# Thinking differently about racism, refugees, and anger – (perhaps even terrorism) in counselling and psychotherapy.

**…about Racism**

Key words: Afghan, anger, competence, ethical framework, othering, politics, psychosocial space, refugees, standardisation, systemic racism,

A recent paper on cultural evolution in a psychotherapy journal states:

'…we in the West tend to differ from other cultural groups around the world. In this article I will try to summarise key points from this literature to show how certain values and traits have evolved over time, that have led us to accelerate our economic development, develop individualistic models of motivation and 'within-person' psychological treatment for mental health issues.'

Steve Heigham 2022

As counsellors and psychotherapists, we work primarily on one-to-one interactions which sit within socio-political and historic contexts. focusing on the immediate it is possible to lose perspective on the impact and implications of that context. As well as this, aspects of context may not be visible to us as professionals yet blindingly obvious to our clients. When this happens, it can seriously impact therapeutic relationships with counsellors believing that they understand the reality of the client and so proceeding with interventions; or placing inordinate personal responsibilities on clients that create further psychological distress.

Whilst aware of the above 2022 quote consider the following. Five hundred years ago Michelangelo painted the Sistine Chapel. Five hundred years ago there were trade routes from China by sea to India and then to East Africa, as well as related trade routes across Africa.[2][3][4] This shouldn't be surprising as eight hundred years ago probably the richest person in the world was Mansa Musa the ninth Mansa of the Mali Empire, who while on pilgrimage to Mecca in his generosity gifted so much gold whilst on route he temporarily destabilised the Egyptian economy.[5][6] Three hundred years ago India accounted for a quarter of global wealth. Neither the East nor the Southern Hemisphere had experienced The Dark Ages. Civilisation and development had been progressing in their own regional circumstances. In this context, the world's first universities were created in Morocco University of Al Quaraouiyine was established in 859, and Al-Azhar University was established in Egypt in 970 AD. Additionally, hospitals known as bimaristans were built in Persia in the early 9th century, with specific wards for patients exhibiting psychological distress such as mania. [7][8]

But that world changed with European interests in other continents. Eight hundred years ago Marco Polo travelled to China. In the same century, Europeans began using weaponised gunpowder. Though similar developments took place in China and the Middle East in the

following arms race sub-Saharan empires were wiped out or subjugated. India was subjugated as was China. All this comes with:

- the East India Company,
- the 'scramble for Africa',
- British Gunboats forcing the Chinese Emperor to accept the import of opium,
- the Sykes-Picot agreement,
- the genocide of first nation Americans and Australians,
- and slavery.

This 'history' turns 20th-century European wars into World Wars[1]. Following this, the European or Northern Hemisphere peace that followed 1945 can be argued to be based on outsourcing resource wars for the late 20th and early 21st centuries to places renamed the third world (and encircling China with US military bases). From this perspective, Kipling's 'white man's burden'[9] becomes 'International development'. We are taught to collectively forget, in a created language of convenient memes (though the word Palestinian remains in regular use, 'Palestine' appears to be disappearing from the political vocabulary), and global injustice hides in plain sight.

'Until the Lions have their own historian's tales of the hunt will always glorify the hunter.'
Anonymous African proverb retold by Chinua Achebe (1994 Paris review).

There is not a person of the Southern Hemisphere, of the Middle East or even of the far East whose life today has not been impacted personally and psychologically by the processes of European expansionism that predate the development of modern psychology, counselling, and psychotherapy. It is in this hegemonic context that our work has come into being, a context inclusive of white supremacy and capitalism psychosocial enabling professions developed through WEIRD science (science developed through research on Western, Educated, Industrialised Rich & Democratic participants - often university students). We assume that our *knowledge* and skills developed in this context *being scientific* are universal for all humanity. Yet the enduring mental health inequalities in the UK experienced by people of colour indicate that something is wrong. I say this knowing that for more than a generation we have attempted to or talked about 'developing' cultural competence.

Perhaps, there is a need to go back to first principles accepting that what we have as a psychotherapeutic knowledge base is biased. Maybe talking about diversity in counselling and psychotherapy in this context can only be 'talking'. The weight of all the above may well essentialise us all. Perhaps we first need to address who we are being (including our entitlements and assumptions) before we think about how we encounter an 'other' What impact does the above lens have on our ability to relate to those who are ethnically similar or different?

**…about Refugees**

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[1] Alhaji Grunshi, DCM MM serving in the Gold Coast Regiment was the first soldier in British service to fire a shot in World War 1. This took place during the conflict between Togoland and the British Gold Coast in West Africa on the 7th of August 1914.

As citizens of an interconnected world, all of us have responsibility, and opportunity, to do what we can to support victims of war, and create more just and ecologically sustainable ways of living together. Working alongside like-minded disciplines, occupational groups and social movements, the counselling and psychotherapy profession has its own distinctive contribution to make. A crucial aspect of a psychological and psychotherapeutic response to war is to provide therapy for refugees who have lost their homes and identities, and for all those affected by trauma.

John Mcleod 2022

The above Mcleod quote comes from a conference in support of Ukraine. Here it is essential that I declare my positionality, I am writing as a British, Black, male, Muslim, counsellor of Caribbean origin. From this perspective, I am observant of the linguistic and conceptual changes concerning our societal understanding of refugees. With this specifically the contrast in understanding and responding to European refugees as opposed to Afghan refugees (following the removal of British troops) or Syrian Refugees (following an 'outsourced resource war' involving Russia and other powers). These changes encompass the current UK policy on refugees using illegal routes to enter the UK noting that 25% of cross-channel boat people are now Afghan[10].

In a global context, I believe counsellors and therapists have a responsibility to explore the political implications of intersectionality in the therapeutic relationship, in a time of working with the lived experiences of diverse clients with histories and experiences different to us.

In this, I'm using my own experience of working with refugees across diverse communities specifically drawing on my experience working with Afghan refugees over the last six months following the withdrawal of UK troops from Afghanistan and with that their arrival in the UK.

There are some parallels and some differences in experience concerning Afghan and Ukrainian refugees. One thing that is strange for some of the people that I have been working with, is how the invasion of Ukraine by Russia has triggered traumatic memories, and questions about the previous Russian invasion of Afghanistan and the global response then. These indicate part of the problem that we face when we are trying to navigate the impact of geopolitics in highly charged traumatised therapeutic contexts.

What this comes down to is how we negotiate the psycho-emotional and the psycho-social space that is the therapeutic space between counsellors and our clients. Politics lives within these spaces. What is the extent to which we can not only engage with but hold their reality both in terms of who they are being and in terms of what they have experienced, whilst maintaining our own wellbeing?

This whole thing seems to be about humanity, how we reach across a void of understanding to hold in as human a way as possible the lived truth of another which may challenge the fibres of our own integrity. And can we even do that?

I will admit I have been reflecting a lot recently on my own moral distress in this context. Narratives I live in are regularly challenged by the experience of my clients in these extraordinary times.

In the context of therapeutic work in a diverse multi-racial, multi-ethnic, international, plural society how do we see and respond therapeutically to the refugee or different refugees in their context, as opposed to **our** geopolitical landscape?

How do we see not only Russia but our nation our people? Our tacit implications? How do you and I understand international politics as they play out within the mutuality of the therapeutic relationship?

In the light of what is known about transgenerational trauma, when working with victims of state abuse (particularly our own state) healthy human responses may be uncomfortable but not pathological. Recently a colleague heard another social care professional speak of an August 2021 Afghan refugee in the following way…

'There's something fundamentally wrong about that woman.'

Even though our work has an individual focus our clients cannot be individually blamed for enduring processes sometimes even over generations (e.g., 40 years of war in Afghanistan) beyond their control in the best ways that they can.

We need to be humane and respect humanity. Working irrespective of approach from a place of heart. Because 'othering', 'essentializing' clients is political, not therapeutic. Our work is in a network of meanings, we are responsible for understanding those meanings. Challenging and reflecting on our own generally and in our client work. As a profession, we must work with each other to enable the creation of therapeutic spaces which can hold people and their experiences that we cannot. All of this carries serious ethical challenges.

Have we found the ethical framework that holds the divergence of political realities between client and counsellor? As a nation do, we view refugees from Europe differently to refugees from Asia, Africa or the Middle East? Does this impact the therapy they receive? My limited experience of working with Afghan refugees has indicated that the support commissioned by the Home Office has focussed on accommodation, education, employment, and physical health and that this has been generally accepted by partner agencies implicitly devaluing the significance of the psychological trauma many carry.

As a field, if we are faced with communities of non-Europeans experiencing war-based trauma do we all have a moral responsibility to address this appropriately or does this come down to the responsibilities of kindred marginalised communities – if the marginalised must give appropriate support to the marginalised what of SCoPEd 'WEIRD' standardisation? With competing world views and understandings of reality who isn't right?

No - I am not saying that everyone is right in how they understand reality and what they therefore do. But nor can we create a judgemental space that holds 'our morality' at the centre. I am asking, if we have understandings of right and wrong and moral frameworks

that differ across context and time, how do we create the ethical spaces to hold humans therapeutically and what they believe?

How do we focus our humanity on those on the edge of our understood humanity?

**…about Anger**

Following on from the above there is a necessary question. Can a client who has been systemically 'othered' bring their real self, their whole self to the therapeutic relationship? Can they even bring their reality to the gatekeepers of therapeutic agencies? Or to consider this differently…

Do marginalised people have to be good to be cared for?

Is there a 'human right' to be one's actual or sincere self in a therapeutic context?

A lot of our framing of mental well-being is in relation to distress and with this pain and sadness. We talk about people being wounded and with this we talk about people healing. Sometimes we even talk about our clients being patients, perhaps because there is with good reason a clear framing of our work with the sick person - benevolent healer dyad.

Though we know that anger can be a secondary emotion, a response to pain, therapy often addresses this differently. With anger comes the potential of threat and often anger is seen as exactly that - threatening. A threat elicits a response to nullify the threat. The response is often to control.

All of this makes sense in the immediate context of agency or counsellor, but one reality of the history presented above is centuries of external control, an intergenerational reality. Noting the inequalities mentioned above - how might this pattern relate to the relatively small numbers of people of colour and particularly Black and Brown men or even Black women for example that are successfully engaged in the therapeutic process? There are tropes about the angry black man or the angry black woman. These have played out within Law enforcement fatally[2]. People of colour are underrepresented in therapeutic engagements and overrepresented in the justice system. Could the former be a precursor to the latter?

Anger may mean threat, but anger is not an action it is an emotional state. Interpretations of that state may lead to pre-emptive actions of control. Yet like pain or sadness, it is an emotional state experienced by people across social groupings. Our professions should be able to work with this therapeutically across ethnicities.

**…terrorism**

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[2] In 2016 former Aston Villa footballer **Dalian Atkinson** appeared to stagger at two police officers before one deployed a Taser. The ex-footballer was tasered for 33 seconds, more than six times the standard five-second phase. Mr Atkinson was also kicked in the head at least twice by the same police officer. Mr Atkinson died. The police officer was jailed for 8 years for manslaughter. Mr Atkinson had a history of mental health problems.

Briefly, regarding terrorism, pain can turn to anger. If political violence by Northern States has inflicted pain for centuries with questionable justification on others, then what does it mean when the political violence we call terrorism (as opposed to freedom fighting, or war) occurs in this historic context?

I do not condone violence. I know it happens and sometimes it is legitimate, but often not. I believe we have a responsibility to understand where it comes from. As professionals, we all have legal duties including our public health responsibilities regarding terrorism. But terrorism is not new in the UK. During 'the troubles' mental health professionals were not engaged in the defence of the realm as we are now through PREVENT and did not carry the same responsibilities. Over 25 years of The Troubles it is believed that the IRA alone killed 1700 people of the 3500 total killed in the conflict. Since the beginning of the war on terror following 9/11, there have been less than 100 terrorist-related deaths in Britain.

**Considering implications of Systemic Racism, in counselling & psychotherapy**

From the above, it can be argued that racism impacts the way we therapeutically understand and support people of colour including refugees. It can also be argued that racism impacts our ability to address complex feelings including anger in clients of colour as well as our conception of or approach to the concern of terrorism as this relates to counselling and therapy.

'References to 'systemic', 'institutional' or 'structural racism' may relate to specific processes which can be identified, but they can also relate to the feeling described by many ethnic minorities of "not belonging". There is certainly a class of actions, behaviours and incidents at an organisational level which cause ethnic minorities to lack a sense of belonging. This is often informally expressed as feeling "othered". However, as with hate incidents, this can have a highly subjective dimension for those tasked with investigating the claim.'

Commission on Race and Ethnic Disparities 2021

"If" racism is systemic within British society - it is likely to be in mental health provision. In such a context, racism will probably impact differentially on:

- *who can access counselling or psychotherapy,*
- *the context in which a person can access counselling or psychotherapy,*
- *the level of need, and how need is assessed to access counselling or psychotherapy,*
- *engagement in the therapeutic process,*
- the understanding of the client's implicit and explicit counselling goals,
- the competence of the counsellor to address the clients lived experience,
- the depth of the therapeutic intervention,
- *the length of the therapeutic relationship,*
- the outcome of the intervention,
- *the wellbeing of the client,*
- and in multi-agency interventions the client's interactions with other agencies such as education local authorities or the justice system.

If racism is systemic in British society, then in this context refugee status and client's presentations of anger will probably be viewed differently across ethnicities potentially causing differential access to therapy and differential outcomes concerning therapy. Concerns in mental health provision regarding Race are not new. The Department of Health programme Delivering Racial Equality in Mental Health was completed after 5 years in 2009. The plan, unfortunately, had little impact relying significantly on the appointment of community development workers to address issues of access to existing mental health services. Most often this work focussed on helping ethnic minorities 'understand' mental health and access existing services, in some situations, these workers did attempt to adapt existing services to the needs of minority communities. It can also be argued that by this time following the publishing of several NHS reports documenting ethnic inequality in mental health provision that the focus of the initiative was not on addressing racism in mental health systemic or otherwise but on addressing diversity and inequality. But if the problem is systemic then it will require a forensic examination of what we do, the how, and the why. This process would need to be championed by experts in each of our fields this the ability to facilitate structural change. We would have to actively do the work rather than expect it to be done on the periphery. Such work would for example include having to ask questions such as:

> How many of our counselling and psychotherapy training programmes have appropriate training provision concerning race and diversity to enable our trainees to work effectively in a culturally diverse society?
> How do we work towards systems that are culturally competent within the context of systemic racism?
> How many counselling and psychotherapy supervisors are culturally competent?
> Who should counsellors qualified from training programmes that have not facilitated cultural competence work with and not work with?

In 2022 the Race and Healthcare Observatory report; Ethnic Inequalities in Healthcare; A Rapid Evidence Review, regarding mental health found the following which support an understanding of systemic racism in mental health provision:

> *'Ethnic minority groups experienced clear inequalities in access to Improving Access to Psychological Therapies (IAPT); overall, ethnic minority groups were less likely to refer themselves to IAPT and less likely to be referred by their GPs, compared with White British people. Evidence was identified for inequalities in*
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> *the receipt of cognitive behavioural therapy (CBT) with ethnic minority people with psychosis less likely to be referred for CBT, and less likely to attend as many sessions as their White*
>
> *counterparts…*

Evidence across ethnicities relating to:

- *who can access counselling or psychotherapy,*
- *the context in which a person can access counselling or psychotherapy,*
- *the level of need, and how need is assessed to access counselling or psychotherapy,*
- *engagement in the therapeutic process,*
- *the length of the therapeutic relationship,*

*…The review provided strong evidence of clear, very large and persisting ethnic inequalities in compulsory admission to psychiatric wards, particularly affecting Black groups, but also Mixed Black & White groups and South Asian groups. There was also evidence of harsher treatment for Black groups in inpatients wards, e.g., more likely to be restrained in the prone position or put into seclusion.'*

- the well-being of the client

Counselling, psychotherapy and mental health provision must be bigger in an interconnected interwoven world. That the above quote would indicate it is at present the personal realities of people of the Southern Hemisphere, of the East need to be engaged with in ways that are enabled **by us doing our necessary work** to understand them. The presence of a systemic problem requires a systemic response to address the problem. The problem of racism in mental health provision is evidenced by its context in a wider problem of racism in health provision as demonstrated by the 2022 Race and Healthcare Observatory report, the 2022 BMA delivering Race equality in medicine report and the 2022 BMA Racism in medicine report. Though the focus of both later reports is on racism and its effects on medical staff in the NHS they serve as evidence of the systemic problem of racism in health as it impacts people of colour clients or professionals who engage with our primary provider of health services both physical and mental indicate further the systemic nature of racism in health provision. All of this is why I believe we must think differently.

Stephen Abdullah Maynard

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