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Towards a Rainbow-Coloured Therapeutic Community

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ABSTRACT *A rainbow-coloured therapeutic community is a term inspired from South Africa's Rainbow Nation after its 46-year period of apartheid. This term does not just represent the fact that South Africa is diverse but that skin colour was not going to be the defining factor in valuing the needs and wishes of its citizens. In the UK acute mental health services are overrepresented by people of colour. Most would agree that the caring profession should reflect the community that it serves, but will this be enough to reduce the overrepresentation of people of colour in acute services and inspire them to seek a service at an earlier stage? In this article I will look at the current state of play and then look at the efforts people have made to change the situation. Copyright © 2011 John Wiley & Sons, Ltd.*

Key words: mental health; colour; black and minority ethnic; rainbow-coloured

A rainbow-coloured therapeutic community is a term inspired from South Africa's Rainbow Nation after its 46-year period of apartheid. This term does not just represent the fact that South Africa is diverse but that skin colour was not going to be the defining factor in valuing the needs and wishes of its citizens.

'Towards a rainbow-coloured therapeutic community' is an idea that puts into metaphor the hope of a mental health community in the UK that truly addresses the needs of black and minority ethnic (BME) people and a possible road map to getting there. The therapeutic community in this context refers to state-registered professionals involved in mental health work, such as psychotherapists, counsellors, psychoanalysts, psychologists, psychiatrists and allied professionals.

In the UK acute psychiatric mental health services are overrepresented by people of colour. It is therefore reasonable to assume, if we accept that there is nothing intrinsically deviant about the BME community, that preventative therapeutic services are not meeting the specific needs of the BME community. But what are the specific needs that need to be addressed and how could these be met? Ultimately the overrepresentation in acute mental health services is a measure of the overall mental health of the BME population, so it is of concern not just to those who find themselves in acute services but also the BME community as a whole.

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Also, can the rainbow-coloured therapeutic community ideal of attending to the therapeutic needs of 'all' come about just through having a therapeutic community that accurately reflects the diversity within its population?

There are then two strands to the rainbow-coloured therapeutic community idea. The first is having diversity in the therapeutic community that reflects the current diversity of UK citizens, and the second is orientating the therapeutic community, professional bodies and the state towards making primary care more 'fit for purpose' for BME individuals.

The arena of race and thinking psychologically about race issues is extremely difficult to navigate around and feels like opening a can or worms. You don't want to open the can because you know what's inside; and even as you resolve yourself to opening the can you wince every time the worms wriggle out. This global somatized response to race is a deep challenge, but what is useful to note is that it is possible to move from overwhelming discomfort to tolerable discomfort around race issue, as with many other psychological phenomena.

In this article I will be using the term 'black' and 'black issues'. The term 'black issues' is used by Dr Isha Mckenzie-Mavinga in her book *Black Issues in the Therapeutic Process* (Mckenzie-Mavinga, 2011) and describes well the focus of this paper. 'Black' is a political and sociological term, identifying a group of people who have been most vulnerable to the oppression of white racism owing to differences in skin colour. 'Issues' in this context refers to any concern, problem, dynamic, feeling or experience raised about black people, by themselves or by white people. 'Black issues' is used as opposed to the focus on 'white issues' that lie at the heart of Eurocentric theory, images and power structures.

I will first explore the current state of affairs and then explore some ideas on what would need to change in order to place equal value on the felt needs of BME clients.

The Sainsbury Centre for Mental Health, 2002 conducted a review of the relationship between mental health services and African and Caribbean communities. Dr Shirley Tate states in its forward that

> There is a profound paradox at the centre of black people's experience of mental health services in England. Young black men, in particular, are heavily over-represented in the most restrictive parts of the service, including secure services. And black people generally have an overwhelmingly negative experience of mental health services. Yet these same communities are not accessing the primary care, mental health promotion and specialist community services which might prevent or lessen their mental health problems. They are getting the mental health services they don't want but not the ones they do or might want. (Tate, 2002, 6)

She goes on to say:

> We have reached a point in the relationship between the black communities and mental health services where there are truly Circles of Fear . . . We are delivering expensive, poor quality mental health services that do not match the needs and aspirations of the clients and their families. Whatever the reasons we need to turn this around and break the Circles of Fear. (Tate, 2002, 4)

Some of the key findings of the report were as follows:

(1) There are circles of fear that stop black people from engaging with services.
(2) Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well integrated with the community.

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(3) Black people come to services too late, when they are already in crisis, reinforcing the circles of fear.
(4) Primary care involvement is limited and community-based crisis care is lacking.

From the Sainsbury Centre report it is clear that the services currently provided for BME individuals are not fit for purpose. Lennox Thomas, psychoanalytical psychotherapist, in his article 'Getting help; what have you got to lose' (Thomas, 2008, n.p.) asks 'Why don't black and Asian people use therapy? There is history there. Like all institutions of power and authority Psychiatry has been wielded against minorities. Psychotherapy has been subsumed under the heading of Psychiatry and there is no doubt that this institution has been seen as dangerous and untrustworthy.' He goes on: 'Mental health services have a poor track record as far as racism and prejudice is concerned. There is a sense of blaming the ill for their illness instead of looking at the underlying factors. It's only quite recently that the total picture has been publicly talked about.'

So what are the underlying factors that Thomas talks about and what is the total picture?

The Sainsbury Centre report highlights oppressive forces both internal to black people in the form of what might be called the internal oppressor, and outside oppressive forces in the form of unwelcoming and unempathic services.

Having become accustomed to struggle, some BME people will wait until their mental health symptoms and distress are at an advanced stage before seeking help. Sadly, the control they feel they can exercise over their symptoms can get out of hand and very quickly they are overwhelmed and sectioned. This is the internalized oppressor at work.

Dr Aileen Alleyne, psychodynamic psychotherapist, in her clinical research (Alleyne, 2005) talks about 'daily micro acts of racism' that build up over time to become stress that contributes to mental ill health. This silent stressor works in the background of the unconscious and acts as a major stressor, with all the consequent effects.

What is clear is that there is little or no thought given towards attending to the complex psychology of working with BME clients in general mental health care, resulting in a poor and untrustworthy service. The pattern of experience for BME mental health users is also a pattern that is replicated in the BME experience while training to become a psychotherapist or counsellor (although in some training this is changing), where their essential experience as a black person is not met and there is silence around their experience.

The talking therapies are a unique profession in that its aim is to make sense of what is, ordinarily, confusing with regard to your relationship to the self and to others. Psychotherapy theory that is taught in mainstream psychotherapy training is excellent at organizing and describing the relational dynamics between individuals and sometimes groups. When it comes to helping students to think about how relationships across difference manifest themselves in the area of race, however, the profession is more often than not found wanting.

There is a general feeling across the profession that theories that are already to hand like transference, projection or splitting, as they stand, are more than enough to describe what happens between people of different racial groups. If there are conflicts between student and trainer, where each could be described as a member of a particular ethnic group or race, the current theories, organized as they are, do not support the experience or describe the whole landscape. Sure there is transference and projection going on but there is also

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something else which the trainer, who has the role of organizing the interaction to aid the student, struggles to articulate. These traditional ideas need developing to include black issues.

Teachers who are, in other areas, competent, flexible and lucid with regard to relational dynamics and who can articulate what is going on between people, in the area of race seem lost. Talking about the relational dynamics seems more possible in the area of gender, for instance. A male teacher and female student can understand some of the difficulties that might arise between them because the politics of men and women are so well documented and lie in the sphere of almost everyone's consciousness, even if you disagree with gender politics.

Erotic transference is used to described a certain aspect of gender issues which again you might chose to ignore, but it is there to be picked up somewhere down the line if client work is stuck. When issues around race arise, however, there seems to be a paralysis of thought where it becomes very difficult to respond in a way that decreases the emotionality of the situation despite good intentions. Silence is the next best solution in this situation but, as can be attested to by the many therapy students I have spoken to over the years, this also does nothing to decrease the emotionality of the race dialogue either.

For many BME trainees the four-year professional training is just the beginning, a framework for further learning. They often have to go away on their own and learn about the complex issues of racism in the profession for their own self-protection and learn about the complex psychology of working with BME clients because it was not taught in their training. Not knowing these issues, which are common to many clients from minority communities, renders the therapy inadequate at best.

At this point I want to recognize the good intentions of non-BME people who really want to move things forward. It could be said that even with good intentions things do not move forward and it could be that the proclamations of good intent are not real and are part of the mechanism which continues the status quo. This may be so at times, but my own view is that I have met many non-BME people who have had the courage to work through internalized oppressive behaviours even thought it's so easy to avoid having to do this. These people have a genuine desire and intent that is not fake or duplicitous and have significant contributions to make in this area.

From all of this, questions spring to mind. Is it possible to have theories that describe the process of what happens between individuals from different ethnic groups? Are there theories that integrate black issues into psychotherapy training? And also, can such theories operate separately from the politics of race which lives within the general public consciousness?

There are many that have, over the years, brought together a body of work that speaks of the issue of race in the therapy room and therapeutic thinking, like Dr Aileen Alleyne (2005), Dr Isha Mckenzie-Mavinga (2011), Lennox K. Thomas (1992), Colin Lago (2005), Valerie Batts (1982), Jaffar Kareem and Rowland Littlewood (1992), Judy Ryde (2009) and Dr Farhad Dalal (2002), to name a few. The political landscape of race forms a part of all these theories where in effect your are, to coin a phrase, putting 'racial politics on the couch'.

There have been successful organizations that have developed, and put into practice, ways of working with BME clients that have resulted in very long waiting lists. The Nafsiyat intercultural therapy centre (Kareem, 1992), set up by Dr Jaffar Kareem and his colleagues, opened in 1983 to provide a specialist psychotherapy service to black and other ethnic and

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cultural minorities and is still continuing to do so. Nafsiyat was also instrumental in developing intercultural therapy.

Nafsiyat showed that BME and non-BME therapists could be trained to work interculturally to a high level and deliver a valued and sought-after service – something that was thought only BME people could provide. Nafsiyat, a small voluntary organization, could be seen as a template for other similar services or a model that could be integrated into statutory services.

The advantage Nafsiyat had in providing the service was that it did not have to contend with historic institutional racism which normally hampers any state attempts to innovate in this way. To overcome the institutional racism aspect of state services, the state might – in the first instance – have to create more Nafsiyat-like services and then when this is done legislate on some level to regulate this within statutory services.

So far I have explored the problem of inadequate primary mental health for BME clients and an apparent paralysis of thought in the psychotherapy profession as a whole on matters of race. I have also pointed out that there is a body of theory that articulates black issues that has developed over the years that could transform these services and liberate psychotherapy in this area. Despite the presence of this theoretical thinking, however, there is reluctance to make a space for these theories to exist within the current framework of psychotherapy training and thinking. For these theories to make an impact on the lives of BME individuals through mainstream theory and practice, I have suggested that change might need to come about through government legislation.

I will continue by describing one organization's approach to increase the numbers of BME therapists in the therapeutic community, with an understanding that more BME therapists would probably prelude any formal changes to psychotherapy theory to include a black empathic approach.

The Black and Asian Therapist Network (BAATN, http://www.baatn.org.uk/) was set up in 2002 and currently has well over 400 members. Its aim was to bring the black and Asian therapeutic community together for mutual support and inspiration. It was also set up to develop theory and become a catalyst for change. BAATN wanted to support the significant number of BME therapy students who drop out of their training due to the difficulties they encountered. These students felt that their hurts were not recognized and understood, and it became too toxic an environment to continue.

One of the initiatives undertaken by BAATN is to host student support groups which aimed to be a place for students on therapy courses to contemplate the forces that they were struggling with as black and Asian people in their training and in there lives and to have their struggles acknowledged and engaged with. Another BAATN initiative is a mentoring scheme where qualified and experienced black and Asian therapists offer to support black and Asian students on a one-to-one basis.

Many students have said that this support has been invaluable to them and central to them making it through to the end of their course. The hope that they felt in being met with empathy for their situation was transformative. It is sad that students feel that they cannot get the support they need within their training.

To conclude, the idea of 'a rainbow-coloured therapeutic community' has two ideas within it: firstly, finding ways to increase the numbers of BME therapists in the therapeutic community; and secondly, the therapeutic community as a whole having a more integrated black empathic approach.

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At present there is no universal language and theory to talk about issues of race, which is a central experience in many BME people's lives. Without a language to describe the experience it is near impossible to help significant numbers of people.

I have suggested that government might need to legislate towards developing an approach that integrates black issues in training and within therapy providers; also that there are organizations that are getting the BME therapist community together to develop ideas that support trainees to complete their training and inform and influence the wider therapeutic community about black issues.

We know the figures for mental health problems in minority communities, and we know the reticence in those same people to be proactive with their psychological well-being. It is the hope of this author that the therapeutic community, the professional bodies regulating the therapy profession and the government can find their way towards a rainbow-coloured therapeutic community for the good of us all.

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