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An African Psychology Perspective on White Supremacy within UK Clinical Psychology

Erica Mapule McInnis

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ABSTRACT: This article analyses UK institutional racism in Clinical Psychology from an African psychology perspective and suggests the more apt term 'global system of White supremacy' rather than 'racism.' Underlying psychological mechanisms such as implicit bias against Black people and favouritism towards White people are argued to impact clinical psychologists before, during and after training alongside issues such as class and disability.

KEY WORDS: African psychology, institutional racism

Let us look to where we could be if the past were different. The year is 2040.

- Several African countries send aid to the U.K. post Brexit (A referendum vote in 2016 for Britain to leave the European union)
- No longer needing to fund projects in African countries, the charity Comic Relief funds what was the NHS (National Health Service)
- The UK pays reparations rather than aid to the continent of Africa due to the Trans-Atlantic slave trade
- African Psychology is standard both as a university module and course with appropriate accreditation from supporting regulating bodies and trade unions
- Children and adults are taught African psychology as one of several paradigms for emotional wellness and happiness
- Teaching Kemetic[1] origins of psychology are standard (Akbar, 1994) and decolonising the curriculum is both interwoven throughout courses and an integral part of professional training bodies

1 Kemetic refers to ancient Egyptian philosophies, cultures, spiritual practices and ways of being practiced in North Africa by Black people. These greatly influenced ancient Greek philosophers who developed western psychology (Akbar 1994, James 1976).

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- Progressive university psychology training courses now hold 1-day seminars to add Eurocentric thinking to an African based curriculum
- There are a range of tools to incorporate African psychology into clinical work, supervision and research
- Health services are reclassified as healing and transformation services. As appropriate, they offer multidimensional and holistic healing such an exercise, nutrition, mindfulness, traditional healing, and flow and high vibrational living strategies (Craig, 2013; Csikszentmihalyi, 2002; Nobles, 2006)
- Children and young people are taught to General Certificate of Secondary Education (GCSE) level about the British empire and different forms of colonialism from the perspective of interruption to the progress of the African doctor, engineer, architect and leader enslaved

Could this future be too woke[2] for some people?

Where are we now?

Almost two decades ago, I wrote an article (McInnis, 2002) on Institutional Racism in the NHS and Clinical Psychology. This was post the McPherson report (McPherson, 1999), produced following the murder of Black teenager Stephen Lawrence which highlighted racism at various levels in the UK Police Force. Hence, the atmosphere was ripe for analysis of institutional racism in other institutions.

Nearly 20 years later, the Psychology of Racism at an institutional level (Fernando, 2017) appears to have been joined by 'Big Brother'[3] at the governmental level. For example, government policies and a state enforced 'hostile environment' towards anyone who may appear foreign contributed to the Windrush scandal. The latter saw a plethora of law-abiding British citizens (some of whom served or contributed to 'rebuilding' the UK post war), wrongly classified as illegal immigrants. This led to threats and deportation, emotional turmoil, constant fear with self-removal by some, loss of homes, separation of families, loss of employment, loss of access to health and social care services and in some cases, early death (Gentleman, 2019; Vernon, 2019).

This was a major blow to the psychological well-being of families and communities as elders in Black[4] cultures are often keepers of wisdom and integral to child rearing in extended

2 'Woke' is a contemporary term to mean alert to injustice in society, particularly racism. (Merriam Webster Dictionary).

3 'Big brother' is a term for an oppressive all-powerful government or organization monitoring and directing people's actions. This phrase is widely used in the book '1984' by George Orwell. (Merriam Webster Dictionary).

4 Black means individuals of high skin pigmentation with ancestors originating in Africa. It is acknowledged there is variation of skin pigmentation in Black communities and some experiences of Black communities may

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family structures, (Boyd-Franklin, 2006; Boyd-Franklin, 1989; Karenga, 2010). Fighting deportation of an elder can drain a family's resources both emotionally and financially. This was and is a great disaster for both Black and White communities as many UK families are multi-racial (McInnis and Moukam, 2013). This disaster is to the extent the term 'Maafa'[5] (Great Disaster to people of African ancestry: Ani, 1997) is more applicable as a continuation of injustice based upon racial differences.

Race based hostility is in UK social and recreational settings (Kick It Out's Equality Charter, 2019; Cleland and Cashmore 2013) and fundamentally global, as demonstrated by the need for the Black Lives Matters Movement. The latter publicised Black people's experience of dehumanising police brutality and failures of the criminal justice system to protect (Heatherton and Camp, 2016). Reporting such events has the potential to further traumatise and invoke fear, particularly when repeatedly shared on social media (Segundo, 2017). Given such traumas mainly affect Black people, are UK psychological therapy services equipped with something other than a Eurocentric response? Furthermore, would individuals affected meet referral criteria set by providers of therapy services, given many will have co-existing resilience (Keyes, 2009)?

According to Reddie (2019), xenophobia is now a part of UK culture. Xenophobia is like racism, but instead of fearing or distrusting people predominantly because of the colour of their skin, fear or distrust is because of their nationality or that they seem foreign. I argue deep pigmentation of skin can arouse suspicion of foreign status whether applicable or not.

How does racism manifest then and now?

Institutional racism is the existence of historical and current policies, laws and practices that provide worse treatment or access to goods, services and opportunities for certain racial groups. In short, society is structured so that people of the highest skin pigmentation (darker in complexion), have worse experiences, although the impact can vary depending upon coping, resilience and other factors (Eddo-Lodge, 2017). As this is a global phenomenon, it is argued that it is better defined by its recipients as a 'global system of White Supremacy'[6] (Fuller, 2016).

Workplace experiences

Black people too frequently become troubled individuals in troubled workplace institutions

be common to other oppressed marginalised or disempowered communities. Reference to White people means Caucasian. It is acknowledged there are a multitude of variations within both Black and White communities.

5 'Maafa' in Kiswahili is a great disaster, African holocaust, dehumanising circumstance (Ani 1997, pg 12; Ani 1994, pg 3).

6 It is acknowledged in Western cultures, White (Caucasian) English is often respected as superior to White Irish/ Scottish or Welsh. Furthermore, that White British is then often perceived or treated as superior to White Eastern European (those recently migrating from Eastern Europe).

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(Obholzer and Roberts 2009). Such institutions either unconsciously or consciously select a person to voice or process a grievance. This is often to 'work through' or voice on behalf of a group, difficult, dis-owned and anxiety provoking aspects of the workplace. It is argued Black people are frequently selected for this task firstly, due to favouritism to White people and secondly, as they have a history of doing the work others do not want (Eddo-Lodge 2017). Indeed, they often find themselves with limited options due to circumstances as follows: 'In Acute, PCT [Primary Care Trust], Mental Health and Learning Disability and Care trusts, BME staff were significantly over-represented in disciplinary proceedings' (Archibong and Darr, 2010). Furthermore, Black and Minority Ethnic (BME) staff disproportionately experience bullying and harassment (Lintern, 2017). Although recommendations are in place which may improve the situation, over-representation in disciplinary proceedings often contributes to a scarcity of effective role models for Black communities.

Fein (2018) gives the example of job interviewers behaving in a colder interpersonal style to Black interviewees, leading Black interviewees to behave in a more nervous and awkward style.

> *"In short, the Whites' racial stereotype and prejudice actually hurt the interview performance of the Black candidates…it seemed to confirm the interviewers' negative stereotype – but this poor performance was caused by the interviewers, not the interviewees"* (Fein, 2018, pg 20).

Although this may not be the only issue at play, how often does this happen in clinical psychology and the systems they work in?

Fein (2018) goes on to suggest communication of distrust towards Black people reduces their sense of belonging. It leads them to deeply feel that 'people like me do not belong here'. It is argued this may be particularly pronounced for Black psychologists as they rise within a profession that is predominantly White and steeped in racism (Guthrie, 1998; Turpin and Coleman, 2010). Furthermore, Fein states the esteem of the group a person strongly identifies with (e.g., Black), is important to how they see themselves. Therefore, it is reasonable to expect the police shooting of a Black youth in 2011 which led to riots in multiple UK cities, for a period of time both affected the self-esteem of Black professionals and how they were seen by colleagues. Indeed, I know of employees in inner city local authority buildings being sent home early - such was the threat considered to face staff in such institutions (Allen, 2019). How were Black professionals judged by their colleagues?

How does racism in the psychology industry affect White people?

White psychologists benefit from White Privilege (McIntosh, 2003), which is an invisible package of unearned assets society gives those with White skin regardless of social, political, or economic circumstances. These include cultural affirmations of White people's worth; presumed greater social status; and freedom to move, buy, work, play, and speak freely. The

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effects can be seen in professional, educational, and personal contexts and implies the right to assume the universality of one's own experiences, marking others as different or exceptional while perceiving oneself as normal. It is my perception White psychologists and colleagues are instantly trusted in the workplace due to advantage and favouritism bestowed to Whiteness (DiTomaso, 2015). Whereas Black psychologists often need to prove themselves, and then co-work with embarrassment from colleagues who were initially highly suspicious of them.

A system of White supremacy can include use of, or co-existence with; other forms of oppression due to class, gender and disability (Akala, 2018; Eddo-Lodge, 2017; Jackson-Lowman, 2014; Reeve, 2012). This is to say the combination of being Black, achieving and disability can attract attack. The weapon of choice can be to inconvenience, delay or obstruct reasonable adjustments for their disability; regardless of how minor their disability. Provision of support to cope with a simultaneity of oppression can present further issues. Many Black and White allies, sensitive to issues of race report to be working class. Then, class can become a tension between middle class Black psychologists and Black or White allies.

Whether intentional or not, implicit bias that Black British are inferior can lead to assumptions that Black people are untrustworthy, lying, shirking on the job and likely to be aggressive. I recall situations when male, White trainee clinical psychologists were assumed qualified, and I as a Black woman assumed to be the unqualified trainee. This could be for a number of reasons, including race. Reddie (2003) discusses the concept of 'hierarchy of credibility', a ranking system of whose accounts are believed, which has Black women at the bottom.

It would seem implicit bias impacts Clinical Psychology in varied ways (Patel, 2012; Aitken and Dennis, 2012; Sue, Capodilupo, Torino, Bucceri, Holder, Nadal and Esquilin, 2007). Turpin and Coleman (2010) suggest some progress regarding potential inequalities within the application process and in raising the awareness of Clinical Psychology as a profession to Black people. However, they note much room for improvement. Regarding Clinical Psychology training, Adetimole et al (2005) offer insight to their experience.

> *"We did not want to be misunderstood as betraying our course, peers and tutors, as some of them were supportive. As Black people, we often have to be very careful about how we talk about our experiences, because of our hyperawareness of other people's anxieties, feelings of guilt, anger or suspiciousness towards us"*(Adetimole et. al., 2005, p. 11).

What is described seems an example of the concept of White fragility. This is where in various settings, White people come to expect racial comfort lowering their ability to tolerate racial stress (e.g., Black people voicing the issue of race). Even a minimum amount of conversing about such issues becomes intolerable, triggering a range of defensive moves such as anger, fear, and guilt, and behaviours such as argumentation, silence, and leaving the stress-inducing situation (DiAngelo, 2011). It's as if Black people intermittently have access to rights

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and privileges, only if they make White people feel comfortable in their Whiteness.

Even when some institutions have diversity strategies in place, they can be misapplied or misunderstood as oppression of White people. This can result in engendering far-right White nationalism. Thus, the status quo does not change. Indeed, fear from some White people of oppression seems very misplaced, as DiTomaso (2018) suggests it is 'favouritism to White people which impacts greatest' against Black people. Given this key finding, will there be a time when monitoring of institutions considers favouritism to White people, not only discrimination against Black people?

According to DiTomaso (2018), institutional racism leads institutions to essentially work better for White people than for Black, so personal hostility in the form of macro or micro aggression is not necessarily needed as White people gain from existing structures. Simply put, '"the ultimate White privilege is the privilege not to be racist and to still benefit from the existence of racial inequality" (DiTomaso, 2018 pg 61).

The argument is not that any White people do not face any barriers in the workplace, as they do. Black people experience these barriers with additional ones. As Black British are not a homogenous group (McInnis, 2018), in addition to race, implicit cultural bias may vary depending upon prejudices about countries of recent origin. Regarding support, some Black British communities' function better than others. Furthermore, some individuals lack relatives in the same country depending upon migration patterns within their family and the number who stayed in their country of origin (stayed home).

Potential Solutions

Black people have the capacity for self-preservation in the harshest of conditions, as demonstrated by the survival of enslaved ancestors and the Windrush generation of the UK. Therefore, the time has come to curtail commentary on racism in the hope the oppressor will stop (Parham, 2002). The belt and braces approach would be to combine this with optimal rather than sub-optimal values, thinking and functioning for transformation (Myers et. al., 2018; Parham, 2002). African Psychology situates oneself in the field of psychology in relation to and from Africa (Ratele, 2017, pg 274). It expands the understanding of the human experience to include notions of energy (within and between persons). Furthermore, vibration and how that may influence mood, thought and interaction, and considers that increased healing may come from changes in community connectedness (Grills, Nobles and Hill, 2018). Such strategies are needed for the spiritual subsistence of those characterised by dominant western society as 'the other', in order for Afrikans[7] to build interior empires of strength for the journey ahead in multiple settings. It is no longer about 'stop doing X,' but it is

7 The spelling of Afrika with a 'k' instead of a 'c' reflects reclamation of an identity that is different from that which has been constructed through colonialism. It refers to people of African ancestry with high skin pigmentation (Wilson, 1993 and 2014).

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about 'let's repair and heal damage done to our Black ancestors and start doingY'. This is not to say the needs of other oppressed, marginalised and disempowered groups are not important. Furthermore, many Black people also belong to other disempowered and oppressed groups. But as often said in response to 'All Lives Matter,' when 'Black Lives Matter' is mentioned; yes, all lives do matter, but at the moment we are talking about Black Lives.

Why is this important?When clinical situations create frustrations for Black therapists lacking appropriate cultural frames of reference; our next generation is at risk of being 'young, gifted, and Black with inappropriate professional training' (Parham et. al., 2011). This is training which does not meet the needs of the people they see or have meaning.What is sought is a framework which does not validate by comparison to White normative standards, but ethical standards amongst the best in Afrikan functioning in constant exchange with the contemporary world (Karenga, 2010). However, this is not a 'nine to five' pursuit as healers need to integrate African-centred principles to their own life (Parham et. al., 2011). Indeed, African centred psychology is about life affirming principles that bring order and harmony to the life of both client and healer as the healer cannot facilitate spiritual enlightenment and illumination without such a state being accessible to themselves. It calls for use of healing concepts, tools and thinking abundant within Black communities in the therapy room such as reflecting on proverbs and Ananse stories (Lawford, Rowe, McInnis and DeLoach, in press), and traditional West African wisdom concepts such as Adinkra symbols as a tool for wellness (Adom et. al., 2016; McInnis, in preparation).

As we enter a new decade, we call for communities most likely accepting of African centred therapy to have it available. Furthermore, African centred supervision and organisational principles for high vibration functioning for all. A manifesto is a call to action (Elkins, 2009; McFall, 1991), so a new Clinical Psychology Manifesto is called for which liberates, similar to as proposed for Educational Psychology (Wright, 2017). African centred cosmology, ideology, principles and practices are numerous and outside the scope of this paper, but include (Karenga, 2010; Grills et. al., 2018; Parham et. al., 2011):

- Notions of life sustaining African cultural rituals
- Remembering and respecting ancestors
- Spiritness
- Self-knowledge including racial identity as a key to wellbeing
- Pursuit of optimal rather than sub-optimal ways of being and functioning
- Purpose
- Values such as Nguzo Saba
- Principles such as Ma'at and
- Dimensions of African self-consciousness such as Divinity,Teachability, Perfectibility, Free Will, and Moral and Social Responsibility

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Summary

The thrust of this paper is that implicit bias against Black people and preference for White people is fundamental to understanding the impact of institutional racism. Multiple institutions, governments and countries with this viewpoint have become a global system of White supremacy (Fuller, 2016). It is acknowledged not all White people permanently uphold the system of White supremacy, but in my experience those who do often out-weigh or out-power those who do not. Furthermore, they are sometimes joined by Black people who want to improve their position within the system of White supremacy rather than dismantle it. My article in 2002 focussed upon defining and detecting racism. Amos Wilson (Wilson, 1993 and 2014), defined racism as a system for determining whose children will be fed first and who's last. This article alludes to theoretical models for understanding, betterment and transformation to a higher self particularly for Black people. This is regardless of strategies which may be against Black people whether intermittent, seasonal or in residence (Myers et. al, 2018; Parham et. al., 2011). This paper in no way says other forms of oppression do not exist, it is just that they may be better explored elsewhere.

In this article, some of the tactics of the system of White supremacy have been exposed. This is not presented to create unnecessary fear but awareness, as to be prepared can be forewarned. Organisations such as the Association of Black Psychologists (ABPsi) have an international reach developing therapies and offering initiatives designed to rescue, reclaim and restore African character, consciousness and conduct to recalibrate the future human trajectory of Afrikans (Grills et. al, 2018).

Do we want more people with Black faces in psychology who peddle a paradigm which inappropriately works from a deficit model when it comes to the psychology of Blacks (Parham et. al., 2011)? Or do we want more people who can make a difference 'seed by seed,' making the very institutions which deliver services for clients abundant with approaches to meet people where they are?

Dedication and Acknowledgement

Dedicated to the ancestors including my late father Jeremiah Eric McInnis (1928 – 2017). A man who planted seeds to bear fruit and shade for others to benefit. May we continue the journey started by our ancestors, even when the road is tough, because we have a great past and an even greater future.

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"The Struggle is Real": Exploring the Experiences of Black, Asian and Minority Ethnic UK Clinical Psychology Doctorate Applicants

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ABSTRACT: This paper aims to understand the experiences of BAME DClinPsy applicants within the current climate where there is an increase in prominence of institutional racism.

KEY WORDS: Black and Ethnic minority, BAME experience, Clinical psychology training, Racism

A diverse NHS workforce is beneficial for patient care (West & Dawson, 2012) and increasing diversity in the NHS workforce is a long-term objective of the Department of Health (DoH, 2003). A Workforce Race Equality Data Standard Report (Kline et al, 2017) identified that different professional groups working within the NHS have differing levels of ethnic diversity, with clinical psychology notably poor in this area. For many years, the lack of diversity within the profession has been controversial, with the ratio of BAME clinical psychologists (9.6%; Baker & Nash, 2013) not correlating to the ratio of the wider BAME population within the UK (13%; Office of National Statistics, 2011). The diversity of the clinical psychology workforce is an important contributing factor in ensuring people are able to access services that reflect their own culture and personal identities, and allowing the possibility of choice surrounding diversity across therapists and psychologists (Turpin & Coleman, 2010).

Undergraduate psychology is a popular choice for BAME students; 12% of students on these courses are from BAME backgrounds (Turpin & Fensom, 2004). Clinical psychology doctoral training statistics (Leeds Clearing House, 2016) highlighted 12% of the total applications came from a BAME background, aligning with undergraduate numbers. However, just 7% of those BAME applicants were accepted onto a clinical programme. From the same source; 81% of all applications were from people from White backgrounds, 86% of people accepted were from a White background. This suggests that the under representation of those

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from BAME backgrounds begins at the DClinPsy selection stage. The question remains; why is it more difficult for BAME applicants to meet basic selection criteria and be accepted onto clinical courses, whilst the opposite occurs for people from White backgrounds?

Understanding the experiences of individuals from BAME backgrounds pursuing clinical psychology training is important to understand the barriers they may face. By gaining an understanding, our profession can address these barriers and thereby create diversity within the discipline. This study aimed to gain knowledge and insight into how people from BAME backgrounds experience pursuing a place on clinical psychology doctorate courses in the UK.

Methodology

Participants

Ethical approval was granted from the University of Hertfordshire's Health and Human Sciences Ethics committee. In line with Interpretative Phenomenological Analysis' criteria to create a homogenous sample, 8 female participants from BAME groups were recruited who were working within the London regions in psychologically related roles (see Table 1). Ages ranged from 24-30 years old.

Table 1: Participant Characteristics

Pseudonym	Ethnicity	Place of Birth
Jasmine	Black British	England
Monica	Black British	England
Priya	Black British	England
Kim	Black British	England
Fatima	Asian British	England
Elizabeth	Black British	England
Mary	African	Zimbabwe
Charlene	Black British	England

All participants were recruited from a voluntary group for "aspiring clinical psychologists" providing peer support and a space to discuss training.

Procedure

A semi-structured interview schedule was developed based on relevant literature, drawing on IPA guidance (Smith, Flowers & Larkin, 2009), in addition to feedback following a pilot interview. Interviews lasted between 45-110 minutes, were audio recorded and transcribed verbatim.

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Analytic Process

Data analysis followed the Smith et al. (2009) guidelines, which involved becoming 'immersed' in the data to identify initial themes. Connections were made between initial themes to form 'clusters'. These clusters formed superordinate and subordinate themes. These steps were repeated individually for all eight interviews. Finally, connections and patterns of relatedness were sought between all themes from all transcripts.

Tracy's (2010) eight criteria for evaluating the quality of qualitative research were used throughout to guide the design, execution, analysis and reporting processes.

Results

A summary of the themes is shown in Table 2.

Table 2: Super-ordinate themes and Subthemes

Super-ordinate theme	Subtheme
The challenge of negotiating multiple identities and narratives	• The meaning of choosing a career in mental health
	• Negotiating personal and professional values
Grappling with White privilege	• The hardship of dealing with racism
	• "Black tax" and the struggle of not being White
Finding value in being a BAME applicant	• Comfort in connections
	• The gift of resilience

The challenge of negotiating multiple identities and narratives

- ***The meaning of choosing clinical psychology as a career***

There were accounts from participants explaining more about their internal motivation for this career and what choosing clinical psychology meant to them. Charlene speaks about the silence that her community has around mental health. However, there appears to be an urgency in her language and in wanting to share her knowledge and experience with her community.

> *"I needed to tell people about it. I needed to tell people about it because it's something that shouldn't be unknown."* (Charlene)

This silence was also mentioned by Fatima. Fatima uses the term 'ignorant' here, perhaps indicating her impression that there is a lack of mental health awareness and acceptance

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within her community. However, it could also be indicative of her frustration around her communities' views on mental health and the stigma associated with it. Stigma around mental health is a topic which many participants spoke about.

> *"We need Bengali, Muslim, British individuals in this field to make us aware of what it's about, rather than being ignorant to it."* (Fatima)

- ***Negotiating personal and professional values***

Once participants had decided to pursue a career in clinical psychology, they discussed having to negotiate between their personal and professional values and identities. This included the intersection of their BAME status, gender and socioeconomic background. Participants spoke about their families' expectations of them as females and how the pursuit of the course may interfere with these expectations.

> *"…a female - they need to stay at home, take care of their family and trying to get onto the course may interfere with that because you never know if it can happen for you".* (Jasmine)

Other familial influences included the opinions of status and earning potential of a career in clinical psychology. This may make it more difficult to maintain motivation in pursuing this career, if family support is not present.

> *"My family don't really get the psychology thing because you need to make money when you're older to support a family and be a real doctor, be a dentist, do banking or whatever, because of that."* (Priya)

Priya references that a culturally acceptable and traditional role would be to become a "real" doctor; thus making the implication of a difference between different Dr titles. The effect of socio-economic background on their pursuit was also spoken about.

Participants also spoke about the intersectionality of BAME status and socioeconomic background.

> *"I can't speak the way they do. I can't argue my points very well … that was probably one of my biggest struggles, expressing myself in a way that sounds professional and convincing. They were good at that, and they also had everything in their kit…like research experience. I didn't have that".* (Mary)

Mary minimises her own experiences and skills such as articulation, whilst simultaneously assuming people from White British backgrounds will be efficient in these areas. These comparisons could be linked with participants' descriptions of social injustice and experiencing

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disadvantaged social circumstances which limited educational opportunities.

> *"People from BAME backgrounds - their parents may be immigrants and may have had to go to poorer or more deprived areas. From my background living in one of the most deprived boroughs in England, we didn't have great education…or great developmental initiatives - we didn't get that opportunity".* (Fatima)

Honorary contracts may be an important factor impacting on the duration required to gain relevant experience for the clinical course. However, only privileged applicants have the means to undertake an unpaid position.

> *"She has the privilege of not working because she's middle class, so she was able to volunteer… but for me, I needed to work. I don't come from money like that".* (Jasmine)

Grappling with White privilege

- ***The hardship of dealing with racism***

White privilege was a term used by the majority of participants when discussing inequalities and challenges experienced in their pursuit of training. There were accounts of overt racism from service users.

> *"He [service user] just starts going on about Black people and I was just sitting there thinking, Okay, I've got to hold my mouth. I have to keep my mouth shut. And he turned to me and was like, Um, do you mind me making jokes about black people?"* (Kim)

Kim reflected that she felt she had to "hold her mouth", which may indicate a feeling of being silenced. Other participants also experienced this feeling and related to the idea that one shouldn't talk about racial abuse. These quotes highlight how participants had to undertake emotional work in order to rationalise or dismiss their experiences of racism and feeling silenced.

> *"I didn't speak about it to him either, because I thought, you know, it's nothing. We shouldn't be talking about it".* (Fatima)

> *"The patient didn't want to see me because I was Asian - she said it was because she had a previous partner who was Asian and she was white and so she didn't feel comfortable seeing me, so I'm not sure if that was racist or not".* (Priya)

Positive discrimination was another facet participants described contending with. The increased push for diversity within the profession may have left BAME applicants feeling

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different from those traditionally accepted to this programme.

> "*I'm also aware that they would want to have a certain amount of people from BAME backgrounds. So, I feel like that's even more challenging that I'm from that background because then I wonder sometimes whether I will get on because I deserve it or because I'm Black".* (Mary)

- ***'Black tax' and the struggle of not being White***

The term 'black tax' was mentioned by Mary in her interview. This phrase suggests there is a price to pay for being from a BAME background. It speaks to participants feeling there was an uneven playing field where they had to do more and work harder to have the same chances and opportunities as White colleagues.

> *"There's that continuous assumption that if you're from a BAME background, you kind of have something called 'Black tax', where you work more to get the same result as someone else".* (Mary)

Some participant accounts reported being the only person from an ethnic minority background within the teams they were working and what impact this had.

> *"I tend to usually be the only black person in my role. So, I think it has impacted my experiences because I tend to always be that minority".* (Elizabeth)

Charlene echoes Elizabeth, but continues to say how intimidated she feels.

> *"There's times where you might be the only person from that kind of ethnic group or from any ethnic group and sometimes it can be quite intimidating".* (Charlene)

Finding value in being a BAME applicant

- ***Comfort in connections***

Although participants described difficulties in fitting in with the White majority, they also spoke of the connections and support they found with other BAME colleagues.

> *"I think that there's a lot of support out there, and it's nice to have a network of people that actually share my views, and have similar experiences".* (Monica)

In addition to feeling supported by BAME peers, having BAME supervisors gave participants a space to be themselves and reflect on their experiences of being from a BAME background.

> *"When I did my first draft [of my doctorate application], my supervisor said,"This isn't you, you're*

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trying to be who you think they want you to be as opposed to being yourself and you didn't mention anywhere about your experience of being a Black woman". (Jasmine)

- ***The gift of resilience***

Having this space to reflect on their positions and experiences, allowed some participants to recognise the strengths of coming from a BAME background.

"She taught me to just be confident and be more assertive, because there's going to be things that others may not know or have insight into and you will be valuable". (Charlene)

Between the stories and narratives of hardship faced by participants, there was an emerging sense of resilience within them.

"Being underestimated allows you to work harder because you're going to be judged because you're Black basically or from a BAME community anyway.They're not going to sort of expect you to have these sorts of skills or qualities". (Charlene)

Discussion

Barriers for BAME applicants

Participants reflected on dilemmas of pursuing a career within clinical psychology when their professional and families' goals did not align, i.e., how to meet the familial expectation to marry and start a family, when their professional goals were still so uncertain. This concern was not found in research conducted in trainee and qualified psychologist BAME groups (Shah et al., 2012; Odusanya et al., 2017), suggesting these issues may be more prominent for those pre-qualified as the future remains uncertain.

Participants spoke of the intersectionality of their experiences being from BAME and lower socio-economic backgrounds and the impact this had on their opportunities, such as the reliance of non-paid placements and jobs to gain experience. This speaks to the multiple barriers people from BAME backgrounds may face on their pursuit of clinical psychology.

Difference and racism

Racism was a challenge experienced by all participants. This included overt racism and micro-aggressions. Some participants appeared hesitant to label experiences as racist. In navigating these experiences and attempting to ascertain whether interactions had racial connotations, participants undertook tough emotional work (Hochschild, 2003), which involved questioning, rationalising or dismissing these experiences.

Not fitting in

It is arguable that the normative position of clinical psychology is being a White British female

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from a middle-class background (Baker & Nash, 2013) and participants felt that as a result, they had to work harder to feel worthy of pursuing clinical training. Interestingly, participants recalled courses calling for more ethnic diversity in their cohorts, actually maintaining and reinforcing their feelings of needing to work harder. Participants reported concerns of a narrative that people from BAME backgrounds were not offered places on training courses because they deserved it, but due to quota requirements. This narrative has been mentioned in research since 2005 (Adetimole et al., 2005) and has resulted in BAME applicants questioning their own abilities and White applicants questioning BAME applicants' abilities (Rajan & Shaw, 2008).

Working relationships

Participants shared their experiences of working with BAME supervisors and how they raised issues around culture and race more confidently and openly than those from White backgrounds. This aligns with research suggesting BAME supervisors are more likely to spend time discussing multicultural issues. (Hird et al., 2004).

Participants spoke highly of peer support networks and described them as a community where their professional trajectory was validated and enhanced. By finding a safe space with other BAME applicants and trainees, it could be suggested there is an assumed implicit and non-judgemental understanding around issues of race and culture.

It is concerning that no participant described being able to foster a supportive relationship with regards to BAME issues with a white colleague or supervisor. This may suggest further work is needed in the training of supervisors around the importance of considering issues of race and culture and supporting supervisees to talk about these concerns.

Limitations

All participants were recruited from the same "aspiring clinical psychologists" prequalification group. Interest in the project was overwhelming with many people wanting to take part in the study and thus, other recruitment strategies were not employed. This is appropriate for an IPA study, which requires homogeneity, but limits generalisability.

Future research

A study focused on the experience of male BAME aspiring clinical psychologists within the profession would be an important next step. This is a group of individuals who are arguably more of a minority group than females from BAME backgrounds. Longitudinal research is also needed in this under-considered area. For example, looking at the trajectory of BAME clinical psychologists and whether their experiences change or remain constant throughout, from pursuing a place, to training, to newly qualified working life and further along the career path.

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And in the Clinic?

The intersection of BAME identity and socioeconomic status compounds the disadvantage that this group faces. Having a placement year as part of undergraduate courses may provide opportunities for those who cannot gain important clinical experience due to their finances. Our study highlights the difficulty experienced by participants to find relevant jobs and discussed their inability to take honorary positions over paid positions. It may therefore be useful for doctorate courses to explicitly state their flexibility in relation to relevant experience.

Participants discussed their concerns about feeling unable to raise issues of race and culture with white colleagues or supervisors. This suggests the need for training to be offered to supervisors highlighting the necessity of raising these issues routinely with all supervisees. This could promote applicants from BAME backgrounds feeling validated and understood by their supervisors, irrespective of their supervisor's ethnic background and would also ensure issues around race and culture are not solely left to BAME professionals to address and thus may alleviate some of the perceived burden (Patel & Fatimilehin, 2005). Training could be provided as part of the existing post-qualification training in supervision that is in place around the UK or through 'top up' continuing professional development (CPD) courses which highlight issues around difference and provide examples of best practice when working in culturally sensitive ways with colleagues and service users from BAME backgrounds.

Participants discussed positive discrimination. In order to attract BAME applicants, training courses should be more explicit about their commitment to supporting BAME applicants and trainees (Patel et al., 2000). It may be helpful to provide clarity around why BAME applicants are encouraged and to explicitly state courses are looking to diversify cohorts in order to diversify the profession; and perhaps highlighting why this need exists. This may aid BAME applicants in feeling worthy of gaining places, rather than believing they are meeting course quotas (Adetimole et al., 2005).

Finally, it was mentioned in the introduction that proportionally fewer BAME applicants are accepted than those who apply. Therefore, it will be important to consider the interview process and the biases that may exist at this stage. Training could be provided to psychologists who are involved in selection procedures on how to recognise their own biases.

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Rights, Psy and forms of Slavery

Lauren Tenney

Lauren Tenney, PhD, is a psychiatric survivor and activist first involuntarily committed at age 15. Her work aims to expose the institutional corruption which is a source of profit for organized psychiatry, and to abolish state sponsored human rights violations, such as murder, torture and slavery. www.laurentenney.us

ABSTRACT: This paper explores the interaction of racism, psy theory and practice and slavery in late nineteenth century psychiatry and psychology.

KEY WORDS: dysesthesia, segregation, drapetomania, whipping, treatment

In North America, the discipline of psychology emerged with the reorganization of the American Psychiatric Association. Medical doctors via the American Psychiatric Association became more particular about who could be part of their trade organization, newly named as such in 1921. Earlier, in the American Medico-Psychological Association (established 1892), the real fight between medical doctors and doctors of philosophy took place, as non-medical doctors snuck their way into the Association of Medical Superintendents of American Insane Institutions, (AMSAII, established 1844), as a way to force the state to submit power and resources to non-medics.

The American Psychological Association formed in 1892, the same year as the American Medico-Psychological Association, not due to coincidence, but due to the blockage of non-medical doctors into what eventually becomes the American Psychiatric Association. The early divisions between psychiatry and psychology can also be positioned as issues around the attempts of the fields to be considered legitimate medical practices, and the efforts of the medical doctors to bar entry to non-medical people.

From the inception of the AMSAII, issues of race were addressed. For example, in 1844, one of the committees established at the first meeting of the AMSAII was the 'Committee on Institutions for Colored Insane.' In modern times, it is hard to imagine that it was only in 1995 that the Office of Ethnic and Minority Affairs of the American Psychological Association established specific work on what racism is, how it exists within psychology, and ways to promote antiracist experiences.

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Historical Racism

Psychiatry, since its inception, holds a tremendous amount of power within American society. Vanessa Jackson (2001) exposed the roles of Benjamin Rush, MD, a signatory to the Declaration of Independence, and Doctor Samuel Cartwright, in the establishment of the practices of scientific racism and the roles of doctors promoting and maintaining systems of slavery and segregation in nineteenth century America. Jackson (2005) also points to the creation of psychiatric diagnoses specific to those enslaved, exhibited via desires for freedom and noncompliance with orders, as grounds for whippings as cure and prevention.

The stark reality is that people get very offended when I say that when the person enslaving someone could no longer control the person they were trying to enslave, they turned to the alienist/mad doctor/physician/psychiatrist, who had (eventually), created segregated institutions where they would offer their 'treatment' of medically sanctioned whippings, re-creating the colonial legal status of the whipper and the whipped within the mad doctor industry. Cartwright supported the medical treatment of *"whipping the devil out of them"* as a *"preventive measure against absconding or other bad conduct"* (Cartwright, 1851/1967, p. 709). Cartwright in the most degrading way dismisses people freed and focuses his concern on *"rascality"*, or what he proposed to be dysesthesia: *"…to be like a person half asleep, that is with difficulty aroused and kept awake"* (p. 710). When concerning those actively enslaved, *"The disease is the natural offspring of negro liberty - the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks"* (p. 710). After explaining the supposed disease that caused people enslaved not to behave the way those enslaving them wanted, Cartwright offers the foundational problem and the 'physiological' cure:

> *"The skin is dry, thick and harsh to the touch, and the liver inactive. The liver, skin and kidneys should be stimulated to activity, and be made to assist in decarbonising the blood. The best means to stimulate the skin is, first, to have the patient well washed with warm water and soap; then, to anoint it all over with oil, and to slap the oil in with a broad leather strap; then to put the patient to some hard kind of work in the open air and sunshine…any kind of labor will do that… No sooner does the blood feel the vivifying influences…the negro seems to be awakened to a new existence, and to look grateful and thankful to the white man whose compulsory power has restored his sensation and dispelled the mist that clouded his intellect."(p. 712)*

For decades, psychiatric trade organization publications and often the minutes of the American Psychiatric Association, from its inception in 1844 under the auspice of AMSAII forward, included the debate about segregated institutions of where treatment of people enslaved ultimately would occur. This had a pronounced dividing line in Virginia, specifically between Dr Galt at the Williamsburg Asylum and Dr Stribling at the Staunton Asylum. The debate was whether people who were enslaved who supposedly needed treatment for their insanity could be 'treated' in the same buildings as white people. Galt, a proponent

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of integrated institutions suggested white people would not be able to tell the difference from those enslaved in the institution as 'servants,' from those who were enslaved and institutionalized for 'treatment.' Since they would be working on the farms and shops, the white people would not know they were even there at the institution.

Opposition to integrated institutions included ideas that white people would know people of African descent would be there, and the institution for whites would be thought to be belittled by the presence of people who were enslaved. White supremacy was staunch and took the stance that people enslaved ought not to be allowed in the same buildings as the white insane, unless as their servants. Segregationists eventually won the battle within AMSAII and the win for Stribling led to the development of segregated institutions throughout the United States in the second half of the nineteenth century.

People often suggest to me that modern psychiatry either does not know about psychiatry's historical involvement with and promotion of slavery or it avidly makes reparations because modern psychiatry acknowledges the discipline's role and is appalled by that same history. Both statements are false. For example, in the same publication that explained the ways possession is considered by contemporary psychiatry to have culturally-specific criteria there is an undated presentation on the DSM-5 (Nuckols, n.d.). The presentation starts in the 1840s with the following point then jumps to the 1880s, without any retraction of fact or written acknowledgement of the heinous realities of a) slavery and b) drapetomania:

> *"1840 1 DX – US Census – Idiocy/Insanity -Also in the 1840s, southern alienists discovered a malady called Drapetomania – the inexplicable mad longing of a slave for freedom."(p. 2)*

Of course, far from 'discovering' the malady, as with any psychiatric label the alienists, in this case Cartwright in 1852 rather than 'the 1840s,' simply invented it. The third edition of Stedman's Practical Medical Dictionary published in 1914 still included an entry for drapetomania, defined as 'Vagabondage, dromomania; an uncontrollable or insane impulsion to wander.'

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Oliver Twist and Anti-Semitism

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ABSTRACT: This article offers a critical reading of the portrayal of Jews in film and other versions of the novel *Oliver Twist*.

KEY WORDS: Propaganda, Jew, Little St Hugh, Fagin, blood libel

Alec Guinness's portrayal of Fagin in David Lean's film had been controversial, leading to riots when the film was shown in Germany and to trouble with the Hollywood censors; but I treated this as proof that the book was not the gentle read some had come to regard it as (Calder, 1993). It seems incomprehensible to me that it was thought acceptable to put on screen a Fagin made to look like a figure from Nazi anti-Semitic propaganda and that only three years after the world had discovered the enormity of the Holocaust – see Drazin (2013) for a discussion of the contemporary controversy.

An article in the Independent (Vallely, 2005) once quoted Milton Kerker, writing for the Jewish Theological Seminary of America: "*Fagin is no ordinary villain. He is the traditional medieval Jewish bogeyman, the Jew who is not a mere vicarious atavism of Satan, but the grotesque Jew, the crafty Jew in whose heart Satan is actually lodged".* Dickens introduces his villain with him standing before a fire, fork in hand, with a villainous and repulsive face, and matted red hair, which was just the hair traditionally worn by the devil in medieval mystery plays. Dickens several times refers to Fagin as the *"merry old gentleman"*, an ancient euphemism for the devil (Vallely, op.cit), as is the phrase Bill Sikes uses when he says Fagin looks as if he has come straight from *"the old 'un without any father at all betwixt you"* (Dickens, 1837-9/1985, p.398).

The novel's antipathy to Fagin as a Jew is so deep that he is referred to as 'the Jew' more than 250 times in its first 38 chapters. In chapter nine he is referred to as a Jew 29 times, but by his name only three. Such is the diabolical picture we are given of Fagin that we take it for granted he should be executed at the end of the novel. Yet, as John Sutherland (1997) has

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argued, it is not at all clear what capital offence he has committed. As Fagin himself asks when Oliver visits him in the condemned cell: *"What right have they to butcher me?"* (Dickens, 1837-9/1985: p.472).

Mardock (2005) suggests *"Dickens' attitudes toward actual Jews reflect the typical complexity of liberal Victorians"* and offers a reading of Riah in Our Mutual Friend (Dickens' last completed novel) that looks back, not to Fagin and Oliver Twist, but to Shylock and The Merchant of Venice. He argues that Dickens uses Riah as an 'anti-Shylock' and uses him to critique his own society's presentation of the stage Jew.

Oliver Twist is remembered for the power of its characters and set pieces rather than for the elegance of its plotting. Reading it, you are aware that it was written in instalments and sense that much of the plot is set out towards the end of the book in an attempt to bring some kind of order to the extraordinary scenes he has created. He is not wholly successful. For, as Morgentaler (2000) reminds us, Oliver's resemblance to his mother is so strong that it is evident to Mr Brownlow the first time he lays eyes on the boy, even though he knows her features only from a portrait.

Yet, the plot also requires Oliver to bear an equally striking likeness to his father. So Brownlow recalls towards the end of the novel: "*Even when I first saw him in all his dirt and misery, there was a lingering expression in his face that came upon me like a glimpse of some old friend flashing on one in a vivid dream.*" (Dickens, 1837-9/1985: p.438). Just as Fagin's appearance is enough to damn him and condemn him to the gallows, so Oliver's saves him and restores him to his rightful station.

But there is another undercurrent to the plot equally anti-Semitic and may reveal Dickens' knowledge of the extent of historical distrust and hatred of Jews. As Nancy tells Rose Maylie during the meeting that seals her fate, because Sikes believes she has informed on him: *"A bargain was struck with Fagin, that if Oliver was got back he should have a certain sum; and he was to have more for making him a thief, which this Monks wanted for some purpose of his own."* (Dickens, 1837-9/1985: p.362-3). We know better than Rose what Monks' purpose was…

Blood libel

This dishonouring or defiling of an innocent Christian boy at the hands of a Jew is reminiscent of the 'blood libel', which accuses Jews of murdering Christian children so they can use their blood as part of religious rituals. Yet, it feels more closely related to the local cults of boy martyrs that flourished in England in the 12th and 13th centuries. The best known of these cults, dating from 1255, is that of 'Little St Hugh of Lincoln,' whose shrine still stands in the cathedral and who is mentioned in Chaucer's *Prioress's Tale* and Marlowe's *The Jew of Malta*.

Mundill (1998), however, suggests the first such cult is that of St William of Norwich, which dates from 1144, whose shrine was believed to be the site of miracles. Mundill identifies further examples of these cults at Gloucester in 1168, Bury St Edmunds in 1181, Bristol in 1183 and Winchester in 1192. He traces further cases of Jews being accused or convicted

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of the murder of a Christian child into the 13th century, including one where the supposed victim was found alive and another where the boy's mother was later charged with murder. In 1244, a shrine to a dead baby whose body supposedly bore the marks of ritual murder was erected at St Paul's Cathedral.

You can still find the remnants of the shrine to 'Little St Hugh' (he was never canonised by Rome), in Lincoln cathedral. It survived intact until the Reformation, or possibly even until Cromwell's Commonwealth, but a recent visitor (Backwatersman, 2012) found that: *'the bones of Hugh (who, of course, never asked for any of this) are relegated to an obscure aisle, accompanied by an apology which states (quite correctly) that 'such stories do not rebound to the credit of Christendom' and ends 'so let us pray: forgive what we have been, amend what we are, and direct what we shall be.'*

According to Morrell (1993), the shrine was moved to its current location and the apology put in place in 1959. The apology replaced a straightforward telling of the story of Hugh's martyrdom because, in the words of the Dean, the Revd DC Dunlop, the Dean and Chapter did not wish *'to see things that are untrue up on the walls of the cathedral'*. That untrue thing was an anti-Semitic fantasy, the full version of which was recorded by the 13th-century chronicler Matthew Paris (quoted in Hill, 1948: p.224-5):

> *'This year about the feast of the apostles Peter and Paul, the Jews of Lincoln stole a boy called Hugh, who was about eight years old. After shutting him up in a secret chamber, where they fed him on milk and other childish food, they sent to almost all the cities of England in which there were Jews, and summoned some of their sect from each city to be present at a sacrifice to take place at Lincoln, in contumely and insult of Jesus Christ. For, as they said, they had a boy concealed for the purpose of being crucified; so a great number of them assembled at Lincoln, and then they appointed a Jew of Lincoln judge, to take the place of Pilate, by whose sentence, and with the concurrence of all, the boy was subjected to various tortures.*

Paris goes on to detail the boy's tortures, which mirror Christ's suffering on the cross, in loving detail before concluding: *"…and after tormenting him in diverse ways they crucified him, and pierced him to the heart with a spear. When the boy was dead, they took the body down from the cross, and for some reason disembowelled it; it is said for the purpose of their magic arts"*. Goller (1987) tells us what happened once the boy's body was found: *"Hardly had the suspicion been voiced that the Jews of Lincoln had committed a ritual murder when Copin, the Jew in whose courtyard the body had been found, was imprisoned and threatened with torture and death, should he not tell the truth. With his statement we are already in the realm of fiction"*.

It is from Copin's statement that the idea that the whole Jewish community in England was implicated in the boy's death comes – the same 'admission' was forced from a Jew in Norwich in 1144. Henry III came to Lincoln to supervise the investigation himself and 18 Jews were hanged in London because they refused to testify in front of a purely Christian jury. A further 72 were later pardoned and released from the Tower of London. Goller also

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traces how the legend of Little St Hugh developed through folk ballads and nursery rhymes. One telling of it, the bowdlerised folk song Sir Hugh, survives to this day and was recorded by Steeleye Span in 1975.

What shall we do with Oliver?

What, then, to do about *Oliver Twist*? One approach is that adopted by a Mr Rosenberg, who in 1949 called for both *Oliver Twist* and *The Merchant of Venice* to be dropped from the curriculum of schools in the city of New York because they tended to *'engender hatred of the Jew as a person and as a race'*. The school board declined to do so, leading to a court case which Mr Rosenberg lost (American Library Association, 2017).

Oliver Twist proved a particularly unstable text as it was retold from the start. Dickens was plagued by pirated editions of his early novels, some of which tried to fool the reader into thinking they were the real thing while others burlesqued the original. That instability carried over into the film adaptations as directors struggled with the novel's byzantine plot and has been equally apparent more recently as adaptations have looked for ways of challenging, curbing or disguising the novel's anti-Semitic elements.

Lionel Bart chose the first route, giving Fagin all the best tunes. Though radio stations in the 1960s were obsessed with 'Food Glorious Food', it is the sinuous music of 'Reviewing the Situation' that the viewer is likely to remember. Add in the lyrics where Fagin declares *"I'm finding it hard to be really as black as they paint"* and Dickens devilish villain is taking the first steps on the path to becoming a hero – or at least an anti-hero.

In 1999, Alan Bleasdale wrote a television adaptation that, though it altered many details, took the novel's plot more seriously than Dickens did in that we saw Oliver's father and Monks in the first episode with Oliver not appearing until the second. Talking to the Guardian (Brown, 1999), Bleasdale identified three problems with the novel: Dickens's love of implausible coincidence, his sentimentality and its anti-Semitism. *"I did not want to portray a Jewish person or an immigrant in this day and age as an out-and-out villain,"* said Bleasdale, but he retained the speech rhythms of Dickens's original Fagin. So when Robert Lindsay, who was to play Fagin, read the script he said, *"I can't play him as other than Jewish*." The portrayal, said Bleasdale, was softened by making Fagin *"a failed magician, an immigrant from Prague, who seduces the children through magic, hot sausages and gin,"* suggesting it owed much to the ghost of Ron Moody from *Oliver!*

In the graphic novel Fagin the Jew by Will Eisner (2003 – also discussed in Kaufman, 2017) Eisner explains its genesis in his introduction:

> *'A few years ago, as I was examining folk tales and literary classics for possible graphic adaptation, I became aware of the origins of ethnic stereotypes we accept without question. Upon examining the illustrations of the original editions of Oliver Twist, I found an unquestionable example of visual defamation in classic literature. The memory of their awful use by the Nazis in World War II, one*

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hundred years later, added evidence to the persistence of evil stereotyping. Combating it became an obsessive pursuit, and I realized that I had no choice but to undertake a truer portrait of Fagin by telling his life story in the only way I could.'

Eisner's Fagin tells his story in the condemned cell, though as Sutherland (1997) points out, it is not at all clear from Dickens' novel that he has committed a capital crime – perhaps readers have always taken the devilishness that surrounded the character as justification enough. Fagin's parents, he tells us, arrived in London from somewhere in Middle Europe – *"How they made the journey, God only knows"* – and found a community where Jews were not subject to pogroms or special laws. They also found, though, that the Ashkenazim, Middle European Jews like themselves, were seen as socially inferior to the established Sephardim from Spain and Portugal.

In an afterword, Eisner suggests that both Dickens and his illustrator George Cruikshank presented Fagin as a classic stereotypical Jew 'based on ill-considered evidence, imitation and popular ignorance'. The novel's pictures of Fagin, he argues, are based on the appearance of the Sephardim, whose features, hair and complexions were the result of 400 years living among Latin and Mediterranean peoples. Ashkenazi Jews, by contrast, had come to resemble the Germans among whom they lived and there were many blonde Jews *'as a result of rapes that occurred during pogroms*.' The novel's reliance upon such old stereotypes confirms the theory that its anti-Semitism has deep roots.

Eisner gives the young Fagin suitably Dickensian adventures. As a little boy he is put to work peddling needles and buttons on the London streets. When his father is murdered and his mother dies from illness and hunger, he is taken into the household of a wealthy Jewish man, Eleazer Salomon, who dreams of establishing a school for the Jewish boys of the East End. Fagin is 17 when the school is founded and he goes to work there as a caretaker, only to be thrown out when he falls in love with Rebecca Lopez, the daughter of another of its wealthy backers. With little to fall back on, Fagin turns to crime and is eventually caught and transported for handling stolen goods. Returning to London after ten years of slavery, he finds crime is still the only career open to him:

"Broken in body, in fragile health, I was in appearance a shuffling greybeard, the result of the horrors of penal life and imprisonment.
However, I still had me wits about me. Sharper than ever were my skills, which were honed in the penal colonies.
In London, I had finally established myself. I was no longer naïve: gone was the promise that fuelled my hope of a grand future. I was what the urchins who worked for me would one day become".

From then on, Eisner tells the tale much as Dickens told it. There is, though, a final act of retelling which sees Fagin positioned as a wronged child every bit as much as Oliver. For

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Eleazer Salomon turns out to have been a benevolent bachelor like Mr Brownlow; he regarded the young Fagin as his son and was heartbroken when he disappeared after being thrown out of the school by Rebecca Lopez's father. Unlike Oliver, Fagin was never rescued - rather than being his fortune, his face damned him. Salomon's money went to the Lopez family instead, to be inherited by Oliver Twist when he married Rebecca Lopez's daughter.

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Race, Racism and the Psy Project

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ABSTRACT: Psychology and clinical psychology are embedded in theories and praxis that are essentially racist and reactionary. This paper does its utmost to offer some hope that the psy project can emerge as an egalitarian endeavour.

KEY WORDS: Ananse, oppression, rabbi, eugenics

Cross-cultural studies of so-called depression by researchers in the industrialised regions presuppose a dichotomy of mind and body and related theory of emotion. Emotions are, however, not constituted the same way in different cultures. The anthropologist Clifford Geertz regarded ideas and emotions as cultural artefacts (Geertz, 1973).

Anthropologists and cross-cultural psychologists argue that affects are inseparable from cultural systems of meaning; culturally informed models of what might be described as depression should investigate indigenous or ethno-psychological models of dysphoric affects. Themes include factors such as indigenous categories of emotion, the predominance of particular emotions within societies and ethno-physiological accounts of bodily experience of emotions (Jenkins et al, 1991). Conceptions of emotion are embedded within notions of self, characterized as varying along a continuum between egocentric and socio-centric. Individuals with a more socio-centric sense of self are considered to be more relationally identified with others than those with a more egocentric sense of self, who try to function as individuals. The former have often been associated with non-Western/indigenous cultural traditions, the latter with traditions attuned to post-industrial materialism.

An understanding of emotions as intrapsychic events, feelings or introspections of the individual (rather than the individual, community or ancestors) is predominantly a Western conceptualisation. The Ifaluk of Micronesia, however, don't conceptualise thoughts and emotions solely within the individual. Rather, these can be found in relationships between persons or within events and situations. The Pintupi peoples of Australia have a kin-based

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conception of self in contrast to people following more westernised traditions where self is seen as constituted by individuality. For example, in White, middle class, affluent, heterosexual communities it tends to be individual children who are marked as depressed rather than families or communities, although there is an increasing acknowledgement amongst psychology practitioners that poor housing, persistent assaults on one's character and sense of self due to a system of institutional racism, decrepit infrastructure and poverty create environments where the experience of oppression is frequently identified as depression.

Whether attempting to heal individuals or communities, some 80% of the world's population includes herbs, dance, incantation and prayers to ancestors or gods and different forms of spirituality. Since 3,000 BCE, Ayurvedic medicine has emphasized the importance of three doshas: Vata, Pitta and Kapha (tri-partite systems are also integral to Western notions underlying, for example, psycho-analysis and Cognitive Behaviour Therapy). In Ayurveda, disease and illness originate from an imbalance in the three energies and a disconnection from nature (again, the notion of imbalance can be found in Western traditions from Humoral theory to the metaphor of 'brain biochemical imbalance'). Amongst other ills, Ayurveda is used for: Alzheimer's disease, fear and overwhelm, asthma, cancer, dementia, and high blood pressure.

The philosophies of the Nile Valley and ancient Egypt feature prominently in African psychology (Browder 1992, Nobles 2006) along with many diverse African cultural principles with contemporary derivatives (Parham 2002). African tradition in talking therapy sessions can include reflecting on proverbs or sayings familiar to particular families or communities which represent strategies for dealing with life situations and traditional wisdom using, for example, Ananse stories. Ananse is a folktale character taking the form of a spider with the spirit of wisdom and all knowledge of stories. A parallel might be drawn here with the 'teaching tales' of family therapist, Milton Erickson (Rosen, 1982).

The 7,000 year old history of Judaism involves prayer and the role of rabbi/rebbe who counsels after the gabai (rebbe's assistant), has met with people and then: *"After interviewing the supplicant about his family, his background and his troubles, the gabai delivers the kvitl* [written description of the presenting problem] *and an oral report to the rebbe."*(Zborowski and Herzog, 1995). This might be seen as analogous to a psychiatric intake session or psychological assessment carried out by an assistant psychologist.

These early paragraphs (written to present something of a contrast to the - stereotypical - teaching offered on some Clinical Psychology doctoral programmes), cannot do justice to the wealth of understanding and healing represented within cultures different from the overwhelmingly white hegemony to be found in theories and practice underlying much of modernist psy in Northern industrial global regions. The consequences for people not fitting the arbitrary norms of a psychology dominated by individualism and capitalism have been considerable. For some, the theories and consequences epitomise racism.

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Psychology and racism

Between 1900 and 1939, British eugenicists included the psychologists Burt, Spearman and Pearson (holder of the inaugural Galton chair in eugenics at University College, London). Writing on Beyondism, the eugenics movement he founded, the US psychologist Cattell (progenitor of Cattell's 16 PF Personality Inventory) claimed, *"The vast majority of humans on the planet are 'obsolete' and… the earth will be choked with the more primitive forerunners unless a way is found to eliminate them…Clarity of discussion…would be greatly aided if genocide were reserved for a literal killing off of all living members of a people…and genthanasia for what has been above called 'phasing out,' in which a moribund culture is ended, by educational and birth control measures,"*(Cattell, 1972). Cattell was writing just 30 years after the Holocaust.

Intellectuals such as the socialist Webbs, Havelock Ellis and George Bernard Shaw, as well as the Black shirts of Oswald Moseley were all eugenicist. Notions of unbounded 'spectrum disorders' and 'family histories' of madness can be positioned alongside the eugenic thrust of the first half of the last century. 'Risk' of inheritance of certain so called disorders is now a standard assumption in psychiatry and underlies UK protocols for tests and scans of potentially Down's Syndrome foetuses carried out in ante-natal clinics. In combination with the idea of a disorder spectrum and the desirability of 'health' (for the purposes here defined as a comfortable life and the absence of debilitating illness), screening foetuses is equivalent to screening children and, where deemed necessary, inscribing[1] then prescribing to those children (Newnes, 2016).

Although Terman developed the Terman-Merrill Index (an early measure of IQ), as a means of offering specific schooling to *"less educable"* children, he was less sanguine in his approach to race: *"Dullness seems to be racial – psychologists and their IQ tests are the beacon light of the eugenics movement."*(Murchison, 1930). Tasked with selecting suitable military entrants, the psychologist Brigham had this to say, *"Our data indicate clearly the intellectual superiority of the Nordic race group."* (Brigham, 1923). Fears of 'degeneration' of the gene pool led, in the US, to forced sterilization of thousands of - frequently poorly educated - African Americans who scored poorly on the Binet-Simon tests of intelligence. As recently as the 1970s, black people were argued as intellectually inferior to white people by scientists in the USA, such as William Shockley (Shockley 1971)[2].

And...

In the UK, the profession of clinical psychology has accepted mostly white applicants for training despite many applicants from diverse cultures. One survey a decade ago, found the

1 'The act of writing upon.' See; Newnes (2016) for a detailed explanation of this term as it applies to psychiatric diagnosis.

2 In 1978, my friend Audrey Campbell, a woman with no less than three doctorates and immense personal authority, finally had enough of living in New Orleans when told by a white woman to sit at the back of a Greyhound bus.

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acceptance rate for (overwhelmingly white) women to be 85 per cent of applicants, (Turpin and Coleman, 2010). The profession, unlike medicine and veterinary science, has consistently failed to change its ethnic profile. Strategies to increase diversity have been put forward since at least 1989 (see; Davenhill, et al.,1989 and Bender and Richardson, 1990). Since 1998, courses have made some alterations to selection criteria in an attempt to increase diversity while developing teaching materials to 'raise awareness' of cultural diversity (Patel et al, 2000). In 2000, the Division of Clinical Psychology (DCP) formed a Special Interest Group in Race and Culture Issues as part of this process.

A comparison may be made with the state of the discipline in the US. Graduate programmes in psychology were originally closed to women and members of ethnic minority groups. Between 1879 and 1920, 10,000 doctorates were awarded in psychology; eleven of these went to Black students. In the following half century (to 1966), of 3,767 doctorates awarded, eight went to African Americans (Albee, 1969). Subsequent to the formation of The Association of Black Psychologists (ABPsi) in 1968 and associations for Hispanic, American Indian and Asian American psychologists, the American Psychological Association (APA) created a Board of Ethnic Minority Affairs in 1980. By 1986, there was a Division-Society for the Psychological Study of Ethnic Minority Issues. Numbers of Black and minority ethnic psychologists increased. The impact of the Historically Black Colleges and Universities (HBCU), (which in times of segregation accepted and trained black students) should not be underestimated. These HBCU not only provided institutions primed for later generations of Black students to attend, but often had Black lecturers and courses set up to meet their needs.

In 1986, there were 16,519 clinical psychologists with PhDs in the US; 505 were Hispanics, American Indians and African Americans, (a total of 3 per cent). For the African Americans involved (159), this was, however, a 20-fold increase over the previous 60 years (Heckler, 1986). Three years later, the proportion of Black and minority ethnic students being awarded PhDs in clinical psychology had risen to 10 per cent of the total. This may reflect changes in access for education amongst Black and minority communities, policy changes on the part of the APA (Mays and Albee, 1992), and the work of associations such as the ABPsi.

In the UK, DCP-sponsored strategies to increase the proportion of trainees from Black and 'minority' ethnic backgrounds have borne little fruit. Following the initial report in 1989 cited above, there were regular surveys and projects (see, for example, Bender and Richardson, 1990; British Psychological Society, 2004; Turpin and Fensom, 2004). Ten years ago, Turpin and Coleman (2010) concluded that in relation to psychology and diversity, '*… the road to hell was paved with good intentions.*' A British Psychological Society (BPS) 'action plan' was drawn up, but not monitored. A further BPS Professional Practice Board action plan was not implemented. In fact, it was superseded by the Equalities Policy of the BPS. There was also a 'diffusion of responsibility' (Turpin and Coleman, op. cit) across three DCP subgroups (the Group of Trainers, the Special Interest Group in Race and Culture and the Managers' Faculty).

Clinical Psychology and Diversity: Progress and Continuing Challenges reveals that

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in the 10 years 1994–2004, the average acceptance rate for applicants to training from 'non-white' backgrounds was 6.2 per cent. The last four years of the time period reviewed saw an average acceptance rate of 8 per cent. Between 2004 and 2009, this figure increased to 9.6 per cent, a rise the authors describe as, 'extremely disappointing'. (Turpin and Coleman, op cit). Based on an analysis of Clearing House Data applications for clinical psychology training places, those identifying as white British are twice as likely to be accepted as those from Black and Minority Ethnic backgrounds, and three times as likely as those identifying as Black (Murphy, 2019).

It is tempting to analyse the lack of substantive change in the area of diversity in terms of the usual suspects; institutionalised racism, a changing political and governmental context which leaves all but the most administratively well-resourced professions unable to respond quickly enough to policy change at national level; the amount of BPS work taken on by a relatively small number of members who mostly have full-time (academic) employment; and the slowness of large bureaucracies enmeshed in other large bureaucracies. It is equally possible to suggest that the goal of achieving a supposedly 'more representative workforce' is misguided; the historical Eurocentricity of clinical psychology theory and praxis (a concern repeatedly raised by groups such as the DCP Special Interest Group in Race and Culture), creates too great a challenge if attempting to make such praxis 'fit' a more diverse population. Perhaps, as Mays and Albee have commented when discussing psychotherapy, clinical psychology is something for white middle-class professionals to be delivered by white middle-class professionals[3]. Whether or not the reader concurs with such a position, the lack of change since 1989 would suggest that the profession has been unable to achieve its stated goals, though reiterating those goals is now part of professional praxis. The profession is faced with a paradox. Wedded to a philosophy of individualism, yet expecting that theories, research and psychological therapies can be generalised, it might conclude, pace Sartre, that *'Hell is other people'* because everyone is different. It is a position the profession resists.

3 Mays and Albee note that ethnic minorities, whatever their characterological, community and creative strengths are more likely to be poor, live in substandard housing, suffer educational disadvantages and other examples of discrimination. At the same time, they are more likely to suffer a wide range of physical health problems from increased tooth decay to cirrhosis. Citing, amongst others, Flaskerud, they suggest that members of ethnic minorities more often seek help from traditional healers, root doctors, clergy, herbalists and family and friends. By contrast, there are more psychotherapists per capita in Washington DC than anywhere else in the world – the majority from the white area of Northwest Washington. Mays, V. M. and Albee, G. W. (1992). Psychotherapy and ethnic minorities. In D. K. Freedheim (Ed.), *History of Psychotherapy: A century of change*. Washington, DC: American Psychological Association, pp. 553–559; Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, 22 (2), pp.127–141.

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But...

The search for multi-culturalism in psychology is hardly new. Pittu Laungani (1936-2007), for example, caused something of a stir in the field of cross-cultural counselling and psychotherapy. He saw client-centred counselling (a reflective western approach), as unsuited to those from India, who would favour a more directive approach to therapy, with guidance and advice (a position reflected in the Indian Psychological Society's statement of purpose; see, Newnes, 2018). For Pittu, the western approach to psychotherapy tended to operate on a horizontal model and assumed equality, whereas an Indian model would be vertical, with the therapist as the guru or guide. He suggested an East/West counselling bridge resting on eight pillars or dimensions, four western and four eastern - individualism and communalism; cognition and emotionality; free will and determinism; materialism and spiritualism.

A recent special issue of Clinical Psychology Forum (2019) places racism under the gaze as do articles by McInnis (2017), Ackah (2020) and Bellesi et al. (2020). To know about the racist roots of psychology, both in its institutions and praxis may, however, be a purely academic exercise when studying or working in contexts that privilege white, heterosexist theories and practice. Undergraduate psychology teaching remains wedded to individualism and theories of internality rather than community. Post-graduate clinical psychology teaching may well emphasize context or human rights (see, for example the Liverpool and East London (UEL) programmes), but a question remains whether thousands of years of cultural meaning should become an add-on to modernist psy, or replace it.

Clinical psychologists offering services to people with different cultural and ethnic backgrounds to themselves are almost forced to rely on theories and methods incompatible to the position of the other. For practitioners from, for example, an observant Jewish background, leaving work before sunset on a Friday in winter may be easily accommodated. Would that same practitioner have been exposed to the Jewish roots of Western psychological theory and practice (Newnes, op cit) in their training? Do trainee Clinical Psychologists get exposed to African origins of psychology (see, for example, James, 1954/2013; Hilliard, 1995) in a useful and informed manner? Do lecturers bring a cross-cultural critique to bear when presenting material on, say, Dialectical Behaviour Therapy or the inscription of autism? Again, as an academic exercise, these ideas are not so difficult.

Judy Ryde (2020) suggests that the first step for the discipline is apology. In the case of UK psy, that apology could mirror that of the Australian Psychological Society made to Aboriginal and Torres Strait Islander people, acknowledging psychology's role in contributing to the erosion of culture and to their mistreatment[4].

Acknowledging white privilege would require more than a critique of and apology for psychology's racist past and contemporary role in oppression. A structural change (at least

4 https://www.psychology.org.au/About-Us/who-we-are/reconciliation-and-the-APS/APS-apology and see; Carey et al, 2017.

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in the UK), might involve changes to the current committee structures of the DCP. This has the advantage of being in the control of the Discipline, although the process would, no doubt, be beset by contextual obstacles. For example, there are no BME, White, or religious faculties. Instead, the faculties focus on identified (or inscribed) populations - Older People, Eating Disorders, Addictions and so on. These divisions reflect arbitrary service groupings rather than acknowledging (and celebrating) inter-sectionality.

In pursuing a more culture sensitive path, however, clinical psychology runs the risk of being overtaken by a potentially lethal degree of soul-searching and, as an individualistic endeavour, bound to fail.

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Holding Up the Mirror: Deconstructing Whiteness in Clinical Psychology

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Sanah Ahsan is a liberation and community psychologist. Her work centres on compassion, decolonising understandings of 'mental health' and embracing each other's madness.

ABSTRACT: 88% of UK Clinical Psychologists are White (BPS, 2015). This study explores how nine white, middle-class female psychologists in London understand whiteness in clinical psychology.

KEY WORDS: Whiteness, class, PoGM, complicity

> *"For the master's tools will never dismantle the master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change."* – Audre Lorde (1984)

I begin this paper by asking the reader to join my attempt to "dismantle the master's house" of Clinical Psychology with a critical use of the "master's tools". I hope the reader can maintain a curious approach to the psychological theories and academic references used, recognising that these resources have a recursive relationship with whiteness. I also wish to clarify the terms 'whiteness' and 'people of the global majority' (PoGM).

Whiteness is the systemic rules, norms and discourses that produce (and reproduce) the dominance of those socially racialised as white (DiAngelo, 2018). Whiteness is often invisible to its benefactors yet remains an oppressive reality to PoGM. Nevertheless, systemic whiteness is not synonymous with white people (who are not a homogeneous group), and PoGM are also capable of reinforcing whiteness. I use the term PoGM instead of 'people of colour' because the latter term centres whiteness as default (Lim, 2020).

The experience of whiteness

In 2020, the myth of a post-racial Britain has been desecrated by racially traumatising global events. Institutions are forced to reckon with the extent of their racism, and the harm it causes, and British Clinical Psychology (CP) is not exempt. CP has long been criticised for

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being 'white psychology for white folk'; for pathologizing PoGM; for its complicity in the Islamophobic 'Prevent' scheme and for being overtly and covertly racist (Wood & Patel, 2017). CP sits within mental health (MH) services where PoGM are more likely to be diagnosed with schizophrenia, sectioned, treated as inpatients, restrained by staff, given high doses of medication, and less likely to receive psychological therapies in comparison to their white counterparts (Fernando, 2017). Nevertheless, the impact of CP's whiteness is not limited to service recipients. In 2019, the discipline was criticised for racism after an enactment of a slave auction at a Group of Trainers in Clinical Psychology conference, and for its insufficient response to the effects on black trainees (Busby, 2019).

According to latest British Psychological Society (BPS) demographics, 88% of psychologists are white and 80% are female (BPS, 2015), a demographic which has shaped the profession since the 1970s (Goodbody & Burns, 2010). Given the entry salary is £30,764 (BPS, 2015), a degree in psychology is a mandatory requirement and a 'class-ceiling' in university access exists (Friedman & Laurison, 2019), CP can be described as a middle-class profession. Holding up the mirror to the majority identity (white middle-class female psychologists: WMFPs), to investigate their relationship to whiteness, is imperative.

Why are there still so many white psychologists?

White British applicants have a 1 in 5 chance of being shortlisted for interview for CP, compared to 1 in 13 for PoGM applicants (Clearing House, 2017). Systemic barriers such as unpaid assistant psychologist posts, a lack of belonging in elitist education, and institutional racism are explanatory factors. The pathway into the profession is underpinned by meritocratic assumptions; yet, rather than individual capability - time, financial privileges and support networks are often rewarded (Wood & Patel, 2017). 'Widening access' initiatives aiming to 'increase diversity and representation' (Turpin & Fensom, 2004) assume that the presence of PoGM trainees will neutralise systemic whiteness within the profession. Yet, despite these initiatives existing for over three decades, PoGM psychologists remain consistently underrepresented (Tong et al., 2019).

How does whiteness shape the 'evidence-base' and therapeutic approaches?

CP presents itself as an objective 'science,' regardless of its history rooted in colonialism, eugenics and empiricism (Patel, 2003). This 'science' is shaped by an 'evidence-base' disproportionately representing WEIRD (Western, Educated, Industrialized, Rich, Democratic; Henrich et al., 2010) populations, who constitute 5% of the global population (Arnett, 2016). This research is often presented as scientific and value-neutral, and informs courses and training resources commonly delivered by white lecturers. WEIRD research informs NICE guidelines which recommend psychological therapies for clinical practice. Therefore, Eurocentric, psychocentric models of distress grounded in individualism (e.g. Cognitive Behavioural Therapy), dominate the profession (Rimke, 2016), obscuring systemic, racial and political trauma as explanations

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of distress. Locating distress within individual psyches places responsibility for recovery solely on individuals and individual coping mechanisms (Afuape, 2016). Psychological approaches centring systemic oppression in understanding distress, which emphasise collective healing (e.g. liberation psychology; Afuape & Hughes, 2015) are not mandatory to UK training courses, whereas CBT is.

The concept of therapist neutrality may offer a 'professional' justification for silence rather than engagement in social-justice informed practice. How psychologists use their formulations holds great power. It is unlikely psychologists would suggest a woman with a history of sexual abuse participate in a therapeutic space with nine men. Contrastingly, PoGMs with racial trauma are placed into white-dominated spaces (Griffiths, 2020). When people can no longer tolerate therapy, their departure maybe 'formulated' by the therapist through a Cognitive Analytic lens of 'reciprocal roles' (e.g. abandoned becomes abandoner), instead of acknowledging racism. Racial trauma is commonly pathologised (Fernando, 2017). As Menakem (2017) describes: *"Trauma decontextualized in a person looks like personality. Trauma decontextualized in a family looks like family traits. Trauma in a people looks like culture."*

Study Rationale

Lipsitz (2006) states that attention must be focussed not only on those harmed by systemic processes, but also toward the majority who benefit from the resulting inequities and whose identities are often deemed invisible: a shift from the position of researcher to researched. It is therefore imperative to understand the viewpoint of the dominant group in CP. To date, there is no UK research explicitly exploring experiences of whiteness from the professional majority group perspective.

Methodology

Nine participants (self-identified WMFPs), were recruited using opportunity sampling from responses to an advertisement in the BPS Psychologist magazine. Inclusion criteria required training in the UK and current or previous employment in London NHS Trusts. The focus on London was due to its racially diverse population, somewhat reflected in MH services (Turpin & Coleman, 2010). Face-to-face semi-structured interviews were conducted (range: 58 - 88 minutes) in 2019, focussing on participants' understandings of whiteness, how it operated in therapy, as well as in the wider profession.

Verbatim transcripts were analysed using Interpretative Phenomenological Analysis (IPA), following Smith, Flowers & Larkin's (2009) recommended process. Grounded in phenomenology, this approach offers an 'insider perspective' of a systemic process. Through line-by-line coding and commentary, analysis moved from descriptive to interpretative, identifying patterns and distinguishing between emergent and superordinate themes. Additionally, IPA's double hermeneutic approach enables a consideration of one's own difference and interpretational lens as a PoGM researcher on the outcome of analysis. However,

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to reduce researcher bias and ensure consistency across findings, themes and collated data, a WMFP academic supervisor linked to the research was involved in naming and identification of themes.

Themes

Three interrelating superordinate themes emerged from interview data: 'the white profession', 'therapy is a white idea based on white peoples' experiences' and 'we don't see ourselves as white.' All three theme titles are direct participant quotations. Table 1 below illustrates the themes and uses example quotes with anonymised identifiers to illustrate participants' personal relationship to whiteness and experience of whiteness in the profession and in therapy.

Table 1: Superordinate Themes, Emergent Subthemes and Quotes (continued overleaf)

Superordinate Theme	Emergent Subtheme	Direct Quotation
The White Profession	This white bubble	*"I really want the profession to be more diverse, but I don't want it to happen at the expense of really good potential white psychologists."* - Becky *"It is a profession created by white people..there's a power to create what a clinical psychologist looks like"* - Jane
	It's not to do with individual merit	*"Almost exclusively the people who applied for our voluntary assistant post were white middle class women. It struck me that they were in a position where they could"* - Julie *I applied five years and faced kind of, a lot of rejection. It's not what they're looking for. My friend of colour got on the first year, when no one else got in. She joked at her own expense, about it being the fact that she was black"* - Becky

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Superordinate Theme	**Emergent Subtheme**	**Direct Quotation**
Therapy is a white idea	You're not gonna get this cos your white	*"I have a young person in front of me who has black skin, explaining to me why she doesn't want dark skin. I can see her choosing words carefully and feeling like she needs to explain it, that although I'm not really gonna understand, they almost have to be apologetic that it's their fault that they could bring something outside of my range of experience.There's an inadequacy, like I wish I could be black right now and give you a different experience"* - Sophie
	White middle class families end up getting more	*"White, middle-class are not going to be the kind of families who'd ever end up being referred to social care… there is a sense of knowing how to use your power and an understanding of how the system works."* - Amy
We dont see ourselves as white	Not wanting to identify with it	*"We don't see ourselves as white, do we really? I don't think we're forced to look in the mirror. It is never really pointed out to you.Whereas if you are black or brown, your experience is- you are reminded of it"* - Abi *"I think I feel quite bad. And then probably like it stops me from really getting into conversation like I probably think there is that resistance if I am honest."* - Jo
	I'm often treading on eggshells	*"I find it hard to talk about these things. I find it anxiety-provoking"* - Julie *"I have been conscious of not wanting to say something that is discriminatory"* - Anne
	I am committed to keep on thinking about this stuff	*"We shy away from power and the responsibility that comes with that.We have the knowledge to stick heads above the parapet for some things, but not this.We need to do more."* - Hannah

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Exploring the Themes

How do WBMF clinical psychologists understand whiteness?

Participants' sense-making of whiteness focussed on both a racialised, individual level of being white, as well as wider understandings of structural whiteness. Participants had rarely 'been forced to look in the mirror' (e.g. Abi), and reflect upon being racialised as white, as captured by the superordinate theme 'we don't see ourselves as white.'

Conflict arose for participants in the subtheme 'not wanting to identify with it', resulting in emotional manoeuvres in response to whiteness which may be understood as white guilt (Rasmussen & Garran, 2019). A psychoanalytic framework suggests anxiety about owning one's own part in negative social processes triggers unconscious defensive reactions (e.g., denial, splitting). Acknowledging one's privileges requires confronting the de-idealized self: split off parts of the self previously projected onto the 'other' become relocated inside oneself (Segal, 1977). Unconscious defensive reactions against these processes create self-imposed limits to engaging with one's white embodiment and, as participants experienced, can result in fearful paralytic silence(e.g. *"It stops me from getting into conversation"* - Jo), rather than justice (Kinouani, 2020).

Participants identified supervision and therapy (and the interview itself), as spaces that help raise unconscious behaviour into consciousness. Pendry (2012) highlights the importance of the client-psychologist-supervisor triad in working with whiteness, and the supervisor's ethical responsibility in prioritising this.

The statement, 'I am committed to keep thinking about this stuff,' highlights participants' awareness that professional power comes with the responsibility of anti-racist work. An awareness of 'difference' without challenging individual and structural whiteness is mere 'verbalism' (Afuape, 2016), reflected in participants' simultaneous awareness and complicity (e.g. *"We shy away from the power and responsibility"* - Hannah). For psychologists cultivating social justice-informed practice, an interactive relationship between action, willingness and awareness is vital.

How do WBMF clinical psychologists understand how whiteness might influence therapy?

The subtheme, 'I'm often treading on eggshells' demonstrates participants' fear when addressing whiteness with clients, often couched in an unwillingness to compromise neutrality, make assumptions or make things worse (e.g. *"…not wanting to say something that is discriminatory"* - Anne). Several participants understood being white as a barrier to therapeutic work, underpinned by assumptions that the client had negative perceptions of this. For some participants, black therapists were idealised as being more competent in racial matters (e.g. *"…I wish I could be black right now and give you a different experience"* - Sophie). Perhaps both good and bad projections are made onto black psychologists to alleviate intrapsychic tensions and the responsibilities WMFPs carry when working with the complexities of race-relations in

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therapy. Participants' varied references to blackness in particular may align with reports of anti-blackness within the profession (Paulraj, 2016).

'Therapy is a white idea' showed participants' awareness of therapy propagating psychocentrism (Rimke, 2016) and erasing indigenous healing knowledge, whilst being complicit with the political notion that social problems can be treated through individual behaviour change (Afuape, 2016).

The subtheme 'white middle-class families end up getting more' reflects the perceived racialised, class-defined identities of clients as influential to clinical outcomes, particularly in risk assessment and referral. This aligns with literature reporting the unconscious primitivisation of black service users in particular, manifested by greater sectioning, restraint, entry through the criminal justice system and over-medicating (Kilomba, 2008). White professionals assessing risk may see more of themselves reflected in white clients (Lowe, 2018), perceiving less risk in the familiar. Psychodynamic manifestations of both love and hatred for the self are, however, complex; participants' frustration at the privileged expressions from white people may be understood as a projection of the unwanted parts of the self.

Finally, the subtheme 'you're not gonna understand this because you're white' encourages reflection on the reported benefits (e.g., diversity of cultural knowledge), of having greater representation in the profession (Gibbs et al., 2019). Individuals with strong racial preferences reportedly benefit from being ethnically matched with a psychologist (Cabral & Smith, 2011). However, with evidence of PoGM trainees 'losing themselves' to fit into the landscape of whiteness, entrenched structural whiteness in the profession may be more influential than the number of PoGM bodies physically present (Martinot, 2010).

How do WBMF clinical psychologists understand the influence of whiteness on the profession?

The theme 'the white profession' highlighted participants' awareness of structural whiteness in the profession, as well as the dominance of white bodies (e.g. psychology teams, clinical training, assistant posts). Some participants understood this lack of diversity to be un-representative of client perspectives, whereas others found comfort amongst white professionals viewing diversification as a potential threat (e.g. *"I don't want this [diversification] to happen at the expense of white psychologists"* - Becky). Dalal's (1993) group psychoanalytic ideas suggest safety is strengthened in the white in-group via the unconscious processes of marginalising the out-group.

The subtheme 'this white bubble' highlights participant awareness of structural processes upholding the status quo, including gatekeepers (e.g. white interviewers, white lecturers) and dissemination of ideologies of the dominant group such as through white resources and knowledge (e.g. *"It's a profession created by white people"* - Jane). White psychologists' unconscious investment in this status quo may mean they identify themselves as positive and legitimate knowledge sources, colonising the subjective consciousness of PoGM as negative

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(Fanon, 1963). From a Kleinian perspective, a depressive stance recognises that PoGM may be (un)consciously both desired and feared; therefore, fear of, and desire for, diversification in the profession perhaps co-exist.

The subtheme 'it's not to do with individual merit' demonstrated that most participants understand pathways to the profession afford access to an elite group of socio-economically privileged, often white, communities. Yet, some participants understood that being white is a disadvantage in accessing the profession, believing that specifically black applicants benefit from the need for diversification acknowledged by the BPS (Turpin & Fensom, 2004). This is perhaps another participant reference to anti-blackness, and can be described as 'white victimisation': a psychological defence against the unconscious realities of white privilege (Lipsitz, 2006).

Implications

Structural shifts must be led by the professional organisations and universities to address the issues discussed. Academic and clinical recruitment practices must prioritise PoGM representation across lecturers and staff, as well as white psychologists working to relinquish power and offer PoGM leadership and voice. Access to the profession could be improved by valuing lived over clinical/academic experiences in short-listing; mandatory PoGM interview panel representation and interview questions exploring experiences of oppression and how these might inform psychological practice. Anti-racist teaching (e.g., white psychologists holding spaces to dismantle whiteness together) must be threaded through training, rather than tacked onto UK training courses. PoGM must have the power to consume, construct and produce their own knowledge during training and post-qualification. Therefore, diversification of the curriculum (e.g. mandatory reading by PoGM authors) and inclusion of liberation and indigenous psychological approaches in training is crucial. Furthermore, legitimising non-academic knowledge through PoGM music, poetry and arts may facilitate further deconstruction of whiteness.

On an individual level, psychologists must move past processes of complicity, intellectualisation, avoidance, denial or silent paralysis and centre their discomfort. A key question for psychologists is: how can discomfort (in self-confrontation) be normalised rather than avoided or enacted? The analytical space of reflection and intellectual debate may be more familiar than the embodied experience of confronting whiteness, as somewhat reflected in participants' intellectual responses. Part of the psychologist's anti-racist work is becoming embodied: staying with the tightening throat and chest, recognising that this is a healthy place to return to meet an opening for change.

Limitations

There are several limitations to the sampling in this study. Focusing on white identity risks emphasising that which is already centred, and risks centring the individualised psychology of

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racist identities rather than systemic processes. However, it successfully addresses criticisms of critical race theory for ignoring the lack of individual agency in systemic processes. Recruitment methods may have attracted psychologists already engaged in thinking about whiteness. Although including White-British participants was necessary to ensure a representative sample of the dominant group in the profession, experiences of being 'white other,' 'white-passing' or working class have their own complex differences, which were beyond the focus of this research (Bueno-Hansen & Montes, 2019). Additionally, the relationship between whiteness and differing racialised groups is only touched upon in the data analysis and requires further research, especially given that black people are the most disadvantaged by systemic whiteness (e.g. Tangel et al., 2019).

There are challenges to taking a critical approach to phenomenological data. Furthermore, it is difficult to predict what my race, professional position and gender meant to participants. My racial difference may have evoked greater self-awareness and sensitivity for participants, however, the honesty in responses suggests otherwise. Through regular supervision with a WMFP supervisor and keeping a diary throughout the research process, I managed my emotional responses to the research as encouraged by IPA's critical realist position.

The spectrum of racism

Menakem (2017) describes all people racialised as white as existing on a spectrum of racism from devout to complicit. The nine participants in this study were aware of the operation of whiteness in the profession, yet remained complicit. Participant responses indicate that the question CP needs to be asking itself is not *if* racism is taking place in the profession, but *how* is it taking place? The discussion above draws on psychological theories to help critically examine behaviours attached to whiteness, and highlights some of the processes through which harm can occur.

As Eula Biss (2020) states, *"You might be stuck on this team, but you don't have to play by its rules."* WMFP committed to dismantling the 'rules' of structural whiteness must actively engage with their own and each other's embodied discomfort and resist defensive manoeuvres (e.g., intellectualisation). The stakes are too high for PoGM and individual practitioners to rely on voluntary engagement in deconstructing whiteness. Structural changes must be driven by professional bodies including the BPS to show that anti-racist praxis is a core competency for psychologists, rather than an intellectualised debate or an optional 'reflective' exercise.

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I Refuse to Choose: Culture, Trans-Culturalism and Therapy

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Sim Roy-Chowdhury is a clinical psychologist and systemic psychotherapist and until recently has been a Clinical Director at East London Foundation Trust. He is interested in the creation of versions of psychology and psychotherapy practice that are located within the social, cultural and political contexts within which people live their lives.

ABSTRACT: In this exploration of culture and transculturalism theoretical accounts are offered which are able to capture the complexity of the experience of migration. These accounts are considered within the context of a psychological therapy

KEY WORDS: Trans-culturalism, languaging, culture, psychotherapy

An exploration of the meaning of culture and the promotion of an approach to psychotherapy that is sensitive to cultural difference is an act of subversion in the UK in 2020. The Brexit vote has brought to the surface xenophobia and racism in Britain. Indeed, far-right nationalism is on the rise in Europe, the US, India and around the world. My interest in trans-culturalism, a propensity to locate oneself within more than one culture, across cultures, is a riposte to this far-right worldview.

Psychology and psychotherapy are situated within these nationalistic discourses and the profession of clinical psychology has had its own struggles to move its theoretical base and practice away from a Euro-American hegemony imposed upon people irrespective of their cultural referents. Writers including myself (Roy-Chowdhury, 2013), have argued that a change in practice amongst therapists must be accompanied by structural and systemic changes in the delivery and organisation of psychological therapy services, placing these services outside traditional settings, where 'therapy' is constructed and provided alongside, in partnership with members of local communities. Evidence of a pressing need for changes in theory, practice and structure is provided by a MIND survey (MIND, 2013) of users of Improving Access to Psychological Therapies (IAPT) services that found as few as 10% of people who identified themselves as coming from an ethnic minority background felt that their therapist had demonstrated an adequate level of cultural sensitivity. In contrast, 75% of therapists believed their own practice to be culturally sensitive. Consequently, Khan (2020) argues that for 'people of colour,' psychological therapies are not fit for purpose.

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This then, is a paper about culture, trans-culturalism and therapy across cultures. It is also an exploration of the meaning of culture, particularly where an individual locates herself within more than one culture. For two such people working within a therapy context, how can we make sense of the numerous cultural influences evoked? In much of my work and writing, I emphasise the complex interplay of influences upon each individual subjectivity and encourage resistance against explanations that fix the individual within homogenising, reductive accounts. This is, no doubt, one expression of my own internal experience of cultural diversity, of a refusal to choose between two cultural identities.

Culture: what it is and what it is not

> *"Culture is the collective programming of the human mind that distinguishes the members of one human group from those of another. Culture in this sense is a system of collectively-held values."* (World Federation for Mental Health (WFMH), 2007)

Within the terms of this definition, culture is a fixed, static set of characteristics attributable to a group of people who share a culture. Such a static, de-contextualised, definition allows for little movement for people within a cultural location, all of whom are seen to share a common view of the world. The definition cannot accommodate the experience of trans-culturalism, where individuals position themselves uniquely and idiosyncratically to more than one set of cultural referents. We can see the pervasive influence of cultural referents even in the definitional preferences that can come to dominate within that culture.

The WFMH definition posits that culture is 'programmed' into the individual mind, which draws our attention to the propensity for collectivist phenomena to be reinvented within the ambit of Western individualism. The Euro-American 21st century predilection for computer metaphors to describe the human condition is also in evidence. These essentialist definitions do not seem to me to capture the complexity of the phenomenon that we observe; they certainly do not allow me to construct an account that would capture my own trajectory through culture. My preference is for Krause's (1998) ethnographic representations of culture. She makes use of the work of the anthropologist Geertz (1993) in defining culture as:

> *'A web of meaning rather than a series of patterns of behaviour, and the anthropologist can study this web as she studies a collection of texts by straining 'to read over the shoulders of those to whom they properly belong … Societies like lives, contain their own interpretations'.* (Krause, 1998: 16, quoting Geertz, 1993: 452–53)

Hence, culture does not only make available to the individual a behavioural repertoire, but presents particular orientations toward behaviour, which provide contexts for understanding beliefs, motivations and emotions. An important aspect of the definition of

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culture that I am proposing is its interactional and contextually bound nature. Each individual is positioned uniquely in relation to the repertoires of meaning and behaviour available within a culture, and enacts this positioning in contextually-specific ways. Culture is made and remade within each interaction and within each social context. Laird (1998) puts it in this way:

> *"…culture is an individual and a social construction, a constantly evolving and changing set of meaning…it is always contextual, emergent, improvisational, transformational and political; above all it is a matter…of languaging, of discourse."* (p. 28–9)

The contextually-bound nature of cultural expression may seem to some readers as a somewhat abstract idea; let me see if I can explain it from my experience. I have been to Calcutta to visit my family accompanied by two partners (on separate occasions, of course), who are English and had previously not known me in an Indian context. Each of those two people have remarked upon the transformation of the person whom they had thought that they each knew rather well into someone other than that person. This is more than my use of the Bengali language, a mysterious and wholly subliminal use of Indian movements and gestures, but also a more profound way of being in the world. A perhaps trivial example is the huge delight that I would take in storytelling within my family. The smallest incident, which, within an English interactional context, would barely warrant a remark would be spun into the most elaborate of tales, a Joycian epic created from an encounter with a spider in the bathroom.

Doing culture in therapy

The task for this section is to take the theoretical issues, the ways of imagining culture described in the preceding section and to look at the implications of the application of different perspectives within the therapy context. In acknowledgement of my dual professional identities, as clinical psychologist and systemic psychotherapist, I will confine myself to therapy with families. This is not intended to be a guide to the right way of talking about culture in therapy. I am aided in my endeavour by an earlier co-written paper (Pakes and Roy-Chowdhury, 2007), which describes part of a qualitative research study. The aim of the study was to subject family therapy sessions to a discursive analysis in order to analyse the ways in which culture is evoked in therapy talk and the effects upon participants of these various ways of talking about therapy. One of our findings concerned the effects upon participants of the reification of culture. We found that:

> *"The discursive effects in the therapy of assumptions relating to a reified account of 'culture' are shown to constrain the conversation through the construction of artificial dichotomies and limited and troubled subject positions. These constraining discursive effects can be linked to reduced cultural*

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> *sensitivity…because the complexity of 'culture' and peoples' positions in relation to 'culture' cannot be fully taken into account."*(Pakes & Roy-Chowdhury, 2007: 281)

We discovered that where culture is talked into being as a homogenous set of beliefs held by those who belong to that culture, this closes down the therapeutic space for people to express their own complex and perhaps contradictory positioning in relation a variety of cultural influences, which are created differently within different ecological niches. A conversational reification of culture (for example, in relation to family communication, marital choice, career decisions), does not capture the trajectory of cultural transition. Rather, only a more limiting acceptance or rejection of cultural norms is available to participants, redolent of Derrida's (1978) logic of 'binary oppositions'. A view of culture as a homogeneous set of beliefs and practices is not at all uncommon, and indeed one might even identify this as the dominant Euro-American narrative.

As a psychotherapist, how then, might one avoid giving voice to this cultural narrative that culture can be conceptualised as something homogeneous and consistent, to which one either adheres or one does not in relatively unproblematic ways? Falicov (2005) points up the complexity of 'emotional transnationalism', where migrants feel the pull of the cultures, mediated often not by direct experience, but by inter-generational stories, and respond to these resonances in idiosyncratic ways. She draws upon a piece of qualitative research by Stone, et al., (2005) which examines family stories of American migrant families, to point up the sheer unpredictability of the process of acculturation. She suggests to the clinician that 'linear acculturation theories are becoming outdated' and that one should keep in mind that:

> *"In most families, continuity and change are happening side by side, in creative non linear ways. Some family members may adhere to certain customs, such as home remedies, but the same members, or others, may oppose the arranged marriages favoured in the culture…More than ever, we have to tell ourselves not to stereotype, but to ask about values and preferences with respectful curiosity."* (p. 403)

Krause (1998) suggests that the benefits to the therapist of learning more about the lives lived by others, through travel, friendships, art, literature, is not only that we may be better informed about the shape of other people's lives but also that we may learn more about what it is that we take for granted. Drawing upon the work Bourdieu (1990), she refers to this taken for granted assumptive base as 'doxic' material. This is the socially constructed basis upon which we take up our place in the world: it is how we think of our subjectivity, agency, the relationship between self and others, family patterns, hierarchies and inter-relationships. This material feels natural to us and hence we are only ever partially aware of its existence. However, open, meaningful contact with the lives that others lead allows us glimpses of this doxic material and helps us, as clinicians, to develop a greater awareness of the assumptions

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that we make.

A conclusion

The striking of a careful balance where culture is available as a construct that can open up, rather than close down, spaces for people in making sense of their lives may come to be seen as requiring enormous skill of the clinician. In my own work, I have sought to avoid this by drawing upon an approach to therapy that puts a concern with fostering a strong therapeutic relationship (Roy-Chowdhury,2015) and the taking of a non-expert position (Anderson and Goolishian, 1992), at the core of this endeavour. My conclusion rejoices in the simplicity of the interventions available to the psychotherapist in prompting the emergence of stories of culture. During my own lengthy psychotherapy, on occasion, following an account that I might give of an aspect of my life, my therapist would pause, reflect and enquire, 'I wonder if there might be a cultural dimension to this?' That would be all. I would be free to either take up this thought, or, as the suggestion was made with such humility, to reject it. I realize that I am at risk of idealising these therapeutic encounters but I do not recall a time that I felt this simple question to be an unhelpful remark.

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Indigenising the Curriculum in Australian Psychology

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ABSTRACT: 'Indigenising the Curriculum' aims to redress the under-representation of Indigenous people in the Australian staff and student university population, and Indigenous knowledge in the university curriculum. This reform has been occurring for around two decades and though progress has been slow, there is some optimism that these reforms could create an anti-racism platform upon which we might build socially progressive programs of teaching in psychology.

KEY WORDS: Indigenous, curriculum, cultural assumptions, apology

Indigenising the Curriculum (ItC) dates back to the 1990s. It centres on a recognition that colonisation has supplanted Indigenous knowledge systems with Eurocentric ones. Knowledge was stripped from the European colonies, loaded up with Western cultural assumptions designed to serve Western socio-economic and political interests and then returned to the colonies and used to reconfigure their social systems and institutions. In the early days, this process was blatant, fervent and unapologetic with the main cultural loading being Social Darwinism. Knowledge drawn initially from South America was taken to Britain, reconfigured to promote the Theory of Evolution and then exported back to the colonies in the form of Race Theory and Eugenics, which was used to explain why Indigenous people were inferior to their European colonisers. By the 1960s, a push back against this process took effect, largely due to the political activism of Indigenous people and a weakening of the Western political ability to maintain control over its colonies. This push back took time to impact teaching in higher education and when it did, it took its most consolidated form through the ItC project. Work on ItC is being undertaken most notably in Australia, Canada, India, New Zealand, the United States and throughout the continents of Africa and South America. ItC is most often presented as the means to make the educational environment more accessible for Indigenous people, more respectful of Indigenous knowledge and to improve the retention of Indigenous students. Australia lags other countries with the project only really taking hold around 2008

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and progress has been slow since then.

Indigenous people in Australia

On January 26 1788, the 'First Fleet' moored at Sydney Cove signalled the beginning of the British colonisation of Australia. At that time, the land was home to more than 230 Indigenous nations (Aboriginals and Torres Strait Islanders), who had lived with the land for more than 40,000 years. The British declared the land *'Terra Nullius'* (land of no one) - a legal term signifying that the inhabitants of the land had no legal claim of sovereignty. This declaration was met with resistance by the Indigenous nations which was suppressed with military force by the British. An estimated Indigenous population of between 300,000 and 1 million prior to colonisation was reduced to around 60,000 in the years following colonisation. Despite that violence, the Indigenous nations did not cede sovereignty.

The state-sponsored genocide during the early years of colonisation was soon accompanied by control through social policies that enforced ghettoization (Indigenous people were moved into missions and reserves); assimilation (Indigenous children were removed from their parents –the *Stolen Generation*); and welfarism (strict monitoring of social behaviours to ensure compliance with authorities). A broad level of institutionalised racism soon spread across the social, political and cultural domains through the embedding of paternalism and protectionism into white Australian culture. Today, paternalism and protectionism are the defining, seldom scrutinised, mainstream responses in Australia to Indigenous people – assumed by both the political left and right to be a morally appropriate response to the Indigenous 'problem'.

An example of this protectionism was the Northern Intervention National Emergency Response Act of 2007 (known as 'The Intervention') which imposed upon Indigenous communities in Australia's Northern Territory health checks, alcohol bans and increased police surveillance. Though the Act was repealed in 2012, many of those measures remain in place in 2020 under the 'Stronger Futures in the Northern Territory Act of 2012'. The measures taken under these Acts have had little to no positive impact upon Indigenous people in the Northern Territory and their main effect has been to signal the government's willingness to infringe on the basic human rights of Indigenous people. Paternalism and protectionism are positioned against earlier forms of colonial violence so as to pass as benevolent forms of power even though they are closely connected to that earlier form of violence. To be protected requires the protective intervention of the self-same forces that Indigenous people need protection from, and it maintains the identity of the protected as subjugated. The Catholic church had a particularly insidious role in violence undertaken in the name of protectionism, for which it eventually apologised in 1996.

The markers of the ongoing violence against Indigenous people can be found in the social and health statistics on Indigenous peoples that are now regularly reported under a Federally funded and administered 'Close the Gap' (CtG) strategy. That strategy was initiated

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in 2008 and its stated intention was to make improvements in Indigenous people's social and health outcomes by 2030. The inequalities it cited were shocking. Life expectancy for Indigenous people was on average 10 years less than non-Indigenous people with 45% of Indigenous men and 34% of Indigenous women dying before the age of 45 (Australian Bureau of Statistics, 2009). The 12th annual CtG report published in 2020 reported that there had been no progress since 2008 to close the life expectancy gap and that there had been a widening gap regarding infant mortality (Australian Bureau of Statistics, 2016). The ineffectiveness of CtG is serving the interests of those who wish to promote the notion that the problems experienced by Indigenous nations are immutable and due to characterological defects of Indigenous people. In fact, the failures of the CtG strategy are attributable to the inherent paternalism of the approach adopted (driven top-down with insufficient consultation with Indigenous communities). Considering how the Australian government has given the CtG strategy woefully inadequate funding, how it is poorly planned and poorly coordinated, it, along with 'Stronger Futures', resembles a protection racket.

Who is Indigenous?

Any discussion of the history of Indigenous people in Australia traverses the politically contentious area of 'people naming'. It is an area replete with diverse definitions that operate between various politico-legal jurisdictions and heated, unreconciled debates. This has resulted in international definitions remaining generic and imprecise.

Colonisation and loss of sovereign powers sit at the heart of how the term 'Indigenous' is deployed internationally. Groups that claim Indigeneity but are largely denied that claim are those in positions of legal and political sovereign power. So, a colonised group primarily has a legitimised claim for Indigeneity if that group orients itself to the colonising group and accepts an identity defined by defeat and victimhood. The terms 'First People' and 'First Nations' are available and taken up by many groups as preferred labels given they are not subjugating labels. Referring to First Nations in an Australian context has the effect of creating an identity that focuses on 40,000 years of lived culture rather than on 200 years of colonial occupation. But, the Indigenising the Curriculum project (ItC) cements the identity *Indigenous* into the debate.

Psychology's racist practices against Indigenous Australians

Psychology has a shameful history in relation to Indigenous nations. It is not alone in that regard (see Connell, 2016). Psychology and anthropology made up a distinctly malicious partnership when they embraced theories linked to scientific racism during the early years of colonisation. This was tied to the popularity in academic circles from the late 1800s onwards of Social Darwinism which theorised that human development was on a trajectory that began with the simplistic and evolved to the complex. Indigenous people were characterised as less evolved humans and as childlike. For example, the Indigenous Protection Boards set up in the

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late 1800s to 'look after' the welfare of Indigenous people referred to their role as acting in *loco parentis*.

Some of the early work of psychology in Australia was motivated by a scientific concern that the Indigenous population of Australia was dying out and that there was the risk that their extinction would occur before science had properly gained sufficient knowledge about them (Chase & Turner, 1973). By the 1920s and 1930s, that interest grew in intensity and scientists flocked to central Australia around the township of Alice Springs seeking out Indigenous communities. They congregated mostly on missions run by the Christian church and reserves set up by the government where they had a captive audience of Indigenous people to study.

Early psychometric testing of Indigenous people produced ambiguous results but was filtered to serve a particular agenda (Dudgen, Rickwood, Garvey & Ridley, 2010). The research pushed to the public by politicians and the media was that Indigenous people performed poorly in key areas of psychological functioning (Kearney, 1966). This reflected an appetite of the politicians and non-Indigenous society for a narrative that explained the disadvantage experienced by Indigenous people and became a means for the States and Federal government of Australia to maintain resistance against Indigenous nations' political claims over land sovereignty.

That early psychological work proved rich pickings for political manipulation because it took little or no account of social, political and historical context. The trauma experienced by Indigenous people of being displaced from their homelands, the forced removal of children from their families and the deteriorating conditions on reserves in which they were placed that was causing death through starvation, largely did not figure in the psychologists' analysis. For example, during the early years of the Stolen Generation the prominent anthropologist-psychoanalyst Géza Róheim stated that the anxieties displayed by children who were forcibly removed from their parents was an expression of the Oedipal complex. The legacy of psychoanalytic work on Indigenous people in Australia remains today in the way that its focus on 'dreaming' has become a cultural trope for how Indigenous peoples' cultures are represented to non-Indigenous people. But Stanner, the anthropologist who coined the term 'The Dreaming', made a further important observation about Australian culture. He coined the phrase 'the Great Australian Silence' (Stanner, 1968) to sum up how Australians had effectively erased their memory of the violence of colonisation.

That forgetting was very evident in the work of psychologists along with their political naivety and insensitivity. No anticipation was made or responsibility taken for how knowledge produced by psychologists could be appropriated for harmful, political purposes or that there was any reason to cite or in any way acknowledge in their empirical reports the state-sponsored violence that was impacting the very population they were studying. Psychology appeared little troubled by this up until 2016 when it made a formal apology to Australian Indigenous people about its shameful past.

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The APS, AIPA and the Australian Indigenous Psychology Education Project

In 2016, the Australian Psychological Society (APS) published its Apology on the APS website (APS, 2016). In its opening paragraph, it acknowledged the poor social situation of Indigenous Australians and buffered this with a statement that it was important for psychologists to tell the stories of 'strength and resilience' of Indigenous peoples. The Apology listed some of the ways psychology had been complicit in the marginalisation of Indigenous people and then listed the APS's new commitments to Indigenous Australians. Those commitments are more or less what constitutes the minimal standards for professional conduct specified in the APS Code of ethics published in 2007 (APS, 2007). The parsimonious nature of the APS commitments is troubling, but there is more that is troubling. The Apology's use of the term 'resilience' in no way pointed to how that concept might be understood from an Indigenous perspective - as an ecological, system-level, cosmologically centred concept (Kirmayer et al., 2011). Rather, it was left to hang with no critical interrogation to alert the reader to take care with it and to not assume the Western understanding of it (i.e., that it is an individual trait). This is worrisome because the Western version of 'resilience' has become a marker for the solution offered by psychology for social ills – a focus on inverse, depoliticised risk factors. It depoliticises social problems by inviting the question: 'what can individuals do to protect themselves from social harm?' The Apology also refers to Indigenous peoples and communities and not to Indigenous nations which side-lines Indigenous sovereignty issues (Riggs, 2013). And, the de-politicization of the harm being apologised for is further cemented in the final sentence of the Apology that cites the organisation's aspiration to improve Indigenous people's "social and emotional wellbeing" with no mention of the need for political change. Indeed, the word political or any derivative of it is entirely absent from the document. There is much else to be troubled by the Apology and I explore some of that some more below, but first I consider what sparked the Apology and then what followed it.

The APS turn towards atonement was largely sparked in 1988 (Dudgeon, Rickwood, Garvey & Gridley, 2010) - the Bicentennial of the invasion of Australia by the British. Despite the 24th International Congress of Psychology being hosted at a time of political heat where Indigenous issues were being discussed front and centre in Australian society, the only representation of Indigenous people at the congress was a section in a photographic exhibition called *'Indigenous Aspects of Australian Psychology,'* which consisted of a series of unapologetic photographs of Aboriginal skulls collected for scientific measurement. This was followed by an article published in the *Annual Review of Psychology* (Taft and Day, 1988) that offered a turgid portrayal of Indigenous people.

In 1993, the APS established a working party whose remit was to produce guidelines for psychologists working with Indigenous people which much later became an adjunct to the APS Code of Ethics. But, it wasn't until 2008 that the Australian Indigenous Psychologists Association (AIPA) formed in partnership with the APS and not until 2011 that the APS made a commitment to change through partnering with the AIPA to develop a Reconciliation

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Action Plan (RAP) (APS, 2012). Overall, the RAP was focused on working on areas of mutual interest and in bi-partnership with Indigenous people. There was no hint in the RAP of friction or potential conflict or any real sense that the project would capture any of the antagonism between Indigenous and non-Indigenous people that had characterised the politics of Australia for 200 years.

The developing role of the AIPA, the APS apology, and the RAP all led to the formation of the Australian Indigenous Psychology Education Project (AIPEP). The AIPEP was funded to develop frameworks, guidelines and strategies to introduce cultural responsiveness to the training of psychologist and to increase access to psychology training for Indigenous people. In 2016 the AIPEP published the *Curriculum Framework* document (AIPEP, 2016). In the 2019 Australian Psychology Accreditation Council (APAC) Accreditation Standards, it is stated that APAC had become a co-signatory to a Statement of Commitment in relation to advancing the work of AIPEP and AIPEP frameworks. Thus, the AIPEP framework document became the first formalised attempt taken by psychology in Australia to Indigenise the Curriculum.

The framework document holds some promise, particularly when it refers to the 'third space' approach advocated by Dudgeon and Fielder (2006). The 'third space' is that which sits between Indigenous and Western knowledge systems, or as a space between the colonised and the coloniser. It is a space defined as full of friction, conflict and tension and is seen, for that reason, as the space that creates opportunities for a transformation of knowledge and new ways of knowing to emerge. But, the overarching problem with the framework document is that the 'third space' appears an anomaly, as though it was something that leaked into the document but not something structurally integrated into it. Nowhere else in the document is there a recognition of the potential for disharmony and conflict. Nowhere else is there consideration that Indigenous and Western knowledge systems might sit fractiously together. But the slight muddying in the Framework document where there is some leakage that spoils such harmonic tones gives us an opportunity for teasing out factors that maintain psychology's political inertia regarding Indigenous issues.

Re-embedding a racist agenda into the Australian psychology curriculum

Australian psychology has an impoverished understanding of its own history, the problematic reconciliation framework it ascribes to, and the paternalist protectionism it exudes towards Indigenous people that embeds racist practices into the psychology curriculum.

History and forgetting

'The Great Australian Silence' is inscribed in psychology. Institutionalised forgetting is something psychology has a habit of doing - providing a reconstructed historical account that serves its own purpose (Fryer, 2008). Harris (1980) described psychology as using history for ceremonial use (self-celebration), rather than for critical reflection. The latter disrupts the idea that psychology fits the mode of a fully-fledged scientific profession. This

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might explain why scholarship in and critical teaching of the history of psychology has been in a precarious position within psychology (Chamberlain, 2010). A critical reading of the history of psychology reveals a sequence of internecine conflicts between various factions of the discipline. Rather than a linear progression of increasing canons of knowledge, we find circularity, contradiction and frequent self-inflicted implosions. We find a history pitted with a series of crises relating to its object of study, its method of analysis and whether psychology can be considered a 'proper' science. Further, a critical reading of its history reveals psychology is influenced heavily by political and cultural shifts in society to the point that it appears servile to economic and political interests, rather than to discovering empirically objective 'truths'. Particularly revealing is its attempts to supplant other disciplines, such as psychiatry, to gain power, prestige and resource - see, for example the scandal reported in the '*Hoffman Report*' (Hoffman et al., 2015). We find psychology keen to construct itself as a profession aligned to medicine and biology. As a political strategy, this would make perfect sense given the ongoing insecure funding position of the humanities in higher education – particularly in recent years with increasingly right-leaning governments in the US, UK and Australia which has resulted in waning support for the arts, social sciences and humanities (Brock, 2014). So, psychology steadfastly promotes its links to biomedicine. Because of this and the lack of lessons learnt from the past, psychology continues to operate as a vessel to route and support eugenic ideas into Australian politics.

Reconciliation and remembrance

Before non-Indigenous culture can begin to understand Indigenous culture, it needs to understand itself. The Australian historian Jim Berryman cites three key characteristics of Australian settler culture. These are: an acceptance of its British heritage; the adoption of a Judeo-Christian belief system; and an adherence to the rational principles of enlightenment. Berryman states these three themes are particularly pronounced in Australian centre-right politics and among conservative commentators (Berryman, 2015). This context helps us pry out important points of disruption between Australian psychology and Indigenous knowledge systems that pivot around conflicting ontological and theological systems (see Sampson, 2000 for an important discussion of these). Australian psychology, and more generally Western psychology, stands on the primacy of the individual, the singularity of reality and a reductionist method of enquiry. This ontology aligns closely with the doctrine of the Catholic church (the most dominant religious institution in Australia) with the belief in *one God* translating through secular institutions into the ontology of *one Truth*. This is not a conspiratorial theory of the church smuggling God into psychology, but more an appreciation of how religious doctrine becomes baked into a culture and those doctrines remain, even if only as a distant echo, in cultural and social institutions long after they have undergone a process of secularisation (Butterfield, 1961).

The subtlety of the transmission of religious dogma through disciplinary practices

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such as psychology, are often latent and require deep interrogation, though they also are readily surfaced in such things as the APS member group *Christianity and Psychology* which aims to 'Increase the dialogue between Psychology and Christianity in mutually beneficial ways' (https://groups.psychology.org.au/capig/). What is certain is that psychology exists as a body of theory and practice with a complex body of inherited assumptions and ideas (Butterfield, 1961) and if these are not surfaced in the ItC project, the project will falter. The differences between Australian psychology, grounded in a monotheist, objectivist, reductionist scientific paradigm, conflict starkly with Indigenous knowledge systems which are grounded in an animistic-polytheism, subjectivist, holistic paradigm. Under Indigenous knowledge systems, to look for simple objective truths is not only culturally alien but deemed to be ultimately futile (Fatnowna & Pickett, 2002). This conflict extends to the very process undertaken by the APS, AIPA and AIPEP in relation to Indigenous people. The 'reconciliation' project starts with an assumption that the 'truth' will heal and rebuild a shattered past and that truth is one that is absolutist, objective and universal rather than contested, negotiated and transformative. You have to be certain about what you are sorry for before you can say you are sorry. This sits at the very heart of the reconciliation project that is structuring how Australian psychology is embarking upon ItC. Historical truths must be constructed into a singular account that is anointed with 'objective truth' and then any wrong doings named in that account are cleansed through the act of confession. The theological undertones here are clear - confession cleansing the soul. It also renders Indigenous history through a Western lens, reinforcing the subjugated, powerless identity and victimhood of Indigenous people, the omnipotence of the all-conquering non-Indigenous people, and re-inscribing the trauma of the former through the act of redemption and remembrance for the latter. In this way, saying sorry hurts more than it 'heals'. We must consider the echoes of Christian dogma in the ItC project in psychology and ask if the project is one more instance of colonial brutishness towards Indigenous people.

Nakata (2004) has argued that the Indigenising the Curriculum is a project that is much more complex and contested than might appear from what we read in guideline documents that are coming out from various professions such as psychology. Nakata warns that any approach to the project that aims to simply put Indigenous knowledge "in the mix" runs the serious risk of becoming a project of assimilation (Hauser, Howlett and Matthews, 2009). It can quickly become an extension of the colonialist project as Indigenous knowledges are deposited into higher education repositories ripe for trawling by transnational corporations – such as has happened to Indigenous health remedies that have been trawled by pharmaceutical companies and turned into corporate profit (Connell, 2016).

It needs to be considered whether Australian psychology's redemptive approach to Indigenous issues might be dovetailing into the centre right political space in Australian culture and providing a point of least friction between Australia's conservative commentators and human rights activists. If it is, this is a dangerous compromised position to be adopting. It

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creates potent blind spots when the underlying ontological, theological and political positions are concealed. One might say that psychology has replaced the notion of *terra nullius* with the notion of *spiritus nullius* (a denial that there existed or exists a theist grounding to the mainstream activities of the profession of psychology or in the ambitions of ItC, and a denial of the deep routed theological disruptions ahead).

Though the ItC project in Australian psychology is at an early stage, there is much more room for pessimism than there should be. Primarily that is in relation to the social institution where the project is being implemented – higher education. With a corporatist and managerialist turn taken by the higher education sector in Australia, we are seeing increased: pressure for academics to use institutional templates to structure their learning activities; external benchmarking of courses and programs; growth of an auditing culture to such dominance that almost every aspect of the learning and teaching environment is subject to panopticon systems of surveillance and control; crude, popularist ranking systems to increase competition between and within universities; and, alignment of all teaching and learning practices and initiatives to corporate strategic plans. All of this is having the effect of narrowing the curriculum, not widening it (Connell, 2016), the opposite direction required for the ItC project to succeed.

The likelihood is that ItC will introduce Indigenous knowledge through quarantined and regulated spaces. If ItC is done right, we should anticipate strong resistance from both academics, administrators and managers within higher education as positions of privilege and power and systems of vested interest will be unearthed and will cause concern and upset (Howlett, Ferreira, Seini & Matthews, 2013). Paternalistic practices might be particularly difficult to shift, given they are often sealed in the rhetoric of benevolence and philanthropy. The ItC project demands profound transformations if it is to disentangle itself from its racist past. Presently, Indigenous knowledge in the Australian psychology curriculum is given a space to be seen but not heard.

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A Framework for Clinical Psychologists to Understand and Talk about Race

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ABSTRACT: This systematic review explores the concept of racial inconsistency as a framework for clinical psychologists in understanding and talking about race.

KEY WORDS: race, racism, clinical psychology, systematic review, racial inconsistency

Race has been defined as 'the notion of a distinct biological type of human being, usually based on skin colour or other physical characteristics' (p.182, Delgado, Jean, & Harris, 2017). From the early 18th century, this essentialist biological notion of race has been used to segregate, exploit and abuse Black and other ethnic minority individuals and establish White power and privilege (Olson, 2005). Prior to the 18th century, concepts of 'race' and 'racism' did not exist in their current form (Kendi, 2019), and although laws now exist against acts such as slavery and racial abuse, White privilege and racism persists to this day (Wood & Patel, 2017). In this paper, the researchers position themselves as understanding 'race' to be a social construct that does not exist objectively or biologically, however, they strongly believe that racism is still prevalent in society today. The terms 'race' and 'racism' are therefore used with this understanding in mind.

Race as a System of Power

'Whiteness' is a term used to describe the perceived superiority of White people in society (Butler, das Nair, & Thomas, 2010). This term refers to race as a system of power and encompasses three aspects: firstly, White majority group racial identity for those seen by society as fitting with the norm; secondly, racism and bias against those who are not seen as White; and thirdly, racial privilege in which White is the norm against which others are compared (Lyubansky, 2011).

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In recent decades, Whiteness and other race-related concepts have been understood as embedded social constructs with real-world consequences, as opposed to reflecting objective characteristics of an individual. Race is argued to be a *'product of social thought and relations [with] categories that society invents, manipulates, or retires when convenient'* (p.9, Delgado et al., 2017). Kendi (2019) defines race as *'a power construct of collected or merged difference that lives socially'* (p. 35). For example, in cases of violence committed by someone perceived to be White, the act is attributed to the individual; however, if the same act were to be committed by someone perceived to be Black, then it is attributed to some *'characteristics of "them" or "those people".'* (p.7, Jackson, 2015). This serves to maintain the positive image of being White and the lower status of those seen as Black (Jackson, 2015). The real-world consequences of this system are privilege and advantage for those who fit with the White norm and oppression and abuse towards those who do not (e.g. Delgado et al., 2017).

Racism in the UK

Incidents of racism in the day-to-day lives of people from disadvantaged racial groups are well documented. For example, Black people report that they have to *'work twice as hard to get half as far in life' as they are 'questioned, harassed…all for essentially "living while black"* (p.1, Anderson, 2018). Those from disadvantaged racial groups in the UK are more likely to encounter abuse, be wrongly convicted of shoplifting and be treated differently because of their appearance (Booth & Mohdin, 2018); racism is considered to be 'business as usual' for those oppressed and discriminated against (Benson & Lewis, 2019).

Kendi (2019) argues that racism occurs as a result of racist policy. He describes how this policy embeds the concept that it is people with specific characteristics (e.g. skin colour) that are the problem, leading to a vicious cycle of racist ideas: *'Racist ideas make people of colour think less of themselves, which makes them more vulnerable to racist ideas. Racist ideas make White people think more of themselves, which further attracts them to racist ideas'* (p. 6). This internalisation of racism is well documented (e.g. Ahmed, Aziz, Batchelor-Hunt, Shaheen, & Harker, 2018). For those who identify as Black, this may result in a sense of worthlessness and powerlessness. For those identifying as White, this may result in a sense of entitlement and privilege (Bivens, 2005).

Blank et al. (2004) discuss the disconnect in modern society in the way that racism is seemingly frowned upon, and yet racist policy still persists. They describe modern types of racism, such as indirect (e.g. blaming disadvantaged racial groups for their position in society) and ambiguous (e.g. favouring Whites who are in a position of power). Kendi (2019) describes the prevalence of those who pride themselves on rejecting the racist statements of others and yet are in denial of the ways in which they themselves are racist. He argues that *'denial is the heartbeat of racism'* (p.9, Kendi, 2019), as those who describe themselves as 'not racist' are allowing racial inequalities to persist through inaction; he asserts that one can only be racist or anti-racist (i.e. actively fighting racism).

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The terms 'post-racial' and 'colour-blind' have been used to describe a society that is free from racial inequality, however, these ideas have been strongly refuted (Hirsch, 2018; Ikuenobe, 2013). Colour-blind refers to a virtue in which skin colour is viewed as irrelevant in relation to the worth of a person (Jones, 2016). Post-racial refers to a society that no longer needs to discuss race as racism no longer exists (Ikuenobe, 2013). It has been argued that these terms only perpetuate the myth of racial equality, resulting in denial and inaction in response to persistent racist policy and abuse (The Runnymede Trust, 2016). The literature describes the undeniable prevalence of racism and the way in which society continues to be structured around race (e.g. Ikuenobe, 2013).

Race and Mental Health

It is well-established that higher rates of distress exist in disadvantaged racial groups as a result of persistent racism (e.g. Memon et al., 2016). Historically, individuals have been labelled with psychiatric diagnoses by psychologists and psychiatrists to justify oppression and reinforce the superiority of White people (Fanon, 1967). For example, the prevalence of certain diagnoses (such as psychosis), is recorded as abnormally high in disadvantaged racial groups and identical behaviours or experiences are recorded as more severe when seen in African Americans compared to those who are White (Kutchins & Kirk, 1999).

For those seeking support, there are race-related barriers in accessing mental health services. Recent research shows how individuals from disadvantaged racial groups face multiple barriers in accessing services as they experience insensitivity, racist abuse and a power imbalance between themselves and White clinicians (Memon et al., 2016). These barriers have persisted for many years despite government efforts to tackle this, for example with the 'Delivering Race Equality in Mental Health Care' action plan (Department of Health, 2005).

The behaviour of clinicians towards those individuals seeking support is informed by the racial category which they perceive the individual as 'belonging to'. Campbell (2012) describes how attributing a racial group to individuals is a way of ensuring our survival in a world based on racist power. He describes an ingrained desire to form relationships which enhance our own position in some way, and by default this results in a position of powerlessness for the 'other'. For example, a White clinical psychologist is likely to perpetuate patterns of racial power and privilege in the therapy room when working with individuals from disadvantaged racial groups. The individual may not feel that the therapeutic space is safe or respectful as a result, leading to emotions such as anger and distress (Pascoe & Smart Richman, 2009).

This is only a brief overview; however, it illustrates the importance of clinical psychologists understanding race and its impact on our work. It would be a travesty not to include race in our formulations and therapeutic work with clients, and therefore we need to be able to talk about race and acknowledge the ways in which we perpetuate racist power.

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Racism in Clinical Psychology

Despite its importance, clinical psychologists are rarely trained in addressing and working directly with race as the profession is embedded in Whiteness (Wood & Patel, 2019). There is a lack of racial diversity within the profession and we are blinded by a Western evidence base. The majority of theories are written by White academics and the 'evidence' which backs up these theories are based on studies of White people (e.g. Turpin & Coleman, 2010).

On clinical psychology training courses, those with a minority racial status are still seen as 'other', with an assumption of inferiority in difference (Adetimole, Afuape, & Vara, 2005). For the few trainees who identify as Black, the profession is viewed as one which continues to reinforce inequalities and does not represent the communities it attempts to serve (Odusanya, 2016). This may be a legacy of the way in which the institution of therapy has maintained racist structures with mental health diagnoses being used to discriminate against minority racial groups (Fernando, 2017). Through collective Whiteness, clinical psychologists are likely to have *'the privilege to live…without ever needing to be aware of [their] whiteness and how it might be impacting their life'* (Lyubansky, 2011).

It may feel uncomfortable for White clinical psychologists to start discussions about race, yet without meaningful action racism will persist in clinical psychology (Wood & Patel, 2019). Efforts are already being made to address issues of race and racism in clinical psychology (e.g. Berg et al., 2019), however, these efforts are not widespread. Establishing a framework within which clinical psychologists can understand and talk about race may be a step towards more widespread change.

Racial Inconsistency

For many years, social institutions have asked individuals to select a racial identity from a list of categories (Rockquemore & Brunsma, 2002). This enables these institutions to process race (e.g. collect data on protected characteristics), but it could be argued that this ensures the continuation of an oppressive colonial society as race is viewed as a static characteristic (Blank et al., 2004). With the rise of multicultural communities in the UK, society's categories no longer seem to fit for a growing number of people. Whilst acknowledging the profound impact of race, researchers in fields such as sociology are questioning how race should be understood in relation to the categories used (e.g. Boonzaier & van Niekerk, 2019; Delgado et al., 2017; Jackson, 2009; Roth, 2016).

Roth (2016) suggests multiple dimensions of race, with individuals potentially being classified or self-identifying differently within each dimension. She describes how an individual's race may be considered as their racial identity, racial self-classification, observed race, reflected race, phenotype and racial ancestry. This is supported by studies which suggest 'race is changeable, contextual and multi-dimensional' (p.29, Boda, 2018). Race is described as fluid across both time and context, highlighting that race is not static but 'inconsistent'. Her term 'racial inconsistency' will be used throughout this paper to explore race as a fluid and

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multi-dimensional construct.

Purpose of this Review

As professionals working in the UK context of providing a healthcare system for all, this review aims to support clinical psychologists to understand and work with race and racism. This review aims to explore racial inconsistency as a useful framework for clinical psychologists to understand and talk about race and consider the implications for clinical psychology practice.

This project systematically reviews the qualitative literature on racial inconsistency, defined as fluidity and multiple dimensions of race. A meta-ethnographic review of qualitative literature was chosen to gain both breadth and depth of understanding around this subject (Noblit & Hare, 1988; Siddaway, Wood, & Hedges, 2019).

Systematic Literature Search

A systematic search of the literature was conducted using IBSS, APA Psycnet, Embase and Web of Science using the search terms 'race OR racial' AND 'fluid OR fluidity OR dimension OR dimensions' AND 'identit* OR experience*'. Exclusion criteria were then used to select the literature: 1) Literature using a quantitative methodology or approach, 2) written in a language other than English 3) literature that considers race as an essential characteristic of the individual, 4) literature that does not conceptualise race as a fluid or multidimensional construct.

The reference lists of the remaining seven papers were then searched by hand for any further relevant papers resulting in a total of 12 papers for review: Brubaker (2016), Campbell et al., (2016), Frable (1997), Jackson (2009; 2012), Morning (2018), Okamura (1981), Rocha (2018), Roth (2016), Snipp (1997), Song & Hashem (2010) and Wilson (1984).

Synthesis

Three constructs were identified by the meta-ethnographic synthesis: dimensionality of race, racial structure of society and racial identity and the individual.

Dimensionality of Race

Race was consistently described as a social construct – something we 'do' as a society rather than something that individuals 'are'. The papers describe how race is not unitary or fixed, but multi-dimensional. Race is seen as having a wealth of possible dimensions, including (but not limited to): self-assigned racial identity, the race ascribed by others based on appearance, genetic racial ancestry, or racial classification on legal documentation. The possibility of an individual being classified differently across different dimensions of race was identified.

The papers discuss how these dimensions of race do not exist exclusively, but intersect and interact with one another. In this way, these papers view race as fluid – changeable across time and situations depending on a range of contextual factors. Individuals are therefore able

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to hold multiple racial identities simultaneously, or potentially hold a more ambiguous racial identity that may not align with any defined category.

Racial Structure of Society

Racial classification is described as an organising principle of society, as we look to understand other people. Inequality in power is seen as a key factor in the development of racial identity as it establishes a strong sense of 'us and them'. The papers describe how racial classification is used as a method of societal control, marginalising disadvantaged racial groups and increasing White power and privilege.

Race may not always be the most salient and relevant factor guiding interactions in society. The papers suggest that other aspects of identity (e.g. class, gender, sexuality) may at times be seen as more relevant in determining a sense of 'us and them', however, these aspects of identity will always intersect. The relationship between both racial and other aspects of identity is therefore complex in how they may interact and intersect to define an individual's sense of self within society, their behaviour within it and how society responds to them.

Several papers describe how the concept of race has changed in recent years, from one based on fixed and stable heredity to one of more ambiguous kinship and belonging. As this change progresses, racial categories used historically in research and public policy are becoming more complex and nuanced. This is potentially problematic as there is less clarity in the concept of a racial minority, making it difficult to draw evidence-based conclusions from research on inequality and allocate scarce resources to address oppression.

The papers described oppression and racist abuse as a common experience for individuals who are perceived by society as a racial minority. These negative experiences have an impact on psychological wellbeing with individuals not being understood and being disconnected from others. Racially disadvantaged individuals are likely to seek safety and a sense of community with other people who share similar oppressive experiences in relation to race. In particular, this may occur for individuals who are labelled by society as a race which they do not identify with.

Alternatively, individuals may want to seek safety as they hold a racial identity that is subject to criticism and policing in society and the media. The papers also discussed a post-racial stance of 'racial resistance' being held by some groups in which they actively reject any form of racial classification or categorization.

Racial Identity and the Individual

These papers describe how we look for racial sameness and difference in order to understand the social world around us. In classifying and seeking out others who we perceive to be like 'us' and distancing ourselves from those who we see as different ('them'), we are able to build our own racial identity and develop relationships with those who share similar racial experiences. This may also result in a sense of 'belonging' to a certain racial category and the

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internalisation of characteristics associated with that category (e.g. power or powerlessness).

Authors describe how the racial classification of the self and others can have an effect on both the behaviour and wellbeing of individuals. With classification of the self and others comes a deeper understanding of where power lies in relation to race. This understanding influences behaviour in social situations that then reflects existing racial inequality. Wellbeing is also affected in relation to the racial experiences of individuals.

The authors explored how the fluidity and multi-dimensionality of race may compound the effect of negative racial experiences. As race may change across dimensions, over time and context, these experiences may be directed towards multiple dimensions of a person's racial identity and/or exist in some contexts but not others.

In the past, race has been understood as a fixed construct and racial classification was seen by some as a true reflection of racial identity. These papers present an alternative view, describing racial identity as developing within a historical, societal and environmental context. The papers discuss a range of both structural and cognitive influences on individual racial identity development.

Structural influences could include stories of racial identity from family or friends, historical narratives from wider society, or current experiences of oppression and racist discrimination. Cognitive influences may include our interpretation of the behaviour of others, beliefs about race, or comparisons of our self with others.

Discussion

Racial inconsistency may be a useful framework for clinical psychologists to understand race and racism in relation to individual wellbeing, wider society, public policy and research. Understood in this way, race is a multi-dimensional social construct with inconsistent dimensions which intersect and interact in a way that is fluid and changeable. Each dimension of race combines and interacts to oppress or privilege individuals in unique and multiple ways. Racial inequality is a key factor in the development of racial identity and racial classification is used as a means of societal control. Racial inconsistency may compound negative experiences of race or alternatively act as a protective factor against psychological distress; each experience will be complex and unique in relation to race as these dimensions shift and change.

Society is not post-racial or colour-blind, but continues to be structured by race. This structure plays a role in the development of racial identity, but also results in the racist actions and ideas which perpetuate racist abuse for those from disadvantaged racial groups. Race can be considered both as a powerful and influential force in our lives and as an inconsistent and dynamic social construct. Race can be understood as inconsistent whilst acknowledging the existence and impact of racism and oppression.

Racial inconsistency presents race as a complex social construct with real-world consequences and exists as a viable concept set apart from the myth of a post-racial or colour-blind society. It is hoped that with this framework to understand race, clinical psychologists

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may feel more confident to start conversations with both clients and colleagues on this topic and begin to take anti-racist actions against racism and oppression.

Implications for Clinical Psychology

Clinical practice

The findings of this review lend themselves to a critical community psychology framework as they require us to focus on our position as psychologists within a fluid and multidimensional system of power/powerlessness and dominance/oppression (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011). Reynolds (2011) describes how those in the helping professions are well-placed for justice-doing, meaning that we can 'work to change the real conditions of people's lives rather than helping them to adjust to oppression' (p.29); however, this will be in contrast to the racist system clinical psychologists will be used to working in (Fernando, 2017).

If we are to encourage social change, then a process of thinking, acting and reflecting on race may be necessary. A focus on sharing experiences and strategies with all stakeholders is needed in order to challenge the current consensus (Berg et al., 2019; Kagan et al., 2011). Sarantakis (2017) describes taking a step away from 'knowing' when working with people with different racial backgrounds and experiences. This is in contrast to the various papers written about achieving cultural competencies (e.g. Geerlings, Thompson, Bouma, & Hawkins, 2018), which imply cultural differences are something which can be fully understood. A stance of cultural humility is suggested in which White clinicians are open to the values of others, rather than being held to the superiority of their own.

In trying to elicit change towards a society which accepts and embraces racial inconsistency, there may be a fine line between trying to work in solidarity as an ally with disadvantaged racial groups (Reynolds, 2013) and being blind to the 'oppressive potential of well-meant performances of care' (p.7, Parker, 2019). It is possible that at times the most effective action will be to simply to listen from a position of humility, allowing for a change in power relations so that racially disadvantaged individuals can step forward with their own knowledge and expertise (Parker, 2019).

Research

The findings support longstanding criticisms on the empirical basis of clinical psychology in relation to Whiteness in the profession (e.g. Salari Rad, Martingano, & Ginges, 2018) and the perpetuation of racist structures (e.g. through the use of diagnostic categories; Fernando, 2017). Without change in this historic pattern, clinical psychologists will be unable to effectively research, and understand racial inconsistency and its impact.

It is therefore important to approach research with a critical mindset; particularly when considering research on inequality, but equally in conducting or appraising any evidence on which our psychological theories are based. The demographic details of both the participants

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and researchers should be considered, and whether the findings are likely to reflect race as a fluid and multi-dimensional construct.

It has been suggested that studies using observed race (e.g. described by the researcher), may be more accurate in assessing inequality compared to those which use self-classification by participants. This is because the former is more likely to reflect the oppression the individual may experience from others in society, as this relates to how others perceive them rather than how they perceive themselves (Telles & Lim, 1998). Alternatively, McCall (2005) suggests an inter-categorical approach to research in which the provisional use of categories allows the researcher to map out the complex changes in inequality between different social groups.

Training

In order to develop an understanding in the profession of diverse racial lived experiences, we need to be valuing diversity as part of the admissions process (Withers, 2005). This is only a starting point for change however, as there are also a range of systemic barriers to diversity in clinical psychology training which need to be addressed by those in positions of power and responsibility (Bawa et al., 2019).

As a consequence of the hierarchy of supervision in healthcare professions, it can take an average of 17 years for theory to be translated into practice (Institute of Medicine, 2001). Trainees are usually supervised by those who trained many years ago, therefore restricting the uptake of newer ways of thinking and working. The answer may therefore lie in shaping the understanding those training in the profession, equipping them with the confidence to embed this in their practice and provide training for their colleagues and supervisors (Patel & Fatimilehin, 2005).

Those teaching and supervising trainee clinical psychologists should model a stance of cultural humility (Sarantakis, 2017), considering how trainees can integrate this into their practice and research. Teaching and supervision could incorporate time for trainees to deconstruct their own experiences of racial privilege and oppression, examining how these experiences may intersect in their own lives (e.g. Berg et al., 2019).

Racial inconsistency as a framework

The implications presented here are only a selection of ideas based on the interpretation of racial inconsistency by researchers identifying as White clinical psychologists. Despite the best efforts to include comments and considerations of those who are experts by either experience or profession, this article cannot claim to reflect some of the diverse views of those with experiences of race which are different to our own. As White clinical psychologists, there are likely to be times when we continue to engage with racist policy, use racist language or reinforce racism and we assume this review will be no exception. We are aware that we may have missed certain literature as a result of being new to writing about race and may have limited what we accessed as a result of restricting the search to articles written in English, for

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example.

Final Summary

Racial inconsistency is a useful framework within which clinical psychologists can begin to understand and talk about race. Through the lens of racial inconsistency, race can be understood as fluid and multi-dimensional, resulting complex and dynamic experiences for individuals. These experiences can be understood as relating to systems of power and White supremacy in society and impact the wellbeing of individuals.

Clinical psychologists should consider the way in which our profession has developed from a place of White power and privilege. We need to decolonise our therapeutic practice, research and training by changing our practice to address and attend to race. By doing this, we may be able to improve the relevance of clinical psychology for the multi-cultural UK population, effectively supporting individuals with a variety of racial experiences and begin to engage in dialogical conversation and anti-racist action in the community.

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Book Review

Aspergers Children. The Origins of Autism in Nazi Vienna
Edith Sheffer

W.W. Norton & Company, 2018, £12.29
ISBN: 978-0-393-60964-6

How might you respond to a book? Might it be life-changing, the kind of volume you wish had never seen the light of day, a novel you never want to end? My first reaction to Asperger's Children was to email the author thanking her for the combination of research and lucid prose that makes it un-put-down-able and terrible all at once. I read it in a two day orgy of glued-to-the page masochism.

The essence of this volume is a ghastly and thorough investigation of the work of Hans Asperger, a man committed to the supposed succour of children he branded Autistic-psychopaths, only to be responsible for condemning dozens to death in Spiegelgrund, a Nazi killing centre in Vienna. Asperger not only lived to tell the tale (whilst frantically re-writing some of his best-selling works) but (courtesy of Lorna Wing) found his name attached to what is now one of a range of supposed conditions on the autistic spectrum. By the time of his death in 1980 he had published over three hundred articles, had been appointed director of the University of Innsbruck Children Hospital and, in 1962 was appointed permanent director of the University of Vienna Children's Hospital (the psy industry is beyond parody). His concept of curative education was slowly transformed into special education.

Although Sheffer hesitates to draw comparisons with Nazi psychiatry and the modern day, similarities can be easily found: the fluidity of inscription (the way diagnoses shift according to the observer and the zeitgeist), the lack of meaningful numbers of subjects studied and science rather than scientism during diagnostic endeavour, the highly selective use of data to prove a particular thesis and so on. At the heart of Asperger's eventual diagnostic position was the concept of Gemüt – a term loosely translated as *"community spirit"* or, less fancifully, contributing to the aims of the State. In Germany and Austria after the Anschluss, Gemüt implied working – even existing – with the Volk in your heart, whether in turning a blind eye to the persecution of Jews and gypsies, joining the SS, or actively participating in the destruction of Jewish businesses and, ultimately, the Holocaust. Gemüt can fit neatly with critical perspectives on modern day inscriptions of ADHD and Schizophrenia. Put simply; if you refuse to play the game dictated by the needs of the class-room (the need to be disciplined) or the needs of Capitalism (to pay attention to productivity rather than voices), then you will be inscribed and excluded. Extermination is gradual via

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life shortening medication, soul destroying moral orthopaedics or exclusion and incarceration.

Asperger attended the Vienna conference of the German Society for Child Psychiatry and Curative Education in September, 1940. Gemüt was a major theme. Officials from the Reich Ministry of the Interior, the Reich Health Office and the Reich Ministry for Public Enlightenment and Propaganda attended in strength. Though not invited as a speaker, he witnessed Nobel Laureate Julius Wagner-Juaregg (progenitor of fever therapy – injecting patients with malaria – for shell shock: see, Newnes, 2018; A Critical A-Z of Electroshock) given a rapturous welcome, Villenger (a Reich psychiatrist who recommended labour colonies for children lacking Gemüt; Villenger committed suicide in 1961 when his ties to the T4 euthanasia programme were made public), and Walther Hecker, founder in 1934 of the first youth preventative centre; by 1939 there were six, paving the way for Heydrich to call for the construction of "Juvenile Protection Camps," sometimes run by the SS and frequently as harsh and deadly as concentration camps. Sheffer presents a balanced picture of Asperger's reports on the conference; he selectively under-reported speakers calling for expulsion and incarceration of children showing insufficient commitment to the Volk and emphasized those recommending curability. At the same time he re-edited his work on Psychopathic Autism to include references to Gemüt and moved towards a position of un-educability for some children, a position that ultimately led to his recommendations of children from six to sixteen for transfer to the two killing wards of Spiegelgrund.

Asperger's 1944 treatise on Autistic Psychopathy included a preface locating his work *"…within the intellectual framework of the Third Reich."* (p.242) Uta Frith translated it in 1991, preferring "autism" to Autistic Psychopathy and didn't include the preface. Lorna Wing went further. Before her death in 2014 she said, *"I would like to throw all labels away today, including Asperger's syndrome, and move towards the dimensional approach. Labels don't mean anything, because you get such a wide variety of profiles."* (p.243)

Sheffer points to the need for survival as one factor in Asperger's shifts towards Gemüt as a major factor in diagnosis. He never joined the Nazi party and continued to call for a gentle approach to children despite a zeitgeist emphasizing the expense of maintaining "useless" lives. At the same time she directs attention to his referrals to the Spiegelgrund killing wards and the possibility that, like other Austrian intellectuals and psychiatrists he could have left Vienna before the war. And Spiegelgrund did not only take children with obvious disabilities; many were simply illegitimate children of Austrians too poor to feed them. Some parents were relieved to hand their children over, others fought hard to have them released. Some children were incapacitated by blindness or epilepsy, others were deemed asocial and condemned because they had turned to prostitution to find money for food. The similarity with today's randomness of entry into the ""health" system is striking.

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Psy has an embarrassing history of those who suspend conscience for the sake of survival within the zeitgeist – from the eugenicists Spearman, Pearson and Burt, via Jung and his avowal of Nazi supremacy, Rogers and his abandonment of those branded schizophrenic for the sake of his research in psychiatric institutions in the 1950s, to current digital purveyors of Big pharma sponsored nonsense like the Psychtimes, to those who maintain psychiatric labelling of people for the sake of cultural capital. Asperger is far from unique and the complexity of his position as expert continues to be experienced by many psy professionals. This volume is both a tribute to that complexity and a shining example of historical research.

Craig Newnes

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