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Contents

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1

Denial and the Myth of Post-Racism

This chapter takes a look at the myth that the work on racism is finished and how this functions as denial in the context of racism, thus inducing a silence that inhibits the explicit engagement of black issues in the therapeutic process. Howitt and Owusu-Bempah (1994) describe this occurrence as racism having 'changed its clothes' (p. 9).

It is generally assumed that institutions in the UK are in a discourse of post-racism – a neo-colonial period of acceptance, tolerance, understanding and living in harmony with our differences. Therefore, the assumption is that racism is no longer relevant to healthy psychology. This assumption is far from the truth. Things appear to be OK on the surface, until we hear of a racist incident in the media. Multiculturalism is doing its job of integrating diverse cultures and experiences into employment and social institutions. The media portrays more affirming images of brown-skinned people. The art and music world is edging its way past tokenism. The education system takes bullying and racial abuse more seriously, and there are laws to curb overt racist abuse.

However, the mythology of a post-racism period (Mckenzie-Mavinga, 2010) has created a denial of where psychological therapies stand in the process of supporting awareness and change in this area. As a result, hesitation to address racism, based on the belief of a post-racism period, serves to stagnate challenges to institutional racism and the growth of anti-oppressive practice. Any progress is then relegated to individual therapists and students, who soldier on, often with little support. This important concern raises the question of what gets bypassed or passed on in the client therapist–supervisor triad? Racism has permeated the psyche and continues to be a fearful, guilt-ridden theme that may be addressed by its victims and rarely acknowledged by its perpetrators. This oppression, in all its guises, needs to be an ongoing concern in order to preserve the integrity of therapeutic work and client welfare.

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The women's movement was accused of whitewashing women of colour. Sexism and homophobia permeated the black power movement, and racism and sexism impact gay and lesbian communities. Multiculturalism has thus arisen out of a need to understand and eliminate oppressions within and between different ethnic and minority groups and their respective individual intersecting identities. Intersecting identities is a conceptual model of ways that individual and socially constructed identities such as gender, race, sexuality and spirituality influence individual personal development processes. Therefore, by considering a person's ethnicity, place of origin, cultural background, spirituality, gender and sexual orientation, a greater understanding of their identity development and experiences of oppression can be gained.

In this respect, internalized oppression, a term given to destructive attitudes and behaviours that result from the distress caused by oppressions such as racism, must be considered. Lack of opportunity to express hurt caused by oppression contributes to internalized oppression. The oppression is sometimes re-enacted against the self and others causing low self-concept and feelings of powerlessness.

Attempts to understand denial as a response to these discourses have thus become a feature of ongoing efforts to process how the hurt of prejudice impacts on the unconscious psyche; however, learning about the impact of racism and oppressions does not give licence to assume the work is done. A stuckness that prevents active involvement in addressing racism and cultural oppressions underpins the mythology of a post-racism period.

A greater understanding of diversities has led to equality legislation and more challenge to institutional oppressions. These are the outward, more observable, signs that contribute to the myth of post-racism. The unconscious and internal effects of oppression and intra-cultural dynamics have been addressed to a lesser degree and usually within specialist agencies such as PACE LGBT+ mental health charity, Nafsiyat Intercultural Therapy Centre, the Refugee Therapy Centre, the Asian Family Counselling Service, the Women's Therapy Centre, and One in Four therapy for sexual abuse survivors. These agencies grew out of a need for marginalized voices to be heard.

The challenge is upon us to unpick this mythology in an ethically sensitive way that supports individuals and institutions. Below I have listed some pointers relevant to this transitional process.

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- Individuals and institutions must recognize and work towards anti-oppressive practice in therapeutic relationships and supervision.
- It is important to raise issues of 'difference' in a sensitive, therapeutically supportive manner.
- Remember that all of us, no matter how well trained, have difficulties with issues of difference, including black issues. Individuals need acknowledgement of the different levels of awareness and experience that they may be at with this.
- White therapists and supervisors have an ethical obligation to be non-defensive about the impact of racism.
- Black and Asian therapists and supervisors must be aware of over-identifying with black issues and work with the diversity within black and Asian communities.
- Flexibility is important, as black issues often challenge our theoretical commitments – for example, our understanding of transference and counter-transference dynamics, or using a strictly person-centred approach.

Choosing to be silent plays into the mythology of post-racism. White tutors, quoted below, evaluating a black issues workshop on a training course explain how they can choose to be silent or choose to have a voice because they may not be directly impacted by racism.

Tutor 1: I remember that training day and I think that that was quite a moment for me. There have also been other moments that have been challenging for me in the teaching of this course ever since it started. I am aware of how I am often reluctant to speak. It isn't that I am not thinking about things; it is that I am often reluctant to speak. There are times when we are reminded by Isha to think about things and I say, 'Yes it is another thing on my list to do.' I don't know that I feel any bolder. I feel more secure in myself and in my thinking about where I am, but I don't think I am any braver than ten years ago about confronting racism or addressing black Issues. There is sometimes a borderline between those two things. I like the way that white students have become bolder and braver. I suppose that I was saying that knowing that black people have to deal with things that I never have to deal with from the minute you set out side of your house and there are things that I can pretend are not happening.

Tutor 2: I am thinking about speaking, about having a voice, and as two white tutors leading a workshop, the fear that came with that. Also one of the things that I felt about the continuous input of black

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issues through the postgraduate training and all the discussions that go with that outside of the teaching time have made me slightly more able to speak. I was thinking about one of the things that both white and black students from a different perspective, is being able to continue my voice despite my anxiety. But I still censor myself even after all this time. I don't know, in terms of evaluation, how that influences the students, if I am doing that. The other thing is, there still seems somehow, not to have been picking up when two white people are working together. It doesn't seem to be translated across to other oppressions. At the end of all of this, I have learnt masses, and I still find it a struggle and it's still difficult and it still causes me anxiety and it's still painful.

Tutor 1 clearly demonstrates how slow change can be, in that she has 'not felt much braver approaching black issues in ten years'. Tutor 2's evaluation shows that she continues to 'censor herself'. It is important to observe the consequences of this behaviour, as censoring can translate into the student's perception of therapeutic behaviour and, indeed, into the therapeutic relationship, subsequently perpetuating denial of racism.

Both these voices dispel the myth of post-racism. Tutor 1 uses the concept of bravery in situating an experience that many black people face on a daily basis; however, I am aware that black people also have ways of coping with their powerful feelings about racism. Here denial can happen from a survivor perspective. Each individual has his or her own ways of coping with racism, whether from the survivor or perpetrator perspective. We are where we are, and you are where you are on this challenging theme. However, as a therapist it is not enough to just acknowledge where you are, because this stuckness and silencing can contribute to the mythology of post-racism. I want to encourage therapists to consider the importance of deciding to work through the ongoing challenge of racism and its imposition on the psyche.

When observing students responding to racialized concerns, I found that although non-intentional, the needs of the white students became prioritized over the learning of black students and subsequently black students become their facilitators. This is where the mythology of post-racism becomes operative, because in this situation racism gets transferred into an unconscious dynamic that perpetuates a subservient, less-educated position of the black student. Tutors, therapists and supervisors are positioned in an educative role and have a responsibility to challenge this aspect of institutional racism, otherwise the mythology of a post-racism phase can be perpetuated.

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Hussain and Bagguley's study (2007) supports this concern. They interviewed 114 young female students of Indian, Pakistani and Bangladeshi background (p. 24) and asked them about their experiences of learning. The study concluded that

> Insufficient attention to the impact of isolation, racism and Islamophobia was a primary concern. In addition, 'racism and homophobia in universities have all too often been brushed aside'. (p. 144)

You may be wondering why this has become an important concern, or you may be thinking why am I making an issue of something that is not really apparent. These concerns echo familiar questions asked by trainees. Samples of these questions are presented below.

- Do we focus too much on the colour of each other's skin and consequently generate unnecessary barriers?
- Is this a class issue rather than a race issue?
- If I haven't got an issue with racism, is it that I am not aware?
- Do I compensate in my behaviour when I deal with black issues, to hide my prejudice?

These questions indicate that the challenge of racism is not just about being politically correct. There are deeper, more fundamental, concerns that may need to be resolved. For example: saying the right thing about racism in the right way, or not saying in case of causing offence. I shall attempt to address some of these questions and their relevance as we journey through the book. The challenges identified require a particular type of empathic approach. I have called this 'a black empathic approach' (Mckenzie-Mavinga, 2009, p. 58). A black empathic approach offers a response that specifically and sensitively relates to a client's racial and cultural experiences as they express them and as the therapist intuitively recognizes them as an element of identity and psychology.

I encourage readers to ask questions, but don't stop there or confuse the question as the answer. Defensiveness that arises from trying to cope with the emotions associated with racism causes the mythology of a post-racism period that I am addressing. It is therefore important to reflect on your personal response to both the questions and possible solutions. One solution is to seek peers, supervisors and supportive individuals to voice your fears and concerns to, with a view to gaining insights that will support your practice.

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Wheeler (2006) supports Tuckwell's (2002) suggestion that 'the attitudes and beliefs about race and culture are thus implicit in the interpsychic world of both the counsellor and client, and these impact on counselling interactions in various ways, whether in homogenous dyads or racially culturally mixed dyads. In view of deeply held assumptions about race and culture with the intra-psychic life and interpersonal functioning, it is essential that counsellors be alert to racial and cultural dynamics that arise in the counselling process' (p. 149), and that 'unless counsellors have come to an awareness of themselves as racial and cultural beings, their capacity to work effectively with these dynamics will be considered impeded' (p. 150).

This is the work of unpacking the mythology of post-racism, and I want readers to join with me in addressing this challenge to institutions that train in therapeutic practice. The way to start is by taking on board the voices of black and Asian trainee therapists and actively developing a multicultural anti-oppressive curriculum. Below are some examples of those voices. We must consider whether they get heard and responded to in training and clinical supervision.

- I am wondering why, as a black woman, up to now, I have not thought of bringing black issues into my relationships with white clients?
- What if a client rejects me when I am a counsellor, because of my African Caribbean heritage?
- Why is it that I don't feel as good as white contemporaries? Most of the theory and models are from non-black backgrounds, and this has an impact on black culture. It does not fit into the way we think. How can we work with this?
- What if this is an issue with racism in the counselling process, and every time I reflect on it the client changes the subject? Then, when I address that, the client says 'That is not what I am trying to say' and I still feel something is not quite right? Considering this resistance on the client's behalf, should I address my fear and uncertainty of dealing with black issues with my client?

It is important to listen to these questions in the context of the experience and process of these individuals, because the development of their therapeutic ability also relies on their self-concept as subjects of racism.

In this whole challenge of racism in therapeutic practice, I frequently feel gagged, yet the irons that muzzle me are a feature of the past. How do you feel when you are intuitively aware that racism is functioning in a situation? Being aware but not attending to the oppression causes racism to become internalized because ideas about post-racism set in

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and can cause low institutional esteem and low self-esteem. I use the concept of 'black Western archetypes' to describe the collective unconsciousness of this process (Mckenzie-Mavinga, 2009). These are inherited psychological patterns influenced by racist images, behaviour and attitudes. They are carried in the unconscious life of individuals and recognizable in outer behaviour. They are also portrayed in family structures, perpetuated by the collective unconscious, within social structures, throughout history and reinforced by tradition and culture.

The human psyche processes cultural concepts and internalizes both the positive and negative elements of prejudice and oppression that individuals and communities inhabit. Racism is a prejudice that in its extreme has created hostile and dangerous discourses. It doesn't take much to recognize the damaging influence of groups such as the Ku Klux Klan, the British National Party and the Nazi regime, all products that developed out of negative, hateful archetypes. Uninterrupted, these harmful insights are passed intergenerationally and instilled into the early life and developmental processes of both survivors and perpetrators of racism. Individuals are not born with these oppressions, but they easily become influenced by outward manifestations of them, if parents and carers are not aware of the damage they can cause.

We learn to manage these harmful influences by projecting them onto others or suppressing them into the shadow part of our psyche. Jung (1972) explains 'the shadow' of the inferior traits of others perpetrated in a trickster style. This is where denial, silencing and gagging become functional.

Humans are steeped in archetypes that collectively uphold oppressions. These archetypes are harboured within families, educational institutes and organizations. They are brought to light by insights about challenge and change that become training elements and can transform attitudes and the behaviour of individuals. Surely this means that the human psyche needs ways to therapeutically heal its path from the intergenerational processes of racism.

The black Western archetype is one aspect of what gets passed on intergenerationally. Black Western archetypes have fuelled social discourses such as the underachievement of black boys in the UK educational system and over-representation of black people in prisons and the mental health system. The proposition of 'drapetomania', which an American physician, Samuel A. Cartwright, in 1851 attributed to African slaves who attempted to flee captivity, can be seen to have fuelled misdiagnosis and over-representation of black people in the mental

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health system. A greater emphasis on the historical consequences of this injustice may provoke ways of coping with multidimensional oppressions, and intergenerational trauma caused by racism.

It could be said that the mythology of post-racism is exacerbated by the internalization of white archetypes. It is a painful and difficult battle to stay awake and present enough to challenge the idea of a post-racism mythology; yet, not attended to as an aspect of denial, this schism can create an unconscious defence against supporting clients who experience racism.

This process can be associated with the defence of splitting, a coping mechanism where individuals transfer bad feelings into some other place (Klein, 1946). The mythology of post-racism may, indeed, fundamentally be caused by splitting, which invokes silence due to the prospect of really getting into the underbelly of racism and addressing it.

Tuckwell (2002) suggests that the silence occurring in the face of racism is damaging to the therapeutic relationship. Left unattended, this silence can result in the client leaving their therapy (p. 138). I have first-hand experience of how Eurocentric influences can drive clients away. The Rasta man whom I refused to give advice to did not return. The black woman who walked out and never returned seemed furious with me because I kept rigid boundaries about time and money. Of course, there were other reasons why these clients had difficulty conforming to what might look like my assimilative behaviour, but I am also pretty sure that my training and initial silence about the cultural dynamics of forming a therapeutic attachment were relevant to these situations. Looking back, I can see how the theories of counselling that I was taught and my own silence were provoked by naivety or fear of upsetting the apple cart by addressing our diversities as black people.

This most crucial silence that suggests numbness and lack of connection led to inactivity about cultural dynamics and assimilation. I am sure that both clients were already familiar with the response and looking for more culturally appropriate support. As I recall, in terms of intra-cultural dynamics it was a learning curve for me. I came face-to-face once again with past loss of my black heritage, and I had to process my rejection issues as a black, mixed-heritage woman, abandoned by black clients. Whilst attending to the domestics of setting up a contract, I was buying into the mythology of post-racism, because the meetings lacked attention to the likely reason these clients had sought after me as a black therapist.

I suggest that the idea of post-racism is a figment of recognition trauma, and this mythology is built on denial, probably evoked by a fear of

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the magnitude of racism and other intersecting oppressions. Recognition trauma is a developmental process to be worked through, a phase, like Klein's depressive phase (Klein, 1975). Having gone into the phase and explored its symptoms and hurts, it is generally possible to move through it into a more empowered and liberated position. This process can be supported by building what is known by Byfield (2008) as 'cultural capital'. In the case of young black scholars, the term cultural capital was used to identify levels of support derived from family, peers and educators. A high level was seen to build and maintain a confident, black identity. Those with lower cultural capital achieved lower results in school. Therapists can reinforce this by offering cultural empathy, which places an emphasis on connecting and engaging with the cultural elements of the therapeutic process on a deeper more meaningful level.

Transculturalists such as d'Ardenne and Mahtani (1989); Eleftheriadou (1994) highlighted the cultural elements of the relational process between therapist and client and the impact of the therapist's attitude to diversity in the therapeutic space. Their approach emphasized an expectation of the therapist to re-evaluate their own prejudices and experiences of oppression in order to be with the client's experiences of diversity and oppression. Upholding a mythology of post-racism can inhibit this responsibility, if not attended to, upholding a mythology of post-racism can inhibit this responsibility.

In the first place, trainers have a responsibility to re-evaluate their attitude and approach to teaching anti-oppressive practice and unlearning silences about racism. Dhillon-Stevens (2004) specifies that:

> We need to be extremely questioning of ourselves and our own assumptions and being very patient and not punitive with supervisees who may be beginning to think about these issues. (p. 155)

She advocates that we must be aware of the dangers of perpetuating oppression within the therapeutic relationship. From this perspective, I have devised some key areas for therapists and supervisors to consider when addressing racism.

Key areas for therapists and supervisors

- Therapists and supervisors must acknowledge and understand the nature and impact of difference and similarity, identity, racism, culture and belief systems in the therapeutic relationship.
- Supervisors and therapists must accept that clients may experience specific or intersecting oppressions in addition to racism.

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- Therapists and supervisors must examine the impact of racism and other oppressions on their own personal development process and the client's developmental process.
- Therapists and supervisors must develop ways of being present in the client's process of cultural identity development, racism and other oppressions.
- Most importantly, therapists and supervisors must find ways to engage with each other and clients in anti-oppressive, empowering ways that support intercultural and intra-cultural experiences and the challenge of racism.

Unconscious racist stereotypes passed on intergenerationally and through sociocultural processes can be explored using the concept of the black Western archetype. Unconscious racist stereotypes perpetrate homogeneity and create a mindset that brands all black people as one and all Asian people as one. This stereotype uses features such as skin tone, class and immigration status to undermine the client's specific racialized identity development and individual life experience.

Asian people, for example, are subject to the impact of colonization and the effect of collective cultural practices. These practices are sometimes experienced as restrictive, when confused ideas are taken on. Forced marriage, for example, as opposed to arranged marriage, is oppressive and tantamount to heterosexism, and individuals outside of this cultural context often view both in the same bag, as though they are one and the same and therefore both negative. Confused perspectives of the multicultural aspects of Asian communities can create exoticism, ill-informed approaches that do not fit the Asian clients' real experiences. In the same way, connections and differences between Africans and African Caribbean and Asian Caribbean people can become confused and homogenized.

Homogeneity pervades assumptions that uphold a post-racism mythology like a kind of monochrome mask. Combined with assimilation, whether involuntary or imposed via immigration processes, it can contribute to oppression. We are all affected by and feel cultural assimilation at some level throughout our lives, so consideration of this feature of human development is important. A client's assimilation process can influence their levels of engagement with a therapist and may cause hesitation to discuss cultural experiences, racism or abuse. Assimilative processes may support racist attitudes when levels of personal assimilation are viewed by a therapist as an indicator.

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This is a vital area for consideration. Pro-assimilation attitudes can create ruptures in the therapeutic process and appear problematic if not processed in supervision. One student asked the question:

> What do we make of the world out there, which is still stuck in the collective unconsciousness of inequality/colonization/slavery/denial of heritage and history, that denies a psychologically secure base within which both client and therapist have to engage?

The above question shows concern about the frameworks that underpin cultural assimilation. As individuals, we are in that world, coping with the collective unconscious every day. This ongoing dilemma is coupled with the mythology of post-racism and denial. The student quoted above is drawing attention to how trauma and attachment issues link to the impact of racism and its intergenerational causes.

I had a client who came to see me because she had become aware that she was a descendant of black relatives. She was very light-skinned and she had been passing as a white person. Her fiancé became aware of her black heritage and he broke off the engagement. Understandably, the client was distraught. She was disappointed at the thought of coming to terms with her newly discovered identity and the racism she was facing. I was disappointed that she did not return after the third session, because as a black, mixed-heritage woman, I was prepared to offer her some support for her situation. I felt that my own disposition would have helped to provide a secure base from which she could re-evaluate her identity and recognition trauma, but this was not so.

A Ghanaian man seeing a white female therapist was deeply hurt about the racist behaviour he was receiving from colleagues. His white counsellor was empathetic and seemed aware that he was suffering from overt and covert racism at work. He described how a toy monkey had been placed on his desk. He was beside himself with frustration and hurt, and very concerned that this had caused him to revert to smoking and drinking and the intergenerational cause of letting his father down if he left the job. The therapist became distracted and began to focus on the addictive behaviour rather than the hurt from racism. She may have deferred to her denial of the main concern – racism – resulting in collusion with institutional racism and the mythology of racism (Alleyne, Tuckwell, Shears and Wheeler, 2008). Layers of shame associated with experiences of racism need to

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be considered: the internalized shame from the racism, the client's shame at their experiences, the therapist's shame at their inadequacy and the supervisor's shame at their denial or low level of support. These are all elements of attending to the challenge of racism and denial.

Whatever happens at the point when racism is disclosed is crucial to the client's assimilation process. This is subsequently influenced by the therapist's level of conformity to Eurocentric theory and their experience of supervision.

Freedom and support to develop the therapist's own style and anti-oppressive practice is important to the supervision process. This process must include ways of addressing racism. Defensiveness and denial about racism should not be an option for trained therapists. If the supervisor is embroiled in a post-racism mindset, the therapist may not receive adequate support to face their defensiveness and denial about racism. This pattern can be viewed as part of a therapeutic process.

I am fully aware of the many times I have felt defensive about the material I am addressing and my fears of further oppressing a client or supervisee. Alongside my fears about defensive attitudes, I am willing to face the challenges of transparency and disclosure that need to accompany this process, lest I contribute to the maintenance of a collusive institutional pecking order.

The following reflective questions about the challenge of racism in therapeutic practice may help therapists to unravel denial and the mythology of post-racism.

1. As a psychotherapist/counsellor:

a. What therapeutic discipline/s inform your practice?
b. In thinking about the challenge of racism in therapeutic practice, can you share your experience of and some of the challenges that have arisen for you during your practice and clinical supervision?
c. Do you feel able to take these challenges to your supervision?
d. If yes, what makes it safe for you to do so?
d. If no, what limitations, blocks or difficulties get in the way?

2. In your own therapy and supervision:

a. What are the challenges of racism in your own therapy and supervision?
b. What works well when the challenge of racism is present?
c. What limitations, blocks or difficulties get in the way?

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3. With supervisees:

a. How do you approach the challenge of racism in the client/therapist dyad?
b. What works well in your approach? What are the challenges?

4. How did you feel whilst reflecting on these questions?

For the sake of transparency I want to share my own responses to these questions.

The therapeutic disciplines that I am influenced by have accumulated through a heuristic integrative journey as a therapist. I trained in psychodynamic therapy. The experience was not a very happy one when I realized that I felt marginalized as the only black trainee and there were no black tutors. I felt that no one really understood my situation as a black woman in a minority training situation. Very little support was offered when I attempted to raise these issues.

My first therapist was a white man who appeared to light up a cigarette whenever I raised challenging material. One day I challenged him about this, and after that he no longer smoked in my sessions. That was the era when smoking was allowed anywhere, and I felt respected by his action. We never touched on the issue of racism. After that, my therapist, supervisor and tutors were all white women. They all claimed that because they had no experience of being black, I was a challenge to them. Their naivety acted as a get-out clause for lack of response to my concerns about racism. Consequently, I was stuck in a mire of confusion and I did not feel sufficiently supported to explore my black issues and the impact of racism on my development as a counsellor.

I muddled through with the support of my homegirls and the one gay man on the course, who experienced similar marginalization. My first client was a white, gay man and using my experience and knowledge of an anti-oppressive approach, we achieved some important steps. We also discussed our limitations given the differences between us. In the supervision group, I shared the impact of my client's racist phantasies, but it fell on deaf ears.

After my training I was unable to locate a black supervisor, who I thought might be more empathic to my situation. I selected another white female. My internalized racism kicked in, and although I had expressed my need for attention to the impact of black issues and racism on my clinical disposition, I found it very difficult to follow this

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through. Her approach was psychodynamic and to a degree I felt supported, but I also felt overpowered by her approach and eventually found the courage to raise my concerns with her. I told her that I had wanted her to support me to develop my own therapeutic style and I had felt stifled and dismissed by her interpretations.

She accepted my challenge and we began to work out a way of allowing my voice rather than her dominating my approach with Eurocentric theory. That was a landmark for me because I was challenged to assert myself against her white power and her imposing Eurocentric theory on my work with black clients. On reflection, I would have been better helped if she had been able to challenge me and support me with the ethnic and racialized elements of my client work.

Along the way, I have been greatly encouraged by groups such as the Association of Black Counsellors (ABC) and a growing plethora of writing on racism and oppression in the therapeutic arena. My involvement with the Black and Asian Therapists Network (BAATN) has also been supportive. I am sure that without these groups I would have remained isolated.

I now have a better understanding about how racism permeates the psychological development of individuals. I work with this in a variety of ways. My approach stems from the knowledge that to be silent can perpetuate oppressions. I have found my voice, and although there are times when I am not sure what to say, I am aware that individuals may experience a whole gamut of oppressions throughout their lifetime. If the individual happens to be black/African/Caribbean or Asian, I am aware that it is highly likely that whatever cultural oppressions they may experience, these are likely to be compounded by racism. I do believe that therapists should hold this reality and be willing to address and explore the impact of racism on individual process. I may therefore acknowledge my level of cultural awareness and decide to use what I have named as a black empathic approach.

Some clients register with me because they specifically want a black woman to empathize with them, making the process less traumatic than having to explain and justify their experience of racism to a therapist who may be in denial. Taking into account how racism often creates silence and internalized hurt, I pay attention to signs of repression. This can show up when a client is sharing concerns about other oppressions such as sexism or homophobia, but they may ignore the impact of racism. I look for signs of denial that they may also be experiencing racism. Racism has a way of fixating onto other oppressions, and because it does not always show up in an overt way, it can cause clients

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to trivialize this oppression. One way of opening a dialogue about racism is to take a history of possible oppressions at the initial stages of the therapy. This can be viewed as essential to the client's developmental process.

Sometimes when clients approach me specifically because they are black and want to explore experiences of racism, I will ask them what they expect to receive from a black woman. This helps to open a space for the impact of internalized racism, which can create a rift in the therapeutic relationship if not addressed. This became apparent when a black woman whose skin tone was much darker than mine shared that at her workplace she had been hurt by a light-skinned manager. I noted the information as an operative pre-transference and that an area of our work together might be unpacking where racism is played out in shadism and the harmful nature of the internal oppressor. Pointing out my awareness of our diversity as black women, and my lighter skin, seemed to encourage her that I was willing to go to that awkward, painful place of shadism as a facet of racism within her experience.

I have now developed a peer-supervision relationship with a black colleague to support my own black empathic approach. This need arose due to the number of black clients and supervisees that I was attracting because of my outspokenness about black issues in the therapeutic process. This setup allows me the freedom to explore the impact of my own internal oppression on the therapeutic relationship. I also have the privilege of supporting my colleague with his challenges about racism, and we engage in the mutual challenge about the dynamic of racism and intersecting oppressions within our professional relationship. For example, there are sometimes blind spots and possible collusion. My co-supervisor is male, and I am challenged to notice and address the inter-gender dynamics in addition to racism. Due to my past issues with men, this is an area that I continue to work on.

I take my concerns about racism to my own therapy and supervision. This is not always easy, because racism can impact in such a way that it sometimes makes me feel like I am losing my mind, or perhaps overemphasizing it where it may not exist. I sometimes feel overwhelmed by powerful feelings such as anger. Sometimes internal messages create denial, so although I have made a decision to bring it to these support forums, I sometimes forget and focus on something less important. I sometimes find it difficult to take ownership of areas where I may be oppressing a client and maintaining a silence, so my ignorance goes unnoticed. As someone who basically had to raise myself, I can also find it difficult to ask for help when I feel stuck, and then the reflective

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process goes out of the window. In short, I do not believe in a post-racism period. Being party to this idea reinforces denial and there is evidence all around to dispel this mythology.

Summary

In this chapter I have outlined the challenges of attitudes that perpetuate a post-racism status quo and the pitfalls of believing this discourse. There are several ways to approach this dilemma. Therapeutic practice and clinical supervision must provide a space to unpack the impact of this discourse. Therapists and supervisors must take responsibility for the gaps created when a post-racism approach is taken. Silences must be unpacked. Perpetuation of racism and the powerful feelings that create denial are a main concern. Homogeneity, assimilation, internalized negative cultural messages and oppression have been identified as important areas for consideration. I want to impress the importance of remaining aware that racism intersects with other oppressions, but has significant impact on both survivor and oppressor. Clients who are both survivors and oppressors should be facilitated to explore their projections and hurts.

Humiliation, guilt, naivety and hostility contribute to denial as a form of psychological gagging and create one of the biggest challenges to racism in therapeutic practice. Institutional and individual responsibility to address the impact of racism on the psyche is key to the progress of therapy training and practice. The impact of racism and oppression on the psyche is not a new phenomenon for psychotherapy, counselling and other therapeutic approaches; however, therapeutic disciplines have generally relied on traditional theories, rigidly binding them to steer away from the challenge of racism. Unlike when traditional models are applied, therapists and supervisors may struggle with the cultural aspects of integrating transcultural therapies, and their supervisory support must be appropriate.

The challenges of Eurocentric theory dominating practice and the need for therapists to create an integrative, culturally aware, anti-oppressive practice are paramount in this chapter about the mythology of post-racism. I have reiterated concepts such as gagging, black Western archetypes, a black empathic approach, cultural empathy and recognition trauma. I want readers to use these concepts and reflect

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on the ethical context of how they approach the challenge of racism in therapeutic practice. I am keen that this should also be reflected in how they cope with the silencing nature of racism. If this particular knowledge and understanding is not transferred into practice, it will be of little use. Therapists need to feel competent to address complex issues such as racism in their practice and be supported by their supervisors and respective organizations.

The remaining chapters will support therapists and supervisors faced with particular challenges about racism, denial and mythology in their practice. It is my greatest wish that readers will use the information and the exercises as a supportive framework for their own personal challenges about racism in therapeutic practice and develop supervision for personal support in this area.

Pointers:

- Therapists, supervisors, and training groups can invest in time to reflect on the impact of a mythology of post-racism on their work and supportive relationships.
- Reflecting on silence and denial in the therapeutic triad is key to understanding where the mythology of post-racism may uphold or interrupt the relational process.
- Regular re-evaluation of the use of traditional therapeutic approaches and their application to the challenge of racism is important.
- Racism has an impact on white people as members of the perpetrator group and on the personal development and whole lives of black and Asian people. It is important to remember that racism can also be an unconscious process.
- Ask your peers to engage in a dialogue about the challenges of racism in therapeutic practice.

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Index

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