‘Imposter Syndrome’- is that what I should call it? by Lakeitha Williams.

I was still in Primary School when my mum sat me down and told me that I would need to work twice as hard to get to the same places as my white friends, and that I still may fall short of the same opportunities. She explained, and really well I feel, that I may apply for jobs or Universities and be rejected because of the colour of my skin or my name. However, and I think my mum knew at the time, it does not matter how carefully you explain it, there is no way of articulating it in a way that compares to the experience.

I grew up in one of the least ethnically diverse areas in the country. I attended a college where I was 1 of around 40 racially minoritized students in a population of approximately 1,800 students. I graduated from a Russell Group University, despite Black individuals making up just 4% of Russell Group students. I am studying my Master of Science degree at a university where 4.3% of all postgraduate students are Black. For as long as I remember I have existed as a minority. I have been conscious of my otherness, and I have been aware that I have always been where I am against all of the odds. I have been a small percentage no matter where I placed myself. However, none of this prepared me for my experience of the psychology profession.

Clinical psychology is widely known as a competitive career path, with a 22% success rate for 2021 applicants. Once qualified, Black, Asian and Minority Ethnic (BAME) individuals make up 9.6% of clinical psychologists and just 1.7% of clinical psychologists identify as Black. Assistant psychologist roles are often part of the journey to qualifying as a clinical psychologist and have consequently adopted the competitiveness of the clinical psychology doctorate, with a reputation of being difficult to obtain. Despite an unimaginable sense of pride when I initially accepted the job, I almost instantly felt an overwhelming sense that I did not belong, and that I was experiencing everything alone.

I began attending meetings along with psychologists, including psychologists outside of my own team and not one of them looked like me. Every single psychologist was white. I am yet to meet a psychologist of a similar ethnicity to myself, either Black

or mixed White/Black Caribbean. Both through my studies and through work, I have only come across one clinical psychologist who is racially minoritized and they identify as Asian. I have always been able to channel my frustrations into my work however for the first time I was really starting to think: 'What is the point?' and I questioned whether it was a career worth pursuing, at the expense of my mental wellbeing.

Clinical psychology is undoubtably a career that will elicit difficult emotions, however many fail to consider the added emotional difficulties for ethnic minorities when navigating a system that has historically been oppressing them.

Assumptions

I am certain that all of those who are racially minoritized can give an example of a time that they have fallen victim to implicit biases, and in clinical psychology there is no escape. The mental health system, and specifically clinical psychology, tells me that I do not belong every single day that I work. For example:

When introducing myself, it is often highlighted that my name is difficult to say, that they 'will never remember that!' or ask: 'Is there anything shorter that I can call you?' despite the fact that I can think of countless white names with the same number of syllables that are not shortened. I often also get asked where my name originates from or 'where it comes from' on a regular basis, again reminding me that according to these individuals I could not possibly be from here. This is pushed further when I state that my *British* parents actually created my name themselves as I am often faced with 'No surely not! That sounds like it is from [insert any non-western country here]'. I have even had individuals insist that they google it for me as I must be incorrect about my own name.

Again, when introducing myself, other professionals have often been surprised that I am the Assistant Psychologist with comments such as 'Oh right!' Or some instantly assume that I am another job role, such as a support worker or working as agency staff. This has occurred to the extent where a clinical psychologist who I had attended numerous meetings with assumed that I was a support worker when running into me on a ward. There is of course nothing wrong with those roles, it just shows that these microaggressions may run a little deeper than the general mental health profession, and that clinical psychology appears to reject me because of my race more so than other mental health professions.

Similarly, when I mention that I am studying my masters it is nearly always assumed that this is at a polytechnic university rather than the Russell Group University that I am. Again, I am not criticising polytechnic universities, I am emphasising that I am being told that I could not possibly belong in the places that my white colleagues associate themselves with.

There are also the assumptions that every Black individual will fall victim to. Perhaps my tone was a little too sharp one day, or I did not show a soft enough expression in my face, if this is the case then I am likely to be perceived as 'angry'. If I do not show enough enthusiasm or drive, however, I may be considered 'lazy' or 'unmotivated'. Working within clinical psychology as a person of Black heritage is a constant balancing act between allowing others to see my motivation whilst simultaneously diluting it so that it is not regarded as aggression. This is particularly problematic when considering the nature of psychology where we are often offering an alternative perspective to other professionals.

'Working in a multidisciplinary team'

Psychologists are working within a system which the biomedical model of distress dominates. Therefore, much of the job entails communicating biopsychosocial explanations of distress to individuals who focus on biological explanations. When all goes to plan, professionals can work collaboratively to develop an understanding of an individual and it works nicely. However, clinical psychology fails to acknowledge how difficult this process may be for ethnic minorities who are vulnerable to assumptions and being perceived negatively. Individuals who are already carrying out a balancing act of demonstrating their passion yet not being considered confrontational are placed into the centre of situations where they must suggest alternative perspectives.

I am often interrupted and spoken over in meetings, I have had times where I have spoken, had people look at me and simply just not respond to me or turn around. The value of my role and therapeutic input has been questioned to my face. I have been told that the reason a service user, who has a history of struggling to engage, is engaging with me is because I am a young female (because it could never possibly be because of my hard work!). And of course, when I began to present as frustrated at how I was being treated, this was highlighted to everyone within the team, and I was perceived as

problematic. It is difficult not to question how much of this would have happened, if any, if I was a white male.

Service user's experiences of racism

Racial assumptions are so damaging to our mental health because it is difficult to clearly validate and challenge, it elicits a 'Was that racist?' question rather than a 'That was racist' statement in my mind. This expedites feelings of paranoia and mistrust, with no one being able to confirm these feelings. It is unsurprising that racially minoritized service users then turn to their clinician to confirm this, especially when their clinician is also an racially minoritized and consequently, we both know that there is a shared experience there, even if neither of us say it. Professionals working in clinical psychology must address the experience whereby racially minoritized individuals sit in meetings, conversations with colleagues, emails etc. with these 'was that racist?' thoughts, whilst also being asked 'was that racist' by service users. I have observed a number of situations with racially minoritized service users and questioned if their race is causing them to be treated differently. I know that white service users can act very similarly but the Black service user will be secluded. I know that sexually inappropriate comments from Black service users can result in them being moved wards, whereas from white service users it may be laughed off or viewed as a consequence of their mental health difficulties. This is difficult because I cannot detach myself from it, the subconscious assumptions being made about service users are likely being made about myself and yet I have a responsibility to ensure that service users feel safe.

Being treated as an imposter is not a syndrome

I could say that I *feel* as though I do not belong in clinical psychology, but the truth is I am told that I do not belong. From the lack of representation, the statistics showing how rare it is that I am here and to the daily microaggressions- I am told that I am not accepted in clinical psychology. This is why I felt uncomfortable when what I was experiencing was described as 'imposter syndrome' by colleagues and supervisors and I admittedly began using the term myself. However, 'syndrome' implies that my experiences are something that are internal and abnormal, as though there is something wrong with me for feeling that way. Feeling as though I do not belong in clinical psychology is a response to being told that I do not belong- by the system and indirectly

by individuals. By labelling these experiences as 'imposter syndrome', we invalidate very real experiences which consequently prevents us from working towards change.

It could admittedly be my own mistrust that a white person is making assumptions about me that results in it being an uncomfortable experience when I discuss racism in supervision. However, I have felt as though supervisors do not really want to have that conversation, or have encouraged me to seek to discuss it elsewhere (with it once being suggested that I approach an Asian psychologist about this) which can result in me feeling unsupported and as though I am fighting the system alone.

More to this, if I do not feel as though I can talk about my own racist experiences, it is difficult to discuss my experiences working with service users who are also being subjected to racism which can feel as though I am carrying the effects of racism for two people. It is difficult, as a person of colour, to know who is 'safe' to talk about racial experiences with and supervisors are not an acceptation. Clinical psychology must be actively anti-racism so that ethnic minorities know that it is a safe space to have those uncomfortable conversations, in this case we cannot be passive.

I am hopeful that if clinical psychology uses the understanding that it has for other difficult life experiences, then we can work towards racial equality within the system. However, the mental health system – and clinical psychology more specifically – is still a difficult environment for people of colour and we need to be active about changing this. There is a lot of work to be done, but I believe that we can get there.