just keep going, don't make a fuss, don't draw attention to yourself. So, I learned very early on to carry things quietly instead of saying I was struggling.” (Ruth)

Within this framing, distress is positioned not as a signal for support, but as a test of endurance. Similarly, Vicky described the absence of a shared language for emotional vulnerability, suggesting that silence was not accidental but culturally patterned:

“There wasn't really language for emotional vulnerability in my family... if you were upset, it was just seen as something you had to deal with quietly. You just got on with things.” (Vicky)

These accounts illustrate how distress becomes normalised and internalised, rather than named or externalised. Participants often described retrospectively recognising that they had invalidated their own experiences, drawing on cultural narratives that framed suffering as something to be tolerated rather than explored:

“I didn't have a reference point for anything different. Everyone around me seemed to be carrying things without complaining, so early on I just thought this is what coping looks like. I didn't realise that what I was doing was actually just swallowing everything and pretending to be okay.” (Ruth)

“Because no one around me named mental health, I started doing it to myself. I invalidated my own experience a lot... I told myself it couldn't really be that bad. I'd compare myself to other people and think, you're just being weak, you need to toughen up, especially as a Black woman in these spaces.” (Vicky)

For some participants, this cultural silencing intersected with institutional responses that further minimised distress. Caroline described how early help-seeking attempts were met

with reassurance that framed their experience as ordinary stress rather than something requiring attention:

“It wasn’t just one person saying it, it was repeated across different conversations. I’d raise concerns and I remember being told I was just stressed, or that it was normal student anxiety, but it didn’t feel normal to me at all. Over time, that message stuck, and I stopped trusting my own instincts about needing help.” (Caroline)

Analytically, this subtheme highlights that distress is not simply delayed in recognition but actively re-interpreted through culturally and institutionally sanctioned meanings. Strength, endurance, and coping become moralised virtues, while vulnerability risks being read as weakness or failure. Across cases, participants did not describe a lack of insight or denial, but rather a learned relational stance in which silence functioned as protection. Distress remained unspoken not because it was absent, but because speaking it did not yet feel possible, legitimate, or safe. Underlying this silence was the broader stigma attached to mental health problems a stigma that exists in any community, but which intersected here with cultural norms of strength and racial stereotypes to render vulnerability especially unspeakable.

This subtheme helps illuminate why help-seeking often occurred later, and under conditions of cumulative pressure, rather than at the onset of distress. It also foregrounds how early meaning-making around mental health sets the stage for later decisions about whether, when, and where to seek support within training and NHS contexts.

4.2.2 Subtheme 2: Academic Transitions and Training as Catalysts for Escalating Distress

Across participants’ accounts, a key turning point in the recognition and escalation of distress occurred during academic transitions, particularly entry into doctoral training. While

earlier distress had often been held through cultural silencing and personal endurance, the demands of training were described as overwhelming existing coping strategies, bringing distress into sharper focus both psychologically and somatically.

Participants described training as qualitatively different from previous academic experiences. The intensity, pace, and emotional labour of clinical psychology training appeared to interact with pre-existing vulnerabilities, producing a sense that distress was no longer manageable or ignorable. Angela reflected on how the early stages of training evoked a familiar sense of emotional overload:

“Before the doctorate I could usually hold things together, even when I was struggling. I had my ways of getting through. But once training started, everything felt amplified. The workload, the placements, the expectations it all came at once. The first year of training reminds me a lot of that time... it’s very intense... there’s just not a lot of support. I realised very quickly that the coping strategies I’d relied on before just weren’t enough anymore.”
(Angela)

Here, training is not simply demanding, but reminiscent of earlier periods of vulnerability, suggesting that academic transition functions as a reactivating context rather than a neutral challenge. For several participants, distress was experienced not only cognitively but physically, with heightened bodily awareness signalling that something had shifted:

“When training started, it was like something switched on in me that wouldn’t switch off again. I remember constantly feeling on edge, like my body was always braced for something bad to happen. Even when nothing was going wrong, I was waiting to be criticised or to be told I wasn’t good enough.” (Vicky)

This bodily hypervigilance appeared to mark a departure from earlier coping strategies rooted in endurance. Ruth similarly described how the transition into university and later training disrupted their ability to dismiss distress as transient or manageable:

“Before training I could keep everything contained, but being in that environment changed things. University life triggered something in me that I couldn’t ignore anymore. The pressure, the comparisons, being one of the few Black trainees it brought everything I’d been pushing down to the surface.” (Ruth)

Participants often spoke about the cumulative nature of pressure, rather than identifying a single precipitating event. Angela captured this sense of emotional accumulation, where multiple demands converged without adequate containment:

“Assignments, placement hours, supervision, trying to have a life outside of training none of it ever stopped. It just was so much like it was all just on top of each other. There was no breathing space to recover before the next demand arrived.” (Angela)

Analytically, this subtheme illustrates how academic and professional transitions operate as threshold moments, where previously effective strategies of silence and self-reliance begin to fail. Training does not create distress in isolation; rather, it exposes the limits of culturally sanctioned coping mechanisms. The intensity of doctoral training appears to strip away the protective ambiguity that previously allowed participants to reinterpret distress as normal stress, instead forcing a confrontation with unmet emotional needs.

Importantly, participants did not describe this escalation as sudden insight or crisis alone, but as a gradual erosion of capacity. Distress becomes visible when the structural and emotional demands of training exceed what can be carried privately. This reframes help-

seeking not as delayed awareness, but as a response to contextual overwhelm, setting the stage for later meaning-making about where support can safely be sought.

4.2.3 Subtheme 3: Reaching a Threshold Where Distress Can No Longer Be Held

For many participants, distress became recognisable as something requiring support only after reaching a personal threshold where existing coping strategies were no longer sufficient. While earlier experiences of distress had been silenced, normalised, or endured, participants described reaching a point of emotional exhaustion or depletion that disrupted their ability to continue functioning as before. This moment was often characterised not by sudden crisis, but by a gradual realisation that “pushing through” was no longer possible.

Several participants described this threshold as an embodied experience of burnout or emotional collapse. Angela reflected on the cumulative toll of distress during training:

“I was crying at small things, and everything felt heavy. I was very kind of depressed, very overwhelmed, very burnt out, drained. That feeling made it clear that pushing through wasn’t an option anymore.” (Angela)

Here, distress is articulated as an accumulation of emotional states rather than a discrete episode, suggesting a slow erosion of capacity rather than an abrupt breakdown. Similarly, Vicky described a moment of reckoning, where continued denial of distress became untenable:

“I’d been trying to hold it together for so long, smiling through everything, saying yes to every demand. But eventually it caught up with me. I reached a stage where I couldn’t keep pretending I was fine. I realised I was exhausted, emotionally empty, and something had to give.” (Vicky)

This acknowledgement marked a shift in how distress was understood. Rather than being framed as manageable stress or temporary difficulty, it began to be recognised as something that exceeded personal endurance. Ruth described a growing awareness that existing coping strategies were no longer protective:

“I couldn’t ignore it anymore. I was exhausted, emotional, and not functioning the way I used to. That was the point where I realised I needed help, even if I didn’t know where to get it. I knew something had to change, but I had no idea what asking for support would actually look like.” (Ruth)

Importantly, participants did not describe this threshold as a clear or empowering turning point. Instead, it was often accompanied by confusion, uncertainty, and ambivalence about what seeking support might entail. Distress became visible before pathways to care felt accessible or safe. For some, this recognition was intertwined with a sense of failure or self-criticism, shaped by earlier cultural and institutional messages that valorised coping independently.

Analytically, this subtheme highlights that help-seeking emerges not from early insight alone, but from a breakdown in the viability of silence. The recognition of distress as uncontrollable represents a critical shift in meaning-making, where participants are forced to reassess their relationship to vulnerability and support. However, reaching this threshold does not automatically translate into accessing care. Instead, it creates a heightened awareness of need alongside increased anxiety about exposure, judgement, and consequence.

This subtheme therefore completes GET 1 by illustrating how distress moves from being culturally silenced, to intensified by academic transitions, and finally to a point where it demands recognition. This trajectory sets the foundation for subsequent GETs, in which

participants grapple with the risks, limitations, and moral complexity of seeking support within the NHS and training environments they inhabit.

It is worth clarifying the relationship between GET 1 and GET 2, given the surface similarity between cultural silencing and the performance of wellness discussed below. GET 1 and GET 2 are not separate or overlapping descriptions of the same phenomenon, but represent a sequential and causal relationship between a foundational coping mechanism and its later, context-specific application. GET 1 documents how participants learned, through cultural scripts of strength and endurance, to regulate and contain distress before entering clinical psychology training; this capacity for emotional restraint was already internalised by the time participants began their professional training. GET 2, discussed below, then shows how this pre-existing capacity is consciously activated and intensified once participants enter a professional environment characterised by racialised scrutiny and evaluative pressure. Training did not create participants' capacity for silence; rather, it raised the perceived stakes of breaching that silence, transforming an already-learned coping mechanism into a more effortful, sustained, and psychologically costly professional performance. GET 1 should therefore be read as the foundation on which GET 2's performance of wellness is built and intensified, rather than as a separate or competing account of the same underlying experience.

4.3 Overview of GET 2: Performing Wellness and Competence Under Racialised Scrutiny

This Group Experiential Theme captures participants' experiences of navigating doctoral training while simultaneously managing heightened visibility and scrutiny associated with being Black within predominantly White academic and clinical spaces. Across accounts, participants described an ongoing awareness that their behaviour, emotions, and perceived competence were more likely to be noticed, interpreted, and judged through racialised lenses.

As a result, participants often felt compelled to carefully manage how they presented themselves, particularly in relation to mental health and vulnerability.

Participants' narratives suggest that being a Black trainee clinical psychologist was not experienced as a neutral identity within training, but as one that carried additional representational and emotional burdens. Mental health problems were therefore not understood solely as personal experiences, but as potentially risky disclosures that could confirm stereotypes, undermine credibility, or invite heightened surveillance. This GET reflects how participants made sense of the need to perform wellness, resilience, and professional competence as a strategy for survival within systems they experienced as uneven and evaluative.

4.3.1 Subtheme 1: Hypervisibility and the Burden of Representation

A central feature of participants' accounts was a sense of being acutely visible within training spaces, often linked to being one of very few Black trainees in their cohort or placement setting. Participants described a heightened awareness of themselves as being noticed not just as individuals, but as representatives of a wider racialised group. This hypervisibility shaped how they understood their presence, behaviour, and emotional expression within academic and clinical contexts.

Ruth described how racial identity intensified feelings of being seen and scrutinised:

“In a cohort where most people don't look like you, you can never really blend in. Being Black... it makes you feel even more visible. Everything you say, everything you do, feels like it's being watched in a different way to everyone else.” (Ruth)

For some participants, this visibility was experienced as both isolating and pressurising. Vicky reflected on the emotional weight of occupying a minority position

within the cohort. Participants also described this visibility as shaping how their actions might be interpreted. There was a sense that mistakes, struggles, or expressions of distress could be generalised beyond the individual, reinforcing stereotypes or shaping perceptions of Black trainees as a group. Vicky captured this intertwining of mental health and racial identity:

“That makes me more cautious about showing vulnerability. There’s this internal pressure not to confirm stereotypes, not to be seen as less resilient or less capable.” (Vicky)

This numerical underrepresentation appeared to amplify a sense of responsibility to represent oneself well, not only for personal credibility but to counter negative assumptions about Black professionals more broadly. Mary Anne articulated how this visibility was inseparable from racial identity:

“I was basically the only one like me, and then there was like 1 White person who was not White, English White British.” (Mary Anne)

Analytically, this subtheme highlights how hypervisibility operates as a relational and contextual phenomenon rather than an internal trait. Participants were not simply aware of being different; they experienced difference as carrying interpretative consequences within training spaces. This burden of representation constrained how participants felt able to occupy space, contributing to careful self-monitoring and a narrowing of what felt permissible to express. Hypervisibility therefore functions as a precursor to later strategies of emotional containment and performance, setting the conditions under which vulnerability is experienced as risky rather than relational. This risk is compounded by the stigma that continues to surround mental health problems even within healthcare professions, a stigma sharpened, for these participants, by racial stereotypes that cast Black professionals as either excessively resilient or inherently less capable.

4.3.2 Subtheme 2: Fear of Stereotype Confirmation and Constrained Emotional Expression

Across participants' accounts, a pervasive fear of confirming negative racial stereotypes shaped how emotional distress was expressed, managed, or concealed within training and clinical settings. Participants described an ongoing awareness that displays of vulnerability, frustration, or emotional difficulty might be interpreted not as human responses to pressure, but as evidence of personal or professional inadequacy, filtered through racialised assumptions about Blackness.

Several participants articulated how this fear operated as a form of internal regulation, influencing how they spoke, behaved, and presented themselves in both academic and clinical spaces. Caroline described the careful calculation involved in expressing distress:

“When you’re Black on a course like this, mistakes don’t feel neutral. There’s always that fear that if you say the wrong thing, people start questioning whether you should even be here. So, you end up holding back parts of yourself just to feel safe.” (Caroline)

This concern was not limited to formal evaluations but extended into everyday interactions with peers and supervisors. Participants described monitoring their emotional tone, word choice, and level of openness to avoid being perceived as “too emotional,” “unstable,” or “unable to cope.” Ruth reflected on how racial identity shaped the perceived risks of emotional disclosure:

“Any time I felt overwhelmed, I had to think carefully about how to express it. I’d ask myself, will it feed into stereotypes about Black people being too emotional? So instead of being honest, I’d often just keep quiet and say I was fine.” (Ruth)

For some, this fear was reinforced by an awareness that Black trainees were afforded less tolerance for visible struggle. Mary Anne captured this perceived imbalance succinctly:

“A black person is not going to get the same amounts. I know people hate when you say stuff like this where you don't get you don't you don't get as much rope to hang yourself.” (Mary Anne)

Within this context, emotional expression became tightly constrained. Participants often described choosing silence or emotional neutrality as safer options, even when experiencing significant distress. This restraint was not experienced as a lack of insight or willingness to engage, but as a strategic response to anticipated judgement. The emotional labour involved in this self-monitoring was described as ongoing and exhausting, contributing to feelings of isolation and disconnection within training spaces.

Analytically, this subtheme illustrates how fear of stereotype confirmation functions as a powerful organising force in participants' meaning-making. Emotional expression is not simply a personal choice, but a racialised risk calculation, shaped by histories of misinterpretation and unequal consequences. Vulnerability, in this context, becomes something to be managed rather than shared. Crucially, this is not simply a professional risk calculation: it reflects the broader stigma of mental health problems, which inside healthcare systems as much as outside them can be associated with weakness, unsuitability, or impaired judgement. For racialised trainees, this generalised stigma fuses with racial prejudice, creating a compounded threat in which disclosing mental health problems risks confirming both.

Crucially, the constraint documented in this subtheme is best understood not as a general response to professional norms around emotional display, but as a targeted, pre-emptive strategy directed at the specific risk articulated more fully in GET 4: that emotional

expression, once disclosed, will itself be racially misinterpreted, with anger read as aggression and assertiveness read as threat, and that this misinterpretation will in turn compromise professional reputation and fitness-to-practise standing. Participants did not appear to constrain their emotional expression simply because professional contexts generally call for composure; they constrained it because they anticipated specific, racially inflected professional consequences if they did not. The constraint documented here is therefore the preventive response, and the racialised misinterpretation and reputational risk detailed in GET 4 is the threat it is designed to prevent. This constriction of emotional expression not only limits access to relational support but also reinforces the need to perform competence and stability, a pattern that is further elaborated in the subsequent subtheme on performing wellness as a survival strategy.

4.3.3 Subtheme 3: Performing Wellness as a Strategy for Survival

For many participants, the combined experience of hypervisibility and fear of stereotype confirmation led to the active performance of wellness, resilience, and professional competence. Rather than feeling able to occupy training spaces as emotionally complex individuals, participants described adopting a carefully curated presentation of themselves that emphasised coping, stability, and productivity. This performance was not experienced as inauthentic in intent, but as necessary for survival within environments perceived as uneven, evaluative, and racially loaded.

Participants spoke about presenting a version of themselves that appeared emotionally contained, even when internal experiences were marked by distress. Grace reflected on the irony of training within a profession centred on mental health while feeling unable to be openly unwell:

“It feels deeply ironic... there’s very little space to be a human who is struggling.” (Grace)

This sense of contradiction was echoed by others, who described the expectation to model psychological robustness as incompatible with their lived realities. Vicky articulated the effort involved in sustaining this presentation:

“Even on days when I was barely coping, I still felt like I had to show up smiling and professional. Around peers and supervisors, it can feel like you’re performing wellness, because admitting you’re struggling feels too risky.” (Vicky)

The performance of wellness extended beyond formal assessments into everyday interactions, shaping how participants engaged with peers, supervisors, and academic demands. Abigail described how even routine encounters required careful emotional calculation:

“I was constantly thinking about how I came across, how my words might be interpreted, whether I sounded confident enough. Every interaction felt like something I had to calculate, instead of just being able to exist naturally like other people seemed to.” (Abigail)

In this context, wellness was not simply an internal state, but a visible signal of professional suitability. Participants described a pressure to demonstrate that they could cope, manage stress, and remain functional, particularly in contrast to racialised assumptions that positioned Black trainees as either overly resilient or inherently vulnerable. Maintaining this performance often came at a personal cost, contributing to exhaustion, emotional disconnection, and delayed recognition.

Analytically, this subtheme highlights how performing wellness operates as a protective adaptation within training, rather than a marker of genuine wellbeing. Participants’ accounts suggest that the appearance of coping was prioritised over the experience of being supported. This performance served to manage risk, preserve credibility, and navigate

racialised expectations, but simultaneously limited opportunities for authentic connection and care. In completing GET 2, this subtheme illustrates how hypervisibility and fear of stereotype confirmation culminate in a sustained effort to appear well, reinforcing a cycle in which distress is carried privately while competence is performed publicly.

4.4 Overview of GET 3: Training and University Structures as Failing to Contain Distress

This Group Experiential Theme captures participants' shared experiences of training and university structures as emotionally insufficient, inconsistent, or actively unsafe when navigating mental health problems. Across accounts, participants described formal systems of support such as personal tutoring, pastoral care, and university wellbeing services as procedurally available but experientially lacking. Rather than functioning as reliable containers for distress, these structures were often experienced as symbolic, reactive, or disconnected from the realities of being a Black trainee clinical psychologist.

Participants' narratives suggest that institutional responses to distress were shaped by risk management and policy adherence rather than relational understanding. As a result, participants often felt that responsibility for managing their mental health was subtly shifted back onto them, reinforcing isolation and self-reliance. This GET reflects how universities were made sense of not as neutral or protective environments, but as systems that struggled to respond meaningfully to distress, particularly when intersecting with race, power, and professional identity.

4.4.1 Subtheme 1: Personal Tutoring and Course Responses Feel Procedural Rather Than Containing

Across participants' accounts, personal tutoring and course-level responses to distress were experienced as procedurally correct but emotionally uncontained. While participants described being listened to at a surface level, these interactions did not translate into a sense of being held, understood, or meaningfully supported. Instead, support encounters were often characterised by policy-driven responses that felt disconnected from participants' lived experiences.

Caroline described how attempts to raise concerns were met with institutional redirection rather than relational engagement:

“Every time I tried to talk about how overwhelmed I was, the conversation seemed to shift very quickly into processes and procedures. Whenever I raised concerns, it felt like I was being pointed back to a policy rather than actually listened to. It didn't feel like anyone was really trying to understand what I was experiencing as a person.” (Caroline)

This response positioned distress within predefined frameworks, limiting space for complexity or emotional exploration. Similarly, Abigail reflected on how institutional priorities appeared to centre risk management rather than addressing harm:

“It felt like the conversation wasn't really about me, it was about the system. The response felt very procedural, like they were more worried about managing complaints than addressing harm. I left feeling like a problem to be managed, not a person that was hurting.” (Abigail)

Here, the emphasis on procedure is experienced as eclipsing care, leaving participants feeling managed rather than supported. Mandy's account further illustrates how this procedural orientation played out within personal tutoring relationships:

“I would pour my heart out, my personal tutor would listen, nod, empathise, and then nothing would change. I'd leave feeling like I'd spoken but not actually been heard.” (Mandy)

Although empathy was expressed, its lack of follow-through rendered it ineffective.

Taken together, these accounts suggest that support existed in form but not in function.

Analytically, this subtheme highlights how institutional responses to distress were experienced as performative rather than containing, contributing to a growing sense that course structures were ill-equipped to offer meaningful emotional support. This experience laid the groundwork for later disengagement from university-based support and the internalisation of responsibility for managing distress.

4.4.2 Subtheme 2: Cohort Culture and Reduced Psychological Safety

Across participants' accounts, the culture of the training cohort emerged as a significant factor shaping their sense of psychological safety. Rather than functioning as a supportive peer community, cohort spaces were often experienced as competitive, guarded, or dismissive, particularly in relation to discussions of race, mental health, and vulnerability. This context influenced how safe participants felt to speak openly about distress or to seek understanding from peers.

Several participants described an environment in which openness about mental health felt risky, not only because of assessment processes, but because of how peers responded to expressions of difficulty. Caroline reflected on the emotional tone of cohort interactions:

“In theory the cohort is meant to be supportive, but in reality, it doesn't feel like a space where you can be vulnerable. There's a lot of judgement, comparison, and unspoken competition, especially when you're already different.” (Caroline)

For some, this lack of safety was intensified when conversations touched on race or systemic inequality. Participants described moments where attempts to raise these issues were

met with discomfort, defensiveness, or silence. Abigail described the impact of these responses:

“Whenever I tried to bring up something about race or how I was struggling, people would go quiet... that silence felt louder than any comment. It made me feel like I’d said something uncomfortable instead of something real.” (Abigail)

This silence was experienced not as neutrality, but as a form of disengagement that left participants feeling exposed and unsupported. Angela similarly described how sharing struggles was often met with minimisation or lack of attunement:

“Opening up about how hard things felt, the responses were always very surface level. People would change the subject, make jokes, or downplay it. Attempts to share struggles were met with dismissal.” (Angela)

Participants also reflected on the competitive dynamics within the cohort, where comparison and performance appeared to take precedence over mutual care. The sense that peers were simultaneously colleagues, competitors, and future professionals contributed to an atmosphere of guardedness. In this context, vulnerability risked being interpreted as weakness, further constraining open dialogue.

Analytically, this subtheme illustrates how psychological safety is not only shaped by formal institutional structures, but also by peer culture. Participants’ accounts suggest that when cohort spaces lack openness, reflexivity, and accountability, they can replicate broader systemic dynamics of silencing and exclusion. It is worth noting that this silencing did not occur in a vacuum: the stigma attached to mental health problems within healthcare professions where distress can be read as professional unfitness made peers as well as participants reluctant to engage openly with vulnerability. Rather than offering a buffer

against institutional pressures, cohort culture in these cases often compounded feelings of isolation, reinforcing the need to manage distress privately and to seek support elsewhere.

4.4.3 Subtheme 3: Structural Support Gaps Shift Responsibility onto the Trainee

Across participants' accounts, gaps in structural and institutional support led to a gradual repositioning of responsibility for managing distress onto the individual trainee. Rather than experiencing the course as a reliable source of care, participants described coming to understand their wellbeing as something they were expected to manage independently. This shift was not always explicit but emerged through repeated experiences of limited or ineffective support.

Angela described the material and emotional consequences of these support gaps, highlighting the expectation that trainees would seek and fund their own care:

“And because of the way our course is, you can't access university, like support the same way like an undergrad would, so you just feel quite stuck and so I've had to like kind of pay my own money to get support. It hasn't really been readily available.” (Angela)

This experience reflects how institutional responsibility is displaced onto the individual, framing distress as a private matter rather than a shared concern. Over time, repeated encounters with unresponsive or generic support appeared to reduce participants' willingness to continue seeking help. Mandy captured this process of withdrawal:

“Every conversation started to sound the same. The same phrases, the same advice, the same responses, regardless of what I was actually saying. After a while I stopped reaching out because it felt scripted. It didn't feel like anyone was really engaging with me as a person.” (Mandy)

Here, disengagement is framed as a rational response to predictability rather than apathy. For some participants, the decision to cope alone was also shaped by a loss of trust in the course as a safe or helpful resource. Mary Anne articulated how this erosion of trust fundamentally altered their help-seeking decisions:

“At first, I believed the course would be there if I needed support, but that changed over time. After a few experiences where I didn’t feel heard or taken seriously, something shifted. It felt unsafe because I didn’t trust the course to help. Reaching out stopped feeling like support and started feeling like risk.” (Mary Anne)

Analytically, this subtheme highlights how structural deficiencies in support do more than fail to alleviate distress; they actively reshape how trainees understand responsibility for their wellbeing. When institutional care is perceived as inaccessible, ineffective, or unsafe, self-reliance becomes the only viable option. This internalisation of responsibility contributes to isolation and reinforces the need to seek support outside formal training structures, completing GET 3 by illustrating how institutional gaps translate into individual burden.

4.5 Overview of GET 4: NHS and Trust-Based Support Is Constructed as Risky Due to Power, Proximity, Racism, and Permanence

This Group Experiential Theme captures how participants made sense of accessing mental health support within the NHS Trust in which they are employed as trainees. Across accounts, NHS support was rarely constructed as a neutral or safe source of care. Instead, it was frequently experienced as a context of potential exposure: exposure to racialised interpretation, to permanent documentation, to professional judgement, and to blurred boundaries between being a trainee colleague and a service user.

Participants described navigating a complex dual identity, where seeking help meant entering systems staffed by colleagues, supervisors, or services in which they might later work. Within this context, the ordinary dynamics of help-seeking were transformed into matters of professional risk management. The proximity of mental health support services, the permanence of records, and the perceived likelihood of being misunderstood or judged through racialised lenses collectively shaped the meaning of NHS support as something potentially unsafe rather than supportive. This GET therefore reflects not a general reluctance to seek care, but a carefully reasoned assessment of the structural risks embedded in Trust-based pathways.

4.5.1 Subtheme 1: Proximity and Boundary Blurring Between Trainee and Service User

A central concern across participants' narratives was the lack of clear separation between their professional roles as trainees and their potential identities as service users. Accessing NHS support meant entering systems populated by colleagues, supervisors, and services that were part of their everyday professional world. This overlap created a sense that help-seeking would collapse important boundaries and expose private aspects of their lives to those with evaluative power.

Vicky described how this dual positioning complicated the idea of accessing care:

“Because we train and work in the same Trust, everything overlaps. The services I could be referred to are the same ones I might apply to work in. So, when I think about getting help, it doesn't feel like a clean separation between my professional and personal worlds.” (Vicky)

Here, the distinction between being a trainee and being a person in need of support becomes blurred, undermining the possibility of help-seeking as a private or protected act.

Abigail similarly emphasised how structural proximity made it difficult to imagine NHS support as genuinely confidential:

“Everything felt too close together. The people I trained with, the services I worked in, the systems I would be referred into it was all the same world. There was no clean separation between trainee and service user. It felt like stepping into care would mean exposing parts of my private life to the same system that was assessing my competence.” (Abigail)

This absence of separation was experienced not simply as inconvenient, but as fundamentally unsafe. Participants described being acutely aware that services they might approach for support were the same services in which they hoped to build their careers. Mary Anne captured this tension directly:

“...that was the thing it would be a very real possibility, that’s I’m going to be looking for jobs in exactly these services in a couple of year’s time...you don’t need to know my business.” (Mary Anne)

For participants, this proximity transformed help-seeking into a professionally risky endeavour. Accessing support was not imagined as stepping into a neutral therapeutic space, but as entering a network in which personal difficulties could become known within professional circles. Analytically, this subtheme illustrates how the organisational structure of NHS training environments reshapes the meaning of care. Rather than being a route to safety, Trust-based support is experienced as a site where personal vulnerability and professional identity collide. This boundary blurring forms a foundational element of GET 4, setting the stage for further concerns about documentation, racialised interpretation, and reputational consequences in the subsequent subthemes.

4.5.2 Subtheme 2: NHS Records and Permanence Transform Care into Exposure

Alongside concerns about proximity and boundary blurring, participants described a powerful anxiety about the permanence of NHS records and the ways in which documentation could shape how they were perceived in the future. The act of seeking support was not understood simply as a confidential clinical process, but as something that would leave a lasting professional trace. Within this context, documentation was experienced as a mechanism through which distress could become fixed, labelled, and potentially career-defining.

Caroline articulated this fear of permanence directly:

“It doesn’t feel like notes that can just disappear or be forgotten. Once something is written down in the NHS, it feels permanent. It feels like it becomes part of who you are in the system, not just something you’re going through at the time.” (Caroline)

Here, records are not constructed as neutral accounts of care, but as enduring narratives that might follow a trainee throughout their career. The permanence of documentation was therefore understood as carrying risks beyond the immediate moment of help-seeking, extending into future placements, references, and professional opportunities. The possibility of being “known” within the Trust in particular ways shaped how safe participants felt to disclose difficulties.

This sense of permanence reframed the meaning of accessing support altogether. Rather than being experienced as an opportunity for relief or understanding, it was often imagined as a form of exposure one understood to carry particular risks for racialised trainees. To disclose difficulties was to risk being seen through the lens of stigma, prejudice, and racial stereotype: as inherently less capable, less resilient, or less suited to the profession. The permanence of records meant that this exposure was not momentary but potentially career-defining. Grace captured this shift in meaning:

“When I think about asking for help, I don’t picture feeling held or supported. I picture being seen, recorded, and judged. Accessing support feels less like care and more like exposure. It feels like making myself visible in ways I can’t control.” (Grace)

This quotation illustrates how the institutional context transforms help-seeking from a private therapeutic act into a public and professional risk. The language of exposure suggests vulnerability to judgement, interpretation, and potential misrepresentation. Participants therefore approached NHS support not only in terms of what help it might offer, but in terms of what might be lost through being documented as unwell.

Analytically, this subtheme highlights how the bureaucratic structures of the NHS fundamentally reshape the phenomenology of care. The permanence of records, combined with the evaluative nature of training, means that seeking support is experienced as a high-stakes decision rather than a routine health need. This perception of documentation as potentially consequential reinforces participants’ reluctance to engage with Trust-based services and contributes to the broader construction of NHS support as risky, completing a central element of GET 4.

4.5.3 Subtheme 3: Racialised Misinterpretation and Lack of Choice of Clinician

A further dimension shaping participants’ reluctance to access NHS support was the expectation that their distress might be interpreted through racialised lenses, combined with a lack of control over who would provide that care. Participants described feeling unable to choose clinicians who were culturally attuned or safe, leaving them vulnerable to being misunderstood within assessment and therapeutic processes.

Mary Anne highlighted how the structure of NHS services limited personal agency in help-seeking:

“And you can't choose when you go to the NHS, you just get who you get.” (Mary Anne)

This lack of choice was experienced as particularly significant given the power dynamics involved in mental health assessment. Participants were aware that clinicians would hold authority to interpret their experiences, make diagnostic judgements, and create permanent records. The inability to select a clinician therefore heightened feelings of vulnerability and uncertainty about how their difficulties might be framed.

For Abigail, this concern was explicitly tied to racial identity and the fear of being misread:

“I’ve seen how Black people’s emotions are interpreted differently in professional spaces. Anger gets read as aggression, assertiveness gets read as threat. So, when I thought about accessing NHS support, I didn’t trust that my distress wouldn’t be read differently because I’m Black. I worried that what I experienced would be framed in a way that didn’t reflect what I was actually feeling.” (Abigail)

Here, help-seeking is constructed not simply as an encounter with an individual professional, but as an interaction embedded within wider societal stereotypes about Black people and mental health. Participants anticipated that their emotions, behaviours, or narratives could be interpreted more harshly, pathologised more quickly, or viewed with greater suspicion. This expectation shaped how safe NHS services felt, even before any direct contact had occurred.

Analytically, this subtheme illustrates how concerns about racism operate alongside structural constraints to further transform the meaning of NHS support. The combination of having no control over clinician allocation and fearing racialised misinterpretation created a context in which accessing care was experienced as a gamble rather than a right. Participants

therefore approached NHS pathways with caution, recognising that the risks involved were not only professional and bureaucratic, but also cultural and interpersonal.

4.5.4 Subtheme 4: Professional Consequences and Reputational Risk

Beyond concerns about proximity, documentation, and racialised misinterpretation, participants also made sense of NHS support as risky because of the potential professional consequences attached to disclosure. Accessing mental health care within the Trust was not experienced as separate from their identity as trainees, but as something that could directly influence assessments, progression, and future employment opportunities.

Vicky highlighted how the evaluative role of supervisors shaped the perceived risks of seeking help:

“Everything in training is assessed. Your competence, your professionalism, your readiness to qualify. Supervisors sign off your placement... disclosure feels risky. It feels like being vulnerable with the same people who are judging whether you’re fit to practise.” (Vicky)

Here, the power held by supervisors to assess competence and fitness to practise transforms the meaning of help-seeking. Rather than being a private health decision, disclosure becomes entangled with performance management and professional judgement. Participants were acutely aware that those responsible for supporting them were often the same individuals responsible for formally evaluating them, creating a tension between vulnerability and career security.

Grace similarly described how even a single admission of difficulty could alter how they were perceived within professional networks:

“As a trainee you’re constantly being assessed, even when it’s not official. I’ve seen how quickly labels stick. One disclosure can change how people see you, and once that happens it’s hard to undo.” (Grace)

This quotation captures the fragility participants associated with professional reputation. Disclosure was imagined as potentially irreversible, capable of reshaping others’ views of their capability, reliability, and suitability for clinical work. The fear was not only that difficulties might be recorded, but that they might become defining features of their professional identity.

Analytically, this subtheme demonstrates how help-seeking within NHS contexts is interpreted through the lens of career risk. Participants’ concerns were not limited to immediate therapeutic encounters, but extended to longer-term implications for references, employability, and professional standing. Underpinning this reputational anxiety is the stigma that mental health problems carry within healthcare settings: the persistent, if often unspoken, association between psychological distress and professional unfitness. For Black trainees, this generalised sanist stigma is layered with racial prejudice, the stereotype that emotional vulnerability signals incompetence, making the reputational stakes of disclosure uniquely high. In this way, accessing support was understood as a high-stakes decision with consequences that could reach far beyond personal wellbeing. This subtheme completes GET 4 by illustrating how structural power dynamics and reputational anxieties reinforce the construction of Trust-based support as something to be approached with caution, if at all.

4.6 Overview of GET 5: Safety Is Pursued Outside Formal Systems Through Culturally Attuned Care, Religion, Peer Solidarity, and Values-Based Recommitment

This Group Experiential Theme captures how participants responded when university and NHS pathways were experienced as unsafe, exposing, or insufficient. Rather than

withdrawing from support altogether, participants described actively constructing alternative routes to care that felt psychologically safer and more controllable. Across accounts, support was sought in spaces that were clearly separated from professional evaluation, organisational surveillance, and racialised interpretation.

Participants' narratives suggest that the decision to seek help outside formal systems was not driven by a rejection of therapy or psychology, but by a desire for privacy, autonomy, and cultural attunement. Private therapy, global majority peer networks, and personal value systems emerged as key resources through which participants could access emotional support without the professional risks associated with Trust-based services. This GET therefore reflects a process of creative and intentional self-protection, in which participants built supportive ecologies that allowed them to remain both psychologically held and professionally engaged.

Across this GET, participants' underlying experiences of institutional risk and the need for safety outside formal systems were strikingly convergent; what varied was not whether participants sought alternative sources of safety, but which specific resources they drew on and how readily available those resources were to them. Divergence within this GET is therefore concentrated in participants' interpretations of, and coping strategies for, a shared underlying experience, most clearly in the differing roles of faith and spirituality (Section 4.6.5) and in the differing accessibility of peer solidarity depending on cohort composition (Section 4.6.3), rather than in the experiences themselves.

4.6.1 Subtheme 1: Private Therapy as Safety Through Separation from Professional Identity

A central feature of participants' accounts was the decision to seek private therapy as a means of creating clear boundaries between personal mental health support and professional

life. In contrast to NHS services, which were experienced as intertwined with training and employment, private therapy offered a space that was perceived as confidential, independent, and free from organisational consequence. This separation appeared fundamental to participants' sense of safety and ability to work through distress they felt.

Vicky described how the distance between private therapy and professional identity transformed the experience of help-seeking:

“What I needed was a space where I wasn’t a trainee, wasn’t being assessed, wasn’t being evaluated in any way. I just wanted to be a person who was struggling. Having support that’s completely separate from my professional identity feels much safer. It means I can be honest without worrying about consequences.” (Vicky)

Here, safety is explicitly linked to independence from training structures. Support becomes acceptable when it is disentangled from systems that hold power over assessment, progression, and reputation. Similarly, Caroline emphasised how the absence of connection to the NHS or university was central to their decision:

“I didn’t want my support to be linked to any system that had power over my career. My training already controls so much of my life. Private therapy felt safer because it had nothing to do with my training. It felt like the only space that truly belonged to me.” (Caroline)

This account highlights that safety is not only about the therapeutic relationship itself, but about the wider context in which that relationship sits. The neutrality of private therapy allowed participants to engage as individuals rather than as trainees under evaluation. For Abigail, this independence created a rare sense of psychological relief:

“Even when people were being supportive, I was still careful about what I said and how I said it. Private therapy felt like the only option where I could breathe. It was the first space where I didn’t feel like I had to protect myself professionally.” (Abigail)

The language of breathing conveys what participants themselves expressed as emotional constriction associated with institutional pathways, and the contrasting spaciousness found in private care. Analytically, this subtheme illustrates how private therapy is constructed not simply as an alternative service, but as a fundamentally different kind of space: one in which vulnerability does not carry professional risk not because distress is absent, but because private therapy sits outside the institutional structures where sanist stigma and professional surveillance converge to render mental health disclosure a perceived threat to fitness-to-practise standing. Choosing private therapy therefore represents an active strategy for reclaiming agency and safety, enabling participants to access support while preserving their professional identities.

4.6.2 Subtheme 2: Cultural Attunement Reducing the Emotional Labour of Explanation

Alongside the desire for separation from professional identity, participants consistently described the importance of finding support that was culturally attuned. For many, private therapy was not only valued because it was independent of the NHS, but because it offered the possibility of being understood without the burden of repeatedly explaining cultural context, racial experiences, or identity-based nuances. Participants described this reduction in emotional labour as central to feeling safe and genuinely supported.

Vicky reflected on how the need to educate a therapist about cultural background would undermine the purpose of therapy itself:

“I knew from the start that I wanted a Black therapist, because I needed a space where I wouldn’t have to translate myself. I’d seen how often my experiences got misunderstood in training, and I didn’t want that to happen in therapy too. The thought of finally asking for help and then spending weeks educating someone about my culture just felt exhausting. I didn’t want to spend my sessions explaining my background.” (Vicky)

This quotation highlights how, within mainstream services, participants anticipated that significant time and energy would be spent justifying or contextualising their experiences before therapeutic work could even begin. The prospect of having to translate oneself was experienced as exhausting and potentially invalidating.

For Ruth, this concern shaped an intentional search for a therapist who shared aspects of their identity:

“The idea of opening up about really personal things to a White therapist who might not have that lived experience just didn’t feel safe to me. I needed someone who would already understand the cultural context without me having to educate them. That’s why I was intentional about finding someone Black.” (Ruth)

Here, cultural attunement is framed as a proactive strategy for ensuring safety and understanding. The desire for a Black therapist was not expressed as a preference based on comfort alone, but as a means of reducing the risk of misinterpretation and creating a therapeutic space where experiences of race and culture would be immediately recognised.

Similarly, Mary Anne captured the emotional toll associated with having to constantly interpret oneself for others:

“...but there's that experience of trying to translate myself across a culture that's really exhausting.” (Mary Anne)

This account conveys the fatigue that accompanies navigating predominantly White professional environments and underscores why culturally attuned support feels necessary rather than optional. Participants described wanting therapy to be a place of relief, not another setting in which they had to manage misunderstandings or microaggressions.

Analytically, this subtheme illustrates how cultural attunement is experienced as a core component of psychological safety. Participants were not seeking therapy that ignored race, but therapy that could hold it competently without requiring additional labour from them. In this way, choosing culturally aligned support represents a deliberate attempt to access care that feels genuinely therapeutic rather than burdensome, reinforcing GET 5's broader narrative of constructing safer alternatives outside formal systems.

4.6.3 Subtheme 3: Peer Solidarity as Containment and Validation

In addition to private therapy, participants consistently described peer relationships, particularly with other trainees from global majority backgrounds, as a crucial source of emotional containment. These peer connections were experienced as spaces of safety where distress could be shared openly without fear of judgement, surveillance, or misinterpretation. Unlike formal institutional supports, peer solidarity offered immediate understanding and validation rooted in shared experience.

Caroline described the unique sense of relief found in these relationships:

“With most people on the course I’m still careful about what I say and how I say it. But when I’m with other Black trainees, I can drop all of that. Talking to other Black trainees is the only time I feel like I can fully exhale, like I don’t have to perform or explain myself.”

(Caroline)

The metaphor of being able to exhale conveys how rare and precious these spaces were. Within predominantly White training environments, participants often felt required to remain guarded and self-monitoring. Peer connections with other Black trainees provided a contrast, allowing participants to relax emotionally and to feel understood without effort.

Similarly, Grace highlighted how these relationships removed the need for constant self-justification:

“When I’m with other Black trainees, I don’t feel questioned or analysed. People just get it. I don’t need to explain or justify my experience. I can just say how I’m feeling and be believed.” (Grace)

This account illustrates how peer solidarity reduced the emotional labour that characterised many other professional interactions. Shared cultural and racial understanding meant that experiences of racism, microaggressions, and distress could be acknowledged without debate or defensiveness. Participants described these peer spaces as uniquely validating, offering affirmation that their difficulties were real and legitimate.

A point of variation within this subtheme is also worth making explicit. The strength and availability of peer solidarity as a source of containment was not uniform across participants, but appeared to depend on the number of other Black trainees within a given participant's cohort. Participants who described being part of a cohort with a comparatively greater number of Black trainees spoke of more readily available, sustained peer support of the kind described above; participants in cohorts with very few or no other Black trainees described this resource as less consistently available, even though they too were, by definition, in a minority within their training programmes overall. This suggests that peer solidarity, while a genuine and valued source of containment across the sample, was not experienced as equally accessible by all participants, and that even small differences in cohort

composition could meaningfully shape participants' access to this form of support. This represents a difference in the practical availability of a shared coping strategy, rather than a difference in participants' underlying experience of needing such support, both of which were consistently described as necessary.

Analytically, this subtheme demonstrates how informal networks functioned as vital protective resources when formal systems were experienced as unsafe. Peer solidarity provided a form of collective holding that counterbalanced the isolation described in earlier GETs. Significantly, the relief these spaces offered was inseparable from the stigma that marked mental health disclosure elsewhere: within formal systems shaped by prejudice and racial stereotype, being unwell carried the risk of being seen as unfit; within peer spaces, shared experience dissolved that stigma and allowed distress to be named without consequence. These relationships did not replace professional support, but they offered a parallel system of care in which participants could be fully seen and believed. In this way, peer connections formed an essential component of the alternative support ecologies that characterise GET 5.

4.6.4 Subtheme 4: Lived Experience as Ethical Grounding and Professional Recommitment

Across participants' accounts, lived experience of mental health problems did not only shape how support was sought, but also how participants understood their developing professional identities. Rather than leading to withdrawal from the profession, these experiences were frequently reframed as a source of ethical grounding and motivation to practise differently. Participants described their personal histories as providing a moral compass that informed how they wished to relate to future clients and to the systems in which they would work.

Grace articulated this sense of transformation clearly:

“Thinking back to how misunderstood I felt as a service user, it changed the way I see my role now. I wanted to be the kind of professional I didn’t have...someone who listens properly, who thinks about culture, and who doesn’t dismiss people’s experiences.” (Grace)

Here, lived experience becomes a template for change. The absence of understanding or compassion in participants’ own journeys was described as generating a commitment to offer precisely those qualities to others. Personal suffering was therefore reinterpreted not only as a challenge, but as a resource that could shape more humane practice.

Caroline similarly reflected on how lived experience fostered a heightened sense of responsibility and care:

“Having been on the other side of the system, I’m constantly aware of how much power professionals hold. I know how easily people can feel unheard or harmed. What I’ve lived through makes me more careful, more ethical. It makes me think about every interaction, every decision, and how it might land for someone who’s vulnerable.” (Caroline)

This quotation suggests that experiencing distress from the position of a service user created deeper awareness of power, vulnerability, and the potential for harm within clinical systems. Participants described this awareness as influencing their professional values, encouraging greater sensitivity and reflexivity in their approach to psychological work.

For Abigail, these experiences strengthened rather than weakened their commitment to the profession:

“Going through my own struggles has shown me how easily systems can fail people like me. Instead of pushing me away from psychology, my experiences make me more determined to do better and to be different for the clients I’ll work with.” (Abigail)

This determination illustrates how, despite the difficulties described across earlier GETs, participants maintained a strong investment in psychology and in the possibility of change from within. Rather than abandoning the system, they positioned themselves as future agents of improvement.

Analytically, this subtheme demonstrates that seeking safety outside formal systems did not equate to disengagement from professional identity. Instead, lived experience functioned as a stabilising and orienting force that helped participants to remain connected to their vocational values. This subtheme highlights how participants constructed pathways to care that protected their wellbeing while simultaneously nurturing a renewed commitment to ethical, compassionate practice. Their experiences therefore became a foundation for resilience and purpose, even in the face of institutional challenges.

4.6.5 Subtheme 5: Faith and Spirituality as an Unrecognised Anchor

For some participants, faith and spirituality emerged as important sources of strength, meaning, and emotional stability. These aspects of identity were described as providing an internal framework for coping with distress and navigating the challenges of training. However, participants also reflected on how spirituality was largely absent from, or implicitly marginalised within, psychological training and NHS contexts. As a result, a significant dimension of their support system remained unacknowledged within formal professional spaces.

Angela described the centrality of faith to their way of understanding the world:

“My faith... informs everything about how I see the world.” (Angela)

This account positions spirituality not as a peripheral coping mechanism, but as a foundational lens through which experiences of distress, resilience, and purpose are interpreted. Faith was described as offering comfort, direction, and a sense of grounding that extended beyond what psychological models or services could provide. For participants who drew on spiritual resources, this dimension of support was experienced as deeply personal and sustaining.

At the same time, participants noted that such sources of support were rarely recognised or validated within psychological training. Angela reflected on the disconnect between their lived experience and the culture of the profession:

“Yeah, but obviously my faith has been a big part that's kind of helped me, not kind of...completely go off the rails of like just quit the course completely. But obviously it doesn't really get acknowledged beyond like oh, this is like a social graces and protective factor.” (Angela)

This lack of acknowledgement created a sense that an important aspect of their identity and coping was rendered invisible within academic and clinical contexts. Participants described feeling that psychological spaces privileged secular, individualised frameworks of wellbeing, leaving little room for spiritual or faith-based understandings of distress and healing.

It is important to note that this subtheme represents a clear point of divergence rather than convergence across the sample. Faith and spirituality were described as a central, organising lens for understanding distress and resilience by Angela alone; no other participant drew on religious or spiritual frameworks to a comparable degree when making sense of their

experiences. Rather than treating this as a limitation of the analysis, this divergence is retained here as a genuine feature of the idiographic data: it illustrates that, even within a sample sharing race, professional role, and broad experiences of institutional risk, participants drew on markedly different internal resources to sustain themselves, and that for at least one participant, a resource entirely absent from formal psychological and NHS frameworks served a function that, for other participants, was served by peer relationships, private therapy, or professional recommitment. This divergence is consistent with IPA's commitment to representing both shared and idiosyncratic meaning-making, and cautions against reading GET 5 as describing a single, uniform alternative support ecology used identically by all participants.

Analytically, this subtheme highlights how some participants constructed additional forms of support that existed outside both NHS services and conventional psychological models. Faith and spirituality functioned as private anchors that helped sustain emotional wellbeing, even when formal systems felt unsafe or inadequate. However, the perceived absence of space for these perspectives within training also contributed to a sense of cultural mismatch between participants and the profession. In completing GET 5, this subtheme illustrates the diverse and personally meaningful ways in which participants sought safety and stability beyond formal institutional pathways.

5.0 Discussion

5.1 Overview

This discussion interprets the findings of the empirical study in relation to the theoretical and empirical literature reviewed in the introduction. The study asked: how do Black TCPs with lived experiences of mental health problems make sense of their experiences navigating mental health support within the NHS Trust where they are employed? GETs generated through IPA provide a detailed account of that experience, and the discussion that follows connects these findings to the frameworks and literature that framed the study at the outset.

The overarching argument to emerge from the findings is that the barriers Black TCPs face in accessing mental health support are not primarily attitudinal or individual. They are structurally produced and racially specific, shaped by the intersection of professional identity, lived experience of mental health, and racial positioning within systems that were not designed with this population in mind. This argument extends and substantiates the intersectional (Crenshaw, 1989, 1991) and Critical Race Theory (CRT; Delgado & Stefancic, 2017) frameworks introduced in the empirical introduction by grounding their structural claims in the phenomenological accounts of participants.

The discussion proceeds by interpreting each GET in relation to the empirical introduction, before offering a broader theoretical synthesis. Implications for clinical training and the NHS are then considered, followed by critical reflection on the study's strengths and limitations drawing on the methodology chapter, and directions for future research. The discussion closes with a summary of the study's contributions.

5.2 Interpretation of Findings

5.2.1 GET 1: Distress Emerges Through Cultural Silencing, Delayed Recognition, and Cumulative Pressure

GET 1 reveals that participants' journeys toward recognising and seeking support for their mental health problems were shaped long before they entered doctoral training. Cultural narratives of strength, endurance, and emotional restraint absorbed through family and community meant that distress was normalised, privately carried, and actively re-interpreted as something to be managed rather than named. The introduction identified cultural stigma as a significant deterrent to help-seeking among Black individuals, noting that norms emphasising self-reliance and emotional control can exacerbate shame and isolation (Bhui et al., 2015b; Mantovani et al., 2017; Clement et al., 2015). GET 1 deepens this understanding by revealing its phenomenological mechanism, showing that stigma did not only operate externally as a social deterrent but was internalised as self-regulation. Ruth's account of learning 'very early on to carry things quietly instead of saying I was struggling,' and Vicky's description of telling herself, 'you're just being weak, you need to toughen up, especially as a Black woman in these spaces,' illustrate how cultural silence became a learned relational stance. Participants did not lack insight into their difficulties; they had been taught to override it.

The introduction noted that training environments can heighten existing vulnerabilities, particularly for Black trainees who navigate 'White spaces' where racial awareness is limited (Daloye, 2022; Metrustry & Hodge, 2025). GET 1 confirms this, showing that doctoral training functioned as a threshold experience at which previously sufficient coping strategies failed. Angela's description of the training year reminding her of earlier periods of emotional overload, and Vicky's account of her body being 'always braced for something bad to happen,' illustrate how training did not create distress in isolation but exposed the limits of strategies of silence

and endurance. This reframes delayed help-seeking not as avoidance but as a structurally produced response to the exhaustion of available coping resources.

5.2.2 GET 2: Performing Wellness and Competence Under Racialised Scrutiny

GET 2 reveals what happened once participants entered the training environment. The introduction's discussion of racialised experiences in clinical psychology training including heightened self-surveillance, emotional labour, and tokenism (Daloye, 2022; Faheem et al., 2024; Metrustry & Hodge, 2025) is given concrete phenomenological form here. Being numerically rare within predominantly White cohorts was experienced not simply as difference but as consequential visibility, carrying a sense that one's actions, struggles, and expressions could be read as representative of Black trainees more broadly. Vicky's reflection that being Black on the course meant 'mistakes don't feel neutral' captures the representational weight that participants carried in training spaces.

The introduction identified compounded stigma as a specific challenge for Black TCPs, arising from the intersection of cultural expectations of emotional competence, racialised stereotypes, and professional norms of composure (Tay et al., 2018; Crenshaw, 1991). GET 2's second subtheme makes this compound legible, whereby fear of stereotype confirmation operated as an organising force shaping how emotional expression was managed or suppressed. Ruth described carefully calculating whether expressing distress might 'feed into stereotypes about Black people being too emotional'; Mary Anne noted that a Black person does not 'get as much rope.' These accounts illustrate that emotional restraint was not a personal preference but a structurally compelled adaptation, a rational response to perceived differential consequences within an evaluative environment.

The result, captured in GET 2's third subtheme, was the sustained performance of wellness. Grace's reflection on the 'deeply ironic' experience of training within a mental health

profession while feeling unable to be openly unwell, and Vicky's description of 'showing up smiling and professional' even on days of barely coping, articulate the gap between internal experience and professional presentation that characterised participants' daily lives. The introduction identified this tension directly, noting that training cultures associating wellness with professional credibility and distress with impairment can compel trainees with lived experience to conceal aspects of their identities (Rothschild, 2021; Knight et al., 2022). GET 2 confirms this and adds that for Black TCPs, the concealment is racially as well as professionally motivated, making the performance more effortful, more sustained, and more costly.

5.2.3 GET 3: Training and University Structures as Failing to Contain Distress

GET 3 documents participants' experiences of formal support within their training courses and universities, finding those structures procedurally present but experientially hollow. The introduction noted that institutions failing to provide psychologically safe spaces for reflection risk reinforcing self-stigma among those they train to foster openness in others (DCP, 2020; Knight et al., 2022). GET 3 shows this failure in practice. When participants did attempt to disclose distress, course and personal tutoring responses were experienced as shaped by risk management rather than relational understanding. Caroline described being 'pointed back to a policy rather than actually listened to'; Abigail felt 'like a problem to be managed, not a person that was hurting.' The appearance of support was maintained; its substance was absent.

The introduction's discussion of stigma and disclosure in training contexts noted that trainees engage in strategic disclosure based on perceived psychological safety and anticipated reactions (Knight et al., 2022; McCormack et al., 2021). GET 3 shows what happens when those perceptions are confirmed: trust erodes progressively. Mandy described disengaging from help-seeking because 'every conversation started to sound the same,' and Mary Anne

described a shift from believing the course would offer support to feeling that 'reaching out stopped feeling like support and started feeling like risk.' This is not passive disengagement but the rational withdrawal of trust from a system that had repeatedly demonstrated it could not hold what participants brought to it.

GET 3's second subtheme cohort culture as a source of reduced psychological safety extends this picture into the peer environment. Participants described cohorts that were competitive and unable to hold discussions of race or vulnerability with genuine openness. The introduction identified heightened self-surveillance as a feature of Black trainees' experience in predominantly White training environments (Daloye, 2022; Faheem et al., 2024); GET 3 reveals how cohort dynamics can intensify rather than buffer this. When Abigail's attempts to raise racial concerns were met with silence that felt 'louder than any comment,' the cohort was not a space of professional solidarity but one that replicated the broader patterns of racialised silencing the introduction had described. Finally, GET 3's third subtheme reveals how structural gaps in support displaced responsibility for wellbeing onto individual trainees. Angela's account of having to 'pay my own money to get support' illustrates how institutional failure does not simply leave need unmet but reframes distress as a private matter, a process of individualisation with direct consequences for how future help-seeking is understood and approached.

5.2.4 GET 4: NHS and Trust-Based Support Is Constructed as Risky Due to Power, Proximity, Racism, and Permanence

GET 4 is the most distinctive contribution of this study. The introduction established that NHS healthcare workers frequently report fears about confidentiality, privacy, and professional repercussions when considering accessing support through their employer, and that these concerns are heightened for racially minoritised staff navigating a 'double bind' in

which disclosure risks reinforcing negative stereotypes about competence (Kinman et al., 2020; Kinman & Teoh, 2018; Nazroo et al., 2020). GET 4 reveals that for Black TCPs, these general features of NHS employment are qualitatively intensified through four interlocking dimensions that together transformed NHS support from a potential resource into a site of potential exposure.

The first-dimension proximity and boundary blurring captures the structural reality that Black TCPs train, work, and might seek care within the same institutional space. Vicky's description of services where 'everything overlaps,' and Mary Anne's reasoning that she would be 'looking for jobs in exactly these services in a couple of years' time,' illustrate a conflict of interest that is architectural rather than incidental. The introduction noted the unique tensions arising from the NHS's dual role as both employer and provider of care (Kinman et al., 2020); GET 4 reveals that for clinical trainees, this duality is experienced not as a minor complication but as a fundamental structural problem that makes any clear boundary between professional and patient identities impossible to maintain.

The second-dimension permanence of documentation adds a temporal quality to these concerns. Caroline's account of NHS records feeling like they 'become part of who you are in the system' illustrates how participants understood clinical documentation not as a time-limited record but as an enduring narrative capable of following them into future placements, references, and employment. The introduction identified that concerns about career repercussions are a significant deterrent to disclosure for healthcare professionals with mental health problems (Tay et al., 2018; McCormack et al., 2021), and that for Black TCPs the absence of clear guidance on how lived experience is handled within professional standards exacerbates uncertainty (DCP, 2020; HCPC, 2023; BPS, 2023). GET 4 shows the lived consequence of that uncertainty, such that when the stakes of documentation are unclear and the consequences potentially irreversible, silence becomes the only rational option.

The third dimension racialised misinterpretation and lack of clinician choice connects directly to the introduction's account of NHS mental health systems as sites where Black service users encounter diagnostic bias, risk-focused assessment, and coercive pathways at disproportionate rates (Nazroo et al., 2020; Morgan et al., 2020; Memon et al., 2016). Abigail's account of fearing that distress would be 'read differently because I'm Black that 'anger gets read as aggression, assertiveness gets read as threat is grounded in a historically informed understanding of how Black people's emotional expressions are misread in White-dominated institutional settings. The inability to choose a culturally aware clinician within NHS pathways intensified this concern. Participants were aware that they would be assigned whoever was available, and that this clinician would hold the power to interpret their experiences, make diagnostic judgements, and create permanent records without any guarantee of cultural attunement or safety.

The fourth-dimension professional consequences and reputational risk situate the other three within the specific evaluative context of clinical training. Vicky's description of supervisors simultaneously responsible for assessing fitness to practise and to whom trainees might disclose distress captures a structural conflict that the introduction identified in principle (Tay et al., 2018; Kinman et al., 2020) but that GET 4 renders phenomenologically specific. Grace's observation that 'one disclosure can change how people see you, and once that happens it's hard to undo' illustrates how participants experienced professional reputation as fragile and disclosure as potentially irreversible. Taken together, the four subthemes of GET 4 demonstrate that Black TCPs' avoidance of NHS Trust-based mental health support was not irrational or culturally driven but a carefully reasoned response to structural conditions that made help-seeking genuinely and disproportionately risky.

5.2.5 GET 5: Safety Is Pursued Outside Formal Systems Through Culturally Attuned Care, Religion, Peer Solidarity, and Values-Based Recommitment

Private therapy was chosen as a structural necessity rather than a preference, providing the separation from professional identity that NHS pathways could not. Vicky's account of needing 'a space where I wasn't a trainee, wasn't being assessed,' and Caroline's description of private therapy as 'the only space that truly belonged to me,' articulate a need for structural independence from evaluative contexts that is directly consistent with the introduction's identification of confidentiality and professional privacy as central concerns for healthcare workers seeking support from their employer (Kinman et al., 2020). The emotional relief this separation produced, described by Abigail as 'the first space where I didn't feel like I had to protect myself professionally,' speaks to the pervasive cost of the self-protective vigilance documented throughout the earlier GETs.

Actively seeking therapists who shared aspects of participants' racial and cultural background, and who were therefore perceived as more likely to offer culturally attuned care, was a further feature of their alternative support strategies. The introduction's engagement with intersectionality illuminates this, showing that when race, professional identity, and lived experience of mental health intersect, care that cannot engage with all of these dimensions cannot adequately address the experience it is meant to contain (Crenshaw, 1991; Collins, 2000). Participants did not anticipate culturally misattuned therapy as simply less helpful; they anticipated it as requiring an additional expenditure of emotional and explanatory labour that would undermine therapy's purpose. Mary Anne's articulation of cross-cultural translation as 'really exhausting,' and Vicky's reflection that she 'needed a space where I wouldn't have to translate myself,' make this burden concrete. The introduction identified emotional labour and self-surveillance as features of Black trainees' professional

experience (Metrustry & Hodge, 2025); GET 5 shows how these features extend into therapeutic spaces where they remain unsupported by cultural understanding.

Peer solidarity with other Black and global majority trainees offered a qualitatively distinct form of support: immediate, validating, and free from the self-protective vigilance that characterised most other professional interactions. Caroline's description of time with other Black trainees as 'the only time I feel like I can fully exhale,' and Grace's account of peer spaces where 'people just get it,' illustrate how shared racial and cultural understanding can create containment that formal services rarely provide. The facilitative role of trust, cultural resonance, and shared identity identified in the literature (Mantovani et al., 2017; Williams et al., 2021) is confirmed here, with the additional finding that this resource was structurally precarious, contingent on the presence of other Black trainees within cohorts where representation remained limited.

GET 5's fourth subtheme, lived experience reframed as ethical grounding and professional recommitment, is the finding most directly in dialogue with the introduction's treatment of lived experience within clinical psychology. The introduction cited the DCP's (DCP, 2020, 2022) emerging guidance positioning lived experience as a potential resource for empathy, therapeutic attunement, and reflexive practice (Huggett et al., 2023; Knight et al., 2022). GET 5 provides empirical support for this aspiration in this specific population, where participants described their experiences of inadequate, unsafe, or culturally misattuned care not as wounds that compromised their clinical development but as resources that deepened their ethical commitments. Grace's articulation of wanting to be 'the kind of professional I didn't have,' Caroline's reflection that her experiences make her 'more careful, more ethical,' and Abigail's determination to 'do better and be different for the clients I'll

work with' all demonstrate that lived experience, when not suppressed or pathologised, can be a genuinely generative dimension of professional identity.

Finally, faith and spirituality as an unacknowledged anchor, GET 5's fifth subtheme, highlights a gap in how psychological training engages with the inner resources Black trainees draw on. Angela described faith as foundational to her sense of meaning and to her ability to remain in training, while also observing that it was rarely acknowledged within the profession beyond a 'social graces and protective factor.'

5.2.6 Extending Prior Research

Read individually, each GET discussion above shows points of confirmation between this study's findings and prior literature on Black trainees', healthcare workers', and service users' experiences of mental health stigma and institutional racism. Read together, however, the contribution of this study lies less in confirming that these difficulties exist, which prior literature, reviewed in the introduction and summarised in the systematic review in Chapter 2, has already established, and more in three specific ways in which the present findings move beyond that existing evidence base.

First, this study identifies the precise mechanism by which previously documented difficulties are produced, rather than simply documenting their presence. Prior literature established that cultural stigma deters help-seeking (Bhui et al., 2015b; Mantovani et al., 2017; Clement et al., 2015) and that racialised scrutiny shapes Black trainees' professional conduct (Daloye, 2022; Faheem et al., 2024; Metrustry & Hodge, 2025), but largely treated these as parallel, separately operating barriers. GET 1 and GET 2 together demonstrate that these are not parallel barriers but a single developmental sequence: a capacity for emotional silence learned in childhood and adolescence, prior to and independent of clinical training,

that is then specifically reactivated and intensified once a participant enters a professional, evaluative environment. This sequential, developmental relationship between pre-existing cultural coping and its later professional activation has not, to the candidate's knowledge, been previously documented in the empirical literature on Black trainees or Black healthcare professionals, and offers a more precise account of why interventions aimed solely at the training period may be addressing only the latter half of a process that began much earlier.

Second, this study identifies a structural configuration of risk that is specific to, and has not previously been documented within, the population of Black trainee clinical psychologists. Prior research on NHS healthcare workers' reluctance to access employer-provided mental health support (Kinman et al., 2020; Kinman & Teoh, 2018) and on Black service users' experiences of NHS mental health care (Nazroo et al., 2020; Morgan et al., 2020; Memon et al., 2016) has, to date, largely treated the employee experience and the service-user experience as belonging to separate bodies of literature, concerning different populations occupying different positions within the NHS. GET 4 demonstrates that Black trainee clinical psychologists occupy both positions simultaneously and within the same institutional space, such that the risks documented in each separate literature (professional and reputational risk for employees; racialised misinterpretation and coercive pathways for service users) combine and compound rather than simply co-occurring. This dual-position structural risk, made possible specifically by the trainee's status as simultaneously NHS employee, trainee under evaluation, and potential service user within the same Trust, represents a population-specific extension of two previously separate evidence bases rather than a confirmation of either in isolation.

Third, this study extends existing, largely aspirational literature on lived experience within clinical psychology training (DCP, 2020, 2022; Huggett et al., 2023; Knight et al.,

2022) by providing empirical, idiographic evidence of how lived experience of mental health problems is integrated into Black trainees' professional identity in practice, rather than treated only as a policy aspiration or training recommendation. GET 5's fourth subtheme shows lived experience operating as a source of ethical grounding and professional recommitment specifically when formal systems fail to provide adequate support, suggesting that the integration of lived experience into clinical identity may be most likely to occur not despite institutional failure, but partly in response to it. This finding extends the existing literature's largely prospective framing of lived experience as a resource clinical psychology training programmes ought to draw on, by showing a process through which some Black trainees already draw on it themselves, under specific institutional conditions that the prior literature has not characterised.

Taken together, these three extensions, a developmental mechanism linking pre-training coping to in-training performance, a population-specific structural risk configuration arising from dual employee/service-user positioning, and an empirically grounded account of how lived experience becomes integrated into professional identity under conditions of institutional failure, represent the principal ways in which this study moves beyond confirming existing literature on stigma, racialised scrutiny, and institutional risk, toward providing new, population-specific theoretical and empirical contributions.

5.3 Theoretical Synthesis

Reading across all five GETs, the findings substantiate and extend the two theoretical frameworks that anchored this study. Intersectionality (Crenshaw, 1989, 1991; Collins, 2000; Bowleg, 2012) and Critical Race Theory (Delgado & Stefancic, 2017) together provide a framework for understanding how structural, relational, and intrapsychic experiences are co-

constituted rather than independent, and how the identities of Black TCPs take on compounded meaning within the specific institutional field of NHS clinical training.

The findings demonstrate this precisely. The performance of wellness (GET 2) cannot be understood solely as impression management within professional contexts but must be read in relation to racialised expectations of competence and stereotypes of emotional expression. The perceived failure of training structures (GET 3) reflects not only general limitations in support provision but the ways in which institutional responses are differentially experienced when filtered through racialised positioning and concerns about legitimacy. In this way, intersectionality shifts the interpretation from one of general trainee difficulty to one of structurally patterned, identity-contingent experience.

The fear of stereotype confirmation documented in GET 2 is not reducible to race or professional identity alone. It arises because racialisation and professional identity as a trainee under evaluation are simultaneously active within the same institutional space, making emotional expression carry a racialised professional cost that neither identity dimension alone would produce. The four-dimensional risk structure of GET 4, proximity, permanence, racialised misinterpretation, and professional consequences, similarly cannot be understood by disaggregating its components. It is precisely because Black TCPs occupy the interlocking positions of racialised person, mental health service user, and trainee accountable to evaluators within the same institution that help-seeking is transformed into a high-stakes act of risk management. In each case, what is most significant about participants' experiences is produced at the intersection of identities and the institutional context in which those identities are made consequential, such that the intersection itself is the phenomenon.

Critical Race Theory's central claim that racism is normalised and embedded in social institutions, not reducible to individual prejudice, is directly substantiated by the data.

Participants did not describe isolated encounters with racist individuals. They described systems: cohort cultures that silenced racial disclosure, pastoral structures that redirected distress into proceduralism, NHS pathways that entangled care with professional evaluation, and documentation practices that made vulnerability permanent, whose design produced racialised effects regardless of the intentions of those operating within them. CRT's rejection of colour-blind approaches (Ladson-Billings, 1998) is particularly relevant to clinical training contexts, where discourses of professional objectivity and neutral competence assessment can obscure the racialised dynamics shaping who is and is not safe to be vulnerable. Together, the frameworks reframe the findings: the barriers Black TCPs face are not produced by individual failures of empathy or awareness, but by structural arrangements that require structural redress.

Three specific CRT concepts illuminate the GET 4 findings with particular precision and resist the reduction of those findings to description alone. The first is the permanence of racism (Bell, 1992): participants did not experience institutional risk as contingent or correctable, they anticipated it as durable. This expectation was not pessimism but a historically grounded reading of how NHS systems have consistently treated Black service users, and it finds structural echo in the literal permanence of electronic records that GET 4's second subtheme documents. That the record does not expire mirrors, at the individual level, what CRT identifies at the systemic: racialised disadvantage is not an anomaly awaiting correction but a stable feature of institutional design.

The second concept is whiteness as property (Harris, 1993), whereby professional credibility and fitness-to-practise standing function in this context as a form of reputational capital whose value is racially unequal. For Black TCPs, this capital is simultaneously more fragile, because racialised readings of distress, as Abigail described, transform emotional expression into evidence of incapacity, and more costly to protect, because protection requires

the sustained suppression of the very mental health needs that disclosure might address. The asymmetry is structural, not incidental.

The third concept is interest convergence (Bell, 1980): the NHS's interest in retaining Black trainees and its interest in managing fitness-to-practise liability converge in ways that are structurally incompatible with safe disclosure. Since the Trust functions simultaneously as employer, evaluator, and care provider, there is no pathway through which a Black TCP can seek support without activating the institution's competing interest in its own risk management. This is why, as Section 5.4 argues, the problem cannot be resolved through better signposting or confidentiality reassurance: structural separation is precisely what the institution's converged interests militate against, and naming that convergence is the theoretical work CRT enables that a purely descriptive account of participants' fears cannot do.

5.4 Implications

5.4.1 For Clinical Psychology Training Programmes

The findings carry direct implications for the design of clinical psychology training. Most urgently, the structural entanglement of pastoral and evaluative functions identified across GETs 3 and 4 as a core source of unsafe exposure must be addressed. The DCP (2020) guidance on supporting lived experience in training recognised the importance of this separation in principle. However, the findings suggest it has not been realised in practice. Training programmes should ensure that genuinely independent pastoral support is available to all trainees, provided by individuals with no evaluative role, and clearly communicated as separate from fitness-to-practise processes. For Black TCPs, this independence is not a convenience but a prerequisite for safe help-seeking.

Cohort culture identified in GET 3 as a determinant of psychological safety requires active programme-level attention. Environments that are competitive and unable to hold discussions of race and vulnerability do not simply fail to support Black TCPs; they compound isolation and reinforce the self-protective strategies documented in GET 2. Programmes committed to supporting Black trainees should cultivate conditions for genuine reflexivity, including structured spaces where racial dynamics can be explored openly, explicit curriculum content on race and professional identity, and clear responses to racialised silencing within cohort settings. Finally, the reframing of lived experience as professional resource in GET 5 should be reflected in training culture. The DCP's (2020, 2022) steps toward normalising lived experience within professional identity are supported by the findings of this study. When this normalisation is genuine rather than gestural, it produces practitioners with deepened ethical commitment and critical reflexivity.

Implementing these recommendations is, however, unlikely to be straightforward, and it is worth considering the barriers that training programmes are likely to encounter. Separating pastoral support from evaluative processes, as recommended above, requires dedicated staffing distinct from existing academic and clinical tutor roles, which represents a real resourcing commitment for programmes already operating within constrained higher education budgets; without ring-fenced funding or workforce allocation specifically for this purpose, such separation risks remaining a stated principle rather than a realised structure, much as the DCP's (2020) existing guidance on this separation has not, according to the present findings, yet translated into practice. Building genuine cohort-level openness to discussions of race and vulnerability is a further significant undertaking, since it requires sustained curriculum development and staff training in facilitating these conversations, neither of which can be achieved through a single training session or module, and both of which depend on staff and cohort members being willing to engage openly with material that may be personally and

professionally uncomfortable; broader literature on implementing anti-racism interventions in healthcare and educational settings identifies exactly this kind of institutional and individual resistance, alongside the risk of initiatives being watered down into less specific or less accountable forms, as a recurring barrier to sustained organisational change (Hassen et al., 2021). Finally, embedding a genuine, rather than gestural, normalisation of lived experience within training culture requires not only policy commitment but also a shift in how competence and fitness to practise are assessed, an area that training programmes may be reluctant to revisit given the regulatory and professional accountability attached to these processes.

5.4.2 For NHS Mental Health Services

GET 4 identifies specific structural features of NHS Trust-based support that require redesign, not better communication. The structural conflict of interest inherent in clinical training where help-seeking means entering systems populated by colleagues, supervisors, and services in which participants hoped to build careers cannot be resolved through awareness campaigns or signposting. It requires the establishment of referral pathways for clinical trainees that are demonstrably independent of their employing Trust, with clear firewalls between clinical records and occupational health, fitness-to-practise, or supervisory processes. The introduction noted that NHS Staff Mental Health Hubs and People Plan provisions were established for this purpose, but that uptake remains low among racially minoritised staff (West et al., 2020). The findings indicate this reflects not a communication failure but a rational response to structural risks that current provisions have not adequately addressed.

The absence of clinician choice within NHS pathways, experienced as a significant deterrent in GET 4's third subtheme, also warrants direct attention. The introduction identified cultural responsiveness and clinician representation as facilitators of help-seeking (Mantovani et al., 2017; Williams et al., 2021); GET 4 confirms this and adds that the inability to exercise

any choice over who provides care in a context where cultural misinterpretation carries both clinical and professional consequences was experienced as removing the final layer of protection available to participants. At minimum, NHS services should actively facilitate referrals to culturally specific or independent providers for trainees who identify Trust-based pathways as structurally unsafe.

The barriers to implementing these recommendations are likely to be substantial, and are worth setting out directly rather than treating implementation as a straightforward extension of the recommendation itself. Establishing referral pathways genuinely independent of a trainee's employing Trust requires inter-Trust commissioning arrangements, information governance solutions that allow records to be held outside the employing organisation, and ongoing funding, none of which can be resolved at a single-Trust or single-service level; existing qualitative research on implementing workplace health and wellbeing services within the NHS identifies financial constraints, a pressurised operating environment, and organisational reluctance to prioritise staff wellbeing investment over patient-facing service provision as recurring and difficult-to-resolve barriers to exactly this kind of service-level change (Quirk et al., 2018). Facilitating meaningful clinician choice, including referral to culturally specific or independent providers, is similarly constrained by existing workforce shortages and the uneven geographical distribution of culturally diverse clinical psychology staff across NHS Trusts, meaning that even a genuinely committed Trust may be unable to offer this choice in practice without wider workforce-level change extending beyond any single Trust's control. Taken together, these barriers suggest that the structural redesign called for in this section is necessary but unlikely to be quickly or easily achieved, and is more realistically pursued as a longer-term, system-level commitment than as a set of changes a single training programme or Trust could implement unilaterally.

5.5 Strengths and Limitations

This study has several strengths and several limitations that require acknowledgement. The use of IPA was well-suited to the research question, enabling detailed, theoretically grounded engagement with how participants made meaning of their experiences and preserving the idiographic richness of individual accounts while generating interpretative group-level themes (Smith et al., 2009).

The researcher's positionality as a Black trainee clinical psychologist with lived experience of the phenomena under investigation was a genuine methodological resource. It facilitated recruitment through professional networks that might otherwise have been inaccessible, supported the development of trust within interviews, and informed the interpretative process with insider knowledge. Reflexivity was maintained throughout through a research diary and supervisory discussion with the research team, consistent with best practice in qualitative methodology (Finlay, 2021; Berger, 2015), ensuring that this positionality was critically examined rather than simply asserted.

The constructivist epistemological stance maintained consistently across the study from the ontological position articulated in the introduction through to the design, data collection, and analysis ensured coherence between philosophical commitments and methodological choices. The integration of intersectionality and CRT as analytic frameworks from the study's inception, rather than as post-hoc additions, shaped the research questions and the interpretative approach in ways well-suited to the complexity of the phenomenon under investigation.

The most significant limitation concerns sample homogeneity. All eight participants were female, six participants were of Black African heritage, one of Black mixed heritage, and one of Black Caribbean heritage. This was not the result of deliberate exclusion. The female composition reflects the demographic reality of UK clinical psychology doctoral

training, where approximately 85% of trainees are women (BPS, 2022), and the recruitment pathway which drew on networks for Black TCPs and trainees with lived experience is likely to have reached women disproportionately, as research consistently documents that women are more willing to discuss personal mental health experiences in professional contexts (Mackenzie et al., 2006). The near absence of Black Caribbean heritage participants is more difficult to explain and may reflect the specific networks through which the study was advertised, or differential rates of participation linked to training programme geography.

The sample size, while consistent with IPA methodology's idiographic principles and sufficient to generate the depth of analysis the approach requires (Smith et al., 2009), means the findings are not statistically representative and should be understood as idiographic, offering depth rather than generalisability.

Similarly, the study does not disaggregate within the category 'Black' by heritage, migration history, generational status, or faith background all of which may shape the specific configurations of cultural narrative and institutional experience documented across the GETs.

Finally, as with all retrospective qualitative research, participants' accounts represent their current sense-making of past experiences rather than unmediated records of events, and the meanings attributed to experiences may have evolved through the reflective process of participation itself.

5.6 Future Research

Several directions for future research emerge from the findings and from the limitations identified in Section 5.5. The first set addresses gaps produced directly by this study's sample and design; the second attends to the structural conditions this study has named but cannot evaluate.

The exclusively female sample points most immediately to the need for research centring Black male-identifying and non-binary TCPs. The cultural archetype of the strong Black woman (Wallace, 1978; Woods-Giscombé, 2010) operated as a significant organising force in how participants narrated and suppressed distress, and this does not translate straightforwardly to Black men or non-binary trainees. Research with these groups should attend to the distinctive cultural scripts and patterns of racialised scrutiny that shape their help-seeking, and should examine which features of the institutional exposure documented in GET 4 operate across gender and which are femininity-specific. Future research should also attend to heritage diversity within the category of Black. The near-absence of Black Caribbean participants means that heritage-specific dynamics, including intergenerational institutional mistrust and the distinct cultural frameworks documented in the SLR (Bailey & Tribe, 2021; Lawrence et al., 2021), are not represented in the findings. Targeted recruitment through Caribbean community organisations and BAATN networks would enable research testing whether the patterns documented here span Black African and Caribbean trainees or are heritage-specific.

Longitudinal research tracking Black TCPs' wellbeing and help-seeking across all three years of doctoral training would address a significant gap left by the present study's cross-sectional design. The demands of each training year are qualitatively different, and the experiences documented here may develop or shift across this arc. Longitudinal designs would also enable examination of whether changes to pastoral policy produce measurable changes in trainees' reported safety and help-seeking behaviour. Participatory action research (PAR) conducted with Black TCPs as co-researchers would complement this by enabling co-design and evaluation of support structures grounded in the specific features identified in GET 4. Existing PAR frameworks in mental health demonstrate that co-produced designs generate evidence more responsive to community-defined needs (Ocloo et al., 2024; Minkler

& Wallerstein, 2011), and a PAR approach would be particularly appropriate given that participants had already constructed informal care ecologies outside institutional systems.

Beyond the present study's design limitations, research is needed on the structural conditions themselves. The theoretical synthesis in Section 5.3 identified the convergence of the NHS's roles as employer, evaluator, and care provider as the architectural source of the help-seeking risks documented in GET 4. Research comparing independent pastoral support models across DClinPsy programmes in England, examining whether programmes with genuine firewalls between pastoral and evaluative functions produce different patterns of disclosure and wellbeing among Black trainees, would directly evaluate this claim. The DCP (2020) guidance provided a framework for this separation in principle; whether any programme has implemented it in a form that Black trainees experience as genuinely safe remains unknown. Related research is needed on whether NHS Staff Mental Health Hub provision addresses the structural risks identified here or replicates them in a different institutional form. The present findings suggest that uptake barriers for Black TCPs are structural rather than informational: a trainee who understands that a Staff Hub operates within the same Trust as their placement, shares information governance systems with occupational health, and is staffed by colleagues who may be encountered professionally, has rational grounds for scepticism that a communications campaign cannot resolve (NHS England, 2020a; West et al., 2020). Research evaluating actual Hub governance arrangements against the structural risk criteria identified in GET 4 would make a significant contribution to policy and practice.

Finally, GET 5 documented faith not as a supplementary coping resource but as a foundational meaning-making framework through which distress, resilience, and professional purpose were understood. The SLR identified Black Majority Churches as effective partners

in reducing stigma and facilitating pathways to care (Codjoe et al., 2023). Research examining how DClinPsy programmes can engage with faith and spirituality as legitimate dimensions of trainee identity, for example through partnerships with BAATN or faith-based counselling organisations, would extend this evidence base into the training context and may increase trainees' willingness to seek support.

5.7 Conclusions

This study set out to explore how Black trainee clinical psychologists with lived experience of mental health problems make sense of navigating NHS mental health support during their doctoral training. Through Interpretative Phenomenological Analysis of eight in-depth interviews, five Group Experiential Themes were generated, offering a coherent and detailed account of that experience: from the cultural silencing of distress that preceded training, through the racialised pressures and institutional failures encountered within it, to the alternative care ecologies participants constructed in response. Taken together, these themes make visible a set of structural conditions that have not previously been described with this degree of phenomenological specificity, and they locate Black TCPs' help-seeking not as an individual psychological act but as a negotiation with interlocking systems of power, visibility, and professional consequence.

The findings substantiate and extend the frameworks of intersectionality (Crenshaw, 1989, 1991) and Critical Race Theory (Delgado & Stefancic, 2017) by demonstrating, through lived accounts, that the barriers Black TCPs face are structurally produced and racially specific, and are not reducible to individual attitudes, cultural stigma, or personal reluctance. The proximity of participant and clinician within a shared NHS Trust, the permanence of electronic records, the racialised interpretation of distress, and the disciplinary weight of fitness-to-practise concerns together constitute a pattern of institutional exposure

that is specific to this population and has been under-theorised in the existing literature.

Naming that pattern is, in itself, a contribution. The findings move the conversation beyond deficit-framed accounts of help-seeking among Black trainees and toward an analysis of the conditions under which safe disclosure becomes possible.

Equally important is what participants described as the alternative terrain on which safety was eventually achieved. Private therapy accessed outside the NHS, peers who shared racial and cultural reference points, faith communities, and the reclaiming of lived experience as ethical grounding for practice emerged not as supplementary resources but as the primary architecture of recovery. That this architecture sits largely outside the institutions tasked with supporting trainee wellbeing is itself a finding of structural significance: where formal systems have failed, Black TCPs have built the conditions of their own containment, often at significant personal and financial cost. Any response that takes these findings seriously must resist the temptation to co-opt what participants have constructed privately and must instead reform the institutional conditions that made such constructions necessary.

The specific implications of these findings for training programmes, NHS mental health services, and the profession as a whole are set out in Section 5.4. The directions for future research, including work with Black male-identifying and non-binary trainees, disaggregation within the category of Black, longitudinal tracking of wellbeing across training, and participatory action research positioning Black TCPs as co-designers of support structures, are outlined in Section 5.6. These are not peripheral recommendations but necessary next steps if the evidence generated here is to translate into sustained structural change.

Ultimately, this study contributes a detailed, theoretically grounded account of an experience that has been present within the profession of clinical psychology but largely

undocumented within its empirical literature. Its value lies less in the novelty of any single finding than in the coherence of the picture that emerges when the accounts of Black TCPs are taken seriously on their own terms. This is a picture in which distress, silence, performance, institutional risk, and creative repair are inseparable from one another and from the racialised conditions in which they arise. If the profession is to be a place where Black trainees with lived experience of mental health problems can remain, be well, and practise with integrity, the conditions under which they currently negotiate support must change. The evidence presented here is a foundation for that work; what it calls for is not incremental adjustment but structural transformation, undertaken with the urgency and moral seriousness the findings demand.

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Appendix

Appendix A.

University of Hertfordshire Ethical Approval

To: Hillary Agyei-asare

Your application for ethics approval for the study listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: The Experience of Black Trainee Clinical Psychologists with Lived Experiences of Mental Health Problems Navigating Mental Health Support in the NHS

Your UH protocol number is: **0569 2025 May HSET**

This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': [UH Ethics Approval \(instructure.com\)](https://instructure.com).

This ethics approval expires on 12/06/2026

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances

Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions

Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix B.

Participation Information Sheet



UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS (‘ETHICS COMMITTEE’)

FORM EC6: PARTICIPANT INFORMATION SHEET

1 Title of doctoral study

The Experience of Black Trainee Clinical Psychologists with Lived Experiences of Mental Health Problems Navigating Mental Health Support in the NHS

2 Introduction

You are being invited to take part in a doctoral study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University’s regulation, UPR RE01, ‘Studies Involving the Use of Human Participants’ can be accessed via this link:

<https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs>
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 What is the purpose of this study?

The purpose of this study is to investigate the unique experiences of Black trainee clinical psychologists (TCPs) who have personally encountered mental health challenges and have considered seeking support from their employing NHS Trust. By focusing on the intersection of race, professional identity, and mental health, the study aims to fill a critical gap in the literature on how Black TCPs manage their dual roles as both mental health care providers and recipients. The study will explore the distinct challenges they face in seeking support within the same NHS environment where they work, and how these experiences may be influenced by race and identity.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment/care that you may receive (should this be relevant).

5 Are there any age or other restrictions that may prevent me from participating?

Participants will be adults ages 18 and above.

6 How long will my part in the study take?

If you decide to take part in this study, you will be involved in one interview that will last for approximately 60 to 90 minutes. The study will be carried out by the research over a term of two years in partial fulfilment of the Doctorate in Clinical Psychology in the University of Hertfordshire.

Supervisor - Natalie Kemp
Email - n.kemp4@herts.ac.uk

7 What will happen to me if I take part?

You will be asked to read the participation information sheet and if you consent to take part you will be provided with the consent form to read and sign. Then you will be invited for an online interview. Interviews will last approximately 60 to 90 minutes and will be recorded using Microsoft teams with participants' consent. Audio recordings will be transcribed verbatim for analysis.

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

Retelling experiences about mental health challenges which occur during training could bring up a variety of feelings. The researcher will be offering a debrief at the end of the interview and a debrief resource sheet will be provided to the participants.

9 What are the possible benefits of taking part?

The benefits of taking part in this study include:

1. Contributing to Change: By sharing their insights, participants contribute to a better understanding of the unique experiences faced by Black trainee clinical psychologists with mental health challenges, potentially leading to improved support and policies within the NHS.
2. Advancing Cultural Competency: Participants' perspectives can help inform more culturally competent mental health care practices, benefiting future Black mental health training professionals and enhancing awareness around race, mental health, and professional identity within clinical settings.
3. Professional Impact: By taking part, individuals contribute to a growing body of research that aims to create a more inclusive and supportive training environment, potentially influencing the experiences of future trainees in similar roles.

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

To protect participants' confidentiality, pseudonyms (participants can choose their own) will be used in all transcripts, reports, and publications. Digital recordings will be encrypted, and transcripts will be anonymized before analysis. Data recording will be stored on encrypted and password protected software. All data will be stored securely in compliance with the General Data Protection Regulation (GDPR). Data will be stored in secure University of Hertfordshire ~~OneDrive~~.

12 What will happen to the data collected within this study?

- The data collected will be stored electronically, in a password-protected environment secure University of Hertfordshire ~~OneDrive~~, for 24 months, after which time it will be destroyed under secure conditions. All data collected in this study, including participant consent forms and

recordings where relevant, will be stored in a secure, UH supplied storage location until the end of the research/assessment process and then securely destroyed. Anonymized quotes will be used in publication, infographics and presentations.

- The hard copy data collected will be stored in hard copy by me Hillary Agyei-Asare Researcher in secure encrypted and password protected one drive on password protected computer for 24 months, after which time it will be destroyed under secure conditions.
- All data collected in this study, including participant consent forms and recordings where relevant, will be stored in a secure, UH supplied storage location until the end of the research/assessment process and then securely destroyed.
- The data will be anonymised prior to storage.

13 Will the data be needed for use in further studies?

The data collected will not be re-used or subjected to further analysis as part of a future ethically approved study.

14 Who has reviewed this study?

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is <enter>

15 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing by email: h.agyei-asare@herts.ac.uk

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

Secretary and Registrar
University of Hertfordshire
College Lane



Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix C.
Consent Form



I have been given details of my involvement in the study.

I have been told that if any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in it.

2) I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3) In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4) I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of anonymised data being deposited in a repository with open access (freely available).

5) I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of participant.....

Date.....

Signature of principal investigator...

.....

Date.....

Name of (principal) investigator [in BLOCK CAPITALS please]

HILLARY AGYEI-ASARE

**UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN
PARTICIPANTS
(‘ETHICS COMMITTEE’)**

**FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS**

STUDY TITLE - The Experience of Black Trainee Clinical Psychologists with Lived Experiences of Mental Health Problems Navigating Mental Health Support in the NHS

I, the undersigned
FULL NAME *in BLOCK CAPITALS*:

.....
.....

Please give contact details here, sufficient to enable the investigator to get in touch with you.

EMAIL ADDRESS *in BLOCK CAPITALS*:

.....

hereby freely agree to take part in the study entitled -

|
.....
.....

(UH Protocol number 0569 2025 May HSET)

1) I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants.

I have also been informed of how my personal information on this form will be stored and for how long.

Appendix D.
Debrief Sheet

Debrief for Participants

Thank you for taking part in our study on the experiences of Black trainee clinical psychologists accessing mental health support during training. Your insights are incredibly valuable and will contribute to a better understanding of the unique challenges faced by Black individuals in the clinical psychology field.

Purpose of the Study

The aim of this study was to explore the experiences and perspectives of Black trainee clinical psychologists when it comes to seeking and accessing mental health support during their training in the NHS. We hope that by listening to your experiences, we can identify potential barriers and areas for improvement in mental health support systems for Black trainees within the field of psychology.

Confidentiality and Data Use

Please rest assured that all information you provided will remain confidential and anonymous. The data collected will be used solely for research purposes and will be presented in a way that ensures your privacy. Only aggregated results and general insights will be shared in publications or presentations.

Impact and Support

We understand that discussing personal experiences with mental health support can be emotionally impactful. If this study has raised any uncomfortable feelings or you find yourself needing additional support, please consider exploring the following resources:

1. Mindfulness and Relaxation

- Practicing mindfulness can help manage stress and improve emotional well-being. You may find free resources on apps like **Headspace** or **Calm** that offer guided meditation and mindfulness exercises.
- Taking regular walks in nature can also be a grounding way to reduce stress and promote mental clarity.

2. Books and Reading

- Consider reading “**The Black Mental Health Guide**” by Ndidi Boakye or “**Why I’m No Longer Talking to White People About Race**” by Reni Eddo-Lodge. These books provide insights into navigating mental health and race-related challenges.

3. Music and Relaxation Techniques

- Listening to music can be a powerful tool to manage stress. Playlists for relaxation, self-reflection, or uplifting moods are available on streaming platforms like **Spotify** and **YouTube**.

4. University Support

- Don’t hesitate to reach out to your personal tutor or student support services at your university. They are there to support you in both academic and personal matters and can offer guidance on accessing mental health resources.

5. Mental Health Support Services

- **NHS Talking Therapies** (formerly IAPT) provides free, confidential therapy and support in the UK. Visit their website or consult your GP for a referral.
- **Mind:** This UK charity offers free resources and a helpline to assist with mental health support (0300 123 3393, or text 86463).
- **Student Minds:** This UK-based organization provides mental health support specifically for students. They have online resources and peer support options.
- **Samaritans:** Available 24/7 for emotional support, Samaritans can be reached at 116 123 for free in the UK.
- **Black Minds Matter UK:** Offers free therapy sessions for Black individuals to help address their mental health needs.

Contact for Further Information

If you have any questions, concerns, or would like to discuss your participation further, please do not hesitate to reach out. Thank you again for your valuable contributions to this study.

Access to Results

If you would like a summary of the study findings once they are available, please let us know, and we will ensure you receive access.

Thank you for your time, openness, and contributions. Your experiences will play an essential role in improving mental health support for future generations of Black trainee clinical psychologists.



Appendix E.

Major Research Project Poster

THE EXPERIENCE OF BLACK TRAINEE CLINICAL PSYCHOLOGISTS WITH LIVED EXPERIENCES OF MENTAL HEALTH PROBLEMS NAVIGATING MENTAL HEALTH SUPPORT IN THE NHS

CALL FOR PARTICIPANTS!!!

WHAT IS THE STUDY ABOUT?

1. To explore the lived experiences of Black trainee clinical psychologists with mental health difficulties.
2. To understand the unique experiences faced by these individuals when seeking support in the NHS.
3. To investigate how race and professional identity intersect with mental health service use for Black trainees.

WHO CAN TAKE PART?

- Self-identify as Black
- Trainee Clinical Psychologist
- Training on Doctorate of clinical psychology in England
- 18+
- Have lived experienced of mental health problems
- **Considered** accessing mental health support within the NHS

HOW WILL YOU SHARE YOUR STORY?

You will be interviewed online on Teams for approximately 90 minutes.



HOW CAN I FIND OUT MORE?

If you are interested in taking part or would like more information please email me at h.agyei-asare@herts.ac.uk
I am student at University of Hertfordshire and that the outcome will contribute to my Doctorate of clinical psychology degree.



When reviewed will include - This study has been reviewed by: The University of Hertfordshire Health, Science, Engineering and Technology Ethic Committee with Delegated Authority.



The UH protocol number is 0569 2025 May HSET



Appendix F.
Interview Schedule

Lived Experience of Mental Health challenges as a trainee clinical psychologist

1. Could you tell me a story of your mental health challenges that feels comfortable to share. Please use whatever words you feel most comfortable with.
2. What is it like to be a trainee clinical psychologist and experiencing mental health challenges?

2. Being a Black person working as a trainee clinical psychologist

- This research focuses on Black trainee's experience of mental health challenges. I'd like to ask further about whether you feel your racial identity shapes or influences this experience?

- How have your mental health challenges as a black trainee influenced different aspects of your personal and professional life?
- What are your thoughts and feelings on the level of diversity and representation within your cohort and workplace?
- Can you tell me about the value, challenges and support you have experienced from having mental health difficulties?

3. Considering Mental Health Support within Their NHS Trust

3. Have you received mental health support from your employer, or have you considered it?

3a. If considering it, what

- **How would you describe your thoughts and feelings about accessing mental health support within the NHS?**
- **How does being a trainee in the NHS influence your decisions around seeking mental health care?**
- **What are your thoughts and feelings on how colleagues or supervisors might perceive you if you sought mental health support?**
- **What alternatives to workplace mental health support have you considered, and what influences your preferences?**
- **How does your racial identity interact with your experience of considering support for your mental health in the NHS trust where you work?**

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Appendix G.

Example of a Typical Participant Interview Transcript Table – noting to experiential statements, Angela

Transcript Excerpt	Descriptive / Exploratory Notes	Linguistic / Conceptual Notes	Experiential Statement (ES)
[1] "I think it was very intense because I had to fund the course myself and I was also living outside of home so it meant that I also had to fund my life as well basically. And because I was doing the masters full time, it meant that obviously I couldn't work full time so I had to work like late long shifts or at night. So I worked for a crisis service and I think it just took a toll like on my mental health that I was very kind of depressed, very overwhelmed, very burnt out drained." (ANGELA, 1:28)	ANGELA describes a perfect storm of converging pressures: academic intensity, financial strain, and an emotionally demanding night job in a crisis service. The cumulative toll is rendered viscerally, depression, overwhelm, exhaustion. There is a sense of no way out, of being trapped between competing demands.	Note the accumulation in "depressed, very overwhelmed, very burnt out drained", a list that escalates without pause, mirroring the relentlessness ANGELA experienced. "Took a toll" is an idiom that implies something being paid out over time, suggesting a slow depletion rather than a single crisis. The phrase "fund my life" is striking, as though simply existing required effort and resource.	ES1: The participant experienced profound burnout and emotional strain during their master's due to intense academic and financial pressures.
[2] "I was crying at small things, and everything felt heavy. I was very kind of depressed, very overwhelmed, very burnt out, drained. That feeling made it clear that pushing through wasn't an option anymore." (ANGELA, richer version, 1:28)	ANGELA articulates a bodily, affective heaviness. The reference to "crying at small things" suggests a threshold had been crossed, the body was communicating what the mind was trying to manage. The moment of recognition ("made it clear") marks a turning point.	"Everything felt heavy" is an embodied metaphor, weight as psychological experience. The phrase "pushing through wasn't an option anymore" carries the language of exertion and physical endurance, suggesting ANGELA had been operating with considerable effort for some time before collapse.	ES1 (continued): The participant's physical and emotional responses, crying, heaviness, exhaustion, signalled that the limits of endurance had been reached.
[3] "And then that was the first time that I'd access like counselling. So I contacted like my university mental health team, and yeah, they basically gave me like, a few sessions of counselling through those sessions, I realised... maybe I need to change my job." (ANGELA, 1:49-2:07)	This is framed as a moment of awakening. Access to support, even brief and basic, enabled a shift in perspective. ANGELA moves from enduring a situation to recognising the agency to change it. This is significant: support did not 'fix' ANGELA but opened space to see alternatives.	"The first time that I'd access", the phrasing suggests this was not part of an existing repertoire. The tentativeness of "maybe I need to change my job" suggests newly emerging awareness rather than confident decision-making. The counselling appears to function as a mirror rather than a solution.	ES2: Accessing university counselling was the participant's first recognition that change and external support were necessary.
[4] "But I would say like the first year of training reminds me a lot of that time. When I was in my master's because it's very intense academically and... there's just not a lot of support and I think what makes it what makes first year kind of worse is that you can't. You have to kind of continue at it." (ANGELA, 2:07-2:27)	ANGELA draws a direct line between past and present suffering, framing training as a re-experiencing of prior burnout. The compulsory nature of continuing ("you have to") is presented not as motivation but as constraint, there is no exit. This intensifies the sense of entrapment.	"Reminds me a lot of that time" is temporally rich, the present carries the emotional memory of the past. "You have to kind of continue at it" is delivered with a resigned tone, as if the lack of choice is itself the problem. The inability to stop or step back amplifies distress.	ES3: Entering clinical training re-evoked earlier distress because the demands felt similarly overwhelming but with even less support.

Transcript Excerpt	Descriptive / Exploratory Notes	Linguistic / Conceptual Notes	Experiential Statement (ES)
[5] "It's not very diverse, but then when they kind of sold the course, it's like, oh, we're in London, it's going to be so diverse... but then on the course, it's that she's so foreign... it creates a culture where you can't, like, complain because you're, it's such a privilege to be on the course." (ANGELA, 4:25-4:45)	ANGELA describes a betrayal of expectation: the diversity promised in recruitment was not reflected in the actual cohort. The word "sold" carries connotations of commercial persuasion. The culture created, where gratitude is demanded and complaint is silenced, is identified as a structural problem, not an interpersonal one.	"Sold the course" positions the programme as a commodity, the participant as a consumer who has been misled. The phrase "culture where you can't complain" is key, the problem is not simply that others dismiss, but that a systemic norm suppresses expression. "Such a privilege" is used ironically, it functions as a silencing mechanism dressed as opportunity.	ES4: A lack of diversity and the dominance of white middle-class norms created feelings of exclusion and silencing within the cohort.
[6] "Anytime I tried to reach out to like my peers or other trainees, a lot of it, especially if it was like white middle class or upper class people, it was very much dismissive like 'Oh well, it's such a privilege to be here.' Opening up about how hard things felt, the responses were always very surface-level. People would change the subject, make jokes, or downplay it." (ANGELA, 5:05-5:23)	Peers are not experienced as sources of support but as barriers to expression. The dismissal is framed in class and racial terms, the "privilege" discourse was wielded by those who were not experiencing the same marginalisation. ANGELA is effectively told that struggle is inappropriate given their position.	Direct reported speech ("Oh well, it's such a privilege to be here") brings the dismissiveness into the room. The list of peer responses, "change the subject, make jokes, or downplay it", communicates the breadth of avoidance. This is not individual rudeness but a pattern of deflection.	ES5: Attempts to share struggles with peers were met with dismissal, leaving the participant feeling unable to voice concerns safely.
[7] "During my time on 1st year that I started to have like family things and just like personal things and it just was so much like it was all just on top of each other... And then uni days are so long and I'm commuting in and my commute is like one hour and a half and it's just crazy that it's just so much. So I actually find this time harder than before." (ANGELA, 5:23-5:46)	ANGELA maps the topology of a crushing year: academic pressure, family difficulties, a long commute, and no support, all simultaneous. The phrase "all just on top of each other" conjures images of being buried. The conclusion, that this is harder than the burnout of the master's, is particularly arresting.	"It was all just on top of each other" has a physical quality, pressure from multiple directions converging. The repetition of "just" across the passage ("just like personal things", "it's just so much", "it's just crazy") suggests an exhaustion with language, ANGELA is struggling to convey the accumulation adequately. "Harder than before" is a direct comparison that emphasises escalation.	ES6: Personal and family stressors compounded the pressures of academic life, making the first year feel unmanageable.
[8] "When you have real-life experience, it's actually quite triggering... but there's not enough care given." (ANGELA, referenced in PET 2 analysis; see also transcript discussion of course material)	ANGELA draws attention to how their own history becomes an invisible risk within training. Material that is presented neutrally to others is experienced by ANGELA as emotionally activating. The absence of acknowledgement from the course, the "not enough care given", compounds the experience of being unseen.	"Triggering" is both a clinical term and a personal disclosure. In using it, ANGELA simultaneously names an experience and places it in a professional register. "Not enough care given" is a passive construction, it invites thought about who is responsible for that care and why it is absent.	ES7: The participant's lived experience made course material emotionally triggering in ways that felt unseen by others.
[9] "My faith... informs everything about how I see the world... but it doesn't get acknowledged." (ANGELA, referenced in PET 3)	Faith is positioned as an organising framework for ANGELA's worldview, not merely a private practice. The absence of acknowledgement within psychology is experienced as a form of erasure, a structurally imposed invisibility of a significant dimension of identity.	"Informs everything" is totalising, faith is not one feature of ANGELA's life but its architecture. "Doesn't get acknowledged" carries resignation; ANGELA is not demanding recognition, simply noting its absence. The gap between how ANGELA understands the world and how psychology understands it is rendered quietly painful.	ES8: The participant's faith provides grounding and resilience, yet they feel psychology marginalises spiritual perspectives.

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Transcript Excerpt	Descriptive / Exploratory Notes	Linguistic / Conceptual Notes	Experiential Statement (ES)
[10] "Nothing really beats lived experience... you can empathise with people better." (ANGELA, referenced in PET 3)	ANGELA reframes their struggles as assets. Lived experience, the same source of pain within training, becomes a clinical resource. This reflects a sophisticated integration of professional and personal identity, though the surrounding context suggests this is not sufficiently valued within the training environment.	"Nothing really beats" is a confident, affirming superlative, a rare moment of certainty and pride in ANGELA's account. "Empathise better" connects personal suffering to professional competence, suggesting that the very things the course marginalises are what make ANGELA a potentially exceptional clinician.	ES10: Lived experience is seen as a valuable source of wisdom that enhances empathy and psychological practice.
[11] "If you say you're struggling... that's going to be met with hostility." (ANGELA, referenced in PET 4)	ANGELA identifies a direct relationship between disclosure and punitive response within the training environment. This is not an imagined fear but an inferred reality based on ANGELA's interpretation of the institutional culture. Vulnerability is unsafe, not merely unwelcome.	"Met with hostility" is a strong formulation, not indifference, not discomfort, but active antagonism. This escalates the stakes of disclosure significantly. The conditional framing ("if you say") frames honesty as a risk calculation, not a natural act of communication.	ES11: The participant perceives the course as hostile to trainees who disclose difficulty, particularly around issues of representation.
[12] "I don't think it is for people like us... I love the job but I hate psychology as the way that it is." (ANGELA, referenced in PET 4)	This is a profound bifurcation: ANGELA can love clinical work while experiencing the profession of psychology as fundamentally excluding. The phrase "people like us" operates as both a racial and class marker, a quiet assertion of solidarity with others similarly positioned.	"People like us" is inclusive, ANGELA positions themselves within a collectivity of marginalised trainees. "I love the job but I hate psychology as the way that it is" is a structured paradox, it refuses simplification. The word "hate" is unusually strong in this context and carries the weight of sustained disappointment.	ES12: The participant feels alienated from the culture of psychology and believes the profession is not designed for people like them.
[13] "Just because this the course doesn't offer anything like my course tutor is all primarily academic. Your supervisor on placement is all to do with placement, so outside of that there's no other support that's available... I've had to like kind of pay my own money to get support." (ANGELA, 19:09)	ANGELA systematically maps the absence of support: the course tutor is academic only; the supervisor is placement-focused; peer support is inaccessible due to cultural disconnection. Each possible avenue is foreclosed. Self-funding therapy becomes the only option.	The list structure ("my course tutor is... your supervisor is...") enacts the process of elimination ANGELA has undergone. "Pay my own money" places a material, financial dimension on emotional need, vulnerability has a cost. The phrase "kind of pay" is softened, as if ANGELA is reluctant to name the injustice directly.	ES13: The absence of embedded support in training forced the participant to self-fund essential therapy.
[14] "I presented a case of someone and the clinicians weren't even listening like one of them openly said, like, oh sorry, I was writing up my notes. I wasn't even listening. And I was just thinking like this is actually a person's life here." (ANGELA, 21:12)	This is a vivid, specific memory, a named moment of witnessed disregard. ANGELA's response ("this is actually a person's life") reveals a moral indignation that contrasts with the clinician's casualness. The scene functions as a concrete embodiment of systemic failure.	Direct reported speech ("sorry, I was writing up my notes") makes the clinician's dismissal immediate and undeniable. "A person's life" is a humanising assertion against the clinician's administrative framing. ANGELA narrates as both witness and judge, the moral position is clear.	ES14: Witnessing dismissive or uncaring NHS clinicians created deep mistrust in NHS mental health support.
[15] "I realised from that like if these are the up-and-coming psychologist, I don't know if I don't know if people are safe. I don't know if it's safe out there." (ANGELA, 24:22)	ANGELA extrapolates from one case presentation to a systemic fear. The up-and-coming psychologists, ANGELA's own peer group, are seen as embodying a harmful ideology around distress and social inequality. This creates a vertigo: ANGELA	The repetition, "I don't know if I don't know if", captures genuine uncertainty and distress. It is not rhetorical; it reads as ANGELA processing, in real time, what they have seen. "Safe out there" is a broad, encompassing concern, not for one client	ES15: Seeing up-and-coming psychologists pathologise distress rooted in social inequality made the participant doubt the safety of services for people like them.

Transcript Excerpt	Descriptive / Exploratory Notes	Linguistic / Conceptual Notes	Experiential Statement (ES)
	is training to become part of a system they distrust.	but for all people who might encounter this system.	
[16] "When I became a trainee, one of our first lectures that week, they basically said that like for trainees and a lot of clinical psychologists like mental health. The reported mental health kind of concerns or issues is quite high and they actually told us that the first week, so I kind of felt like, well, fair enough. Like, I'll just get support then like there was no like stigma." (ANGELA, 25:48)	The institutional framing of trainee mental health, delivered in the first week, acted as a permission structure. ANGELA describes a shift from hesitancy to ease, facilitated not by personal readiness but by institutional normalisation. This is an example of structure enabling rather than hindering wellbeing.	"Fair enough. Like, I'll just get support then" is colloquially casual, the relief is palpable. ANGELA's earlier hesitancy is implicitly contrasted here by the ease with which they now speak of seeking support. The university lecture functions as an authoritative normalising voice.	ES16: Becoming a trainee normalised seeking therapy and reduced earlier hesitations about stigma.
[17] "I actually haven't [disclosed to supervisors], like, I actually haven't at all... I'm still quite cautious... my supervisors were very like admin driven as opposed to like reflective." (ANGELA, 28:28–28:42)	Despite greater openness with peers and willingness to access therapy, ANGELA has not disclosed to supervisors. The explanation is structural, supervisors were task-focused, not relationally open. The possibility of disclosure is anticipated but not yet enacted.	The repetition "I actually haven't, like, I actually haven't at all" has the quality of a confession, surprising even to ANGELA. "Cautious" implies calculation; disclosure involves risk assessment. "Admin driven as opposed to reflective" articulates a distinction between two modes of professional relating, and identifies which type makes space for the human.	ES17: Despite openness with peers, the participant remains cautious about disclosing struggles to supervisors.
[18] "I just feel like they're not going to understand me like they just wouldn't. So I think being black. It also it makes me kind of think maybe I should just speak to other black people... So it does really deter me and also like because the field is like majority white, I just feel like they're just not going to understand me." (ANGELA, 33:46–34:14)	ANGELA articulates a racialised calculus of therapeutic safety. Being black shapes where support can be sought, the field's whiteness is not an inconvenience but a structural barrier. ANGELA's preference for black therapists is framed not as prejudice but as a protective response to anticipated misunderstanding.	"They're not going to understand me", the verb "understand" carries both emotional and cultural weight. Understanding here is not merely empathy but racial literacy. The reluctant "maybe I should just speak to other black people and just call it a day" communicates weariness, the labour of seeking culturally competent support is exhausting.	ES18: Structural stigma, racial misunderstanding, and rigid therapeutic models deter the participant from accessing NHS support.

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Appendix H.

Example Personal Experiential Themes (PETs), Angela

Personal Experiential Theme (PET)	Related ESs	Interpretative Account of Meaning	Supporting Quotes from ANGELA
PET 1: Overwhelming Psychological Strain and Re-Emerging Burnout in Training	ES1, ES3, ES6	The participant experiences training as emotionally draining, echoing past burnout and exacerbated by personal stressors. The demands of the master's and the doctoral programme are experienced as compounding rather than sequential, with no breathing space between them.	"I was very kind of depressed, very overwhelmed, very burnt out drained." (ANGELA, 1:28) "The first year of training reminds me a lot of that time... it's very intense... there's just not a lot of support." (ANGELA, 2:07) "It just was so much like it was all just on top of each other... I actually find this time harder than before." (ANGELA, 5:23)
PET 2: Marginalisation, Cultural Dissonance, and Racialised Isolation	ES4, ES5, ES7, ES9, ES18	The participant feels culturally unsafe, silenced, misunderstood, and emotionally triggered in environments lacking racial awareness or representation. The diversity promised at recruitment stands in stark contrast to the homogeneous reality of the cohort and clinical field.	"It's not very diverse... you end up like struggling in silence." (ANGELA, 4:45) "It was very much dismissive... 'it's such a privilege to be here'." (ANGELA, 5:05) "I just feel like they're not going to understand me... I think being black makes me more selective." (ANGELA, 33:46)
PET 3: Lived Experience and Faith as Unrecognised Anchors Within Psychological Training	ES8, ES10	The participant draws strength, nuance, and empathy from lived experience and spirituality, yet feels these are unrecognised and undervalued within psychology. The very resources that ground ANGELA's identity and clinical insight are rendered invisible by the dominant culture of the profession.	"My faith... informs everything about how I see the world... but it doesn't get acknowledged." (ANGELA) "Nothing really beats lived experience... you can empathise with people better." (ANGELA)
PET 4: Disillusionment with the Culture of Psychology and Lack of Structural Support	ES2, ES11, ES12, ES13	The participant experiences the training environment as hostile, lacking support, and shaped by norms that exclude people like them. ANGELA loves the clinical work but is alienated from the profession's <u>culture</u> and must self-fund the support the course fails to provide.	"If you say you're struggling... that's going to be met with hostility." (ANGELA) "I don't think it is for people like us... I love the <u>job</u> but I hate psychology as the way that it is." (ANGELA) "I've had to pay my own money to get support... the course doesn't offer anything." (ANGELA, 19:09)
PET 5: Mistrust and Fear Toward NHS Mental Health Services	ES14, ES15, ES16, ES17	Observing dismissive, <u>pathologising</u> practice and rigid systems leads to deep mistrust of NHS care despite increasing personal openness to therapy. ANGELA is simultaneously more willing to seek support as a trainee and more convinced that NHS support cannot be trusted.	"Clinicians weren't even listening... this is a person's life." (ANGELA, 21:12) "If these are the up-and-coming psychologists, I don't know if people are safe." (ANGELA, 24:22) "When I became a trainee, it normalised it... I felt able to get support." (ANGELA, 25:48) "I haven't disclosed to supervisors... I'm still cautious." (ANGELA, 28:28)

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Appendix I.

Table of PETs to GETs, All Participants

Participant	PET	Personal Experiential Theme (PET) Title
GET 1: Distress Emerges Through Cultural Silencing, Delayed Recognition, and Cumulative Pressure		
A.O	PET 1	Overwhelming Psychological Strain and Re-Emerging Burnout in Training
C.B	PET 1	Cultural Silencing and the Hidden Beginnings of Distress
E.O	PET 1	Early Distress and the Invalidation of Emotional Experience
N.A.F	PET 1	Burnout, Grief, and the Collapse of Safety During Training
S.T	PET 2	Learning Silence as Survival
T.P.C	PET 1	Cultural Silencing and the Gradual Emergence of Distress
GET 2: Being a Black Trainee Means Living Under Racialised Scrutiny While Performing Competence and Wellness		
A.O	PET 2	Marginalisation, Cultural Dissonance, and Racialised Isolation
C.B	PET 3	Navigating Training While Managing Personal Vulnerability
C.B	PET 4	Racialised Visibility, Scrutiny, and the Weight of Representation
E.O	PET 2	Performing Stability to Protect Credibility
E.A	PET 3	Hypervisibility and Emotional Self Protection
M.A	PET 4	Racism as Systemic and Unavoidable
N.A.F	PET 3	Racialised Surveillance and the Need for Constant Self Monitoring
S.T	PET 3	Performing Competence While Carrying Private Distress
T.P.C	PET 2	Performing Competence While Carrying Private Vulnerability
T.P.C	PET 3	Racialised Visibility and the Burden of Representation
GET 3: Training Cultures and University Structures Are Experienced as Emotionally Unsafe, Performative, or Hostile		
A.O	PET 4	Disillusionment with the Culture of Psychology and Lack of Structural Support
E.O	PET 3	Racialised Disconnection Within the Cohort
E.O	PET 4	Feeling ~~Unheld~~ by University Structures
E.A	PET 1	Racism as a Rupture of Safety in Training
E.A	PET 2	Institutional Minimisation and Loss of Trust
E.A	PET 7	Anger, Grief, and Moral Injury
M.A	PET 2	Training as an Amplifier of Distress
M.A	PET 3	Institutional Support as Hollow and Performative
M.A	PET 7	Anger as Self Protection and Resistance
N.A.F	PET 2	Vulnerability as Risk Within Evaluative Systems
S.T	PET 4	Cultural Isolation Within Training and the Profession
S.T	PET 5	Conditional Safety in Relationships of Power
GET 4: NHS and Trust-Based Support Is Constructed as Risky Due to Power, Proximity, Racism, and Permanence		

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Participant	PET	Personal Experiential Theme (PET) Title
A.O	PET 5	Mistrust and Fear Toward NHS Mental Health Services
C.B	PET 2	Systemic Misattunement and the Emotional Labour of Being Understood
E.O	PET 5	Supervision Without Safety
E.O	PET 6	Institutional Support as Risky and Insufficient
E.A	PET 4	Boundary Collapse and Ethical Alarm
E.A	PET 5	Avoiding NHS Support as an Act of Self Preservation
M.A	PET 1	Feeling Failed Rather Than Cared For
M.A	PET 5	Power, Surveillance, and Fear in Professional Relationships
M.A	PET 6	Rejecting the NHS as a Site of Care
N.A.E	PET 4	Mistrust of NHS Mental Health Support as a Racialised Trainee
S.I	PET 1	Early Institutional Harm and the Racialisation of Distress
S.I	PET 6	Institutional Support as Insufficient and Risk Laden
T.P.C	PET 4	Mistrust of NHS Support as a Containing Space
GET 5: Safety Is Pursued Outside Formal Systems Through Culturally Attuned Care, Peer Solidarity, and Values-Based Recommitment		
A.O	PET 3	Faith and Lived Experience as Unrecognised Anchors Within Psychological Training
C.B	PET 5	Mistrust of NHS Support and Search for Safe, Culturally Affirming Spaces
E.O	PET 7	Seeking Safety Outside Formal Systems
E.O	PET 8	Holding Faith and Lived Experience as Quiet Anchors
E.A	PET 6	Choosing Private Therapy for Safety and Autonomy
E.A	PET 8	Lived Experience as Resistance and Recommitment
M.A	PET 8	Finding Solidarity Outside Broken Systems
M.A	PET 9	Lived Experience as a Critical Lens on Psychology
N.A.E	PET 5	Lived Experience as a Source of Empathy and Clinical Depth
S.I	PET 7	Finding Safety Outside the System
S.I	PET 8	Lived Experience as Ethical Grounding
T.P.C	PET 5	Strategic Help Seeking and the Pursuit of Psychological Safety

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Appendix J.

Example Experiential Statements for all Participants

Participant Code	Pseudonym	ES No.	Experiential Statement
A.O	Angela	ES1	The participant experienced profound burnout and emotional strain during their master's due to intense academic and financial pressures.
A.O	Angela	ES2	Accessing university counselling was the participant's first recognition that change and external support were necessary.
A.O	Angela	ES3	Entering clinical training re-evoked earlier distress because the demands felt similarly overwhelming but with even less support.
A.O	Angela	ES4	A lack of diversity and the dominance of white middle-class norms created feelings of exclusion and silencing within the cohort.
A.O	Angela	ES5	Attempts to share struggles with peers were met with dismissal, leaving the participant feeling unable to voice concerns safely.
A.O	Angela	ES6	Personal and family stressors compounded the pressures of academic life, making the first year feel unmanageable.
A.O	Angela	ES7	The participant's lived experience made course material emotionally triggering in ways that felt unseen by others.
A.O	Angela	ES8	The participant's faith provides grounding and resilience, yet they feel psychology marginalises spiritual perspectives.
A.O	Angela	ES9	Diversity within NHS teams felt superficial, with psychology roles remaining predominantly white and privileged.
A.O	Angela	ES10	Lived experience is seen as a valuable source of wisdom that enhances empathy and psychological practice.
A.O	Angela	ES11	The participant perceives the course as hostile to trainees who disclose difficulty, particularly around issues of representation.
A.O	Angela	ES12	The participant feels alienated from the culture of psychology and believes the profession is not designed for people like them.
A.O	Angela	ES13	The absence of embedded support in training forced the participant to self-fund essential therapy.
A.O	Angela	ES14	Witnessing dismissive or uncaring NHS clinicians created deep mistrust in NHS mental health support.
A.O	Angela	ES15	Seeing up-and-coming psychologists pathologise distress rooted in social inequality made the participant doubt the safety of services for people like them.
A.O	Angela	ES16	Becoming a trainee normalised seeking therapy and reduced earlier hesitations about stigma.
A.O	Angela	ES17	Despite openness with peers, the participant remains cautious about disclosing struggles to supervisors.
A.O	Angela	ES18	Structural stigma, racial misunderstanding, and rigid therapeutic models deter the participant from accessing NHS support.
N.A.F	Mary Jane	ES1	The participant experienced extreme burnout compounded by grief, academic pressure, and delayed disability support.
N.A.F	Mary Jane	ES2	Repeated deaths and family crises destabilised the participant's emotional world while usual sources of support were unavailable.
N.A.F	Mary Jane	ES3	Training coincided with a profound sense of unsafety and fear that the course could not be trusted to offer protection.
N.A.F	Mary Jane	ES4	Disclosing vulnerability within training was experienced as risky and likely to invite surveillance or punishment.
N.A.F	Mary Jane	ES5	Supervisory responses felt inconsistent, with some offering containment and others responding defensively or restrictively.
N.A.F	Mary Jane	ES6	The participant became increasingly cautious and guarded after a negative supervisory experience.
N.A.F	Mary Jane	ES7	Prior experiences of racialised misinterpretation heightened vigilance about being perceived as dangerous or unstable.
N.A.F	Mary Jane	ES8	Being Black required constant monitoring of safety cues and careful self-presentation to avoid severe consequences.
N.A.F	Mary Jane	ES9	The inability to choose NHS clinicians intensified fears of encountering racial bias or cultural misunderstanding.
N.A.F	Mary Jane	ES10	The participant experienced cultural translation as exhausting and incompatible with seeking help during crisis.
N.A.F	Mary Jane	ES11	Witnessing dismissive and unsafe professional behaviour eroded trust in NHS mental health services.
N.A.F	Mary Jane	ES12	Concerns about future employability and reputational risk strongly shaped decisions to avoid NHS support.
N.A.F	Mary Jane	ES13	Lived experience of distress was understood as deepening empathy and clinical insight.
N.A.F	Mary Jane	ES14	Course and placement environments were experienced as culturally homogeneous and racially isolating.
N.A.F	Mary Jane	ES15	Expressions of distress by white peers were normalised while similar behaviours by Black trainees were scrutinised.

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E.O	Caroline	ES1	The participant experienced early depressive symptoms as isolating and minimised by professionals.
E.O	Caroline	ES2	University demands intensified existing anxiety and self-doubt.
E.O	Caroline	ES3	The participant felt pressure to appear emotionally stable to counter racial stereotypes.
E.O	Caroline	ES4	Experiences of subtle racism contributed to emotional withdrawal within the cohort.
E.O	Caroline	ES5	The participant felt unseen and unsupported by their personal tutor.
E.O	Caroline	ES6	Attempts to raise concerns were met with generic or procedural responses.
E.O	Caroline	ES7	The cohort environment felt competitive and emotionally unsafe.
E.O	Caroline	ES8	The participant monitored their speech and emotions to avoid being misinterpreted.
E.O	Caroline	ES9	Fear of being judged as 'unfit' shaped decisions around disclosure.
E.O	Caroline	ES10	Placement supervision felt task-focused rather than relational.
E.O	Caroline	ES11	Observing dismissive attitudes toward service users of colour heightened mistrust.
E.O	Caroline	ES12	NHS wellbeing offers were perceived as superficial and tokenistic.
E.O	Caroline	ES13	The participant avoided NHS support due to concerns about documentation and permanence.
E.O	Caroline	ES14	Private therapy was experienced as safer due to separation from training systems.
E.O	Caroline	ES15	Cultural understanding was prioritised when seeking therapeutic support.
E.O	Caroline	ES16	Informal peer support with other Black trainees provided emotional relief.
E.O	Caroline	ES17	Faith and spirituality offered grounding but felt incompatible with academic psychology.
E.O	Caroline	ES18	Lived experience informed a strong commitment to anti-oppressive practice.
M.A	Mandy	ES1	Early engagement with mental health services was experienced as dismissive and misattuned.
M.A	Mandy	ES2	The participant felt blamed for struggling rather than supported.
M.A	Mandy	ES3	Training intensified existing mental health difficulties rather than containing them.
M.A	Mandy	ES4	The university was experienced as prioritising reputation over trainee wellbeing.
M.A	Mandy	ES5	Personal tutoring was experienced as performative and ineffective.
M.A	Mandy	ES6	The participant felt emotionally abandoned during periods of acute distress.
M.A	Mandy	ES7	Racism was experienced as embedded and normalised within training spaces.
M.A	Mandy	ES8	The participant felt gaslit when raising concerns about race or wellbeing.
M.A	Mandy	ES9	The cohort was experienced as complicit through silence or defensiveness.
M.A	Mandy	ES10	Supervision felt unsafe due to power and lack of accountability.
M.A	Mandy	ES11	NHS mental health care was experienced as bureaucratic and dehumanising.
M.A	Mandy	ES12	The participant felt over-surveilled and under-supported by NHS systems.
M.A	Mandy	ES13	Accessing support was perceived as carrying professional punishment.
M.A	Mandy	ES14	The participant disengaged from institutional offers of wellbeing support.
M.A	Mandy	ES15	Anger functioned as a protective response to repeated invalidation.
M.A	Mandy	ES16	Peer support outside formal structures became essential for survival.
M.A	Mandy	ES17	The participant rejected narratives of resilience imposed by the profession.
M.A	Mandy	ES18	Lived experience sharpened a critical stance toward psychology as a discipline.

C.B	Ruth	ES1	Early mental health difficulties were obscured by cultural expectations to be strong and silent.
C.B	Ruth	ES2	University life triggered a worsening of symptoms and a sense of detachment that signalled something was wrong.
C.B	Ruth	ES3	Seeking GP support felt emotionally risky due to stigma, fear of being judged, and fear of being misunderstood.
C.B	Ruth	ES4	The GP appointment left the participant feeling unseen because their cultural and personal context was overlooked.
C.B	Ruth	ES5	NHS therapy required emotional labour as the participant had to teach the therapist about their cultural world.
C.B	Ruth	ES6	The decision to seek help was gradual and driven by reaching an emotional limit despite cultural taboos.
C.B	Ruth	ES7	Being a trainee with mental health challenges creates tension between professional expectations and personal struggles.
C.B	Ruth	ES8	Being Black heightens visibility and inhibits openness about mental health challenges.
C.B	Ruth	ES9	Racial identity shapes emotional expression and help-seeking because of internalised expectations of resilience.
C.B	Ruth	ES10	Mental health difficulties have increased the participant's self-awareness, self-compassion, and authenticity.
C.B	Ruth	ES11	Lived experience deepens empathy and enhances therapeutic presence with clients.
C.B	Ruth	ES12	Lack of diversity and cultural representation within training environments contributes to feeling isolated and hyper-visible.
C.B	Ruth	ES13	Disclosing struggles to supervisors feels risky due to fear of judgement and professional consequences.
C.B	Ruth	ES14	The dual role of trainee and potential service user in the same NHS Trust creates anxiety and mistrust.
C.B	Ruth	ES15	External, culturally-matched therapy feels safer and more validating than NHS or Trust-based support.
C.B	Ruth	ES16	Racial identity amplifies fear of stereotyping, scrutiny, and being perceived as less competent if seeking NHS support.
S.T	Grace	ES1	Early sectioning and inpatient care were experienced as frightening, coercive, and stripping the participant of agency.
S.T	Grace	ES2	The participant experienced racialised surveillance and harsher interpretations of behaviour as a Black child in inpatient care.
S.T	Grace	ES3	Interactions with white European staff were experienced as cold, condescending, and dehumanising.
S.T	Grace	ES4	Support from African agency staff was experienced as warmer, more relational, and affirming.
S.T	Grace	ES5	Early harmful NHS experiences led to a lasting mistrust of mental health services.
S.T	Grace	ES6	The participant learned to survive by concealing distress and avoiding disclosure.
S.T	Grace	ES7	Entering clinical training re-activated earlier trauma and vulnerability.
S.T	Grace	ES8	Being a trainee created pressure to perform competence while privately struggling.
S.T	Grace	ES9	Racial identity intensified hypervigilance around how emotions and behaviours were perceived.
S.T	Grace	ES10	The cohort environment felt dismissive and invalidating of global majority experiences.
S.T	Grace	ES11	Lack of representation contributed to isolation and a sense of not belonging.
S.T	Grace	ES12	The participant experienced one early supervisory relationship as safe and humanising.
S.T	Grace	ES13	Subsequent supervisory relationships felt procedural and emotionally unsafe.
S.T	Grace	ES14	University-provided therapeutic support was experienced as superficial and inadequate.
S.T	Grace	ES15	Seeking NHS support as a trainee felt unsafe due to power, surveillance, and career risk.
S.T	Grace	ES16	Fear of racialised judgement shaped decisions around disclosure.
S.T	Grace	ES17	Informal support from global majority peers was experienced as protective and containing.
S.T	Grace	ES18	Lived experience shaped a strong ethical commitment to relational and culturally attuned practice.

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T.P.C	Vicky	ES1	Early emotional distress was normalised and obscured by family and cultural expectations to cope, persevere, and avoid emotional vulnerability.
T.P.C	Vicky	ES2	Anxiety and low mood intensified during academic transitions, creating embodied hypervigilance and emotional disconnection despite external functioning.
T.P.C	Vicky	ES3	Appearing 'fine' externally led to persistent self-invalidation and delayed recognition of the seriousness of distress.
T.P.C	Vicky	ES4	Clinical psychology training reactivated anxiety and imposter feelings, intensifying shame about struggling while training to support others.
T.P.C	Vicky	ES5	Being a trainee with mental health difficulties creates pressure to perform emotional stability under constant professional evaluation.
T.P.C	Vicky	ES6	Lived experience of distress deepens empathy and reflective capacity but increases emotional labour and internal strain.
T.P.C	Vicky	ES7	Racial identity and mental health are experienced as inseparable, with cultural narratives of strength inhibiting openness about vulnerability.
T.P.C	Vicky	ES8	Being one of few Black trainees heightens visibility and self-monitoring, increasing caution around emotional expression.
T.P.C	Vicky	ES9	Fear of confirming racial stereotypes leads to minimisation and concealment of distress within professional spaces.
T.P.C	Vicky	ES10	Limited diversity within training and placements contributes to feelings of isolation, guardedness, and uncertainty about psychological safety.
T.P.C	Vicky	ES11	Observing NHS cultures of burnout and cynicism erodes trust in the system's capacity to hold personal vulnerability.
T.P.C	Vicky	ES12	The possibility of becoming a service user within the same Trust feels exposing due to blurred boundaries and power hierarchies.
T.P.C	Vicky	ES13	Decisions about seeking NHS support are shaped more by risk management and reputational concerns than by emotional need.
T.P.C	Vicky	ES14	Disclosure to supervisors feels threatening due to fears of altered perceptions, surveillance, and long-term professional consequences.
T.P.C	Vicky	ES15	Seeking private therapy outside the NHS provides a sense of safety through separation from professional identity.
T.P.C	Vicky	ES16	Culturally attuned therapeutic support reduces emotional labour and enables fuller, less guarded self-expression.
F.A	Abigal	ES1	The participant experienced direct racist comments within teaching spaces as shocking and destabilising.
F.A	Abigal	ES2	Overhearing racist talk among peers eroded trust in the cohort.
F.A	Abigal	ES3	Racism was experienced as minimised or mishandled by course staff.
F.A	Abigal	ES4	The participant felt suddenly hyper-visible and unsafe within training spaces.
F.A	Abigal	ES5	Anxiety increased around being emotionally exposed to peers who held power or prejudice.
F.A	Abigal	ES6	The participant became acutely aware of boundary collapses between trainee, colleague, and service user.
F.A	Abigal	ES7	The local NHS talking therapies service was perceived as ethically unsafe due to peer overlap.
F.A	Abigal	ES8	Fear of being known, recognised, or discussed shaped help-seeking decisions.
F.A	Abigal	ES9	The participant anticipated racialised judgement within NHS assessment processes.
F.A	Abigal	ES10	University wellbeing services were experienced as inadequate and naïve about power.
F.A	Abigal	ES11	The decision to seek private therapy was experienced as protective and necessary.
F.A	Abigal	ES12	Cultural understanding was prioritised in choosing a therapist.
F.A	Abigal	ES13	Private therapy allowed fuller emotional honesty without professional consequence.
F.A	Abigal	ES14	Ongoing anger and grief emerged following institutional inaction.
F.A	Abigal	ES15	The participant felt disillusioned with psychology's claims to ethics and safety.
F.A	Abigal	ES16	Lived experience sharpened awareness of how systems reproduce harm.
F.A	Abigal	ES17	The participant remained committed to practicing differently despite mistrust.
F.A	Abigal	ES18	Survival within training required constant calculation and restraint.

Appendix K.

Self-reflection During Interviews

Self reflection 7/1/26

During interviews, I remained mindful of moments where participants' experiences resonated with my own, using active listening and open-ended questioning to allow participants to lead narrative. During analysis I will hope to remain grounded. However I can see how it may be difficult seeing as I am an insider researcher.

I want it to remain grounded in the participant experiences, voices and perspective. In order to do so I will continue using supervision as a means to reflect on myself and the data's impact on me. Also my impact on the data.

It is a step at a time but for now I will remain mindful while I am interviewing.

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Appendix L.

Example GETs Clustering for a Participant

Participant TPC

Cluster A

PET1 - Cultural silencing and the gradual emergence of distress ES1, ES2, ES23

"There wasn't really the language for emotional..."

"I just remember constantly feeling on edge..."

"I invalidated my own experiences a lot..."

Cluster B

PET2 - Performing compliance while carrying private vulnerability

PET3 - Racialised visibility and the burden of representation ES4, ES5, ES6

PET2 - "Even on days when I was barely coping, I still..."

"My lived experience made me more empathetic..."

PET3 - "I don't think I can separate my experience of mental health..."

"often I'm one of the only Black trainees..."

"There's internal pressure not to confirm stereotypes..."

"It makes you question whether it's safe..."

Common thread distress that existed but could not be named, expected or recognised

Cultural norms that protected emotional vulnerability then because of self-invalidation

Mechanism is each clinical encounter presenting recognition for - disclosure phase

PET2 concerns the active concealment of distress within professional training environment. The gap between internal experience and external presentation. Performance driven primarily by demand and evaluative power of training context.

Cluster C

PET4 - Mistrust of the NHS as a containing space ES11, ES12

"I've overheard how people talk about patients..."

"Because we train and work in the same trust everything overlaps..."

Cluster D

PET5 - Strategic help seeking and the pursuit of psychological safety ES13, ES14, ES15, ES16

"It feels less like accessing care and more like the managing..."

"Supervisor held a huge amount of power..."

"Having support that completely separate..."

"I didn't want to spend my sessions..."

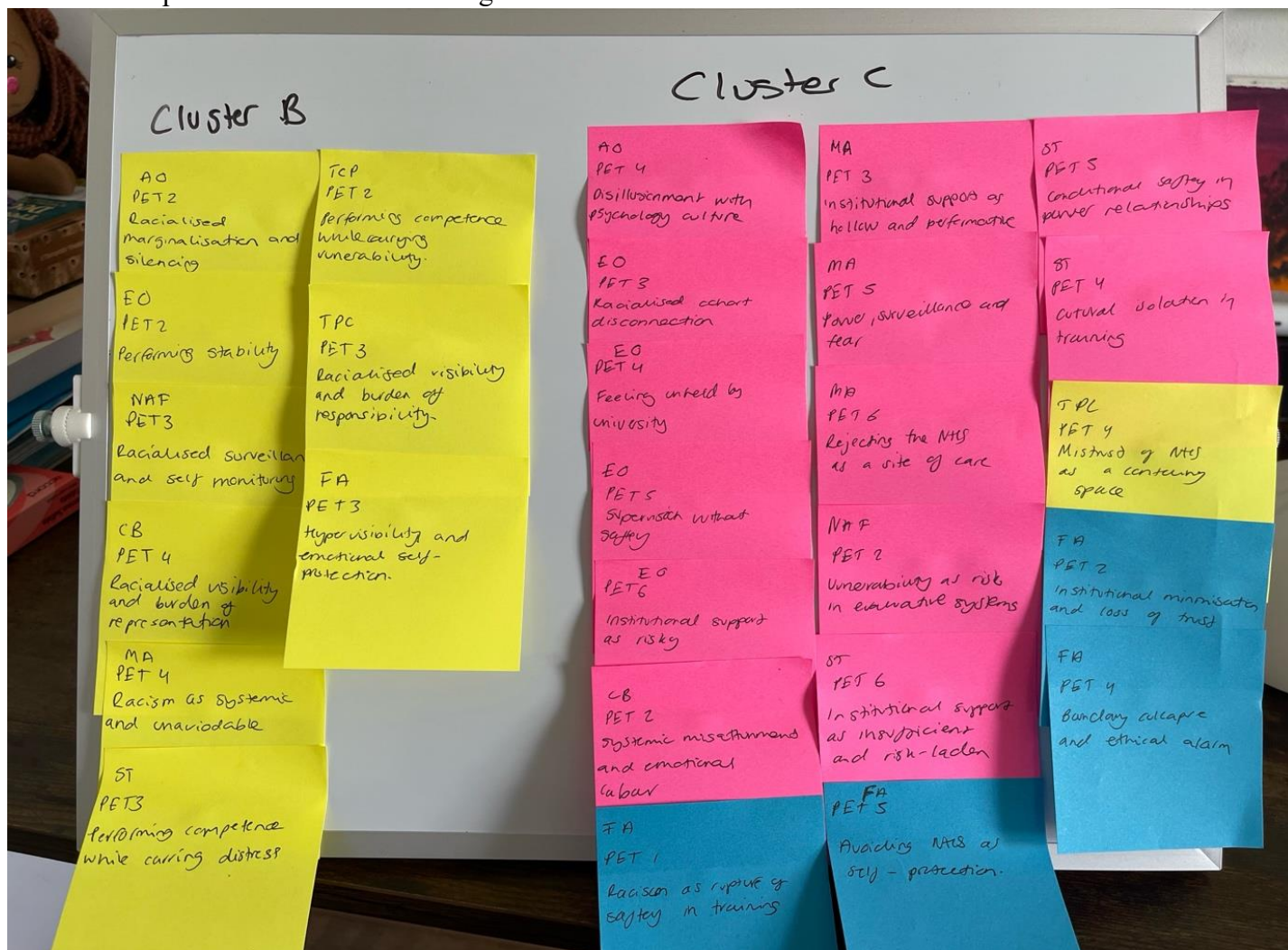
PET 4 sits in cluster C because the source of mistrust is structural. The NHS as an institution and its burnout culture and depersonalisation produces an unsafe work environment. No active decision making in cluster C but one in cluster D.

Solution Based. Did not simply exorcise care. She navigated towards safety. Private, culturally sensitive and outside the NHS reflected calculated self-protective response to an unsafe institution.

The Experience of Black Trainee Clinical Psychologists with Lived Experiences of 208 Mental Health Problems Navigating Mental Health Support in the NHS

Appendix M.

Example of Cross Case Clustering into GETs — Cluster B and Cluster C



The Experience of Black Trainee Clinical Psychologists with Lived Experiences of Mental Health Problems Navigating Mental Health Support in the NHS

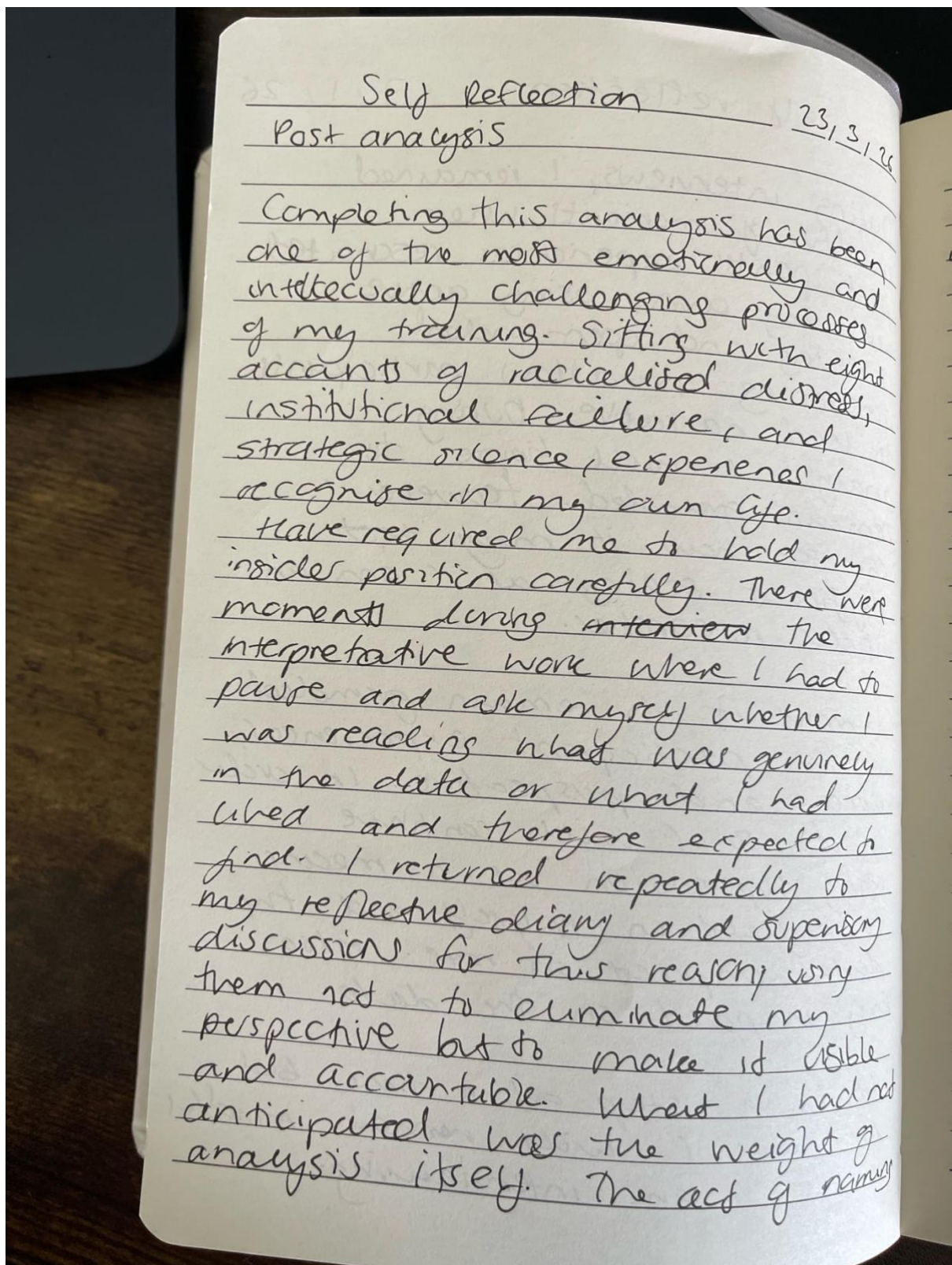
Appendix N.

Table of Recurrence of Themes

GETs	Subthemes	Angela	Mary Anne	Caroline	Mandy	Ruth	Grace	Vicky	Abigail
GET 1: Distress Emerges Through Cultural Silencing, Delayed Recognition, and Cumulative Pressure	<i>Distress Initially Hidden by Cultural Scripts of Strength and Coping</i>			x		x		x	
	<i>Academic Transitions and Training as Catalysts for Escalating Distress</i>	x				x		x	
	<i>Reaching a Threshold Where Distress Can No Longer Be Held</i>	x				x		x	
GET 2: Performing Wellness and Competence Under Racialised Scrutiny	<i>Hypervisibility and the Burden of Representation</i>		x			x		x	
	<i>Fear of Stereotype Confirmation and Constrained Emotional Expression</i>		x	x		x			
	<i>Performing Wellness as a Strategy for Survival</i>						x	x	x
GET 3: Training and University Structures as Failing to Contain Distress	<i>Personal Tutoring and Course Responses Feel Procedural Rather Than Containing</i>			x	x				x
	<i>Cohort Culture and Reduced Psychological Safety</i>	x		x					x
	<i>Structural Support Gaps Shift Responsibility onto the Trainee</i>	x	x		x				
GET 4: NHS and Trust Based Support Is Constructed as Risky Due to Power, Proximity, Racism, and Permanence	<i>Proximity and Boundary Blurring Between Trainee and Service User</i>		x					x	x
	<i>NHS Records and Permanence Transform Care into Exposure</i>			x			x		
	<i>Racialised Misinterpretation and Lack of Choice of Clinician</i>		x						x
	<i>Professional Consequences and Reputational Risk</i>						x	x	
GET 5: Safety Is Pursued Outside Formal Systems Through Culturally Attuned Care, Religion, Peer Solidarity, and Values Based Recommitment	<i>Private Therapy as Safety Through Separation from Professional Identity</i>			x				x	x
	<i>Cultural Attunement Reducing the Emotional Labour of Explanation</i>		x			x		x	
	<i>Peer Solidarity as Containment and Validation</i>			x			x		
	<i>Lived Experience as Ethical Grounding and Professional Recommitment</i>			x			x		x
	<i>Faith and Spirituality as an Unrecognised Anchor</i>	x							

Appendix O.

Self-reflection Post Analysis



structural harm in systemic,
~~interpretative~~ interpretative language
felt simultaneously validating
and exposing. Seeing experience
like performing wellness and
vulnerability as risk coher across
eight independent accounts
was, in one sense, affirming.
In another sense it was ~~stern~~
this was not individual struggle
but a pattern, and naming
it as such felt both necessary
and ~~to heavy~~ heavy.

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Appendix P.

Example Participant ES to PETs with Final Clusters





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Data Extraction Table

Text South London, UK (SLaM NHS Foundation Trust IAPT services)

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Text