# The Tavistock and Portman
## Leaders in mental health care and education

# Tavistock and Portman E-PRINTS Online

**BOOK CHAPTER**

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## The Tavistock and Portman NHS
### NHS Foundation Trust

Black people[1]'s negative relationship with mental health services and lack of access to psychological therapies has been a serious problem in Britain for at least 25 years. Most of the literature and discourse about this problem have focused on factors such as racism and cultural insensitivity in mental health services. Whilst these factors are important, in this paper I will suggest that black people's fear of mental health services also arises from intra-psychic conflicts linked to fears of betraying their parents, family, culture and community. This perspective is based on the experience of developing a community based psychotherapy service for young black people and their parents. It arose out of a major theme in the work, which was that of experiencing a strong ambivalence from many black people towards mental health services in general, including psychotherapy. Initially this ambivalence was expected and seen as understandable given black people's negative experience of mental health services in particular, and of racism in general in British society. However, over time and after much clinical work, this ambivalence came to be understood as a form of resistance to relinquishing familiar defenses and a fear of betraying attachment figures, even though these caused pain and suffering.

I will illustrate this thesis by describing the experience of ambivalence in our work with black clients and by providing a detailed case example. However, it is important to note that the ambivalence we encountered was not only with black clients, but was also within organisations and in ourselves. Being able to understand and work with ambivalence has

[1] In this chapter, the term black people refers to people who regard themselves as black or are categorised as Black Caribbean or Black African, Mixed parentage (Black and White), or Black Other. They were the target group of the psychotherapy service described as they have consistently suffered from above average rates of admission and detention to psychiatric hospitals as well as being less likely to access psychological therapies.

therefore been central to the task of making psychotherapy more accessible to black people in the UK. Before describing this experience and the case example, I will first try to make clear what I mean by 'ambivalence' and then put black people's lack of access to psychotherapy in the context of their relationship to mental health services in the UK.

**Ambivalence**

Freud's theory of the instincts postulates a basic dualism: hate derives from the self-preservative instincts and love from the sexual instincts. Freud thought that whilst love and hate present themselves as complete opposites in their content, at certain points they can each be ambivalent in their aim. Melanie Klein (1935, 1937, 1940) built on Freud's theory by placing ambivalence at the core of psychological development. She believed that the infant at first splits its mother into a gratifying/good mother and a frustrating/bad mother as a means of protecting itself from being harmed by the bad, or of harming the good mother.

With good enough care the baby develops a capacity for integration and comes to see that the mother who is hated for frustrating it, is the same mother who is loved for gratifying it. This awareness of ambivalence – the co-existence of its love and hate produces a sense of concern and responsibility and with it a move from concrete to psychological awareness. Ambivalence thus heralds the capacity to know oneself, to tolerate unpleasant traits in oneself and to hold a more complete image of the other. The sense of loss and

sorrow that accompanies it, however, cannot be avoided as acknowledging that one loves what one hates is acutely painful (Parker 1995).

People also vary in the extent to which they can tolerate and manage their loving and hating feelings towards the same object. Cultural expectations may also make the expression of love, or hate, easier or more difficult.  Acknowledging ambivalence also confronts the individual with his/her guilt towards the object. Our society inhibits acknowledgement, discussion and exploration of ambivalence probably as a defence against facing our contradictory and imperfect aspects.

The concept of ambivalence suggests that both love and hate exist in any relationship. In psychoanalytic practice, however, it is common to observe that one of these feelings towards the therapist is often hidden. I hope to show that the concept of ambivalence is not only useful in clinical work but can also help us to better understand and work with the challenges that exist between mental health services and black communities.

**Black people and adult mental health services in the UK**

For several decades there have been concerns about black people's relationship with mental health services.  Rates of admission of black people to psychiatric hospitals have been three to five times higher than the national average for whites (Healthcare Commission 2008). Black people are also more likely to be compulsorily admitted to

psychiatric hospitals under the Mental Health Act 1983, more likely to be diagnosed as suffering from a psychotic illness and more likely to receive physical treatments as opposed to psychological therapies (Keating et al 2002, Sashidharan 2003, Department of Health 2005, Williams et al 2006). Keating et al's (2002) view that black people's negative experience of psychiatry has created a "circle of fear" has been widely accepted. They describe this circle as involving a reluctance to ask for help when it might be needed; consequently untreated problems become crises, often leading to compulsory admission to hospital, thus reinforcing a fear of mental health services and so the circle is perpetuated. This issue is believed to be a product of prejudicial assumptions and stereotypes within mental health services about black people, as well as,a failure to understand the cultural and social circumstances of black communities and thus their reluctance to seek help (Care Services Improvement Partnership 2006, Keating 2007). These perspectives see the reasons for black people's fear of mental health services as a product of their social circumstances in the UK, stigma, racism and cultural ignorance within mental health services.

**The mental health of black children and young people**

There have been numerous studies, and some initiatives, to address the appropriateness of adult psychiatric provision for black people. However, there has been scant attention paid to the experience of black children and families in Child and Adolescent Mental Health Services (Malek & Joughin 2004). The available evidence gives cause for concern. Black children and young people appear to be more at risk of developing mental health

problems. Firstly, **t**hey are over-represented in a number of at-risk groups with greater mental health needs. These include children in public care, young offenders, children excluded from school and residents of poor neighbourhoods, (Social Exclusion Unit 2002, Adolescent Health BMA 2003 p27-29). Secondly, their experience of racism, both personal and institutional, is also likely to have an adverse impact on their mental health, especially as children (MIND 1988, Fernando 1988, Goldberg and Hodes 1992, Wilkinson 1996, Clark et al 1999, McKenzie 2003). Thirdly, whilst the relationship between parental mental illness and their children's mental health is not straightforward, there is undoubtedly an increased risk of attachment difficulties, depression and behavioural problems for children of parents with mental health problems, particularly for those whose parents' have chronic mental health problems (Rutter and Quinton 1984, Radke-Yarrow et al.' 1992). According to the Department of Health (1998), 30% of all parents with dependent children have a mental illness. At least one-third of these children will themselves develop significant psychological problems and a further third will develop less severe emotional and behavioural difficulties (DH 1998).

A comprehensive report on young carers estimates that nearly a third are supporting parents with mental health problems and that 15 per cent of these young carers are from minority ethnic communities (Dearden and Becker, 2004). However, they also point out that young carers from minority ethnic groups are under-represented in surveys and are less visible to services. A  Social Care Institute of Excellence (2008) research  briefing states that mental health problems among black and minority ethnic parents is compounded by socio-economic disadvantage and lack of treatment, and is likely to have

more enduring effects upon their children and contribute to their over-representation in public care.

The Office of National Statistics national survey in 1999 of the mental health of children and adolescents in Great Britain found that nearly 10% of White children and 12% of Black children were assessed as having a mental health problem (Meltzer et al 2000). A recent study has found that a young black person living in London is four times more likely to be an inpatient in a psychiatric ward than a young white person (Sainsbury Centre for Mental Health 2006). This study points out that the mental stress and vulnerability of young black people is further exacerbated by difficulties in accessing appropriate and supportive mental health services. This has also been the conclusion of a research study by Young Minds (2005), which found a number of barriers to Child and Adolescent Mental Health Services for black and minority ethnic groups including: a lack of appropriate and accessible information, language and communication barriers, stigma associated with mental illness and insensitive treatment arising out of stereotypes held by professionals.

Service culture, professional practices and anxieties prevent CAMHS (Child and Adolescent Mental Health Services) engaging with black communities, especially those who are alienated and from socio-economically disadvantaged backgrounds (Lowe 2006). Bhugra and Bhui (1998) also argued that there are physical and psychological barriers erected by psychotherapy service providers.   These include a failure to understand context and needs and a tendency to pigeonhole and stereotype individuals

rather than provide culturally tailored services. There is also a lack of culturally skilled therapists. Littlewood (1992) argues that there is an underlying theme of racism which keeps therapists away from addressing these issues.

**Ambivalence and the relationship to help**

The reluctance of black adults and young people to engage with mental health services is a major contributory factor to their higher rates of hospital admission and more coercive interventions, including compulsory detention. This reluctance is commonly understood to be a product of black people's negative experience of mental health services, stigma and the lack of culturally appropriate mental health services. Our experience of developing and delivering a psychotherapy service to young black people and their families has led us to conclude that black reluctance to ask for and accept help from mental health services is a more complex phenomena than this popular explanation suggests. Our experience of ambivalence towards this service, from colleagues, organisations and black clients led us to observe that there were also important, but less obvious, unconscious reasons for young black people's reluctance to seek or accept help from mental health services. It is to these hidden and unconscious factors that we now turn.

In 2001, the Adolescent Department at the Tavistock and Portman NHS Foundation Trust was seeing relatively few adolescent patients from black and minority ethnic backgrounds. The Trust was committed to making its services more accessible to black communities and supported an initiative, based on consultation with black community

groups, to establish a service aimed at young black people. The Service was called the Young Black People's Consultation Service (YBPCS) and it aimed to provide therapeutic consultations of up to 4 appointments for emotional/psychological problems to young black people aged 14– 25 and their parents. Although modelled on the long established Young People's Consultation Service, the YBPCS was different in a number of key respects: it was targeted at young black people, also worked with parents, was led by black therapists and aimed to see young black people not just at the clinic, but also in community settings they considered to be more accessible and comfortable.

The decision that YBPCS would be led by black clinicians was an important means of addressing concerns that black people cannot trust or be understood by statutory mental health services (Keating et al 2002), or that their treatment is based on inaccurate assumptions and stereotypes (Sashidaran 2003, Keating 2007, Department of Health 2005).There is a long tradition within health and social care of developing initiatives to make services more accessible to specific groups of people who are more vulnerable to illness or social exclusion but who do not access universal services e.g. women who have suffered from rape or domestic violence. There is also evidence that many Black and minority ethnic have a strong preference for receiving services from staff from a similar ethnic and cultural background (see Hill 2003).

Whilst there was strong management support for this initiative, staff involved in the service experienced some surprising opposition and hostility from a wide range of people. A number of colleagues were uneasy with the idea of a separate service for black

adolescents, and thought it smacked of apartheid in service provision. A local white community organisation, which specialised in providing counselling to young people, complained that they had not been consulted about this new service and felt that such services should be provided in the voluntary sector. A number of commissioners whilst expressing concerns about poor outcomes amongst black youths did not wish to fund separate services for minority groups. At the same time the service was also warmly welcomed by a number of black community groups and non mental health agencies, including Schools, Family Support groups, and Youth Work agencies. The simultaneous experience of support and hostility for YBPCS left the small service team feeling involved in a battle between in our view the 'progressives' (us) and the 'reactionaries'(them). Against this background YBPCS became operational in November 2002.

The sense of 'us and them' pervaded the service in its initial years. At the time it was understood simply as a reflection of the level of professional support for or against this kind of initiative. It was only years later that I came to think of these political camps as reflecting a deeper organisational and community ambivalence towards this service and thus a resistance to changing the status quo, psychologically and organisationally (see Lowe 2006).

**Black people's ambivalence to psychotherapy**

In practice a number of the black adolescents referred by teachers, learning mentors and youth offending team workers did not attend appointments offered. Some promised that they would come and did not turn up, or arrived at the wrong day, at completely the

wrong time, or 45 minutes late. These experiences would at times lead us to feel that we were wasting our time and resources and that we should terminate the project. At other times we were overwhelmed with the take-up of the service and had to place young people's names on a waiting list. Some of the young people who turned up for appointments expressed doubts in our ability as apparently " black middle class professionals" to be able to understand where they were coming from and what they were having to deal with.

It may be that the ambivalence we experienced from young people was a product of the general ambivalence of adolescents towards being helped and making serious commitments. Adolescence is very much a period of turbulence, when young people try to free themselves from dependency and develop their own authority and identity in the world (Briggs 2002). But there was also a fear of mental health services including psychotherapy, especially NHS managed ones. Such services were perceived to be more interested in controlling black minds than caring about them. Psychotherapy for a significant amount of black people we came across was therefore associated with mind control and psychological oppression. As a 15 year old black secondary school pupil put it: "Are you crazy, do you seriously think that I would go to see a psychotherapist?"

Whilst there are many young people from different cultural backgrounds who express disgust and fear about seeing a therapist, it would be mistaken to assume that the reasons for this attitude are the same across different ethnic groups. There is a long history of distrust between blacks and whites; the former slaves and slave-masters, the colonised

and the coloniser. The domination of blacks by whites has been a major part of Western culture since Columbus 'discovered' the New World, and western science or pseudo science (see Fryer 1984, De Gruy Leary 2005) has played a significant part in justifying and perpetuating that domination. The ideas of Linnaeus (1758), Blumenbach (1865), Gobineau (1865) , Galton (1869), Freud (1913, 1915b), Jung (1939a), Jensen (1969) and Eysenck (1971, 1973) among others supported the notion of a racial hierarchy, with black people regarded as the most savage, unintelligent and psychologically primitive of the human races. Black people have therefore historically been understandably suspicious of the psychological sciences, including psychoanalysis.

A number of clients explained that their reluctance to seek or use psychotherapy was because they felt it to be an act of betrayal of both their family and community. This could be thought about in a number of ways, but in my clinical experience it communicated the existence of a painful conflict within the client's internal world: between the self and other important internal objects. Avoiding emotional/psychological help can often be a defence against acknowledging and facing this internal conflict out of fear that it would result in unbearable feelings of pain, guilt, and loss. The following case example is provided to illustrate and explore in more detail the meaning of the ambivalence we faced in our clinical work and its implications for the mental health of black communities.

**Clinical illustration: Barry**

Barry was 15 years old when he was referred to the YBPCS by his Head of Year at his secondary school. He was seen as a bright but troubled young man who had a tendency to truant and to be verbally aggressive to some teachers. At the time of his referral for a consultation, his non-attendance at school had increased and he was believed to be using drugs and getting involved in petty crime.

At his first appointment, Barry arrived about 20 minutes late. His first statement as he came into the room was " I don't need any counselling" but he sat down and without prompting proceeded to speak with some passion about his situation. He liked school but there were some good teachers and some bad and dishonest ones. The latter he hated and as he spoke his mind, he was not popular. Consequently he got into trouble but he didn't care what these teachers thought, because he wasn't going to put up with their crap. There were some alright teachers like Mr K, his Head of Year. In fact it was the only reason he had come to the appointment. Mr K had kept going on at him about at least "checking out the counselling". Before I was able to say anything, Barry's mobile phone rang and he said "what's up blood" and told his caller "shit man, will see you soon". He then turned to me and said, "I have to go, I have an appointment at the Barbers, but if you want I can come back another time". I said that I had put aside four appointments at the same time each week for the consultation, and that I would be here next week at the same time. He said ok I will see you then and rushed off.

I found that I liked Barry and thought that there was something engaging about his simultaneous distance and closeness, a sort of 'I don't need you but I will stay near

attitude'. The ambivalence in the transference was powerful, I felt like an important and desired father with a starved, vulnerable but wary and angry child. There was on one hand an apparent independence and defiant rage and on the other hand a need and desire for emotional connection and support. This was strongly present in our first meeting and I thought was also apparent in his very split relationship with teachers at school.

Barry was about ten minutes late for our next appointment. As before he spoke easily, but with an attitude which said 'I don't mind telling you this, because it doesn't really matter to me and I am not scared of anyone and I can take care of myself'. He told me that his father was a bastard, who left when he was conceived. His father hadn't wanted Barry's mother to have him and when she had refused to have an abortion, he had walked out. His father only maintained contact with his first son, Barry's older brother, sending him birthday presents and Christmas gifts from America, where he now lives.

Barry hated his brother who was two years older. They frequently fought. The family had a two bedroom flat and in order to reduce the fighting, the mother had given up her bedroom so that each boy had their own bedroom and she slept in the living-room. Barry hated his father too. I felt myself feeling terribly angry with this father but also very sad and tearful for Barry. I said to Barry that his anger with his father and brother was clear and understandable to me, but that I wondered how that affected him and whether other things about him got hidden by the anger. Barry seemed confused by my comment and said "No I am alright, but I want to prove to those bastards including those at school that I will become something".

In the last of our four sessions, Barry talked about his paternal grandmother, who had died two years before. He was angry about that because she had been a good person and had been like a mother to him. For the first time since I had met Barry, he looked visibly sad. He couldn't understand why good people died early and bad ones did not. His grandmother had looked after him and his brother, when his mother had been depressed and unable to look after them. She had always made sure he got birthday presents and Christmas presents, used to have them over with his cousin and Aunts for Christmas meals. He had been so surprised when she died, especially because on the day before she died, he had visited her and she had looked so well as if she was making a complete recovery.

I felt shocked and moved by this story. I had not realized he had had such an important and loving grandmother. Barry had obviously chosen not to share this information with me, when he had spoken about his family before. It seemed a very important aspect of his story but one that was hidden and less easy to talk about. I wondered whether the school and his Head of Year had known about his grandmother's death and how catastrophic it had been for him. I offered Barry an interpretation, which went something like this. I said that I thought it was not a coincidence that he had told me about his grandmother's death on the last of the 4 sessions. I think he had told me this because he had come to trust me and was able to share something about himself that was very important and precious, which was the loss of his grandmother and the sadness and vulnerability which I assumed this produced in him.

Barry responded by saying with some feeling in his voice that after his grandmother had died, he felt shocked and angry but after a while he used to feel sad especially when he went home after school in the evening  and on week-ends because he used to always visit his 'gran' on a Saturday and stay until Sunday. He put on weight after that because he started to eat much more, particularly chocolates. As it was the last of the 4 sessions, I asked Barry whether he had any thoughts about the consultation and how he wanted to proceed. He said it had been alright, better than he had expected, but he didn't know what to do now. I said I thought we had developed a good relationship and had touched on some important things that needed further exploration and that it might be difficult for him to see the relationship come to an end; as like with his Gran, it might feel like a premature ending.

Barry said "Yes I am surprised that the 4 sessions have come to an end so quickly". I thought his fear of rejection made it too difficult to ask me to continue, so I said that if he wanted to continue seeing someone like me for therapy, to talk about things, he could ask and a referral could be made for open-ended therapy. As the time to end had been reached, I said that he may want to think about this  more, and discuss it with his Head of Year and his mother before making a decision.

Barry said that that he would like to go ahead, that his mother wouldn't mind, but agreed to talk to his Head of Year about it beforehand.  A week later the Head of Year contacted me to say that Barry wanted to continue having therapy but would prefer to continue with

me. Following discussion in the team, I agreed to take on Barry for long term once weekly psychotherapy but, as he was under 16, I thought it was important to obtain mother's agreement. Several attempts to meet with his mother failed; I learnt, initially from the Head of Year and later from Barry, that his mother suffered from depression and had given her agreement for him to have therapy if he wanted to.

We continued to work for about 8 months, punctuated by Christmas and Easter holidays. Barry attended his appointments regularly, though he missed a few and was frequently but not always late. During these 8 months he kept me as a good object. There were no expressions of criticisms or frustrations with me. He used the therapy to talk about his irritations, achievements and conflicts with others especially his brother, teachers and sometimes mates. Barry's truancy from school was greatly reduced, there were fewer angry incidents with teachers and his school work improved. Soon there were confident predictions that he would do well in his forthcoming GCSEs. A major theme in his therapy was his attachment to the school and how hard it would be for him to leave. He was angry that the school did not have a 6$^{th}$ form and that as a result he would have to go away from his local area next year. At an unconscious level I thought Barry was experiencing the end of school as a rejection. The school had provided him with a secure base and a number of vital attachments over 5 years in which he had a powerful experience of being known, wanted and valued by a few available, safe, consistent and responsive parental figures. He did not want to leave and was contemplating the ending of the school year with dread.

I interpreted some of Barry's difficulties about ending with school, as a concern about whether it would also mean ending with me or whether he and I could survive this transition. In fact, about one month before his GCSEs, Barry was banned from entering the school except for taking his GCSE exams. This come about as a result of an incident in which he verbally abused and threatened a female teacher. I tried to make contact with Barry on several occasions in order to arrange an appointment at a mutually convenient venue outside of the school, but I never heard back or saw Barry again. Attempts to arrange a meeting with the school proved unsuccessful because Barry's Head of Year was leaving and the whole school seemed to have other priorities as it winded down towards the close of the school year. I was angry with Barry and the school, as well as sad and worried about how he was coping with what he would have experienced as a rejection. I thought Barry would be feeling shocked and depressed about dealing with this double bereavement alone. On the other hand, he may have returned to a familiar defensive position of 'I don't need anyone- fuck these bastards' as a way of pre-empting an experience of rejection and loss.

**Discussion**

Barry's hatred of his father was obvious, but his need to be loved by him and to love him was hidden from himself. At school, his ambivalence was similarly split: there were good teachers and bad teachers, no in-betweens.

In the transference, I was initially suspect but quickly became a good object. Whilst Barry and I had done some useful work during the 8 months, it was very difficult for him

to own and think about his angry, hostile feelings towards me. I was treated as an ideal father figure, who did no wrong and that he had no complaint about.    Unconscious hostile feelings were displaced onto the bad teachers in the school, and through this a positive relationship was maintained. This split served an important defensive function, to unconsciously protect me from his aggressive feelings, but more importantly to protect himself from getting in touch with his destructive feelings towards his good objects and thus his own capacity for destructiveness.

As the work progressed it became clear that Barry was not only in a rage with his father but also with his somewhat idealised grandmother. His grandmother's death was a psychological catastrophe.  He sometimes thought that if he had been a better person his grandmother would not have died so early, suggesting that to some extent he felt partly responsible for her death. As a result of this phantasy he was even keener to protect his good objects from any of his anger or criticism. At a psychic level, Barry had suffered a triple blow: the rejection by his father, the premature loss of a good object (grandmother, school and possibly me) and an unconscious conviction of an innate badness and destructiveness

The absence of a robust good parental figure in his life left Barry with a deep yearning for one. Despite his many stormy battles at school, he had in fact developed a deep attachment to a number of teachers, particularly his current Head of Year, who he felt had understood him and stood by his side over the past 5 years. Barry's not wanting to leave school and his anger with the school for not having a sixth form was an expression of

how painful he found the prospective loss. His lack of control about leaving the school was in many ways a re-experiencing of his feelings of loss and helplessness about his father's rejection, his mother's emotional abandonment, his grandmother's death, and the loss and forced separation which ensued.

I felt sad that Barry had provoked such an abrupt end to attending school and therapy and angry that the Head Teacher had made a decision to exclude Barry without consulting the professionals working with him. I felt impotent, like the weak mother or the absent father he had described. Barry's behaviour and the response of the Head Teacher had highlighted his unacceptable aggression without recognition of his desperate wish to stay on. In the end it was easier for Barry to be 'kicked out' than to face the pain of helplessness, dependency and his fear of rejection.

The abandonment of the therapy was in many ways a re-enactment of Barry's experience of rejection. But on this occasion he was doing the rejecting, before it was done to him, and to that extent he was showing his identification with the aggressor-father. Whilst Barry's s distrust of his parents not to abandon him led to his rejection of me and therapy, I think it was the pain of mourning the loss of his father and the terror of facing his anger with his mother and grandmother that were the most difficult issues to address. Barry was not able to become aware of his ambivalence. As a result he less able to acknowledge his pain and internal conflicts and thus break free from them.

So was Barry helped by his experience of psychotherapy? In many ways it may appear that he had not changed much or given up his victim identity. His internal working model of relationships based on his early experience of his parents remained largely intact as he continued to feel hurt and angry, and largely to expect rejection not help from others. But it is equally true that Barry's trajectory had been altered, even if temporarily, as a result of his use of therapy. His truancy from school had stopped, his drug taking and aggression at school had decreased and he did take his GCSE exams which had seemed unlikely prior to his starting therapy. Despite his flight from therapy, I think that Barry had overall strengthened his belief in his good internal and external objects. Roughly a year later I heard from a Learning Mentor that Barry had done well in his GCSEs and was doing his A' levels at a local 6th Form.

**Making psychotherapy more accessible to black people: implications for black people and for mental health organisations.**

Each generation, in every community, inherit functional and dysfunctional aspects from previous generations. Barry's father's rejection of his son was brutal and psychologically damaging. How could he be so unfeeling towards an innocent and helpless child? We know that individuals tend to repeat what they internalise during their earliest relationships and therefore might wonder if something traumatic happened to Barry's father in his childhood which he re-enacted in his relationship with Barry. The intergenerational transmission of trauma is a well recognized phenomenon which is of utmost relevance to black communities given the repeated traumas they have suffered

under colonialism, slavery and white racism over the centuries (Alleyne 2005, Leary 2005).

But addressing repetition compulsion, the impulse to re-enact early traumatic experiences, involves overcoming a number of challenges. Firstly, the compulsion to repeat one's experience, to stay with the familiar even if it is painful, is often easier than risking the perceived trauma of new experiences. Secondly, the compulsion to repeat an experience is a form of connection to a parent, albeit a negative connection.  As I think Barry showed, giving up the pain of his abandoning parental figures is unconsciously feared as a loss – a loss of connection to his father, mother and grandmother, in effect a loss of identity. This anxiety might be too unbearable to face and a range of defences mobilized to avoid it. Psychotherapy, as a means of psychic change, can therefore be perceived as a threat to identity: personal and cultural. Furthermore as psychotherapy in the UK is still commonly associated with whiteness, it can be perceived as an even greater threat - a new form of white colonisation as opposed to psychological help.
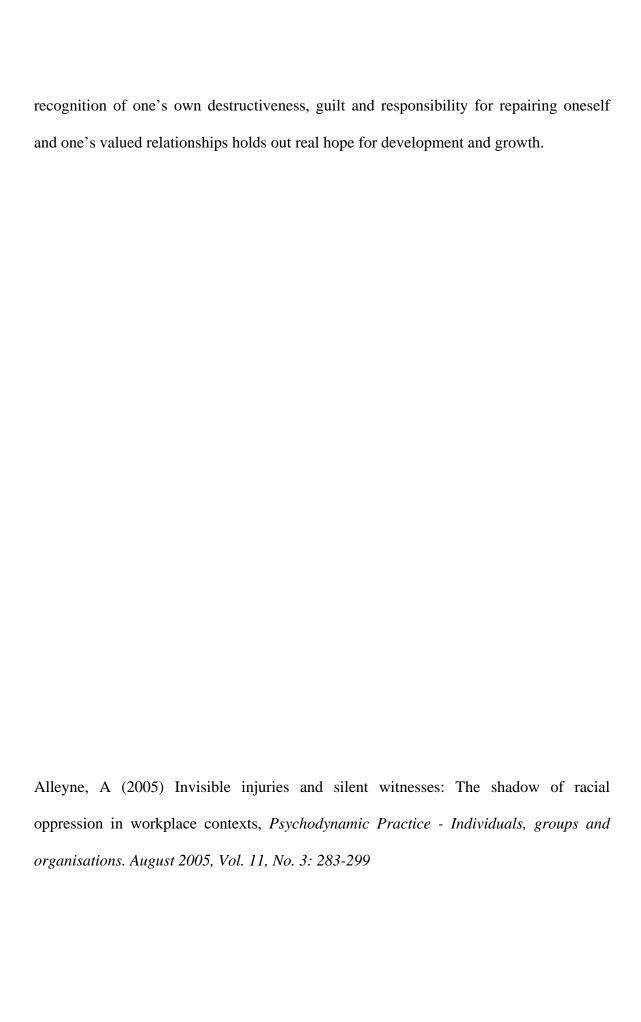
Mental health organisations and psychotherapists need to recognize that mental health services in the UK are not perceived as neutral by black communities, and in fact are often regarded as a threat rather than a source of support. But although it is vital that we keep in mind the social reality of racism and how this has shaped black people's relationship to psychological help, it is also important to keep in mind that such external realities always interact dynamically with an individual's internal reality.  This needs to

be grasped if we are to engage young black people who may present as disaffected with services.

Whilst I have tried to show how intra-psychic conflicts can prevent black people from engaging positively with mental health services, I hope that it has also become evident that it is not only the client who needs to work with their ambivalence to facilitate change. Mental health organisations and professionals, including psychotherapists, need to recognize their social and historical position in relation to black communities. This is not only a history of care but also of neglect and racism. Mental health professionals need, therefore, to recognize and work with their ambivalence towards black people if they are to create an environment where distrust, fear and unresolved conflicts can be engaged with in a manner which promotes growth.

**Conclusion**

Mental Health services in the UK are often equated with white control and are regarded with fear and distrust by black communities. Whilst this attitude is understandable given black people's negative experience of such services, it also seems to fulfil an unconscious defensive function; that of preventing black people from facing their fear, distrust and hostility in relation to their internal objects, primarily parents. To confront one's roots (parents, family, culture), can feel too painful and may expose too much personal vulnerability. It may also risk shattering fantasies of simply being a victim, be it of one's family and or of white racist society. Harrowing as it might be, however, the path through

recognition of one's own destructiveness, guilt and responsibility for repairing oneself and one's valued relationships holds out real hope for development and growth.

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