EJQRP (2024) Vol. 14, 158-174 © 2024 The Author/s ISSN: 1756-7599

European Journal for Qualitative Research in Psychotherapy

www.EJQRP.org

Exploring the Experience of Racialisation and Subsequent Experiences of Psychological Therapy for Black and Multi-ethnic Clients in Ireland

Karen M. Doyle and Barbara Hannigan

School of Psychology, Trinity College Dublin, Ireland *Email*: doylek19@tcd.ie

Abstract: Research suggests pervasive disparities in mental health diagnoses, levels of care and treatment outcomes for Black or Multi-ethnic service users compared to white service users. This study explores the mental health implications of being racialised and subsequent experiences of psychological services. Studies show that increased race related stressors over time increase the likelihood a person will experience psychological distress. Research also suggests that the personal biases of mental health service providers may impact their competencies and success rate when working with Black and Multi-ethnic clients. In this study, semi-structured interviews were conducted with 10 Black or Multi-ethnic participants who had recently engaged in psychological therapy in Ireland. Data were analysed using the Generic Descriptive Interpretive Qualitative Research Analysis (GDI-QR) approach (Elliott & Timulak, 2021). All participants shared lived experiences of negative mental health implications of being racialised. These were expressed as feelings of not belonging, experiences of racism or discrimination, feeling silenced by cultural and social stigma, and feeling inequitably burdened compared to their white peers. Participants typically reported barriers to access as conflicting values between cultures, previous negative experiences, waitlists, lack of previous knowledge of mental health, and inadequate services for Black service users. Barriers to engagement were mismanagement of racial dynamics and a perceived lack of attunement between service provider and client. Conversely, participants also spoke of growth promoting therapy experiences that strengthened the therapeutic bond. Suggestions for change include adjustment to practice and training for psychologists, in addition to suggestions that could increase accessibility to services for Black and Multi-ethnic service users.

Keywords: Psychotherapy; Colourblind ideology; Irish Services; Anti-racist practice

This qualitative study aims to extend our understanding of Black and Multi-ethnic clients' experiences of psychological therapy in Ireland. In doing so, participants recount their therapeutic experiences, along with their earlier experiences of being racialised, exploring if such earlier experiences could potentially influence their therapeutic experience.

After decades of research, enquiries into race and psychological therapy ensues due to the pervasive and well documented disparities within the field of mental health between Black and Multi-ethnic groups, and white service users (Bartholomew et al., 2021; Connors et al., 2022; Quirke et al., 2022). Disparities have been noted in diagnostic bias, reduced quality of care, poorer treatment outcomes and lower levels of treatment adherence and engagement (Maura & Weisman de Mamani, 2017). According to the Irish 2022 Census results there are now more than 140,000 people who identify as Black, Black Irish and those of a "mixed background", with 13% of the overall population identifying as an ethnicity other than white (Central Statistics office, 2022). With growing multi-ethnic populations, gaining an understanding of disparities in mental health treatments and increasing more equitable health outcomes, should be a serious public health concern (Connors et al., 2022).

Race and Racialisation

The term "Black and Multi-ethnic" has been used throughout this study. How an individual chooses to identify is deeply personal, and while recognising this, for the purpose of gathering and disseminating information in a coherent way, a common term was chosen based on terms that were frequently used by participants. Even so, the term can be problematic as it is centred around participants being Black or Multi-ethnic *in relation to* whiteness in the context of racialisation. The white experience in Ireland has historically been categorised as normative, but whiteness is not the norm for the majority of the global population. Progressive terminology such as "People of the global majority" (Lim, 2020) coined by the work of Rosemary Campbell-Stephens (Campbell-Stephens, 2021) has been referenced more often in recent literature pertaining to race, to highlight the audacity of the elite white minority that continue to act with the confidence of the majority.

The concepts and definitions of race and ethnicity have varied within existing psychological research and have been used interchangeably and through subjective understandings. Race has at times been used to denote a physical identifier and at others a social construct of oppression. Such variations in how race has been defined therefore has led to different paths of investigation and when examining disparities in care. But seeing race as a biological differentiator predefines "otherness," and is problematic and misleading. Geneticists have been refuting this concept for decades, confirming that all humans are 99.9% genetically identical and at the DNA level there is no genetic basis for race (Duello et al., 2021).

Race and racial difference are relatively recent constructs and are widely understood as a legacy of the transatlantic slave trade. These terms came into use in modern language a long time after groups from different continents encountered one another. Anthropological studies have shown that the practices of racialisation; the categorisation of humanity based on the presumption of biological inferiority, was an attempt at justifying the inhumane decision to select Africans to be slaves for the economic benefit of the then American leaders (Pierre, 2020). Towards the end of the 17th century these man-made social categories solidified, succeeding in upholding white supremacy, and creating a definitive new racial distinction between Black and white and a corresponding social ranking system. Throughout the 19th century America saw an increase in migration from Asian and European communities. These migrants were placed into the racial ranking system along the white – Black continuum. For the Irish migrants, they were initially placed below the other Europeans but were eventually assimilated as white (Smedley & Smedley, 2005).

In relation to Ireland and Irish services, gaining an understanding of disparities becomes complex. Ireland has a long history of anti-imperialism, which has often given way to the idea that there cannot be a racist Irish society. Researchers have examined this premise, looking at both anti-black racism (Joseph, 2018), and racism against the Traveller community, (McKey et al., 2022; Mcveigh, 1992; Quirke et al., 2022) and have found this premise to be untrue. Such studies have indicated that racial hierarchical structures and experiences of discrimination are present within Irish society, Irish systems and Irish Institutions, including our health care systems (Bojarczuk et al., 2015). Irish results show striking similarities with studies conducted in the UK and the US (Misra et al., 2021; Nwokoroku et al., 2022; Rabiee & Smith, 2014). In line with these studies, it is the position of the researcher that race is a problematic social construct which normalises and privileges white people, including herself, and devalues and discriminates against Black and Multi-ethnic groups. In doing so, "out-groups" are created, often pathologizing the negative consequences that result from such discriminatory treatment. Contrary to some beliefs, it is as present in Ireland as it is in the UK, the USA and across the globe, creating "a hierarchical ordering of race, often finding Africans at the bottom and Europeans at the top" (Joseph, 2018).

While the origins of racial categories are well documented as a purposeful social construct, the depths of its negative implications are very real and remain pervasive. To ascertain

today that race is no longer problematic, and to adopt a racial colourblind ideology would be to deny and or minimise the inequalities now present from centuries of discrimination and racism (Neville et al., 2006). An individual who holds such colourblind assertions may "see the human beyond their race" and may condemn individual, explicit acts of racism. But their ideology simultaneously supports a "new racism" one that is often more covert, that disregards the institutional and systemic racism, maintaining a discriminatory racial status quo.

Race, Mental Health, and Mental Health Care

The effects of racism, or race related stress can be described as stress caused by experiencing ones environment as unsafe or harmful based on experiences of discrimination or racial bias that a person has endured (Aggarwal & Çiftçi, 2021; Hunter et al., 2017). Studies show a strong and enduring relationship between consistent/repeated experiences of racial discrimination over time, and increases in symptoms of anxiety, psychological distress and depression (Wallace et al., 2016; Williams, 2018). Discrimination and racism that results in race related stress presents in many forms; systemic, institutional, and interpersonal. In terms of care giving, high levels of negative cultural stereotypes held by white practitioners can guide expectations and interactions with others, impacting and reducing the quality of service provided to people racialised as Black or Multi-ethnic (Hamed et al., 2022; Williams, 2018).

Historically, and due to the differing of opinions on the concept of race, research on race and racial disparities (and consequently training of health care professionals) has at times been underpinned by well-meaning and progressive ideas (Hirshbein, 2021). At others, research has perpetuated structural racism in studying race as a biological concept and an inferiority of racial groups (Smedley & Smedley, 2005). In a review paper on race/ethnic inequalities in severe mental illness, and their treatments, Nazroo et al. (2020) asserts that service providers need to understand how an individual's identity becomes racialised, how these identities are interacted with in terms of structural, interpersonal and institutional racism, and the consequences of such discrimination (Nazroo et al., 2020).

Opposing researchers and practicing clinicians such as Singh, have denounced ideas such as these as "emotionally charged rhetoric" (Singh, 2019) and consistently held a view that racism per se has no role in service provision and such a focus "is both misleading and harmful" (Hawkes, 2006). Arguing that if we attribute institutional or structural racism as a "simplistic notion" of ethnic difference in healthcare or disproportionate mandatory detention, we drive a wedge between the people who need care and the services they need. It is the view of both researchers', Karen Doyle and Barabara Hanigan, that this

latter standpoint minimises years of oppression and the impact it has had on structures, institutions, and individuals. They also play a large role in shutting down vital conversations about race.

In terms of diversity, at the time of this study there was an absence of data pertaining to ethnicity of the 4000+ psychologists registered with the governing body of Psychologists, The Psychological Society of Ireland (PSI). Instead, results from a recent members survey carried out by the Irish Association for Counselling and Psychotherapy (IACP) were sourced. Findings showed that 91% of all responding therapist were white with less than 1% identifying as African or "Any other Black background" (Ryan & Kirkwood, 2021). There is only one organisation in Ireland known to the author, Black Therapists Ireland, which offers Black and Multi-ethnic clients the opportunity to work with Black therapists who share and understand their heritage (Black Therapists Ireland, 2020). The questions then arising are, how culturally equipped are Irish practitioners and Irish services to meet the needs of Black and Multi-ethnic clients? And, how flexible are the practices and philosophical underpinnings of the psychological interventions that are taught and practiced here?

Much of the philosophical and scientific underpinnings of modern psychology as studied and taught in Ireland are westernised. It is a scientist-practitioner model that has been driven by research and "norms" centred around white middle-class Euro-Americans. In 2010 the acronym WEIRD was introduced (Azar, 2010) by a group of researchers that found 96% of participating research subjects (from top scientific journals in the mid 2000's) were from western, educated, industrialised, rich and democratic backgrounds (Muthukrishna et al., 2020). In this way, cultural differences with psychological relevance are being omitted. As an example, existing research shows that Black and Multi-ethnic clients often value and prioritise religious and cultural customs over westernised values. Westernised notions such as self-actualisation and the importance of meeting individual needs often do not fit with the traditional cultural values of community care and interdependence of humanity. In such cultures, one's responsibility towards fellow humans for the common good, commonly known as "*Ubuntu*" for people of African origin (although can be expressed differently between communities and languages for example

"*mutunchi/iwa/agwa*" in Nigeria) is valued over individualism. Such values recognise that the individual is part of a much bigger, more significant world and that individuals should harness their energy to promote equity, reciprocity and empowerment of others (Mugumbate & Chereni, 2020).

Cultural Competency and the Concern of Adherence

Much of the current multi-cultural training relevant to race and cultural variance is presented in terms of diversity and multicultural competency. Models of Cultural Competency (MCC) such as the Multicultural Framework (Sue et al., 1992) were developed to address a lack of multicultural awareness, skills and competencies within the counselling profession when working with Black and Multi-ethnic clients. Within the more traditional MCC models, aspects such as attitudes, knowledge and skills are emphasised with a focus on learning, increasing skills and expanding cultural knowledge. In comparison, the more recent theories such as the Multicultural Orientation (MCO) Framework (Owen et al., 2014) is focused more on a way of being with the client rather than what to do. This way of being is developed through cultural humility and cultural comfort (Owen et al., 2014). Studies have shown that when a client assesses a clinician as culturally competent, therapeutic outcomes are more positive (Bartholomew et al., 2021; Gundel et al., 2020), with cultural comfort showing the most promise in terms of what predicts cultural competency levels (Hook et al., 2023).

Cultural comfort is the degree to which clinicians can (with ease) be humble, curious, open, non-assuming and respectful towards clients cultural identities different to their own (Owen et al., 2017). This would indicate that for the white clinician to provide adequate and equitable mental health care, providing and experiencing cultural comfort, they should be self-aware about their own racial identity. They must also be knowledgeable about concepts of race and racialisation and prepared to meet aspects of ethnicity, racialisation, and racism in all clinical presentations for Black and Multi-ethnic clients. This involves an understanding of whiteness as an ethnic group, one that positions white peoples' race as invisible in today's society, where they do not have to address privilege or their automatic inclusion should they choose not to, nor do they experience threats to their safety or discrimination due to the colour of their skin (Nkomo & Al Ariss, 2014).

Researchers have shown that despite concerted efforts to educate with comprehensive governmental reports (Bojarczuk et al., 2015; Lau, 2008; Sashidharan, 2003), and to train clinicians to be culturally sensitive, adherence and practice may not be reflecting instruction outside of controlled studies (Hamed et al., 2022; McMaster et al., 2021). In a study of 109 published articles that evaluated training models for cultural competency, it was found that only one saw any change in staff attitude and behaviour post training (McMaster et al., 2021). McMaster et al. (2021) argues that unaddressed bias could create attitudinal incongruence and play a role in maintaining racial disparities in healthcare. Additional findings from extensive research and training in antiracism and diversity conducted by Paradies and colleagues in Australia indicated that essentialism and the generation of negative emotions such as guilt can often be a negative byproduct of such cultural trainings (Kowal et al., 2013). Meaning that in an effort to bridge divides, some trainings can intensify them. In a study of 32 diversity training programs, they found that although 50-60% of participants displayed less racial prejudice after training, 15-20% showed an increase of such behaviours post training.

Research has suggested that many white people are unaware of the complexities of racism and of their position of privilege within the racial hierarchy that perpetuates it (Hochman & Suyemoto, 2020). It is also suggested that this lack of awareness in health care providers could lead to discriminatory behaviours while simultaneously believing themselves not to be racist (Hochman & Suyemoto, 2020). Such studies indicate that completing cultural competency training does not necessarily equate to culturally sensitive practices.

Reported Barriers and Facilitators to Accessing and Engaging in Therapy

Acknowledging this continued lack of understanding of disparities in health care, researchers have sought direct feedback from Black and Multi-ethnic service users and their perceptions of barriers and facilitators to accessing and engaging with mental health services. Themes of a personal nature that show up consistently as barriers included stigma toward mental health (self, public, cultural and institutional), cultural and religious attitudes, where spiritual and religious beliefs were attributed to symptoms of mental illness and faith based treatment was supported more than medicalized treatment (Misra et al., 2021). Difficulties in recognising mental health problems and accepting diagnosis, a fear of being unheard or silenced often due to the discomfort of the therapist in discussing racial identity and racism, or colourblind ideologies (Long, 2022).

Other reported service barriers included feeling misunderstood or pathologized for the distress Black and Multi-ethnic clients experience (Memon et al., 2016;

Nwokoroku et al., 2022; Rabiee & Smith, 2014). Excessive wait times and cultural naivety (Memon et al., 2016), microaggressions such as invalidation or minimisation (subtle and everyday verbal and nonverbal slights that communicate hostile, derogatory or negative attitudes (Ong, 2021)) and insensitivity to their needs all appeared as barriers to engagement. The importance of such studies show that racial bias, racism, stigma and discrimination, could negatively impact mental health (Chang & Berk, 2009; Long, 2022; Misra et al., 2021; Power et al., 2017). Some facilitating themes included the simple offer of support, feeling listened to and cared about, and in some cases the provision of medication (Rabiee & Smith, 2014).

Methodology

The current research employed an exploratory qualitative research design to examine the lived experiences of Black and Multi-ethnic clients, in their experiences leading up to and during attendance at psychological therapy.

Ethical Approval

Ethical approval for this study was obtained from The School of Psychology Research Ethics Committee (SPREC), Trinity College Dublin. Participants were fully informed of the nature of the study, including the interview schedule prior to conducting interviews. Recruitment posters did not explicitly identify the researcher as white, so time was taken at the beginning of each interview to acknowledge and discuss any feelings the participants may have been experiencing with regards to the researcher being white. Confidentiality and the limits of confidentiality were described in the Information Sheet and again before the commencement of each interview. Participants were made aware of the potential risk of speaking about content which may be difficult for them and were provided with contact details of several supportive agencies whom they could reach should they experience any distress resulting from participation. The participants were also contacted by email to check in on their well-being within one week of the interview, as an additional measure.

Participants

Participants in the study were made up of nine women and one man, whose details were anonymised, and each participant was assigned a pseudonym. All participants were educated to college level with four attaining bachelor's degrees and five attaining Master level degrees. Initially the target was to recruit 20 participants, but the recruitment process was more difficult than anticipated. Although not directly discussed with self-selected participants, when we consider existing research, the low participation may have been due to a lack of trust in the white researcher and their intentions, fear that as a Black or Multi-ethnic participant they might not be understood or be experienced through an invalidating white lens, along with the stigma attached to mental health difficulties and the meaning associated with putting themselves forward for such a study.

Requirements for Participation – Inclusion/ Exclusion Criteria

Participants were required to be over the age of 18, have attended psychological therapy in Ireland and self-report as non-clinical for anxiety and/or depression with no risk for suicide or self-harm. Recruitment posters called out for participants who identified as Black or Mixed-race. Feedback through the interview process prompted the removal of the term "Mixed-race" and its replacement with the term "Multi-ethnic".

Procedure: Recruitment

Participants were recruited over several social media platforms asking interested parties to contact the primary researcher. The following organisations (who report a large Black and Multi-ethnic audience), A Lust for Life (A Lust for Life, n.d.) and Black and Irish (Black and Irish, n.d.), shared the recruitment poster on their Instagram and Facebook pages calling for participation in the study. In addition to this, the poster was reshared by a well-known influencer and mental health advocate in the Black community advocating her support of the study. Participation was on a voluntary basis and no payment or incentive was provided for participation in the study.

Instruments

Interested parties contacted the primary researcher and were provided with a study Information Sheet and Consent Form by email. This contained details of the study, data protection, confidentiality, funding, and ethical approval. Participants were encouraged to contact the researcher with any questions. On return of the signed Consent Form, participants were sent a Demographic Questionnaire (Table 1) and the Interview Schedule, to review over a two-week thinking period before an interview time was scheduled. Following the

interviews, participants were sent a Debrief Sheet which included details of support services available and thanking them for their participation. The interview schedule was built using existing research, which helped develop questions and sections pertaining to identity formation and racialisation, familial and community influences, and experiences and expectations of psychological therapy.

Data Gathering

Individual, audio recorded, semi structured interviews were conducted with each of the ten participants, each lasting between 90 and 110 minutes. Eight interviews were conducted over a secure zoom call, and two interviews were conducted in person on the Trinity College Dublin campus. The Interview Schedule contained 14 open ended questions, along with consent for the interviewer to request further elaboration if needed.

Questions were constructed so that each participant could share their own unique experience of living in the world while identifying as a Black or Multi-ethnic, of mental health and of mental health services in Ireland. The interview schedule included questions pertaining to the participants' personal development, their cultural influences and finally their expectations and experience of therapy. For example, a question on development read as follows: "You described your racial or ethnic identity as x. How in your experience has this part of your identity contributed to your development as a person and how has it changed over the years as you grew up?" In terms of cultural influence, one question read "From your experience, how do your family, friends and community view mental wellbeing, mental health difficulties, and psychological therapy?" With regards expectations and experiences of therapy, participants were asked "Were there any issues to do with race, racial identity or racism relevant to your experience that you wanted to bring to therapy? If so, was it discussed, and was it you or your therapist who brought it into the work?" Encapsulated within the generic approach to descriptive-interpretive qualitative research (Elliott & Timulak, 2021) is the notion that the data collection is in itself part of the analysis. This means that the formation of the questions used to gather data is a form of analysis, shaped by the theories and research that have come before them. Aiding the creation of broad topics of investigation before the data is gathered, while allowing for the topics to be adjusted accordingly as the new data emerges during analysis (Elliott & Timulak, 2021).

Data Analysis

The method chosen for analysis of the data was Generic Descriptive Interpretive Qualitative Research Analysis (GDI-QR) (Elliott & Timulak, 2021). This type of analysis is flexible yet structured in its approach, which is conducive to recording both concrete answers and more abstract themes within the narrative of the participants. This method was chosen as a natural fit for the exploratory nature of the study and most suited to the style of the researcher. In accordance with the philosophical underpinning of the GDI-QR approach (Elliott & Timulak, 2021), the research was viewed and analysed through a guiding framework of dialectical constructivism, of meaning making for participants in their development in relation to the society they are situated within, and the research itself where participants and data were actively engaged with by the researcher through experiential means to construct meaning within the context.

All ten interviews were transcribed, read and re-read in an effort to fully understand the information in the context of the participant's story. The data were cleaned of nonfluencies in speech (which may distract from the content) and situational content, while every effort was made to retain the idiosyncratic elements of the participants' experience. Data relevant to initial themes were isolated as meaning units, each capable of communicating a clear message either explicitly or implicitly within the larger context of the data. Similar meaning units were organised into categories that captured the core messages being communicated under the relevant domain.

Samples of the data analytical process were discussed and reviewed on a number of occasions with the research supervisor, in a process of cross-case analysis. Additionally, a credibility check was conducted on sample transcripts by two additional researchers, and a cross comparison of the data was conducted with discrepancies between principal researchers' analysis and the other research team members were highlighted, discussed, and consensually agreed. The research team was made up of the primary researcher, a trainee counselling psychologist, two trainee counselling psychologists in their first year of training and the research supervisor, a counselling psychologist and assistant professor of psychology.

Results

Four overarching domains captured the main themes of the results, these are 1) How racialisation impacts identity and

psychological well-being 2) Factors influencing help seeking behaviour for Black and Multi-ethnic clients 3) Rupturing or damaging experiences of psychological therapy 4) Growth promoting therapy experiences that strengthened the therapeutic bond. When discussing categories, representativeness was calculated by frequency in the following way; eight participants or more was calculated as general representativeness, categories reported by at least half was typical, two or more participants; variant, and categories with only one participant are referred to as unique (Elliott & Timulak, 2021). It may also be important to note that within the four domains, many of the cases participants recounted were real, lived experiences, but participants at times reported a strong felt sense of expected experiences. This felt sense, based on a history of being racialised has at times been equally powerful in motivating behaviours.

Pseudonym	Sex	Age	Racial/ethnic identity	Country of birth	Age (moved to Ireland)	Age (therapy in Ireland)
Rosa	Female	38	Mixed race/Multi-ethnic - Afro Latina/German Jewish	United States	33	34
Ida	Female	30	African Irish	Democratic Republic of Congo	6	26
Maya	Female	24	African	Nigeria	23	24
Audre	Female	32	Black African	Nigeria	15	18
Ruby	Female	29	Black	France	26	27
Coretta	Female	23	Black British, ethnically Ghanaian	UK	18	19
Nyame	Female	30	African	South Africa	27	28
Kathleen	Female	40	Black and Mixed Race	UK	21	27
Robert Lee	Male	24	Black British Irish and Nigerian	UK	4	8 or 9
Patrisse	Female	23	Black Irish		6 months	18

Table 1: Demographic Characteristics of Participants

Domain 1: How Racialisation Impacts Identity and Psychological Well-being

Generally, participants reflected on the development of their identity, how they were treated as a person of Black or Multi-ethnic heritage and how this influenced their mental health. Categories created within this domain were as follows; the need and costs of belonging, race related stress and its psychological impact, feeling burdened by racial stereotypes and inequity and lastly, feeling silenced in their psychological distress.

The Need and Costs of Belonging

Generally, participants spoke about how their human need to belong often went unmet because of being racialised. As a result, they often felt that they were not accepted or that they did not fit in with peer groups, which often left them feeling isolated, confused, and distressed.

> For me being Black and Irish has always been confusing. From a young age until now. In the Black community they're like you're too white, you're too Westernized. But then in the white or Western community they'll say where are you from originally, [indicating] you're not one of us. So, I've always felt confused (Ida)

In an attempt to minimize these distressing feelings participants went on to describe the actions they would often take to improve their quality of belonging and the costs associated with them. Participants typically reported having adjusted their identity to meet the need and expectations of others. Often described as code switching, whereby behaviour or appearance is adjusted (at great emotional expense) to optimise the comfort of others in order to achieve desired success (McCluney et al., 2021). There was a sense that to be fully themselves, to share their concerns about how they or others were treated, they risked losing what little sense of belonging they may have created.

> Listening to teachers in the school, if I hear the (majority white) staff talking about students, they might be talking about the Black student's hair, or Black boys being especially aggressive, or a joke that's not funny, I will have to pick and choose if I was going to intervene and risk losing even that little bit of a sense of belonging. Yeah, [decide to] put that on the line or just ignore it and move on (Rosa)

Typically, participants described the positive experience of finding a sense of self-acceptance, which was often accompanied by feeling connected to others. Participants spoke about changes within themselves such as age, maturity, and of meeting people who have similar stories and experiences. This provided them with the courage to recognise their own positive attributes, rejecting otherness and embracing all parts of themselves.

Race Related Stress and its Psychological Impact

Participants shared their direct experiences of being 'othered' and distressed by racial bias and racism. Findings have shown that people who experience racism report higher levels of anxiety, guilt or shame, avoidance or numbing, suggesting an overlap with symptoms typical of Post-Traumatic Stress Disorder (PTSD) (Kirkinis et al., 2021). Participants generally recounted experiences from a young age, where they described peers in school treating them differently because of their skin colour, ranging from entitled questioning of the

participant and their heritage, racist name calling and isolation, through to physical racist attacks. One participant recalls how her five-year-old brother had once come home upset and covered in oil,

> We went up the road, me, my older sister, and my brother and we saw the kid and his parents outside, and his dad was like changing his motorcycle oil. That's how he realized that the oil was actually mechanical oil, and they were just laughing, they were just laughing at all three of us (Patrisse)

Participants also typically spoke of the pain and fear they felt, seeing acts of violence and discrimination against people who looked like them, and the trauma they felt was passed down

through generations. Vicarious racism is racism experienced indirectly and can include racially motivated rhetoric against an entire racial group not just an individual. Such attacks can be experienced as personally threatening and can result in fear, negative self-evaluation and poor mental health (Chae et al., 2021).

> Seeing global news which I felt was amplified in Covid, where terrible things were happening to Black people, and because our connectivity with the internet, it was so hard like every day to see something else and to be like, OK, my [skin] colour is still a reason to die. I was getting very tired and probably powerless, hopeless. It's like a dead weight you carry all the time (Ruby)

Typically, participants spoke about societal structures and attitudes towards race and racism, describing how in their experience, white people are fearful of race conversations. That “people would rather engage in the mental gymnastics of avoiding the topic rather than stepping into it” (Rosa). Some participants spoke of the “binary views of racism” within Irish society, explaining that people felt that because they were once oppressed, they cannot be the oppressor (Coretta), and that some people believe these microaggressions are acts of playful banter and should be received that way (Robert Lee).

Participants described their experiences of having developed a heightened awareness, a vigilance that’s always present, always watching for how others treat them and being prepared to protect themselves.

> You never know if like the attitude of people around you are because of the colour of your skin you know, you’re always wondering, and I'm trying to keep that voice down because it's not [an easy] life to always wonder, but it's still there (Ruby)

In contrast to this approach, two participants spoke about their need to minimise or recategorize experiences of microaggressions or racism to retain peace of mind.

> I have one friend that told me, no matter what happens, unless it's like really bad and someone is spitting on you, try not to see that as racism, just, like make fun of them in return. So, I consciously try to tell myself it's not racism. If I register it in my head as racism, I will start to get scared for my safety, I just try to think of it like this person is just plain stupid. That's just how I just look at it. I just say, well, you're just being ignorant (Maya)

Feeling Burdened by Racial Stereotypes and Racial Inequity

Typically, participants spoke about the additional burden they carry and the inequity they face within racialised social structures and institutions. Participants recounted the difficulty of feeling defined by others, how it should be their right to define themselves, along with the burden of being socially disadvantaged and having to endure mistreatment because of the colour of their skin. As they grew into adulthood, the biases they felt as children transferred to adult aspects of their lives including the workplace, where they described the same perceived biases and unfair treatment but in much more subtle ways.

> I was just hitting wall after wall for promotions and job moves. I couldn't help but feel like there was bias. Of not being white, not being Irish, whatever, and watching younger colleagues who were white and Irish, less experienced and getting promoted ahead of me (Rosa)

A variant number of female participants relayed the extra mental burden they carried in order to survive and succeed when constantly coming up against intersectional discrimination and social stereotypes.

> My Father always told me you're a woman and you're Black, so you have to work 10 times more than anyone else around. I was like, that's not fair, because it means you work harder, but then you also get tired faster, and like, it's a lot to carry (Ruby)

Feeling Silenced in their Psychological Distress

All participants spoke about a felt sense of being silenced in their emotional difficulties by cultural beliefs of the Black

communities, racial stereotypes such as the strong black man/ woman or a fear that showing vulnerability would invite further discrimination. This very often left them to deal with their pain and mental health difficulties alone, as other adults, such as teachers "were part of the problem." (Patrisse). Participants typically reported that they had tried to broach difficult subjects with family or community but that their responses made them fearful of a similar reaction in the future.

> I remember telling my mum that I'd been called "a Paki" at school and there was something about her reaction that made me think, OK, this is a lot heavier than what I thought it was. … I sort of subconsciously made a decision somewhere that I was going to have to figure this stuff out on my own (Kathleen)

There was also a clear message from some families and communities that discussions around family trauma and mental health were to remain closed. There was stigma and a lack of understanding attached to mental health difficulties, and many participants shared that their family consensus was that to struggle with mental health was to be "mad" or "overly dramatic", or in the case of participants from Nigerian or Ugandan heritage, it was reported as "taboo". Knowing how their community and family saw mental health, they feared they too would be viewed in this way.

Domain 2: Issues Influencing Help Seeking Behaviour

Participants spoke of several areas of influence when discussing their desire and ability to access psychological support. These included influences such as cultural attitudes of their communities and families, and the availability or lack of availability of adequate services for Black and Multi-ethnic service users.

Cultural, Community and Familial Influences

Participants typically recognised attitudinal changes towards mental health with each generation, where a variant number reported that support from family or friends made it easier to talk about and access psychological therapy. Simultaneously, they recognised the westernised culture of mental well-being and psychological therapy is still often in conflict with traditional views and values of their ethnic community, making it difficult to seek help. Cultural shame and a general misunderstanding about mental health was typically referenced. Needing therapy was seen in many families as something to be ashamed of, and so was blocked for some participants due to families being embarrassed. For others it wasn't an option because there was little to no knowledge of it as they grew up and priorities were different.

> Growing up in Nigeria I wouldn't have even known what therapy was. Nigeria is the poverty capital of the world, millions of people earn less than $1.00 a day so of course the main priority is food rather than therapy, or when you get malaria, the priority is to fight that, not get therapy (Audre)

A further conflict that was typically present was between religion and psychological therapy as a means of support. In broader terms, it may be seen as Black families refuting the possibility of mental health difficulties within their community as it was viewed as "a white man's disease". In times of difficulty Black communities were often advised to "pray on it" (Robert Lee). Participants expressed their love and respect for their cultural heritage, trying to embrace it, but recognised that at times of great difficulty, they needed more, and would like their community to be more accepting and open to other possibilities.

Service Availability and Expectations of Care

Typically, the participants described how their employer, or their educational provider enabled them to get access to psychological therapy through employee assistance programmes or college counselling. They acknowledged that without this support, they may not have otherwise been able to avail of therapy due to the financial investment required for private sessions. Participants addressed the difficulty of service wait lists, with particular emphasis for the Black or Multi-ethnic client. That although the waitlists applied to all ethnic groups, that for Black or Multi-ethnic clients, due to the cultural and racial stigma they had to contend with, this often meant that they would only reach out in crisis. That their request for help should be viewed with a sense of urgency, and that these cultural factors were being overlooked when they were placed on long waitlists.

> I needed to book an appointment. I needed the help now. I don't want to book an appointment that takes a week to get back to me, I might not be alive in a week (Maya)

Participants spoke about being unsure of what to expect from therapy, whether it will be a place where they will feel heard and understood, with particular concern that their experience as a Black person in the world may not be understood by a white therapist. They typically reported a fear that their pain would be viewed through the social stereotype of the strong Black woman and their experiences would be questioned.

When these concerns were raised, they would be dismissed or go unheard, and that their experience of being isolated and different because of their heritage would be pathologized and misunderstood.

There were also concerns raised regarding the competency of therapists. One participant shared her experience of enquiring if the therapists work in an intersectional way, as she was a Black woman with an eating disorder, she was told that they let everyone in.

> I'm like OK this is not 1956. You're not doing anything by literally letting people of colour in. I'm asking if the treatment and the training of your professionals is intersectional. [He responded that] the treatment doesn't have to be intersectional because we treat people by disorders (Coretta)

Coretta's response captures many of the concerns of the participants.

> All the treatment of the disorder is rooted in white women and white girls' experiences. You can't treat me for my disorders because you're not factoring in other aspects of identity (Coretta)

Although participants typically reported at least one positive experience of psychological therapy, the issue most frequently commented on in terms of influencing help seeking behaviour were the participants' previous negative experiences with therapy, and the lasting effects of these interactions. Generally, participants recounted experiences in varying psychological therapy services which left them feeling hesitant and fearful of returning to therapy in the future.

A variant number of participants spoke about their excitement of finding Black Therapists Ireland (2020), that they wished it had been available to them when they were younger. Typically, participants spoke of their desire to work with a Black therapist in the future, believing it would provide them with an immediate sense of ease and much less of an obligation to explain their circumstances. But that representation for Black and Multi-ethnic groups within the profession is much less than what is required and so it is often not a viable option due to location or lack of availability.

Domain 3: Rupturing or Damaging Experiences of Psychological Therapy

When recounting actual experiences in therapy, participants generally shared at least one experience where they either felt the relationship between themselves and their therapist was ruptured, or they felt harmed by the intervention chosen by the therapist. These were placed in categories of perceived mismanagement of racial dynamics in therapy, and/or general missteps by the therapist. The outcome of these negative experiences often resulted in a reluctance to share, and fear of judgement in the therapeutic relationship.

Perceived Mismanagement of Racial Dynamics

Participants most often spoke of how their experiences as Black men or women, racial dynamics and racism were addressed or avoided in therapy between themselves and their therapist and a typical reluctance to speak about race with white therapists.

> At the beginning of therapy, they're confident but then when I bring up race, sometimes they stammer, and they their body language changes. Like a lot of abuse victims tend to do, I read a lot from body languages. I'm very good at knowing when someone is uncomfortable, so when I speak about race and their body is like moving and changing, I'm just like, OK, that's obviously an uncomfortable conversation (Audre)

When describing lived experiences of discussing racism with the therapist, they experienced microaggressions such as the therapist minimising their experience or becoming defensive which motivated participants to withhold information or leave therapy.

> They always say the same thing, ah sure ignore the racist… it's almost like they think there's a switch you can just press ignore…. Its dismissive, like do you not think if I had that switch, if I could ignore, I would've done it (Audre)

One participant, Kathleen, shared her experience of a therapeutic group as "the most damaging psychological experience I've ever had". She described her many difficult experiences in the group, including the group members response when she spoke about racial issues, "we're white we can't understand", followed by a refusal to participate.

> I once tried to explain to a group member about racism. She started to cry and said I was attacking her, and I felt pressure to put my feelings aside and make it ok for her, having to deal with her white fragility (Kathleen)

Kathleen also spoke about the facilitator's response, to an experience as a Black woman that she had shared by telling her

that she wasn't really black. She recalls the incident vividly and how deeply damaging this "cruel and clumsy intervention" was. She recalled that the facilitator's perceived incompetence to manage the racial dynamics in the group throughout, left her feeling silenced in her distress, angry, unsafe, and dealing with anxiety and nightmares in its aftermath. Audre spoke of her first experience of psychological therapy with a reputable mental health agency after experiencing a sexual assault. She spoke to her therapist of her struggle with immigration agencies, homelessness, and multiple traumatic events that she had endured in the lead up to the assault.

> Because she didn't know the system, with her biases, she made me feel like it was my fault and she focused on this rather than on the pain of what I had just been through. I know her intentions weren't to hurt me but after 15 years what she said still haunts me, it's still part of my trauma. It was like a second assault (Audre)

Variant participants spoke about power dynamics in therapy, highlighting the potential impact of racial power dynamics for the client.

> It encapsulated everything I tried to avoid. The therapist was an older white woman, and she was cold, and I was immediately triggered as she represented the people who caused the most harm in my life (Patrisse)

Participants spoke of therapeutic interventions that they felt were biased or culturally insensitive, where therapists displayed a lack of knowledge or understanding of their cultural heritage, their values, and their experience, sometimes followed by an encouragement to follow westernised practices.

> Put yourself first put yourself first, put yourself first, every other [therapist] says. You don't owe your family anything. That's a 1st world attitude, third world countries, we don't put ourselves first, we are a community. You know we're not a single person (Audre)

Therapists' attitudes or interventions at times resulted in the participant having to take on the role of educator, which they felt was an unfair burden on them. They felt they were there to seek help not to provide it. It also impacted their sense of being understood and diminished their hope and expectations for the work, often leading to early unilateral termination of the therapy.

General Missteps or Misattunement of the Therapist

Other areas of rupture, separate to race, were typically described as interactions or interventions where the therapist didn't seem to understand them or what they needed, for example a misattunement where the therapist seemed to be following a path that felt unhelpful for the participant.

Domain 4: Growth Promoting Therapy Experiences that Strengthened the Therapeutic Bond

All participants recounted at least one experience of therapy where the bond with the therapist and their interactions with them cultivated a sense of attunement, trust and safety. Some participants acknowledged that there may have been ruptures, but despite these, the therapy was a positive experience for them. For these participants, experiences of being heard, understood, and cared for, allowed them to engage in the process with the therapist more fully despite often approaching therapy guarded.

> …I just kind of said she's not gonna pry anything out of me like it's just whatever I tell her, I tell her. But then I found that that wasn't the case, and I couldn't help myself from telling her absolutely everything (Patrisse)

In their narratives, participants spoke indirectly of their therapists' skills of active listening, reframing, and showing concern, all of which helped them to feel connected in the therapeutic relationship, ultimately facilitating the therapeutic work.

> It's been great so far. I mean the therapist I see she's very supportive. And she listens more than most people in my life. They actually listen and understand better than most people, much better than people in my family to be honest with you. So, she's been very helpful (Robert Lee)

Uniquely, Nyame spoke about times that her therapist didn't understand the cultural complexities of some of the examples she raised. She suggested that the therapist educate herself in between sessions and return to the topic in the following session. She expressed gratitude towards her therapist for doing her own work in between sessions to accommodate this and felt that this strengthened their connection and made her feel that her voice was important. Other participants referred to how race was addressed in therapy. That race and racism may not have been their primary focus on entering therapy, that there were more pressing matters they wanted to speak

about, but the offer to discuss issues of race and racism was viewed as a positive.

Four participants also spoke of the immediate sense of ease when sitting with a Black therapist, but that meeting with a Black therapist isn't necessarily without difficulties too. Kathleen described it in this way; "I think if you put two Black people in a room together, your starting point is different." Overall, the participants explained that having at least one positive experience in therapy helped them to overcome their negative therapeutic experiences, igniting hope for the possibility of positive therapeutic encounters in the future.

Recommendations

As interviews concluded, each of the ten participants were asked to share recommendations for white therapists when embarking on a therapeutic relationship with a Black or multi-ethnic client. The following is a themed representation of their combined responses.

1. The therapist needs to evaluate their own racial identity. To become aware of their own biases, their level of comfort in discussions of race, and the white therapists' position of privilege. Acknowledge the dynamics of race in the room rather than leaving it unspoken. Participants stressed that if you have not "done the work" your body language will show the client your discomfort and will inevitably shut down the work. (participants 1,8,10, and 12)

2. It should be a priority and a responsibility to use the many podcasts, Instagram pages and books focused on the Black or Multi-ethnic experience, to educate yourself as therapist/ psychologist. Do not probe or expect your client to be your educator in sessions. (participants 4,1,10 and 12)

3. Do not assume you know how a client identifies because of how they look. Don't assume that the Black or Multi-ethnic client is comfortable talking about race or racism, nor assume the opposite. Don't be afraid to ask these questions, include experience of the Black man or woman as a standard intake question. (participants 4,5, and 9)

4. Understand the cultural complexity and associated stigma with regards mental health and therapy. Often, when a Black or Multi-ethnic client seeks help, they may already be in crisis and initiating work should be viewed with a sense of urgency. (participants 5 and 6)

5. Allow the client to speak about painful things including racism and discrimination without question or offering solutions or reasoning, even if it raises discomfort for you as a white therapist. Listening without bias or judgement to that human being in front of you before anything else will be invaluable to you and your client as you build trust and safety. (participants 6 and 11)

6. Expect and accept that therapy with a Black or Multi-ethnic client will be different to therapy with a white client. If you have educated yourself, if you have done your own work on your own position on race then great. If not, "don't gamble with my life by learning along the way, this is my trauma" (Patrisse)

7. "Privileged people respond well to privileged people." Use your position in society to join the conversation as an ally. (participants 8 and 10)

Discussion

Many of the findings of this Irish study are reflective of the existing American and UK based literature cited previously. Participants in this Irish sample report similar challenging and facilitating experiences of accessing psychological therapy. In terms of facilitation, there was a typical response of receiving help through educators or employers via student services or employee assistance programmes. This was highlighted as a supporting factor which has not been as visible in previous studies. Personal factors challenging access to therapy were raised such as cultural shame and stigma of mental health (Misra et al., 2021; Nwokoroku et al., 2022), expectations based on previous experiences and fear of the unknown. Participants spoke about navigating a complex conflict of personal needs, cultural beliefs, and societal attitudes all within the context of the available services, which in their experience centred on the white experience as the norm.

Similarly, on participants' engagement with therapists and services many of the findings of previous UK and U.S. studies were present for this Irish sample (Hamed et al., 2022). Participants typically reported both a desire and a hesitancy to bring the topic of race and racism into the therapy room. Sometimes the reluctance was with the participants; fearful that they would be misunderstood by their white therapists.

That they may be subject to further invalidation or retribution, or that they may lose the bit of support they have by making the therapist uncomfortable. At other times the hesitancy to discuss race or racism belonged to the therapist, noticeable by the client through the therapists' body language and verbal responses. There were reports of perceived culturally insensitive interventions based on what the participants felt were the therapists' own biases (Arora et al., 2022; Williams, 2018) and a lack of cultural knowledge (Chang & Yoon, 2011). Participants at times felt that in the face of these interventions it was necessary for them to become the educator in the therapeutic space which they felt was an unfair burden on them as clients.

Experiences of being heard and cared for felt validating for participants. It cultivated an increased sense of trust in the therapist and the therapeutic work, allowing the participant to use the therapy to work through their difficulties (Arora et al., 2022; Rabiee & Smith, 2014). Participants expressed gratitude when service providers acknowledged race and racial differences in their experiences, expressing an openness to discuss race and a willingness to educate themselves. The ability of the service provider to listen without judgment or provide solution focused interventions were viewed as vital aspects to the therapeutic process and facilitated growth in both the alliance and the work.

This paper argues that the way a participant experiences the world as a Black or Multi-ethnic individual has an impact on their mental health, how they present, what they expect, and how they will experience psychological therapy (Nazroo et al., 2020; Wallace et al., 2016). Many participants reported that at times in their lives they have felt silenced in their mental health difficulties and typically spoke about living with a hyper-awareness and a need to protect themselves from pervasive and painful experiences of racism. Many of the women spoke of the additional burdens they are obligated to carry in being defined by others, and the confusion of being disadvantaged because of the social construct of race.

The present study argues that by "not seeing" race, or the trauma and stressors associated with it (Maharaj et al., 2021) when it is so salient, the service provider may inadvertently repeat harmful events, or deny core painful aspects for the client. The parallels between earlier experiences in a racialised world, and the reported experiences of therapy became increasingly pronounced in participants narratives. Clients felt like they had to codeswitch or minimise their experiences to "belong" with their therapist. Feeling silenced in the work through microaggressions and biased responses such as to ignore racism. There were also repetitions of vigilance and protective behaviours in the therapy room, to stay guarded and not tell "too much," to protect themselves from culturally insensitive interventions. They felt unfairly burdened with the educator role and having to work harder in therapy than white clients, sharing strong emotions about therapists' personal responsibilities.

Strengths and Limitations

The majority (9) of the participants in this study were female. Participants were self-selected and there is a noticeable disparity between the number of men and women who participated. Existing studies show that mental health for Black males was often situated within notions of masculinity, strength and that mental health difficulties were associated with weakness (Memon et al., 2016), and that services were thought to be discriminatory towards Black males (Meechan et al., 2021). This may have reduced the number of men accessing psychological therapy or willing to participate in such a study. On review of the recruitment process there could have been a much broader sample of participants had there been a broader outreach to communities for recruitment.

The qualitative nature of the study is considered a great strength of the work as it allowed for deeply personal and illustrative narratives. There were 14 questions on the interview schedule so focus may have inadvertently been redirected from areas that needed further exploration in an attempt to address all 14 questions. Participants were asked to share the gender and racial identity of their Irish therapist, but as interviews transpired many participants brought more than one experience for which we did not have details. Explicit questions on the number of therapists, ethnic/cultural identity of each and an examination of successful or unsuccessful attributes could have been a rich data source but only become visible as a good source after the interviews had already commenced.

Clinical implications and future Recommendations

The findings of this study suggest that being racialised as Black or Multi-ethnic (and the associated stress of racism and discrimination), impact and inform a client's experience of accessing and engaging in therapy. The weight of this study lies in the personal experiences of its 10 participants. For each participant to share their experiences of pain as a result of racialisation, with me, a white researcher has been an incredibly humbling experience. As an experienced psychotherapist and psychologist each of their stories have created a deep shift in my attitudes towards myself as a white

practitioner and my position of privilege. Their gift in sharing has brought clarity about my personal responsibility to clients in my therapy room and within the majority white profession of psychology. It remains clear that adjustment is needed in services to provide adequate support to Black and Multi-ethnic service users. Refusing or being unable to feel the emotional cost of racism, to repeat traumas in the therapy room, and to cause harm as described by these participants when this is avoidable, is a direct violation of the ethical codes that governs the profession. For each practitioner and service leader to truly engage with these experiences and the proposed recommendations from a curious, non-defensive, humble position could lead the way to more equitable practices for Black and Multi-ethnic clients.

Each of the suggestions provided herein by participants are vital. As a personal responsibility, the individual practitioner should engage in a process of self-examination of their own racial identity and biases. There should also be an expectation that practitioners acknowledge and address the discomfort that will most likely arise in the process. As stipulated by the participants, this requires a real-world cultural education and a deep and personal exercise of gathering knowledge which may disrupt the white practitioners existing knowledge of race and racialisation. It should be recognised that regardless of the presentation, therapeutic work with Black and Multi-ethnic clients will be, and should be different due to the pervasive discrimination of being racialised as depicted in the results of this study. This learning should not be attempted in the therapy room with the client. Further research is imperative in examining the isolated effect of addressing racialisation and its effects in treatment for Black and Multi-ethnic client outcomes. Such research could help to promote adjusted practice and support policy and educational change.

These educational practices should be expanded on and incorporated into the structures and institutions of Irish mental health care by adjusting training requirements, policies and procedures and holding each other accountable. Training institutions and governing bodies are uniquely positioned as gatekeepers to the profession, stipulating adherence to training and self-exploration in personal therapy. With the knowledge we now have on the efficacy (or lack thereof) of simplified multicultural trainings, more conscientious effort is required to increase the white practitioners understanding of the Black or Multi-ethnic client's experience. This can be started with a re-evaluation of multicultural training programmes, expanded reading beyond the west and open dialogues. Collectively we must begin to understand racism beyond individual acts of racism. Anti-racist practice involves understanding that much of our collusion in racism is conditioned and accepted as the norm, to change and grow we need to acknowledge our position within a white supremacist world, not deny it.

Finally, as stigma within the Black and Multi-ethnic community is reported as another consistent barrier to accessing treatment, it is recommended that community services build outreach programs. These programs would aim to engage the community in safe spaces to create two-way education, building trust and enabling new pathways to care for such clients. In addition, focused support for the training and employment of more Black and Multi-ethnic professionals into psychology, counselling, clinical and psychotherapy programmes could increase equity and representation in addition to making support more accessible and relatable for Black and Multi-ethnic service users.

Acknowledgements

A bursary was received by the primary researcher in the form of a research award by the Irish Association of Counselling and Psychotherapy (IACP) in the latter stages of this research.

References

A Lust for Life. (n.d.). *A Lust for Life*. Instagram. Retrieved May 13, 2023, from https://www.instagram.com/p/CfD7_IrKkI9/?igshid=NjZiM2M3MzIxNA==

Aggarwal, A., & Çiftçi, A. (2021). Colorblind racial ideology, sense of belonging, and racism-related stress in Asian Indian international students. *Psychological Reports*, *124*(5), 2251–2271. https://doi.org/10.1177/0033294120961063

Arora, S., Gonzalez, K. A., Abreu, R. L., & Gloster, C. (2022). "Therapy can be restorative, but can also be really harmful": Therapy experiences of QTBIPOC clients. *Psychotherapy*, *59*(4), 498–510. https://doi.org/10.1037/pst0000443

Azar, B. (2010, May 1). Are your findings 'WEIRD'? *Monitor on Psychology*, *41*(5). https://www.apa.org/monitor/2010/05/weird

Bartholomew, T. T., Pérez-Rojas, A. E., Bledman, R., Joy, E. E., & Robbins, K. A. (2021). "How could I not bring it up?": A multiple case study of therapists' comfort when Black clients discuss anti-black racism in sessions. *Psychotherapy*, 60(1), 63-75. https://doi.org/10.1037/pst0000404

Black and Irish. (n.d.). *Black and Irish*. Home [Facebook Page]. Retrieved May 19, 2023, from https://www.facebook.com/BlackandIrish/

Black Therapists Ireland. (2020). *Black Therapist Ireland*. https://www.blacktherapistsireland.ie/

Bojarczuk, S., Marchelewska, E., & Prontera, M. (2015). Ethnic minorities and mental health in Ireland: Barriers and recommendations. *Cairde*. www.cairde.ie

Campbell-Stephens, R. M. (2021). *Educational leadership and the global majority: Decolonising narratives*. Springer Nature.

Chae, D. H., Yip, T., Martz, C. D., Chung, K., Richeson, J. A., Hajat, A., Curtis, D. S., Rogers, L. O., & LaVeist, T. A. (2021). Vicarious racism and vigilance during the COVID-19 pandemic: Mental health implications among Asian and Black Americans. *Public Health Reports*, *136*(4), 508–517. https://doi.org/10.1177/00333549211018675

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Chang, D. F., & Yoon, P. (2011). Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research*, *21*(5), 567–582. https://doi.org/10.1080/10503307.2011.592549

Connors, E. H., Arora, P. G., Resnick, S. G., & McKay, M. (2022). A modified measurement-based care approach to improve mental health treatment engagement among racial and ethnic minoritized youth. *Psychological Services*. https://doi.org/10.1037/ser0000617

Duello, T. M., Rivedal, S., Wickland, C., & Weller, A. (2021). Race and genetics versus "race" in genetics. *Evolution, Medicine and Public Health*, *9*(1), 232–245. https://doi.org/10.1093/emph/eoab018

Elliott, R., & Timulak, L. (2021). *Essentials of descriptive and interpretive approaches to qualitative research: A generic approach*. American Psychological Association (APA). https://doi.org/https://doi.org/10.1037/0000224-000

Gundel, B. E., Bartholomew, T. T., & Scheel, M. J. (2020). Culture and care: An illustration of multicultural processes in a counseling dyad. *Practice Innovations*, *5*(1), 19–31. https://doi.org/10.1037/pri0000104

Hamed, S., Bradby, H., Ahlberg, B. M., & Björkert, S. T. (2022). Racism in healthcare : A scoping review. *BMC Public Health*, 1–23.

Hawkes, N. (2006). Health policy: English NHS reforms made easy. *BMJ: British Medical Journal*, *333*(7569), 645.

Hirshbein, L. (2021). Racism and mental health: Historical perspectives on the limits of good intentions. *Society*, *58*(6), 493–499. https://doi.org/10.1007/s12115-021-00627-2

Hochman, A. L., & Suyemoto, K. L. (2020). Evaluating and dismantling an intervention aimed at increasing white people's knowledge and understanding of racial justice issues. *American Journal of Orthopsychiatry*, *90*(6), 733–750. https://doi.org/10.1037/ort0000506

Hook, J. N., Hodge, A. S., Sandage, S. J., Davis, D. E., & Tongeren, D. R. Van. (2023). *Differentiation of self and cultural competence : A systematic review of the empirical literature*. *8*(1), 50–61.

Hunter, C. D., Case, A. D., Joseph, N., Mekawi, Y., & Bokhari, E. (2017). The roles of shared racial fate and a sense of belonging with African Americans in Black immigrants' race-related stress and depression. *Journal of Black Psychology*, *43*(2), 135–158. https://doi.org/10.1177/0095798415627114

Joseph, E. (2018). Whiteness and racism: Examining the racial order in Ireland. *Irish Journal of Sociology*, *26*(1), 46–70. https://doi.org/10.1177/0791603517737282

Kirkinis, K., Pieterse, A. L., Martin, C., Agiliga, A., & Brownell, A. (2021). Racism, racial discrimination, and trauma: A systematic review of the social science literature. *Ethnicity and Health*, *26*(3), 392–412. https://doi.org/10.1080/13557858.2018.1514453

Kowal, E., Franklin, H., & Paradies, Y. (2013). Reflexive antiracism: A novel approach to diversity training. *Ethnicities*, *13*(3), 316–337. https://doi.org/10.1177/1468796812472885

Lau, A. (2008). Editorial delivering race equality in mental health services. *Advances in Psychiatric Treatment*, *14*, 326–329. https://doi.org/10.1192/apt.bp.107.004986

Lim, D. (2020). I'm embracing the term 'people of the global majority'. *Regenerative Medium*.

Long, C. (2022). Racial identity and uncertainty in psychotherapy: Perspectives of Black clients and their therapists. *International Journal of Applied Psychoanalytic Studies*, *January*, 1–18. https://doi.org/10.1002/aps.1737

Maharaj, A. S., Bhatt, N. V., & Gentile, J. P. (2021). Bringing it in the room: Addressing the impact of racism on the therapeutic alliance. *Innovations in Clinical Neuroscience*, *18*(7–9), 39–43.

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, *24*(3–4), 187–210. https://doi.org/10.1007/s10880-017-9510-2

McCluney, C. L., Durkee, M. I., Smith, R., Robotham, K. J., & Lee, S. S. L. (2021). To be, or not to be…Black: The effects of racial codeswitching on perceived professionalism in the workplace. *Journal of Experimental Social Psychology*, *97*(09), 104199. https://doi.org/10.1016/j.jesp.2021.104199

McKey, S., Quirke, B., Fitzpatrick, P., Kelleher, C. C., & Malone, K. M. (2022). A rapid review of Irish Traveller mental health and suicide: a psychosocial and anthropological perspective. *Irish Journal of Psychological Medicine*, *39*(2), 223–233. https://doi.org/10.1017/ipm.2020.108

McMaster, K. J., Peeples, A. D., Schaffner, R. M., & Hack, S. M. (2021). Mental healthcare provider perceptions of race and racial disparity in the care of Black and white clients. *Journal*

of Behavioral Health Services and Research, *48*(4), 501–516. https://doi.org/10.1007/s11414-019-09682-4

Mcveigh, R. (1992). The specificity of Irish racism. *Race & Class*, *33*(4), 31–45. https://doi.org/10.1177/030639689203300403

Meechan, H., John, M., & Hanna, P. (2021). Understandings of mental health and support for Black male adolescents living in the UK. *Children and Youth Services -Review*, *129*(July), 106192. https://doi.org/10.1016/j.childyouth.2021.106192

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (2016). Perceived barriers to accessing mental health services among Black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open*, *6*(11), 1–9. https://doi.org/10.1136/bmjopen-2016-012337

Misra, S., Jackson, V. W., Chong, J., Choe, K., Tay, C., Wong, J., & Yang, L. H. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States : Implications for interventions. *American Journal of Community Psychology*, 486–512. https://doi.org/10.1002/ajcp.12516

Mugumbate, J. R., & Chereni, A. (2020). Now, the theory of Ubuntu has its space in social work. *African Journal of Social Work*, *10*(1).

Muthukrishna, M., Bell, A. V., Henrich, J., Curtin, C. M., Gedranovich, A., McInerney, J., & Thue, B. (2020). Beyond western, educated, industrial, rich, and democratic (WEIRD) psychology: Measuring and mapping scales of cultural and psychological distance. *Psychological Science*, *31*(6), 678–701. https://doi.org/10.1177/0956797620916782

Nazroo, J. Y., Bhui, K. S., & Rhodes, J. (2020). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociology of Health and Illness*, *42*(2), 262–276. https://doi.org/10.1111/1467-9566.13001

Neville, H., Spanierman, L., & Doan, B. T. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, *12*(2), 275–290. https://doi.org/10.1037/1099-9809.12.2.275

Nkomo, S. M., & Al Ariss, A. (2014). The historical origins of ethnic (white) privilege in US organizations. *Journal of Managerial Psychology*, *29*(4), 389–404. https://doi.org/10.1108/JMP-06-2012-0178

Nwokoroku, S. C., Neil, B., Dlamini, C., & Osuchukwu, V. C. (2022). A systematic review of the role of culture in the mental health service utilisation among ethnic minority groups in the United Kingdom. *Global Mental Health*, 9, 84–93. https://doi.org/10.1017/GMH.2022.2

Ong, A. D. (2021). Racial incivility in everyday life: A conceptual framework for linking process, person, and context. *Perspectives on Psychological Science*, *16*(5), 1060–1074. https://doi.org/10.1177/1745691621991869

Owen, J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research*, *27*(1), 102–111. https://doi.org/10.1080/10503307.2015.1078517

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*(4), 283–290. https://doi.org/10.1037/a0037420

Pierre, J. (2020). Slavery, anthropological knowledge, and the racialization of Africans. *Current Anthropology*, *61*(S22), S220–S231. https://doi.org/10.1086/709844

Power, P. M., Harte, C., Barnes-Holmes, D., & Barnes-Holmes, Y. (2017). Combining the implicit relational assessment procedure and the recording of event related potentials in the analysis of racial bias: A preliminary study. *Psychological Record*, *67*(4), 499–506. https://doi.org/10.1007/s40732-017-0252-1

Quirke, B., Heinen, M., Fitzpatrick, P., McKey, S., Malone, K. M., & Kelleher, C. (2022). Experience of discrimination and engagement with mental health and other services by Travellers in Ireland: Findings from the All Ireland Traveller Health Study (AITHS). *Irish Journal of Psychological Medicine*, *39*(2), 185–195. https://doi.org/10.1017/ipm.2020.90

Rabiee, F., & Smith, P. (2014). Understanding mental health and experience of accessing services among African and African Caribbean Service users and carers in Birmingham, UK. *Diversity and Equality in Health and Care*, *11*(2), 125–134.

Ryan, L., & Kirkwood, K. (2021). *IACP Members Survey 2021*. Irish Association for Counselling and Psychotherapy. https://iacp.ie/behaviour-and-attitudes-research

Sashidharan, S. (2003). From outside to inside: Improving mental health services for Black and minority ethnic communities in England. *Mental Health Review Journal*, *8*(3), 22–25.

Singh, S. P., & Burns, T. (2006). Race and mental health: There is more to race than racism. *BMJ*, *333*(7569), 648–651. https://doi.org/10.1136/bmj.38967.410428.68

Singh, S. P. (2019). How to serve our ethnic minority communities better. *The Lancet Psychiatry*, *6*(4), 275–277. https://doi.org/10.1016/S2215-0366(19)30075-6

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real : Anthropological and historical perspectives on the social construction of race. *American Psychologist*, *60*(1), 16–26. https://doi.org/10.1037/0003-066X.60.1.16

Sue, D., Arredondo, P., & McDavis, R. (1992). Multicultural counselling competancies and standards: A call to the profession. *Journal of Counselling and Development*, *70*(March/April), 477–486.

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. *American Journal of Public Health*,

106(7), 1294–1300. https://doi.org/10.2105/AJPH.2016.303121

Williams, D. R. (2018). Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. *Journal of Health and Social Behavior*, *59*(4), 466–485. https://doi.org/10.1177/0022146518814251

About the Authors

Karen M. Doyle originally qualified as a Psychotherapist in 2012, and subsequently completed a Doctorate in Counselling Psychology in Trinity College Dublin. Karen has practiced within the Irish Health Service Executive, the Irish prison service, private and voluntary organisations. She is an accredited member of the IACP and currently works in Private practice as Director of Pathways to Change Psychology and Counselling Services. Info@pathwaystochange.ie

Barbara Hannigan is a registered Counselling Psychologist, and Fellow with the Psychological Society of Ireland (PSI) and Assistant Professor of Psychology with The Doctorate in Counselling Psychology at Trinity College Dublin. She has been practicing as a counselling psychologist, for more than 27 years. She has published widely including academic peer reviewed, journal articles, conference presentations, symposia and book chapters and she regularly reviews for a range of journals. More recently researching Life-story research of people with phenomenal and diverse lives such as breast cancer survivors, LGBTI peoples' life-stories, and presently with World Renowned Master Therapists and Academics. She also continues in private practice as Director of Counselling Psychology Consultancy Services and Co-Director of Pro-psychology Consult