October 2024

ADVANCING ANTI-RACIST THERAPY FOR RACIALISED COMMUNITIES

EQUALITY TRUST

BLAM

For further information on the issues raised in this paper, please email info@equalitytrust.org.uk

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Contents

Glossary

Anti-Black Racism: A specific form of racism targeting Black people, characterised by prejudices, discrimination, and systemic inequalities that disadvantage Black people and communities. It includes both overt actions and subtle biases in areas like education, employment, healthcare, and law enforcement, leading to social and economic disparities that disproportionately affect Black people.

Antiracist research and practice: An approach that actively opposes racism by identifying, challenging, and changing the policies, behaviours, and societal structures that perpetuate systemic racial inequalities. In research, it involves methodologies that uncover and address racial biases, aiming to dismantle inequities and promote justice. In practice, it encompasses actions at individual, institutional, and systemic levels to advocate for racial equity and inclusion.

Disparities: Refers to differences in outcomes, measured by quantitative data indicators (for example, poverty rates) or qualitative data indicators (for example, lived experiences)

Discrimination: The unequal treatment of individuals or groups based on their race or ethnicity. It involves actions, policies, or behaviours that disadvantage people due to racial prejudice, often overlapping with broader systems of racism that reinforce and perpetuate these disparities.

Eurocentric: A perspective or worldview that centres on European culture, values, and history, often considering them as superior or normative, while marginalising or ignoring the experiences and contributions of non-European societies. This term is used to describe biases in academia, media, and institutions that prioritise Western or European contexts over diverse global perspectives.

Internalised Racism: Occurs when people belonging to a marginalised racial group begin to believe and accept negative stereotypes, attitudes, or beliefs about their own group. As a result, they may doubt their abilities, feel inferior, or even discriminate against members of their own community, reinforcing harmful ideas without realising it.

Race: A social construct used to categorise people based on physical traits such as skin colour and ancestry. Race is a key determinant of a person's social location, status, and power in society and often serves as a basis for social inequality and discrimination.

Racism: The combination of prejudice with structural and institutional power, leading to systemic inequality and discrimination that is enforced and sustained through social, political, and economic control.

Structural Racism: A system in which public policies, institutional practices, cultural representations, and other societal norms work collectively to perpetuate racial inequity and maintain racial group hierarchies. It involves the cumulative and compounding effects of societal factors—such as housing, education, employment, and healthcare—that systematically privilege some racial groups while creating disadvantage for others.

Institutional Racism: Discriminatory policies, practices, and procedures within and across institutions and organisations that chronically favour or disadvantage certain racial groups. This form of racism is embedded in the operations of institutions like schools, businesses, legal systems, and healthcare facilities, leading to unequal access, opportunities, and treatment based on race. For example, if a school's policies make it harder for students of a particular race to succeed.

Interpersonal Racism: Prejudiced attitudes and discriminatory behaviours between people that reflect and perpetuate racial stereotypes and biases. This includes direct interactions where one person intentionally or unintentionally expresses prejudice or discrimination toward another based on their racial or ethnic background, such as through microaggressions, jokes, harassment, or overt hostility.

Psychotherapy: A treatment method where people work with a trained mental health professional to address and manage emotional, psychological, or behavioural challenges. Through talking and various therapeutic techniques, psychotherapy helps people understand their feelings, develop coping strategies, and make positive changes to improve their mental well-being and overall quality of life.

Racialised groups or communities: Refers to all groups that lack the privileges of White people due to the socially constructed process of racialisation. However the term is limited by not explicitly mentioning racial identities or ethnicities.

Racial stress and trauma: The emotional and

psychological distress experienced by people due to racism and discrimination. This stress arises from ongoing or acute incidents of racial bias, prejudice, microaggressions, or systemic inequalities, which can accumulate over time and lead to trauma. Racial stress and trauma significantly affects mental health and well-being, and requires culturally appropriate support and interventions.

Racial wellness therapy: A therapeutic approach that focuses on addressing the psychological and emotional impacts of racism and racial stress on individuals. It aims to promote healing, resilience, and well-being by acknowledging and processing experiences related to racial stress and trauma.

Statutory services: Services that the government is legally required to provide, as mandated by law or legislation. In the UK, these services include essential public services such as healthcare (NHS), education, social care, policing, and housing support. They are funded and regulated by various government bodies to ensure that citizens have access to basic needs and protections under the law. These services are distinct from non-statutory or voluntary services, which are not legally mandated and are often provided by charities or private organisations.

Whiteness: Centres the experiences, values, and perspectives of White people, often positioning them as the societal norm. Whiteness involves the privileges and power afforded to people perceived as White, maintained through social, economic, political, and legal systems. Examining whiteness helps to understand how racial hierarchies are established and perpetuated, contributing to systemic inequalities, dehumanisation, and subjugation of non-White people.

White supremacy: An ideology based on the belief that White people are superior to those of other racial backgrounds and should dominate society. It promotes the idea that White cultural, social, and political practices are the standard, leading to systemic racism and oppression of non-White people and communities. It has been used to justify forms of violence and maintain racial hierarchies.

Zuri Therapy: A form of racial wellness therapy structured as a series of workshops offered by the Black, Learning and Mental Health (BLAM) organisation. It centres hope and decolonial wellness practices to recognise and heal from racial trauma for Black people and communities in the UK. It incorporates lessons on recognising the effects of racial trauma combined with healing techniques such as centring Black joy, somatic exercises, building recovery plans, art therapy, and creating self-trust, amongst others.

Note on terminology

Discussing ethnicity requires that we be as specific as possible. Instead of using acronyms such as BME or BAME, we have opted for "racialised communities" when referring to multiple communities experiencing racial inequality. We use this term to highlight that race is a sociopolitical construct and to emphasise the experience of being racialised, rather than using it to define a community or identity.

Throughout this report, race-related terms are capitalised only when directly modifying a person-based noun (e.g., "Black people" or "White therapists"). Broader references to race, systemic concepts, or ideologies remain lowercase (e.g., "white supremacy" or "whiteness").

Any other language used in this report mirrors that of the original sources referenced.

Executive summary

The COVID-19 pandemic, the resurgence of the Black Lives Matter movement, and race riots across the UK have made the psychological toll of racism more visible and urgent. Racism is not just an isolated act of discrimination; it is a pervasive and cumulative force that shapes every aspect of life for Black and racialised people. It is a fundamental cause and driver of poor mental health, causing trauma and race-based stress and disparities in mental health outcomes.

However when people from racialised communities, particularly Black people, need treatment arising from racial injury, they are met with unsafe pathways to care, culturally inappropriate services and ultimately experience poorer outcomes. Statutory health services in the UK have largely failed to tailor their approaches to address racial trauma, and engagement with systems that lack acknowledgement or understanding of racism's effects can exacerbate mental health struggles. Dominated by Eurocentric understandings of mental health and treatment options, these services often employ "race-neutral" approaches that overlook the cultural and racial nuances that shape experiences of trauma and stress. This results in missed opportunities for healing and furthers racial discrimination, perpetuating disparities.

This report calls for an urgent reevaluation of how we address mental health in the UK by examining the intersections of racism, inequality, and mental health. The ongoing physical and psychological toll of racism with little recourse for support makes racial trauma a public health emergency. Crucially, racial wellness therapy and community-led approaches, such as Zuri Therapy, are essential alternatives that are able to address current gaps in statutory services. Racial wellness therapies offer promising models in reducing mental health disparities, fostering healing, and providing culturally relevant care for Black and racialised communities. By recognising the impact of racism on mental health and advancing community-based interventions, policymakers and practitioners can contribute to a more inclusive and responsive mental health system.

"It's important to know that this is an emergency. When you have a Black person going through racial discrimination and they can't find support, that is an emergency." – Zuri Therapy participant

What is Racial Trauma?

Racial trauma is the psychological and emotional distress caused by repeated exposure to racism, discrimination, and race-based stressors.

It particularly affects Black and racialised communities in the UK, where structural, institutional, and interpersonal racism intersect to significantly harm mental health. This trauma can be experienced directly (through personal encounters with racism), vicariously (by witnessing harm to others such as through hate crimes which act as 'message crimes to entire communities'), or even intergenerationally, as the effects of historical racism and ongoing discrimination are passed down. Black people in the UK often experience these racial traumas firsthand, which result in heightened levels of stress and mental health disparities.

This type of trauma can often manifests through even "small" but cumulative incidents like microaggressions, threats, and shaming, leading to symptoms such as anxiety, depression, hypervigilance, changes in self-perception, physical health issues (e.g., high blood pressures and ulcers), epigenetic changes (e.g. lower birth weights and accelerated ageing), and sleep disturbances.

Section Briefs

Section 1

Section 1 explores how modern disparities faced by Black and racialised communities in the UK have deep roots in colonialism, enslavement, and racial capitalism. Discriminatory practices have been sustained and reproduced through anti-Black and xenophobic legal and economic policies, such as the Nationality and Borders Bill and the Windrush Scandal, leading to poor mental health and premature death of Black and racialised people. These historical injustices have shaped inequalities across income, wealth, education, housing, deprivation across urban and rural areas, and the criminal justice system. These inequalities compound with other social factors and group memberships across gender, sexual orientation, faith, and migration to create and intensify racial trauma. In combination, this structural, institutional, and interpersonal racism lead to a cascade of poor mental health outcomes for Black and racialised communities, including higher levels of stress, frustration, feelings of social defeat, demoralisation and psychological distress. Despite race-related stressors being recognised as legitimate traumas, racial trauma remains poorly understood. Current definitions of trauma and treatments for PTSD are often rooted in individualist frameworks that exclude the political, economic and cultural contexts that enable them. This mental health paradigms fails to address the cumulative nature of racial trauma, and its impact on individuals and entire communities. By excluding structural inequalities as root causes of distress, services often misdiagnose or inadequately address these challenges. Only by integrating the impact of racism as a primary driver of mental health can effective interventions for racial trauma be developed and mental health systems be transformed to become more inclusive and responsive.

Section 2

Section 2 examines how mainstream psychology has roots in Eurocentric ideologies, historically positioning White, middle-class experiences as the norm while marginalising or excluding racialised voices. This has led to models of therapy that often pathologise racialised people, and fail to incorporate their sociopolitical and cultural realities. Consequently, therapeutic practices,

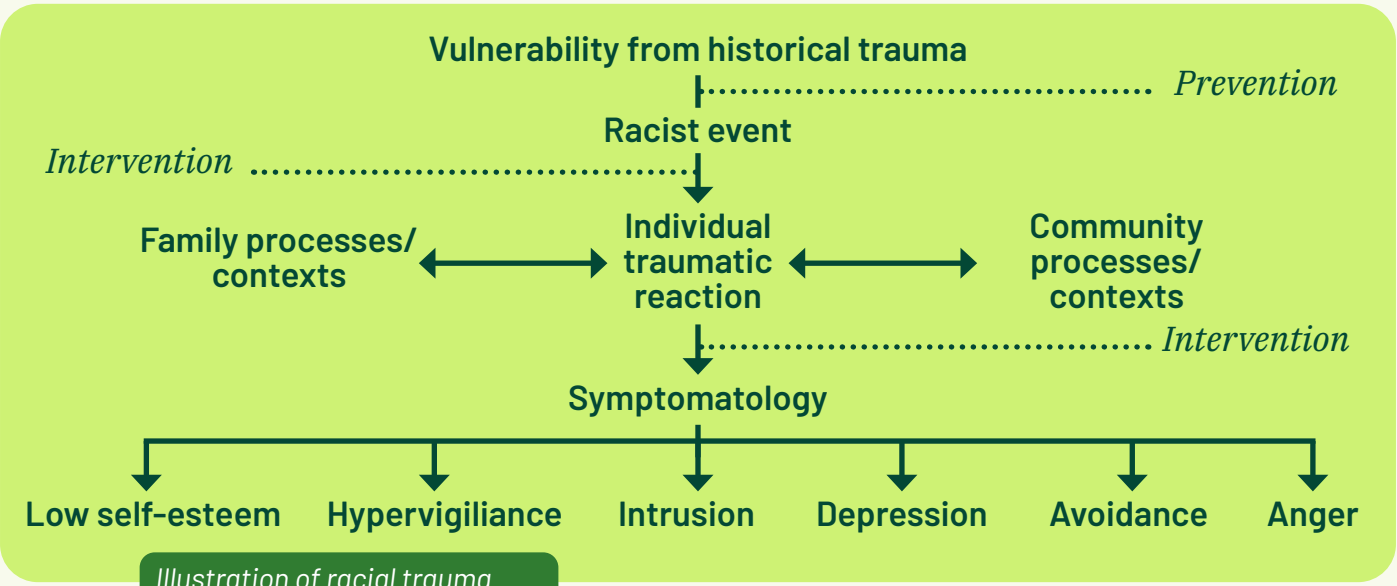


Illustration of racial trauma

such as Cognitive-Behavioural Therapy (CBT), overlook the impact of structural racism and inadequately address racial trauma.

Black and racialised communities in the UK face significant barriers to mental health care, often accessing services through the criminal justice system. Black people are 40% more likely to receive mental health care via criminal justice pathways and are 3.5 times more likely to be detained under the Mental Health Act than their White counterparts. Additionally, overdiagnosis of severe mental health conditions, like psychosis, and subsequent over-medication—particularly among young Black males—result in serious health risks, such as cardiac and neurological complications, leading to premature death. Such disparities, compounded by misdiagnoses (e.g., mental health symptoms mistaken for physical ailments like diabetes), drive mistrust in statutory services like the NHS. Fear of stigmatisation and racially biased treatment also discourages many Black people from seeking support. Healthcare professionals racially discriminated against at least 65% of Black Britons, and 75% of those aged 18–34 have grown more reluctant to seek help.

Therapeutic relationships between White practitioners and racialised clients are often strained due to inadequate training and lack of confidence to address racism. Practitioners may avoid or mishandle discussions on race, contributing to further harm or dismissal of racial trauma in therapy. Practices such as colour-blindness, racial stereotyping, and cultural assumptions often leave Black clients feeling unseen and invalidated. To improve care and address these disparities, it is essential to train therapists in culturally responsive approaches, ensuring they can safely navigate conversations about race, racism, and their impact on mental health.

Section 3

Section 3 spotlights voluntary sector organisations emerging as critical sites of intervention that provide culturally responsive and trauma-informed support for Black and racialised communities. Filling statutory service gaps, community-based interventions prioritise the needs and interests of racialised people in their design, implementation and evaluation. Programs like BLAM's Zuri Racial Wellness Therapy offer safe spaces for Black people to address mental health and racial trauma. Zuri Therapy, informed by Afrocentric principles and decolonial practices, has demonstrated its effectiveness in helping participants understand and process how structures of inequality, including privilege and oppression, affect mental health on a personal level. Four main lessons were extracted from participants involved in the case study:

1. **Culturally relevant therapy**: Participants gained a clear understanding of racism and its consequences for their mental health and wellbeing
2. **Value of Black therapists with alternating therapeutic approaches**: Participants' experiences in Zuri Therapy revealed the benefits of having Black therapists with alternating therapeutic approaches, ranging from somatic exercises to art therapy, allowing for a comprehensive approach to healing racial trauma. For many, this was the first time they had access to a Black therapist, highlighting the need for a more diverse mental health workforce.
3. **Free or low-cost services:** Offering therapy sessions at no charge or low cost was invaluable to participants, who often faced both financial barriers and systemic inequities that make accessing quality care difficult.
4. **Group-based spaces dedicated to Black people:** Created a space where the narratives of Black women were centred, and the nuanced experiences of misogynoir. Participants also reported that being

surrounded by other Black women helped alleviate feelings of isolation that often stem from being the only Black person in predominantly white spaces. the group dynamic promoted mutual aid, empowerment, and solidarity among participants. The recognition of shared struggles enhanced the healing process, providing an empowering context that validated individual and collective experiences.

- 67% felt misunderstood or dismissed by a mental health professional because of their racial or ethnic identity
- 57% of participants reported feeling safe and supported in their ethnic and/or racial identity when accessing formal therapy. This number changed to 90% when using Zuri Therapy
- 53% of participants reported that formal therapy acknowledged their nationality and/or immigration status as relevant dimensions of their mental health and identity. This number changed to 80% with Zuri Therapy.
- 50% of participants reported that formal therapy addressed communal or intergenerational healing and trauma in sessions. This number changed to 100% in Zuri Therapy
- 90% reported Zuri Therapy had been helpful or very helpful in understanding and addressing their lived experiences with racism or racial trauma, while 100% called for increased access to racial wellness therapy.

Key Recommendations for Advancing Racial Wellness in Mental Health

Prioritise authentic co-production and lived experiences

Move beyond traditional research methods like Randomised Control Trials by centering racialised stories and qualitative experiences to better inform care systems. Authentic community co-production democratise decision-making, distributes power, and holds authorities accountable. Developing better co-produced evaluation mechanisms, particularly in racial wellness therapy, can ensure services are truly responsive to the needs of racialised communities.

Call for better research and data

Improve data collection methods to capture more nuanced intersections of race, trauma, and mental health. This may involve introducing research methods that consider non-verbal, emotional, and visual experiences of racial inequalities and mental illness (which are generally considered 'less graspable') in order to provide progressive responses. Additionally, future data collection, investment, and infrastructure needs to better represent older racialsed people and adequately capture historical experiences of racism and discrimination, to enable more robust understandings of the effects of racism on health outcomes over the entire life course.

Support and fund community-led initiatives

Increase long-term investment in community-led mental health services led by and for racialised communities. These services bridge gaps in trust between racialised communities and statutory services. They also focus on early intervention, prevention, and advocacy, helping to reduce the reliance on crisis-driven interventions that disproportionately affect Black and racialised individuals. Increased funding allows expanded access by allowing organisations to remove financial barriers to mental health therapies and workshops.

Support voluntary sector partnerships

Strengthen collaboration with community organisations to design and deliver mental health support that overcomes the harms and barriers caused by racism, and build stronger partnerships with mainstream health services.

Mandatory anti-racism counselling education

Centre whiteness and its impact as a fundamental problem in the mental health field, ensuring that training explicitly explores how whiteness shapes therapeutic practice and the patient-therapist dynamic. Embed dedicated, compulsory courses on race, colonialism, and the impact of white supremacy into all counselling programs. Ensure this education is delivered by Black or racialised facilitators to avoid potential microaggressions and intimidation in learning spaces.

Enshrine anti-racism in the MHA

Incorporate anti-racism as a core principle in the new Mental Health Act to make it fit for purpose, addressing racial disparities in access, treatment, and outcomes to ensure mental health services are response to the needs of racialised communities.

Implement institutional reflection and leadership

Appoint an independent Equalities Champion with the authority to spearhead cross-government actions, focusing on addressing racial disparities in the NHS and across all healthcare systems. his role should be empowered to actively name, challenge, and address institutional whiteness and racism in policies, service delivery, workforce training, and clinical practice.

Strengthen discrimination laws and remove financial barriers

Improve legal frameworks to make it easier for employees to navigate and report workplace racial discrimination. Provide dedicated financial assistance and affordable legal recourse options for racialised people facing workplace discrimination, reducing financial barriers that limit access to justice.

Introduction

Racialised communities living in the UK disproportionately face poor mental health. When people of Black African, Black Caribbean, Bangladeshi and Pakistani heritage access the limited mental health services available, they often experience racism from these services. Therapy has rarely been able to meet the needs of racialised people. 'Colour-blind' or 'race-neutral' definitions of trauma have become the standard, while the direct and indirect exposures of racialised communities to racism across generations have been ignored. In large part, mainstream psychology is a product of the European worldview. Historically, Europeans have excluded racialised voices from the scholarship and practice of the field since its establishment – yet another consequence of racism. This has led to poorer outcomes for Black and racialised communities, and lost trust in statutory services providing mental healthcare.

A small but growing area of research is exploring how structural, institutional and interpersonal racism can function as stressors, impacting mental health and access to care. Racial stress and trauma, involves the psychological, emotional and physiological harm from experiences of racism. It includes direct and perceived discrimination, which can elicit feelings of danger, shame and stress. Racial trauma typically stems from repeated exposure to such experiences, both firsthand and through witnessing such harm to others, leading to ongoing psychological injury. Racialised people, especially Black communities, are not only enduring the cumulative effects of racism, but also have been forced to assume feelings of personal responsibility for the range of inequalities affecting them. The failure to address these inequalities and to provide appropriate support, despite the rising levels of poor mental health, has raised racism to the level of a public health emergency.

Community-based racial wellness therapies are designed to provide culturally responsive and trauma-informed support. Programs such as Zuri Therapy fill a crucial gap created by the institutionalised anti-Blackness experienced in statutory services such as the NHS. These initiatives focus on creating safe, affirming spaces where Black people can address mental health and racial trauma without the biases, racial discrimination, and lack of understanding

often encountered in state healthcare systems. By tailoring therapeutic practices to the lived experiences of Black people, such programs counteract the shortcomings of public services, which frequently fail to deliver equitable, culturally competent care.

Relevance

Despite the myriad racist incidents racialised people experience in their lifetimes and the likelihood that they may seek therapy for them, racial stress and trauma is under-recognised.

While racism and racial health inequalities have been recognised for over 50 years, mainstream policy and academic work have minimised their significance in mental health, especially prior to the COVID-19 pandemic, the Black Lives Matter movement, and race riots across the UK, resulting in limited interventions and a lack of evaluation for such policies.[1]

Policies surrounding citizenship, migration and economic austerity measures inordinately impact racialised communities, compounding existing racial health inequalities. These policies reinforce racialisation and contribute to worsening socioeconomic outcomes, which drive health disparities. An effective mental health paradigm demands a move beyond acknowledging that racism and inequality exist, towards understanding the structures and processes that perpetuate racial inequality and shape people's lives and opportunities. However, despite public statements supporting racial equality, little concrete action has been taken and the British government has often shifted the focus away from racism, exemplified by the 2020 Commission on Race and Ethnic Disparities, which downplayed racism and instead emphasised social mobility.[2]

The unending presence of racial discrimination and hate crimes makes it essential to document the nature and effects of racial trauma as well as the interventions focused on healing from these personal, vicarious and collective experiences.[3] To

'The Celebration' statue of Cyrille Regis, Brendon Batson and Laurie Cunningham.

1 James Nazroo, "Race/Ethnic Inequalities in Health: Moving Beyond Confusion to Focus on Fundamental Causes," *IFS Deaton Review of Inequalities,* (Institute for Fiscal Studies, 2022).

2 Ibid

3 Lillian Comas-Díaz, Gordon Nagamaya Hall, and Helen Neville, "Racial Trauma: Theory, Research, and Healing," *American Psychological Association* 74, no. 1 (January 2019).

address racial trauma among Black and racialised communities, we must understand how racism contributes to poor mental health outcomes prior to treatment and how Eurocentric models of mental healthcare can be dismantled. Research should support efforts to improve interventions such as racial wellness therapy that challenge such outdated models. Effective interventions must consider diverse perspectives, including those from communities, service users, voluntary organisations and professionals, and tailor care that reflects lived experiences. Establishing a mental health paradigm that is responsive to the experiences of Black and racialised communities is necessary for the delivery of safe and equitable person-centred care.

Aims and layout

This report is a collaboration between Black Learning Achievement and Mental Health (BLAM) and The Equality Trust. It advocates for the recognition of racial trauma as a public health crisis and seeks to address the relationship between racial trauma, socioeconomic inequality and mental health in mainstream psychology.

Section 1 explores the connection between modern socioeconomic inequalities and structural racism, revealing how these disparities have roots in colonial legacies and racial capitalism, and how they compound to develop racial stress and trauma.

Section 2 critically examines the culture of whiteness and institutionalised anti-Blackness in the NHS and other statutory mental health services. It details how Black people in particular have inadequate access to safe pathways to care, culturally appropriate service experience and poorer outcomes. Therapeutic relationships between predominantly White practitioners and racialised clients are often strained because of insufficient or absent training and the confidence to address racism. This risks increasing harm in therapy or missing opportunities to validate racial trauma, in turn perpetuating the disparities in mental health care and treatment.

Section 3 evaluates the effectiveness of community-based mental health approaches in addressing racial trauma. It uses BLAM'S Zuri Racial Wellness Therapy as a case study to highlight how Black communities have created their own therapeutic approaches to centre racial wellness, and how they are able to fill the gap of mistrust created by state and institutional failures by offering complementary services. Lessons are extracted for broader implementation, with the understanding that culturally relevant therapy is not a one-size-fits-all.

Section 4 synthesises findings to provide recommendations.

By addressing these aims, the report seeks to catalyse change in psychotherapy to widen access to racial trauma-informed therapy and culturally relevant mental health services. It focuses on the specific issues affecting Black people living in the UK, while recognising that other racialised communities also experience racial stress and trauma.

Methodology

This report is a product of an extensive review of both grey and academic literature published in English. As racial trauma has not been a focus in either grey or academic literature, intersecting bodies of literature surrounding racism, mental health inequality, racial trauma, socioeconomic inequalities and psychology from leading organisations and journals were explored. Reference lists of relevant reports and journals were used to find more related literature until saturation was reached. Methods of systematic reviews were not applied, but contextual and theoretical analysis using our own social scientific expertise was used.

In order to gain as many insights as possible within the available time limit, a mixed-methods approach was used by collecting primary qualitative data. Online surveys (10 respondents) and one-to-one interviews (9 in total) were conducted from users of BLAM's Zuri Racial Wellness Therapy. This primary data used an interpretative phenomenological analysis, which is primarily concerned with examining an individual's lived experience.[4] Questions in the semi-structured interviews were broad and flexible, allowing participants to elaborate on their own accounts without being stifled by interview schedules. The interviews were then transcribed verbatim before being subjected to analysis

4 Jonathan Smith, Michael Larkin, and Paul Flowers, *Interpretative Phenomenological Analysis: Theory, Method and Research* (SAGE Publications, 2009).

described by interpretative phenomenological analysis study.[5]

The research saw limitations surrounding participant engagement. The sample of service users were all women. Because of stigma around mental health and seeking help, Black men remain infrequent users of Zuri Therapy. Moreover, as many users of racial wellness therapy often access this service during periods of transition (e.g. moving between jobs, pivoting careers, leaving school, and entering or leaving relationships), they often have limited time and capacity to participate in surveys and interviews. Voluntary sector organisations working in mental health spaces also rely on limited resources such as funding or grants, which meant that compensation for overworked and underprivileged Black service users could not be offered, alongside the limited time for staff to dedicate towards further disseminating the survey. Future research around racial trauma should be directed at engaging with people from those communities with longer time frames and financial recompense for their time.

5 Ibid

Section 1: Contextualising socioeconomic and racial inequalities in developing racial trauma

"How can people give you space for kindness or wellness when they don't even believe your experiences exist?"

– Zuri Therapy participant

In the UK, people from Black and racially minoritised communities face persistent and widespread inequalities that impact their lives on every level. These disparities originate from the historical treatment and categorisation of said communities – a process known as racialisation (see Appendix A).

This economic, cultural, legal and political process has not only influenced the types of identities that exist, but also how each identity has been valued in society. The broad and ceaseless inconsistency with which these identities have been valued has caused damage to the psychological and physical health of racialised people. The longer racial inequalities persist, the more this damage accumulates, and heightens their risks of developing racial stress and trauma.

Mental health inequalities are often examined at the level of individual risk. Focusing on exposures to single-event traumas or the level of socioeconomic deprivation often overlooks how these risks and the responses to them are shaped by racism.[6] While most people think of racism as interpersonal acts of discrimination (e.g. someone refusing a service based on skin colour), the reality of racism as a complex structure with many levers goes misunderstood or, arguably, obscured by design.

Even when this reality is included, analyses of racism's impact on mental health lack depth, particularly in understanding how these different levers of racism each influence and reinforce one another to produce and shape these risks.

Recognising how past and present inequalities are bound to this structure can help us better grasp the ways racial categories are maintained and treated in the UK and ultimately foster a comprehensive approach to addressing racial trauma and stress beyond individual interventions.

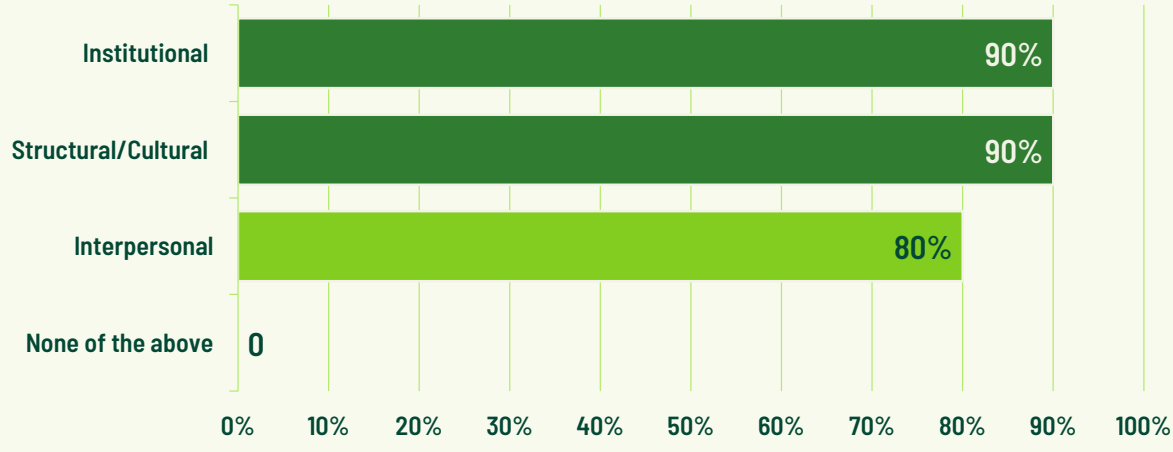
Connecting colonial legacies with modern racism

The Black radical tradition offers a critical perspective on contemporary inequalities that frames the lived experiences of Black people

When participants were asked: "How has racism affected you, if at all?"

- 90% responded experiencing structural racism
- 90% experiencing institutional racism
- 80% experiencing instances of interpersonal racism

Figure 1: Prevalence of racism among participants



6 James Y. Nazroo, Kamaldeep S. Bhui, and James Rhodes, "Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism," *Sociology of Health & Illness* 42, no. 2 (February 2020): 262–76.

within a continuum of systemic violence and dispossession over centuries. Modern-day oppression, incarceration and exploitation can be seen as the continuation of the brutal history of British colonialism, enslavement and racial capitalism. These disparities are not merely remnants of historical injustices, but are actively reproduced through legal and economic structures today that shape access to key resources such as economic opportunities, physical safety and social capital.

Legal and economic structures

The law gives us the impression that it reflects natural, inevitable rules and standards, rather than socially agreed norms. While the law exploits this impression to appear neutral or unbiased in function, it codifies discriminatory practices and prejudices as legitimate policies.[7] Anti-Black policies and anti-immigrant practices have been written into the British constitution, demonstrating the lasting legacy of state-sanctioned white supremacy in the country. Such laws have led to the poor mental health and premature death of Black and racialised people.[8]

From the early 2000s, the UK has implemented racist and Islamophobic laws and policies under the slogan of "countering terrorism". In this time, Muslims have witnessed a culture of fear burgeon around them.[9] At a new peak of xenophobic and anti-refugee sentiment, emboldened by the rise of right-wing ethnonationalist movements around the world, the UK voted for Brexit. In its aftermath, overt racist incidents and racial hate crimes spiked.[10] The Windrush scandal, which came to light in 2018, involved people from the Caribbean being wrongly detained, denied legal rights, threatened with deportation and, in many cases, wrongly deported from the UK by the Home Office. Many of those affected were legal residents who had come from the British colonies before 1973, prompting inquiries into the violent and reckless design of the UK's legal immigration system. In 2020, the murder of George Floyd in the United States and the patterns of assassinations and brutality against unarmed Black people by law enforcement evoked global protests and reaffirmed the Black Lives Matter (BLM) movement. This concurred with the COVID-19 pandemic, which magnified the existing health disparities experienced by Black and South Asian Britons, who suffered disproportionate mortalities from infection.[11]

The Old Port of London Authority Building

7 Patrick R. Grzanka, Kirsten A. Gonzalez, and Lisa B. Spanierman, "White Supremacy and Counseling Psychology: A Critical–Conceptual Framework," *The Counseling Psychologist* 47, no. 4 (May 1, 2019): 478–529.

8 Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*, vol. 21 (University of California Press, 2007).

9 Tabish Khair, *The New Xenophobia* (Oxford University Press, 2016).

10 Satnam Virdee and Brendan McGeever, "Racism, Crisis, Brexit," *Ethnic and Racial Studies* 41, no. 10 (August 21, 2017): 1802–19.

11 Office for National Statistics. "Why Have Black and South Asian People Been Hit Hardest by COVID-19?," December 14, 2020.

In recent years the concept of racial capitalism has gained increasing attention for its assertion that racism and capitalism have co-developed and are thus intertwined. It suggests that the global economic system, from its colonial-era inception onwards, has thrived through the exploitation of Black and other racialised people for maximum profit.[12] Economic and social systems in capitalist societies are not just neutral market forces, but also are deeply influenced by racial dynamics, from the enslavement of African people and their descendents to the exploitation of labour in formerly colonised countries and migrant workers from those countries, as well as the continued economic disparities faced by racial communities in the UK. In the current job market, one example of how racial capitalism manifests itself is through the racial clustering of Black people into insecure and low-paying jobs. Black women in particular are overrepresented in low-paid personal care occupations and are more likely to experience "in-work" poverty.[13]

These recent policies and practices should not be seen as historical anomalies, but instead as reflections of a more accurate chronicle of British history: white supremacy and nationalism has been institutionally sustained in law, governance, culture and civic life for nearly 500 years. Framing these events as "exceptional" erases this history and effectively presents as an amnesia in White British people, who may deny the normality of racism since they have "never had a problem with race" despite its being legally and economically embedded in British society.[14]

Compounding anti-Black racism and inequalities

Alongside existing deficiencies in public services, structural inequalities caused by racism have broader implications for how state policy continues to persecute the poorer, racialised and socially excluded sections of society. Contemporary economic inequalities faced by racialised communities, and Black people in particular, are distinct and complex, covering education, income and employment, housing discrimination, disproportionate policing and sentencing, and poverty and deprivation across urban and rural areas.[15] These inequalities further compound the adverse effects of discrimination when intersecting with other social factors and group memberships such as gender, sexual orientation, faith and migration. In combination, such disparities cause a cascade of poor mental health outcomes for Black and racialised communities, including higher levels of stress, frustration, feelings of social defeat, demoralisation and psychological distress.[16] Even more, the psychological distress of inequality experienced by parents is often passed down to children, creating a perpetuating cycle of disadvantage and poor health – also known as intergenerational trauma. The psychological toll of racism calls for an urgent reevaluation of how we address mental health in the UK.

> "You begin your day with someone not wanting to sit next to you on the bus. It's small but it's also not. Later, you'll be in line and someone else avoids you, and then by the evening it's another thing, and it doesn't go away. There is a lot that weighs you down and you don't have time to process it because then another day begins. And we can't just say,'Oh that's terrible' and move on. We can't do that. We can't just put it down.
>
> – Zuri Therapy participant
>
> One thing people don't understand is that it's happening all the time. It's not one thing. It's not just a race riot. It's a small tiny thing when it happens, but it never ends."
>
> – Zuri Therapy participant

Education

For many Black British children, school is often the first place where the scale of racism becomes apparent. Recent survey data found that the vast majority of young Black people have experienced

12 Carmen Gonzalez and Athena Mutua, "Mapping Racial Capitalism: Implications for Law," *Journal of Law and Political Economy* 2, no. 2 (August 1, 2022).

13 "Why Low Pay Is a Racial Justice Issue," Living Wage Foundation, October 2023.

14 Patrick R. Grzanka, Kirsten A. Gonzalez, and Lisa B. Spanierman, "White Supremacy and Counseling Psychology: A Critical–Conceptual Framework," *The Counseling Psychologist* 47, no. 4 (May 1, 2019): 478–529.

15 Heidi Safia Mirza and Ross Warwick, "Race and Ethnicity," *IFS Deaton Review of Inequalities* (Institute of Fiscal Studies, 2022).

16 Kate Pickett, Aini Gauhar, and Richard Wilkinson, "The Spirit Level at 15," *The Equality Trust*, July 2024.

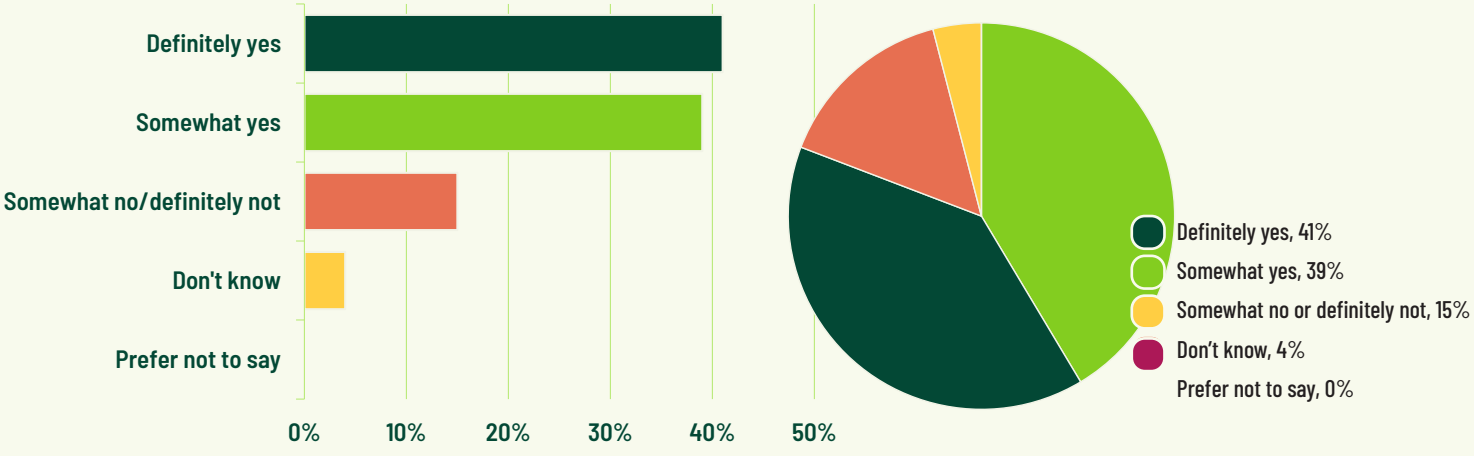
racism at school.[17] In the YMCA's Young and Black report, 90% of young people had heard or witnessed racist language at school, with 51% of Black boys saying that they heard it "all the time." In the same study, one in two young Black people said that racial stereotypes hindered their academic achievement.[18]

Evidence primarily derived from England suggests that persistent attainment gaps for Black students may indicate the discriminatory impacts of school policies and practices. In a survey carried out by the Black Equity Organisation, 50% of the respondents said that the teacher workforce and the school curriculum failed to reflect Black culture.[19] Bullying and harassment related to race also remain a significant issue in schools. A 2023 UK government survey found that 31% of school leaders and teachers had encountered reports of racist bullying in the past year. Black and Asian leaders reported witnessing or receiving such reports more frequently, at 46% and 47% respectively. In the 2021/22 school year, Gypsy/Roma pupils were most likely to be suspended or excluded, followed by Black Caribbean and Mixed White/Black Caribbean students. Unequal experiences at school also follow young Black people into higher education. Only 6% of Black school-leavers attend a Russell Group university compared with their White counterparts, and only 58% of Black students who are residents in the UK are awarded a First- or Upper Second-Class Honours degree compared with 81% of White students.[20] [21]

Income and employment

In UK workplaces, race discrimination remains prevalent. (Fig. 3) Reports consistently show that racialised people face disparities in income and employment compared with their White counterparts, including ethnicity wage gaps, barred career advancement and systemic barriers to wealth accumulation, such as through housing. Between 2021 and 2022, Bangladeshi and Pakistani workers faced the largest pay disparities compared with White British workers, earning 17.7% and 9.3% less, respectively.[22] Similarly, Black workers experience a significant pay gap, earning on average 7.8% less than their White British counterparts. These pay gaps tie closely with occupational segregation, since racialised workers are disproportionately represented in low-paid roles such as caring, leisure, sales, customer service and labouring jobs. Black workers in particular are most likely to be found in low-paying occupations.[23] Moreover, the rise in zero-hour contracts, a form of insecure employment with no guaranteed hours, has disproportionately affected racialised workers. From 2013 to 2019, the number of ethnic minority workers on zero-hour contracts increased by 96%, compared with a 29% increase for White British workers.[24]

Figure 2: Perceptions of racial discrimination in educational attainment



17 "Young and black: The young black experience of institutional racism in the UK," *YMCA England & Wales*, October 2020.

18 Ibid

19 Beth Swords and Ramya Sheni, "Black lived reality: why we need systemic change," *Black Equity Organisation*, September 2022.

20 "Black, Asian, and Minority Ethnic student attainment at UK universities," *UniversitiesUK*, May 2019.

21 "Black British voices," *Black British Voices Project* (University of Cambridge, August 2023).

22 "Racial Discrimination in Great Britain," *Equality and Human Rights Commission*, July 2024.

23 "Race Disparity Audit." *Cabinet Office*, May 2018.

24 "Racial Discrimination in Great Britain," *Equality and Human Rights Commission*, July 2024.

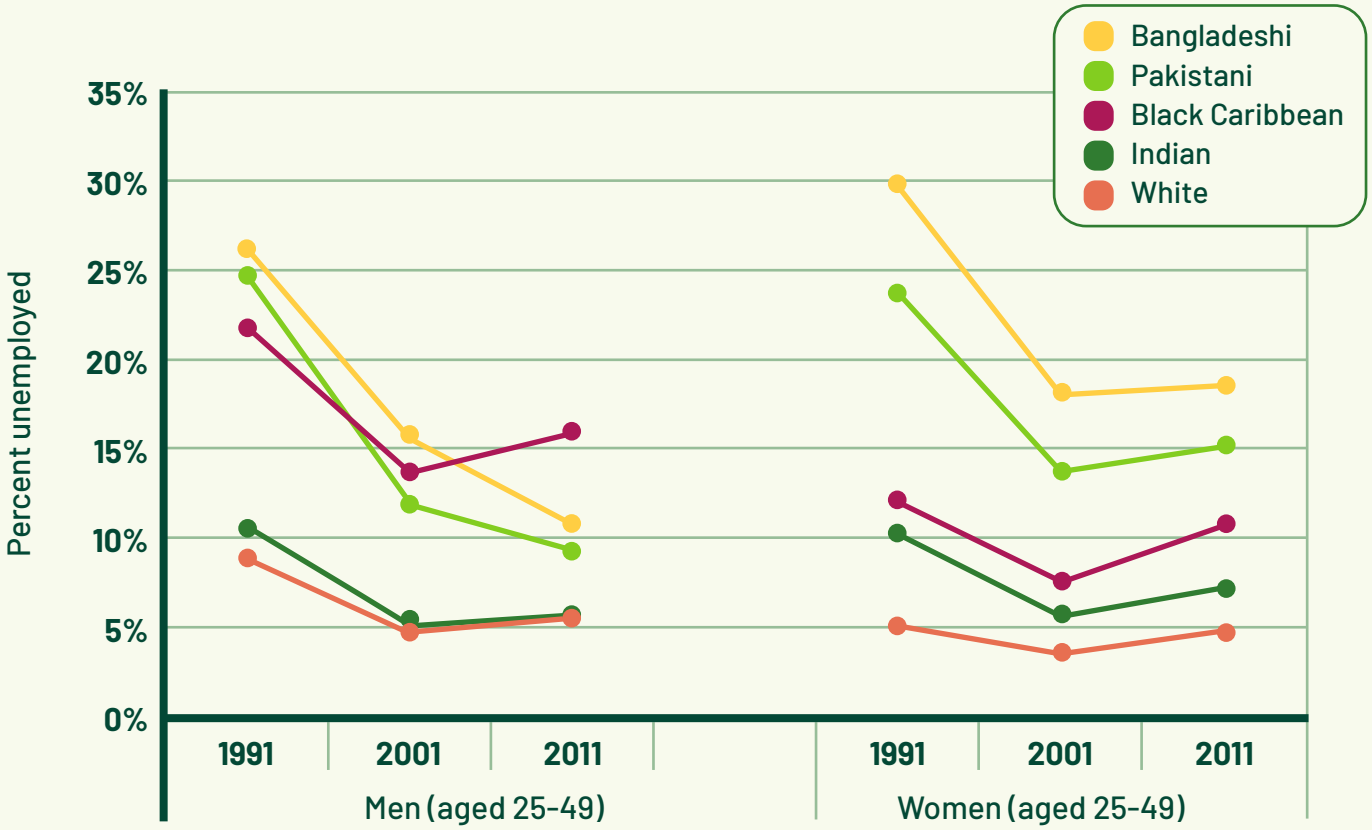


Figure 3: Persisting ethnic inequalities in employment in the UK[25]

The large pay gaps experienced by Black and racialised workers are heavily influenced by racial discrimination and the complex barriers they face in accessing and advancing in their careers. In the Young and Black report, over 50% of respondents cited bias and prejudice as the main barriers to securing employment, with 78% experiencing racist language in the workplace.[26] Additionally, the Black British Voices report revealed that 98% of respondents felt the need to compromise their identity to fit into the workplace.[27] For example, 70% of respondents from the same survey felt the need to alter their hair to be 'more professional'. Hair discrimination in workplaces often pressures Black people to change their natural hairstyles to fit Eurocentric standards, leading to cultural erasure and reinforcing the idea that Black features are not acceptable or desirable. Even protective hairstyles like braids and locs, which are essential for Black hair health, are often viewed negatively, burdening Black professionals with the need to constantly navigate perceptions of their hair in professional spaces. Hair discrimination impacts self-esteem and mental health especially amongst younger Black people, who feel the need to fundamentally alter aspects of their cultural identity in order to avoid judgement and be successful in their employment.

Discrimination is also evident in recruitment, promotion and training opportunities, as well as in access to mentors, role models and professional networks.[28] Racist treatment shapes the day-to-day experiences of Black workers, who are shown contempt, belittled by managers and colleagues, and have their concerns dismissed. Black workers are more likely than their White counterparts to be subject to disciplinary processes, receive low scores on their performance appraisals, be given more challenging and less popular tasks, and face unfair criticism and bullying.

Alarmingly, the vast majority of those who report being bullied, harassed or worse in the workplace do not feel able to report this to their employer. Navigating workplace racism costs significant time and effort, since proving discrimination involves gathering evidence and parsing complex bylaws. As well, seeking recourse to justice incurs

25 Dharmi Kapadia, James Nazroo, and Ken Clark, "Have Ethnic Inequalities in the Labour Market Persisted?," in *Bristol University Press eBooks*, 2015, 161–80.

26 "Young and black: The young black experience of institutional racism in the UK," *YMCA England & Wales*, October 2020.

27 "Black British voices," *Black British Voices Project* (University of Cambridge, August 2023).

28 "Racial Discrimination in Great Britain," *Equality and Human Rights Commission*, July 2024.

> "The financial cost of protecting your mental health as you progress in your career is too high. Organisations and businesses have endless support, but as an individual fighting against racism, you have none. Your options are either to leave these workplaces you've worked so hard to get into, which are filled with racism, and lose your financial safety, or keep your financial safety but have to stay embedded in that place that's harming your mental health."
>
> – Zuri Therapy participant

> "Who is holding these managers to account when Black people are so easily fired or just hired into such low positions? If the people holding power aren't being held to account, how can we set up structures that will be safe for us?"
>
> – Zuri Therapy participant

a financial burden due to the limited access to legal support, high costs of litigation, and the distress of an uncertain outcome. As racism and discrimination determine the types of jobs accessible to people, the pay they receive, and practices around promotion, retention and demotion, it is unsurprising that 53% of Black children live in poverty – double the rate for White children.[29] Moreover, 6.4% of the Black population are trapped in insecure work, compared with just 3% of White people.[30]

Housing and geography

Racialised groups face discrimination in accessing mortgages and housing. People from ethnic minority backgrounds are more likely to be turned down for mortgages or to pay higher rates than White applicants with similar financial profiles.[31] As income levels determine access to other essential amenities and goods – particularly since the enforcement of a benefit cap in 2013, which limits the social security benefits that people can receive – Black people fare significantly worse than White people in terms of being able to afford adequately-sized housing and adequate energy with which to cook food and heat homes. Out of the 4.4% of overcrowded households in England, the rates are significantly higher for Bangladeshi (28.7%), Pakistani (20.7%), and Black African (20.7%) headed households, compared to White-headed households.[32] Additionally, racialised communities are overrepresented in low-quality housing and areas with higher levels of pollution, highlighting the tangible impact of economic racism on psychosocial functioning and health.[33]

Two significant case studies underscore the dangers of substandard housing. In 2017, the Grenfell Tower fire in London claimed 72 lives. The majority of victims belonged to poorer and ethnic minority groups. In 2020, 2-year-old Awaab Ishak died due to exposure to mould in his social housing flat in Rochdale, England. These tragedies, alongside other public scandals, highlight the alarming persistence of structural inequalities, where obscene and rising wealth has often been directly gained from neglectful and exploitative public housing practices.

The wider influence of impoverished and often racialised pockets of deprivation across inner-city and rural areas worsens these housing challenges. Areas lacking green spaces, leisure facilities, safe and shared public spaces, and access to healthy food exhibit a powerful socio-epidemiological correlation: psychiatric conditions not only occur at higher rates in lower socioeconomic areas, but also cluster together.[34] This clustering indicates that these areas are not just sites of economic deprivation but also hotspots of mental health crises.

Policing and sentencing

Law enforcement's history of violence against Black communities has eroded trust in the institution. When the state not only authorises violence in the name of protection but also disproportionately exacts it against racialised people, stress and trauma become predictable. A 2023 independent review of the Metropolitan Police in London identified the force as

29 Andrew Sparrow, "More Than Half of UK's Black Children Live in Poverty, Analysis Shows," *The Guardian*, January 3, 2022.

30 "BME workers on zero-hours contracts," *Trade Union Congress*, June 2021.

31 Solomon Y. Deku et al., "Ethnic Minorities' Access to Mortgages in the UK: The Undesirable Impact of the Great Financial Crisis," *Finance Research Letters* 45 (March 1, 2022): 102183.

32 "Racial Discrimination in Great Britain," *Equality and Human Rights Commission*, July 2024.

33 Liz Gadd et al., "How Will the Climate and Nature Crises Impact People From Black, Asian and Ethnic Minority Communities?," *Race Equality Foundation*, May 2023.

34 Vijaya Murali and Femi Oyebode, "Poverty, Social Inequality and Mental Health," *Advances in Psychiatric Treatment* 10, no. 3 (May 1, 2004): 216–24.

institutionally racist as a result of its over-policing of Black people and broader issues of racial discrimination in the organisation.[35] Black people are 3.3 to 3.5 times more likely to face police use of force compared with their White counterparts.[36] Despite constituting 14% of the UK population, Black and minority ethnic people make up 27% of the prison population and are more likely to receive harsher sentences for the same crimes.[37] Additionally, the growing use of facial recognition technology by police, with its inbuilt racial biases, has codified discriminatory practices in law enforcement.[38]

Young people experience particularly severe disparities in detention and sentencing in Britain. In 2023, 50% of the youth custody population came from Black, Asian, Mixed, and Other ethnic groups, with Black children representing 26% of those in custody despite only making up 6% of the general population aged 10–17.[39] Young people who experience higher levels of racial discrimination also show increased trauma symptoms and higher rates of delinquency, suggesting that racial stress and trauma play a significant role in contributing to the racial disparities observed in juvenile delinquency.[40]

Gender, sexuality, disability, and faith

Among other social aspects, race intersects with gender, age, disability, sexuality and faith to create complex challenges for people in racialised communities. Alongside financial insecurity, these intersections can place, for instance, women and queer people at long lasting risk of racial trauma and poor mental health. Black and racialised women often encounter racism, financial abuse and misogynistic violence, further complicating their ability to seek mental health support.[41] Black women specifically face misogynoir: the specific hatred, dislike, distrust and prejudice directed towards Black women. Almost one-third (31%) of Black women report being unfairly passed over for or denied a promotion at work; this rose to nearly half of disabled Black women (45%).[42]

Black women also face biased medical practices dating back to the creation of gynaecology, where they were subjected to unethical experiments and treatment under the assumption that they could endure more pain than their White counterparts. This harmful stereotype persists today, as studies indicate that some medical professionals still believe Black women have higher pain thresholds, leading to inadequate pain management and poorer health outcomes.[43]

Black and racialised LGBTQIA+ people experience stigma and discrimination in both racialised and

35 Baroness Louise Casey DBE CB, "Final Report: An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service," *Metropolitan Police*, March 2023.

36 "Racial Discrimination in Great Britain," *Equality and Human Rights Commission*, July 2024.

37 "Table 1.4: Offender management statistics quarterly: April to June 2020," *Ministry of Justice*, October 2020.

38 "Briefing on Facial Recognition Surveillance," *Big Brother Watch*, June 2020.

39 "Youth Justice Statistics: 2022 to 2023 (Accessible Version)," Youth Justice Board, January 25, 2024.

40 Hye-Kyung Kang and David L. Burton, "Effects of Racial Discrimination, Childhood Trauma, and Trauma Symptoms on Juvenile Delinquency in African American Incarcerated Youth," *Journal of Aggression Maltreatment & Trauma* 23, no. 10 (November 26, 2014): 1109–25

41 WHEC et al., "Women's mental health and wellbeing: Access to and quality of mental health services," *Women's Health & Equality Consortium*, 2016.

42 Clare Wenham et al., "BME Women and Work," *TUC Equality Briefing*, 2020.

43 Rolonda Donelson, "Misogynoir in Medicine: How Bias in the Medical Field Places Black Women'S Lives at Risk," O'Neill Institute for National & Global Health Law, July 10, 2024.

queer communities. They reported higher rates of depression (62%) and eating disorders (22%) compared with 11% for White LGBTQIA+ people.[44] Faith and culture also complicate the process of seeking help and 'coming out' partly due to the psychological stress of environments often marked by homophobia, stigma, and direct and indirect discrimination. Young, Black, Muslim and LGBTQIA+ women have often noted the racism encountered in queer spaces, as well as Islamophobia and homophobia in day-to-day life.

Migration and citizenship

The legacy of oppressive immigration policies, practices and laws has left many migrants, particularly those fleeing war, grappling with profound loss and trauma. Migration often reduces support networks, including family and community. The stress of being uprooted, followed by social and linguistic isolation, increases migrants' vulnerability to depression, inflammation and other illnesses. Ethnocentrism and nativism shape the disparity in treatment between racialised, asylum-seeking people and White migrants and refugees. The Nationality and Borders Bill attempted to legalise the inhumane treatment of refugees and deepen racial inequalities, while the Homes for Ukraine scheme offered an entirely different experience to the majority White, Ukrainian asylum seekers.[45] Recent race riots across the UK targeted Black people and refugees, stoked for years to a boil by a media and political system that has upheld anti-Blackness and inequality by scapegoating migrants, Muslims, and Black and Brown people.[46] A study by South East London Community Health investigated the relationship between discrimination and common mental health disorders based on migrant status and ethnicity.[47] The findings revealed that recent migrants and Black ethnic groups were more than twice as likely to experience discrimination compared with any other group.

Black people are 3.3 to 3.5 times more likely to face police use of force compared with their White counterparts

Understanding racial trauma and stress

The explanations and evidence for trauma have been contested as simplistic in representing the complexity of social structures, personal adversities and the mental and bodily changes that accompany racial injury.[48] [49] Together,

44 Chaka L. Bachmann and Becca Gooch, "LGBT in Britain: Health report," *Stonewall* (YouGov, 2018).

45 IGPP, University of East London Centre for Social Justice and Change, and University of East London Centre for Research on Migration, Refugees and Belonging, "Global Justice in Refugee Crises," *Institute of Government & Public Policy* (United Kingdom of Great Britain and Northern Ireland, 2022.).

46 "Briefing: The Link Between Inequality and the Far Right," *The Equality Trust* (blog), August 14, 2024.

47 S.L. Hatch et al., "Discrimination and common mental disorder among migrant and ethnic groups: findings from a South East London Community sample," *Social Psychiatry and Psychiatric Epidemiology* 51 (2016): 689–701.

48 Robert T. Carter, "Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress," *The Counseling Psychologist* 35, no. 1 (2007).

49 Thema Bryant-Davis and Carlota Ocampo, "Racist Incident–Based Trauma," *The Counseling Psychologist* 33, no. 4 (June 16, 2005): 479–500.

> "You have to fight for everything because of the assumptions made about who you are, and no one wants to see beyond that."
>
> – Zuri Therapy participant

these factors cumulatively cause racial trauma. Racial stress and trauma refers to the ongoing exposure and toll of race-based discrimination at interpersonal, institutional, and structural levels. Whether as a result of subtle or overt racism, racial stress and trauma inflict deep psychological wounds, leaving behind scars that may not be visible but exert profound and lasting effects on the mind, body and spirit. While conventional therapies may focus on trauma's effects on personal growth, safety and self-expression, the effects of racial stress and trauma are not just individual; they are felt through entire communities of colour.

This type of trauma has similar features to post-traumatic stress order (PTSD) or complex PTSD. Racial trauma is distinct, however, in that it involves repeated exposure to race-based stressors, notably in the form of 'small' incidents. Such stressors include microaggressions, threats of harm, humiliating or shaming incidents and witnessing racial discrimination against other people of colour. These can result in emotional responses including anxiety-depression, avoidance, feelings of anger and hypervigilance (Figure 4),[50] as well as hormonal changes (e.g. greater allostatic load or 'wear and tear' on the body);[51],[52] epigenetic changes (e.g. cellular damage, lower birth weights, accelerated ageing);[53] behavioural changes (e.g. either only affiliating with or avoiding one's racial in-group); sleep and memory-based changes (e.g. nightmares and flashbacks); spiritual changes (e.g. questioning one's faith); changes in self-perception (e.g. internalised racism); disassociation (e.g. feeling numb or having out-of-body experiences); negative thoughts (e.g. a person might lose trust in other people or worry that all authority figures want to harm them); and physical impacts (e.g. higher blood pressure, fatigue, headaches, heart palpitations and ulcers). See figure 4: illustration of racial trauma. [54]

Development of racial trauma

Racial trauma can be experienced (i) systemically, (ii) interpersonally and/or (iii) historically. Systemically, racism is uniquely traumatising as it is an almost continual reminder of one's marginalisation and occurs without a time limit, entering all facets of a person's life, including community interactions, access to resources and wellbeing, and education. Persistent feelings of not belonging, being undervalued and lacking entitlement to support can adversely affect mental health. When people engage with systems that fail to recognise or address these issues, it can trigger new mental health challenges and worsen existing mental health difficulties.

Trauma can be experienced directly, such as through personal experiences of racial discrimination or violence (primary trauma), or vicariously, through exposure to graphic images or distressing stories of racial violence (secondary trauma). Racism does not need to be experienced firsthand to create a sense of threat, since interpersonal incidents of racism reflect attitudes towards entire communities, rather than individual members.[55] For example, as victims of hate crime realise they have been targeted for characteristics they cannot change, they may fear "repeat victimisation", which can lead to them modifying how they live their lives.[56] They are more likely to suffer from higher levels of vulnerability, depression, anxiety, nervousness, an extreme sense of isolation and long-lasting fear, and poor

50 Nicole Williams, "Addressing Whiteness and Racism in Clinical Psychology: White Clinical Psychologists' Experiences within Leadership" (PhD Dissertation, University of East London, 2022).

51 O. Kenrik Duru et al., "Allostatic Load Burden and Racial Disparities in Mortality," *Journal of the National Medical Association* 104, no. 1–2 (January 1, 2012): 89–95.

9684(15)30120-6

52 James W. Collins et al., "Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination," *American Journal of Public Health* 94, no. 12 (December 1, 2004): 2132–38.

53 Arline T. Geronimus et al., "'Weathering' and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States," *American Journal of Public Health* 96, no. 5 (May 1, 2006): 826–33.

54 Adapted from Farzana T. Saleem, Riana E. Anderson, and Monnica Williams, "Addressing the 'Myth' of Racial Trauma: Developmental and Ecological Considerations for Youth of Color," *Clinical Child and Family Psychology Review* 23, no. 1 (October 23, 2019): 1–14.

55 Satnam Virdee, *Racism, class and the racialized outsider* (Bloomsbury Publishing, 2014).

56 "Understanding the Needs of Hate Crime Victims," *OSCE* (OSCE Office for Democratic Institutions and Human Rights, 2020).

mental health more broadly.[57] [58]

For adolescents, there is also a significant association between their exposure to race-related traumatic events online (defined as seeing images or videos of others from their ethnic background being beaten, arrested, detained or shot by police officers) and poor mental health outcomes.[59] Traditional media in the UK has fuelled racism over the course of decades, shifting from overt anti-Blackness to more covert tactics, such as in the criminalising portrayal of Mark Duggan in British media after he was murdered by the Metropolitan police, as well as the demonisation and vilification of refugees and asylum seekers depicted as "swarms" in tabloids and broadsheets alike (who are predominantly Black or Brown). Media exposure, by way of photographs and film, mediates our understanding of reality by altering the way we see and interpret the world, often replacing direct experience with an altered version of reality.[60] During the Black Lives Matter movement, graphic images and videos of Black people experiencing violence or brutality were widely shared. Critical race theorists criticised how the widespread desensitised distribution of violent images of Black individuals contrasted with the more protective portrayal of White victims of violence, reflecting and reinforcing the notion that Black lives were less valuable and contributing to a broader devaluation of Black suffering. This distribution of violence against Black people led to vicarious trauma among viewers in Black communities who were directly impacted by the depicted realities.

Racial trauma is also cumulative. This means that every next exposure to racial discrimination and its consequences builds on the previous exposure. The cumulative effects of historical loss, forced assimilation, widespread mistreatment and daily indignities faced by racialised people can result in a trauma affecting generations. Experiences of both past and present injustices have been found to pass down as psychological distress from one generation to the next.[61] This collective trauma, often referred to as "soul wounds", stem from historical atrocities like colonisation, slavery and genocide, and can be triggered by even minor incidents.[62] This cycle of trauma can present as internalised racism and numerous long-term consequences for mental health and overall wellbeing.[63]

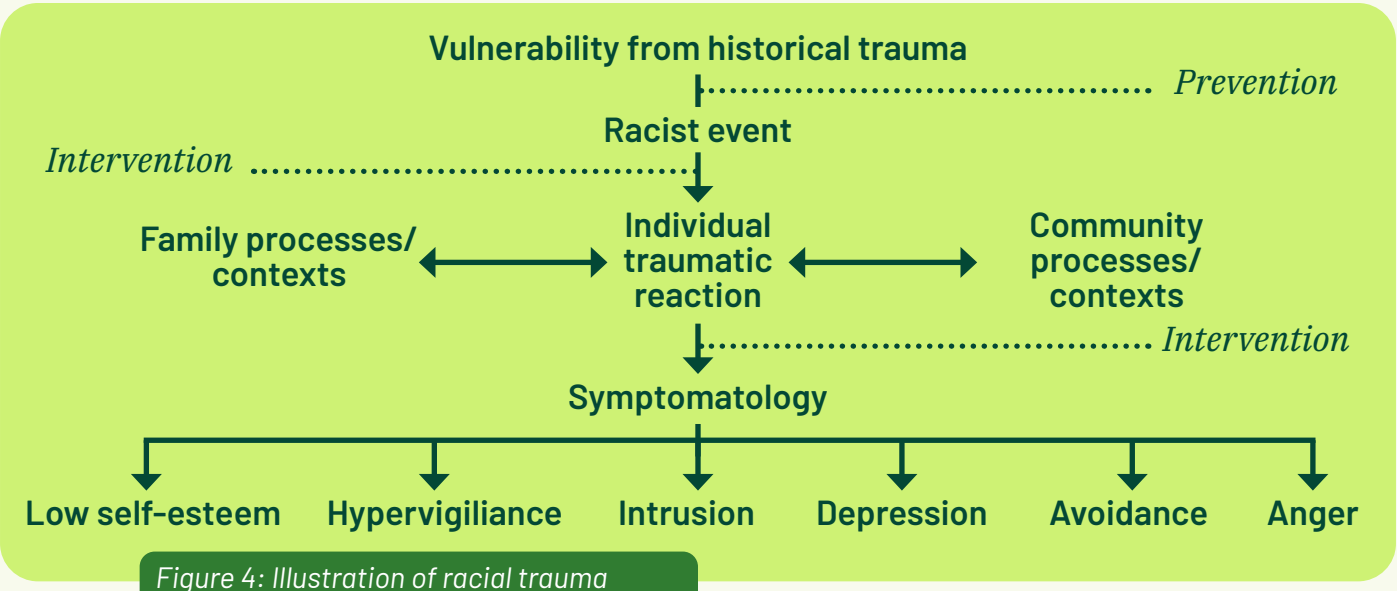


Figure 4: Illustration of racial trauma

57 Ibid

58 Sarah Stopforth et al., "The Enduring Effects of Racism on Health: Understanding Direct and Indirect Effects Over Time," *SSM - Population Health* 19 (September 1, 2022): 101217.

59 Brendesha M. Tynes et al., "Race-Related Traumatic Events Online and Mental Health Among Adolescents of Color," *Journal of Adolescent Health* 65, no. 3 (September 1, 2019): 371–77.

60 Susan Sontag, *On Photography* (Farrar, Straus and Giroux, 1977).

61 Debra Minsky-Kelly and Becki Hornung, "Structural Whiteness in Mental Health: Reexamination of the Medical Model Through a Lens of Anti-Racism and Decolonization," *International Journal of Social Work Values and Ethics* 19, no. 2 (August 19, 2022): 153–73.

62 Lillian Comas-Díaz, Gordon Nagamaya Hall, and Helen Neville, "Racial Trauma: Theory, Research, and Healing," *American Psychological Association* 74, no. 1 (January 2019).

63 "Three Million: A Road to the Past," *BBC* (BBC Sounds, 2024).

Under-recognition of racial trauma

Although race-related stressors have been recognised as legitimate traumas, they have yet to be named a public health concern or emergency in the UK. This is partly due to the current mental health paradigms in the country and how the White experience is currently centred. Excluding racism and inequalities as primary drivers of chronic stress conditions can result in incorrect or insufficient diagnoses and treatment.[64] Current definitions of trauma and treatments for PTSD are often rooted in individualist assumptions, which exclude the political, economic and cultural contexts that enable them. For racialised people, these definitions may be naive.

The DSM-5 and ICD-11,[65] leading manuals for mental health research and diagnostic reference internationally and in the UK, both continue to exclude racial stress and trauma from their definitions. Scholars have noted that white privilege and racial bias are inherent to the DSM because of its failure to capture the complexity of traumatic experiences across racial and ethnic lines, such as not considering covert discrimination, institutional racism or media exposure, and instead privileging direct exposure to interpersonal racist incidents that would fall under PTSD.[66] Racial trauma is then likely underreported due to clinicians' limited awareness, biases, and discomfort in addressing racial issues, along with the restrictive and exclusionary criteria of the DSM-5 and ICD-11.[67] However, some scholars argue that current framings of racial trauma risk pathologising normal and appropriate reactions to discrimination or unjust treatment.[68] Continued discussion of racial trauma is therefore necessary to develop more preventative solutions.

> "We need to understand our history – our own sources of knowledge – and that Western psychology doesn't necessarily help or fit like a glove, because we've had different journeys." – Zuri Therapy participant

64 Debra Minsky-Kelly and Becki Hornung, "Structural Whiteness in Mental Health: Reexamination of the Medical Model Through a Lens of Anti-Racism and Decolonization," *International Journal of Social Work Values and Ethics* 19, no. 2 (August 19, 2022): 153–73.

65 The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and the International Classification of Diseases for Mortality and Morbidity Statistics, Eleventh Revision

66 Farzana T. Saleem, Riana E. Anderson, and Monnica Williams, "Addressing the 'Myth' of Racial Trauma: Developmental and Ecological Considerations for Youth of Color," *Clinical Child and Family Psychology Review* 23, no. 1 (October 23, 2019): 1–14.

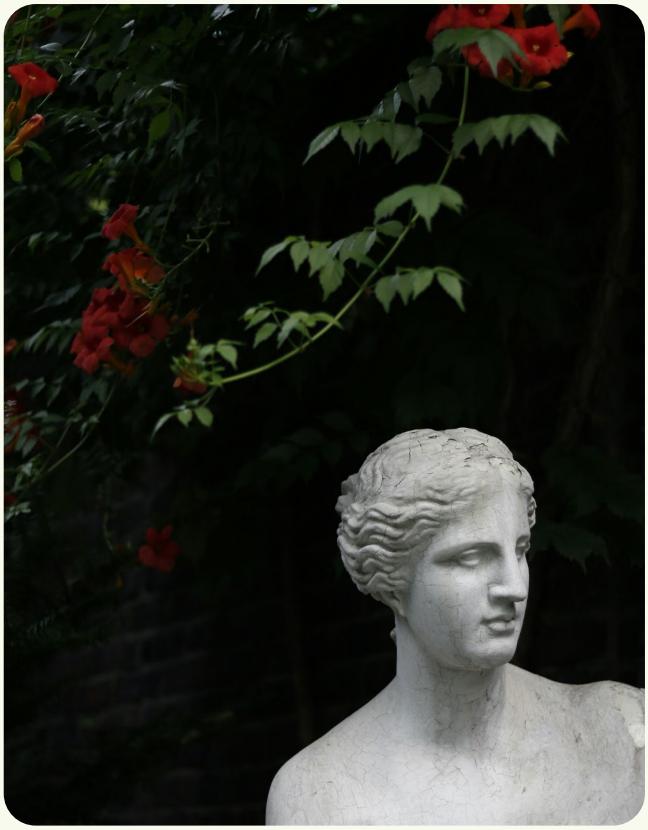
67 Ibid

68 Tyler Rainer et al., "Structural Racism in Behavioral Health Presentation and Management," *Hospital Pediatrics* 13, no. 5 (2023): 461–70.

Section 2: Conceptualising the culture of whiteness in mental healthcare provision and psychotherapy

The racist roots of psychology

Present-day psychologists may be hesitant to frame clinical psychology and psychological science as political or cultural.[69] Yet historically, psychology has produced studies of personality, IQ, motivation, accomplishment, "merit" and other measures of competency that have established and reinforced a 'science' of racism.[70] Many of these studies, produced with flawed or falsified research, advanced 'scientific' racism well into the twentieth century, and helped spread theories legitimising the oppression of Black people and positioning White people as psychologically superior and complex.[71] How intelligence was determined was of prime interest to nineteenth-century psychologists, who would misuse and misconduct race-related research that 'naturalised' the political and economic disparities between White and Black people, as in the false association of skull size with intelligence and the eugenic principle of biologically inherited behaviours. These theories went on to inform public policies on colonisation, immigration and education, including curricula in Oxford and Cambridge universities, labour policies in India and South Africa, and the Aliens Act 1905. The growing medicalisation of mental illness and distress, and the subsequent rise of psychiatry and psychology as disciplines, deepened the perceptions of racialised people as behaviourally unwell, as seen in the invention of disorders like drapetomania,



which was proposed to explain why enslaved Black people tried to escape slavery.

More recently, decades of research to uncover human psychology have largely uncovered truths for a small and unrepresentative sample of people — those who live in Western, educated, industrialised, rich, and democratic (WEIRD) nations.[72] Even within these studies, the cultural differences between racialised groups are not deeply attended to. However, growing theoretical and empirical work acknowledges that humans are fundamentally cultural, and so cultural differences are also psychological differences, including norms and attitudes to the degree in which both are enforced.[73] For example, Black people may develop ideas and beliefs that are normal in their cultures but are then deemed "abnormal" by mental health institutions.[74] As Dr. Robert Guthrie argues,

"... psychological diagnosis is in itself often misleading and tells us little about the client; however, it reveals much more about the

69 Joseph P Gone, "Is Psychological Science A-cultural?," *Cultural Diversity & Ethnic Minority Psychology* 17, no. 3 (January 1, 2011): 234–42.

70 Andrea L. Dottolo and Ellyn Kaschak, "Whiteness and White Privilege," *Women & Therapy* 38, no. 3–4 (August 31, 2015): 179–84.

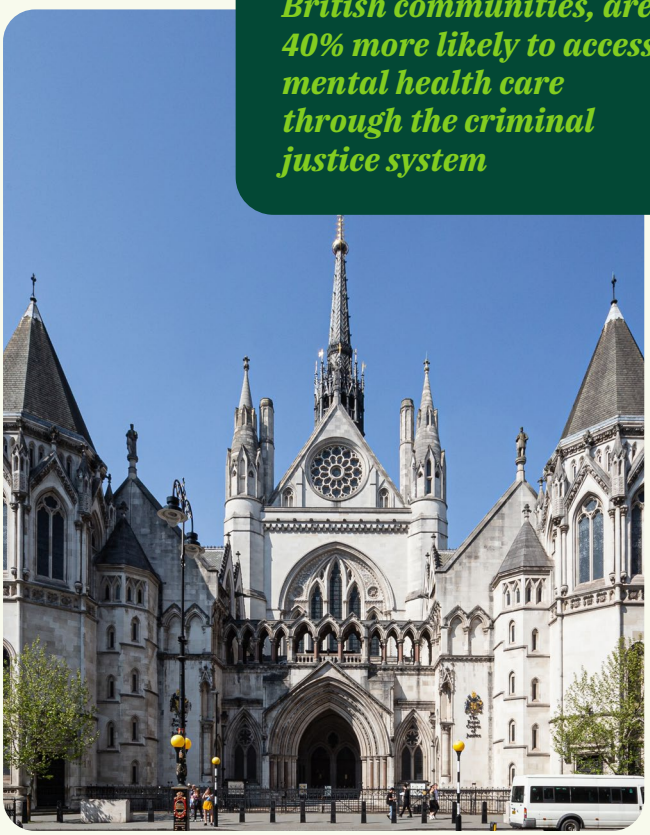
71 Debra Minsky-Kelly and Becki Hornung, "Structural Whiteness in Mental Health: Reexamination of the Medical Model Through a Lens of Anti-Racism and Decolonization," *International Journal of Social Work Values and Ethics* 19, no. 2 (August 19, 2022): 153–73.

72 Joseph Henrich, Steven J. Heine, and Ara Norenzayan, "The Weirdest People in the World?," *Behavioral and Brain Sciences* 33, no. 2–3 (June 1, 2010): 61–83.

73 Michael Muthukrishna et al., "Beyond Western, Educated, Industrial, Rich, and Democratic (WEIRD) Psychology: Measuring and Mapping Scales of Cultural and Psychological Distance," *Psychological Science* 31, no. 6 (May 21, 2020): 678–701.

74 Frantz Fanon, *Black Skin, White Masks* (Grove Press: 2008).

Racialised groups in the UK, particularly Black Caribbean, Black African, and Black British communities, are 40% more likely to access mental health care through the criminal justice system



environment in which the observer finds the individual…behaviours labelled as bizarre in one culture might be considered acceptable in another culture even when these cultures are contiguous rather than separated by continents or great distances…normalcy categorization and labelling follows the needs of the power holders in a given society."[75]

Guthrie identifies "White" as a yardstick by which all others are measured and judged. In the therapeutic context, this features in the ways counselling psychologists are often taught that "race is a characteristic of those who are not White", and thus devalues our understanding of distress in racialised people.[76]

Traditional Eurocentric psychology is poorly equipped to heal the trauma that many Black people have and experience daily, including racial trauma. Scientific theories of the 'self' have been largely developed from the experiences of White, middle-class, heterosexual men, while disregarding the historical and sociopolitical experiences of being racialised. Black people's voices are effectively suppressed in the literature and research, which has gone on to design, develop and deliver mental health services to them. Unsurprisingly today, mainstream health services in the UK fail to meaningfully provide for the specific needs of Black people.

While overt anti-Black racism may no longer be endemic to psychology, both individual and institutional racism persist. The past 50 years of psychological literature have brought increased attention onto racism and the various dimensions of whiteness, including racial attitudes, identity and privilege. However, psychology research at this time, including more 'multicultural' approaches, still supported existing racial hierarchies in two ways: by "othering" non-White people who were the target of research, or by omitting the impact of racialisation on psychological development and neuroscience.[77] Looking ahead, the current push for diversity and intersectionality in the field of psychology will keep failing to improve the outcomes for Black and racialised people so long as the discipline keeps White mental health as the benchmark. [78] [79]

Racism: a public health emergency

Structural racism is a fundamental cause and driver of racialised disparities in mental health.[80] Current mental healthcare models create significant barriers to delivering person-centred care to racialised groups.[81] Often perceived as "pathologising" and "Eurocentric", these dominant models tend to enable rather than prevent racist

75 Robert V. Guthrie, "The psychology of African Americans: An historical perspective," in *Black Psychology*, 3rd ed. (Cobb & Henry Publishers, 1991), 33–45.

76 Andrea L. Dottolo and Ellyn Kaschak, "Whiteness and White Privilege," *Women & Therapy* 38, no. 3–4 (August 31, 2015): 179–84.

77 Ibid.

78 Patrick R. Grzanka, Kirsten A. Gonzalez, and Lisa B. Spanierman, "White Supremacy and Counseling Psychology: A Critical–Conceptual Framework," *The Counseling Psychologist* 47, no. 4 (May 1, 2019): 478–529.

79 Andrea L. Dottolo and Ellyn Kaschak, "Whiteness and White Privilege," *Women & Therapy* 38, no. 3–4 (August 31, 2015): 179–84.

80 Mohammad S Razai, Azeem Majeed, and Aneez Esmail, "Structural Racism Is a Fundamental Cause and Driver of Ethnic Disparities in Health," The BMJ Opinion, April 9, 2021.

81 Hazem Zohny, "What Is Cultural Safety and How Could It Dissolve Structural Racism in the UK?," Journal of Medical Ethics Blog, July 22, 2021.

"It's important to know that this is an emergency. When you have a Black person going through racial discrimination and they can't find support, that is an emergency." – Zuri Therapy participant

practices in the system. For racialised patients, despite being more likely to experience a mental health problem, they face persistent inequalities in pathways to care, experiences of services, and outcomes, compared with White British patients.[82]

Inequality in pathways to care

Racialised groups in the UK, particularly Black Caribbean, Black African, and Black British communities, are 40% more likely to access mental health care through the criminal justice system.[83] The Mental Health Act (MHA) 1983, which regulates compulsory detention and treatment for mental health disorders in England and Wales, includes provisions under Part III that allow for people in the criminal justice system to be admitted to psychiatric hospitals for compulsory treatment. These provisions account for approximately 30% of detained hospital patients at any time and are frequently used as a coercive pathway for Black individuals, including through detentions, community treatment orders, and compulsory treatment.[84] They also receive less access to voluntary inpatient care as well as fewer primary care interventions.

Despite longstanding efforts to promote less restrictive pathways to mental health care, Black people are still 3.5 times more likely to be detained under the MHA than their White counterparts.[85] This disparity is partly due to higher rates of contact with the criminal justice system and stereotyping as "dangerous" compared to any other group in the UK. Black patients in inpatient settings (e.g. wards) face much harsher treatment, such as prone restraint, being placed in seclusion, and subjected to physical abuse.[86] Additionally, Black African and Caribbean communities encounter barriers in accessing safe pathways to care, with lower rates of self-referral and GP referrals to psychological and talking therapies.[87] A study tracking detentions from 1999 to 2016 associated rising detention rates with economic recession, legislative changes, and the impact of austerity on health and social care services.[88]

Black people are still 3.5 times more likely to be detained under the Mental Health Act than their White counterparts

Inequality in service experience

Racialised people and those in lower socioeconomic groups suffer heightened exposure to stressors and have fewer resources to manage them. This double victimisation is made worse by fears of racist and stigmatising treatment, causing many to disengage from statutory health services. Indeed, healthcare professionals racially discriminated against at least 65% of Black Brits and 75% of those aged 18–34, who have grown more reluctant to seek help.[89] This disengagement is fuelled by negative experiences of racist care and medical neglect, including discriminatory staff attitudes, being misunderstood or disrespected and a lack of continuity of care, leading to fears of harm and concerns about treatment suitability.[90] The sense that the benefits of seeking help do not outweigh these risks means that mental health services become a last resort.

Cultural and religious factors shape how people understand and experience mental health, leading to distinct definitions, ways of describing and talking about mental health, coping strategies and help-seeking behaviours. Healthcare services

82 Kamaldeep Bhui, Simon Dein, and Catherine Pope, "Clinical Ethnography in Severe Mental Illness: A Clinical Method to Tackle Social Determinants and Structural Racism in Personalised Care," *BJPsych Open* 7, no. 3 (April 12, 2021).

83 The Parliamentary Office of Science and Technology, "Mental Health Act Reform - Race and Ethnic Inequalities," *UK Parliament POSTnote*, May 2022.

84 Ibid

85 "Racial Discrimination in Great Britain," *Equality and Human Rights Commission*, July 2024.

86 Ibid

87 Ibid

88 The Parliamentary Office of Science and Technology, "Mental Health Act Reform - Race and Ethnic Inequalities," *UK Parliament POSTnote*, May 2022.

89 The Royal College of Psychiatrists, "Racism and Mental Health," March 2018.

90 Anjum Memon et al., "Perceived Barriers to Accessing Mental Health Services Among Black and Minority Ethnic (BME) Communities: A Qualitative Study in Southeast England," *BMJ Open* 6, no. 11 (November 1, 2016): e012337.

often externalise these differences, resulting in ineffective support and unsatisfactory experiences for patients. This cultural disconnect, along with language barriers in some cases, impedes access to primary healthcare and mental health services for Black and other racialised people.

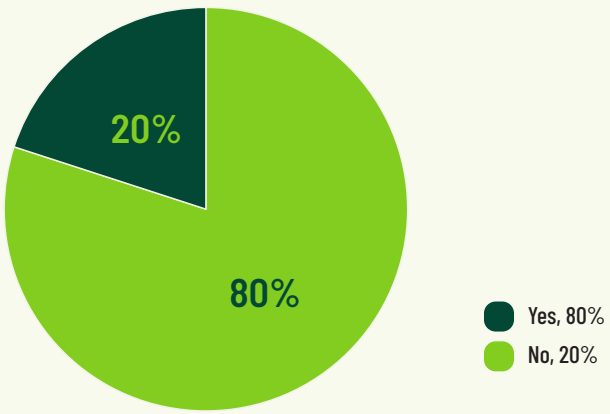
There is a documented bias in the diagnosis and treatment of Black patients. Studies have shown that clinicians struggle to accurately diagnose emotional problems and depression in Black African and African Caribbean patients, often confusing these symptoms with physical conditions such as diabetes or cardiovascular disease.[91] This misdiagnosis is exacerbated by a tendency to focus on physical health issues, which result from the unequal health conditions affecting these groups. Institutional biases play a striking role in this, such as in the recommended adjustment of kidney test results for Black people.[92] As a result, Black patients frequently encounter healthcare services in stigmatised, occasionally criminalised contexts, rather than through voluntary or supportive avenues, which reinforces a cycle of mistrust and disengagement from the healthcare system.

Inequality of outcomes

Significant failures and disparities in mental health prescribing practices and diagnoses for Black people increase the likelihood of racial trauma.[93] While Black people are equally likely to experience more common mental health problems such as anxiety and depression, they are less likely to receive support for these conditions than any other ethnic group. Instead, overdiagnosis rates for severe mental health problems, such as psychosis, are higher for Black people, who are more likely to be overmedicated than recommended for therapeutic courses. Antipsychotic medication is disproportionately and unnecessarily administered to Black patients, particularly young Black males, leading to a range of adverse health effects, including cardiac events, neurological conditions (such as strokes, seizures and Parkinson's disease) and metabolic disorders (such as diabetes and hormonal imbalances). These health complications often result in premature death, creating a clear link between being Black and having poor outcomes when diagnosed with or developing a mental health condition. Alongside overdiagnosis, Black children often receive delayed diagnosis and misdiagnosis.[94]

These findings only add to the already overwhelming body of evidence of structural racism. Despite the length of time over which racial inequalities have been recorded, there hasn't been sufficient motivation or efficacious action to tackle them. For racialised people, the current policy and legal frameworks governing mental health assessment and treatment are seen as a significant obstacle to providing effective, person-

Figure 5: Have inequalities impacted your ability to access quality mental healthcare services (including GP referrals, formal therapy, in-patient care, etc)?



91 Ibid

92 Layal Liverpool, "Is Systemic Racism in Medicine Putting Black People's Lives at Risk?," *The Guardian*, May 29, 2024.

93 Debra Minsky-Kelly and Becki Hornung, "Structural Whiteness in Mental Health: Reexamination of the Medical Model Through a Lens of Anti-Racism and Decolonization," *International Journal of Social Work Values and Ethics* 19, no. 2 (August 19, 2022): 153–73.

94 UK Trauma Council, "Racism, Mental Health and Trauma Research Round Up," March 24, 2022.

centred care. Interventions to care pathways have been proposed throughout periods of public health and NHS activity, but there is little evidence that these are being adopted, developed and reviewed on a national and regional level. Given the complexity of these issues, these actions were likewise time-constrained, underfunded and unengaging, with no discernible or long-lasting change in the disparities in racial pathways to care. This lack of progress in tackling racial inequalities is attributed in part to superficial attempts at a co-production of knowledge and the insufficient adoption of existing community recommendations within services.[95]

Problems in measuring racial trauma

While epidemiological and other data have highlighted ethnic inequalities in mental healthcare in the UK over the past 50 years, analysing the social disadvantages faced by racialised groups is challenging due to a lack of quality data and the complexity of factors like racial harassment, discrimination as well as historical and contextual influences on mental health. Simplistic measures, such as educational attainment or area deprivation, fail to capture the nuanced effects of these factors, especially when crude categories that simplify and fix ethnicity into rigid and overly narrow definitions.[96] Following the classification of Britain's diverse non-White population into the acronym BAME (Black, Asian and Minority Ethnic), 74% of respondents to a Black British Voices survey said they felt uncomfortable with this label, calling it "unhelpfully homogenising".[97]

Safe and equitable person-centred mental healthcare requires models that align with social and anti-racist models of care by addressing the intersections of racism, migration, disability, queerness, complex trauma and religion.[98] But community-driven recommendations are often dismissed as too radical, and attempts at co-production have largely been superficial and tokenistic, causing frustration and disengagement.[99] Further research is needed to better measure and address the intricate intersections of racial and economic inequalities with trauma.

The perils of "race neutrality" in therapy

Examining the impact of whiteness on practitioners

Clinical psychology is considered a career path that is exclusive to, or at least disproportionately comprises, White, heterosexual, able-bodied, cisgendered and middle-class women.[100] As racism and racial trauma are seldom addressed in counselling training courses and therapy rooms, many practitioners are ill-equipped to work safely and ethically with clients of colour. Unconscious biases in clinical work can significantly affect patient–therapist interactions, leading to a poorer quality of therapeutic care and outcomes for racialised groups.[101] While overt racism in therapy is now rare, subtle acts of racism influence interactive behaviours, as well as attitudinal and interpretive responses. These biases often manifest through therapists being reluctant to engage with race, making assumptions based on race or culture, or failing to offer systematic assessments to Black patients as they do with White patients.[102]

Counselling psychologists are ethically, morally and professionally obligated to recognise

> "Black people need the kinds of spaces that racial wellness therapy offers. We need to recognise that history affects psychology. It's not a lie, it's a lived experience. But many of us don't even know that help is out there." – Zuri Therapy participant

95 Narinder Bansal et al., "Understanding Ethnic Inequalities in Mental Healthcare in the UK: A Meta-ethnography," *PLoS Medicine* 19, no. 12 (December 13, 2022): e1004139.

96 James Nazroo, "Race/Ethnic Inequalities in Health: Moving Beyond Confusion to Focus on Fundamental Causes," *IFS Deaton Review of Inequalities,* (Institute for Fiscal Studies, 2022).

97 "Black British voices," *Black British Voices Project* (University of Cambridge, August 2023).

98 Narinder Bansal et al., "Understanding Ethnic Inequalities in Mental Healthcare in the UK: A Meta-ethnography," *PLoS Medicine* 19, no. 12 (December 13, 2022): e1004139.

99 Ibid

100 Sanah Ahsan, "Holding Up the Mirror: Deconstructing Whiteness in Clinical Psychology," *Journal of Critical Psychology, Counselling and Psychotherapy* 20, no. 3 (January 1, 2020): 45–55.

101 Helen Minnis, "Stigma in Practice," *The Lancet Psychiatry* 8, no. 6 (April 16, 2021): 466–68.

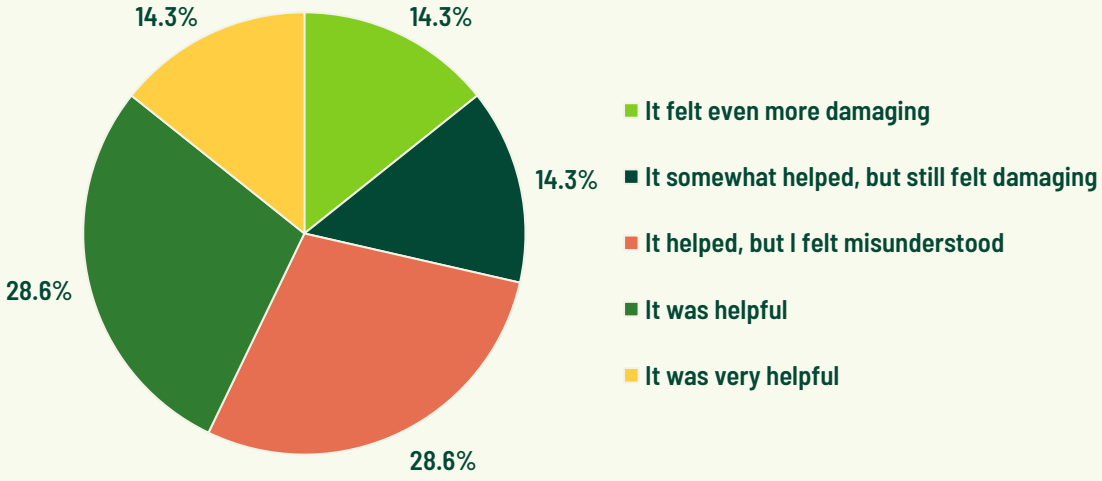
102 UK Trauma Council, "Racism, Mental Health and Trauma Research Round Up," March 24, 2022.

and address Whiteness in their practice. But navigating culturally sensitive treatment presents a significant challenge for mental health practitioners to deliver appropriate care while being mindful of their own cultural identities. Key challenges and fears from White practitioners include being labelled racist, difficulty in acknowledging their own racism, confronting white privilege and having to take responsibility to dismantle racism, all of which can hinder open conversations about race and lead to emotionally disengaged conversations.[103]

Practitioners face a pressing need to understand their role in perpetuating racism, including the discomfort fellow psy practitioners and clients may feel when engaging in discussions about race. However, this discomfort can lead to cognitive, emotional and behavioural avoidance, such as denial of racial experiences, seeking alternative explanations to absolve White individuals from responsibility or guilt, and feelings of helplessness arising from a lack of knowledge about addressing racism.[104] Given these fears, counselling psychologists in the UK have struggled to address racism within training programmes.

Research shows that Black healthcare providers are less likely to exhibit implicit racial biases compared with their White counterparts, highlighting the need for greater diversity and awareness in clinical settings.[105],[106] However, racialised practitioners often feel unable to challenge racist practice when it occurs or to find little support when attempting to introduce approaches that would be more meaningful and appropriate to their diverse patient group.[107],[108],[109] This contributes to higher dropout rates among racialised trainees in British clinical psychology courses, who seek to "survive with their identity and dignity intact".[110] The Eurocentric curricula in psychotherapy training and other internalised racism create a complex environment in which Black and racialised practitioners may also unintentionally uphold racism in sessions. Though diversity remains a necessary pursuit, tackling the structural root of these practices remains the most important pursuit.

Figure 6: How has formal therapy addressed your experiences with racism or racial trauma?



103 Reni Eddo-Lodge, *Why I'm No Longer Talking to White People About Race* (Bloomsbury Publishing, 2017).

104 Nicole Williams, "Addressing Whiteness and Racism in Clinical Psychology: White Clinical Psychologists' Experiences within Leadership" (PhD Dissertation, University of East London, 2022).

105 Ivy W. Maina et al., "A Decade of Studying Implicit Racial/Ethnic Bias in Healthcare Providers Using the Implicit Association Test," *Social Science & Medicine* 199 (May 4, 2017): 219–29.

106 Kamaldeep S. Bhui et al., "Interventions to Improve Therapeutic Communications Between Black and Minority Ethnic Patients and Professionals in Psychiatric Services: Systematic Review," *The British Journal of Psychiatry* 207, no. 2 (August 1, 2015): 95–103.

107 Odusanya et al., 2018, Tam Chipawe Cane and Prospera Tedam, "We Didn't Learn Enough About Racism and Anti-racist Practice': Newly Qualified Social Workers' Challenge in Wrestling Racism," Social Work Education 42, no. 8 (April 12, 2022): 1563–85.

108 Narinder Bansal et al., "Understanding Ethnic Inequalities in Mental Healthcare in the UK: A Meta-ethnography," *PLoS Medicine* 19, no. 12 (December 13, 2022): e1004139.

109 Shamarel O. E. Odusanya et al., "The Experience of Being a Qualified Female BME Clinical Psychologist in a National Health Service" *Journal of Constructivist Psychology* 31, no. 3 (April 7, 2017): 273–91.

110 Nicole Williams, "Addressing Whiteness and Racism in Clinical Psychology: White Clinical Psychologists' Experiences within Leadership" (PhD Dissertation, University of East London, 2022).

Examining the impact of whiteness on clients

The psychologist and therapist Guilaine Kinouani has drawn attention to the harmful consequences associated with therapists' inability or refusal to address race and racism for people of colour within the context of a therapeutic relationship. For Black clients, this creates an uneasy relationship with practitioners and other healthcare providers. Kinouani explains that failing to notice and appropriately acknowledge a client's race – which can be an important signifier of one's identity – can be interpreted as indifference by the client and leave the client feeling invisible. When suffering is not acknowledged or understood, patients who feel disbelieved are less likely to be comfortable or open up during a therapy session.[111] Four subtle forms of racial microaggression, which may never be verbalised, carry power in a given therapy space by influencing interactive behaviours, and attitudinal and interpretive responses: (i) assumptions of White cultural values, (ii) colorblindness/ unwillingness to discuss race, (iii) denial of individual racism and (iv) assumptions of stereotypes.[112]

Examples of these forms of racism, which can be traumatising, include eye-rolling; Black clients being expected to to prioritise White people's guilt and the feelings of their therapists when discussing racism; the emotional labour of explaining racism; being gaslighted and scrutinised by therapists when asked questions such as, "Are you sure that [event] was because of racism?"; assuming that all members of a racialised group will adhere to all of its cultural tenets and norms; and placing the client in a stereotypical cultural box and thereby creating a sense of difference between the White therapist and the non-White client. This gap not only affects racialised clients but also prevents White clients from exploring their own racial identities and attitudes towards race. Discussions about race or white privilege are often met with defensiveness, silence or denial by White people, prioritising their feelings over the experiences of people of colour and shutting down meaningful dialogue.

Scholars have argued that multicultural counselling competencies have yet to adequately address racial inequalities, suggesting that psychologists should adopt a role similar to that of feminist scholars, by focusing on systemic interventions and advocacy beyond individual counselling.[113] Without addressing and altering systems that uphold whiteness, the racism faced by racialised counselling psychologists will likely continue. Some suggest it may even be unethical to focus on diversifying the profession without first tackling its whiteness.[114] [115]

> "I'm 59 now, and I've often found myself having to encourage or ask therapists to take a course in racial wellness therapy so that they can better help me, but they'll respond with, 'I don't need to do it.' I feel I may have shamed my therapists by asking that. Many White therapists don't believe they need to take these courses when getting their licences, and it's a little arrogant."

> "I once spoke to a White woman about my struggles and she said, 'It's because you're a woman.' She only acknowledged the parts she experienced as part of the world. If you've never experienced race as a barrier, you may not see how it exists."

111 Guilaine Kinouani, *Living While Black: The Essential Guide to Overcoming Racial Trauma* (Penguin Books, 2021).

112 Aileen Alleyne, *The Burden of Heritage: Hauntings of Intergenerational Trauma on Black Lives* (Confer Books, 2022).

113 Elizabeth M. Vera and Suzette L. Speight, "Multicultural Competence, Social Justice, and Counseling Psychology: Expanding Our Roles," *The Counseling Psychologist* 31, no. 3 (May 1, 2003): 253–72.

114 Nicholas Wood and Nimisha Patel, "On Addressing 'Whiteness' During Clinical Psychology Training," *South African Journal of Psychology* 47, no. 3 (August 8, 2017): 280–91.

115 Petrishia Samuel Paulraj, "How Do Black Trainees Make Sense of Their 'identities' in the Context of Clinical Psychology Training?" ((PhD Dissertation, University of East London, 2016).

Section 3: Advancing racial wellness therapy

Need for racial wellness therapies

Traditional approaches to therapy often centre personal difficulties without connecting them to larger-scale structural inequalities. This results in a focus on symptoms rather than the root causes of psychological distress.[116] For racialized people, the absence of sociocultural and political context renders treatments for trauma or PTSD insufficient and, at worst, counterproductive. For example, the prevailing emphasis on Empirically Validated Treatments (EVTs), particularly cognitive-behavioural therapy (CBT), narrows the range of what is seen as legitimate therapy.[117] This limits the scope of what is considered legitimate evidence of effectiveness, as CBT and other Western psychotherapeutic approaches tend to isolate the origins and solutions of mental health issues within the individual, neglecting contributors such as discrimination and oppression. This reflects a broader trend in Western cultures to seek uniformity and deem certain ways of being as "correct," sidelining complexity and diversity in thought as threatening.[118] This has in turn marginalised multiple theoretical orientations, which reinforces the marginalisation of racialised and disadvantaged clients.

Accordingly, scepticism around claims of universality across diverse populations have led to explicit calls for systemic change and advocacy within psychology to advance the development of racial wellness therapy. Racial wellness therapies take an intersectional approach to account for how structures of inequality, including privilege and oppression, affect mental health on a personal level. Grounded in critical race theory and Audre Lorde's cautionary maxim, "The master's tools will never dismantle the master's house", this approach is designed to help therapists work with both privileged and marginalised groups affected by white supremacy. Complementing existing practices, racial wellness therapy encourages psychologists to be advocates in therapy, education and broader society, and aims

116 Joseph Henrich, Steven J. Heine, and Ara Norenzayan, "The Weirdest People in the World?," *Behavioral and Brain Sciences* 33, no. 2–3 (June 1, 2010): 61–83.

117 Lauren Rogers-Sirin, "Psychotherapy From the Margins: How the Pressure to Adopt Evidence-Based-Treatments Conflicts With Social Justice-Oriented Practice," *Journal for Social Action in Counseling & Psychology* 9, no. 1 (July 1, 2017): 55–78

118 Ibid

to critique and transform oppressive systems, while guiding effective and ethical practice in therapy and racial wellness. Achieving true health equity for Black people and other racialised groups necessitates alternative therapeutic approaches that promote racial wellness, confront oppression, and drive systemic change.[119]

> "A lot of education is needed, a lot of awareness, even among ourselves. Both within the community and outside the community, a lot of awakening needs to happen."

Emerging evidence for community-based therapy

Voluntary and community sector organisations are vital to addressing the mental health needs of racialised people and filling the gaps left by traditional statutory services. Community-based interventions prioritise the needs and interests of racialised people in their design, implementation and evaluation. By leveraging community knowledge, consulting with marginalised groups and incorporating culturally matched services, these organisations offer tailored interventions with flexible outreach.[120] They can provide refuge from the challenges that racialised communities frequently encounter, particularly because of their cultural awareness, use of community languages, affordability and commitment to creating safe and welcoming environments.[121]

The success of their services comes from the deep relationships and sense of belonging these organisations build with communities. Their leaders and workers are often vocal about systemic inequalities and the inadequacies of mainstream services, identifying approaches that meet the cultural and psychological needs of the communities they serve. The shift from an individual to structural perspective reframes the conversation from multiculturalism to social justice. By viewing individuals as inseparable from the broader network of relationships and institutions, they begin to untangle the dynamics of identity and power.[122] This community-facing approach is particularly essential for racialised communities as it supports the development of collective strategies for resilience and healing to create sustained mental wellbeing for individuals and their communities. In 2018, the Race Equality Foundation was commissioned to conduct focus group consultations with Black and minority ethnic communities as part of the review of the Mental Health Act and women's mental health services. Service users from these communities highly rated and praised the support provided by the voluntary and community sectors both for their guidance in navigating mental health pathways and offering culturally appropriate advice and support.[123]

The need for community-based mental health approaches is crucial, especially for Black individuals who have suffered under the existing health and social infrastructure. Having developed their own effective tools for achieving racial wellness, they are uniquely positioned to bridge the trust gap caused by state and institutional shortcomings. These community-driven services can also complement traditional care with culturally relevant, trusted support that addresses the specific needs of Black communities, which the mainstream mental health infrastructure has often overlooked.

> "Creating community and validating each other's struggles and feelings have been very successful. The fact that we are able to access a service free of charge is a luxury I do not take lightly. [Racial wellness therapy] is needed for many of us to be okay."

Limitations

Voluntary and community sector organisations face several challenges, particularly due to limited funding and the administrative constraints of being predominantly small in scale. Workforce issues (e.g. staff retention and the inability to offer competitive salaries and safeguarding support for therapists) are a point of frustration for these

119 UK Trauma Council, "Racism, Mental Health and Trauma Research Round Up," March 24, 2022.

120 Zoë McHayle, Adetola Obateru, and David Woodhead, "Pursuing racial justice in mental health," *Centre for Mental Health* (Centre for Mental Health, 2024).

121 Ibid

122 Eleonora Bartoli et al., "What Do White Counselors and Psychotherapists Need to Know About Race? White Racial Socialization in Counseling and Psychotherapy Training Programs," *Women & Therapy* 38, no. 3–4 (August 31, 2015): 246–62.

123 Tracey Bignall et al., "Racial Disparities in Mental Health: Literature and Evidence Review," *Race Equality Foundation* (Race Equality Foundation, 2019).

organisations, whose service delivery may be lacking in comparison with statutory services. This largely results from the competitive and short-term funding environment in the UK, which strains relationships within and between organisations. The charity sector sees a lack of overarching leadership and regulation in its provision of mental health services, which makes it difficult to secure consistent funding, provide layouts of best practices or build lasting relationships with funders. At the demographic level, younger and older generations in established communities may have differing views on mental health, creating tensions that hinder collaboration between voluntary organisations. As well, the stigma surrounding mental health, especially among Black men, has resulted in a low male participation, raising the question of whether men-only spaces would be beneficial.

A strategic approach to sector collaboration that does not duplicate resources or alter funding, including longer-term funding cycles and increased investment into these spaces, is essential to ensuring long-term sustainability for necessary service delivery.

Case study: BLAM Zuri Racial Wellness Therapy

Inception and structure:

Developed by BLAM following the murder of George Floyd, Zuri Racial Wellness Therapy offers a space for Black people to process racial trauma. The therapy recognises that trauma is collectively experienced and, as a result, healing must also be collectively experienced. The programme consists of a virtual group therapy session each week over the course of a month, facilitated by diverse Black therapists who explore the complexity of racial trauma and wellness with the aim of moving beyond a one-size-fits-all approach to mental health treatment. Each session is capped at 10 participants, intentionally selected from a range of ages and backgrounds to promote intimacy and deeper engagement. Zuri Therapy is available free of charge and can be accessed by anyone who might benefit from it, irrespective of income or socioeconomic status.

Therapy can be intimidating, especially given the broad and persistent stigma surrounding mental health. Accordingly, Zuri Therapy embraces holistic and intercultural principles, encouraging practices like meditation, breathwork and arts-based therapies to recognise the creative strength of Black culture and connect participants with their heritage. Participants engage in creative activities, such as colour association or collage, to explore their mental space and racial trauma through more organic reflections in an inviting and accessible way. This approach, coupled with somatic techniques and decolonial psychological science among others, not only reduces the stigma traditionally associated with mental health in Black communities but also provides participants with practical tools they can carry with them beyond the sessions.

Ongoing racial violence, such as the murder of Sonia Massey and race riots in the UK, has led to a surge in demand for Zuri Therapy and subsequently long waiting lists. Viewed as an indispensable resource, the therapy fosters a continuing community among participants, who go on to create WhatsApp group chats after the sessions have ended. The programme primarily serves Black women: the dual weight of misogynoir, coupled with the shift towards self-care, along with the stickier stigma of emotional sharing among men, has made Black women more likely than Black men to seek these services. Despite this, Zuri Therapy is growing in popularity and acceptance, namely among millennial and Gen Z participants, who are more willing to share their positive experiences with older family members, fostering a broader acceptance of mental healthcare in the Black community that is used to promote therapeutic views and approaches.

- 67% felt misunderstood or dismissed by a mental health professional because of their racial or ethnic identity
- 57% of participants reported feeling safe and supported in their ethnic and/or racial identity when accessing formal therapy. This number changed to 90% when using Zuri Therapy
- 53% of participants reported that formal therapy acknowledged their nationality and/or immigration status as relevant dimensions of their mental health and identity. This number changed to 80% with Zuri Therapy.
- 50% of participants reported that formal therapy addressed communal or intergenerational healing and trauma in sessions. This number changed to 100% in Zuri Therapy

Guiding philosophies of Zuri Therapy

Grounded in African-centred psychology and the Black radical tradition, Zuri Therapy focuses on collective healing through culturally resonant practices.[124] The therapy builds from the concept of "soulfulness" – specifically through focusing on interconnectedness, spirituality, collective resilience and sensibility, and the need to liberate each other from the historical and ongoing dehumanisation – to help individuals process racial trauma.[125] By emphasising a Soulfulness-Oriented, Unitive, and Liberatory (SOUL) approach, Zuri Therapy moves beyond traditional clinical practices towards more contemplative ones with culturally diverse groups. SOUL approaches are particularly resonant with those who have experienced the intergenerational consequences of genocide, enslavement, colonisation and other past racism, as well as ongoing racism, marginalisation and "dehumanising assaults on the soul".[126]

African-centred psychology, drawing from both diasporic and pan-African traditions, sees mental health as inseparable from social, cultural, and political realities. It emphasises collectivism, offering a diagnostic approach that contrasts with Western values, which tend to be more individualistic. While Western mainstream psychology often relies on quantitative, empirical methodologies with cultural limitations, African-centred psychology takes a qualitative and contextual approach, recognising how culture shapes our perceptions, values, and everyday behaviours.[127] Many Black people living in the UK value such approaches, since Black communities tend to retain a strong element of their cultural roots, which intertwines with the White British culture in which they were raised. One of the central principles of the African-centred approach is that nothing exists in isolation. As such, it enables therapists to incorporate cultural factors in their treatment of patients..

Zuri Therapy directly challenges dominant "evidence-based" medical models and psychotherapies, such as CBT, which often lack cultural relevance for marginalised groups.[128] While medical models overemphasise medication, especially for Black people, decolonial healing models instead foreground connection and relationships that consider safety, control,

124 Zuri translates to beautiful in Swahili

125 Shelly P. Harrell, "Soulfulness as an Orientation to Contemplative Practice: Culture, Liberation, and Mindful Awareness," *The Journal of Contemplative Inquiry* 5, no. 1 (December 26, 2018).

126 Ibid

127 Naa Oyo A. Kwate, "The Heresy of African-Centered Psychology," *Journal of Medical Humanities* 26, no. 4 (December 1, 2005): 215–35.

128 Lauren Rogers-Sirin, "Psychotherapy From the Margins: How the Pressure to Adopt Evidence-Based-Treatments Conflicts With Social Justice-Oriented Practice," *Journal for Social Action in Counseling & Psychology* 9, no. 1 (July 1, 2017): 55–78

the creation of narratives that bridge past and present, and engaging in a grieving process while focusing on rebuilding connections with oneself and the larger world.[129] It emphasises resistance to systemic oppression and promotes self-empowerment through collective healing, a vital component of the work of anti-racist movements. Not only does this promote self-care but also community care. Participants become empowered to act and build resilience in their own communities. As trauma often manifests in physiological ways, Zuri Therapy highlights the mind–body connection through movement-based approaches that can help participants reconnect with ancestral traditions.[130]

In contrast to microlevel, individual interventions – which often focus on confessional values and 'coming to terms' with traumatic experiences, which cannot address the cyclical transmission of trauma across families, communities and generations – Zuri Therapy centres the social determinants of health, where "mental health is delicately woven into the fabric of community, the health of which is only as strong and stable as its members."[131],[132] This relational depth combined with an experiential, cultural and spiritual focus offers profound ways to create healing spaces that honour ancestors and help break cycles of trauma and dysfunction for future generations.[133]

> "I learned how to have compassion for myself and others living in the world that we do." – Racial wellness therapy participant

Key takeaways from Zuri Therapy:

BLAM's Zuri Racial Wellness Therapy is both in demand by Black people living in the UK. It proves capable of having a measurably positive impact on its participants. 90% reported Zuri Therapy had been helpful or very helpful in understanding and addressing their lived experiences with racism or racial trauma, while 100% called for increased access to racial wellness therapy.

"I welcome the bold thinking after the decades upon decades of struggle Black people have had trying to fit in with 'solutions' to our problems that are not designed for us and do not fit."

"This is such a powerful programme and it is needed in the Black community. We have been through and continue to navigate high levels of stress that cause physiological and psychological impacts on our body and mind. It is a moral imperative, but also an economic and financial one."

Culturally relevant therapy: Participants gained a clear understanding of racism and its consequences for their mental health and wellbeing. Before this therapy, they did not realise how deeply racial trauma had affected their mental health. Access to racial wellness therapy, informed by Afrocentric approaches, provided participants with tools and strategies that resonated with their lived experiences and helped address racial trauma more effectively. Discussing the legacy of slavery and generational trauma provided context for participants to understand their emotional and psychological responses, enabling deeper healing. Participants learned to have compassion for themselves and others, acknowledging that their reactions to racism were valid, even if they did not align with how they wished they had responded.

"I never thought it would be possible to peel back the layers of my experiences and look at my trauma in a holistic way with others who can also relate and share similar experiences."

"I learned how racism is tied back to physiology; how you experience the world is different because of the experiences you have. For example, learning that racism biologically puts your nervous system on edge was really powerful. We aren't born with stress, but stress is a big killer for Black ethnic minorities."

Black therapists with alternating therapeutic approaches: Participants' experiences in Zuri Therapy revealed the benefits of having Black therapists with alternating therapeutic approaches. Most service users noted that prior to Zuri, they had never had a Black therapist, which underlines the necessity of diversifying the mental health workforce. This representation allowed them to feel genuinely seen and understood. The rotating therapeutic approaches, based on each therapist's style—ranging from focusing on somatic and biological responses to using art

129 Suzanne Methot, *Legacy: Trauma, Story and Indigenous Healing*, 2019.

130 Ibid

131 Ibid

132 Maureen P. Flaherty et al., "Peacework and mental health: from individual pathology to community responsibility," *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas* 18, no. 1 (2020): 3.

133 "Reflections on Racial Trauma," SurvivorsUK, November 15, 2021.

therapy—created a space for service users to explore various methods of healing and discover what resonated most effectively for them.

"I've never had a Black therapist. But often it is only the people who look like us who know and see what we're going through, and have the ability to innately understand and answer the questions we have about ourselves."

"I didn't realise there were so many different ways to respond to racism, like fawning or making yourself fit in."

Art therapy sessions were particularly impactful, revealing layers of internalised emotions and perceptions. Colour theory played a significant role in exploring personal symbolism, reflecting the deep emotional associations that people can have with colours based on their lived experiences, cultural context, and internalised perceptions. These associations can reveal underlying traumas, cultural identities, or societal influences that shape a person's emotional landscape. By using colour in therapy, practitioners can help clients externalise and process complex feelings, providing a non-verbal means to explore identity, trauma, and self-perception. For Black people, the racialized symbolism of colours like black and white can reveal internalised experiences of race and identity, offering a powerful way to address the impact of racism and cultural narratives on mental health.

"In the art therapy sessions, I came to realise how the colour white offended me so much, and that the colour black was such a dark thing for me, and how that affected the words I use."

Free or low-cost services: Offering therapy sessions at no charge or low cost was invaluable to participants, who often face both financial barriers and systemic inequities that make accessing quality care difficult. Financial barriers exacerbate mental health disparities, as those unable to afford therapy are left without crucial support. Providing free or subsidised sessions ensures inclusivity and accessibility, which are critical for fostering mental well-being within marginalised communities.

Participants in the Zuri Therapy program noted that the absence of financial constraints provided them with an opportunity they would not otherwise have had. The ability to attend sessions without the stress of financial strain meant they could fully engage with the therapeutic process. This level of accessibility is especially significant given the cost of living crisis and deepening inequalities, and the challenges Black communities face including lower socioeconomic status, higher unemployment rates, and income inequality. These economic hurdles often result in inadequate access to mental health care, making free or low-cost services a lifeline for many.

"The fact that we are able to access a service free of charge is a luxury that I do not take lightly. Zuri is needed for many of us to be okay."

"Free online black therapy for women: I never saw those words together in one sentence"

Group-based spaces dedicated to Black people: Group spaces offered a reprieve for Black women from misogynoir. For participants, these spaces become havens where their experiences were not minimised or dismissed, but rather understood and validated. In mainstream therapeutic settings, Black women often encounter a lack of cultural competence, leading to racial gaslighting where their experiences with racism and sexism are questioned or trivialised, undermining their experiences and sense of self.

In contrast, a collective therapeutic environment specifically for Black people, and Black women in particular, served as a powerful counter to these harmful dynamics. The shared understanding of racial and gender-based experiences enabled deeper emotional expression without fear of being misunderstood or judged. It created a space where the narratives of Black women were centred, and the nuanced experiences of misogynoir—such as the expectation of "strong Black womanhood" or being stereotyped as aggressive—could be openly discussed and unpacked.

Participants also reported that being surrounded by other Black women helped alleviate feelings of isolation that often stem from being the only Black person in predominantly white spaces. This communal support allowed them to express vulnerabilities that may not be understood or addressed in traditional one-to-one therapy settings. Furthermore, the group dynamic promoted mutual aid, empowerment, and solidarity among participants. The recognition of shared struggles enhanced the healing process, providing an empowering context that validated individual and collective experiences. Some participants still found value in individual therapeutic sessions, either as a complement to group therapy or as their primary mode of support. The combination of both types of therapy—one that offers the depth of personal attention and the other that provides community and validation—can be particularly effective in addressing the multi-layered experiences of Black women.

Ultimately, group-based therapy for Black women combatted the loneliness, invalidation, and racial gaslighting they often face in both therapeutic and societal spaces, offering a more holistic approach to healing that directly addresses both racial trauma and misogynoir.

"Other women being there too meant that you didn't feel so alone, whereas 1:1 therapy can be lonely."

"It was a night-and-day difference. I felt like I was seen and understood. I could share in an honest way about how I was feeling about everything. I didn't have to filter what was acceptable."

Profile

Intensive Care Unit Nurse | Black African woman

I was getting therapy from a White British therapist and they had no idea what I was going through. It felt very weird explaining racism to another White person; I would hold back because I felt like I was implicating her. When sharing an experience of racial discrimination, she would get defensive and say, 'They probably meant this.' But unless the therapist had come into contact with that other person, there wouldn't be a need to interpret or excuse their response, and I felt like she was unknowingly defending a culture of whiteness.

Everyday decisions are totally dependent on your experience of racism. I used to be this public person, talking to everyone, White or Black, making friends on the bus, at the supermarket. Everywhere I went, I made friends. But as I experienced more racism, I found myself closing up. I would walk looking down – I didn't want anyone to talk to me. I couldn't even walk into a hotel with my husband as the only Black people there because I thought they might spit in my food.

It's not just an individual being affected here, it's an entire family. When I learned how racism affected generations, I couldn't sleep that night. I kept thinking about my grandchildren being affected by what I'm going through right now, and how I needed to cut that cord as quickly as possible. I think about when my husband would hold me at night and I'd be in tears. He would take me on walks. When he's at work, he calls to ask what I'm doing to make sure I'm keeping busy. The whole family is affected.

I wasn't aware of what I was going through, like many other people. But racism, and the stress and depression that comes with it, cannot be ignored. People need to realise when racism happens to them.

On workplace discrimination:

As a nurse, I offer support to patients. This means I need to be healthy and fit for my work, so I can fully care for my patients. I work in the Intensive Care Unit, an enhanced care environment with equipment all over the place. I can't take care of my patients if I myself am not well. If I escalate this and I'm not receiving the help I need, something needs to be done. It shouldn't be ignored, it shouldn't come second. Particularly to managers, HR and decision makers – if they have a team of people going through racial discrimination who can't find the support they need in the organisation's mental health support partnerships, then they should treat it as an emergency and outsource support. They need to go over those boundaries. They have the ability to outsource support, but they don't have the willingness.

I know of staff receiving mental health support not when they're at home but rather in a mental health institution. They just went nuts. If you listen to their stories, it's been one thing after the next. There was no knowledge whatsoever that the way they were being treated was not right, and was purely racism. And they kept rationalising it until it became unbearable.

Recognising and knowing what racism looks like, how it camouflages itself, is so important because racism comes in different shapes, voices and words. But once you recognise it, how do you raise it? Who do you raise it with? Where do you find support? One thing I've come to understand is that we have managers or HR teams who don't care about retaining Black people. The expectation is that if you get the job, you do the job and go home. If you aren't able to do the job, we will recruit someone else. So they don't care at all.

When a staff member going through racial discrimination is not getting the support they need, it should go to the Equality and Diversity team, because these cases of racial discrimination touch that department. Teams need to have a sit-in together and go back to the drawing board and see why these people are not getting the support they need. If their staff are not getting the support they need, they cannot function in their place of work and could be getting into a crisis point where they then need the interventions of serious mental health institutions which affects the staffing level, retention, and

it affects everything when it comes to employment. There is no staff retention, and more money is being used to recruit and recruit, yet they can't retain.

If there is a policy that exists about promoting Black people at work, that also needs to be examined. African people are not being promoted at all. They are not moving up the ladder. I've had nurses who have stayed in this country for 15 years as band fives. Never moved. When there is a position that opens up they tell you can't occupy it because you are lacking, but they refuse to offer training.

There also need to be better policies around freedom to speak in the workplace. They don't keenly look into it but they need to because many loopholes exist in those policies. Many staff are being forced to speak up in front of their managers, so you can't completely open up.

On benefits received from Zuri Therapy:

When I came to Zuri Therapy, I was really happy to meet other Black people. It felt welcoming and encouraging to know that I'm not by myself. I have other fellow Black people who have gone through similar experiences or worse. Just seeing everyone there made me feel at home and accepted that what I was going through was real. And not just real to me, but other people too.

It felt nice to receive therapy from fellow Black people. Although not every therapist shared their own story, they probably had gone through something that would have pushed them to start racial wellness therapy. For them to do that, it meant they had gone through something similar themselves, overcome it and from a place of strength offered that support to others. So the message I took away was: You can also do it. You can also get out of that situation. You can also be strong.

I am now able to recognise racial discrimination from a distance. I can smell it, the way Africans say 'I can smell it from a distance'. I'm at a place where I'm accepting that racism is not new. This has been ongoing, and the probability of it continuing so long as you are in a White country is very, very high.

But now I know how to keep myself well. I know where to escalate it, who to talk to, and I know the people I need to avoid talking to when raising it. I know of different ways to look after my mental health and wellbeing, even when I'm by myself. I know therapy is very good, but most of the time you find yourself alone, like at night. And when those thoughts come, you wonder what to do. But now, I have tools like breathing exercises and focusing my mind on what is important. I can recognise when an environment is toxic and that I don't need to stay in it. Not to say I won't experience the same racism or worse in the place I move to, but at least I have that courage to move elsewhere. And where I'm going, I'm not going as a novice. I have all this knowledge in my mind, and I know what to do.

Whatever they say, I don't let it affect me. I have the courage to know that whatever I am doing is right, and I need to press on. This is the biggest, biggest thing to ever happen to me. To accept that. To move on. Because there are people you cannot change, that this is how they think about Black people. But I was letting their words or thoughts towards me affect my health, and that needed to change.

Through Zuri Therapy, I strongly feel the need to support others who are in the place I was before, in order to come to where I am now. I'm really happy because from the time when I had the therapy, two months ago, I've now been able to support four other people so far.

Recommendations

This failure to consider racism as a cause of poor mental health is a product of social and psychological defences against the pain of noticing injustices. A concerted effort is needed to recognise racial trauma as a public health concern, in order to raise awareness and ensure interventions are culturally appropriate. While the recommendations below are tailored for specific mental health interventions, addressing racial disparities in mental health requires an approach that is responsive to the root causes of poor mental health. This includes tackling the guiding role of structural and institutional racism in wider inequalities including socioeconomic deprivation, housing, income and wealth, the criminal justice system, education, and employment. These comprehensive continue to be overlooked in favour of more technical, individualised, and health-specific interventions that address individual outcomes rather than their reflection of social malaise.

Advancing co-produced research and awareness on racial trauma:

Call for better research and data: Research must be supported that explores the relationship between racism and mental health, and improved data collection methods to capture more nuanced intersections of race, trauma, and mental health. Traditional empirical evidence associated with medical disciplines have contributed to a lack of depth and compassion around what is at stake for those who experience racial and socioeconomic inequalities. This may involve introducing research methods that consider non-verbal, emotional, and visual experiences of racial inequalities and mental illness (which are generally considered 'less graspable') in order to provide progressive responses. Additionally, future data collection, investment, and infrastructure needs to better represent older racialsed people and adequately capture historical experiences of racism and discrimination, to enable more robust understandings of the effects of racism on health outcomes over the entire life course.

Deepen mental health classifications: Develop more accurate classifications beyond simplified ethnic categories like "BAME" to capture complex cultural and intersectional identities. The significance of race on mental health cannot easily be captured in ethnic classifications, and are therefore too crude to effect change. Ethnic and racial categories often oversimplify collective and individual identities, related systems of shared beliefs, culture, kinship systems and implicit behaviours.

Prioritise authentic co-production and lived experiences: Move beyond traditional research methods like Randomised Control Trials by centering racialised stories and qualitative experiences to better inform care systems. Authentic community co-production is essential for addressing racial inequalities, requiring relevant training and meaningful engagement in service development. Co-producing decisions and co-designing solutions democratise decision-making, distribute power, and hold authorities accountable. Developing better co-produced evaluation mechanisms, particularly in racial wellness therapy, can ensure services are truly responsive to the needs of racialised communities.

Develop targeted resources: Create materials (videos, articles, workshops, exercises) specifically addressing racial trauma to be used by schools, workplaces, and healthcare systems to improve understanding and empathy. These resources should also be available online and tailored for the Black community to explore at their own pace.

Increasing community-based mental health support:

Support voluntary sector partnerships: Strengthen collaboration with community organisations to design and deliver mental health support that overcomes the harms and barriers caused by racism, and build stronger partnerships with mainstream health services.

Create safe community spaces for Black communities: Establish and fund free or low-cost safe spaces for Black individuals, particularly Black women, to access mental health support.

Fund community-led initiatives: Scale up long-term investment in community-led mental health services led by and for racialised communities. These services bridge gaps in trust between racialised communities and statutory services.

They also focus on early intervention, prevention, and advocacy, helping to reduce the reliance on crisis-driven interventions that disproportionately affect Black and racialised individuals. Increased funding allows expanded access by allowing organisations to remove financial barriers to mental health therapies and workshops.

Strengthen sectoral leadership: Support building cross-sectoral leadership and oversight for organisations providing mental health support. This leadership would drive deep cultural change by unifying policies and practices across organisations, ensuring that mental health services are responsive to the needs of racialised communities and ensuring the long-term viability of the sector.

Anti-racism in the NHS and statutory services:

Implement institutional reflection and leadership: Appoint an independent Equalities Champion with the authority to spearhead cross-government actions, focusing on addressing racial disparities in the NHS and across all healthcare systems. This role should be empowered to actively name, challenge, and address institutional whiteness and racism in policies, service delivery, workforce training, and clinical practice.

Enforce mandatory anti-racism training: Implement ongoing, comprehensive anti-racism training for all NHS professionals on the history of racism, and its impact on mental health. This should support psychiatrists in reflecting on their own perspectives, behaviours and the role unconscious bias can have on the care they provide, as well as supporting them to challenge inappropriate behaviours.

Ensure equity in service delivery: Shift from equality to equity by acknowledging individual experiences and addressing structural racism's effects, promoting Black professionals to decision-making roles including in budgetary and resource allocation capacities for more inclusive policies and care.

Increase culturally responsive services: Fund earlier and improved access to culturally specific mental health services that are designed with input from racialised communities, providing tailored multi-language services, incorporating culturally specific therapies and practices, and racial trauma-informed care.

Prioritise trust building: Commit to long-term reforms in the NHS to rebuild trust within racialised communities by creating less aversive, more consensual pathways to services to change the culture of care.

Enshrining anti-racism in practitioner training programs:

Mandatory anti-racism counselling education: Centre whiteness and its impact as a fundamental problem in the mental health field, ensuring that training explicitly explores how white supremacy shapes therapeutic practice and the patient-therapist dynamic. Embed dedicated, compulsory courses on race, colonialism, and the impact of white supremacy into all counselling programs. Ensure this education is delivered by Black or racialised facilitators to avoid potential microaggressions and intimidation in learning spaces.

Create safe learning spaces: Provide safe and inclusive educational spaces for both White and racialised therapists to discuss race and its effects on mental health, ensuring a supportive environment that fosters honest reflection and learning.

Integrate an intersectional approach: Incorporate an understanding of intersectionality in training, acknowledging how factors such as race, gender, culture, disability, sexuality, and migration intersect to affect mental health outcomes. This will help therapists tailor interventions more effectively to diverse populations, for example young Black Muslims who identify as LGBTQIA+.

Teach racial wellness treatment interventions: Teach racial wellness therapeutic frameworks to include considering racial trauma during assessment, discussing the effects of racism during psychoeducation, introducing culturally relevant relaxation techniques, guiding clients in recognising emotions linked to racial oppression, and thoughtfully addressing how racism influences trauma-related cognition and memories.

Advancing reforms to the Mental Health Act (MHA):

Enshrine anti-racism in the MHA: Incorporate anti-racism as a core principle in the new Mental Health Act to make it fit for purpose, addressing racial disparities in access, treatment, and outcomes.

Codify inclusive decision-making: Codify the involvement of families and community representatives in care decisions to ensure that cultural and familial contexts are prioritised during mental health interventions. Ensure statutory services adopt community recommendations, reducing the dominance of White, middle-class decision-makers who have little understanding of the needs of racialised groups.

Establish an independent body for data collection under the MHA: To guide future mental health interventions, more robust data on racial trauma should be gathered and managed by an independent body founded on anti-surveillance principles. This ensures Black individuals are not subjected to harmful scrutiny or data policing. The focus should be on culturally sensitive research that builds community trust and addresses racial control systems. By prioritising the lived experiences of racialised communities, the body can develop equitable, inclusive mental health services aimed at addressing the structural causes of racial trauma.

Establish independent oversight and accountability mechanisms: Establish an independent body focused on racial justice to monitor racial disparities, review cases, and ensure accountability. This body should have the authority to review cases involving racialised individuals, investigate complaints of racial discrimination, and recommend corrective actions.

Addressing the impacts of institutional racism on the workforce:

Strengthen discrimination laws: Strengthen legal frameworks by shifting from a reactive, post-discrimination model to a proactive, preventive approach that places the responsibility for enforcing equality laws on organisations and bodies with greater capacity to implement change. Simplify the process for employees to navigate, report, and seek redress for workplace discrimination, including racial and dual discrimination (e.g., race and gender), ensuring more accessible and effective pathways for legal recourse.

Reduce financial barriers to justice: Provide dedicated financial assistance and affordable legal recourse options for racialized individuals facing workplace discrimination, reducing financial barriers that limit access to justice.

Cultural competence in HR procedures: Implement anti-racism training, and ensure HR supports reporting protections by creating safe spaces for Black and racialised employees to directly report racism with freedom to speak and without fear of retaliation.

Support employee wellness: Ensure Black employees are informed of their legal rights and wellness options to address racial trauma in the workplace. Move beyond symbolic Diversity, Equity, and Inclusion (DEI) checklists to engage in deep, structural changes aimed at reducing unconscious bias, building capability to meet the needs of racialised employees in internal organisational policy and procedures, and eliminating workplace racism.

Promote Black leadership: Ensure greater racial diversity in senior management and decision-making roles including budgeting and resource allocation.

Appendix: Construction of race

The concept of race, as we use and understand it today, began to take shape as a local construction in Europe during the 17th and 18th centuries and was used to justify European colonial expansion and the transatlantic slave trade. Race grouped humans in terms of observable physical characteristics such as skin colour, height, hair type, and eye shape.[134] This allowed racial groups to be identified, assigning them meaning and value based on cultural and symbolic traits, and ranking them in a hierarchical order, which created a racialised social structure.

This process of identity formation, by which a group ("White people") gained dominance in opposition to a racialised "Other", justified the domination, marginalisation, and exclusion of those deemed inferior. Whiteness became more than just a characteristic; it set the standard for what is considered normal in society, reinforcing systems of white supremacy.[135] It gained invisible and often unacknowledged advantages and resources, adding to the already strengthened power and capital of whiteness. Whiteness came to represent objectivity, normalcy, truth, knowledge, merit, drive, success, and reliability.[136]

This construction of a racial social order embedded the belief of white supremacy with European colonisers viewing themselves as superior and civilised, and was used to justify the colonisation, enslavement, and the exploitation of Africa, the Americas, and parts of Asia. Today, this dominance of whiteness continues to impact British understandings and learnings of historical events. British colonialism is often glorified or excluded from British state education, further contributing to the ignorance of British history by removing from consideration both the violences of colonialism and the historical contributions from those who are racialised.[137]

Importantly, whiteness is not a single, uniform identity. It varies, like other social identities, upon gender, class, sexual orientation, age, geography, and culture.[138] However, the fact that whiteness both created and requires hierarchy, exclusion, and deprivation is, nevertheless, under acknowledged.

While race is not a biological phenomenon, its socially constructed nature means that racial categories can shift, and the impacts of racism vary across different times, places, and national contexts. The inequalities that arise from these processes are not due to the inherent qualities of racial or ethnic groups, but rather from the meanings that have been historically, culturally, and politically assigned to them/attached to their identities. In other words, it is not the fault of the racialised people that they experience racism, and is precisely why racialisation is a traumatic and dehumanising process.

134 Patrick R. Grzanka, Kirsten A. Gonzalez, and Lisa B. Spanierman, "White Supremacy and Counseling Psychology: A Critical–Conceptual Framework," *The Counseling Psychologist* 47, no. 4 (May 1, 2019): 478–529.

135 R. C. Schooley, Debbiesiu L. Lee, and Lisa B. Spanierman, "Measuring Whiteness: A Systematic Review of Instruments and Call to Action," *The Counseling Psychologist* 47, no. 4 (May 1, 2019): 530–65.

136 Andrea L. Dottolo and Ellyn Kaschak, "Whiteness and White Privilege," *Women & Therapy* 38, no. 3–4 (August 31, 2015): 179–84.

137 Reni Eddo-Lodge, *Why I'm No Longer Talking to White People About Race* (Bloomsbury Publishing, 2017).

138 Andrea L. Dottolo and Ellyn Kaschak, "Whiteness and White Privilege," *Women & Therapy* 38, no. 3–4 (August 31, 2015): 179–84.

For further information on the issues raised in this paper, please email info@equalitytrust.org.uk

The Equality Trust and BLAM wish to extend our sincere thanks to the research participants for their time, candour and courage in sharing their personal experiences of mental health and anti-Black racism. Your openness shed light on the complexities of these issues and provided valuable insights into areas for improvement and opportunities for meaningful intervention. We are deeply grateful.

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