Does your ethnicity matter when selecting future Clinical Psychologists?: an experimental study.

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August 2022

Research submitted in partial fulfilment of the requirements for the degree of Doctor in Clinical Psychology (DClinPsy), Royal Holloway, University of London.

Acknowledgements

I would first like to thank the Clinical Psychologists who generously gave their time to participate in this study. Your genuine interest in this research reminded me that I was pursuing something valuable and important. My thanks also go to those who were not able to participate in the study but facilitated recruitment by sharing my call for participants.

I would also like to thank my supervisors Dr Olga Luzón and Dr Kat Alcock for your continued support throughout this project. Your help and guidance have been immensely valuable, for that I am so grateful. I extend my gratitude to Dr David Murphy, Dr Laura Gilkinson, Dr Madiha Shaikh, Dr Nancy Neath and Dr Annabel Hayes for providing such thoughtful feedback on the materials for the study. Thank you to Dr Shrina Patel and Feisal Anooar for their insights and attention to detail.

Vanessa, thank you for bearing witness to my experiences as an ethnically minoritised Trainee Clinical Psychologist who is trying to make a difference, and for giving me the space to process the emotions that come with this. Your warmth and compassion inspire me to pay it forward.

To my dear parents, thank you for your unwavering support, for instilling in me the value of hard work and for encouraging me to use my voice to fight for justice and equality. You have always kept me grounded to where I come from and reminded me of what is truly important. I will never be able to show you how grateful I am for all the sacrifices you have made to give me the best opportunities in life.

Finally, to my husband and best friend, Jonny - thank you for always believing in me, standing beside me during my toughest challenges, for keeping me laughing and for supporting me every step of the way on this journey.

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Terminology and language

It is worth clarifying the choice of words and phrases used throughout this thesis. Firstly, it is important to define our understanding of the difference between the terms “Race” and “Ethnicity”. The term “Race” had long been used to describe a permanent attribute determined by genetics (d’Ardenne & Mahtani, 1989; Fernando & Keating, 2008; Morales et al., 2018; Quintana, 2007; Shah, 2010). However the biological notion of ‘race’ has been discredited (Phinney, 1996b; Ragavan, 2018) and is now considered a social construct that upholds social and historical ‘racial’ hierarchies rooted in power and subjugation (Hicks & Butler, 2020; Patel et al., 2000; Shah, 2010). Ethnicity, on the other hand, refers to identification with a particular ethnic group (Fernando, 2004; Ragavan, 2018) who share a common language, cultural traditions and place of origin (Betancourt & López, 1995; Morales et al., 2018). Everyone belongs to an ethnic group, though ethnicity is most often used to refer to individuals from non-White backgrounds (Fernando et al., 2005; Ragavan, 2018).

The terms “BAME” and “BME” are often used interchangeably in the literature and refers to “Black, Asian and Minority Ethnic” groups. The use of these terms has been criticised as they classify people who are not White into one category, which not only homogenises people from many different ethnic groups, but is also erasing of the distinctiveness between different ethnic groups (Action for Race Equality, 2022; The Law Society, 2022). Appropriate contexts for use of these terms have been noted such as when making statistical comparisons (The Law Society, 2022). While we acknowledge the limitations of the use of the term “BME” in the empirical paper, it has been used as a shorthand, when referring to individuals who identify as belonging to any ethnic group that is not “White or White British” for the purpose of brevity and simplifying the data for comparisons (Alcock, 2019). It is important to note that the intention of the use of “BME” in this thesis is not to exclude any individuals or to deny the experience of any form of discrimination.

My preferred use of language is the term “ethnically minoritised”, which I have used in parts of the thesis not related to statistical comparisons. I have chosen this term because the word “minoritised” facilitates an understanding that people are actively and systemically minoritised by others, rather than just existing as a minority. The term “ethnically minoritised” takes a more social constructionist approach and confirms that minoritisation occurs through social processes such as power and domination (Milner & Jumbe, 2020; The Law Society, 2022). Other commonly used terms include People of Global Majority (PoGM), People of Colour (PoC) and Racial/Ethnic Minorities (REM) among others (Action for Race Equality, 2022; Ahsan, 2020), though there is no consensus on which is the best or most preferred term to use. It is also important to note that language is continuously evolving and there may be more appropriate phrases that emerge over time.

Lay Summary

Overview

The aim of this project was to get a better understanding about how people from Black and Minority Ethnic (BME) backgrounds experience mental health services as well as access Clinical Psychology as a career path. In chapter 1, we review the research around how people from BME backgrounds experience therapy when they are matched with their clinician based on ethnicity, compared to when they are not matched. Chapter 2 focuses on an experimental study that was designed to test whether cultural aspects of potential shortlisters for Doctoral level training in Clinical Psychology, such as ethnicity, has any influence on the selection of future Clinical Psychologists. Chapter 3 discusses how the first two chapters are related, the impact the findings might have on those affected by these issues and how the findings will be shared more widely.

Chapter 1 - Does ethnic matching between BME service users and their clinician have an impact on the experience of mental health services?

Introduction

The NHS has a duty to promote equal access to its services, however it has been reported that people from BME backgrounds in fact have less access to mental health services and are less likely to benefit from psychological therapies, compared to people from White backgrounds. It is important that mental health services try to meet the needs of individuals from BME backgrounds. As some people said they would prefer a clinician of their own or a similar ethnicity, one idea that has been suggested is to employ more staff from BME backgrounds. It is thought that this could be to do with the level of skill the clinician is perceived to have when it comes to appreciating and working with people from different cultural backgrounds, however there is not enough research to confirm this.

There have been four previous review studies looking at the impact of matching BME service users and clinicians based on ethnicity (ethnic matching). These studies found that BME service users strongly preferred a therapist from their own ethnic background and viewed therapists of their own ethnicity as more positive. Previous research also found that ethnic matching between BME service users and their clinician was associated with attending more appointments, but not necessarily associated with feeling better. There are problems with previous studies such as only looking at people in one country or not collecting enough information, which means that we don't know how much we can rely on their findings or that they will apply cross-culturally.

In our review, we wanted to provide a more up to date report of the research on the impact of ethnic matching between BME service users and their clinician. Specifically, we wanted to find out whether ethnic matching had an impact on how many appointments were attended (attendance) and the service user ending the treatment early (drop out). In addition, we wanted to know more about other aspects such as how connected service users felt to their clinicians (working alliance) and how satisfied they were with the treatment (treatment satisfaction), which has not been done before. We were only interested in studies that paired BME service users with BME clinicians and made comparisons to BME service users paired with non-BME clinicians.

Method

We searched the literature on this topic from multiple databases and narrowed down the search until we were left with 13 studies that covered exactly what we were looking to study. All 13 studies were looked at closely to determine the quality of each paper, and to obtain the information relevant for our review.

Findings

- Attendance - the majority of studies did not find that ethnic matching between BME service users and clinician had an impact on number of appointments attended.

- Working alliance - it was unclear whether ethnic matching between BME service users and clinician had an impact on how connected service users felt to their clinician, this might be because we only found two studies looking into this.
- Drop out - when it came to drop out, we found that ethnic matching between BME service users and clinician has an impact for people of Hispanic, Asian American, Mexican American backgrounds, but not for people of African American backgrounds. However, none of the studies recorded why people dropped out, so we cannot be sure it was to do with the clinician or another reason. Also, all the studies took place in the USA, which means the findings might not apply to people from other countries.
- Treatment satisfaction - there were only five studies that looked at the impact of ethnic matching on satisfaction of treatment. Two of the studies did find that ethnic matching made a difference, and three studies did not. The studies all had a different number of participants which may have impacted the findings. One study suggested that the degree to which a person feels connected to their ethnic group (a term called ethnic identity) might play a part in how much they feel satisfied with treatment when they are ethnically matched to a clinician.

Conclusions

Overall, we found mixed results for the effects of ethnic matching for BME service users on their experience of mental health services. We concluded that ethnic matching likely does not have an impact on attendance but may have an impact on drop out, except for people from African American backgrounds. There was less clarity about the impact of ethnic matching for working alliance and treatment satisfaction because there was not enough high-quality research in these areas to reach a definitive conclusion. It may be that matching on other aspects such as ethnic identity, values or beliefs might be more worthwhile rather than ethnicity. There were a lot of differences between the studies in our review, such as how the information was collected and studied, which also affected our

conclusions. Nonetheless the findings could still be meaningful for mental health services who are striving to provide fair and equal access to all people regardless of ethnic background.

Chapter 2 - Does your ethnicity matter when selecting future Clinical Psychologists?: an experimental study

Introduction

The UK Clinical Psychology workforce is not yet representative of the people it serves. It has long been documented that people from BME backgrounds who apply to train as a Clinical Psychologist are offered a place less often than White candidates. The lack of representation from people from BME backgrounds is also seen in leadership positions in NHS as a whole. Improving the ethnic diversity in the workforce is important because research has shown that it is linked to good patient care. Additionally, it is also important that people from BME backgrounds pursuing or already practicing Clinical Psychology as a career can feel safe, worthy and not marginalised.

Previous research has found that there are a number of barriers for people from BME backgrounds to get their foot in the door of Clinical Psychology. Researchers have found that there is a problem at the earliest stage of the application process to train as a Clinical Psychologist. One of the most significant barriers is getting the right educational qualifications. As it stands, potential candidates are required to have at least a 2:1 degree in Psychology to be considered for the training. Training courses differ on specific entry requirements and some courses state a requirement of a “good” 2:1, for example the UCL course state a requirement of 67% or above. However, many candidates from BME backgrounds have faced additional social or economic disadvantages which has made it more difficult to achieve high grades, and therefore be able to apply for the training. Nevertheless, projects such as open-days, workshops, and mentoring schemes for people from BME backgrounds have been set up to help tackle this problem, though the workforce is still not yet diverse.

There have been theories that suggest that human beings bond more with people that they have more in common with, or at least believe they have more in common with. It has also been suggested that people involved in recruitment are unconsciously more likely to hire someone they perceive as more like themselves, than people they perceive as different to themselves. Other theories have suggested that people who have a higher level of ethnic identity, that is a stronger emotional connection to their ethnic group, have more positive views about their ethnic group. We considered whether perhaps something similar might be happening in the recruitment for Clinical Psychologists, which might explain why there is less ethnic diversity. It could be that the level of ethnic identity of Clinical Psychologists, who act as shortlisters for Doctoral training in Clinical Psychology, may be linked to how they perceive applicants from similar or different ethnic groups. Considering the overrepresentation of successful White applicants and that the workforce is already predominantly White, this may shed some light on why there continues to be a lack of ethnic diversity in the workforce.

Method

We asked 160 qualified Clinical Psychologists take part in our study, half of them were of BME backgrounds, and half were not. They were asked to read personal statements sections of the application form from four random people who applied to train as a Clinical Psychologist in 2017. They were then asked to rate these personal statements on several key areas that are relevant to becoming a Clinical Psychologist, such as having the right knowledge about Clinical Psychology or the ability to be thoughtful and self-aware. Two of the candidates identified as BME, and two of them were not, but the participants in the study were not made aware of which candidates were BME. In addition, participants were also asked to complete two short questionnaires on ethnic identity and personal values. We wanted to find out four key things:

1. Do Clinical Psychologists from BME and non-BME backgrounds rate personal statements from applicants differently?
2. Are BME and non-BME candidates rated significantly differently?

3. Does Clinical Psychologists' level of ethnic identity play a part in how BME and non-BME applicants are rated?
4. Do Clinical Psychologists from BME and non-BME backgrounds differ in what values are most important to them?

Findings

- We did not find that BME and non-BME Clinical Psychologists rated personal statements any differently to each other.
- We found that BME candidates were rated higher than non-BME candidates, on almost all of the key areas.
- Additionally, we also found that although participants were not aware of which candidate was BME, the BME Clinical Psychologists said they were more likely to invite one of the BME candidates to interview and non-BME Clinical Psychologists said they were more likely to invite one of the non-BME candidates to interview.
- We did not find a relationship between participants' level of ethnic identity and the ratings for BME and non-BME candidates. However, we did find that when we accounted for age, gender and whether the participant was BME or not, ethnic identity did partially account for the differences in the ratings for BME candidates.
- We found that values such as 'Power', 'Achievement', 'Tradition', and 'Security' were more important for BME Clinical Psychologists when compared to non-BME Clinical Psychologists.

Conclusions

This is the first study to look at whether aspects such as ethnicity make a difference in how Clinical Psychologists rate personal statements from BME and non-BME applicants. Although we did not find that ethnicity of the recruiter made a difference, there were ideas about why this might be the case. It could be that training and experience practicing as a Clinical Psychologist, over time, has

encouraged more similarity between people. It was interesting that BME candidates were rated higher than non-BME candidates, especially since statistically they are less likely to be offered a place on training courses. This is important for training courses to keep in mind as they continue to implement changes to selection processes to make sure they are not turning away candidates who would make good Clinical Psychologists. It was interesting that BME Clinical Psychologists said they were more likely to invite one of the BME candidates to interview. This fits with the research that found that people are likely to hire someone they perceive as more like themselves. Our study did not find evidence to back up previous research that level of ethnic identity influences views about people of their own or similar ethnic group. However, since participants in this study were not aware of the candidates' ethnic group, we might expect different findings if participants were made aware. There were differences in important values between BME and non-BME Clinical Psychologists, but we didn't test whether this made any difference on the rating of candidates' personal statements. It is important to mention that this study only looked at personal statements, and although this has never been done before, it would be interesting to find out if the results would be different if the whole application form was included. There were some drawbacks to the study that are worth keeping in mind; the fact that people volunteered to take part, that participants were grouped as either BME or non-BME, and that only four personal statements were included. Decisions in relation to these drawbacks were made based on what was possible within a timeframe and what was easiest for the participants.

Chapter 3 - How the chapters relate and how the findings will be shared

The two chapters were linked by their focus on how people connect to others, and the role that ethnic similarity might play. The first chapter focused on the relationship between BME service users of mental health services and clinicians, while chapter 2 related to the relationship between shortlisters for Clinical Psychology training courses and prospective applicants. The overrepresentation of people from White backgrounds making up the workforce within mental health

services, more specifically Clinical Psychology, is a problem that is yet to be solved. This project is hopefully just one step to making Clinical Psychology more ethnically diverse.

The findings from the review could be helpful for how mental health services can continue trying to be fair and inclusive of people from BME backgrounds, but more research is needed to help understand how to best do this. Findings from our research study could provide some ideas for Clinical Psychology training courses as to how they might continue to improve selection procedures. The findings from this thesis have been shared with the Group of Trainers in Clinical Psychology and will be published in academic journals and shared on social media.

Chapter 1: Systematic Review

Does ethnic matching between service user and clinician have an impact on ethnically minoritised service user experiences mental health services? A Systematic Review

1.1 Glossary and definitions

The following phases and terms will be used throughout this review:

Attendance rate – number or proportion of sessions attended or completed by the service user.

Drop-out – early termination of intervention on part of service user, failure to return to next and subsequent appointments.

Dyad – a pair consisting of a service user and a clinician.

Ethnic identity – a multidimensional construct capturing ones' awareness of membership to and cultural beliefs of their ethnic group and the strength of emotional significance of that membership.

Ethnic matching – the matching of service users and clinicians based on ethnic background.

Ethnically minoritised – this term has been chosen as it recognises that individuals do not just exist in ethnic categories but rather have been minoritised through processes of social power and dominance. This term also reflects the fact that while these individuals are considered an 'ethnic minority' in predominantly White counties, they in fact represent majorities of the global population (The Law Society, 2022).

Mental health service – a service or agency that provides mental health support.

Service user – an individual utilising a mental health service. Other terms often used include 'patient' or 'client'.

1.2 Abstract

Previous research exploring the effects of matching service users and clinicians by their ethnic background (hereafter referred to as "ethnic matching") on outcomes related to the experience of using mental health services have so far been inconclusive. A systematic review and narrative synthesis of the current literature was conducted on 13 studies that matched ethnically minoritised service users with clinicians on four key outcomes: attendance, working alliance, drop-out and treatment satisfaction, with comparison to unmatched dyads with ethnically minoritised service users. The Quality Assessment Tool for Quanitative Studies (Thomas et al., 2004) was used to critically assess the methodological rigour of the studies. The findings showed that ethnic matching likely does not have an impact on attendance, but may have an impact on drop out, more so for some ethnic groups than others. There may be support for an effect of ethnic matching on working alliance and treatment satisfaction, but more research is needed. Crucially, this study highlighted the role of matching on psychological variables such as values, beliefs, and worldview, as well as the importance for research to include data on level of ethnic identity, acculturation and language in service user and clinician dyads. The review was limited by the lack of methodologically sound research in this area and differences between studies in how outcomes were defined. Implications for future research and clinical implications are discussed.

1.3 Introduction

It has been widely reported in the literature that individuals from ethnically minoritised groups have less access to and therefore tend to underuse mental health services, have a lower likelihood of benefitting from psychological therapies and are more likely to receive poorer quality of care than those who are not ethnically minoritised (Ahsan, 2020; Fernando, 2017). Several studies have alluded to low socioeconomic status as a major factor involved in these disparities (Brach & Fraser, 2002; Lillie-Blanton & Laveist, 1996; Shin et al., 2005; Snowden, 2012). However, even after controlling for low socioeconomic status, these disparities are still visible, suggesting that financial barriers are not the sole cause of such differences in use and outcome of care (R. R. Owen et al., 2001; Shin et al., 2005). As such, authors have suggested that delivery of mental health services can be enhanced to better address the needs of individuals from ethnically minoritised groups (Brach & Fraser, 2002; Shin et al., 2005).

Several studies have proposed that increasing presence of staff from ethnically minoritised groups is one way to address this issue (Maramba & Hall, 2002), since shared cultural background between service user and clinician may encourage engagement (IAPT, 2009). A study conducted in one area of Ohio, USA, found a statistically significant relationship between ethnically minoritised service users relative use of mental health centres and staffing of ethnically minoritised clinicians, suggesting that the employment of ethnically minoritised staff in mental health services may be appealing to ethnically minoritised service users (Maramba & Hall, 2002; Wu & Windle, 1980). Several other studies have supported the notion that ethnically minoritised individuals exhibit preferences for a therapist of their own or similar ethnicity (Atkinson et al., 1989; Cabral & Smith, 2011; Coleman et al., 1995; Karlsson, 2005; Proctor & Rosen, 1981; Shin et al., 2005; Terrell & Terrell, 1984; Watkins et al., 1989; Watkins & Terrell, 1988).

Researchers have hypothesised that ethnic similarity (see glossary for definition) between service user and clinician result in greater perceived credibility of the clinician at the beginning of therapy (Shin et al., 2005; Sue & Zane, 1987) and that ethnic dissimilarity leads to underutilisation of services, premature termination, and poorer levels of functioning for people of ethnically minoritised backgrounds (Erdur et al., 2003; Shin et al., 2005; Sue, 1988, 1998a), though these findings are mostly derived from studies conducted in the USA. Further, preliminary research has indicated that matching between service user and clinician based on ethnicity is associated with greater number of sessions attended, decrease in drop-out and improved functioning (Maramba & Hall, 2002; Sue et al., 1991).

One of the many possible mechanisms that might offer some insight into the link between ethnic similarity of service user and clinician and more positive outcomes could be 'culturally competent care' (Banks, 1999; Maramba & Hall, 2002; Shin et al., 2005). 'Cultural competence' has been described the ability to appreciate, recognise, and work effectively with people from different cultural backgrounds (Shin et al., 2005; Sue, 1998b). Evidence from the literature suggests that an increase of culturally competent therapists may improve drop-out rates (Krebs, 1971; Maramba & Hall, 2002; O'Sullivan et al., 1989; O'Sullivan & Lasso, 1992; Solomon, 1988; Sue et al., 1991; Watts et al., 1986; Wierzbicki & Pekarik, 1993) and clinical outcomes of people from ethnically minoritised backgrounds (Jerrell & Wilson, 1997; Maramba & Hall, 2002; Rosenheck et al., 1997; Zane et al., 1994). Moreover, there exists some literature suggesting that cultural sensitivity and competence of the therapist may also be associated with service users' treatment satisfaction (Atkinson & Lowe, 1995; Constantine, 2001, 2002; Fuertes & Brobst, 2002; Gim et al., 1991; Karlsson, 2005; Sue, 1998a; Sue & Zane, 1987; Yamamoto et al., 1984), especially for ethnically minoritised service users (Meyer & Zane, 2013), though there is a paucity of high-quality research in this area specifically (Karlsson, 2005).

Although therapists of any ethnicity can deliver culturally competent psychological therapy (Maramba & Hall, 2002), studies have found that that ethnically minoritised service users perceive

therapists of similar ethnicities to be more culturally competent than White counterparts (Constantine, 2001; Karlsson, 2005). This, combined with the greater importance of cultural sensitivity and competency, may be what leads to better outcomes in ethnically similar service user-clinician dyads. It remains unclear whether ethnically minoritised clinicians are in fact more culturally competent than non-ethnically minoritised clinicians, but it has been noted that ethnically minoritised therapists may not deliver therapy any differently than those not ethnically minoritised due to acculturation from academic training (G. C. Hall et al., 2001; Maramba & Hall, 2002). Additionally, others have found a distinction between general therapist competence and cultural competence, such that a culturally competent therapist does not necessarily indicate better therapist competence in general (Imel et al., 2011).

1.3.1 Previous reviews on ethnic matching

To date, there have been four meta-analyses that have contributed to the body of literature around ethnic matching of service user and clinician. The research in this area is scarce and mostly old, which is unlikely to represent societal make up now. The earliest of these, Coleman et al., (1995), reviewed 21 studies between 1977 and 1992 and found that ethnically minoritised service users showed strong preferences for a therapist matching their own ethnicity (d=.73), and a small effect for perceiving therapists of similar ethnicity more favourably than others (d=.20).

A later meta-analysis by Maramba & Nagayama Hall (2002) explored the effect of ethnic match as a predictor of drop-out, utilisation and level of functioning in seven studies between 1991 and 1999. They reported medium effects for drop-out (r=.30), utilisation (r=.40) and a negligible effect for functioning. The authors also noted that among ethnically minoritised participants larger effect sizes for drop-out and utilisation were observed than for Caucasian Americans, suggesting that for ethnically minoritised individuals, ethnic matching was associated with lower drop-out rates and greater number of sessions attended. This study was limited, due to the small number of studies

included in the analyses. The question that then naturally arises is whether and to what extent is there an effect of ethnic matching on clinical outcomes among specific ethnic groups.

To address this question, the third meta-analysis investigated racial-ethnic matching (defined as African American and Caucasian American service users who were matched with clinicians of the same race-ethnicity) on overall functioning, service retention and number of sessions (Shin et al., 2005). This review of 10 published and unpublished articles between 1991 and 2001 found no significant differences between matched and unmatched participants on functioning, service retention or total number of sessions. However, this study was hampered by the lack of detailed and relevant information available in the studies reviewed. For example, some studies did not collect and report data on what type of intervention was offered or service user and clinician characteristics such as educational level, diagnosis, or level of clinician's training. This meant that the authors could only speculate reasons for their findings. They noted that that variation among clinicians in terms of experience, education and cultural competence could have offset any positive effects of matching.

The last, and largest, study conducted a meta-analysis on ethnic matching of service users and therapists on preferences, perceptions and outcomes on 154 studies (Cabral & Smith, 2011). A medium effect (d=.63) was reported for preference for a therapist of one's own ethnicity, as well as a small effect for service users to perceive therapists of the same ethnicity more positive than other therapists (d=.32). With regards to treatment outcomes relating to functioning however, this study found no better effect because of ethnic matching (d=.09). In parallel to Maramba & Hall's work, larger effect sizes were found in studies of African Americans than Caucasian Americans across all the three variables. The authors also noted that heterogeneity of effect sizes across studies may have masked nuanced differences. For example, although most studies showed a preference for an ethnically similar therapist, some studies also documented a preference for therapists of another ethnicity. Other limitations of this review included hypothetical scenarios being used to collect data on preferences, the lack of external validity due to all studies being conducted in North America as well as the lack of experimental studies which would allow a high level of control.

1.3.2 The current review

Despite the evidence from previous work, several questions remain unanswered. Have there been any new ideas on this topic in the 11 years since the last review around this topic? What might be the impact of ethnic matching on utilisation of mental health services in ethnically minoritised populations only? Additionally, to our knowledge there have been no published reviews synthesising the evidence of variables such as working alliance or clients' level of treatment satisfaction as a function of ethnic matching. The current study seeks to provide an updated review of the literature to help answer these questions.

Since larger effects of ethnic matching have been reported for ethnically minoritised service users than for White service users (Coleman et al., 1995; Maramba & Hall, 2002), recommendations for future research have been to focus on individuals from ethnically minoritised backgrounds (Maramba & Hall, 2002; Shin et al., 2005). For this reason, this review will be restricted to studies with ethnically minoritised service users ethnically matched and unmatched to clinicians.

Additionally, previous research have identified inclusion of a White service users matched with White clinicians condition have confounded the associations between ethnic matching and uptake of therapy sessions (Erdur et al., 2003). Therefore, in this review we will only be including studies where either there are no White service users matched with White clinicians conditions or where it is possible to extract only the data relating to ethnically minoritised service users. Given that clinical outcomes, such as symptom reduction, have already been studied with no effect of ethnic matching found (Cabral & Smith, 2011), we have chosen to focus our review on other important therapeutic aspects such as total number of appointments attended, premature drop-out from therapy, working alliance and treatment satisfaction since the effects of ethnic matching on these outcomes are less clear.

1.3.3. Research question

This review aimed to answer the following question: Among ethnically minoritised users of mental health services what is the effect of ethnic matching between service user and clinician on attendance, working alliance, drop-out and treatment satisfaction?

1.4 Method

A systematic review protocol guided by Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA; Moher et al., 2009) was developed and adhered to for this systematic review (Appendix A).

1.4.1 Search strategy

A scoping search on PubMed and PsychINFO was first run to identify relevant keywords. Then an extensive search of the literature using identified terms and synonyms used by respective databases was run. The PICOS format (Centre for Reviews and Dissemination [CRD], 2009) was used, though adapted for the research question of this review, to help identify keywords to be included in the search strategy. Keywords were also selected based on terminology in the existing literature. Boolean operators and asterisks to include variations of truncated keywords were used. The following search terms in all fields of publications were used for searches of databases:

ethnic-similarity OR racial-difference* OR ethnic-difference* OR ethnic-match* OR intercultural OR ethnic-concordance OR cultural-match* OR cross-cultural OR cultural-difference* OR culture-compatible OR racial-match* OR cross-racial OR racial/ethnic-match* OR racial/ethnic-status OR inter-cultural OR ethnic-status

AND

patient-clinician OR patient-therapist OR client-therapist OR therapist-client OR therapeutic-dyad OR client-psychologist OR psychotherapist-client-interaction OR client-clinician OR clinician-client OR healthcare-professional-patient OR staff-client* OR therapeutic-relationship OR staff-service-user OR clinician-patient OR therapist-patient OR patient-psychologist OR psychologist-patient OR patient-healthcare-professional OR client-staff OR doctor-patient OR patient-doctor

AND

experience* OR satisfaction OR dropout OR drop-out OR subjective-wellbeing OR acceptability OR perception* OR engagement OR motivation

AND

"mental health treatment" OR "mental health service*" OR NHS OR psychotherapy OR counselling OR psychology OR support OR "psychological therap*" OR "talking therap*" OR "mental health therap*" OR counselling OR support OR "mental health support"

The search terms were initially identified by the lead researcher and then discussed with supervisors and an expert librarian at Royal Holloway University of London (RHUL) with extensive expertise in running and supporting systematic reviews. As a result, the search terms to be included were amended based on the recommendations provided.

1.4.2 Inclusion and Exclusion Criteria

Inclusion criteria:

- Participants (service users) are
    - users of mental health services
    - of an ethnically minoritised background
    - any age
    - must be ethnically matched with a clinician of any discipline including psychiatrists, mental health nurses, clinical psychologists, psychotherapists and counselling psychologists.

- Must include comparison group of ethnically minoritised service users not ethnically matched with clinician.
- Clinicians in matched conditions are ethnically minoritised, clinicians in unmatched condition are not ethnically minoritised.
- All geographical locations.
- Interventions offered in a mental health setting including but not limited to psychological therapy, care-coordination, or occupational therapy.
- Setting can include hospitals, outpatient clinics, or research facilities.
- Outcomes can include satisfaction, drop-out, subjective wellbeing, acceptability of treatment, attendance rate, working alliance.
- Data can be collected from secondary sources such as clinical records or archival data.
- Peer reviewed journal articles from any year
- Studies can be experimental or observational
- Results from dissertations and theses can also be included if retrieved in the search.

Exclusion criteria

- Participants (service users) are of a non-ethnically minoritised background
- No comparison group, or comparison group is White service users matched with White clinicians
- Participants are not users of a health service for a non-mental health related reason
- Studies that use proxy methods such as vignettes of therapists
- Insufficient detail on how ethnic matching was defined
- Clinicians are not qualified i.e. students
- Intervention is medical or pharmaceutical only
- Only includes clinical outcomes such as distress level, symptom reduction or change in substance use
- Case studies
- Full text unavailable

- Unavailable in English
- Unpublished literature

1.4.3 Study selection

Searches of PubMed, APA PsychINFO, APA PsychArticles and Web of Science electronic database were run three times before the final search on 1st December 2021, which yielded 2,068 records for screening. The study selection process is illustrated in Figure 1. Records were imported into Rayyan, a systematic reviews web app tool for screening for eligible studies (Ouzzani, 2016), and 210 duplicates were removed. The titles and abstracts of remaining records were screened against the eligibility criteria, those that did not meet these criteria were excluded (n=1,826). A second reviewer screened 10% of the records, for which the level of inter-rater agreement was 97.4%, and any conflicts were resolved through discussion. The full texts of 32 records identified as potentially eligible were obtained, 14 more records were identified from hand searching reference lists. The high number of records obtained from hand searching may be due to the selection of search terms used in this review. In total 46 articles were reviewed against the inclusion criteria. During this stage, 33 records were excluded for the following reasons: analyses included White service users matched with White clinicians (n = 9), insufficient data on how service users and clinicians were matched (n = 7), included clinicians that were students (n = 3), had no comparison group (n = 2), included other types of matching in the analysis such as gender or language (n= 2), full text was unobtainable (n = 1), outcome was rated by clinician (n = 1), wrong sample (were not users of mental health services) (n = 1), inconsistency between intake interviewer and clinician (n = 1), combination of any of the above reasons (n = 4). A total of 13 studies were deemed suitable to be included in the review.

1.4.4 Data extraction

All 13 studies were reviewed with reference to the aims of this review and relevant details from each study were extracted into a table (Table 1). Author, date, country of origin, sample details,

outcome details, method of data analysis and key findings were extracted allowing for comparison across studies.

1.4.5 Quality assessment

To assess the methodological quality of each paper, the Quality Assessment Tool for Quantitative Studies (QATQS) developed by the Effective Public Health Practice Project (EPHPP) was used (Thomas et al., 2004; Appendix B). This tool was chosen since it can be used to evaluate a range of quantitative study designs and has demonstrated content and construct validity as well as inter-rater reliability using Cohen's Kappa (Thomas et al., 2004). The QATQS allows study quality to be evaluated across six different components: selection bias, study design, confounders, blinding, data collection methods and withdrawals and drop-outs. For each of these components, a rating of 'Good', 'Fair' or 'Weak' is assigned with a Global Rating for each paper then determined based on the criteria described in the QATQS dictionary (Appendix C). The QATQS was modified for the purposes of this review. As such, the components 'blinding' and 'withdrawals and drop-outs' were not included, since these components related to experimental studies and included studies were predominantly non-experimental, and thus these components were not relevant.

1.4.6 Data synthesis

Although performing a meta-analysis would increase the external validity of the results, heterogeneity between the studies precluded a statistical synthesis of results and thus a systematic narrative synthesis was undertaken. This type of analysis summarised the characteristics and findings of included studies and explored both the relationships and differences between and within studies, in line with guidance from the Centre for Reviews and Dissemination (Centre for Reviews and Dissemination [CRD], 2009). Variations in how studies defined and operationalised ethnic matching is discussed, as well as the methodological quality of each paper. The results from the studies are discussed in relation to one or more of the outcomes identified in the papers: attendance, working

alliance, drop-out and treatment satisfaction, alongside any potential threats to internal or external validity of the findings.

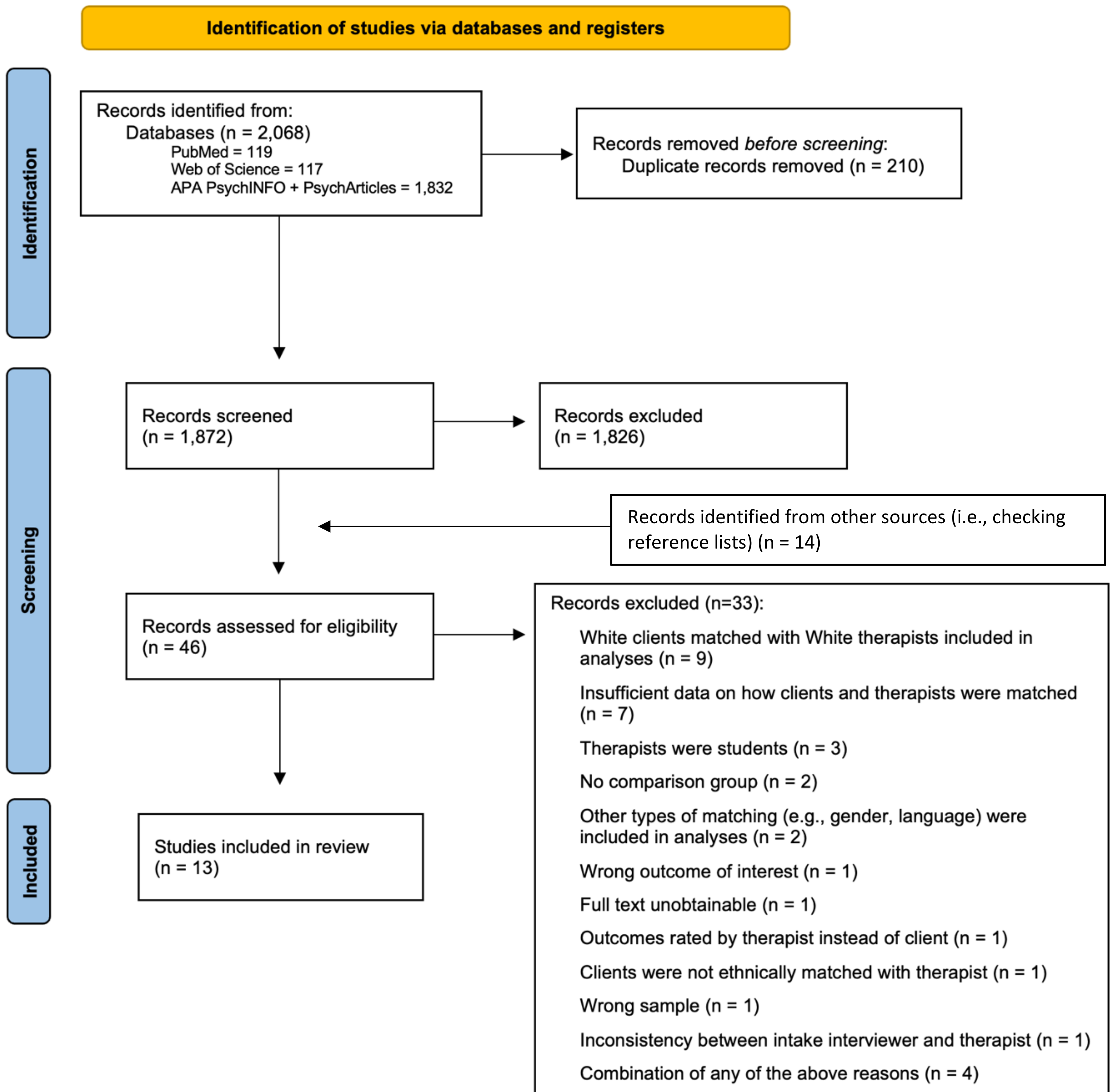

Figure 1. PRISMA flow diagram of study selection process

1.5 Results

Key characteristics of included studies

There were 13 studies published between 1991 and 2013 that were included, Table 1 shows a summary of study characteristics (see Appendix L, Table L1 for detailed characteristics and results of studies included). All but three studies (Farsimadan et al., 2007; Knipscheer & Kleber, 2004a, 2004b) were conducted in the United States. The majority of studies sampled adult populations, except for three which either only sampled or included adolescents in their study (Erdur et al., 2003; Flicker, 2004; Wintersteen et al., 2005). In five studies the service user sample were majority female (Alegría et al., 2013; Erdur et al., 2003; Gamble, 2001; Knipscheer & Kleber, 2004b; Thompson & Alexander, 2006), while three did not specify gender differences in the sample (Farsimadan et al., 2007; O'Sullivan & Lasso, 1992; Sue et al., 1991). None of the studies reported inclusion of individuals who identified as non-binary in terms of gender. Most studies sought participants from community mental health centres or outpatient mental health facilities. The remaining studies drew participants from either university or college counselling centres (Erdur et al., 2003), voluntary agencies (Farsimadan et al., 2007) or a community psychology clinic associated with a university doctoral program (Thompson & Alexander, 2006). One study did not describe the setting but referred to it as "Cannabis Youth Treatment Project".

All studies aimed to measure the effect of ethnic matching, for service users from ethnically minoritised backgrounds on client-rated therapy process variables, as either their primary or secondary objectives. One study was a randomised controlled trial using a sample of adolescents between ages 13-19 (Flicker, 2004). Two were cohort studies (Farsimadan et al., 2007; Wintersteen et al., 2005). Five studies were deemed to be retrospective cohort studies since they used archival data from intake or beginning of therapy until termination, obtained from clinical databases. Five studies implemented a cross-sectional design (Alegría et al., 2013; Gamble, 2001; Knipscheer & Kleber, 2004a, 2004b; Thompson & Alexander, 2006).

A breakdown of the ethnic backgrounds of the clinician was fully described in five studies (Erdur et al., 2003; Sterling et al., 1998, 2001; Thompson & Alexander, 2006; Wintersteen et al., 2005). The ethnicities of service users sampled across all studies, as described by the authors, included: African American, Asian American, Latinx, Portuguese American, South Asian, Hispanic, Turkish, Moroccan, and Surinamese. Three studies also looked at the effect of ethnic matching for White service users (Alegría et al., 2013; Erdur et al., 2003; Wintersteen et al., 2005), however in line with the research question of this review, only data relating to the effect of ethnic matching for ethnically minoritised service users were extracted from these studies.

Some studies only partially described the ethnic backgrounds of therapists. For example, the study by Knipscheer & Kleber (2004a) sampled 114 Turkish or Moroccan service users and described clinicians as either ethnically 'similar' or 'dissimilar', but did not detail further than this. Similarly, O'Sullivan & Lasso, (1992) sampled 161 'Hispanic' service users, and clinicians were described as either Hispanic or non-Hispanic but there was no further information on the specific ethnic backgrounds of these participants. There was even more ambiguity in another study, where service users and clinicians were described as either 'minority' or 'Caucasian' (Wintersteen et al., 2005). Although for the majority of these studies, sociodemographic data was obtained from clinical records, only two papers detailed that service users and clinicians were matched based on self-identified ethnicities (Alegría et al., 2013; Erdur et al., 2003).

For three studies (Farsimadan et al., 2007; Knipscheer & Kleber, 2004b; Sue et al., 1991), there was little to no information on the clinician's role or experience. However, these studies provided enough information to understand the make-up of the service user/clinician dyads, which was more relevant to the research question. Therefore, these studies were still included in this review.

Table 1. *Summary of Study Characteristics and Results of Included Studies*

First author, year, location	***Study Design, Setting***	***Study aims***	***Service user characteristics***	***Clinician characteristics***	***Matched dyads: Client/Clinician ethnicities***	***Non-Matched dyads: Client/Clinician ethnicities***	***Outcome***	***Results***
*Alegría et al., (2013), USA**	Cross-sectional Community outpatient clinic	To examine role of communication and relationship variables across racial groups	Latino (n=24), varying self-identified race and ethnicity (n=35), Age range: 18-78, 56% female	Latino (n=10), varying self-identified race and ethnicity (n=19). Psychiatrists (n=13), Psychologists (n=6), Social workers (n=16), Nurses (n=3).	Latino - Latino	Varying self-identified race and ethnicity - varying self-identified race and ethnicity	Attendance: Service user returning for next scheduled visit	Compared to mixed ethnicity dyads, Latino dyads had higher appointment keeping rates, but these were not statistically significant (0.89 vs 0.62, p>0.05)
*Erdur et al., (2003), USA**	Retrospective Cohort University & college counselling centres.	To understand how outcome and retention in counseling differ as a function of ethnic similarities and dissimilarities between therapists and clients.	Students seeking personal counselling (n=973), Age range: 16-57, 63.5% female	African American (n=11), Hispanic (n=11), Caucasian (n=172).	African American - African American, Hispanic – Hispanic.	African American – Caucasian, Hispanic – Caucasian.	Attendance: Number of sessions completed	No significant effect of therapist ethnicity on least squares mean (LSM) number of sessions between African American matched and unmatched dyads (3.63 vs 3.70, p>0.05) Trend for higher number of sessions completed in Hispanic unmatched dyads than Hispanic matched dyads (*LSM* = 3.15 vs 1.88), though this was not significant after Bonferroni

First author, year, location	*Study Design, Setting*	*Study aims*	*Service user characteristics*	*Clinician characteristics*	*Matched dyads: Client/Clinician ethnicities*	*Non-Matched dyads: Client/Clinician ethnicities*	*Outcome*	*Results*
								correction ($F(1, 68) = 3.84$, $p<.05$.)
Farsimadan et al., (2007), UK	Cohort Voluntary agencies	To establish the effect of ethnic matching on measures of therapy process and outcome in real client-therapist dyads	Various non-White ethnic backgrounds: Indian (n=31), Pakistani (n=16), Bangladeshi (n=10), Sri Lankan (n=2), Middle Eastern (n=8), Black African (n=15), Black Caribbean (n=18). Mean age: 35.6 (matched group), 37.5 (unmatched group).	Not stated	Dyads service users perceived as matched included: Indian - Indian, Pakistani - Pakistani, African Caribbean – African Caribbean, and Indian Punjabi - Pakistani Punjabi.	Unmatched dyads included: Black African - Indian, Indian - Middle Eastern, Pakistani - Black Caribbean, and Sri Lankan - Black Caribbean	Attendance: Length of therapy in weeks Working Alliance: Objectively measured using validated tool	Attendance was not significantly different between the matched (M=9.20, SD=2.82) and unmatched groups (M=9.48, SD=2.76, $p>0.05$) Working alliance was significantly higher in the matched groups (M=65.52, SD=8.74) than in the unmatched groups (M=34.80, SD=7.47, $p<.001$) Regression analyses showed that ethnic matching significantly predicted working alliance ($R^2 = .782$, $F(1, 98) = 356.67$, $p<.001$).
*Flicker, (2004), USA**	RCT Treatment research centre	To examine whether ethnic matching improves treatment engagement, alliance, and	Hispanic Adolescents and parents (n=19), Age range: 13-19, 16% female	9 clinicians. 7 females. Majority Anglo (n=6), Hispanic (n=3). Trained to conduct	Hispanic - Hispanic	Hispanic - Anglo	Attendance: percent sessions attended	Ethnic matching did not significantly predict percent sessions attended ($F(1) = 0.19$, p=0.66)

First author, year, location	Study Design, Setting	Study aims	Service user characteristics	Clinician characteristics	Matched dyads: Client/Clinician ethnicities	Non-Matched dyads: Client/Clinician ethnicities	Outcome	Results
		outcome with Hispanic and Anglo substance-abusing adolescents in family therapy		Functional Family Therapy			Treatment satisfaction: Objectively measured using validated tool	Ethnic matching not found to be significantly predictive of treatment satisfaction ($F(1) = 0.91$, $p=0.34$)
Gamble, (2001), USA	Cross-sectional Outpatient Mental Health Facilities. .	Examined the relationships among the variables of client-therapist ethnic match, degree of ethnic identity, and level of satisfaction with therapy.	Portuguese Americans (n=24), Mean age=40, 58.3% female	N=17	Portuguese American – Portuguese American	Portuguese American - and non-Portuguese	Treatment satisfaction: Objectively measured using validated tool	No significant difference in treatment satisfaction between matched and unmatched groups ($t(22)= -0.59$; $p=0.28$).
Knipscheer et al., (2004a), The Netherlands	Cross-sectional Community Mental Health Care Agencies.	To explore the contribution of ethnicity to therapist characteristics and treatment satisfaction among Turkish and Moroccan outpatients in mental-health care. Does ethnic similarity in the patient–therapist dyad predict service satisfaction?	Turkish & Moroccan adults (n=114), Mean age: 37.1, 48.6% female	N=14	Moroccan – Moroccan, Turkish - Turkish	Moroccan or Turkish – Native Dutch	Treatment satisfaction: Measured using self-constructed one-item forms	No significant difference in service satisfaction between those who were ethnically matched and unmatched ($X^2 = 3.596$, df = 3, p=.309). Logistic regression did not show that ethnic matching was independently predictive of service satisfaction ($\beta = -0.56$, SE = 0.64, Wald = 0.77, $p>0.05$)

First author, year, location	*Study Design, Setting*	*Study aims*	*Service user characteristics*	*Clinician characteristics*	*Matched dyads: Client/Clinician ethnicities*	*Non-Matched dyads: Client/Clinician ethnicities*	*Outcome*	*Results*
Knipscheer et al., (2004b), The Netherlands	Cross-sectional Community Mental Health Care Agencies	To establish the importance of ethnic similarity in mental health care among Surinamese migrants in the Netherlands. Does ethnic matching predict service satisfaction?	Surinamese outpatients (n=69), Mean age=39.2, 74% female	Not stated	Surinamese - Surinamese (75.4%)	Surinamese - indigenous Dutch (24.6%)	Treatment satisfaction: Measured using self-constructed one-item forms	Logistic regression showed that ethnic matching was independently predictive of service satisfaction ($\beta = 4.61$, SE = 2.20, Wald = 4.40, $p<0.05$)
O'Sullivan et al., (1992), USA	Retrospective Cohort Community Mental Health Centre	To test the culture compatibility hypothesis. Hypothesis: lower drop-out rate and more services should be associated with Hispanic clients being treated by Hispanic staff who speak the same language.	Hispanic service users (n=161), Mean age=29.1.	Hispanic personnel (n=15). Clinical psychologists (n=2), Social workers (n=6), Nurse (n=1), Educators (n=4)†	Hispanic - Hispanic	Hispanic - non-Hispanic	Attendance: number of sessions attended Drop-out: having received only one service session	Matched service users attended significantly more sessions than unmatched service users ($t(196) = 2.68$, $p<0.01$) Matched service users had a significantly lower drop-out rate (6.9%) than unmatched service users (17.9%) ($\chi2$ (1, N = 84) = 15.72, $p<0.001$)
Sterling et al., (1998), USA	Retrospective Cohort Outpatient Treatment facility	To (a) replicate previous findings regarding the effect of patient/ therapist race	African American service users (n=967), Mean age=32.3, 44.1% female	Counsellors (n=10). African American (n=6), White (n=4)	African American - African American	African American – White	Drop-out: proportion of patients returning for another visit following	No significant difference in drop-out rate between service users who were matched (82.7%) or unmatched (78.7%)

First author, year, location	*Study Design, Setting*	*Study aims*	*Service user characteristics*	*Clinician characteristics*	*Matched dyads: Client/Clinician ethnicities*	*Non-Matched dyads: Client/Clinician ethnicities*	*Outcome*	*Results*
		and sex-matching as this relates to the early dropout rate of substance abusers, and (b) to extend previous work by examining the impact of such matching on treatment retention and 9-month outcome.					initial intake interview Attendance: "treatment retention" - absolute number of days between first and last visits	with the initial intake interviewer ($\chi 2$=2.41, 1 df, p>0.05) No significant difference in "treatment retention" between the ethnically matched and unmatched groups ($t(367)$ = 0.00, p=0.99)
Sterling et al., (2001), USA	Retrospective Cohort Outpatient Treatment facility	To examine the impact of race- and sex-matching on treatment retention and outcome for a sample of people seeking outpatient substance abuse treatment.	African American service users (n=116), Mean age = 32.8, 36.3% female	Counsellors (n=10). African American (n=6), White (n=4)	African American - African American	African American – White	Drop-out: proportion of patients returning for their first counselling session following intake Attendance: Number of days in individual treatment attended	No significant difference in drop-out rate between service users who were matched (83.3%) or unmatched (85.3%) with the initial intake interviewer ($\chi 2$=0.08, 1 df, p>0.05) No significant difference between matched and unmatched service users with regards to number of sessions attended ($t(71)$ = 0.85, p>0.05)

First author, year, location	Study Design, Setting	Study aims	Service user characteristics	Clinician characteristics	Matched dyads: Client/Clinician ethnicities	Non-Matched dyads: Client/Clinician ethnicities	Outcome	Results
*Sue et al., (1991), USA**	Retrospective Cohort Outpatient Mental Health Centres, Clinics and Hospitals.	Investigated services received, length of treatment, and outcomes of thousands of Asian-American, African-American, Mexican-American, and White clients using outpatient services. Hypothesis: that therapist-client matches in ethnicity and language are beneficial to clients	Asian American (n=3,344, mean age = 35.3), African American (n=3,415, mean age = 34.1), Mexican American (n=2,942, mean age = 33.5) clients	Not stated	Asian American - Asian American, African American - African American, Mexican American - Mexican American	Not stated§	Drop-out: failure to return for treatment after one session Attendance: number of sessions for either terminated or completed (log transformed)	For all groups except African Americans, ethnic match resulted in significantly lower odds of dropping out than unmatched clients Asian Americans: (OR = 0.20, $p<0.001$) African Americans: (OR = 0.96, $p>0.05$) Mexican Americans: (OR = 0.64, $p<0.01$) For each ethnic group, ethnic match was significantly related to greater number of sessions Asian Americans: (Estimated effect = 1.84, $p<0.001$) African Americans: (Estimated effect = 1.15, $p<0.01$) Mexican Americans: (Estimated effect = 1.35, $p<0.001$)
Thompson et al., (2006), USA	Cross-sectional Community psychology clinic	Examines the posttherapy reactions and attitudes of 44 African American	African American service users (n=44), Mean age=37.3, 75% female	8 clinicians. African American (n=4), European American (n=4)	African American - African American	African American - European American	Treatment satisfaction: Objectively measured using	Clients that were ethnically matched with their clinician self-reported significantly higher on the TRS than

First author, year, location	Study Design, Setting	Study aims	Service user characteristics	Clinician characteristics	Matched dyads: Client/Clinician ethnicities	Non-Matched dyads: Client/Clinician ethnicities	Outcome	Results
	associated with a university doctoral program.	clients seen at a university clinic in a midwestern city					validated tool	service users that were unmatched ($F(1,42) = 4.37$, $p<.04$, $\eta^2 = .09$)
							Attendance: number of sessions attended	There was no significant difference in total number of sessions attended between matched and unmatched dyads ($F(1,42) = .02$, $p=.88$)
*Wintersteen et al., 2005, USA**	Cross-sectional "Cannabis Youth Treatment Project"	Explored the effects of gender and racial matching on two key treatment indicators, the therapeutic alliance and retention, in a sample of substance-abusing adolescents.	African American adolescents (n=192), Mean age=15.7, 19% female	14 clinicians. White (n=11), African American (n=2), Latina (n=1).	minority patient –minority clinician	minority patient – Caucasian clinician,	Working Alliance: Objectively measured using validated tool	There was no significant mean difference between matched and unmatched dyads with regards to WAI-P score (*M* diff = -4.01, p=0.32)
							Attendance: attending two thirds of the intended treatment sessions	There was a significant difference between proportions of matched (79%) and unmatched (55%) dyads in terms of attending two thirds of treatment sessions ($\chi2(2, N = 452) = 34.54$, $p < .001$)

Defining ethnic match

There was variation between studies in how ethnic matching was defined. Some used the term 'racial/ethnic concordance' (Alegría et al., 2013). Some studies used the terms 'ethnic matching' and 'ethnic similarity' interchangeably (Knipscheer & Kleber, 2004a, 2004b). One study simply stated 'ethnic matching' with no further description (O'Sullivan & Lasso, 1992). Sue et al., (1991) defined ethnic match as whether clinicians were the same ethnicity as the service user or not.

Two studies used the terms 'ethnically similar/dissimilar' (Erdur et al., 2003; Farsimadan et al., 2007). In Erdur et al., (2003) study, they explained the make-up of dyads (i.e. African American service users with African American or Caucasian clinicians, Hispanic service users with Caucasian or Hispanic clinicians). Similarly, Farsimadan et al., (2007) defined the ethnic groups included in the study and stated that service users were matched with clinicians from the same ethnic group. They also described the unmatched service user-clinician dyads in their study as: Black African-Indian, Indian-Middle Eastern, Pakistani-Black Caribbean, and Sri Lankan-Black Caribbean. Knipscheer & Kleber (2004b) also specified the ethnic make-up of the dyads in the matched (Surinamese-Surinamese) and unmatched groups (Surinamese-Indigenous Dutch).

Other terms used included 'patient/therapist congruence' (Sterling et al., 1998), 'patient/therapist matching with respect to race' (Sterling et al., 2001) or 'racially consistent dyads' (Thompson & Alexander, 2006). Two studies acknowledged a difference between ethnic match and cultural match, in that individuals of the same ethnicity may differ based on culture (Gamble, 2001; Sue et al., 1991). This is also recognised in Flicker's (2004) paper, where the difficulties of grouping culturally heterogenous individuals into one ethnic group is highlighted. For example, there are wide variabilities between people classed as Hispanic, as they may be descendent from Mexican, Puerto Rican, Cuban or another Spanish origin, and may differ with respect to culture. In Flicker's (2004) paper, they chose to focus on the New Mexican Hispanic population and clarified that these individuals were either descendant from Spain, Spain through Mexico or Mexico.

Quality assessment

The methodological quality of included studies can be seen in Table 2. Nine studies were assessed to be globally 'weak', three were rated as globally 'moderate' and only one achieved a rating of 'strong'. It is worth noting that global ratings, while useful as a measure of overall study quality, may fail to account for the nuanced differences between studies or account for strengths not measured in the QATQS. For example, although Thompson et al., (2006) employed a cross-sectional design, they discussed methods of randomising participants to either African American or European American clinicians, using a random allocation sequence. According to the QATQS dictionary, these methods were deemed appropriate to afford each participant the same chance of being in either condition (matched or non-matched) and would be rated highly if the design was an RCT, however, since it was a cross-sectional design, it received a 'weak' rating regardless of randomisation techniques.

The most common area of weakness was the potential presence of confounders, since 10 studies lacked reference to either their presence or how these might have been controlled for in the study. For instance, both studies by Knipscheer et al., (2004a; 2004b) included covariates in their analyses, however it was not clear why only these variables were chosen and what percentage of potential confounds were controlled for. Another common area of weakness was the design component, since many of the studies employed a cross-sectional or retrospective cohort design, and the QATQS values RCT or CCTs more favourably. Six studies were rated 'weak' for selection bias, of these, the level of participation was either less than 60% or not described which influenced the rating. Again, the study design may have accounted for this. For example, the nature of retrospective cohort studies, which rely on archival clinical records, may not have recorded how many selected participants agreed to take part, in the same way a RCT or cohort might do.

Data collection methods was an area of strength for all but five studies. Many studies utilised archival data obtained from clinical records. These were deemed a valid method of data collection since for variables of interest such as number of sessions attended, these are objectively recorded on

clinical systems when patients arrive for appointments. Other studies used objective scales such as The Working Alliance Inventory (Horvath & Greenberg, 1989) or the Client Satisfaction Questionnaire (Larsen et al., 1979).

Table 2 Quality Assessment of Included Studies (Effective Public Health Practice Project (EPHPP), Thomas et al., 2004)

First author, year	***Selection Bias***	***Design***	***Confounders***	***Data Collection Methods***	***Global Rating***
Alegría et al., (2013)	Moderate	Weak	Moderate	Moderate	Moderate
Erdur et al., (2003)	Moderate	Moderate	Weak	Strong	Moderate
Farsimadan et al., (2007)	Moderate	Moderate	Strong	Strong	Strong
Flicker, (2004)	Weak	Strong	Weak	Weak	Weak
Gamble, (2001)	Moderate	Weak	Weak	Weak	Weak
Knipscheer et al., (2004a)	Weak	Weak	Weak	Weak	Weak
Knipscheer et al., (2004b)	Weak	Weak	Weak	Weak	Weak
O'Sullivan et al., (1992)	Moderate	Weak	Weak	Moderate	Weak
Sterling et al., (1998)	Moderate	Weak	Weak	Moderate	Weak
Sterling et al., (2001)	Weak	Weak	Weak	Strong	Weak
Sue et al., (1991)	Moderate	Weak	Strong	Moderate	Moderate
Thompson et al., (2006)	Weak	Weak	Weak	Weak	Weak
Wintersteen et al., 2005	Weak	Weak	Weak	Strong	Weak

Study Outcomes

The studies included in this review described four outcomes of interest relating to service users' experience of therapy. This section will describe the findings and comparisons between studies organised by the outcome. Some studies reported more than one outcome and so each will be reported separately under its respective heading. Table 1 further details how each study defined their outcome(s) of interest.

1. Attendance

Overall, 10 studies examined the difference in attendance rates between service users who were ethnically matched and unmatched with a clinician. There was some variation in how this outcome was defined between the studies, for example some stated 'number of sessions attended' (Erdur et al., 2003; O'Sullivan & Lasso, 1992; Thompson & Alexander, 2006), whilst others used terms such as 'client returning for next scheduled visit' (Alegría et al., 2013), 'length of therapy in weeks' (Farsimadan et al., 2007) or 'percent sessions attended' (Flicker, 2004). These studies were grouped together due to the similarity of outcomes studied, despite variances in terminology.

Three studies reported a significant difference between matched and unmatched groups in attendance rates (O'Sullivan & Lasso, 1992; Sue et al., 1991; Wintersteen et al., 2005). All three studies reported a significant difference in the direction of matched ethnically minoritised service users attending more sessions than unmatched service users. It is difficult to draw specific comparisons between studies due to the variability in study designs. Both O'Sullivan & Lasso (1992) and Sue et al., (1991) were retrospective cohort designs in adult populations, while Wintersteen et al., (2005) was a cross-sectional study of adolescents. Moreover, Wintersteen et al., (2005) sampled only African Americans, O'Sullivan & Lasso (1992) sampled only Hispanic individuals and Sue et al., (1991) included Asian American, African American, Mexican American and White groups (though the last group was not included for analysis in this review). Although the study by Sue et al., (1991) did not provide specific details on the clinicians included in the study, it had the advantage of being a 'moderate' quality study and using a large and ethnically diverse sample of service users (n=9,701),

suggesting a greater potential for the findings to be generalisable than the studies by O'Sullivan & Lasso (1992) (n=161) and Wintersteen et al., (2005) (n=192).

Of the remaining seven studies that did not report a significant difference between ethnically matched and unmatched service users with regards to attendance rates (Alegría et al., 2013; Erdur et al., 2003; Farsimadan et al., 2007; Flicker, 2004; Sterling et al., 1998, 2001; Thompson & Alexander, 2006, 2006), two studies sampled less than 50 individuals and employed a cross-sectional design (Alegría et al., 2013; Thompson & Alexander, 2006). The limitations of such methodologies are worth bearing in mind; nonetheless, studies that employed more rigorous designs (Flicker, 2004), or had larger sample sizes (Sterling et al.,1998; 2001, Erdur et al., 2003) also did not yield significant findings. For example, the study by Farsimadan et al. (2007) reported no significant difference in attendance rates between matched and unmatched dyads findings despite being a cohort study, sampling individuals from a range of ethnic backgrounds, and receiving a 'strong' quality assessment rating.

Taken together, it seems that there may be less empirical support for ethnic matching having a significant impact on number of sessions attended, given that the majority of studies exploring this outcome did not find a statistically significant effect despite variability in service user ethnicities, sample sizes, methodological designs and quality of paper.

2. Working Alliance

Only two studies included in this review explored the effect of ethnic matching on working alliance. Only one was rated as methodologically 'strong' (Farsimadan et al., 2007) in the quality assessment, while the other was rated as 'weak' (Wintersteen et al., 2005). Both studies measured working alliance using the Working Alliance Inventory - Patient version (WAI-P) and collected this data at or after the clients' second or third therapy session. Wintersteen et al., (2005) also administed the therapist version of the WAI, but, this is not included here since our focus relates only to service users' experiences.

Farsimadan et al., (2007) not only reported a significantly higher working alliance in ethnically matched groups but regression analyses also showed that ethnic matching was significantly predictive of working alliance. This is in contrast to Wintersteen et al., (2005)'s study which found no significant difference in service user reported working alliance between ethnically matched and unmatched groups. Wintersteen and colleagues explained that, in their clinical opinion, although ethnic matching may seem appealing, the quality of respect and and connection felt in therapy superceded ethnic matching.

It is worth noting that due to the nature of the therapy offered in the study by Farsimadan et al., only the Bond subscale was used since it was regarded as more important than the Goals and Tasks subscales, whereas Wintersteen et al., (2005) used the complete measure, which may have impacted the results. Still, this review identified a lack of data to provide robust evidence of whether ethnic matching has any impact on working alliance.

3. Drop-out

Four studies explored the impact of ethnic matching between service user and clinician on drop-out rates. Two studies defined drop-out as 'failure to return for treatment after one session' (O'Sullivan & Lasso, 1992; Sue et al., 1991), while the other two studies described 'early retention' or 'return rate', defined as the 'proportion of patients returning for another visit following intake session' (Sterling et al., 1998, 2001). Since the authors discussed their findings in relation to dropping out of treatment, these studies were grouped within the outcome of drop-out for this review.

The study by O'Sullivan & Lasso (1992) found that with the drop-out rate for Hispanic service users who were ethnically unmatched with a clinician was more than double than for those who were ethnically matched (17.9% vs 6.9%, respectively), suggesting that ethnic matching may have an impact on drop-out from treatment in this group of people. In the study by Sue et al., (1991), logistic regressions demonstrated lower odds of dropping out of treatment when service users are ethnically matched with clinicians, among Asian and Mexican Americans, but not among African

Americans even after controlling for predictor variables. The authors also noted that the odds of dropping out were particularly low for Asian Americans than for Mexican Americans. The findings with regards to Mexican Americans from Sue et al., (1991) may fit with that found in O'Sullivan & Lasso (1992), though their classification of service users as 'Hispanic' makes it difficult to directly compare findings due to heterogeneity and cultural differences within this group.

Both studies by Sterling et al., (1998; 2001) did not find an effect of ethnic matching on drop-out rates in samples of African American individuals. Although not significant, the earlier paper reported a slightly larger margin of difference between matched and unmatched groups compared to the later study (4% vs 2%, respectively), which may reflect the larger sample size in this study. Moreover, the interventions in both studies included a group format, which the authors note could have obscured the impact of ethnic mismatching.

All four studies employed the same overarching methodological design but showed mixed findings. The findings from Sue et al., that ethnic matching did not have an impact on drop-out rates among African Americans, may fit with that reported in both Sterling et al., papers since they also sampled African Americans. All things considered, these findings could be indicative that ethnic matching may have effect on drop-out rates among some ethnic groups such as Hispanic, Asian Americans, Mexican Americans, but not others such as African Americans. However, it is worth cautioning against broad generalisations about groups which may have significant within groups differences. Indeed, all four studies were conducted in the United Stated and findings may not be applicable to other settings. None of the studies reported data on reasons for drop-out, so we are unable to draw conclusions on whether drop-out was related to ethnic match/mismatch, or some unrelated reason.

4. Treatment satisfaction

There were five studies that looked at the impact of ethnic matching on treatment satisfaction as an outcome. Two studies measured treatment satisfaction using the CSQ-8 (Flicker, 2004; Gamble,

2001), one used the TRS scale (Thompson & Alexander, 2006) and two used what was described as a self-constructed 1-item form (Knipscheer & Kleber, 2004a, 2004b). Further details of measures used in each study are displayed in Appendix M: Table M1.

Two papers reported greater treatment or service satisfaction when service users were ethnically matched with clinicians than when unmatched (Knipscheer & Kleber, 2004b; Thompson & Alexander, 2006). Both studies were cross-sectional in design, meaning that findings are only reflective of one point in time, however there was variability between the groups sampled. Knipscheer & Kleber (2004b) sampled Surinamese individuals living in The Netherlands whereas Thompson & Alexander (2006) sampled African Americans, replicating findings from other populations.

Three papers did not find a significant effect of ethnic matching on treatment satisfaction (Flicker, 2004; Gamble, 2001; Knipscheer & Kleber, 2004a). Like the studies mentioned above, there was also variability among the service user groups sampled in each study, which could lend support to a conclusion that ethnic matching may not have any bearing on treatment satisfaction. It is worth noting, however, that one problem with Flicker's (2004) paper, is that only mothers' treatment satisfaction was recorded, even though both parents and the adolescent participated in Functional Family Therapy. It is not clear why only the mothers' responses were recorded but more importantly, we cannot be certain if there would be differences in treatment satisfaction between parents and adolescents, or indeed in the overall findings, had the treatment satisfaction of both parents and the adolescent been recorded. The authors also noted that differences between therapists within ethnic groups could have biased the findings. It is interesting that the two papers by Knipscheer & Kleber included in this review, although on different samples, reported differering findings with regards to ethnic matching and treatment satisfaction. Indeed, it may be that there is greater treatment satisfaction among ethnicially matched Surinamese individuals in the Netherlands, as reported in the 2004b paper. Yet, it is worth highlighting that the 2004b study included a slighly larger sample that was more equally distributed in terms of gender, and this may have also had a bearing on the findings. Gamble et al., (2001) sampled 24 Portuguese Americans and did not find ethnic matching to be

predictive of treatment satisfaction. The authors did note however, that treatment satisfaction was significantly related to Portuguese ethnic identity (see glossary for definition) in matched dyads, suggesting a potential mediating effect of ethnic identity on treatment satisfaction when service users are ethnically matched.

1.6 Discussion

Summary

This study aimed to systematically review the literature on the impact of ethnic matching on ethnically minoritised service users' experience of mental health services. Previous systematic reviews in this area have been inconclusive and have not solely focussed on ethnically minoritised individuals, nor have outcomes such as working alliance and treatment satisfaction been explored. The current review identified 13 studies between 1991-2013. These studies investigated the impact of ethnic matching on four key outcomes: attendance, working alliance, drop-out and treatment satisfaction. Information from these studies were extracted and discussed. The methodological rigour of included studies was assessed using the QATQS.

Main findings

Overall, this study found varying evidence for the effects of ethnic matching on experiences of therapy for ethnically minoritised users of mental health services.

With regards to attendance, we concluded that it is likely that ethnic matching does not have a significant impact on number of sessions attended. This finding is consistent with previous work by Shin et al., (2005), but not with Maramba & Hall (2002). We can only speculate about the reasons for such findings, it could be that variations in the way attendance were defined between studies or the types of interventions, and thus number of sessions offered, could have had an impact. Methodological design may have also influenced the findings, for example, both Alegría et al., 2013 and Thompson & Alexander, 2006 employed a cross-sectional design, which is observational, only captures a 'snapshot' and does not allow for change over time to be observed. However, even a study which employed an RCT design, a design more highly regarded than observational designs due to its highly controlled nature, and took place over six months (Flicker, 2004), also did not find a significant result. Given that RCT designs are considered the 'gold standard' in research designs, it

may be that there is truly no significant difference between ethnically matched and unmatched service users in relation to attendance. It is worth noting the possibility that the small sample size (n=19) in Flicker's study did not afford enough power and therefore may have occluded a significant difference to be detected. This is contrasted with the fact that the studies by Sterling et al., (1998; 2001) had sample sizes of 967 and 116, respectively, and neither found evidence of an effect of clinician ethnicity on attendance rates. In this way, the evidence from this review better supported the notion that ethnic matching may not have an impact on attendance rate.

There were only two studies that met the inclusion criteria for this review that explored the effect of ethnic matching on working alliance. Due to differences in methodology and hence findings, it is unclear whether ethnic matching has an impact on the working alliance between ethnically minoritised service users and clinicians, based on these two studies. For example, one could conclude that differing findings were due to differences in samples or geographical setting, that is, adults vs adolescents or UK vs USA. Moreoever, Farsimadan et al., reported a significantly higher working alliance in matched pairs than unmatched pairs using only the Bond subscale of the Working Alliance Inventory, whereas Wintersteen et al., used the complete measure and found no difference. One hypothesis might be that including the Goals and Tasks subscales diluted an effect that may exist soley on the Bond subscale. This could, at least partly, explain why there was a difference in findings between these two studies.

The studies exploring the impact of ethnic matching on drop-out tended to suggest differences between ethnic groups, with significantly less drop-out amongst ethnically-matched Hispanic, Asian American and Mexican American groups than African American groups. Three studies (Sterling et al., 1998, 2001; Sue et al., 1991) found no significant effect of ethnic matching within African American samples, results which are again consistent with some previous research (Shin et al., 2005), but not others (Maramba & Hall, 2002). Though, it is important to recognise that nuanced differences within, as well as between, ethnic groups exist and should not be discounted as they may also have a

bearing on findings. In addition, reasons for drop-out were not reported, so it is difficult to establish whether drop-out was related to the clinician or an unrelated cause.

Finally, when it comes to treatment satisfaction, all five studies sampled different service user groups, making it challenging to draw specific conclusions. However, two studies were able to show support for an effect of ethnic matching in different populations, using different scales to capture treatment satisfaction, which may strengthen the case that ethnic matching may have an impact on overall treatment satisfaction. One study suggested that psychological variables such as ethnic identity may play a part in service users' experiences of therapy when ethnically matched. Indeed, it is possible that differences in levels of ethnic identity rather than simply differences in ethnicity, may account for variability in findings, though further research is needed.

With regard to important factors that might explain the findings of this review, some insights can be noted. It has previously been suggested that ethnicity is merely a demographic variable and on its own does not hold up to explain complex psychological processes in therapy (Karlsson, 2005; Sue, 1998a). Instead, matching on psychological aspects such as values, attitudes, personality, worldviews are better pursuing (Atkinson et al., 1986; Erdur et al., 2003; Knipscheer & Kleber, 2004a; Sue, 1998a). Indeed, there is evidence to support that service users from ethnically minoritised backgrounds have a stronger preference for clinicians with similar attitudes or values rather than of similar ethnic background (Shin et al., 2005).

Additionally, ethnic matching could be more important for certain individuals than for others. One of the studies in our review that found evidence of a relationship between ethnic match and treatment satisfaction, found that this relationship was dependent on level of ethnic identity (Gamble, 2001) – that is, the degree to which a person aligns themselves with their ethnic group (S. D. Brown et al., 2014; Phinney & Ong, 2007). This supports previous research suggesting that similarity in level of ethnic identity provides a stronger effect on the therapeutic process than ethnicity itself (Atkinson & Thompson, 1992; Meyer & Zane, 2013). This also provides clear support for previous studies that

have demonstrated ethnic match to be regarded as more important for those with a stronger Black ethnic identity (Meyer & Zane, 2013; Ponterotto et al., 1988; Shin et al., 2005; Ward, 2005) or for whom issues regarding race and ethnicity are more salient (Meyer & Zane, 2013). One could argue that ethnic matching could be seen as a proxy for matching on these psychological variables since, by and large, people of similar ethnicities tend to hold similar beliefs, values, or worldviews. On the other hand, people of any ethnicity may not necessarily subscribe to the values, beliefs or traditions of their ancestral culture (Atkinson & Lowe, 1995; Karlsson, 2005; Sue, 1998a) and may and have varying levels of ethnic identity (Erdur et al., 2003). These ideas may, at least partly, explain the lack of consistent results when service users and clinicians are matched based on ethnicity. Taken together, it could be that ethnic matching may be more beneficial and preferred for service users who more strongly align with the values of their ethnic identity.

Acculturation may have also played a part in the variability of evidence found in this review. Acculturation is the process of cultural and psychological change which occurs when two or more cultural groups and its members interact (Berry, 2006). It has been stated that the process of being exposed to different ideas through media, education, or interactions with people of a different ethnic group to one's own, it is possible for acculturation to occur in service users or clinicians which may dilute effects of ethnic matching (Betancourt & López, 1995; Karlsson, 2005). In this way, it could be hypothesised that some ethnically minoritised participants had assimilated to the dominant culture where studies took place (which were majority western), potentially overriding any effect of ethnic matching. Replication of these studies in non-western cultures may help to clarify this.

The influence of language must also be noted. While some studies included in this review collected data relating to language (Alegría et al., 2013; Gamble, 2001; Sue et al., 1991), others did not. It is unclear whether service users prefer a clinician who can speak or understand their mother tongue, even if they do not belong to the same ethnic group. Also, one might question whether when language is matched, is there any added value of ethnic matching? In the study by Farsimadan et al., (2007), the authors explicitly stated that although all participants could speak English, most of those

in the matched group received therapy in their native language. In this way, we cannot be certain whether it was ethnic or language matching in this study that facilitated positive outcomes. Moreover, the importance of language may also depend on whether the service user is a first- or second-generation immigrant. For example, a person may be a first-generation immigrant of an Arabic speaking country but may express themselves better in English. They may therefore prefer a clinician who can speak English rather than a clinician from the same ethnic group.

Strengths and limitations of review

The current study provides an update to the existing literature exploring the effect of ethnic matching on outcomes related to therapy and builds on recommendations to investigate this effect specifically in ethnically minoritised users of mental health services. This study is the first to synthesise the evidence on process variables such as working alliance and treatment satisfaction, which are essential when considering the service users' experience of therapy. Moreover, contrasting previous meta-analyses, this review included studies conducted on populations outside of the United States, which helps increase generalisability of the findings. Further strengths of this review include the development and use of a systematic review protocol, searches were run on four electronic databases and 10% of records were peer-reviewed for consistency.

The limitations of the present study should also be noted. This study is constrained by the paucity of methodologically sound studies available on this topic. It has long been suggested that experimental studies on this topic are needed (Karlsson, 2005). For instance, a randomised controlled trial with equal groups of randomly assigned ethnically matched and unmatched dyads with outcomes measured at the beginning, middle and end of treatment might provide more certainty about whether ethnic matching has any impact on outcomes related to service users' experiences of therapy. However, a large sample would be needed and the findings from such a highly controlled environment may not be as generalisable to clinical settings. The present study is also limited due to the number of studies that were excluded on the basis of insufficient information on the matching procedure (n=7). It is possible that such studies could have influenced the findings of this review, but

due to lack of detailed information on who was matched with who and how, we were unable to confidently include these studies in this review. In terms of the inclusion criteria, although matching of a clinician from any discipline in mental health services was included, much of the data obtained reflected psychological therapy only, which may have been a function of many of the search terms being geared towards psychological therapy, so findings may not reflect mental health services on the whole. Further, it must be noted that while a second reviewer screened 10% of records, a second reviewer was not involved in the eligibility or quality assessment stages as it was beyond the scope of the review, though this may negatively impact the reliability of this review.

Lack of sufficient detail in studies included may also present as a limitation. For example, information on clinician education, training or experience was not reported in some studies. It was sometimes difficult to even determine the intervention that was offered to service users. Because of this, it is plausible that ethnic matching may have an impact on service users' experiences when clinicians had a certain level of experience, or in specific interventions, but it is impossible to know for certain in this review. Since these variables were not of primary importance to the research question, they were still included in this review. The lack of data in the articles was a contributing factor as to why a narrative synthesis was conducted in place of a meta-analysis, combined with the fact that there were so few studies with the same research question. Additionally, as discussed in the main findings, factors such as ethnic identity, acculturation and language may interact with ethnic matching and service users' experiences of therapy but exploration of this was beyond the scope of the present review.

Implications for current practice

This review provides some insights into important aspects of clinical work and some implications are worth bearing in mind. Firstly, despite inconsistent results, service users should be allowed freedom of choice when it comes to their care, including who they would like as their clinician (Erdur et al., 2003; Sue, 1988), though, it may not always be possible to accommodate these preferences if there is a lack of diversity in the workforce, or where services are stretched due to high

demand. When it comes to ethnic matching, the findings from this review suggest it either has minimal or significant impact on service users' experiences. There may be specific groups of people that could benefit more, however, too much variability of individual differences in ethnic identity, values, acculturation, and language poses an issue. Regardless, if services wish to maximise the potential benefit of matching service users with clinicians, then matching based on variables such as values, beliefs or ethnic identity might prove more fruitful than matching on ethnicity alone. Though, the additional pressure this puts on services that are already struggling to meet growing need for mental health support must be acknowledged. It makes sense that improving the quality of research in this area is first needed to better understand what makes the most difference, for who and how much, so that any implemented changes are evidence-based. Additionally, as Maramba & Hall (2002) suggest, it is culturally informed processes that make a difference in therapy rather than demographic traits. As it stands, clinical practice should strive to work in ways that are culturally responsive, and there is support for the notion of increasing recruitment of ethnically minoritised clinicians but also training all clinicians to deliver culturally sensitive therapy (Farsimadan et al., 2007). Services that are open to developing or using existing models that are more in line with ideas from non-western cultures might be most successful at delivering culturally competent, safe and meaningful psychological therapy for service users from ethnically minoritised backgrounds.

Future research

This systematic review has highlighted the lack of consistent findings in the literature on the impact of ethnic matching on service users' experience of therapy in ethnically minoritised populations. One could see ethnic match as a proxy for 'cultural' match and thus, results of this type of matching instead could be a potential avenue to explore. Perhaps categorical definitions of ethnicity lack precision (Karlsson, 2005), and so categorisation based on cultural attitudes or cultural commitment might be better suited. Moreover, for consistency, it would be more meaningful if attendance were reported as a percentage of the sessions offered, instead of the crude measure of number of sessions attended. This would make it easier to compare this outcome across different studies, though this method relies on therapists and service users agreeing on a set number of sessions

beforehand. Additionally, with regards to matching, ethnic identity may prove a more relevant variable to measure than ethnicity. More high-quality research that uses sound instruments, is conducted in non-western populations, thoroughly collects data on clinician variables, ethnic identity, level of acculturation and the effect of language is warranted. Nonetheless, a perfectly matched service user and clinician dyad is extremely rare, because of this, any research on such a dyad would have low external validity since its results are only applicable to a small population (Farsimadan et al., 2007; Laungani, 1998).

Conclusion

In conclusion, the study synthesised the current literature on the impact of ethnic matching on ethnically minoritised service users' experience of mental health services**,** with regards to four key outcomes: attendance, working alliance, drop-out and treatment satisfaction. The findings showed that when it comes to ethnic matching, there is an unclear relationship to these outcomes. Potential explanations for these findings include the lack of consistency between studies on this topic and the dearth of high-quality experimental research. In synthesising key findings, this review highlighted that other factors such as ethnic identity, acculturation and language may have a role to play when it comes to matching ethnically minoritised service users with clinicians. Further research in these areas would be helpful to better understand the impact of ethnic matching on ethnically minoritised service users' experience of mental health services.

Chapter 2: Empirical study

2.1 Abstract

It has long been documented that the acceptance rate of applicants from Black and Minority Ethnic (BME) backgrounds to Clinical Psychology training is lower than that of White applicants, resulting in a lack of ethnic diversity in the workforce. The selection process starts with meeting the minimum entry criteria, then moves on to the selection of applicants to invite to interviews, based on written applications. Previous research has found that BME applicants face additional socio-economic barriers to accessing training and that many are not proceeding past the earliest stage of the selection process. This study employed an experimental design to test whether ethnic status (whether BME or not), ethnic identity and personal values of potential shortlisters influenced this process. This study recruited a large sample (n=160) of Clinical Psychologists from both BME and non-BME backgrounds and were asked to rate the personal statements of BME and non-BME applicants. Analysis revealed no differences between BME and non-BME Clinical Psychologists in how they rated applicants, but BME applicants were rated higher than non-BME applications. A model including variables such as age, gender, ethnic status and ethnic identity accounted for 13% of the variance in BME application ratings but was not predictive of either BME or non-BME ratings. BME Clinical Psychologists rated value items Power, Achievement, Tradition and Security significantly higher than the non-BME Clinical Psychologists. Limitations of the study as well as implications for future research are discussed. The findings from this study underscore the importance of improving equity of access to Clinical Psychology training for individuals from ethnically minoritised backgrounds.

2.2 Introduction

It is estimated that only 9.6% of qualified Clinical Psychologists in England and Wales are of Black and Minority Ethnic (BME) background, compared to 13% of the population (Baker & Nash, 2013; Newnes, 2021; Office for National Statistics, 2011; Ragavan, 2018; York, 2020). These figures illustrate that Clinical Psychology as a profession is currently not representative of the population we serve. According to data from 2021 year of entry, the success rates for BME applicants across all Doctorate in Clinical Psychology (DClinPsy) training courses in the UK not only falls short of the expected rate of all acceptances but is 3% lower than the success rate for White British applicants (Clearing House for Postgraduate Courses in Clinical Psychology, personal communication, 10th March 2022). Even with policy changes and increased attention on the lack of diversity in Clinical Psychology in recent years, BME individuals are still less likely to be offered a place on training courses (Odusanya, 2016). This trend has been documented consistently (e.g. Newnes, 2021) and highlights a significant and persistent lack of ethnic representation, diversity, and inclusivity among Trainee Clinical Psychologists, and thus the profession as a whole. With the predicted increase of individuals from BME backgrounds rising to 15% in England and 37% in London by 2031 (Longwill, 2015), tackling the lack of ethnic diversity in Clinical Psychology is even more of a priority.

2.2.1 Background

Ethnic diversity in the NHS

The lack of ethnic diversity in Clinical Psychology cannot be understood without first examining the wider context. A lack of ethnic diversity also extends to the NHS, with evidence showing that across 224 NHS trusts, White applicants were nearly 1.5 times more likely to be appointed from shortlisting compared to BME applicants (NHS England, 2020). Although this could be regarded as an improvement when compared to the 2017 figure (1.60), it still reflects a problematic pattern of unequal outcomes, namely, a disproportionate predominance of NHS staff who are White. This begs the question, what is it about selection processes that leads to these outcomes? Moreover,

the absence of BME individuals in senior NHS roles or in leadership positions such as Trust Boards has long been a concern (Esmail et al., 2005; NHS Institute for Innovation and Improvement, 2009). A survey examining inequalities in governance and leadership in NHS Trusts in London evidenced that only 8% of Trust Board members were from a BME background (Kline, 2014). This figure is a decrease of 1.6% over eight years, suggesting the lack of ethnic diversity among key decision makers in these NHS trusts is a problem that is worsening. More recently, a report documenting lived experiences BME NHS leaders found that the lack of ethnic diversity at leadership level made it harder to speak up about experiences of racism at work (NHS Confederation, 2022). In summary, under-representation of BME individuals is not just an issue in Clinical Psychology in the UK but exists within the health and organisational system in which Clinical Psychologists work.

British Clinical Psychology

Clinical Psychology in the UK was born into a socio-political context which aimed to provide access to free healthcare for all (Pilgrim et al., 2015; Wood & Patel, 2017). As the general population began to diversify in the 1950s - 1970s with individuals arriving in the UK from the Caribbean, India and Bangladesh (Wood & Patel, 2017), practices and models used within Clinical Psychology were critiqued as Eurocentric, blind to its limited utility with individuals who may find these approaches unappealing due to cultural reasons (Morris, 2012; Turpin & Coleman, 2010a; Williams et al., 2006; Wood & Patel, 2017). Since then, many still remark that the evidence base underpinning the models used in Clinical Psychology disproportionately represent WEIRD (Western, Educated, Industrialized, Rich, Democratic; Henrich et al., 2010) groups, which make up only 5% of the global population (Ahsan, 2020; Arnett, 2016). Thus, services largely remain inaccessible to and exclusive of some people who now constitute a large proportion of the British population (Morris, 2012; Wood & Patel, 2017). Furthermore, evidence shows that BME service users are less likely to be referred for ‘talking therapies’ compared to their White counterparts (Ahsan, 2020; Fernando, 2017).

One example of the barriers BME service users face is the significant weight services placed on Cognitive Behavioural Therapy (CBT) models (Ahsan, 2020; Rimke, 2016). CBT remains widely offered as a first-line treatment within services and choice is seldom offered in clinical practice with 58% of NHS service users reporting not having a choice in the type or format of treatment they receive (Mind, 2013). Although CBT can be effective with people from BME backgrounds, it is a model that places more emphasis on the individual, and thus may appeal more to people and cultures in the west who align more with 'individualistic' values (Morris, 2012). In other parts of the world such as Asia, Africa and South America, relational 'collectivist' values are more dominant (Brislin, 2000; Morris, 2012). As such, CBT sometimes finds itself incompatible with these values, rendering it unsuitable for those who may identify more with collectivist ideas (Morris, 2012). Indeed, practices in Clinical Psychology have evolved to incorporate ideas from non-western cultures, for example Acceptance & Commitment Therapy (ACT) or Mindfulness-based therapies, which draw on Buddhist traditions (Kang & Whittingham, 2010). These approaches are taught, although minimally, on UK Clinical Psychology training courses, as are approaches that attempt to understand distress through consideration of systemic oppression and collective healing, which may be more appealing to those aligning with collectivist values (Afuape & Hughes, 2015; Ahsan, 2020). For this reason, there is an increased need for Clinical Psychology training to support research and service models that consider the values and ways of working of different communities. Growing diversity in the workforce could be a useful step towards diversifying the approaches offered in psychological services.

Racism in Clinical Psychology

Clinical Psychology in the UK continues to be critiqued by Clinical Psychologists and service users alike for the presence of conscious and unconscious racism at individual and service levels (Fatimilehin & Coleman, 1998; McInnis, 2002; Patel & Fatimilehin, 2005; Wood & Patel, 2017). In the late 1980s and early 1990s, the British Psychological Society's (BPS) 'Race and Culture Special Interest Group' (SIG) was formed with the aim of acknowledging and examining racism and Eurocentricity within the profession (Fatimilehin & Coleman, 1998). The SIG was closed in 2014

without consultation with its members and with no immediate explanation. It has been suggested that a lack of conversation on these important topics, led to discomfort felt by some Clinical Psychologists when invited to think about how Whiteness is reinforced and reproduced within the profession (Wood & Patel, 2017) and created a space for institutional racism to thrive in British Clinical Psychology.

There was an upsurge in discussions around racism in British Clinical Psychology after a few significant events that occurred in 2019 and 2020. The first example is the painful re-enactment of a 'slave auction' that took place, without due context and support provided, at the Group of Trainers in Clinical Psychology (GTiCP) annual conference in 2019 (Association of Clinical Psychologists, 2019; Wood, 2020). The significant psychological distress caused by this incident (Patel et al., 2020; Wood, 2020) was compounded by the lack of proactive public response or apology from the organisers of the event. Then, in early 2020 the British Psychological Society Division of Clinical Psychology (BPS DCP) annual conference took place, with an overarching theme of social justice and racism, and a specific aim to address the issue of the GTiCP event. During a poster session, one attendee whose project was on supporting African and Caribbean men in forensic services to transition back into the community, returned to find her poster had been graffitied with the words "*Keep BME out of services*" (Sham Ku & Mia, 2020; Wood, 2020). The fact that this had taken place at a professional conference, by a delegate presumed to be a fellow Psychologist; that racism had moved from the covert, to the overt, was particularly alarming and upsetting for those involved. Again, the lack of clarity in what actions were being taken by the organisation and the BPS to address this issue until it was requested by colleagues, served to further reinforce experiences of racism and marginalisation, instead of allyship, in the profession (Sham Ku & Mia, 2020).

In May 2020, amid global COVID-19 lockdowns, the murder of George Floyd by a police officer in Minneapolis, USA, sparked worldwide anti-racist movements and powerful protests which forced institutions to reflect on their complicity in systemic and institutional racism. Universities across the UK made statements attesting their anti-racist stance and commitment to action, including dismantling systemic racism within Psychology (Gillborn et al., 2021; Harper & Purser, 2020). Over a

year later in September 2021 Sarb Bajwa, Chief Executive of the BPS, published a statement acknowledging that the BPS is “institutionally racist” (Bajwa, 2020). This was followed by urgent calls for long-term meaningful change in this discipline of Psychology (De Oliveira, 2020; Gillborn et al., 2021; Thornton et al., 2020). Conversely, this shift towards anti-racism has been criticised by some as ‘politicisation of the BPS’ (Miller, 2020). An opinion letter by Dr Kirsty Miller published, and later retracted, in *The Psychologist* titled “Why I No Longer Wish to Be Associated With the BPS” attracted significant attention due to its claims that agendas of social justice have no evidence base, and that racism, implicit bias and discrimination are ‘unscientific’ (Wood, 2020). Several responses to the letter were received (Sutton, 2020; Wood, 2020), many welcomed the BPS’ reaffirmation of its commitment to anti-racism. Indeed, these examples do not represent the profession as a whole, though it is clear that there is still some division on the topic of diversification of Clinical Psychology (Wood, 2020). Many acknowledge more work is needed to tackle issues of racism, power and privilege in the profession.

2.2.2 Why does ethnic diversity in Clinical Psychology matter?

The relevance of ethnic diversity in the profession may still be unclear, therefore we shall consider some key points regarding the implications of a lack of ethnic diversity in the workforce on four levels: In the therapy room, entry into Clinical Psychology, during training, and finally post-qualification.

In the therapy room

There is a wealth of evidence that diversity within the workforce is linked to good patient care (Alcock, 2014; Dawson, 2009; IAPT, 2009; Kline, 2014; West et al., 2012). The lack of ethnic diversity in the workforce may at least partly explain the barriers BME individuals face to access and benefit from psychological therapy, and increasing diversity could reduce these health disparities (Chapman et al., 2013). According to the IAPT BME positive practice guide (IAPT, 2009), recruitment of staff from BME backgrounds should be encouraged as it may enhance engagement

between service user and clinician if there is a shared cultural background. The Newham IAPT service is one example of culturally appropriate and responsive service delivery. Among other things, this service recognised that the recruitment and training of an ethnically and culturally diverse workforce is one cornerstone to reduce barriers faced by BME communities to access services.

Given the context of global migration changing the ethnic makeup of western populations (Farsimadan et al., 2007) and increasing reports of racism and hate crimes (Ashe et al., 2020; Berg et al., 2019; O'Neill, 2017; Virdee & McGeever, 2018), when psychological services are not ethnically diverse, people who have experienced racial trauma are more often placed in majority White spaces (Ahsan, 2020) where racial trauma is more likely to be pathologised (Fernando, 2017). These service users must then navigate the dilemma of wishing to talk about racial trauma in therapy but not feeling safe to do so, which may lead to dropout of therapy. Consequently, dropout might not be understood by clinicians as a function of an unmet need for safety to talk about racial trauma. Further, there is evidence that some service users of BME backgrounds avoid the subject of racial or cultural issues with White therapists and experience racial microaggressions in therapy (Chang & Yoon, 2011; J. Owen, 2011). In turn, this may contribute to lower treatment satisfaction, weaker therapeutic alliance and poorer clinical outcomes (Chapman et al., 2013; Constantine, 2007; Hall et al., 2015; Holder et al., 2007; Owen et al., 2011).

Indeed, well-intentioned White psychologists expressed a lack of confidence and skills to properly understand issues to do with race when working with BME service users (Ahsan, 2020).Even with frameworks that allow clinicians of any ethnic background to create a safe space for BME service users to feel valued and understood (Burkard et al., 2006; Chang & Berk, 2009), increasing ethnic diversity in the workforce could still be beneficial to the service users' experience of psychological therapy, though responsibility should not solely fall on BME clinicians (Morris, 2012).

The barriers faced by people from BME backgrounds to access psychological therapy is paralleled with barriers faced by people from BME backgrounds who wish to pursue Clinical Psychology training.

Entry into Clinical Psychology

Previous research has highlighted that aspiring Clinical Psychologists from BME backgrounds perceive entry into the profession as more challenging compared to their White, middle-class counterparts (Meredith & Baker, 2007; Turpin & Coleman, 2010a; Williams, 2002; Williams et al., 2006), thus, disincentivising them from choosing psychology as a career path. A lack of exposure to role models within the profession may have contributed to these perceptions. Aspiring Clinical Psychologists have discussed the experience of navigating interviews as individuals from BME backgrounds (Kinouani et al., 2016). They highlighted the hyper-visibility of 'ethnic minority statuses', heightened self-doubt, anxiety and questions about whether they deserve to be in and would fit in and thrive in Clinical Psychology as barriers to performance. They also discussed the consequences of stereotype threat, a process by which people feel at risk of confirming negative stereotypes, on their ability to perform in interviews (Kinouani et al., 2016). Such experiences consequently leave some BME aspiring Clinical Psychologists choosing to conceal minoritised identities, trying to modify themselves to fit what they perceive as favourable by Clinical Psychology courses – a strategy that naturally perpetuates stigmatisation and shame (Kinouani et al., 2016).

A recent qualitative study by Ragaven et al., (2020) uncovered some other ways in which a lack of ethnic diversity affects BME applicants to the DClinPsy in the UK. Eight female BME DClinPsy applicants described having to contend with positive discrimination as a result of the drive to increase diversity in the profession, but also feeling that they had to work harder to be offered the same opportunities as White peers – an experience they termed 'Black Tax' (Ragaven et al., 2020). Participants also spoke about the value of having supervisors also from BME backgrounds. This again, highlights the importance of visible role models aspiring Clinical Psychologists from BME backgrounds.

To sum up, the lack of ethnic diversity in Clinical Psychology affects how hopeful, safe, and worthy BME aspiring Clinical Psychologists feel pursing Clinical Psychology. In turn, this could have implications on what the future landscape of the profession may look like. Consequently, the lack of

exposure to ethnic diversity, and thus role models, may contribute to the challenge of accessing Clinical Psychology training for individuals from BME backgrounds.

<u>During training</u>

Three qualitative research studies have explored the experiences of BME Trainee Clinical Psychologists, (Paulraj, 2016; Rajan & Shaw, 2008; Shah, 2010). All three studies highlighted that BME Trainees grappled with the pressure to assimilate with their majority White cohort, while also holding on to their cultural identities, and the complexity involved in negotiating these roles in a profession that typically privileges Eurocentricity (Prajapati et al., 2019). This felt particularly salient when non-western cultural experiences had been homogenised, reduced, talked about in a way that reinforced stereotypes or ignored altogether in teaching (Paulraj, 2016). Another common theme was the concern around highlighting or challenging issues to do with race and culture (Rajan & Shaw, 2008; Shah, 2010). Trainees from BME backgrounds felt it important to bring attention to issues around race and culture in the classroom or with colleagues, but that it often came at a cost of being labelled, silenced, or positioned as the 'expert' on issues of diversity (Rajan & Shaw, 2008; Shah, 2010). There were also positive aspects identified with being a BME trainee. Some trainees described becoming skilled in shifting cultural identities to suit different contexts, and named using their cultural identities to connect with service users as a strength, skill and a resource (Shah, 2010).

BME trainees have also documented their experiences of racism on Clinical Psychology training courses (Adetimole et al., 2005; Prajapati et al., 2019). Trainees are often placed in settings that are systemically racist, and consequently experiences of discrimination, racism and harassment have been documented (Health Education England, 2022). Indeed, raising incidents of racism with tutors and supervisors can be difficult to navigate due to power imbalances, and BME trainees often do feel concerned about negative personal consequences of raising such issues (Berg et al., 2019). An article written by three Black Trainee Clinical Psychologists mentioned the challenge of calling out experiences of racism due to fears of being ostracised or silenced (Adetimole et al., 2005). They also

stated that they carried these fears around with them, until given the opportunity by a Black tutor to name and explore these feelings. The authors emphasised the need to recruit more Black Clinical Psychologists to lecture on training courses.

In summary, being in a group where your ethnicity is minoritised naturally highlights difference. These studies showed that if left unaddressed, or addressed insensitively, difference can lead to marginalisation, othering and at worst, racism on Clinical Psychology training courses. However, difference can also be a strength and it is important to create spaces where trainees can reflect on using cultural identities to increase working alliances with service users. The literature has also shown how increasing exposure to BME psychologists can help combat negative experiences during training.

Post-Qualification

The lack of representation of BME Clinical Psychologists in services and management, continues to have several significant implications such as, being positioned as an 'expert' on issues to do with race and culture, and having to balance cultural and professional identities or values (Odusanya, 2016). The latter supports previous findings that for BME Clinical Psychologists tensions between personal and professional identities indeed do exist and are associated with personal distress (Goodbody & Burns, 2011). Odusanya and colleagues (2016) also found that BME Clinical Psychologist in the profession expressed lower confidence in their roles or skills. They noted the particular relevance of this in the context of leadership competencies becoming an increasingly important part of the role of a Clinical Psychologist, while the limited number of BME NHS staff being appointed leadership roles still remains (Goodbody & Burns, 2011, NHS Confederation, 2022). The extension of underrepresentation from trainee to qualified level further suggests that the issue is not only specific to Clinical Psychology training but is exacerbated by underrepresentation in the wider systems.

Understanding the implications of underrepresentation in the profession can also be viewed through the lens of the dominant ethnic group in Clinical Psychology. A recent study (Ahsan, 2020) explored nine self-identified White middle-class female psychologists' understanding of Whiteness in the profession. Participants showed an awareness of structural Whiteness in the profession and how the status quo is unconsciously maintained and reproduced through overrepresentation of White psychologists. Participants also demonstrated an understanding that socio-economic privilege affords access to the profession, but also shared opinions that motivations to diversify the profession *benefits* BME applicants, alluding to positive discrimination. The author posited these ideas as references to anti-blackness and were linked to the concept of 'White victimisation', a term used to describe a psychological defence against unconscious White privilege (Ahsan, 2020; Lipsitz, 2006).

Ultimately, it seems that experiences of marginalisation, having to grapple between differing identities and being assigned the role of 'expert' in cultural issues is also present once qualified for some BME Clinical Psychologists. Moreover, some White Clinical Psychologists argue that there seems to be a relationship between structural Whiteness and underrepresentation in the profession, which allows dominance of Eurocentric ideologies to be disseminated. Increasing ethnic diversity in the profession may help to bring balance to this.

2.2.3 The selection process for Clinical Psychology training in England, Scotland and Wales

Individuals wishing to pursue training in Clinical Psychology in England, Scotland and Wales must complete a standard application form through the Clearing House for Postgraduate Courses in Clinical Psychology (CHPCCP). Candidates can apply to up to four training courses at a time. The application form asks open and closed questions about qualifications and experience. Although there is variability between courses, the minimum set of entry requirements consists of: a) holding a first-class or upper-second class undergraduate degree in psychology, entitling the holder to graduate basis

for registration (GBR) with the BPS, b) having relevant work experience and c) having legal right to live and work in the UK. If a candidate meets the minimum entry criteria for any particular training course, their application form is thoroughly reviewed by a selection panel made up of Clinical Psychologists (from both NHS services and universities) against specific guidelines and criteria, who then make decisions about whether to invite the candidate to interview. If successful at interview, the candidate is then offered a place on that training course. The demand for places on Clinical Psychology training courses considerably outweighs the availability, making it a highly competitive application process.

As previously stated, there is a plethora of data evidencing the acceptance rate gap (the ratio of people applying to being offered a place) between applicants from White and BME backgrounds (Cape, Roth, Scior, Heneage, et al., 2008; Cape, Roth, Scior, Thompson, et al., 2008; Davenhill et al., 1989; Griffith, 2007; Scior et al., 2007; Smith, 2016; Turpin & Coleman, 2010b; Wright, 2008). The data also suggests that it is not simply a matter of fewer people from BME backgrounds *applying* to Clinical Psychology training courses, but that not enough are being *offered* a place (Alcock, 2014; Smith, 2016). In contrast, across other minoritised groups such as (dis)ability and sexuality, the ratio of applications to acceptances have been approximately equal while there is a more obvious discrepancy between number of people from BME and White backgrounds applying and being accepted (Smith, 2016), suggesting that this is an issue specifically relating to ethnicity. For example, in 2020 the application/acceptance rate gap was still higher for BME applicants compared to those with a disability, 3% and 1%, respectively (Clearing House for Postgraduate Courses in Clinical Psychology, 2020). Although these figures are an improvement on previous years, they still suggest there is something specific to ethnic background that is driving a discrepancy in acceptance rate.

Barriers to successful applications to Clinical Psychology training for people from BME backgrounds have been noted in the literature. Academic attainment is one such barrier with the data suggesting that with people from BME backgrounds were more likely to have poorer grades (Griffith, 2007; Scior et al., 2007; Turpin & Coleman, 2010b), not because of poorer abilities but factors

relating to the social and cultural context such as discriminatory teaching or assessment practices, poorer quality of learning and less support from families or communities (D. Owen, 2000; Richardson, 2008). Thus, the minimum entry criteria of holding a first-class or upper-second class undergraduate degree in psychology is evidently harder to reach for some BME applicants. The DClinPsy is academically demanding and as such, applicants with stronger academic qualifications have better chances of being selected. Another barrier is the challenge of gaining relevant experience. Securing a role as an Assistant Psychologist is a favoured route into the profession since it affords the opportunity to better understand of the role of a Clinical Psychologist. However, these roles are extremely competitive and therefore difficult to obtain. Moreover, the role is poorly paid and may require being able to travel around the country (Griffith, 2007; Smith, 2016). As such, these roles are not as easily sustained by those who have less financial privilege (Ahsan, 2020; Wood & Patel, 2017), and therefore such pre-requisite is a potential disadvantage for some from BME backgrounds who are more likely to face socio-economic disadvantage or have dependents (Griffith, 2007; Scior et al., 2007). Even professional placements that are offered as part of undergraduate courses are typically unpaid meaning that without working extra hours in a paid role, some students from BME backgrounds may be yet again disadvantaged. Taken together, the issue of lack of access to relevant experience for people from BME backgrounds obscures the possibility of meeting another minimum entry criteria to Clinical Psychology training. Additionally, it also means that people from BME backgrounds are less likely to have access to Clinical Psychologists who can provide good career guidance and support their applications to Clinical Psychology training (Scior et al., 2007). This is particularly pertinent given that knowledge of Clinical Psychology and amount of relevant experience were found to be two of the highest rated criteria to distinguish successful applicants by a sample of shortlisters (Wright, 2008). Critical reflections of this research are presented later.

Initiatives to improve equity of access to Clinical Psychology training

Drives to improve the ethnic makeup of the profession have existed since at least 1989 (Bender & Richardson, 1990; Davenhill et al., 1989; Newnes, 2021). A Widening Access Project was established by the BPS DCP in 2007 to support diversity in the profession (Alcock, 2014; Newnes,

2021). The project, targeted at people from BME backgrounds, aimed to increase awareness about the profession and clarify requirements for entry to training through a series of presentations and workshops delivered by trainee and qualified Clinical Psychologists (Alcock, 2014). In 2010, a review was published to reappraise the recommendations by the BPS about how to improve diversity and evaluate what progress has been made thus far (Turpin & Coleman, 2010b). The authors used data from the BPS DCP Widening Access Project (Turpin & Fensom, 2004) and the English Survey of Applied Psychology (British Psychological Association, 2004). It was reported that significant progress had been achieved in highlighting Clinical Psychology as a potential career to BME undergraduates. Though the authors acknowledged this has not lead to a big enough change in the ethnic diversity of the profession over the five years (Daiches, 2010). No less, the commitment to action plan and actively monitor progress of the recommended actions had not been sustained by the BPS (Turpin & Coleman, 2010a). One of the successes of the project was the creation of a joint taskforce between the London DClinPsy courses (UCL, IoPPN, Royal Holloway, UEL, Salomon's and Surrey), which helped to organise information, events and career guidance for BME individuals interested in Clinical Psychology (Cape, Roth, Scior, Thompson, et al., 2008). The taskforce, together with the DCP, launched an annual event targeting BME' undergraduate students called *"Is Clinical Psychology for Me?"* in March 2007. Although attendees noted there was a significant gap on specific help to gaining relevant pre-qualification clinical experience, the annual event has received positive feedback with 91% of attendees in 2018 stating that the event helped them better understand the requirements for Clinical Psychology training (Alcock, 2019). The need for more practical support for BME individuals was highlighted in studies evaluating the usefulness of open days for Clinical Psychology courses for people from BME backgrounds. For instance, feedback of an open day for BME applicants to the Yorkshire and Humber DClinPsy course in 2018 was overall positive, but there were comments that the open day did not address specific challenges that come with belonging to a BME background (Ketley, 2019; Watson, 2019). To address this need, Higher Education England (HEE) commissioned NHS Trusts to offer paid opportunities for financially disadvantaged aspiring Clinical Psychologists to gain experience e.g., the ASPIRE programme (Higher Education England, 2021b).

To meet the need to improve access to Clinical Psychologists, in 2011, the London-Wide Valued Voices Mentoring scheme was piloted, which matched aspiring Clinical Psychologists from BME backgrounds 1:1 with trainees and qualified Clinical Psychologists (Alcock, 2014, 2019). The UCL DClinPsy course has seen a significant improvement in diversity of cohorts since the mentoring scheme launched (8% acceptances from BME applicants in 2010, compared to 34% in 2020). Similar mentoring schemes aimed at addressing ethnic diversity in Clinical Psychology have been funded by HEE such as the Pathfinder Programme (University of Birmingham, 2022).

In 2015, a pan-London Widening Access initiative to deliver trainee-led career talks in socially and ethnically diverse secondary schools was piloted by UCL. The scheme later expanded to other training courses in London (Scior et al., 2016; Smith, 2016) and the idea to deliver similar workshops in schools has even been picked up by teams within the NHS (Pulham et al., 2019). Some have argued that Widening Access initiatives rely on the assumption that a lack of ethnic diversity is a result of little interest in or knowledge about Clinical Psychology as a career path, which is not necessarily the case (Smith, 2016).

Although there are examples of initiatives to increase ethnic diversity in Clinical Psychology, the rate of progress is still slow (Newnes, 2021; Turpin & Coleman, 2010a). Most recently, HEE commissioned the expansion of NHS-funded places on Clinical Psychology courses across 2020 and 2021 by 60% in order to improve equity of access for BME individuals into training courses (Higher Education England, 2021c). This significant increase in places might indeed tackle the disproportionate disadvantages faced by some individuals from BME backgrounds seeking a career in Clinical Psychology. However, simply increasing presence of BME individuals on Clinical Psychology training courses is not enough to dismantle the problem of systemic Whiteness in the profession (Newnes, 2021; Turpin & Coleman, 2010b). Without tackling the wider socio-political structures and institutional racism within the profession, diversity initiatives can only go so far (Daiches, 2010). Clinical Psychology courses in England have been able to bid for a one-off award of

£74,000 to develop Equality, Diversity and Inclusion strategies in line with the action plan from HEE (Salkovskis, 2021). One such action is to decolonise the curriculum to ensure racism and other forms of discrimination are addressed in teaching (Higher Education England, 2021a). With more individuals from BME backgrounds entering the profession, this is one useful step to ensure that the profession feels safe and equitable to all.

In recognition of the aforementioned barriers that BME applicants experience in accessing DClinPsy training, the GTiCP have developed an optional survey for applicants, separate to the application form, to collect additional data relating to educational, social, and economic backgrounds, with the aim of improving the inclusivity and equity of recruitment processes. Some courses have very recently started to collect this data and introduce a 'contextual recruitment process', though it is not yet known exactly or how many DClinPsy courses subscribe to this process, how the data will be used, or indeed their effectiveness and impact.

2.2.4 Research on Clinical Psychology selection

Given the high number of applications to process in a short amount of time, the validity of shortlisting procedures in Clinical Psychology has previously been questioned (Boyle et al., 1993; Keenan, 1997; Simpson et al., 2010; Wright, 2008). Despite this, there is a dearth of literature on the topic of Clinical Psychology selection procedures. Only two studies relating to predictors of successful applications in general were identified, and three studies specifically addressing factors relating to BME applicants.

A prospective study by Phillips et al., (2004) looking at the year 2000 cohort of applications identified that proxies related to demographic, academic, work experience and reference variables were predictive of applicants being shortlisted. The authors noted a limiting factor of a low response rate for the questionnaire relating to personal variables, which may have affected the findings. A more recent study of the Leeds training course in 2011 adopted a more specific focus on the effect of educational history on success of application (Scior et al., 2015). This study found that applicants who

attended a comprehensive school, had a first degree from a post-1992 university and attained either a 2:1 or 2:2 degree class were more likely to be rejected without an interview. They also noted that applicants who experienced all three of these factors were particularly disadvantaged. This study only used whole degree classification and did not differentiate any effects between high, mid or low 2:1 degrees, making it less comparable to specific entry criteria for training courses that select based on this. Moreover, the authors acknowledged the potential contribution of A-level grades, work experience, references, and personal statements on observed effects but they were but not included in the analyses.

Turning to studies focussing on ethnic differences in selection for Clinical Psychology training, one study examining the UCL training cohorts over the years 2002 and 2003 sought to identify whether there was any inadvertent bias towards BME applicants (Scior et al., 2007). Researchers found that compared to BME applicants, White applicants had significantly higher A-level points, were more likely to have gained a 1st class degree and to have attended "old" universities and were given higher scores by their clinical referees. The study also found marked differences between ethnic groups in the 2003 applicants with regards to rate of success of their applications. An attrition rate of 49% at the earliest stage of selection was noted for individuals from BME or 'other' backgrounds, compared to 29% for White applicants. This suggests that, at least for this cohort, individuals from BME backgrounds were failing to meet the minimum entry criteria for Clinical Psychology training, lending support to the research on barriers to successful applications to training discussed above. Nonetheless, this study was limited by the small number of BME compared to White applicants included in the study (n=144 vs n=962, respectively), therefore findings should be interpreted with caution. Another study looked at the acceptance rates of and factors related to success of Black applicants to Clinical Psychology training (Griffith, 2007). They found that Black applicants were significantly less likely to be shortlisted for interview and offered a place compared to other ethnic groups combined ($z=-2.96$, $p<0.05$), and each ethnic group separately. Further, the authors noted that 20% of Black applicants did not have GBR or a work permit, replicating previous findings that BME applicants fail to meet basic entry criteria (Scior et al., 2007). Although Griffith (2007)

emphasises that this in itself does not solely explain the marked difference in acceptance rates. Additionally, the authors did not comment how many applicants were international and were less familiar the minimum entry criteria for the DClinPsy.

As a follow up to Griffith (2007)'s work, only one study in this area was identified that employed a qualitative approach (Wright, 2008). A content analysis of statements from 21 shortlisters from the Leeds course in order to ascertain the top three criteria to distinguish between successful and unsuccessful candidates. These criteria were 'Reflectiveness' (defined as "An ability to think about experience and demonstrate learning from it about self, CP and research"), 'Knowledge of Clinical Psychology' (defined as "Realistic and informed understanding of CP roles, strengths and limitations") and 'Experience' (defined as "Amount of relevant clinical and research experience"). A sample of 25 applications each from Black, Asian, and White candidates, were analysed and the frequency of occurrence of each criterion was recorded. The authors reported a significant disparity with Black applicants demonstrating less reflectiveness, knowledge of the role of Clinical Psychologists in their personal statements and had less relevant experience than applicants of Asian or White backgrounds. A major flaw of this work was that the criteria, and weight of each, established by the Leeds shortlisters may not be generalisable to all Clinical Psychologists or shortlisters for other courses given the variation in selection criteria between courses. The authors also suggested that demand characteristics may have played a role in that shortlisters may have unconsciously identified criteria they believed were desired by the researchers, rather than their own choices (Wright, 2008).

Taken together, these studies provide empirical evidence of the ethnic differences for successful applications, which has been demonstrated consistently over time. Specifically, ethnic differences in acceptance rates appear to occur at the shortlisting stage (Griffith, 2007). In addition, it also appears that Black applicants have particularly poorer acceptance rates when compared to White applicants. It is worth noting however that most of the research to date has only focussed on demographic, academic, references and work experience variables as predictors of success. As such, more investigation of the personal statements sections of application forms is warranted (Phillips et

al., 2004; Scior et al., 2007). Additionally, research to date have been hampered by analysing application forms of one cohort at a time and mentioned small numbers of BME applicants limiting their findings. The paucity of research in this area, limitations of previous work and the increasing need to improve ethnic diversity in Clinical Psychology underscores the need for the current study.

2.2.5 Relevant theories and constructs of Social Connection

The lack of ethnic diversity in the profession of Clinical psychology may be partially explained through theories of how social connections are formed and the role conscious or unconscious similarity might play in the recruitment process.

The assertion that similarity breeds connection is articulated in the similarity-attraction theory (Byrne, 1971) as well as the principle of homophily, that is, the principle that there is a higher rate of contact between similar people than dissimilar people (Lazarsfeld et al., 1954; McPherson et al., 2001; Ragavan, 2018). Both theories posit that individuals have a greater affinity towards people who are similar to themselves (Berscheid & Walster, 1978; Huffcutt, 2011; Jones et al., 2004), or as the proverb goes, "Birds of a feather, flock together" (McPherson et al., 2001). Consider a scenario when two people first meet, typically the first thing people tend to do is engage in conversations that seek out commonalities in experiences and interests (Gigone & Hastie, 1993; Rivera, 2012). These commonalities then act as a powerful 'emotional glue' that bonds individuals together (Collins, 2004; DiMaggio & Mohr, 2015; B. H. Erickson, 1996; Rivera, 2012). However, these perceptions may not always be accurate. Social identity theory suggests that people overestimate the similarity between themselves and members of the 'in-group' and overestimate the differences between themselves and members of the 'out-group' (Cabral & Smith, 2011; Marks & Miller, 1987; Tajfel et al., 1979). In fact, it has been suggested that because areas of disagreement are not as frequently discussed, people are likely to assume that their friends are more like them then they truly are (Huckfeldt & Sprague, 1995; Jussim & Osgood, 1989; McPherson et al., 2001).

There is extensive evidence from the occupational literature suggesting that recruiters can be influenced by characteristics of the candidate that are unrelated to the requirements of the position, such as tastes, experiences, hobbies and interests (Lareau & Weininger, 2003; Rivera, 2012; Wimmer & Lewis, 2010). In turn, this could unconsciously affect how the candidate is then rated (Cable & Judge, 1997; Huffcutt, 2011; Posthuma et al., 2002; Raza & Carpenter, 1987). That is to say that, recruiters tend to rate candidates they perceive to have more similar characteristics to themselves more favourably than candidates perceived to be dissimilar (Graves & Powell, 1995; Huffcutt, 2011; McHarg et al., 2007; Rivera, 2012; Segrest Purkiss et al., 2006). Erickson and Schultz (1982) highlight this point by demonstrating that establishing similarity between student interviewees and college counsellor interviewers was crucial for whether students were believed to have potential for future success (Rivera, 2012). Thus, it could be argued that the selection process for DClinPsy training may be unconsciously influenced by an affinity of shortlisters towards applicants they perceive as similar to themselves in some way, which may indicate why there continues to be a lack of diversity in the profession.

The construct of values has been described as an individual's set of beliefs central to their personality that act as guiding principles for future goals which transcend specific situations (Allport, 1961; Feather, 2002; Kluckhohn, 2013; Rohan, 2000; Rokeach, 1973; Schwartz, 1992; Verkasalo et al., 2009). Ten motivationally distinct values have been identified and recognised cross-culturally (Schwartz, 1992). In terms of prioritisation of these ten values, there is a well-established pan-cultural baseline with Benevolence, Self-direction, and Universalism as most important, Power, Tradition and Stimulation as least important and Security, Conformity and Achievement in the middle (Schwartz & Bardi, 2001a). To our knowledge, the prioritisation of values among Clinical Psychologists in the UK has not been formally studied, but been mentioned previously (Bajwa, 2020). In relevance to the topic at hand, we may also consider how ratings of personal values in this sample of British Clinical Psychologists compare against pan-cultural norms.

Another important construct to note is ethnic identity. Ethnic identity refers to a part of an individual's self-concept constructed by their awareness of membership to an ethnic group and the emotional significance and value attached to that membership (Kim & Gelfand, 2003; Phinney, 1992). In line with the homophily principle described above, there is evidence that individuals scoring higher on ethnic identity have greater psychological closeness to (Brookins et al., 1996; Kim & Gelfand, 2003) and hold more positive views of their ethnic group (Kim & Gelfand, 2003; Phinney, 1996a). Ethnic identity is a useful psychological construct in explaining individuals' perceptions and intentions during the recruitment process (S. S. Kim & Gelfand, 2003). Although studies on the effect of ethnic similarity on interview ratings have been conducted (Lin et al., 1992; McFarland et al., 2000; Prewett-Livingston et al., 1996; Segrest Purkiss et al., 2006), an individual's membership with an ethnic group does not guarantee an alignment of beliefs, attitudes, or principles associated with that ethnic group. Therefore, it may be more worthwhile to consider the connection to and significance of membership to that ethnic group, rather than simply membership. A study by Kim and Gelfand (2003), on the impact of ethnic identity and recruitment outcomes found that individuals with higher levels of ethnic identity had more positive perceptions of the organisation when recruited with a brochure that included a diversity initiative, when compared to a brochure that did not. These findings suggest that individuals scoring higher on ethnic identity, regardless of ethnicity, tended to value diversity which in turn predicted positive reactions to initiatives that align with these values. Likewise, individuals scoring lower on ethnic identity were less likely to notice or encode diversity initiatives.

Applying these ideas to Clinical Psychology, it could be that Clinical Psychologists scoring higher in ethnic identity may unconsciously hold applicants of a similar ethnic group in higher regard than those from a dissimilar ethnic group or that shortlisters with lower levels of ethnic identity, may not notice and therefore consider an applicant's expression of values aligned with ethnicity or diversity.

To sum, the ideas from theories around similarity-attraction theory and the homophily principle may shed light on some unconscious cognitive processes that might be involved in decision

making in the DClinPsy recruitment process. For example, perhaps this natural and unconscious affinity towards values, experiences or expressions of ideas similar to our own, coupled with the lack of ethnic diversity in the profession, has some impact on the selection processes and therefore might help explain why Clinical Psychology continues to reproduce itself.

2.2.6 The current study

Using a large sample of Clinical Psychologists from across the UK, this study sought to better understand if ethnic status, ethnic identity, and personal values play a role in the shortlisting process of DClinPsy applicants. Two groups of Clinical Psychologists were recruited (BME and non-BME). Employing an experimental methodology, participants were asked to blindly rate application forms while the ethnic status of the applicants were manipulated.

Through seeking judgements from Clinical Psychologists, we aim to build on the work by Wright (2008) though a notable difference of our study is that we are not looking at predictors of success among applicants, but rather possible predictors of favourable judgements among potential shortlisters, namely, ethnic status, ethnic identity, and personal values. We felt it was important to capture the views of potential shortlisters as to what makes better or worse answers to personal statement questions, and whether cultural attributes of shortlisters have any bearing on how applicants are rated. As noted by others, addressing the lack of ethnic diversity in the profession requires effort and commitment from those involved in recruitment of future practitioners (Farsimadan et al., 2007; Whitehead et al., 1999).

To our knowledge, this study is the first of its kind since there are no experimental studies on this topic that examine ratings of personal statements using a large sample of Clinical Psychologists. Conducting this type of work could hopefully provide new ideas into how the selection process for Clinical Psychology could continue to improve to achieve equitable access into the profession for people from BME backgrounds.

Research questions

This study will seek to answer the following questions:

1a. Do Clinical Psychologists from BME and non-BME backgrounds rate personal statements from applicants differently?

1b. Are BME and non-BME applicants rated significantly differently?

2. Is there a relationship between participants’ level of Ethnic Identity and how BME and non-BME applicants are rated?

3. Do Clinical Psychologists from BME and non-BME backgrounds differ statistically in the values they align with?

2.3 Methods

2.3.1 Design

The current study employed a within-subjects experimental design, whereby all participants experienced the same conditions. This was an online study using the survey platform Qualtrics XM. The study was cross-sectional in nature since data was collected at one point in time, and participants were not followed up.

2.3.2 Participants

An a priori power analysis was conducted on a two-tailed t-test between two groups with a medium effect size (d=0.5), alpha level of 0.05 and 80% power, to determine the minimum number of participants required for this study. Since there is no published data available to provide a precise estimate of effect size, guidelines from Cohen (1988) were followed and a medium effect size was estimated (Perugini et al., 2018). The power analysis was based on research question 1, since it yielded the largest required sample size (n=128).

2.3.3 Inclusion criteria

The inclusion criteria were qualified Clinical Psychologists working anywhere in the UK, who had not applied for the Clinical training course at Royal Holloway University of London (RHUL) in the year 2017, for 2018 entry. This was to mitigate the small risk of participants reading and rating their own personal statement, since application forms were drawn from that year of entry. Previous experience of involvement on selection panels for DClinPsy training was not required.

The study recruited two groups, BME and non-BME participants with a minimum of 64 in each group. A total of 160 participants completed the study, 67 were of BME backgrounds and 93 of non-BME backgrounds. Participants who selected any of the following ethnic groups were classified as BME: Asian or Asian British, Black or Black British, Mixed or Multiple Ethnic groups or Other. Participants who selected White or White British were classified as non-BME.

2.3.4 Recruitment

The sample was recruited on a voluntary basis between February and April 2022. A poster for the study (Appendix D) was shared via social media and emails directly to Clinical Psychologists in the author and supervisors' professional and extended networks, DClinPsy training courses and organisations, for example, BPS DCP various regional branch committees, GTiCP and Association of Clinical Psychologists UK (ACP-UK).

2.3.5 Consultation process

During the study development phase, four qualified Clinical Psychologists working in the field were consulted for feedback on the study materials. Suggestions were then discussed with the project supervisors and incorporated into the study, where possible. Responses from the consultation process can be found in Appendix F.

2.3.6 Materials and measures

***DClinPsy personal statements**:* The personal statement portions of real application forms for the Royal Holloway Doctorate in Clinical Psychology were extracted for use in this study. Of the 927 application forms submitted to the Royal Holloway course for 2018 entry (Clearing House for Postgraduate Courses in Clinical Psychology, 2018), four were randomly selected. Firstly, the datafile containing all applications that had given consent for the course they have applied to use their data for research purposes that year was downloaded via the Clearing House for Postgraduate Courses in Clinical Psychology (CHPCCP) by a member of the Royal Holloway course admin staff. The project supervisor (OL) then looked at the actual ratings that these applications received, data which was held by the course admissions team. These applications were ordered by numerical ranking and separated by ethnic status (BME or not BME). OL then selected four applications, based on the application ID number. Two of these received higher rankings (one BME and one non-BME), and the other two received lower

rankings (also one BME and one non-BME). OL then obtained the full application form of these four applicants, extracting only the personal statements. The personal statements were reviewed by OL and any personal identifiable information, including any references to the ethnicity of the applicant, were redacted before being sent to the lead author for inclusion in this study. The ethnic status of the applicant was determined via the data provided in the equal opportunities monitoring part of the application form.

Applications were drawn from the 2018 year of entry (applicants applied in Autumn of 2017) because prior to this, applicants were not asked for consent to share equal opportunities monitoring data with course centres. Applications were not drawn from following years to limit the small risk of the lead author, a current trainee of the Royal Holloway course, identifying the applicant. Drawing applications with the highest and lowest rankings was done to ensure there was a range of quality of the application form as agreed by independent raters (shortlisters for the Royal Holloway course). Selecting two applicants that identified as BME and two that did not was intentional so that research question 1b could be tested.

Rating of applications: A rating form (Appendix I) was developed based on the rating scale and guidance notes used for selection procedures from the UCL Clinical Psychology training course; the scale was further refined upon feedback from the consultation process. The final version of the scale asked participants to rate the suitability of each applicant on seven domains: Values Based Recruitment, Coherent understanding of Clinical Psychology principles, training and practice, Evidence of thoughtfulness and reflection, Realism (e.g., appropriate expectations, motivations, self-awareness), Writing style, Research capacity, Capacity for leadership. The rating form used a five-point Likert scale ranging from ‘Exceptional’ (5) to ‘Unsure/Unable to Rate’ (0). If the latter option was selected, participants were prompted to provide a brief explanation. The minimum each applicant could score was 0, and the maximum was 35. Following the research paradigm by Segrest Purkiss and colleagues (2006), participants were also asked three follow up questions after reviewing each

application: ‘*Would you consider inviting this candidate to interview?*’, ‘*Would you be satisfied if this candidate were to work clinically with a member of your family/friends?*’, ‘*Would you say this candidate identifies as belonging to an ethnically minoritised group*? Participants were asked to respond Yes or No and/or provide further details.

Ethnic identity: Phinney’s Multigroup Ethnic Identity Measure - Revised (MEIM-R; (Phinney & Ong, 2007) was used to capture ethnic identity (Appendix J). The MEIM-R is a brief instrument used to measure an individual’s affiliation to their ethnic group. The tool comprises of two constructs: exploration and commitment. This instrument has demonstrated good internal consistency, typically with Cronbach’s α above .80 (Herrington et al., 2016; Phinney & Ong, 2007; Yoon, 2011), and has been validated across diverse racial and ethnic groups (C. A. Brown, 2001; Chakawa et al., 2015; Herrington et al., 2016; Phinney & Ong, 2007).

Personal values: The Short Schwartz Values Survey was used to capture personal values (SSVS; Lindeman & Verkasalo, 2005; Appendix K). The SSVS is a 10-item instrument developed on the basis of the theory of human values (Schwartz & Bilsky, 1987). The SSVS has been used to explain attitudes and behaviours across many countries (Schwartz & Bardi, 2001a). Schwartz (1992) proposed ten distinct ‘universal’ value concepts (Power, Achievement, Hedonism, Stimulation, Self-Direction, Universalism, Benevolence, Tradition, Conformity and Security), that can be organised into two main domains: Conservation versus Openness to Change and Self-Transcendence versus Self-enhancement. The reliability and validity of the 10-item scale has been demonstrated empirically in Lindeman & Verkasalo (2005). A hierarchy of these 10 values across different nations have been reported, allowing for comparison of value prioritisation against a set of pan-cultural norms (Schwartz & Bardi, 2001b).

2.3.7 Procedure

Participants were invited to take part in the study by clicking on a weblink or scanning a QR code, which linked to the information sheet, online consent form and study materials. Each participant was assigned a unique and random three-digit identifier, which was displayed at the end of participation. Figure 1 shows the flow of participants through the study.

Participants were first required to confirm that they meet the inclusion criteria. Conditions were set so that if participants did not meet the inclusion criteria, they were not able to proceed with participation in the study. For instance, participants were asked "Are you a qualified Clinical Psychologist?". If "No" was selected for this question, the participant was diverted to the end of the survey. The Qualtrics platform records participants' IP address and responses, ensuring that anyone who did not meet the inclusion criteria could not simply refresh the page and try again. Participants were made aware of why they were not eligible to take part and were given details to contact the lead researcher if an error was made.

After confirming eligibility, participants were asked questions relating to their demographics and experience as a Clinical Psychologist. Next, participants were presented with four personal statements from the DClinPsy application forms in a random order. Participants were instructed to read the personal statements carefully as they will be required to rate their suitability for clinical training. After each personal statement, participants were asked to rate the applicant on the various areas of aptitude and three follow up questions described above. The personal statements were presented to each participant in a random order to counterbalance any potential order effects (Reis, 2000; Sternberg & Sternberg, 2010). Finally, participants completed the MEIM-R and the SSVS.

2.3.8 Data Analysis

Data was analysed using STATA 17. All data was assessed for normality distributions, skew and kurtosis. Applications 1 and 4 belonged to candidates who identified as BME and were coded as

such, likewise applications 3 and 4 were coded as non-BME. The data was also explored for missing data and extreme data points were verified. Variables were coded depending on the scale of measurement. Normality of the data was checked and parametric tests were carried out where assumptions were met, but when they were not met, non-parametric tests were used instead.

For research question 1a, an independent t-test was run with the ethnic status of the participant (BME or not-BME) as the independent variable and the mean rating of all application forms as the dependent variable. A paired t-test was run to test research question 1b, with the "condition" of either BME or non-BME application forms as the independent variable and the mean rating of application forms in those conditions as dependent variables. To test research question 2, linear regression models were run with different covariates to establish which variables increase the r^2 of the model. Variables that improved the model were included as covariates in the regression analyses. Two linear regressions were carried out, controlling for age, gender and ethnic status, both with MEIM-R score as the independent variable and either mean ratings of BME applications or mean ratings of non-BME applications as the dependent variables. Dummy variables were generated for categorical data. Finally, Mann-Whitney *U* tests were run to test research question 3, examining the difference between BME and non-BME participants and scoring of each value item of the SSVS. Bonferroni correction was applied to control for the familywise error rate.

2.3.9 Ethics

This study received approval from the Research Ethics Committee of Royal Holloway, University of London via the Self Certification route on 4 October 2021 (ID 2675). See Appendix E for ethical approval confirmation letter.

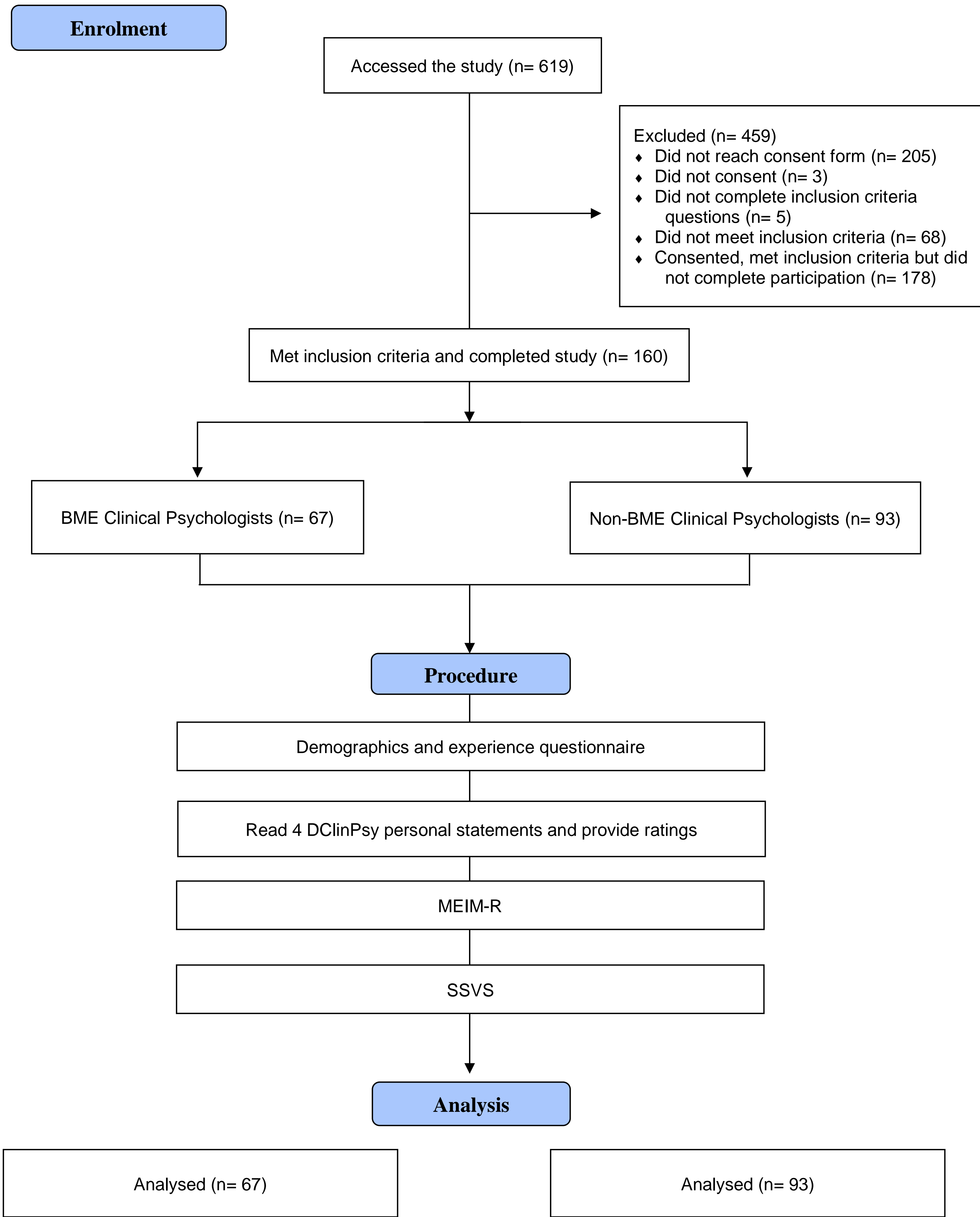

Figure 1. *Participant flow diagram.*

2.4 Results

Descriptive statistics

One hundred and sixty participants took part in the study. The data relating to demographics and experience of the sample is presented in Table 1. Across the whole sample, 58% (n=93) were White or White British and 86% (n=137) were female. Additionally, the majority were in the age bracket of 35-44. Most participants had been qualified for between 1-5 or 6-10 years (27.6% and 28.1%, respectively). Within the sample, 81% had supervised at least one Trainee Clinical Psychologist and 61% of participants had written references for DClinPsy applications, with over half having written less than 5. Of those who said they had written references, 38% estimated that none of the applicants were of BME backgrounds. Less than half of the sample (44%) had experience of being part of selection panel for DClinPsy training courses. Within the BME group, roughly half (52%) identified as belonging to an Asian or Asian British background. There was a greater proportion of females in the BME group compared to the non-BME group (91% vs 82%, respectively), though this was not statistically significant ($\chi2(2) = 3.043$, $p = 0.218$). The BME group were significantly younger than the non-BME group ($\chi2(3) = 10.713$, $p = 0.013$). The non-BME group had written a greater number of DClinPsy references ($\chi2(2) = 10.607$, $p = 0.005$) and a greater number of references for BME applicants ($\chi2(4) = 10.650$, $p = 0.031$) than the BME group.

Table 1. Sample characteristics

	Whole sample (n = 160)		BME group (n = 67)		Non-BME group (n = 93)			
	Number	%	Number	%	Number	%	$\chi2$	p
Demographics								
Ethnic group								
Asian or Asian British	35	21.9	35	52.2				
Other ethnic group	6	3.8	6	9				
White or White British	93	58.1	0	0	93	100		
Mixed or Multiple Ethnic groups	18	11.3	18	26.9				
Black or Black British	8	5	8	11.9				
Gender identity								
Male	22	13.8	6	9	16	17.2		
Female	137	85.7	61	91	76	81.7	3.043	0.218
Prefer not to say	1	0.6	0	0	1	1.1		
Age bracket								
25 – 34	50	31.3	29	43.3	21	22.6		
35 – 44	66	41.3	27	40.3	39	41.5	10.713	0.013*
45 – 54	38	23.8	10	14.9	28	30.1		
55 – 74[a]	6	4	1	1.5	5	5.4		
Experience								
Years qualified								
<1 year	13	8.1	7	10.5	6	6.5		
1 – 5	44	27.6	24	35.8	20	21.5		
6 – 10	45	28.1	18	26.9	27	29	8.487	0.131
11 – 15	18	11.3	8	11.9	10	10.8		
16 – 20	19	11.9	5	7.5	14	15.1		
21+	21	13.1	5	7.5	16	17.2		
Number of Trainee Clinical Psychologists supervised								
None	31	19.4	15	22.3	16	17.2		
5 or less	59	36.9	29	43.3	30	32.3		
6 – 10	30	18.8	12	17.9	18	19.4	5.582	0.233
10+	39	24.4	11	16.4	28	30.1		
Don't know	1	0.6	0	0	1	1.1		
Have written references for DClinPsy applications	98	61.3	40	59.7	58	62.4	0.117	0.733
How many references written								

Less than 5	52	53.1	29	73	23	39.7		
5 – 10	34	34.7	9	22.3	25	43.1	10.607	0.005**
More than 10	12	12.2	2	5	10	17.2		
Roughly how many of these references were for BME applicants?								
None	37	37.8	15	37.5	22	37.9		
Some	25	25.5	5	12.5	20	34.5		
About half	24	24.5	12	30	12	20.7	10.650	0.031*
Most	1	1			1	1.7		
All	11	11.2	8	20	3	5.2		
Have been part of selection panels for DClinPsy courses	71	44.4	31	46.3	40	43	0.168	0.682

[a] Categories collapsed due to small numbers
Pearson $\chi 2$ calculated for differences between BME and non-BME groups, *p<0.05 **p<0.01 ***p<0.001

Outcome data

Using the rating form, the minimum possible score for each applicant was 0 and the maximum was 35. The mean total score for all four application forms combined was 95.6 of a possible 140 (Table 2). Participants in both groups rated Applicant 2 the lowest out of all applications. The mean score on the MEIM-R was 17.2, with the BME group scoring higher (mean = 19.3, SD = 4) than the non-BME group (mean = 15.7, SD = 3.4). This difference was statistically significant ($t(158) = 6.21$, $p < 0.001$, 95% CI: 2.45 – 4.74). Participants in the BME group rated value items Power, Achievement, Self-direction, Tradition, Conformity and Security slightly higher than the non-BME group. Results of significance tests are presented in Table 7.

Table 2. Outcome data

	Total sample (n = 160)		BME group (n = 67)		Non-BME group (n = 93)			
	Mean (SD)	Median (IQR)	Mean (SD)	Median (IQR)	Mean (SD)	Median (IQR)	t	p-value
Application form ratings								
All applications	95.6 (10.3)		95.8 (9.6)		95.4 (10.9)		0.21	0.8304
Applicant 1	25.6 (3.9)		26.2 (3.2)		25.1 (4.2)			
Applicant 2	20.5 (5.0)		20.9 (4.8)		20.2 (5.2)			
Applicant 3	25.2 (3.6		24.8 (3.7)		25.5 (3.6)			
Applicant 4	24.3 (4.8		23.8 (5.1)		24.6 (4.5)			
BME applicants	49.9 (6.3)		50.1 (5.4)		49.7 (6.9)			
non-BME applicants	45.7 (6.3)		45.7 (6.1)		45.7 (6.4)			
MEIM-R	17.2 (4.0)		19.3 (4.0)		15.7 (3.4)		6.21	<0.001
SSVS								
Power	4.3 (1.8)		4.6 (1.8)		4.0 (1.8)			
Achievement		6 (5 – 7)		7 (5 – 8)		6 (5 – 7)		
Hedonism	5.0 (1.7)		5.0 (1.8)		5.0 (1.6)			
Stimulation	5.9 (1.8)		5.9 (2.0)		5.9 (1.7)			
Self-direction		5 (5 – 7)		6 (5 – 7)		5 (4 – 6)		
Universalism		8 (7 – 9)		8 (7 – 9)		8 (7 – 9)		
Benevolence		5 (4 – 6)		5 (4 – 6)		5 (4 – 6)		
Tradition		4 (3 – 6)		5 (4 – 7)		4 (3 – 5)		
Conformity		4 (3 – 5)		5 (3 – 5)		4 (3 – 5)		
Security	5.5 (1.8)		5.8 (1.8)		5.2 (1.7)			

Medians and IQR are reported for non-normally distributed variables

Main results

1a. Do Clinical Psychologists from BME and non-BME backgrounds rate personal statements from applicants differently?

An independent samples t-test was used to compare the mean rating of application forms between BME and non-BME Clinical Psychologists. A Student's t-test was used since the assumption of equal variances was assumed ($F = 0.7874$, $p=0.3059$). There was no evidence of a statistically significant difference in mean rating of application forms between BME and non-BME Clinical Psychologists ($t(159) = 0.21$, $p = 0.8304$, 95% CI: -2.93 – 3.64). This indicates that overall, there were no significant differences in the judgement between both groups.

1b. Are BME and non-BME applicants rated significantly differently?

A paired samples t-test was used to compare participants' ratings of BME applications and non-BME application forms (Table 3). Across the whole sample, a mean difference of 4.13 was observed with BME applications scoring higher than non-BME applications, which was statistically significant ($t(159) = 7.32$, $p<0.001$, 95% CI: 3.02 – 5.25). This result suggests that, on average, BME applications were rated around 4 points higher than the non-BME applications. Two other separate paired t-tests were run, one comparing ratings in the BME group and one comparing ratings in the non-BME group. In both analyses, BME applicants were rated higher than non-BME applicants which was statistically significant. Compared to non-BME participants, it appeared that BME participants rated BME applicants slightly higher (50.07 vs 49.69, respectively), though this was not statistically significant ($t(158) = 0.38$, $p=0.7029$, 95% CI: -1.61 – 2.38).

Table 3. Paired t-tests

	Ratings of BME applications		Ratings of non-BME applications					
	Mean	SD	Mean	SD	Mean diff	t	p	95% CI
Whole sample	49.85	6.29	45.72	6.28	4.13	7.32	<0.001	3.02 – 5.25
BME group (n=67)	50.07	5.43	45.70	6.13	4.37	5.58	<0.001	2.81 – 5.94
Non-BME group (n=93)	49.69	6.88	45.73	6.41	3.96	4.98	<0.001	2.38 – 5.53

Additional analyses

Further analyses were conducted to explore potential differences in ratings between BME and non-BME applicants across the seven domains of aptitude (Table 4). Descriptive statistics revealed that BME applicants were rated higher than non-BME applicants on all of the domains. Paired t-tests showed that all but 'Values based recruitment' were statistically significant. The largest differences were observed for 'Research capacity' and 'Thoughtfulness, reflection and empathy' (1.04 and 0.68, respectively).

Table 4. Paired t-tests

	BME applications		non-BME applications					
	Mean	SD	Mean	SD	Mean diff	t	p	95% CI
Values based recruitment	7.10	1.12	6.89	1.18	0.21	1.87	0.0636	-0.01 – 0.42
Coherent understanding of clinical psychology principles, training and practice	7.44	1.21	6.85	1.12	0.59	5.21	<0.001	0.37 – 0.82
Thoughtfulness, reflection and empathy	7.31	1.19	6.63	1.22	0.68	5.32	<0.001	0.43 – 0.93
Realism	7.03	1.15	6.42	1.22	0.61	5.51	<0.001	0.39 – 0.82
Written communication and writing style	7.29	1.12	6.91	1.34	0.39	3.42	0.008	0.16 – 0.61
Research capacity	7.18	1.36	6.14	1.53	1.04	7.28	<0.001	0.76 – 1.33
Capacity for leadership	6.50	1.40	5.89	1.28	0.61	5.57	<0.001	0.40 – 0.83

2. Is there a relationship between participants' level of Ethnic Identity and how BME and non-BME applicants are rated?

To test this research question, two separate multiple regressions were run with age, gender and ethnic status of participant as covariates. These covariates were chosen on the basis of which variables increased the r^2 and improved the model when included, had a clear rationale for inclusion and what previous research on ethnic identity had included in their models (Kim & Gelfand, 2003).

The first multiple regression examined the potential relationship between participants' level of ethnic identity and mean rating of the BME applications (Table 5). First, a standard linear regression was run without any covariates (Model 1), which did not yield evidence of an association between ethnic identity and BME application ratings ($F(1,158) = 2.94$, $p=0.0881$, 95% CI: -0.032 – 0.455). Inclusion of covariates (Model 2) suggested that age, gender and ethnic status accounted for 13% of the variance in BME application ratings, and this was statistically significant ($R^2 =.128$, adjusted $R^2= .088$; $F(7,152) = 3.19$, $p=0.0035$). The partial regression coefficients showed that ethnic identity was not independently associated with BME application ratings ($t(152) = 1.43$, $p=0.154$) when controlling for age, gender and ethnic status. There was a statistically significant negative association between gender and ratings of BME applications such that participants identifying as male ($B = -3.94$, $\beta = -0.22$, $t(159) = -2.75$, $p =0.007$, 95% CI: -6.78 – 1.11) or selecting 'prefer not to say' ($B = -13.53$, $\beta = -0.17$, $t(159) = -2.21$, $p =0.029$, 95% CI: -25.66 – -1.41) rated BME applications lower than participants identifying as female. This should be interpreted with caution due to the lack of precision demonstrated by wide confidence intervals, possibly owing to the small number of participants in male and 'prefer not to say' categories.

Table 5. Linear regressions for BME applications

	Coefficients (B)	Standard error	Beta	t	p	95% CI
Model 1						
Ethnic identity	0.21	0.12	0.14	1.72	0.088	-0.03 – 0.46
Model 2						
Ethnic identity	0.19	0.14	0.12	1.43	0.154	-0.07 – 0.46

Age*						
35-44	0.75	1.15	0.06	0.66	0.512	-1.51 – 3.02
45-54	-1.62	1.28	-0.11	-1.27	0.206	-4.15 – 0.90
55-74	-0.65	2.61	-0.02	-0.25	0.803	-5.82 – 4.51
Gender*						
Male gender	-3.94	1.44	-0.22	-2.75	0.007	-6.78 – -1.11
Prefer not to say	-13.53	6.14	-0.17	-2.21	0.029	-25.66 – -1.41
Ethnic status*	-1.21	1.11	-0.09	-1.09	0.278	-3.40 – 0.99

*Dummy variables created due to categorical type of data. Indicator variables were as follows: Age = 25 - 34, Gender = female, Ethnic status = BME.

A second linear regression examined the potential relationship between ethnic identity and mean rating of non-BME applications (Table 6). A linear regression without covariates did not demonstrate any evidence of a statistically significant relationship between ethnic identity and ratings of non-BME applications ($F(1,158) = 0.00$, $p=0.9967$, 95% CI: -0.24 – 0.25). A second model including age, gender and ethnic status as covariates also did not yield evidence of a significant relationship between ethnic identity and mean application ratings ($F(7,152) = 0.28$, $p=0.9601$).

Table 6. Linear regressions for non-BME applications

	Coefficients (B)	Standard error	Beta	t	p	95% CI
Model 1						
Ethnic identity	0.00	0.12	0.00	0.00	0.997	-0.24 – 0.25
Model 2						
Ethnic identity	-0.01	0.14	-0.01	-0.09	0.93	-0.30 – 0.27
Age*						
35-44	0.89	1.22	0.07	0.73	0.464	-1.51 – 3.30
45-54	0.79	1.36	0.05	0.58	0.563	-1.89 – 3.47
55-74	-0.67	2.77	-0.02	-0.24	0.809	-6.15 – 4.81
Gender*						
Male gender	-0.02	1.52	0.00	-0.01	0.988	-3.03 – 2.99
Prefer not to say	-7.24	6.51	-0.09	-1.11	0.268	-20.11 – 5.62
Ethnic status*	-0.16	1.18	-0.01	-0.13	0.895	-2.48 – 2.17

*Dummy variables created due to categorical type of data. Indicator variables were as follows: Age = 25 - 34, Gender = female, Ethnic status = BME.

3. Do Clinical Psychologists from BME and non-BME backgrounds differ statistically in the values they align with?

After checking normal distributions of the data, some of the value items did not meet the assumptions for parametric testing. Accordingly, Mann Whitney *U* tests were run to test whether there were any statistically significant differences in median ratings on each of the value items between the BME and non-BME groups (Table 7). Participants in the BME group rated value items Power, Achievement, Tradition and Security significantly higher than the non-BME group. This finding appears to suggest that these values were more important to BME Clinical Psychologists than non-BME Clinical Psychologists in this study. After a Bonferroni correction was calculated and applied due to multiple comparisons, only Tradition and Security remained significant at the new alpha level of 0.005 (adjusting for 10 comparisons). A comparison table of value hierarches of this sample against pan-cultural norms can be found in Appendix M, Table M2.

Table 7. Mann-Whitney *U* tests of Value items of SSVS

	BME group (n = 67)		Non-BME group (n = 93)			
Value item	Mean (SD)	Median (IQR)	Mean (SD)	Median (IQR)	z	p
Power	4.6 (1.8)		4.0 (1.8)		2.111	0.0347*
Achievement		7 (5 – 8)		6 (5 – 7)	2.299	0.0215*
Hedonism	5.0 (1.8)		5.0 (1.6)		0.124	0.9016
Stimulation	5.9 (2.0)		5.9 (1.7)		-0.118	0.9063
Self-direction		6 (5 – 7)		5 (4 – 6)	0.871	0.3839
Universalism		8 (7 – 9)		8 (7 – 9)	-0.180	0.8569
Benevolence		5 (4 – 6)		5 (4 – 6)	0.171	0.8640
Tradition		5 (4 – 7)		4 (3 – 5)	3.250	0.0012*†
Conformity		5 (3 – 5)		4 (3 – 5)	1.118	0.2637
Security	5.8 (1.8)		5.2 (1.7)		2.434	0.0149*†

*significant at α level = 0.05
† significant at corrected α level = 0.005

2.5 Discussion

This is the first experimental study to examine whether cultural factors such as ethnicity, ethnic identity and personal values play a part in the recruitment of future Clinical Psychologists in the UK. A summary of the main findings will now be discussed with reference to relevant literature.

With regards to our first research question (1a), we found no evidence of a statistical difference between BME and non-BME Clinical Psychologists in mean rating of application forms in this sample. This finding may suggest that the ethnic status (whether from a BME background or not) of potential shortlisters for Clinical Psychology training may not have an impact overall on how candidates' personal statements are rated, when blind to the data. Alternatively, it could also be that the process of some BME individuals to modify or conceal parts of their identities in order to fit in with predominantly White groups (Kinouani et al., 2016), occurring over a period of time, may have encouraged uniformity between BME and non-BME Clinical Psychologists. Concerning research question 1b, we found that across the whole sample, BME applicants were rated significantly higher than non-BME applicants. This was also the case when examining BME and non-BME groups separately. This is of particular interest given the context that fewer BME candidates meet the minimum entry criteria for Clinical Psychology training (Scior et al., 2007), but those that do may be exceptionally good candidates. This begs the question, would personal statements of BME applicants that do *not* meet the minimum entry criteria still outperform those from non-BME backgrounds? Further analyses revealed that BME applicants were rated significantly higher than non-BME applicants on all domains except for 'Values based recruitment'. These findings stand in contrast to previous research suggesting that Black applicants tend to demonstrate less reflectiveness and understanding of Clinical Psychology in their applications (Wright, 2008). Specifically, our findings highlighted 'Thoughtfulness, reflection and empathy' as one of the strongest areas where BME applicants outperformed non-BME applicants. Moreover, of all the domains, BME applicants were rated highest on 'Coherent understanding of clinical psychology principles, training and practice'. It is

worth mentioning that the data from Wright's study (2008) was from 2006, and the differences observed in the current study may be, at least in part, due to the proliferation of mentoring schemes for applicants from BME backgrounds, as well as more focussed attention on the need to improve skills in reflection and understanding of Clinical Psychology. Indeed, the narrative that the lack of ethnic diversity in Clinical Psychology is perhaps owing to ethnically minoritised applicants being less able to effectively reflect on their experiences, is one that has been noted to underpin attempts by the profession to improve diversity (Paulraj, 2016).

Results for research question 2 did not yield evidence of a statistically significant relationship between ethnic identity and mean application form ratings for BME or non-BME applicants in this sample. Nonetheless, a second model which included age, gender, ethnic status in addition to ethnic identity was observed to account for 13% of the variance in BME application ratings. This suggests that these variables combined may partially impact how BME applications are rated, though it is unclear in what way. Previous research has suggested that individuals higher on ethnic identity are more likely to be attracted to organisations that explicitly state that they value diversity (Kim & Gelfand, 2003). In line with this research, we might expect that Clinical Psychologists that score higher on ethnic identity may be more drawn towards applicants that reflect on the value of diversity in their application, though this was not tested in this study. Although the BME group scored significantly higher than the non-BME group on the MEIM-R, we did not find robust support for the notion that those scoring higher on a measure of ethnic identity hold more positive views of their ethnic group as suggested previously (Kim & Gelfand, 2003; Phinney, 1996). Namely, we did not observe that BME participants rated BME applicants significantly higher than non-BME participants, nor was there a greater likelihood of BME participants saying they would invite both BME candidates to an interview, compared to non-BME participants. It is worth nothing that participants were blinded to the applicants' ethnicity, which begs the question, would it have made a difference had participants known the ethnicity of the applicants?

The final research question sought to examine differences in values between BME and non-BME Clinical Psychologists. The results showed that BME Clinical Psychologists rated 'Power' (social power, authority, wealth), 'Achievement' (success, capability, ambition, influence on people and events), 'Tradition' (respect for tradition, humbleness, accepting one's portion in life, devotion, modesty) and 'Security' (national security, family security, social order, cleanliness, reciprocation of favours) value items significantly higher than non-BME Clinical Psychologists. After Bonferroni corrections were applied, only 'Tradition' and 'Security' remained significant. Acknowledging the existence of within-group differences (Kim, 2010), there is evidence to support cultural differences concerning values, beliefs and attitudes. For example, important values amongst some Asian cultures include collectivism, conformity to norms and family recognition through achievement (Iwamoto & Liu, 2010; Kim et al., 1999), while cross-cultural differences in values have also been noted between West Germany, North America and Norway (Grunert & Scherlorn, 1990). Therefore, some differences in value prioritisation are to be expected within our sample also. It remains unclear however, whether these differences in value prioritisation have any bearing on which values potential shortlisters are looking out for in applicants' personal statements. Since there were little or no differences in how BME and non-BME participants rated all applications or BME and non-BME applicants separately, it seems that differences in values may not have influenced ratings of applicants, though this was not formally tested in our study. In a study of female Trainee Clinical Psychologists' attractors to the profession, one key narrative was the rejection of power and status as attractors and the endorsement of the rewarding experience of making a difference (Baker & Nash, 2013). Contextualising this with the ratings of value items by the whole sample in this study, 'Power' was expectedly one of the least important of all the value items, however, 'Benevolence' was rated lower than would be expected, given the findings from Baker & Nash's study. Although this is the first study to explore differences in these 10 distinct values among Clinical Psychologists in the UK, comparing the sample in this study to pan-cultural norms, largely similar ratings of 'Security', 'Tradition', 'Power' and 'Universalism' were observed. Notable differences included our sample rating 'Achievement' and 'Stimulation' as more important and 'Benevolence' and 'Conformity' as less important than the pan-cultural norms described earlier (Schwartz & Bardi, 2001b).

Strengths and limitations

The limitations of this study should be acknowledged on balance with the strengths. Firstly, the methodology for determining suitability for Clinical Psychology training is notably crude. Although the rating form was developed based on guidelines for an existing training course, it is not representative of all Clinical Psychology training courses in the UK, which all vary in their specific selection processes. For example, some courses may place greater weighting on clinical references, academic attainment, or research experience than other courses. By conducting a consultation process, we attempted to invite different ideas to ensure the rating form captured an array of important qualities to consider when selecting future Clinical Psychologists, though this was not validated. The supplementary questions were also included as a means of validating the ratings given to applicants. For example, we would expect similarities between proportions of participants who would invite each applicant to interview and application ratings, which was demonstrated in our study. Participants only reviewed the personal statement portion of the application form, which indeed does not reflect the selection process for all Clinical Psychology training courses. Indeed, the findings of this study are not generalisable to training courses that place little or no weight on personal statements. We may not know whether and to what extent references or academic information may have influenced participants' responses in this study, had they also been presented. However, it was decided to present personal statements in isolation in attempt to control for factors suggested to predict shortlisting such as academic attainment, attending 'older' universities, and positive ratings from references (Phillips et al., 2004; Turpin & Coleman, 2010a). In our methodology, we attempted to simulate the real-world selection process as much as was possible, providing some ecological validity, though we must also acknowledge the small number of personal statements selected from one round of applications to one training course cannot reflect the wider pool of applications submitted to the Clearing House each year. Nonetheless, no other studies on this topic have ventured to examine personal statements, therefore this study adds to the body of research in this area and provides a foundation for future research to build on.

Another limitation of this study is the voluntary sample which may have led to selection bias. The study was open to Clinical Psychologists across the country to minimise this risk of bias as much as possible. Indeed, of those participants who were or had been involved in selection for any of the training courses, there was representation in our sample from 22 of the 32 training courses in the UK. It is possible that people with a vested interest or an active role in improving 'diversity' in Clinical Psychology were more likely to take part, which could have influenced the findings. There were also significant differences between the BME and non-BME groups which may have confounded the findings. The response rate is uncertain due to the study taking place online and open to all who met the inclusion criteria rather than participants individually invited to take part. There was also significant attrition with 178 individuals consenting to take part and met the inclusion criteria but did not complete the study. Notwithstanding, we consider the recruitment of a sample size that exceeded the number generated by a priori power analyses a particular strength of this study.

By blinding participants to the ethnicity of the applicants, we hoped to mitigate any potential social desirability effects. It must be noted that findings from the supplementary questions revealed that some participants correctly identified which applications belonged to applicants identifying as BME and which did not, which may have biased the findings. This may have occurred due to participants being aware of this study focusing on ethnicity in selection procedures for DClinPsy. It may also be due to practice effects since participants were presented each personal statement and then asked the supplementary questions in turn. In this way, it could be that after reading the first personal statement, participants were primed to pay close attention to ethnicity while reading subsequent personal statements in anticipation of the supplementary question relating to ethnicity of the applicant. This was considered as a potential limitation in the design stage of the study; however, an appropriate solution was not reached within the timeframe for this project.

A further point to consider relates to the applications included in this study. In order to attempt to control for quality of the personal statements, two of the four applications were ones that

had received higher rankings and two received lower rankings by shortlisters for the Royal Holloway course. These rankings centred on selection guidelines for Royal Holloway University of London in that year. Indeed, these guidelines are not objective or validated, and do not necessarily reflect whether an application would be shortlisted for any other training course and are therefore not a true reflection of application quality. Moreover, the rankings were not based on the personal statement alone but the whole application form. We acknowledge that this method is unreliable and may have also confounded the findings however it was decided as the closest means of attempting to control for quality of personal statements. Nonetheless, all applications were blindly chosen at random in order to minimise bias and maximise validity, since neither the project supervisor nor the lead author saw the personal statements until after they had been selected. One might suggest that including more applications may have improved the variance in ratings, however, the decision to cap the number of applications at four was balanced against the time taken to read and rate each application and the risk of overburdening participants.

Participants in this study were grouped based on ethnic status (BME or not) instead of specific ethnic groups. Although, grouping by ethnicity might have allowed us to explore differences in ethnicity and its impact on application ratings, this was not possible due to small numbers in ethnic groups. Additionally, as others have critiqued, ethnicity is complex, multidimensional and socially constructed, which can have different meanings in different contexts (Erdur et al., 2003; Phinney, 1996b). It would seem that categorising participants by ethnic status, as observed by the researcher, imposes labels that can be considered divisive or 'othering'. However, it has been suggested that for the purpose of research this method may be more accurate than self-classification by participants. This is because the latter relates to how participants see themselves, rather than how others perceive them (Hicks & Butler, 2020; Telles & Lim, 1998). Keeping in mind the limitations of categorising by ethnic status it is a method that has been applied in previous research in this area (Odusanya, 2016; Ragavan, 2018; Scior et al., 2007; Shah, 2010). Notably, the findings relating to the BME group may not be fully representative of people from all BME backgrounds, especially since over half the participants in the BME group were of "Asian or Asian British" background.

Implications and future research

The findings from this study support the need for further research exploring barriers to Clinical Psychology training for BME applicants. In this study, BME applicants significantly outperformed non-BME applicants on overall ratings of personal statements and on almost all domains. It is worth keeping in mind that personal statements form one, yet significant, part of the total application. If this phenomenon truly occurs naturalistically, but BME applicants are not meeting the minimum entry criteria, then there is a risk of turning away potentially suitable candidates for Clinical Psychology training. As a professional body, we may reflect on what effect this might have on our profession and indeed, the clients we serve. Moreover, the findings from this study may be useful for those involved in reviewing selection criteria and processes for DClinPsy training, especially those actively working towards equitable access for people from ethnically minoritised backgrounds.

It was also observed that for three of the four applications, many participants correctly identified the ethnic status of the candidate, even though participants were blinded. Given that participants in our study were given less information about the applicant than in the usual selection process, one may wonder if there are nuanced cues within the personal statements that may indicate the applicant's ethnic identity. If so, it begs the question of whether blinding selectors is even having its intended effect. Perhaps consideration of alternative ways to improve equity in the selection process is needed. One idea for further research could be to replicate this study in another sample, with a blind and unblind group to test if knowledge of the applicants' ethnicity makes a difference to ratings. To our knowledge, some courses have started to remove ethnic identifiers from application forms, though the effect of this it is not yet known. Additionally, some courses play videos involving trainees being interviewed about bias to the selectors, though again it is unclear whether this truly mitigates risk of bias.

Our study also found that a combination of variables such as age, gender, ethnic status and ethnic identity may account for some variability in how BME applicants are rated, though further research is needed to determine in what way. Future research could explore whether a relationship exists between ethnic identity and applications that reflect more on the value of diversity in the profession. At present, demographic data on individuals involved in the shortlisting stages is not always gathered or made public. This would be a useful, not only for transparency and accountability but also as a first step to better understand how selector-related variables might influence acceptance rates.

Future research could explore whether the same results in this study would be seen if the whole application was presented, or at least if the application was divided into a two-stage process, with personal statements presented separately at a different time. It might also be fruitful to examine personal statements of BME candidates that did not meet minimum entry criteria to establish if these findings still hold. It would also be useful to further explore whether, and how much, endorsement of value items by Clinical Psychologists are connected to ratings of applications. Further, it would be interesting to explore differences in ratings between applications that make specific reference to diversity in the profession compared to those that don't. There is great potential to explore this topic in depth using qualitative methods. Some ideas include interviewing BME and non-BME Clinical Psychologists to see if views about what makes a suitable candidate for clinical training are thematically different, or a content analysis of BME and non-BME personal statements to explore potential differences in how they are written.

Conclusion

This study using a large sample of Clinical Psychologists is the first to explore whether and to what extent cultural factors related to potential shortlisters such as ethnic status, ethnic identity and personal values have an impact on how applicants' personal statements are rated. The rationale for conducting this research was underpinned by the lack of ethnic diversity in the workforce and the

disparity of acceptance rates to Clinical Psychology training between BME and non-BME applicants. Despite the shortcomings which have been acknowledged, this study showed when looking at blind personal statements, BME applicants have the potential to outperform non-BME applicants, though ethnic status (whether BME or not) did not seem to have an impact on application ratings. Moreover, participants' level of ethnic identity also seemed to have little or no impact on application ratings. There were differences in prioritisation of values between BME and non-BME Clinical Psychologists, which could be further explored. This study is the first of its kind and provides possible springboards for future research. The findings may also highlight future directions towards improving equity of access to Clinical Psychology training for people from BME backgrounds.

Chapter 3: Integration, impact and dissemination plan

Integration

This thesis comprised of two interrelated chapters, linked by ideas from theories on social connection. The systematic review aimed to explore the impact of ethnic matching on service users' experiences of mental health services. The review highlighted the importance of commonality between clinician and service user based on values, beliefs and worldview on outcomes such as treatment satisfaction, and that level of ethnic identity also plays a role. This provided a rationale for the empirical paper, which used an experimental design to explore how ethnic status, ethnic identity and personal values might influence the recruitment of future Clinical Psychologists.

The project was developed in line with the theoretical perspective that similarity breeds connection (Byrne, 1971) and that this connection bonds people together. In the review, it was observed that ethnic matching between clinician and service user likely has less of an impact on outcomes such as attendance rate, but more so on treatment satisfaction. More research is needed to establish the effect of ethnic matching on working alliance, which is a crucial marker of the therapeutic relationship. Also, the review concluded that there may be individual differences, such as level of ethnic identity, that make ethnic matching significant for some but not others. In the empirical paper, although I did not find that BME Clinical Psychologists rated BME applications higher than non-BME applicants, BME Clinical Psychologists said they were more likely to invite a BME applicant to interview and likewise for non-BME Clinical Psychologists with a non-BME applicant. While we cannot confidently conclude the presence of similarity-attraction due to blinding of the applications, a large proportion of participants correctly identified the ethnic status (BME or not) of these two applicants, perhaps suggesting similarity-attraction at an unconscious level.

Both parts sought to better understand the effect of ethnic similarity, though the review focussed on the relationship between clinician and service user, while the empirical paper focussed on the relationship between shortlisters for and applicants to Clinical Psychology training. Likewise, both parts were underpinned by the lack of ethnic diversity of clinicians in mental health services, but more

specifically Clinical Psychology for the empirical paper. Integrating the findings from both the systematic review and empirical paper suggested that similarity-attraction theory not only has some role in the service users' experience of services, but also at a wider systemic level, though more research in these areas is needed. The conclusions drawn from both parts should be interpreted with caution due to the limited number of studies included in the review and the methodological considerations of the empirical paper.

Recruitment

With regards to the recruitment for the study, the final number recruited was a particular strength, perhaps owing to the interest in the Clinical Psychology community to diversify the profession. Indeed, when disseminating invitations to participate in this research, more people keen to take part than I had initially expected. On the other hand, there were also some who did not respond or did not have the capacity to take part at that time. At first, I was hesitant to share my recruitment poster on social media, as I was concerned about the risk of people not meeting the inclusion criteria taking part. However, after discussing this in supervision, I adjusted the survey to block individuals from taking part if they did not meet the inclusion criteria. I was also selective of where I posted my recruitment poster, for example in closed Facebook groups for Clinical Psychologists in the UK. On reflection, I am happy with this decision because I feel that sharing on social media greatly boosted my recruitment. I did observe that there was an over representation of Asian or Asian British ethnicity within the BME group, and wondered if this might reflect data suggesting that Asian or Asian British make up the largest proportion of BME Clinical Psychologists in England (Longwill, 2015). This might also be a consequence of the fact that individuals from Asian backgrounds seem more likely to hold good degrees compared to people from Black backgrounds (Richardson, 2008). I kept an eye on this during recruitment and actively directed my efforts to recruit more Clinical Psychologists from other ethnically minoritised backgrounds, where possible.

Personal reflections

I was motivated to pursue this area of research by my journey into the profession as well as my experiences as a Trainee Clinical Psychologist from an ethnically minoritised background. My upbringing largely shaped my values of social justice, inclusion, and equality, but working clinically, I also became aware of the richness that diversity (in all aspects) brings to our work with clients. With the help of personal therapy, I reflected on my social identity as a straight cisgender Muslim woman of Mauritian heritage, and what that meant to me personally and professionally. Hearing about other trainees', and indeed having my own, experiences of racism on the course, I decided I wanted to continue working towards inclusivity for us as professionals but also the people we serve. At times, pursuing this research felt like swimming against the current, but I found allyship in supervisors, tutors, colleagues, and peers who helped shoulder the weight of this work and reminded me of why it is important.

Impact

The thesis explored an area that has little published research but has important professional and clinical implications. The findings from the systematic review have the potential to impact service delivery. At present, the lack of ethnic diversity in the workforce precludes freedom of choice for service users, which is a legal right in most cases (NHS Improvement, 2016). Although more research is needed to fully understand the impact of ethnic matching on service users' experiences of mental health services, it is still essential for the workforce to reflect the community it serves. Doing so may help reduce the barriers to accessing services for people from ethnically minoritised communities. This review concluded that ethnic matching between clinician and service user could be beneficial, but more data is needed to better understand in what way, and who might receive the most benefit. At the very least, the findings from this review confirm that services should continue to strive to deliver high-quality, culturally responsive, language-appropriate care for people from all backgrounds.

Research on the selection processes for Clinical Psychology training is currently sparse but emerging. The findings from the empirical paper have the potential to impact how courses choose to

adapt their selection processes for DClinPsy training in the future. The study found that when Clinical Psychologists are asked to rate blinded personal statements, BME applicants are rated higher than non-BME applicants. Thus, it may be helpful to consider reading personal statements in isolation of references, work experience and academic attainment, as at least one course has started to do already. The findings may also highlight the potential of reviewing entry criteria, such as the requirement of a high 2:1 degree, that may exclude some applicants from BME backgrounds who otherwise have strong personal statements. This study is the first of its kind, in that no other studies in this area have employed an experimental design with such a large sample of Clinical Psychologists. This hopefully highlights the feasibility for future studies to employ a similar methodology and provides assurance that this kind of work is worth pursuing.

Dissemination

Preliminary findings of the empirical paper were presented to trainees of the Doctorate in Clinical Psychology at Royal Holloway, University of London on 6th May 2022 and to the GTiCP selection subgroup meeting on 15th June 2022. To maximise impact of findings, the empirical paper will be written up for publication in a peer reviewed journal such as the *Journal of Clinical Psychology & Psychotherapy*, *Journal of Critical Psychology, Counselling and Psychotherapy,* or for publication in the BPS Clinical Psychology Forum. Participants were able to provide written explanations for some of their answers. This data was not formally analysed due to the time constraints of this project. However, the data might provide some rich insights into why participants rated applicants the way they did. As such, I hope to analyse this data and write up for publication separately.

The findings from this project will also be presented to the team in my clinical placement. During recruitment, several people said they would like to be informed of the research findings once complete, so I intend to disseminate the findings directly to these individuals also. I also intend to submit a summary of the systematic review for publication in a special edition on the topic of diversity in the journal of Clinical Child Psychology and Psychiatry (impact factor = 2.5). I will

develop an infographic based on the lay summary for dissemination on social media, since platforms such as Facebook and Twitter helped my study reach a wider number of participants.

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Appendices

Appendix A: Systematic Review protocol

Appendix B: Quality Assessment Tool for Quantitative Studies

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Appendix D: Recruitment poster

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Appendix M: Additional tables

a. Table M1 - Detailed characteristics and results of studies included in systematic review
b. Table M2 - Comparison table of value hierarches of this sample against pan-cultural norms.

Appendix A: SYSTEMATIC REVIEW PROTOCOL

Does ethnic matching between service user and clinician have an impact on service user experiences of mental health services?

INTRODUCTION

Rationale

Diversity in the Clinical Psychology workforce helps increase choice and opportunities for clients to access services that reflect their culture and identities. Increasing ethnic diversity among Clinical Psychologists is linked to better outcomes for clients from BME backgrounds (King et al., 2011). Studies show that ethnic matching between clinician and service user is associated with greater satisfaction, lower dropout and better treatment outcomes (Gamst et al., 2003; Maramba & Hall, 2002; Meyer & Zane, 2013). Presently, the profession is not yet representative of the demographics accessing support from Clinical Psychology services. While there is some clear evidence of the benefits of increasing diversity in Clinical Psychology, the evidence of effects on non-clinical outcomes has not yet been analysed collectively.

Objectives

The objective of this review is to provide a thorough overview of the available literature examining the impact of ethnic matching between service user and clinician on service user experiences related to empirically supported mental health interventions.

METHODS

Eligibility criteria

Type of participants

This review will consider all studies that involve human subjects of any age, residing in any country. The review is to be focussed on users of mental health services and mental health professionals of any discipline including psychiatrists, mental health nurses, clinical psychologists, psychotherapists and counselling psychologists. Users of mental health services must belong to any ethnically minoritised background. Studies must have two conditions, one where ethnically minoritised service users are matched with ethnically minoritised clinicians and one whether they are not matched.

Exclusion criteria:

- Participants in matched condition are not ethnically minoritised.
- Participants are not users of mental health services
- Clinicians not delivering an intervention e.g. administrators / students / assistants

Types of intervention

Interventions of interest to include one-to-one interventions such as intake assessments, reviews, care-coordination, psychological therapy, or occupational therapy. The setting of intervention can include inpatient admission, outpatient appointments, or home visits.

Exclusion criteria:

- Intervention is medical only

Types of outcome measures

The review will consider any service user related outcomes such as experiences, satisfaction, drop out, subjective wellbeing and acceptability of treatment. While measures must capture the experience of service users, they can be self-report or administered by a clinician.

Exclusion:

- Not measured objectively
- Outcome is related to clinician experience
- Outcome is related to symptom reduction

Types of study

Peer reviewed journal articles from any year to be included. The review will consider experimental and non-intervention studies. Results from dissertations and theses will also be included, if published. Studies must have a comparison group.

Exclusion criteria:

- Case studies
- No comparison/control group
- Study does not detail how participants were matched
- Study uses proxy methods such as vignettes
- Full text not available
- English language only
- Unpublished literature

Information sources

We will search the following databases: PubMed, Web of Science, APA PsychINFO and APA PsychArticles. The search strategy is shown in Figure 1 and will include only terms related to or describing the research question. There will be no date restrictions, however the search will be re-run before final analysis to include the most current studies in this review. Dissertations that meet the inclusion criteria will be included in this review, if retrieved in the search. We will not be including unpublished data. We will search the reference lists of studies included in this review and previously published reviews, where relevant.

Search strategy

The search strategy will comprise the following stages:

1) A limited search of PubMed and APA PsychINFO to identify relevant keywords included in the title or abstract.
2) An extensive search of the literature using identified terms and synonyms used by respective databases will be run.
3) Reference lists of relevant studies identified from stage two to be searched.

Query 1	Query 2	Query 3	Query 4
ethnic-similarity racial-difference* ethnic-difference* ethnic-match* intercultural ethnic-concordance cultural-match* cross-cultural cultural-difference* culture-compatible racial-match* cross-racial racial/ethnic-match* racial/ethnic-status inter-cultural	patient-clinician patient-therapist client-therapist therapist-client therapeutic-dyad client-psychologist psychotherapist-client-interaction client-clinician clinician-client healthcare-professional-patient staff-client* therapeutic-relationship staff-service-user clinician-patient therapist-patient patient-psychologist psychologist-patient patient-healthcare-professional client-staff doctor-patient patient-doctor	experience* satisfaction dropout drop-out subjective-wellbeing acceptability perception* motivation	mental-health-treatment mental-health-services nhs psychotherapy psychology psychological-therap* talking-therap* mental-health-therap* counselling support mental health support

Table 1. Search terms for all databases. Terms apply to All Fields. No limits to be included on initial screen.

Study records

<u>Data management</u>

All records from initial screen will be exported from databases and imported into Rayyan, an open-source web-based software programme that facilitates the screening process for systematic reviews. Records will also be imported to the reference management software Zotero.

<u>Selection process</u>

Titles and abstracts of retrieved studies will be screened to identify studies that meet the inclusion criteria. We will retrieve the full text of these studies and assess for eligibility. A second reviewer will assess 10% of these studies for reliability of the selection process and to confirm inclusion in the review. Any disagreements between the two reviewers will be resolved through discussion and assistance of a third reviewer, where required.

Data collection process

Information relevant for data synthesis and to assess the quality of the studies and, such as publication year, sample size, participants, intervention and outcome measures used, will be extracted using a standardised form. Study authors will be requested via email to provide additional or missing data.

Critical appraisal

Articles will be categorised based on study design; RCT, cohort or cross-sectional. These studies will then be assessed independently for methodological validity using the respective checklists developed by the Joanna Briggs Institute.

Data items

For observational studies, we will extract the type of interventions, number of appointments/sessions, mode of delivery (online or face-to-face), sample size, clinician characteristics (occupational title, ethnic background/race), whether the clinician and client were racially/ethnically matched or not, client-specific characteristics (age, ethnic background/race, presenting problem), presence and nature of comparison group. For RCTs, we will additionally extract trial size, duration of follow-up, type of control used, duration of intervention, mode of allocation (i.e. random, systematic etc.).

For all studies, we will use the age limit of 18 as a cut-off between adolescence and adulthood, if this is not clear. If specific ethnic background is not reported the broader ethnic category will be used, for example, South Asian instead of Bangladeshi. It is possible that individual studies may label presenting problems differently and there may be multiple presenting problems if cases are complex. In these instances, for simplification we will use the primary presenting problem and diagnostic categories to categorise the presenting problem, for example, depression, generalised anxiety disorder. Any data items added during the review process will be clearly outlined with rationale.

Outcomes and prioritisation

The primary outcomes will be differences in any outcomes related to the experience of mental health treatment determined by the service user including:

1. Overall satisfaction of treatment
2. Drop-out
3. Number of sessions attended
4. Therapeutic alliance
5. Subjective wellbeing
6. Acceptability of treatment

Studies will be presented and organised by primary outcome. Where a validated measuring tool has been used to quantify an outcome, for example satisfaction, therapeutic alliance or acceptability, the total scores will be reported.

Risk of bias in individual studies:

To assess the risk of bias in each study a validated assessment tool will be used at the study level. The assessment tool used will depend on the study design. For randomised controlled trials, information will be collected using the Cochrane Risk of Bias 2.0 tool, which covers seven domains of potential bias. For each domain, we will describe the procedures taken for each study and a judgement based on the extracted information will be made. Responses are categorised as either 'high risk', 'low risk' or 'unclear' if there is insufficient detail. To assess risk within non-intervention studies, such as cross-sectional or case-control studies, the Newcastle - Ottawa Quality Assessment Scale can be used. This scale uses a 'star' rating method and is divided into three sections assessing selection, comparability, and outcome/exposure. Risk of bias can influence the overall findings, therefore the information collected from these methods will be considered in the data synthesis when evaluating the overall strength of evidence from each study.

Data synthesis

A systematic narrative synthesis will be conducted which will summarise the characteristics and findings of included studies in text and tables. The narrative synthesis will explore both the relationship between and within studies, in line with guidance from the Centre for Reviews and Dissemination.

Meta biases

In order to determine whether any reporting bias is present in RCTs, we will screen the Clinical Trial Register at the International Clinical Trials Registry Platform of the World Health Organisation to determine if protocols were published prior to participants being recruited to the study.

Confidence in cumulative evidence

The quality of the evidence across all studies will be assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group methodology. This approach assesses the quality of the findings across several domains including risk of bias, imprecision, inconsistency, indirectness and publication bias. Quality will be judged as either high (further research is very unlikely to change our confidence in the estimate of effect), moderate (further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate), low (further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate) or very low (very uncertain about the estimate of effect).

Appendix B: QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES (Thomas et al., 2004)

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify ______________________
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

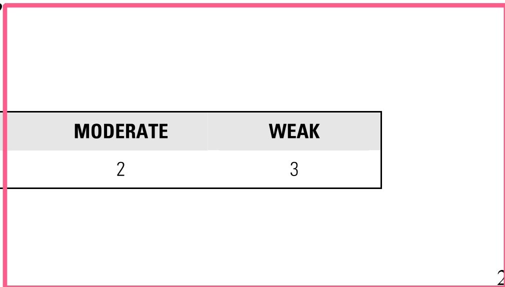
(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3



2

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

<u>GLOBAL RATING FOR THIS PAPER (circle one):</u>

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1 Oversight
2 Differences in interpretation of criteria
3 Differences in interpretation of study

<u>Final decision of both reviewers (circle one)</u>:

1 STRONG
2 MODERATE
3 WEAK

Appendix C: QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES DICTIONARY

Quality Assessment Tool for Quantitative Studies Dictionary

The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended. Mixed methods studies can be quality assessed using this tool with the quantitative component of the study.

A) SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)
An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.

Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)
An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather ‘cases’ of people who already have the outcome of interest and ‘controls’ who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A study that uses observations at multiple time points before and after an intervention (the ‘interruption’). The design attempts to detect whether the intervention has had an effect significantly greater than any underlying trend over time. Exclusion: Studies that do not have a clearly defined point in time when the intervention occurred and at least three data points before and three after the intervention

Other:
One time surveys or interviews

C) CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D) BLINDING

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.

E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWALS AND DROP-OUTS

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.

Score **NOT APPLICABLE** if the study was a one-time interview or survey where there was not follow-up data reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

Component Ratings of Study:

For each of the six components A – F, use the following descriptions as a roadmap.

A) SELECTION BIAS

Good: The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

Fair: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).

Poor: The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B) DESIGN

Good: will be assigned to those articles that described RCTs and CCTs.

Fair: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

Weak: will be assigned to those that used any other method or did not state the method used.

C) CONFOUNDERS

Good: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); **or** (Q2 is 1).

Fair: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) **and** (Q2 is 2).

Poor: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) **and** (Q2 is 3) **or** control of confounders was not described (Q1 is 3) **and** (Q2 is 4).

D) BLINDING

Good: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **and t**he study participants are not aware of the research question (Q2 is 2).

Fair: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2).

Poor: The outcome assessor is aware of the intervention status of participants (Q1 is 1); **and** the study participants are aware of the research question (Q2 is 1); **or bl**inding is not described (Q1 is 3 and Q2 is 3).

E) DATA COLLECTION METHODS

Good: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have been shown to be reliable (Q2 is 1).

Fair: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have not been shown to be reliable (Q2 is 2) **or** reliability is not described (Q2 is 3).

Poor: The data collection tools have not been shown to be valid (Q1 is 2) **or** both reliability and validity are not described (Q1 is 3 and Q2 is 3).

F) WITHDRAWALS AND DROP-OUTS - a rating of:

Good: will be assigned when the follow-up rate is 80% or greater (Q1 is 1 and Q2 is 1).

Fair: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q1 is 4 or Q2 is 5.

Poor: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q1 is No or Q2 is 4).

Not Applicable: if Q1 is 4 or Q2 is 5.

Appendix D: RECRUITMENT POSTER

"WHY IS CLINICAL PSYCHOLOGY SO WHITE?"

If you are a qualified Clinical Psychologist, we need you!

Why are we doing the study?

Our profession is not yet reflective of the people we serve. Despite initiatives to increase diversity on DClinPsy training courses, success rates for people from a "BAME" background is still 6% lower compared to White applicants. We want to better understand if cultural factors that may be relevant during the selection process, might play a role.

or click HERE

https://rhulpsychology.eu.qualtrics.com/jfe/form/SV_bHM6LII6ZJ3dMNg

Who can take part?

- Qualified Clinical Psychologists from any ethnic background
- Did NOT apply to join the 2018 cohort at Royal Holloway
- Being involved in DClinPsy selection panels NOT required

What will it involve?

- 30 minutes of your time
- Reading 4 personal statements
- Completing 2 brief questionnaires
- Participation will be anonymous

Ethical approval project ID: 2675

Contacts

Researcher

Zaynah.Muthy.2019@live.rhul.ac.uk

Supervisors

Dr Olga Luzon - Royal Holloway

Dr Kat Alcock - UCL

Appendix E: ETHICS APPROVAL LETTER

Royal Holloway
University of London
Egham, Surrey
TW20 0EX

Dr John Francis
Research Ethics Officer
Research Services | Research and Innovation
ethics@rhul.ac.uk
www.royalholloway.ac.uk

13 January 2022

Please accept this letter as confirmation that the postgraduate research project titled 'Does your ethnicity matter when selecting future Clinical Psychologists?: an experimental study', with the postgraduate researcher being Zaynah Muthy and the Principal Investigator/Supervisor being Dr Olga Luzon, received approval from the Research Ethics Committee of Royal Holloway, University of London via the Self Certification route on 4 October 2021. The project was approved with the ID 2675.

If you have any queries about the approval of the project, please email Royal Holloway Research Services via ethics@rhul.ac.uk.

Yours sincerely,

Dr John Francis

Appendix F: CONSULTATION SURVEY RESPONSES

Survey responses (4 respondents)

1. The working title of the study is "The role of ethnic identity and personal values when considering suitability for Clinical Psychology doctoral training" What are your thoughts on this title or how can it be improved?

- I think it's good

- It could be simplified perhaps, but you may lose the necessary components

2. What are your thoughts on the recruitment poster?

- Love it! One thing though is I wasn't sure how to make sense of the statistic about access to training being 6% lower amongst people from ethnic minorities compared to white applicants. Is it that of the percentage of successful white applicants, 6% fewer applicants who identify as being from an ethnic minority get on the course?

- I like the QR code. A line about the amount of time participation takes could make it more appealing

- I had a quick look and the 'won can take part' section on the poster was a bit confusing with they way it is worded- I wondered if point 2 and 3 could be simplified/reworded.

- I think your poster in really nice, clear and engaging. with not too much text. I guess the headline is going to hook people who are particularly interested in this area, which of course is quite a lot of people. However, if you want to get a completely representative sample of people doing selection you might want to make the title more neutral, although that might mean making it less attention grabbing, it just depends on whether having a sample biased towards people who are particularly concerned about underrepresntation is a problem for your study or not.

3. Is there any other relevant demographic information worth collecting for this study?

- maybe whether or not the participant is an immigrant to, or born in the uk? And if not born in the uk, when did they move to live here.

- Perhaps years of experience as a trainee supervisor to gather information about closeness of relationship to training programmes?

- Is it worth asking how may references people have written (for people from ethnic minorities) etc how many trainees they've supervised in the demographics? This might be helpful contextual information about how they rate applications.

- The demographics form is familiar as it uses the standard ONS categories so I'm sure it would be easy to use.

4. What are your thoughts on the rating form? Are there any questions worth including / removing?

- Looks really good to me. Was wondering why only the 'unsure' response option asked for people to explain this response, although I can see that asking for all the participants response options to be explained would give you A LOT of data.

- Q9: I'm not sure whether the question refers to working generally (i.e. colleagues) or working clinically with loved ones. If the latter, "work clinically with" needs to be made more explicit than "work with". Q10: Is this question about whether the candidate themselves identifies as belonging to a minority ethnic group or whether the participant identifies them as belonging to a minority ethnic group? For me, it's not clear and there is a subtle difference between them that could be confusing.

- The ratings made sense to me, although I thought the scale seemed to be missing at least a point between "very strong" and "satisfactory but minor concerns"

5. With regards to the MEIM-R, would you be satisfied with the ethnic group categorisations under Q7? If not, how would you prefer to organise ethnic groups?

- I know that some who identify as Arab find it annoying to always be put under the 'other ethnic group' category, particularly as they are a quite a big minority group within the uk.

- Yes

- I thought the MEIM was clear and easy to use.

6. What are your thoughts on the SSVS?

- ooo it's really interesting to think about completing it!! I know that some I would find very hard to answer though, e.g. for item 10 (security) - national security isn't something I think about very often, but cleanliness is quite important to me. Just thought some of the sub-items seem quite different, but interesting to see them grouped together in one item!

- The S-SVS seems a bit abstract and I found it a bit hard to answer although I would have got through it as a participant and I'm not sure there much you can do if its a standardised measure.

7. How long would you estimate participation would take?

ANSWER CHOICES–	**RESPONSES–**
–	0.00%

ANSWER CHOICES–	RESPONSES–
20 - 30 minutes	0
– 30 - 40 minutes	50.00% 1
– 45m - 1 hour	50.00% 1

8. Do you have any other feedback on the study generally?

- Sounds like a really interesting study, good luck!!
- Will you collect information on the level of concern of participants about whiteness being a problem in clinical psychology?

Appendix G: PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Participant Information Sheet

Department of Psychology

Royal Holloway, University of London

Name of study: Does your ethnicity matter when selecting future Clinical Psychologists?: an experimental study.

Lead researcher: Ms Zaynah Muthy

Internal Supervisor: Dr Olga Luzon External supervisor: Dr Kat Alcock

Study summary

We are interested in exploring whether, and to what extent, ethnic status (defined by identifying as belonging to an ethnically minoritised group or not) plays any role, even unconsciously, in how Clinical Psychologists decide whether a candidate is suitable for Clinical Psychology (DClinPsy) training.

Why are we conducting this study?

It is well documented that a diverse workforce is linked to better patient care. Ethnic diversity among Clinical Psychologists is linked to better satisfaction and outcomes for services users from minority ethnic groups. Because of this, it is national NHS policy to ensure the workforce is representative of the communities they serve. However, the NHS recruitment process has been shown to disproportionately favour White applicants. Likewise, the profession of Clinical Psychology is predominantly White, creating a lack of ethnic diversity amongst clinicians necessary to provide better patient care. There are a number of potential reasons why this may be, we are interested in investigating one of these possibilities. This study could shed light on some of the barriers people from minority ethnic groups face to accessing DClinPsy training and whether a lack of diversity in the profession is reflected by a lack of diversity amongst those involved in the selection process.

What will your participation involve?

If you agree to take part, you will be asked to read four personal statements from DClinPsy application forms and then rate each form on a number of key areas. You will then be asked to complete two short questionnaires on ethnic identity and personal values. We will also collect basic demographic information. We anticipate participation should take just over half an hour.

Benefits and disadvantages of your participation

One of the benefits of taking part is that your participation will contribute to the evidence base on this important topic which could be used to inform DClinPsy selection practices in future, and potentially improve ethnic diversity in the Clinical Psychology workforce.

What will happen if you decide to take part?

If you decide to take part, your participation will be entirely voluntary. Your participation in the study will be anonymous and confidential, we will not share or print any of your personal, identifiable information. You have the opportunity to ask questions about the study even after participation.

How will the results of your participation be used?

The results of your participation form the basis of this Doctoral thesis project. We hope to publish our findings in a peer-reviewed journal, and share findings with relevant professional bodies such as the British Psychological Society (BPS) and Group of Trainers in Clinical Psychology (GTiCP), including presentations at conferences. All individual responses will be anonymised. Overall, we hope that our findings will provide some evidence to inform changes or improvements in the selection process for DClinPsy courses, in order to increase the number of successful candidates from ethnically minoritised backgrounds

What happens if issues arise during the course of the project?

If you have any questions or complaints during your participation, you may contact the lead researcher or project supervisor (details below). You can withdraw from the study at any time. Your choice to withdraw will not have any negative impact on you.

Ethical Approval

This project is registered as 'self-certify' under the Research Ethics Committee at Royal Holloway, University of London. Project ID: 2675.

Confidentiality

Data will be collected using Qualtrics, which is GDPR-compliant and will be downloaded as a password protected database and stored on a password protected laptop that is only accessible to the lead researcher. The project supervisor will also have access to the data. The data will be stored on Royal Holloway University of London's secure data server and destroyed after 10 years. Your data will be anonymised and coded using a randomly generated unique identifier to link your responses. Your signed consent form will be stored separately from the responses you provide. The data will be stored in a password protected database, and only accessible to the research team.

Contact details

Lead researcher – Ms Zaynah Muthy, Trainee Clinical Psychologist
Zaynah.muthy.2019@live.rhul.ac.uk

Project Supervisor – Dr Olga Luzon, Senior Lecturer Olga.Luzon@rhul.ac.uk

Data protection

This project will abide by the Data Protection Act 2018 and the research participant privacy notice.

GDPR statement

Important General Data Protection Information (GDPR) Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted on servers within the European Economic Area'. Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your personal data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally-identifiable information possible (i.e., the email address you provide us). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to provide a summary of the study results if requested and/or for the prize draw). The lead researcher will keep information about you and data gathered from the study, the duration of which will depend on the study. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting www.royalholloway.ac.uk/about-us/more/governance-and- strategy/data-protection/ and if you wish to exercise your rights, please contact dataprotection@royalholloway.ac.uk

NB: You may retain this information sheet for reference and contact us with any queries.

Research Participant Consent Form

Name of study: The role of ethnic identity and personal values when considering suitability for Clinical Psychology doctoral training.

Name and email address of supervisor (where appropriate): Dr Olga Luzon, Olga.Luzon@rhul.ac.uk

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

I confirm that have read and understood the information sheet about this study	Yes / No
I agree to participate in this study	Yes / No
I have had the opportunity to ask questions about this study	Yes / No
I have received satisfactory answers to my questions about this study	Yes / No
I understand my participation in this study is voluntary	Yes / No
I understand that I am free to withdraw from the study/research project at any time, without giving a reason and without detriment to myself	Yes / No
I understand that my data will be anonymised and stored for 10 years and destroyed when the project ends	Yes / No

Participant signature...

Participant Name ....

Date ....

Please note that this Consent form will be stored separately from the responses you provide. If you have any concerns about this research, please email ethics@rhul.ac.uk.

Appendix H: DEMOGRAPHICS AND EXPERIENCE QUESTIONNAIRE

Your role and experience

Are you a qualified Clinical Psychologist? Y / N (if no, please do not continue)

How many years have you been qualified? (If newly qualified please state "Less than one year"): ____________

How many Trainee Clinical Psychologists have you supervised? ____________

Have you ever written references for individuals applying to the DClinPsy?

If yes, how many times? ______________
How many of these individuals would you say belonged to an ethnic minority group?

____

Are you or have you ever been part of a selection panel for any DClinPsy training course? Y / N

If yes, how many rounds of applications? ______________

For which training course(s)? _____________________________________

Demographics

Which ethnic group best describes your ethnicity?

Asian or Asian British

Black, African, Caribbean or Black British

Mixed or Multiple ethnic groups

White or White British

Other ethnic group

Which gender do you identify with?

Male

Female

Non-binary / third gender

Prefer not to say

Please select your age bracket

18 - 24

25 - 34

35 - 44

45 - 54

55 - 64

65 - 74

75+

Appendix I: DCLINPSY PERSONAL STATEMENT RATING FORM

Suitability for DClinPsy training: rating of personal statements

Please rate the application forms on the following key areas of aptitude within the clinical and personal domains. Each scale represents particular competencies but are not equally weighted in terms of importance. If a candidate does not score highly on all scales, it may not necessarily mean they are unsuitable to invite for interview. Use your judgement regarding the importance of each area of aptitude when assessing the candidate. There will be a space to express any other aspects you feel are important to consider when rating the form at the end.

Values based recruitment

Demonstration of values aligning with core NHS principles such as: respect and dignity to clients, their families and professionals; commitment to quality of care; displaying sensitivity and putting clients first; speaking up in the interest of the client when things go wrong and providing care that is compassionate and responsive to the needs and wishes of the clients, the families or carers.

Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Coherent understanding of clinical psychology principles, training and practice

The candidate should evidence an understanding of the key aspects of clinical work including the ability to use supervision and guidance appropriately; the ability to form good therapeutic alliances and to communicate effectively with clients and colleagues; the ability to formulate hypotheses and the ability to carry out interventions effectively and creatively. Experiences and learning should be integrated throughout, rather than a list of accomplishments. Candidates should also convey an awareness of expectations during doctoral training including the ability to balance research and clinical work. Candidates should also be aware of the different client groups and contexts in which they could be working in during training. If the candidate demonstrates a proactive effort to learn about the profession and NHS, this could also be evidence of this area of aptitude.

Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Evidence of thoughtfulness and reflection and empathy

The candidate should demonstrate an ability to reflect critically on their work with clients in a sensitive and balanced way. For example, showing an understanding of the strengths and limitations of working in a particular way, and what informed their decision(s). Candidates should be able to convey an ability to self-reflect and show flexibility and creativity in their work.

Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Realism					
The candidate should demonstrate a realistic appreciation of the various roles that a Clinical Psychologist might take (including both positive and negative aspects). Care should be taken if the application appears to have interest in only one particular client group or modality with little or no recognition of how the diversity of experiences gained on training might interact with narrow interests. Evidence of enthusiasm, appropriate independence and self-directed learning could also be rated. Candidates making a career change should demonstrate evidence that the decision to change is realistic and has been considered carefully.					
Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Written communication and writing style					
The ability to communicate clearly and effectively in written form is a fundamental part of the doctoral training, as well as clinical practice. Applications should be rated on: - Use of grammar, syntax, punctuation and spelling - Ability to convey thoughts clearly - Ability to articulate complex ideas in a coherent manner - Capacity to structure information - Capacity to be succinct					
Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Research capacity					
Evidence of the candidate's potential for research could come from peer-reviewed papers, service related research, or the candidate has demonstrated a capacity to understand the research process and the role of research in clinical psychology practice. Candidates should be able to demonstrate good knowledge of research design, analysis and interpretation. Candidates may also demonstrate research experience outside of academia and research settings.					
Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Capacity for leadership

Candidates are not expected to have experience of leadership roles but may show some experience in an ability to effect change, including activism, the capacity to analyse how organisations function and are influenced or an ability to communicate and build professional relationships. Examples of leadership capacities could come from a wide range of activities or contexts for example, providing mentorship to others, teaching experience, or helping to improve services.					
Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Any other key aptitude (please state):					
Exceptional	Very Strong	Satisfactory	Satisfactory but Minor Concerns	Some concerns	Unsure (please explain)

Would you consider inviting this candidate to interview? **Y / N (please explain)**

Would you be happy for this candidate to work clinically with a member of your family/friends? **Y / N (please explain)**

Would you say this candidate identifies as belonging to an ethnically minoritised group? **Y / N / Not sure**

Appendix J: MULTIGROUP ETHNIC IDENTITY MEASURE – REVISED (MEIM-R)

Reference: Phinney, J. S., & Ong, A. D. (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. Journal of counseling Psychology, 54(3), 271.

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Indian, Black or Black British, Hispanic or Latino, White British, Chinese and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be ____________________

Use the numbers below to indicate how much you agree or disagree with each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	4	3	2	1
2. I have a strong sense of belonging to my own ethnic group.	4	3	2	1
3. I understand pretty well what my ethnic group membership means to me.	4	3	2	1
4. I have often done things that will help me understand my ethnic background better.	4	3	2	1
5. I have often talked to other people in order to learn more about my ethnic group.	4	3	2	1
6. I feel a strong attachment towards my own ethnic group.	4	3	2	1

7. My ethnicity is:

   (1) South Asian (Indian, Bangladeshi, Pakistani, Other South Asian)

(2) East Asian (Chinese, Filipino, Japanese)
(3) Black African, Caribbean or Black British
(4) White (White British, White other)
(5) Mixed or Multiple ethnic groups
(6) Arab
(7) Other ethnic group (Hispanic/Latino, any other ethnic group)

8. My father's ethnicity is (use numbers above):

9. My mother's ethnicity is (use numbers above):

Appendix K: THE SHORT SCHWARTZ'S VALUE SURVEY (SSVS)

Reference: Lindeman, M. & Verkasalo, M. (2005). Measuring values with the Short Schwartz's Value Survey. Journal of Personality Assessment, 85(2),170-178.

Please, rate the importance of the following values as a life-guiding principle for you. Use the 8-point scale in which 0 indicates that the value is opposed to your principles, 1 indicates that the values is not important for you, 4 indicates that the values is important, and 8 indicates that the value is of supreme importance for you.

	Opposed to my principles	Not important			Important				Of supreme importance
1. POWER (social power, authority, wealth)	0	1	2	3	4	5	6	7	8
2. ACHIEVEMENT (success, capability, ambition, influence on people and events)	0	1	2	3	4	5	6	7	8
3. HEDONISM (gratification of desires, enjoyment in life, self-indulgence)	0	1	2	3	4	5	6	7	8
4. STIMULATION (daring, a varied and challenging life, an exciting life)	0	1	2	3	4	5	6	7	8
5. SELF-DIRECTION (creativity, freedom, curiosity, independence, choosing one's own goals)	0	1	2	3	4	5	6	7	8
6. UNIVERSALISM (broad-mindedness, beauty of nature and arts, social justice, a world at peace, equality, wisdom, unity with nature, environmental protection)	0	1	2	3	4	5	6	7	8
7. BENEVOLENCE (helpfulness, honesty, forgiveness, loyalty, responsibility)	0	1	2	3	4	5	6	7	8
8. TRADITION (respect for tradition, humbleness, accepting one's portion in life, devotion, modesty)	0	1	2	3	4	5	6	7	8
9. CONFORMITY (obedience, honoring parents and elders, self-discipline, politeness)	0	1	2	3	4	5	6	7	8
10. SECURITY (national security, family security, social order, cleanliness, reciprocation of favors)	0	1	2	3	4	5	6	7	8

APPENDIX L: DESCRIPTIVE RESULTS OF SUPPLEMENTARY QUESTIONS

Results apropos responses to the supplementary questions; '*Would you consider inviting this candidate to interview?*', *Would you be satisfied if this candidate were to work clinically with a member of your family/friends?*' and '*Would you say this candidate identifies as belonging to an ethnically minoritised group*? are described next. These questions were asked while assessing each applicant individually (see Appendix I for rating form and order of questions asked).

Invite applicant to interview

Figure L1 shows the proportion of participants who stated they would invite applicants to interview, by selecting 'Yes' to this question. In order of highest to lowest, across the whole sample. Applicant 3 was endorsed by 94.3% of participants, closely followed by Applicant 1 (93.8%), Applicant 4 (88.1%) and finally Applicant 2 (66.3%). These findings roughly reflect the mean ratings observed for each applicant (see Table 2). One difference between BME and non-BME groups was noted. In the BME group, more participants said they would invite Applicant 1 (BME) to interview than any other applicant, but in the non-BME group, more participants said they would invite

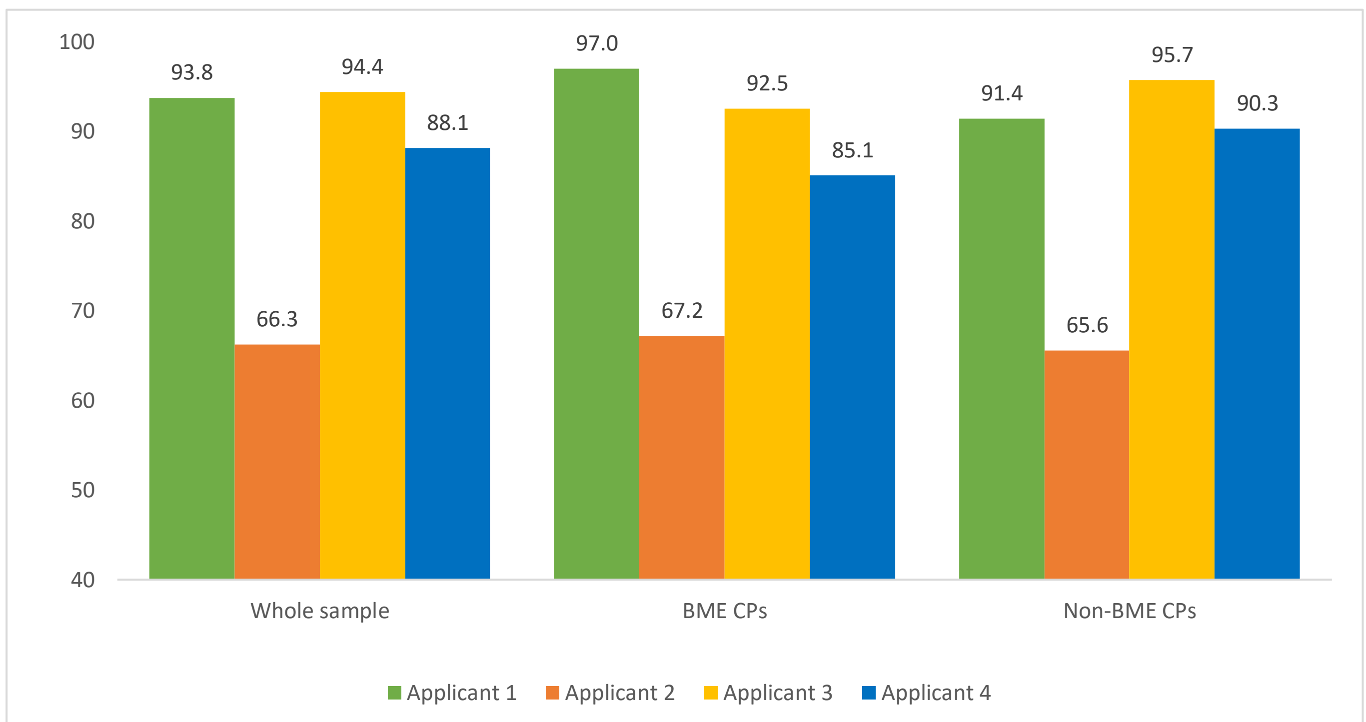


Figure L1. Proportion (%) of sample who stated they would invite applicant to interview. Applicants 1 and 4 were BME, applicants 2 & 3 were non-BME.

Applicant 3 (non-BME) to interview than any other applicant. Compared to the BME group, a greater proportion of the non-BME group said they would invite candidates to interview in general (Figure L2).

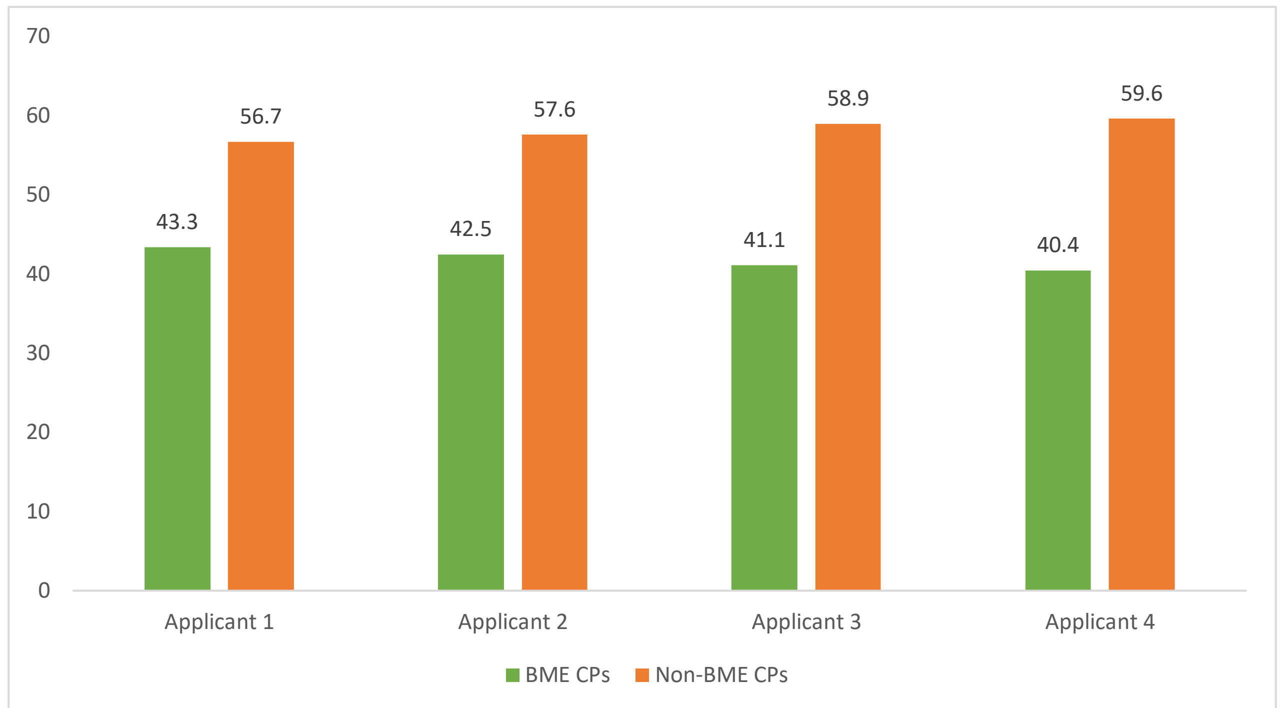


Figure L2. Proportion (%) of participants who would invite applicants to interview, separated by participant ethnic status. Applicants 1 and 4 were BME, applicants 2 & 3 were non-BME.

When looking only at the two BME applications (Figure L3), a stronger majority of BME participants said they would invite Applicant 1 to interview than Applicant 4 (97% vs 85%, respectively). Conversely, in the non-BME group, the proportions of participants who would invite either applicant to interview were roughly similar (91% vs 90%, respectively).

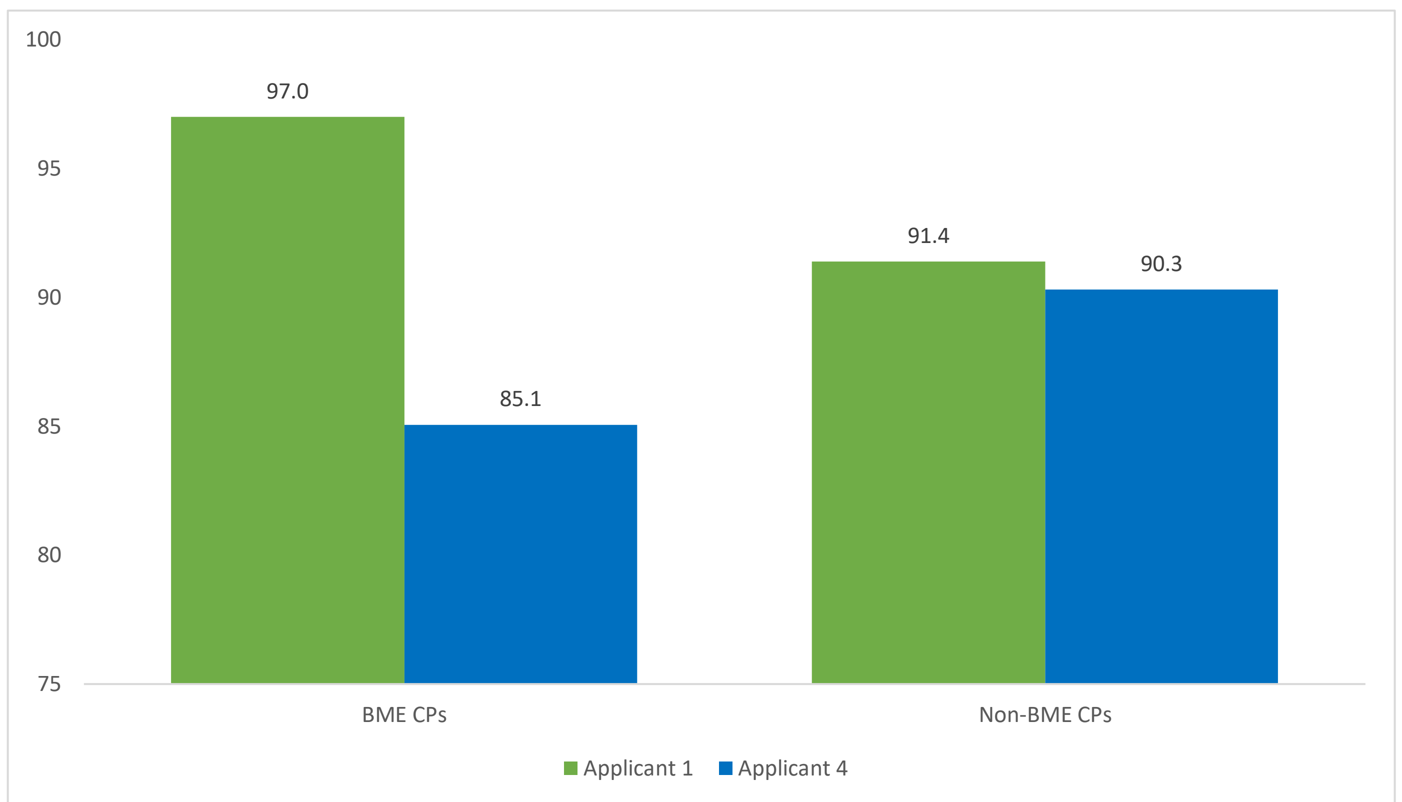


Figure L3. Proportion (%) of sample who stated they would invite BME applicants to interview

Work clinically with member of family/friends

Responses to this question followed a similar pattern as the previous question, with a greater majority of the sample endorsing Applicant 1, followed by Applicant 3, Applicant 4 and finally Applicant 2 (see Figure L4). Similarly, this mirrored the mean ratings these applications received. It was again observed that for the BME group, more participants endorsed Applicant 1 than any other applicants, and for the non-BME group more participants endorsed Applicant 3 was than any other applicants. Again, when looking at the two BME applications (Figure L4), there was a wider margin between Applicant 1 and Applicant 4 (97% vs 81%, respectively) in the BME group compared to the non-BME group (94% vs 86%, respectively), although the difference was less prominent than the previous question.

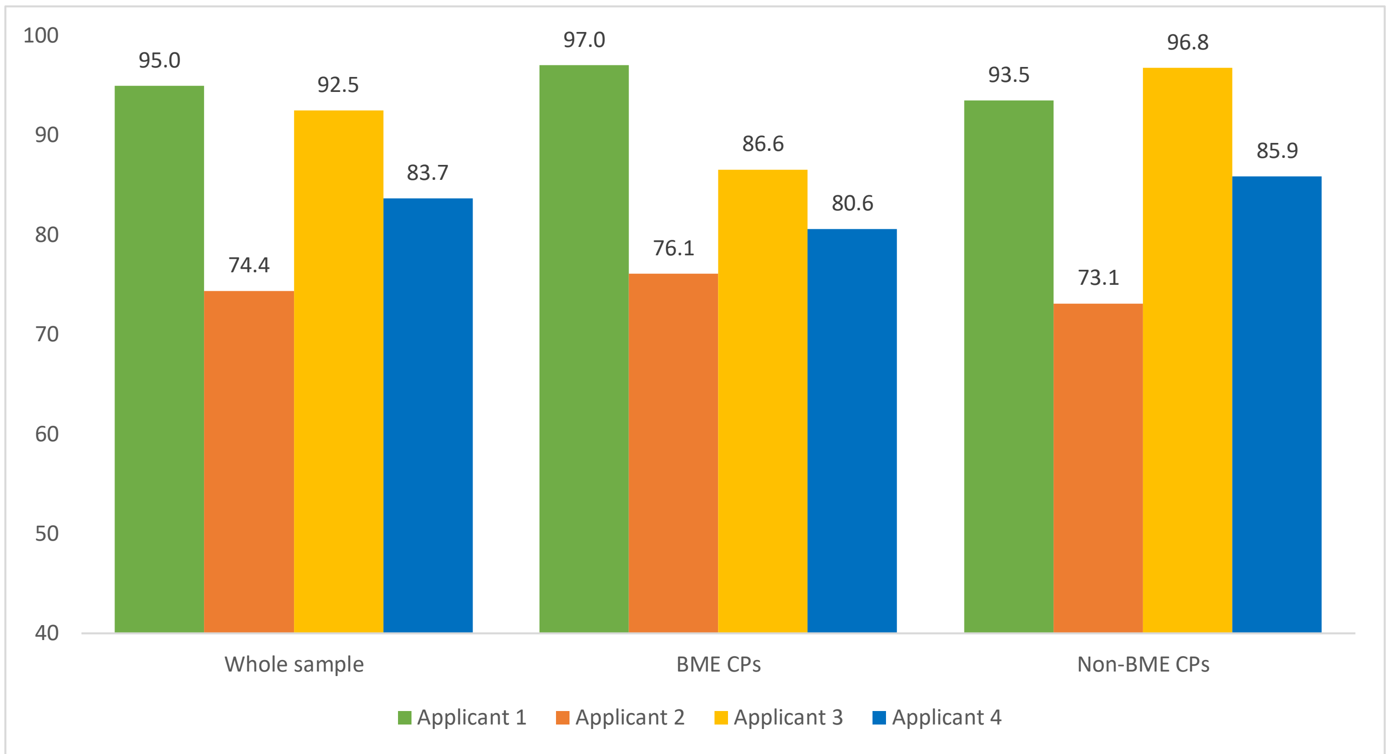


Figure L4. Proportion (%) of sample who stated they would be happy for candidate to work clinically with a family member or friend. Applicants 1 and 4 were BME, applicants 2 & 3 were non-BME.

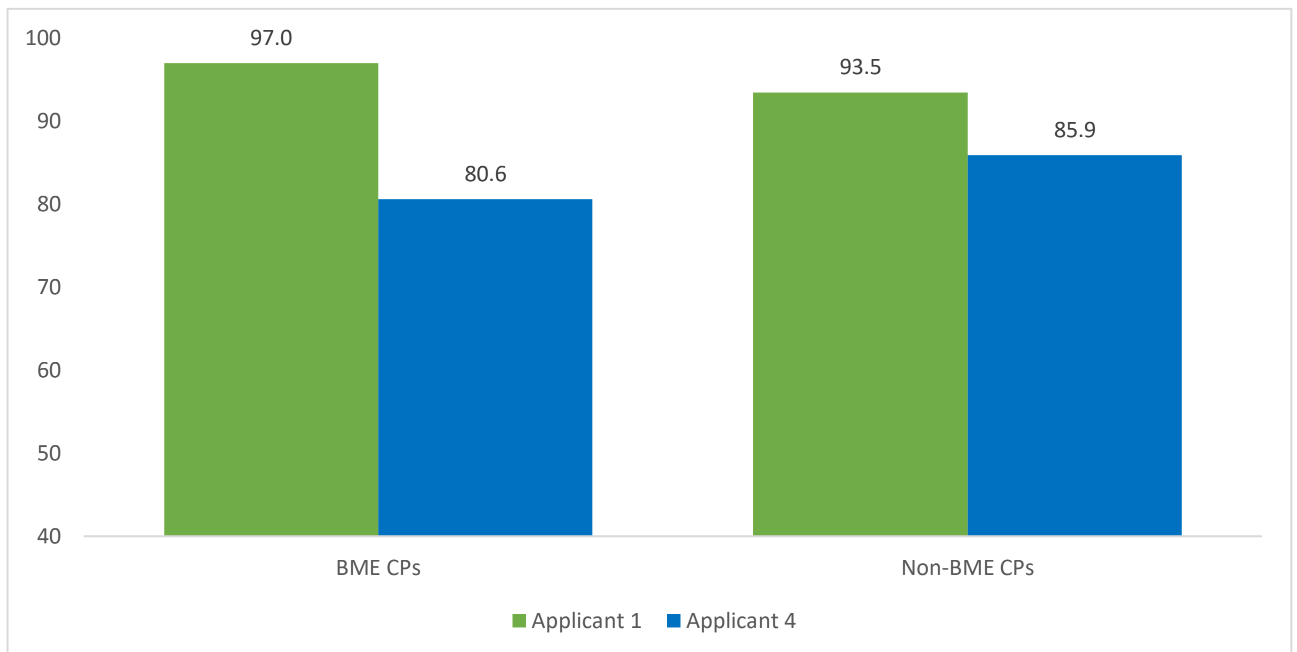


Figure L4. Proportion (%) of sample who stated they would be happy for candidate to work clinically with a family member or friend, separated by participant ethnic status. Applicants 1 and 4 were BME, applicants 2 & 3 were non-BME.

Belonging to BME group

For all applicants, the most popular response was 'unsure' (see Figure L4). Whole sample Yes / No responses to BME and non-BME applications are shown in Figures L5 and L6. Of those who did provide an answer for non-BME applicants, more participants correctly identified both non-BME applicants as not belonging to an ethnically minoritised group. Likewise, more participants correctly identified Applicant 1 as belonging to an ethnically minoritised group, however, when it came to Applicant 4, more participants responded 'No' than 'Yes'.

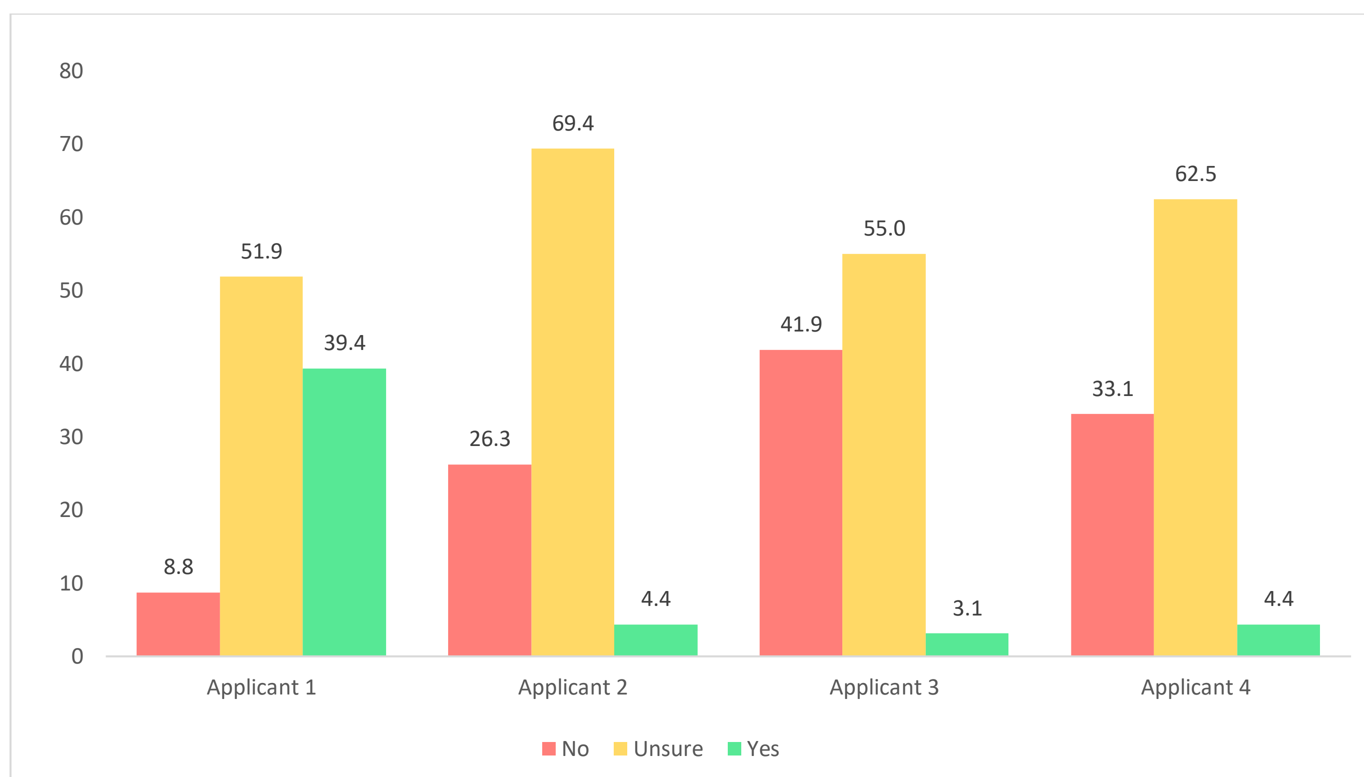


Figure L4. Proportion (%) of responses to "Would you say this candidate identifies as belonging to an ethnically minoritised group?". Applicants 1 and 4 were BME, applicants 2 & 3 were non-BME.

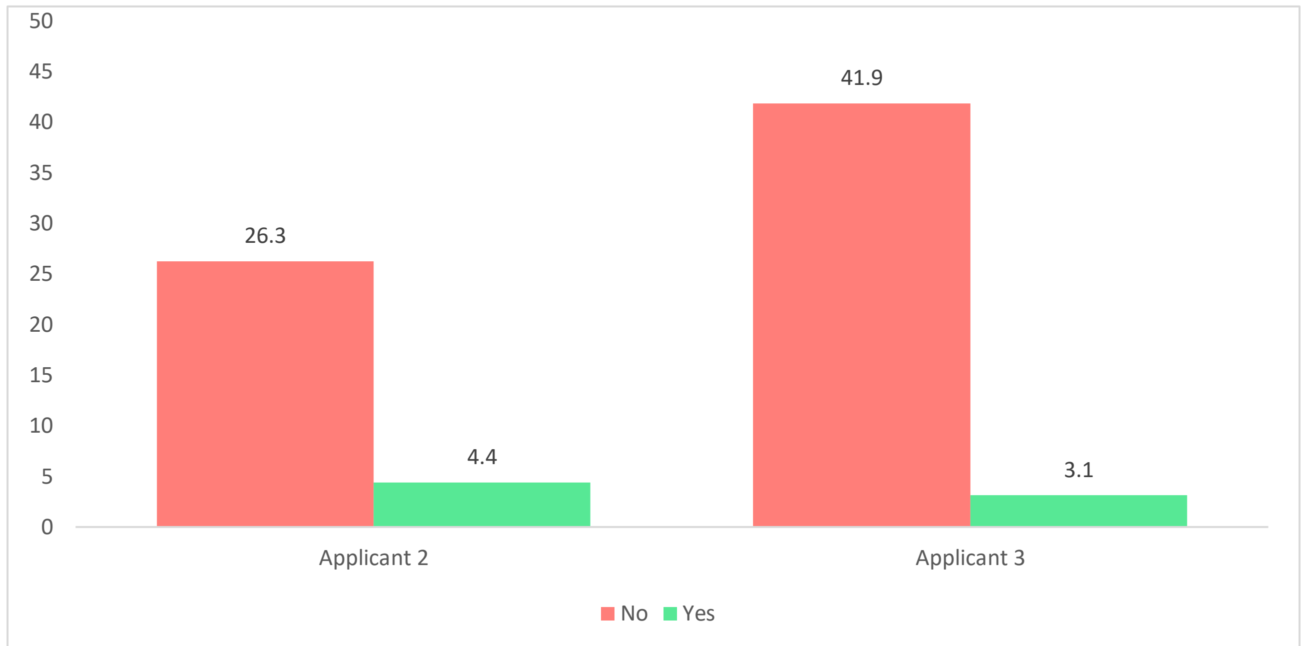


Figure L5. Proportion (%) of responses to "Would you say this candidate identifies as belonging to an ethnically minoritised group?" for non-BME applications.

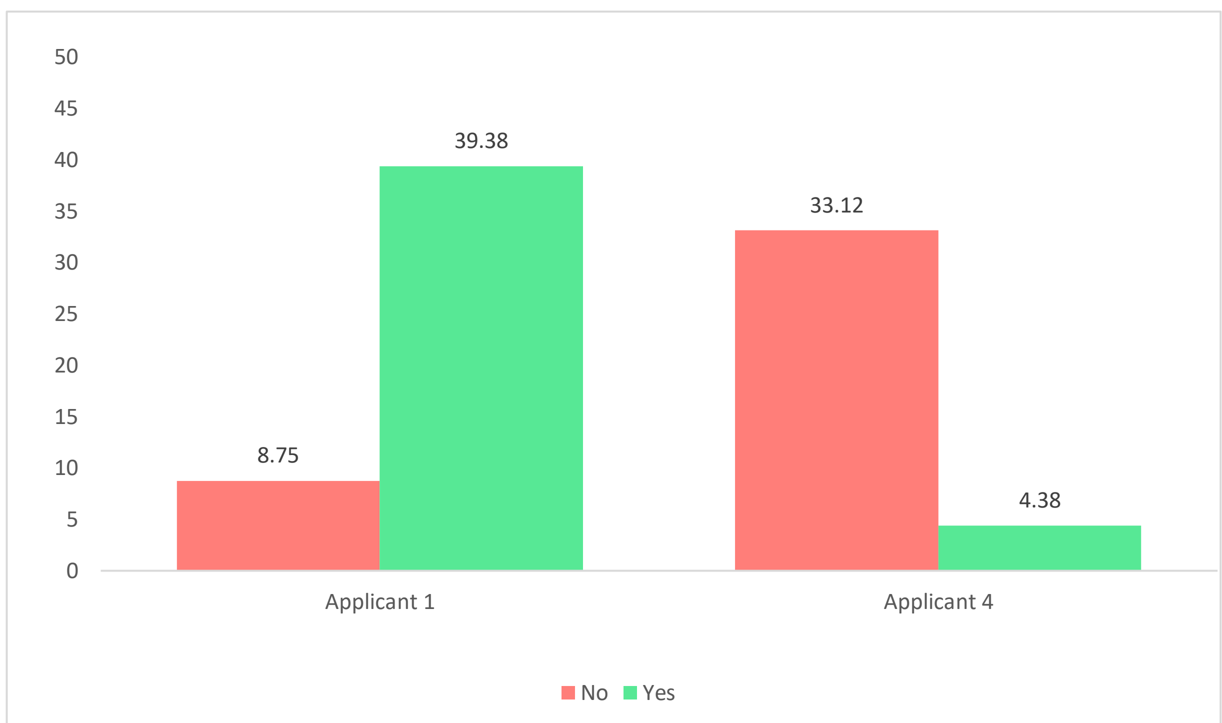


Figure L6. Proportion (%) of responses to "Would you say this candidate identifies as belonging to an ethnically minoritised group?" for BME applications.

APPENDIX M: ADDITIONAL TABLES

Table M1: *Detailed characteristics and results of studies included in systematic review*

First author, year, location	*Study Design, Setting, Aims*	*Service user characteristics*	*Clinician characteristics*	*Matched dyads: Client/Clinician ethnicities*	*Non-Matched dyads: Client/Clinician ethnicities*	*Outcome of interest, how outcome was defined*	*Data collection method*	*Data analysis method*	*Results*
*Alegría et al., (2013), USA**	Cross-sectional Community outpatient clinic To examine role of communication and relationship variables across racial groups	Latino (n=24), varying self-identified race and ethnicity (n=35), Age range: 18-78, 56% female	Latino (n=10), varying self-identified race and ethnicity (n=19). Psychiatrists (n=13), Psychologists (n=6), Social workers (n=16), Nurses (n=3).	Latino - Latino	Varying self-identified race and ethnicity - varying self-identified race and ethnicity	Attendance: Service user returning for next scheduled visit	Clinical records	Generalized linear models adjusting for covariates: patient gender, diagnoses and functional limitations, clinician discipline.	Compared to mixed ethnicity dyads, Latino dyads had higher appointment keeping rates, but these were not statistically significant (0.89 vs 0.62, p>0.05)
*Erdur et al., (2003), USA**	Retrospective Cohort University & college counselling centres	Students seeking personal counselling (n=973), Age range: 16-57, 63.5% female	African American (n=11), Hispanic (n=11), Caucasian (n=172).	African American - African American, Hispanic – Hispanic.	African American – Caucasian, Hispanic – Caucasian.	Attendance: Number of sessions completed	Clinical records	ANOVA	There was no significant effect of therapist ethnicity on least squares mean (LSM) number of sessions between African

	To understand how outcome and retention in counseling differ as a function of ethnic similarities and dissimilarities between therapists and clients.								American matched and unmatched dyads (3.63 vs 3.70, p>0.05) There was a trend for higher number of sessions completed in Hispanic unmatched dyads than Hispanic matched dyads (*LSM* = 3.15 vs 1.88), though this was not significant after Bonferroni correction ($F(1, 68) = 3.84$, $p<.05$.)
Farsimadan et al., (2007), UK	Cohort Voluntary agencies To establish the effect of ethnic matching on measures of therapy process and outcome in	Various non-White ethnic backgrounds: Indian (n=31), Pakistani (n=16), Bangladeshi (n=10), Sri Lankan (n=2), Middle Eastern (n=8), Black African (n=15),	Not stated	Dyads service users perceived as matched included: Indian - Indian, Pakistani - Pakistani, African Caribbean – African Caribbean, and Indian Punjabi -	Unmatched dyads included: Black African - Indian, Indian - Middle Eastern, Pakistani - Black Caribbean, and Sri Lankan - Black Caribbean	Attendance: Length of therapy in weeks Working Alliance: Objectively measured using	Clinical records Working Alliance Inventory - Patient version (WAI-P)	Independent samples t-tests, Regression analyses controlling for	Attendance was not significantly different between the matched (M=9.20, SD=2.82) and unmatched groups (M=9.48, SD=2.76, $p>0.05$) Working alliance was significantly

	real client-therapist dyads	Black Caribbean (n=18). Mean age: 35.6 (matched group), 37.5 (unmatched group).		Pakistani Punjabi.		validated tool		pre-therapy symptoms.	higher in the matched groups (*M*=65.52, *SD*=8.74) than in the unmatched groups (*M*=34.80, *SD*=7.47, *p*<.001) Regression analyses showed that ethnic matching significantly predicted working alliance (R^2 = .782, *F*(1, 98) = 356.67, *p*<.001).
*Flicker, (2004), USA**	RCT Treatment research centre To examine whether ethnic matching improves treatment engagement, alliance, and outcome with Hispanic and Anglo	Hispanic Adolescents and parents (n=19), Age range: 13-19, 16% female	9 clinicians. 7 females. Majority Anglo (n=6), Hispanic (n=3). Trained to conduct Functional Family Therapy	Hispanic - Hispanic	Hispanic - Anglo	Attendance: percent sessions attended Treatment satisfaction: Objectively measured using validated tool	Clinical records Client Satisfaction Questionnaire (CSQ-8)	Multi-factor ANCOVA ANOVA	Ethnic matching did not significantly predict percent sessions attended (*F*(1) = 0.19, *p*=0.66) Ethnic matching was not found to be significantly predictive of

	substance-abusing adolescents in family therapy								treatment satisfaction (*F*(1) = 0.91, *p*=0.34)
Gamble, (2001), USA	Cross-sectional Outpatient Mental Health Facilities Examined the relationships among the variables of client-therapist ethnic match, degree of ethnic identity, and level of satisfaction with therapy.	Portuguese Americans (n=24), Mean age=40, 58.3% female	N=17	Portuguese American – Portuguese American	Portuguese American - and non-Portuguese	Treatment satisfaction: Objectively measured using validated tool	Client Satisfaction Questionnaire (CSQ-8)	T-test	There was no significant difference in treatment satisfaction between matched and unmatched groups (*t*(22)= -0.59; *p*=0.28).
Knipscheer et al., (2004a), The Netherlands	Cross-sectional Community Mental Health Care Agencies To explore the contribution of ethnicity to therapist characteristics and treatment satisfaction	Turkish & Moroccan adults (n=114), Mean age: 37.1, 48.6% female	N=14	Moroccan – Moroccan, Turkish - Turkish	Moroccan or Turkish – Native Dutch	Treatment satisfaction: Measured using self-constructed one-item forms	Assessed with the question: "Were you satisfied with the help provided?" 1 = Completely dissatisfied, 2 = Moderately dissatisfied, 3 = Reasonably	Logistic regression, significance testing using Wald X^2, goodness of fit determined using likelihood ratio X^2 test	There was no significant difference in service satisfaction between those who were ethnically matched and unmatched (X^2 = 3.596, df = 3, p=.309). Logistic regression did not show that

	among Turkish and Moroccan outpatients in mental-health care. Does ethnic similarity in the patient–therapist dyad predict service satisfaction?						satisfied, 4 = Very satisfied.		ethnic matching was independently predictive of service satisfaction (β = -0.56, SE = 0.64, Wald = 0.77, *p*>0.05)
Knipscheer et al., (2004b), The Netherlands	Cross-sectional Community Mental Health Care Agencies To establish the importance of ethnic similarity in mental health care among Surinamese migrants in the Netherlands. Does ethnic matching predict service satisfaction?	Surinamese outpatients (n=69), Mean age=39.2, 74% female	Not stated	Surinamese - Surinamese (75.4%)	Surinamese - indigenous Dutch (24.6%)	Treatment satisfaction: Measured using self-constructed one-item forms	Assessed with the question: “Were you satisfied with the help provided?” 1 = Completely dissatisfied, 2 = Moderately dissatisfied, 3 = Reasonably satisfied, 4 = Very satisfied.	Logistic regression, significance testing using Wald X^2, goodness of fit determined using likelihood ratio X^2 test	Logistic regression showed that ethnic matching was independently predictive of service satisfaction (β = 4.61, SE = 2.20, Wald = 4.40, *p*<0.05)
O'Sullivan et al., (1992), USA	Retrospective Cohort	Hispanic service users (n=161), Mean age=29.1.	Hispanic personnel (n=15). Clinical psychologists	Hispanic - Hispanic	Hispanic - non-Hispanic	Attendance: number of sessions attended		T-test	Matched service users attended significantly

	Community Mental Health Centre To test the culture compatibility hypothesis. Hypothesis: lower drop-out rate and more services should be associated with Hispanic clients being treated by Hispanic staff who speak the same language.		(n=2), Social workers (n=6), Nurse (n=1), Educators (n=4)†			Drop-out: having received only one service session	Clinical records	Chi-Square	more sessions than unmatched service users ($t(196) = 2.68$, $p<0.01$) Matched service users had a significantly lower drop-out rate (6.9%) than unmatched service users (17.9%) ($\chi2$ (1, N = 84) = 15.72, $p<0.001$)
Sterling et al., (1998), USA	Retrospective Cohort Outpatient Treatment facility To (a) replicate previous findings regarding the effect of patient/ therapist race	African American service users (n=967), Mean age=32.3, 44.1% female	Counsellors (n=10). African American (n=6), White (n=4)	African American - African American	African American – White	Drop-out: proportion of patients returning for another visit following initial intake interview Attendance: “treatment retention” -	Clinical records	Chi-square T-test	There was no significant difference in drop-out rate between service users who were matched (82.7%) or unmatched (78.7%) with the initial intake interviewer ($\chi2=2.41$, 1 df, $p>0.05$)

	and sex-matching as this relates to the early dropout rate of substance abusers, and (b) to extend previous work by examining the impact of such matching on treatment retention and 9-month outcome.					absolute number of days between first and last visits			There was no significant difference in "treatment retention" between the ethnically matched and unmatched groups ($t(367) = 0.00$, $p=0.99$)
Sterling et al., (2001), USA	Retrospective Cohort Outpatient Treatment facility To examine the impact of race- and sex-matching on treatment retention and outcome for a sample of people seeking outpatient substance	African American service users (n=116), Mean age = 32.8, 36.3% female	Counsellors (n=10). African American (n=6), White (n=4)	African American - African American	African American – White	Drop-out: proportion of patients returning for their first counselling session following intake Attendance: Number of days in individual treatment attended	Clinical records	Chi-Square T-Test	There was no significant difference in drop-out rate between service users who were matched (83.3%) or unmatched (85.3%) with the initial intake interviewer ($\chi2=0.08$, 1 df, $p>0.05$) There was no significant difference between matched

	abuse treatment.							and unmatched service users with regards to number of sessions attended ($t(71) = 0.85$, $p>0.05$)
*Sue et al., (1991), USA**	Retrospective Cohort Outpatient Mental Health Centres, Clinics and Hospitals. Investigated services received, length of treatment, and outcomes of thousands of Asian-American, African-American, Mexican-American, and White clients using outpatient services. Hypothesis: that therapist-	Asian American (n=3,344, mean age = 35.3), African American (n=3,415, mean age = 34.1), Mexican American (n=2,942, mean age = 33.5) clients	Not stated	Asian American - Asian American, African American - African American, Mexican American - Mexican American	Not stated§	Drop-out: failure to return for treatment after one session Attendance: number of sessions for either terminated or completed (log transformed)	Clinical records	Logistic regression Multiple regressions	For all groups except African Americans, ethnic match resulted in significantly lower odds of dropping out than unmatched clients Asian Americans: (OR = 0.20, $p<0.001$) African Americans: (OR = 0.96, $p>0.05$) Mexican Americans: (OR = 0.64, $p<0.01$) For each ethnic group, ethnic match was significantly related to greater

	client matches in ethnicity and language are beneficial to clients.								number of sessions Asian Americans: (Estimated effect = 1.84, $p<0.001$) African Americans: (Estimated effect = 1.15, $p<0.01$) Mexican Americans: (Estimated effect = 1.35, $p<0.001$)
Thompson et al., (2006), USA	Cross-sectional Community psychology clinic associated with a university doctoral program Examines the posttherapy reactions and attitudes of 44 African American clients seen at a university clinic in a	African American service users (n=44), Mean age=37.3, 75% female	8 clinicians. African American (n=4), European American (n=4)	African American - African American	African American - European American	Treatment satisfaction: Objectively measured using validated tool Attendance: number of sessions attended	The Therapy Rating Scale (TRS) Clinical records	ANOVA	Clients that were ethnically matched with their clinician self-reported significantly higher on the TRS than service users that were unmatched ($F(1,42) = 4.37$, $p<.04$, $\eta^2 = .09$) There was no significant difference in total number of sessions attended between matched and unmatched

	midwestern city								dyads (*F*(1,42) = .02, *p*=.88)
*Wintersteen et al., 2005, USA**	Cross-sectional "Cannabis Youth Treatment Project" Explored the effects of gender and racial matching on two key treatment indicators, the therapeutic alliance and retention, in a sample of substance-abusing adolescents.	African American adolescents (n=192), Mean age=15.7, 19% female	14 clinicians. White (n=11), African American (n=2), Latina (n=1).	minority patient –minority clinician	minority patient –Caucasian clinician,	Working Alliance: Objectively measured using validated tool	Working Alliance Inventory - Patient version (WAI-P)	Not stated	There was no significant mean difference between matched and unmatched dyads with regards to WAI-P score (*M* diff = -4.01, p=0.32)
						Attendance: attending two thirds of the intended treatment sessions	Clinical records	Chi-Square	There was a significant difference between proportions of matched (79%) and unmatched (55%) dyads in terms of attending two thirds of treatment sessions ($\chi2(2, N = 452) = 34.54, p < .001$)

** Study also analysed White service users matched with White therapists, but results are not reported in this review. Mean age and Gender is for total sample.*
† Data on Non-Hispanic staff in the unmatched dyad was not reported in this study.
§ Study reported that 1/3 sample were ethnically matched, 2/3 of sample were unmatched.

Table M2. Comparison of value ratings for BME participants with pan-cultural norms*

Sample: 160 British Clinical Psychologists			**Pan-cultural norms**	
Mean/median rating	Mean rank	Value item	Mean Rank	Mean rating
8	1	Universalism	2	4.42
6	2	Achievement	6	3.85
5.9	3	Stimulation	8	3.08
5.5	4	Security	4	4.38
5	5	Self-direction	2	4.42
5	5	Hedonism	7	3.73
5	5	Benevolence	1	4.72
4.3	8	Power	10	2.35
4	9	Conformity	5	4.19
4	9	Tradition	9	2.85

* pan-cultural norms obtained from Schwartz & Bardi (2001b)