THE QUEST FOR HEALING IN THE BLACK BRITISH COMMUNITY: A REFLECTIVE STUDY OF MENTAL HEALTH CARE IN BIRMINGHAM, *ENGLAND*

by

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ABSTRACT

This study examines the quest for healing in a group of twenty African-Caribbean persons who have a severe and enduring mental illness in Birmingham, England with particular reference to the impact of the Servol Community Trust and a Cultural Therapy Programme.

The study uses the case study method to uncover the meaning of migration, the impact of racism, loss of self and family in addition to other themes which are significant to the health and well being of these persons. Qualitative content analysis is utilized.
The findings were triangulated by data collected from well African-Caribbean persons and care workers through interviews and focus groups.

The findings underscore the importance of the community for the development of identity and the maintenance of health in the face of the trauma of racism. The significance of the African-Caribbean heritage, the nurture of family ties, culturally sensitive and appropriate care and therapy all contribute to the health and healing of African Caribbean persons. The profound absence of God in the lives of those persons suffering from a mental illness in this study heralds the need for a new practical theology as the church is being called to play a new role.

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I wish to thank a number of persons who have contributed to the development of this study and my supervision as I traveled on the journey in the UK and in Jamaica.

My husband Frederick Hickling was there, my parents Amy and Judson Robertson, my supervisors Emmanuel Lartey and Robert Beckford, my colleagues at UWI Elizabeth Thomas- Hope, Anne Crick, Lou-Anne Barclay, Noel Cowell.

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CHAPTER 1

ORIGINS AND INTERACTIONS

I. Outline

Mental illness and the associated stigma present a worldwide challenge; this is particularly evident in the African-Caribbean population in Britain. The community experiences the highest rates of mental illness of all ethnic groups in Britain. After a period of mass migration, which began in 1948, thousands of hopeful West Indians migrated to Britain in search of a better life. Some succeeded in this quest, but many failed and some experienced severe and enduring mental illness and its sequalae. Social isolation, loss of self, family and community, racism, as well as difficulties with the National Health Service, Social Service and the police, continue to be the experience of some up to the present time.

This study examines the impact of a culturally sensitive and safe African-Caribbean organisation and Cultural Therapy on the health and healing of a group of 20 persons with severe and enduring mental illness in Birmingham, the second largest city in England. Birmingham has the second largest African-Caribbean population in the country. These persons have spent long periods of their lives in mental hospitals and now live in the community as a result of the policy of deinstitutionalization.

II. My origins

I am a Jamaican woman of African descent. I have a personal and professional interest in the development and well-being of African-Caribbean and other persons of African descent around the world. My concern about this has led me to pursue studies at the undergraduate and postgraduate levels in psychology and the behavioural sciences, as well as to work in environments that promote development and well-being. I have worked as a psychologist, a management consultant, businesswoman and an educator in the Caribbean and overseas.

Wherever I have worked or studied, I have been concerned about the pervasiveness of racism and the subordinate position held by Black people in many societies. This has been striking in the Caribbean, the United States, in Europe and in South Africa, just to name a few examples. My interest has led to the exploration of history, psychology and other related subjects, together with a commitment to the improvement of Africans in the Diaspora and on the continent of Africa. As an undergraduate in the early 1970s in Jamaica, I was a member of the African Studies Association of the West Indies. This Association was established to provide information about Africa for those of us who were in the West Indies and had recognized that we needed to understand and to retrieve our African heritage. Our colonial experience had resulted in some of us having 'Black Skins with White Masks', a concept identified by Frantz Fanon (1970) the Martiniquan psychiatrist. Some of us had lost our Black identity and had been brainwashed to become 'White people'. Hickling and Hutchinson (1999) subsequently described the 'Roast Breadfruit psychosis' which resulted from this process.

My life and ideas have been significantly influenced by the Jamaican National Hero and Pan Africanist, Marcus Garvey and by the Jamaican musician Bob Marley (1981) whose exhortation has been for us to: "emancipate ourselves from mental slavery, none but ourselves can free our minds." These ideas have also guided the work of my husband, psychiatrist, Frederick Hickling and I, as we have worked in partnership for some 22 years. We both have been committed to improving the mental health and well-being of fellow Jamaicans and members of the African and Caribbean diasporas. My personal and professional life has been influenced not only by these ideas, but also by my commitment as a practising Christian and church elder. I have struggled with my faith and upon reflection, I have had experiences that cause me to concur with Miller (2003) who suggests that:

> The intensity of Euro-Christian imposition encouraged an equal intensity of reaction. One extreme was Garvey's radical theology, in which content and direction were explicitly determined by Black sensibilities. The most obvious carrier of Garvey's legacy in contemporary times is the Rastafarian religion, which was born in Jamaica and has spread throughout the Caribbean and many other parts of the world. What is now described as Caribbean theology also bears the marks of Garvey's legacy, in its political and theological radicalism. The pioneers of this movement have hardly referred to Garvey but I hear him in some of their pronouncements (Miller 2003).

The integration of Black theology, psychology and psychiatry has become a significant goal for me in my personal and professional life. A final influence has been that of feminism and later womanism, through my involvement in Women's Studies at the University of the West Indies and the Women's Movement in Jamaica. As a result, I have developed an interdisciplinary conceptual framework and interdisciplinary methodologies. All of these ideas, concepts and experiences have contributed to my identity and influenced the development of this thesis.

III. Raising the issues

In January of 1997 I had applied to the University of the West Indies to pursue a postgraduate degree in pastoral care and counseling. My present qualification of a Masters in Applied Behavioural Science from the Johns Hopkins University had satisfied entry requirements for the Doctoral programme at the United Theological College of the University of the West Indies. An unexpected opportunity to relocate to Birmingham, England in August 1997, forced me to abandon this academic programme. The job opportunity in the UK would allow my husband and I to continue the work we had been doing in Jamaica, namely the provision of community mental health services for African-Caribbean people.

My decision to pursue a doctoral programme at that time provided the opportunity for me to study and to synthesize the concepts that I had been applying in my personal and professional life. These concepts were drawn from psychology, psychiatry and theology and were all related to the processes of health and healing in the Caribbean. As an African-Caribbean woman working in Jamaica as a psychologist, as a management consultant and as a church elder, I was trying to improve the physical, mental and spiritual health of the clients who consulted me. I had been reflecting on the fact that health and healing were complex processes, which needed to be approached in a holistic manner. Hence, I set out to develop an

understanding of the manner in which these three disciplines interrelated. At that time I was 43 years old, in the midst of the **mid-life transition.**

> The mid-life transition period becomes a link between early and later life. This is the time when people compare what has actually happened with what they previously hoped would be their lifestyle and situation. Most of us face this problem throughout life, but now there is less time to change things. The end seems ever closer as the person begins to focus on signs of physical decline and an awareness of age. This period presents the challenge of trying to face failures and successes, and prepare for a reasonable and relatively happy later adulthood (McMahon 1986, 401).

Neo-Freudian theorist, Erik Erikson identified eight stages of psycho-social development. At that time I was in Erikson's Seventh Stage (middle adulthood): g*enerativity versus stagnation.*

> The 30s to 50s is a time in which we really test our ability to come to terms with life. We can be successful during this time if we give ourselves to other people and to our work – that is, if we *generate* contributions to our own world and the larger world around us....Only then can we feel true satisfaction. The alternative is apathy and stagnation, and we merely continue old patterns, becoming brittle and rigid in outlook (in McMahon 1986, 497).

The decision to relocate to Birmingham came during *the period of transition,* but according to McMahon's conception, it could also have been a period of crisis. Birmingham replaced Kingston as my home and posed a number of challenges in my personal and professional life. One of the challenges was that of becoming a migrant to Britain, a country with a history of racism against Black people Vasciannie (2002). Britain was a country where I would have to start all over again, to build my life away from my family, my career and all the things that I held as important. Living in Britain would make me a member of a visible Black minority and I would cease to be a member of the Black majority in Jamaica. My work in Jamaica had provided

me with some of the skills and knowledge that would enable me to cope with the challenge of my new life in Birmingham.

For four years prior to working in Britain, I was the Jamaican Country Coordinator of a scholarship programme run by the prestigious Georgetown University, for underprivileged adolescents living in Jamaica to pursue tertiary education in the United States. In my capacity as Country Coordinator of the Cooperative Association of States for Scholarships Programme (CASS) in Jamaica I worked for the Centre for International Education and Development (CIED) of Georgetown University that administered the programme on behalf of the United States Agency for International Development (USAID). The CASS programme integrated easily in the context of Connolley House that provided services to both mentally ill and mentally well persons. Our work at the individual and organisational levels helped to restore people to health and also to prevent illness by facilitating individual achievement and organisational health. There was little stigma attached to coming to the psychiatrist, as we were located in the community. Some of the students who were selected for CASS had to be assessed by the psychiatrist as a result of inappropriate behaviour during the orientation programme. We worked in a conceptually and practically collaborative way, from a common understanding of the behaviour of Caribbean people, with all of the clients of Connolley House.

This programme provided approximately 250 scholarships for poor, bright students who could not afford to pay for tertiary education in their own countries in Central America and the Caribbean. The Jamaican quota was 25 scholarships and I was responsible for the recruitment, selection and orientation of the students who would take up tertiary placements at the

community colleges in the USA, where the scholarships were tenable. Throughout the selection process we were seeking to identify the candidates who would be adaptable, academically able and willing to return to make a contribution to their respective communities, as was required in the agreement with USAID. During the period of the orientation we had to prepare them for a cross-cultural study experience in the United States. The orientation included many aspects of American life, the educational system, the US Constitution, the laws and also special preparation of a group of Black Jamaicans or African -Caribbean people for life in a country known for its history of racism.

This work experience had been to prepare the Jamaican students for working in a cross-cultural environment. This work has honed my own cross-cultural skills and I was, therefore, much better prepared for living in the new cultural setting in Birmingham, UK than if I had not had this experience with Georgetown University. Paradoxically the experience was preparing me for what was to come in my own life. In preparing these young Jamaicans for a migratory experience, I was also preparing myself for Britain. In administering the programme I was frequently reminded of the strength, resilience and desire to succeed in the young people I met and interviewed from schools across Jamaica - Young people who were providing leadership in their schools, communities and workplaces, in spite of significant social or economic obstacles. Their lives were a constant reminder that the majority of Jamaicans had overcome horrendous obstacles for centuries, through forced migration from the continent of their ancestors, through slavery and British colonialism. It had been a history of triumph over adversity (Sherlock 2000).

It was during this period that I conceived of the idea of the *Secrets of Success* of the scholarship candidates. This was a concept that I utilized during the interviewing process when I posed the question to the students: "What is the secret of your success?" After a moment of disbelief about the question, after confirming that I had indeed considered them successful, they gave answers, which could be summarized as follows:

- an enduring faith in God to see them through tribulation and help make their dreams come true;
- a desire to make a difference in their families, schools, communities and country;
- the willingness to be a pioneer e.g. the first family member to go to college;
- confidence in themselves and a willingness to keep trying in spite of any obstacles facing them;
- the wish to make their families, schools, communities and nation proud of them;
- a desire to learn the vocational and professional skills that the scholarship provided and share the cross-cultural skills with those who they would meet in the United States; and
- a strong connection to home, family and nation, which was a sign of belonging (Robertson-Hickling 1997).

This question yielded such valuable insights about the candidates that the Centre for International Education at Georgetown University decided to include it in the formal interviewing process in all of the Central American and Caribbean countries where the Scholarship programme was administered.

Like the scholarship winners, I would have the challenge of discovering the 'Secrets of my Success' in Britain. This has also became a template for my work in Britain.

Another challenge was that of abandoning my studies at the University of the West Indies. By relocating to Britain, I was obliged to defer my studies by one year, and apply to pursue a PhD at the University of Birmingham, where as an overseas student, I had to pay tuition and other fees that were considerably higher than I would have paid at the University of the West Indies in Jamaica. I was concerned about the challenges awaiting me in the UK academic setting. Who would supervise my studies in Birmingham? How would I perform after my long absence from academic studies? I had completed my Masters degree at Johns Hopkins University more than a decade before, in 1985.

Gordon-Stair (2000) identified many of the concerns I had, and the challenges that would face me, as she explored the topic of 'Mature Women In Higher Education: Exploring Conflicts and Stresses'.

> The psychological price these women pay is often invisible to the casual onlooker. The guilt, anxiety, and or depression that often accompany the fear of failing as a partner, as a mother and as a student based on the unrealistic expectation of being able to fulfill these roles all the time with the same degree of competence is not unusual. Some experience a sense of alienation from their partners, oftentimes feeling misunderstood about the amount of time they need to spend studying. Others experience guilt, seeing time spent studying as time robbed from their children. Many have not realized their full potential as students, afraid of their desires to go on to further studies. To have such goals, they interpret as being selfish and not caring for the needs of the family. Some of these women therefore are unable to do as well academically as they would because of conflicting demands (Gordon-Stair, 2000, 4).

The challenges that faced me as I contemplated migration from Jamaica were daunting. At one time I even considered not going at all, but

that would have meant abandoning my husband and our life together. I had also considered trying to have a long-distance relationship, where I would 'come and go' - a Jamaican expression which means to commute and to live between two locations. Having considered the options, I decided to go to Britain and start anew. So like generations of migrants from many parts of the world, particularly from the Caribbean where there has been a history of migration, Thomas-Hope (1992) my husband and I travelled to Britain at the end of August 1997, to face our new life.

We had been concerned about the numerous reports of the bad mental health situation in the African-Caribbean population in the UK. My husband had been invited by the British Government to advise on the implementation of an African-Caribbean mental health service, and had made his recommendations through the North Birmingham Mental Health Trust in 1995. Anticipating that there would have been an equivocal response to his recommendations, he had established two private organisations, independent of the National Health Service, to undertake service provision for African-Caribbean patients in Birmingham, in order to demonstrate what could be achieved in the UK for African-Caribbean people with mental health problems who were receiving culturally appropriate care. By mid -1997, the work-permits for himself and his wife that had been applied for by these companies were approved.

In Jamaica we were accustomed to working in a private mental health company which we had established in the late 1970s. Here in Jamaica, a considerable segment of health care is provided by the private sector, in conjunction with the public sector. In Britain the situation is quite different. The National Health Service provides 85% of the health care and the private sector

provides 15%. We recognized that we would need to establish new organisations to provide alternative care for the Black community.

Our response to the inertia of the National Health Service in Birmingham, as I have outlined, was to set up two private companies to provide service. This was not unusual from our perspective, but virtually unheard of in the British context. We were bringing concepts and practices from Jamaica to Britain, from a third world country to a first world country; from the colony to the colonizer!

The formation of these two companies was a response to the need for services to address the mental health issues of the British community. Our thrust into the British mental Health Service was part of the provision of a 'mixed economy of care' advocated by the 'enabling state' Taylor (2001).

Since the 1990s, the concept of the 'enabling state' advanced by Taylor has gained currency. Taylor is part of the Public Services Management Group, at Aston University in Birmingham.

> The enabling state incorporated the changes that had occurred in the early Thatcher years, notably privatization, which enabled competition, contracting out, which enabled an internal market for public goods and services and supply side economics, which in turn reduced industry's dependence on state support (Taylor 2001, 372).

This 'mixed economy of care' entails the provision of health and social care by the public, private and non-governmental sectors in partnership, Taylor (2001).

IV. The case of David Morgan

David Morgan is an African-Caribbean man with severe mental illness,` who was receiving ongoing psychiatric care from the North Birmingham Mental Health NHS Trust (NBMHT). In 1994 he attacked a number of White women

in Rackham's Department Store in Birmingham with a knife, severely wounding them. He was sentenced to serve 13 life sentences for the crimes he had committed. There was clear evidence that Morgan had made repeated attempts to receive appropriate mental health care just prior to the incident, without success. Following the incident, the Black Community in Birmingham petitioned the Birmingham Health Authority (BHA) about the inadequate level of mental health care being provided for the African-Caribbean population.

As a result of the representations made by the African-Caribbean Community in Birmingham, arising from the case of David Morgan, North Birmingham Mental Health Trust invited African-Caribbean psychiatrist, Dr. Frederick W. Hickling (my husband) to Birmingham for a three-month consultancy to advise on the appropriate mental health service for the African-Caribbean community. The outcome of this consultancy was a proposal to the BHA to establish an African-Caribbean Mental Health Service within the NBMHT. Part of this proposal was accepted, which led to the provision of funding for a specialized service for treating African-Caribbean patients with mental health problems. This grant from the British Government resulted in the establishment of the Frantz Fanon Center by NBMHT, in 1996. In spite of promises that Dr. Hickling would supervise the establishment and operationalization of this project, the Frantz Fanon Center was set up without his help, using an alternative model to that which he had proposed.

V. Establishing the private mental health companies

The Hickling Report of 1995 also recommended the establishment of a private and a voluntary organisation within the African-Caribbean community, to

collaborate with and to parallel the NHS African-Caribbean service. This was based on the observation that the majority of the African-Caribbean population in the UK does not access mental health care through the NHS out of fear of racism and discrimination within the system. Although this recommendation to the NHS was not sanctioned officially, Dr. Hickling and his colleague Mrs. Nancy Johnson went ahead and established two private organisations to meet the needs identified. Hickling had anticipated that the recommendations he had made would not have been implemented in their entirety. He moved to pre-empt this, by registering two private companies that would give him and his colleagues a vehicle to provide these services if the NHS did not implement the recommendations. As a result both the Bond Hickling Bartley Institute (BHBI) and Psychotherapy Associates International Limited (PAIL) were established in the UK in 1996, duly registered by law under the Companies Registration Act. These companies were the 'vehicles' that applied to the British Government for work permits for my husband and I to enter the UK to work in the area of ethnicity and mental health. It is in this context that the conundrum I have described relating to my decision to migrate to Britain was grounded.

The Bond Hickling Bartley Institute and Psychotherapy Associates International Limited were established in the aftermath of the David Morgan case in Birmingham. These organisations had been established to help to meet the mental health needs of the Black community. The Institute was named after Dr. Hopetoun Bond, one of the first Black psychiatrists in the Caribbean who practised in the first two decades of the twentieth century in Jamaica, and subsequently in Britain. He was the granduncle of Frederick

Hickling. In addition, the Institute incorporated Dr. Kenneth Bartley, a Caribbean-trained general practitioner who worked with the National Health Service and had a private practice that catered to the African-Caribbean population in Birmingham and its environs. The collaboration between Dr. Hickling and Dr. Bartley resulted in the provision of mental and physical health services at one location. Dr. Bartley had been practising in Birmingham for nearly 20 years and had earned the confidence and trust of many African-Caribbean people. He was supported by his wife Angela, a nurse who had initially been trained in the Caribbean and also in Britain. The Institute was to undertake training and research in Caribbean health, and was established to make it eligible to receive grants from British charities and the British Government.

Psychotherapy Associates International Limited was the international arm of Psychotherapy Associates, an organisation that had been providing services in Jamaica since the 1970s. Psychotherapy Associates International Limited was a mental health assessment and treatment centre situated in Handsworth, Birmingham, committed to providing a range of specific psychiatric, psychotherapeutic and counselling services as well as culturally sensitive preventative mental health treatments in the City of Birmingham initially and later expanding UK-wide. The Mission Statement of this organisation was to develop and make available a range of culturally specific and accessible forms of training and therapy programmes to promote health, education and development, especially to the Black communities. Our mission was based on the view that African-Caribbean people have the same capacity to be creative and productive as all other ethnic groups in the UK.

Psychotherapy Associates International Ltd. was one of a small number of known psychotherapy organisations based in the United Kingdom, offering services to the Black population. This organisation saw itself at the cutting-edge of service development and innovation. It attempted to maintain a focused approach to its strategic development and implementation programme that would phased well into the next millennium and would focus on poverty, training, education and good practice. In so doing, the organisation attempted to explore a range of issues that promote achievement and a sense of belonging, with a focus on training, education and therapy, within the African-Caribbean population. This was carried out in partnership with other organisations operating at the local, national and international levels.

While Psychotherapy Associates International Ltd. was a private company, the Bond Hickling Bartley Institute was established as a not-for-profit company. It was a pilot project in inner-city Birmingham, set up as a company limited by guarantee, with non-profit making objectives. Charitable status was applied for through the Charity Commissioners. The Institute was established out of the necessity to provide psychiatric, psychotherapeutic and counselling services to a section of the community that was unable to afford to pay for treatment privately. The existing directors of Psychotherapy Associates International Limited who provided the same services to fee-paying clients formed the Institute. The Bond Hickling Bartley Institute and Psychotherapy Associates International Limited were designed to work in tandem for the provision of mental health services to people in the community who had, and did not have, the capacity to pay.

The charitable Institute was conceptualised to enable an appropriate source of funding to be accessed, so that a greater number of people could be provided with the help that they needed. The design of the project enabled Psychotherapy Associates International Limited to provide the necessary start-up support services and financial assistance for the Bond Hickling Bartley Institute. The aim was for the BHBI to become self-sufficient and independent with time, and the PAIL to withdraw its support after an initial period of operational service, research and development. An explanation of the organisations that we established to undertake the work in Britain is necessary before a discussion of the other relevant issues can be outlined.

VI. The issues in Britain

One of the issues which concerned our organisations, was the appropriateness of the concepts, models and services utilized in Jamaica for addressing mental health issues in Britain. We were also concerned about the plight of the Caribbean population in Britain and wondered what were the factors that had had a negative impact on the health and well-being of Caribbean people there. The following statistics illustrate the plight of the African-Caribbean population.

In the Criminal Justice System Black people are over-represented in the UK prison population, where17% of the male prisoners in England and Wales are from ethnic minority groups, constituting 6% of the general population. The rates of imprisonment for Blacks were eight times higher than for Whites. Of Blacks over the age of 21, 51% were serving sentences of over four years, as compared to 35 % of Whites (Home Office White paper Cm 3190, (1996).

In the Mental Health Services, Black and ethnic minorities (compared to the 'White' majority communities) are more often diagnosed as schizophrenic, and compulsorily detained under the Mental Health Act. In addition, they are transferred to locked wards from open wards, are admitted to hospital as 'offender patients' and held by police under Section 136 of the Mental Health Act. [1] They are not referred for psychotherapy, and they are given high doses of medication and sent to psychiatrists by the courts.

In the education and schooling system there were a large number of permanent exclusions of Black pupils of compulsory school age. African-Caribbean children were excluded four times more commonly than White children.[2]

The significance of these statistics is that they show an overrepresentation of Black people in some of the major institutions such as prison and mental hospital; and under-representation in terms of scholastic and economic achievement. A note about the size and the experience of the African-Caribbean community follows:

> Between 1948 and 1973 approximately 555,000 persons of Caribbean birth migrated to Britain, the majority before the 1962 Immigration Act effectively cut off further migration...Although the Caribbean community in Britain represents less than one percent of the population, migrants as a percentage of the population of the *home* countries are large...there has been a significant reduction in the size of the Caribbean communities in the last decade, some of it as a result of death, but mostly due to re- and return migration. At the same time, the migrants who arrived in Britain during the 1950s and 1960s are now comfortably in middle-age. Many of their children were born and brought up in Britain. Many are now grandparents. There has been a qualitative change in the structure of the Caribbean community in

[1] [* A section of the UK Mental Health Act that authorizes a police officer to remove a person from a public place]

[2] Department for Education and Employment News, " Minority Ethnic Pupils in Maintained Schools by Local Education Authority Area In England." Jan. 1997 (Provisional), 342/97-30th Oct., 1997

> Britain. At one level, it is a stable community with established lineages and network; at another, it clearly retains elements of transnational mobility (Chamberlain 1997, 2).
>
> Despite the horrors of their exile in Britain, it would be a mistake to believe that the first generation of Afro-Caribbeans regards their experience of living in Britain as an unmitigated disaster. They experience racism and they occupy in their vast proportion the lowest rung of the social hierarchy of Britain. Nevertheless, in material terms, the overwhelming majority enjoys a standard of living in Britain, which many would not have dreamt of back in the Caribbean (James 1992, 244).

Mary Chamberlain is a British social historian who has lived in Barbados and undertaken research on Caribbean migration with particular reference to Barbados. She is currently a professor in the UK. Winston James is a Black British researcher who has written on the Caribbean Diaspora, Caribbean history, politics and political economy. He is currently teaching in the USA.

Chamberlain and James have contributed to our understanding of the lives of African-Caribbean people in Britain. The recognition of the paradox of this migratory experience is important in understanding the ambivalence felt by many African-Caribbean people about Britain. There have been both costs and benefits to the experience, as has been revealed in the lives of many African-Caribbean people.

VII. The mental health system in England

Trends in England were reflective of an international movement that was also taking place in former colonies like Jamaica where previously institutionalized mentally ill people were being de-institutionalized into the community. Referring to the twentieth century, Pattison notes:

> This century has seen mentally ill people returned to the community. In 1961 Enoch Powell, then minister of health, unexpectedly proclaimed

> the demise of psychiatric hospitals and the advent of community care outside institutions as government policy for mental disorders. (Pattison 1992, 150)

The experience of Jamaica's only mental hospital Bellevue, raised significant issues related to the healing of African-Caribbean people diagnosed or living with mental illness in Britain.

Like all mental hospitals, Jamaica's only such facility, Bellevue attracted considerable stigma so members of the public who could keep their mentally ill family members out of the institution preferred private care when their relatives were experiencing mental illness. The Government services cared for more than 14000 patients who were seen by 30 mental health officers who were nurse practitioners in the community at health centres where general healthcare was provided. These mental health officers worked with the Community Mental Health services. There were 30 psychiatrists and 20 psychologists who provided mental health care in the public and private sectors. In addition, nearly 2000 general practitioners and thousands of ministers of religion also provided care. Hickling (2000). Health and healing included the use of pharmacological products, herbal and traditional folk products, talking therapies, African religious rituals and Euro-American religious rituals. Most of this healing was accessed within the community. During the 1970s cultural therapies were used in the mental hospital for purposes of rehabilitation (Hickling, 2004).

Throughout the world, there has been a shift from the provision of mental health services in mental hospitals, to the provision of care in the community. The process is called de-institutionalization and involves patients being discharged into the community, and receiving services provided by

government or private care-givers. The debate about de-institutionalisation is still raging, as some feel that governments have been abdicating their responsibilities as health budgets have been slashed and patients have been re-directed to community facilities. This has been part of the international trend to undertake health reform in the face of rising health costs and economic problems in many countries.

> It is not possible or necessary here to offer an in-depth critique of the various policies, controversies and political agendas that lie behind the current emphasis on deinstitutionalization...The movement from hospital to community has both positive and negative aspects. Positively, there are many long-term patients with various types of psychiatric difficulties who simply should never have been in hospital in the first place. ...In fact, Fuller Torrey speculates that the vast majority of individuals discharged from institutions could live successfully outside the hospital if medication and aftercare services were provided... On the other hand, the reality is that deinstitutionalization has been a disaster for many people with mental health problems (Swinton 2000, 53-54).

The provision of appropriate medication and aftercare is then critical to the health and healing of those African-Caribbean persons with severe and enduring mental illness, who are the focus of this study. The services and therapies provided by an organisation like Servol Community Trust, are also of great significance, and must be culturally sensitive and appropriate.

An extract from the Mental Health Act Commission's 10th Biennial Report notes that services need to be appropriate to the cultural and religious requirements of diverse communities.

> Links into the community and meaningful consultation with Black and ethnic minority groups are central to developing such services, as service changes must be responsive to issues raised in such consultative processes...Some aspects of religious and cultural sensitivity in service provision which have been raised are:
>
> - ensuring that patients have access to worship space, faith leaders and religious/faith groups, and that staff are informed of and sensitive to religious/culturally significant dates.

- ensuring that personal care requirements (such as hair and skin care products are made available to patients.
- ensuring that patients can access culturally appropriate opportunities and materials for leisure and education (Report 9 -10, 2004).

In 1997, the University of Birmingham and North Birmingham Mental Health Trust were commissioned to undertake a study and produce a report on Ethnicity and Mental Health Provision. Among its many recommendations were the four listed below, which are particularly significant for African-Caribbean patients.

- As it is clear that traditional hospital-based care is no longer appropriate or acceptable to the Black communities being served, all staff should receive basic training in the principles of community-based care and alternative service models that are available. There is an urgent need to develop crisis alternatives such as Home Treatment to hospital admission.
- There is an urgent need to review the availability and accessibility of social and psychological therapies for Black and Asian patients. Referral rates and acceptance rates within such services must be monitored according to ethnicity.
- Trusts providing psychiatric care in inner-city areas in particular should be encouraged to develop alternative informal services for Black service users with the emphasis on social care available locally, including supported housing schemes, cultural therapy centres and other informal systems of non-medical care. These alternative services should be monitored on a regular basis.

- All staff who are likely to have contact with Black patients must be given special training on culture and mental health, the impact of racism on the perceptions of staff, the common stereotypes and behaviour of the staff. (University of Birmingham ,1997:vii-ix)

The theme of culturally relevant therapy has been emerging within world psychiatry in recent decades, as many countries are faced with the reality of rapidly enlarging multi-racial and multi-cultural societies. Littlewood (1992a) identifies the psychotherapeutic neglect of minority groups in Britain and most authors are agreed that psychotherapy with Black populations has been generally ignored in world psychiatry.

In most Black countries, psychiatric therapies have usually been based on Western values and approaches, and have often been in opposition to, and in conflict with the therapies offered by indigenous healers. Littlewood (1992b) asks whether there exists a psychotherapy that can acceptably be applied across cultures. Hickling (1988) working from the perspective of the multi-cultural Jamaican society, suggests that Western Cartesian analysis of formalized structures excludes the existence of psychotherapy in the non-Western world. He further suggested that unless psychotherapy is structured within the philosophical conjuncture of dialectics and its application to power and oppression, the question could not be realistically answered.

The idea of culture is conceptualized in different ways by divergent scholastic perceptions. The anthropological and linguistic conception consists of a perception of a historically transmitted system of codes, embodying widely divergent aspects of human life, such as race and ethnicity; language and arts;

religion; social class; and gender identity. Others define culture as a collective expression of a group's personality, its wishes, values and ideology. Acharyya (1992) correctly separates ethnicity from culture, defining culture as referring to milieu, the process of living and the system of values and practices shared by particular groups of people. The revolutionary energy of the popular culture described by the Caribbean psychiatrist Frantz Fanon (1968), posits culture as an ideology in the expression of social metamorphosis and change. The notion of culture as the driving energy of social therapy and change, has also been identified by Freire (1970), demanding the social and ideological transformation of the oppressed and disenfranchised peoples of the world, based on the needs of their own cultural expressions. It is in this context that the concept of cultural therapy is presently being described (Hickling, 2004). There is a significant link between the concept of cultural therapy and the recovery of personhood that Swinton advocates.

In a chapter on creating non-persons (Swinton, 2000) explains that persons with a diagnosis of schizophrenia lose their personhood as a result of their illness. They lose their relationships and much of what is valuable in their lives, because of the devastation caused by their illness. Many of these patients have lost contact with their families and other members of their support system while they have been in mental hospitals. So when they are discharged, from mental hospitals, they have to be re-socialised and rehabilitated in order to become independent persons in their communities. For those patients who have lived for considerable periods of time in mental institutions, it is likely that they have become institutionalised. Goffman's

research shows that not only the patients, but also the staff who care for them, can become institutionalised (Goffman, 1961).

In some countries it is felt that the community services are under-resourced and that the care being given is inadequate. At the same time, it must be remembered that mental hospitals have been extremely controversial in terms of their capacity to treat mentally ill people appropriately. The main treatment modality has been that of custodialization, where people have just been locked up and treated with large doses of medication. Patients have had insufficient opportunity for rehabilitation and, therefore, have difficulty in returning to normal function as human beings. This creates tremendous problems for the patients and for those persons who assist in the care of mentally ill people in the community (Swinton 2000).

Most large mental hospitals have already been closed, and those that have remained open, are slated for closure. In England, the process of de-institutionalization is at an advanced stage, thus many organisations other than mental hospitals are providing the necessary care in the community. These organisations include MIND, the mental health charity and the Richmond Fellowship, a church-affiliated organisation, among others.

Mental Health Trusts have been organized by the National Health Service to cover specific geographical areas. So in Birmingham, where this research was undertaken, there is the North Birmingham Mental Health Trust and the South Birmingham Mental Health Trust. These Trusts are usually in 'partnership' with community-based organisations to provide care for persons with chronic mental illness, who have been in the mental health system for a long time. The services provided by these partnerships also benefit those

persons who are acutely ill. In Birmingham for example there is, Servol Community Care Trust, which is in partnership with North Birmingham Mental Health Trust. The nature of the partnerships varies in their scope, however, whether they are formal or informal it is recognized that the client requires the input of more than one organisation to maintain health and well-being.

In 2004, the British Government merged North and South Birmingham Mental Health Trusts, as part of the larger process of restructuring of the National Health Service. While the definition of health is physical, mental and spiritual well-being, it is recognised that when a person is afflicted with chronic mental illness, the definition has to be adjusted. Indicators of health include: keeping well enough to live independently or in a warden-controlled flat, able to remain on medication without having to be hospitalized; the ability to establish and sustain healthy relationships; the ability to attend college; get a job; care for one's daily grooming needs; and prepare one's food and clothing. These and other indicators of good health, have been identified especially in terms of the lives of people who had lived in isolation and idleness in a mental hospital where things seemed hopeless, and the patients were no longer actively living in the world. In fact, they had given up, felt that they were useless and that there was no future.

If the therapies used do not result in improvements in their health, patients will not comply in taking them. There are currently many problems with African-Caribbean patients who are rarely given talking therapy. Instead, they receive very high dosages of medication and are too often misdiagnosed. Where the medication is prescribed and there are serious side effects,

patients feel worse rather than better. There is also inadequate support for people who are experiencing mental health problems.

Many families have been pathologized in ways described by Robinson (1995) and have been undermined, and yet when people are in trouble there is nowhere else to go. Although there are often valiant efforts made through the social or health services to provide community care and other support, it is frequently inadequate.

The literature on people with chronic mental illness suggests that they often end up isolated, not visited by relatives when they are in hospital and are generally without support systems. This is frequently the result of extended families being undervalued and undermined. It would also seem that the chaplaincy services available could be inadequate, inappropriate or even racist in character. So ultimately, there is no relief for those in need of help and support.

The considerable body of research on mental health issues in African-Caribbeans in Britain has confirmed that this ethnic group is over-represented within the psychiatric facilities, and that they fare much worse than White people in all aspects of psychiatric care (Nwulu 2002, Bhui 1999, Raleigh and Almond 1995 Kareem and Littlewood 1992). Some providers have turned for assistance to mental health providers in the Caribbean, where the clinical provision of psychiatric care for Caribbean people has been successful and acceptable (Hickling, 1993, 1997; Neehall 1991, Bhugra et al 1996).

It is my contention that we need to investigate and adapt those approaches which have efficacy in the cultures of Black British people (Hickling, 1989). There are not enough culturally sensitive organizations and

therapeutic groups available; and those which are currently available, are being underutilized in providing care for the Black British communities (Robinson 1995).

VIII. Servol Community Trust

Servol Community Trust is one of the few surviving African-Caribbean Mental Health service providers in the UK. It was established in 1979 in Birmingham under the name the Pride of Jepthah Resource Centre and established as a charity. It's nam was changed in 1983 to Servol.

During the period it has acquired property from the Birmingham City Council to establish residential properties to provide housing for persons suffering from mental illness. Servol expanded its programmes from Birmingham to London, Dudley and Stoke-on-Trent, where it provided residential, crisis-house and clubhouse facilities for patients with chronic mental illness. Since 1986 it has acquired a property in Birmingham that provides Crisis/ Respite services, supported by North Birmingham Mental Health Trust.

IX. Cultural therapy at Servol

Cultural therapy had been developed at the Bellevue Mental Hospital in Jamaica and had achieved positive results in the treatment of Afro-Jamaican people Hickling (1989). As I have outlined, in 1995 Dr. Frederick Hickling undertook a consultancy for North Birmingham Mental Health Trust, to investigate the establishment of an African-Caribbean service. At that time he met representatives of Servol and other organisations which provided

services for the African-Caribbean population. Servol had been successful in attracting funding for the establishment of a Clubhouse and other rehabilitative interventions. Hence, Psychotherapy Associates International Limited was approached to implement a Cultural Therapy Programme at Servol, the largest African-Caribbean mental health charity in Britain.

a) Assessment of patients

The Cultural Therapy Programme was implemented in three phases; assessment; implementation; and evaluation. Twenty clients were selected to participate in the programme and the study. In Phase II, a large therapeutic group was established and in Phase III, a sociodrama was developed and performed at the Servol National Conference in London. In Phase I, I assessed the clients after reading their case notes[3] and they gave written consent for this information to be used in this and other research studies.

These cases provided insight into the psychological impact of racism on African-Caribbean migrants and their families and the ways in which these persons searched for healing in Britain.

The clients were participants in a process of transformation. This process involved the establishment of a large cultural therapeutic group in which they would be interviewed, observed and data collected. The process included centring, the utilization of anecdotes in the oral tradition, self-disclosure, role-play etc. In Phase II, the large therapeutic group was

[3] A detailed psychiatric examination of the clients had been undertaken using the Present Status Examination (9) Hickling (1997).

implemented and it lasted from September 1997 to April 1998, with sessions three mornings per week, for three hours each day - a total of nine hours per week.

The clients were also visited in the residential homes where they lived, in order to derive relevant contextual data. Phase III lasted from May to June 1998 and resulted in the development of a sociodrama which was performed at Servol's National Conference in London.

b) Implementation of the Programme

Psychotherapy Associates International Ltd had been contracted by Servol to undertake the programme which prepared staff to expand and further develop the Clubhouse concept, using the techniques of Cultural Therapy to provide a new mode of working and caring for clients (Users) and Staff. The training was conducted in a large group, consisting of clients and staff. There was also individual consultation with the clients and staff as part of the process.

This large group was able to build on the Clubhouse concept already implemented in Servol. This concept was pioneered at Fountain House in New York City in 1948, and there are now 350 Clubhouses worldwide, in more than 21 countries. A Clubhouse is a psychosocial and vocational rehabilitation centre for people with mental illness. They join a Clubhouse, become members, and the Clubhouse is committed to them for life. They are neither patients nor clients, but participating members. Members work side by side with staff to run their own meetings and committees at which all decisions are made by consensus.

A Clubhouse is based on the belief that members gain their independence and feelings of self-esteem, by being offered options and by being allowed to make their own decisions in order to regain their independence and feelings of self-worth, so often lost during an episode of mental health treatment (http:// members iinet.net.au/-lorikeet4/19/02). It was also a work-oriented place, which provided opportunities for the upgrading of social and vocational skills. Cultural Therapy combines the use of large group techniques with psychohistoriography - a graphic technique which is used to record the experiences of participants. The material collected is translated into music, poetry, drama and dance, and then performed as a play or a sociodrama.

The convergence of both concepts facilitated the expansion from a one–day per week, to a three-day per week programme. There were several considerations in the planning of the training programme. One of these was the nature of the training process. The essential component of this process was the re-training of individuals, based on a novel method of sociocultural analysis and insight (Hickling, 1988). The staff or caregivers were given orientation in the following areas: in new psychological and vocational training skills; how to run large group meetings; how to facilitate catharsis in mentally ill users; how to recognize and channel abnormal thought processes and behaviour of mentally ill persons into creative activity; and problem-solving behaviour. They were also trained in the acquisition of Cultural Therapy skills, actualization of obscured or hidden personal talents and skills.

The clients were trained in new methods of coping and sharing in the community: channelling abnormal thoughts and behaviour into adaptive

coping skills; acquiring new skills training; reducing of anxiety; raising self-esteem; and improving self and cultural identity. Retraining was also provided in activities of daily living, dealing with dependency, and moving from welfare to work activity. *The aims of the training programme included the* building of individual and organisational capacity to manage change, enhancing access and improving the quality of service.

The training programme also aimed to ensure that staff members would be able to understand the elements of group dynamics, and develop skills to manage large therapy groups and meetings in Servol. Another objective of the programme was to enable the staff to establish work-centered therapeutic activities, combining staff and clients, to transform the organisational culture from that of a residential setting, to the new work-centered therapy. This would result in improvement in staff productivity. Together, staff and clients would understand and manage the change processes at the individual, group, and organisational levels, e.g. resistance, conflict and resolution. The staff would also be better able to plan, evaluate and modify the changes within Servol.

c) Group Process

An integral part of the group process was the emphasis on the physical well-being of each participant evidenced by the starting of each session with physical exercise led by three different group members. The Group Leaders conducted reviews of each session by requesting each member to provide an update on their activities, insights and decisions since the last meeting.

Many cross-cultural issues which reflected the diversity of the group, were raised and dealt with. The group also facilitated the following: the breakdown of barriers between people of different generations - older and younger people; people born in Britain; and those born overseas. Efforts were made to encourage men and women to work harmoniously together, as opposed to being in constant conflict. Service users and caregivers were empowered to speak for themselves about their concerns, and gained insight into mental health issues. The participants shared knowledge of community resources and acknowledged the important role of Servol as service provider, employer and community advocate.

Participants developed new skills enhanced existing ones and received and gave support in dealing with personal difficulties. The training was conducted in a way that required clients and staff to be respectful to each other, and encouraged tolerance between people holding opposing viewpoints. Active listening was also encouraged and participants were to move at their own pace. The training built on individual strengths and participants were taught to value their families and support systems. There was also recognition, agreement and programme design around the fact that all staff members and users could not be present at every session. However, to ensure continuity, it was agreed that there would be a core group of staff members, and that detailed notes would be taken for constant reference. Additionally, participants would receive summary on request.

Preparation, planning, evaluation and modification were central to the implementation of the large group meetings. In addition, a briefing meeting was held after each session, followed by a weekly review. Arising from

developments in the meetings, it was sometimes necessary for the team to respond to individual staff members and clients on a one-to-one basis.

At the start of the each session, the participants were asked to arrange their chairs in the form of a circle. This constituted the first demonstration of efficient structural and functional change by collective activity.

d) Evaluation of the Programme

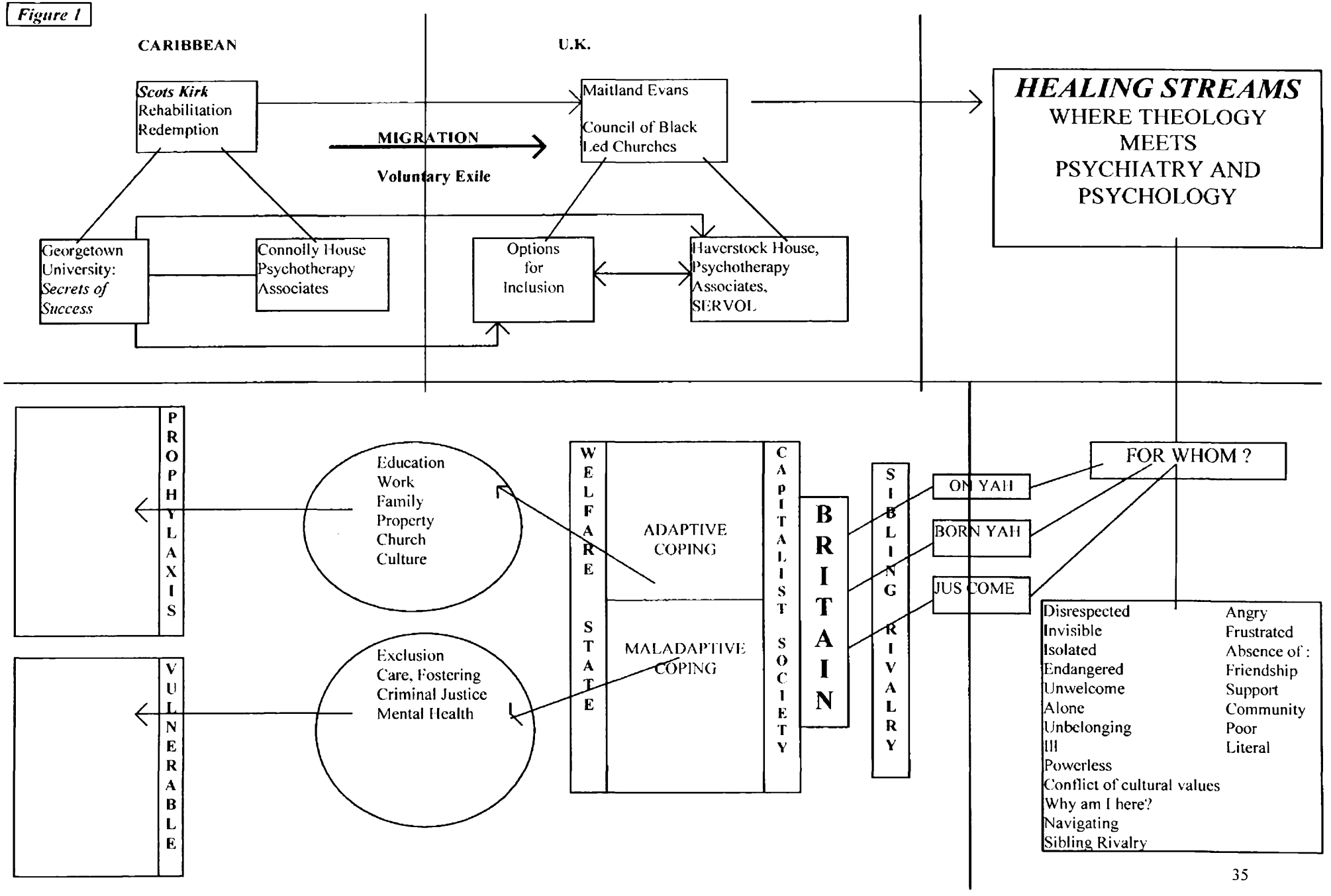
By the end of Phase II the participants had become more self-confident and reported that they felt better. The caregivers noted marked psychosocial progress in the clients and PAIL was invited to develop a sociodrama for performance at the Servol National Conference in London. At the beginning of each session the participants were invited to take part in a 'warm-up' cultural therapy exercise called 'centring', which involved holding hands, standing in a circle and doing a series of stretching, deep breathing and relaxation exercises, mime, singing and dance routines, led by the group therapist. The centring exercise was five minutes long, and philosophically, this type of activity has been proven to draw on the hypnotic, mental and physical processes as in similar cultural expressions such as Yoga, Tai Chi and Karate.

The large group ethnohistorical meeting which usually followed was based on the oral tradition (Brodber, 1992) of group communication. The participants discussed the history and activities of the group, and incorporated anecdotes and folk material of their culture, such as ring games, story telling and improvisation, led by the psychohistoriographic facilitators.

X. The Transforming Hypothesis

The thesis has developed over the period 1998 to 2004 and is reflected in the schema that follows in Figure I, which follows. Initially, I conceived of psychology, theology and psychiatry as the streams that had to converge to provide healing for African-Caribbean people. I, therefore, adopted the holistic, conceptual framework identified by Allen (1995). However, as my work expanded in mental health in Britain, the ideas coalesced around the desire for and the strategies employed for healing African-Caribbean people in response to the experience of racism in Britain, particularly in Birmingham, as well as other factors which contribute to the severe and enduring mental illness that they experience.

Figure 1


CARIBBEAN
U.K.
Scots Kirk
Rehabilitation
Redemption
MIGRATION
Voluntary Exile
Maitland Evans
Council of Black
Led Churches
HEALING STREAMS
WHERE THEOLOGY
MEETS
PSYCHIATRY AND
PSYCHOLOGY
Georgetown
University:
Secrets of
Success
Connolly House
Psychotherapy
Associates
Options
for
Inclusion
Haverstock House,
Psychotherapy
Associates,
SERVOL
PROPHYLAXIS
VULNERABLE
Education
Work
Family
Property
Church
Culture
Exclusion
Care, Fostering
Criminal Justice
Mental Health
WELFARE STATE
ADAPTIVE
COPING
MALADAPTIVE
COPING
CAPITALIST SOCIETY
BRITAIN
SIBLING RIVALRY
ON YAH
BORN YAH
JUS COME
FOR WHOM ?
Disrespected
Invisible
Isolated
Endangered
Unwelcome
Alone
Unbelonging
Ill
Powerless
Conflict of cultural values
Why am I here?
Navigating
Sibling Rivalry
Angry
Frustrated
Absence of :
Friendship
Support
Community
Poor
Literal

This thesis has been based on three platforms. The first is that of African-Caribbean migration, which for some persons became a form of exile. For others, the experience mirrored that of the children of Israel in Egypt, and the whole issue of the Jewish Dispersal. This motif was captured in the Ras Tafari interpretation of the Western world being Babylon, which enslaved and exiled significant numbers of Africans.

Hence the Jamaican singer Brent Dowe of the group, the Melodians (1969) rewrote and sang Psalm 19, which was given international exposure by Boney M.

> By the rivers of Babylon
> Where we sat down and there we wept when we remembered Zion
> For the wicked carried us away in captivity
> Required of us a song
> How can we sing the Lord's song in a strange land
> For the wicked carried us away in captivity
> Required of us a song
> How can we sing King Alpha's song in a strange land?

Yet for others, migration was the new start that Louise Bennett explored in her poem *Colonization in Reverse* in which she looked at African-Caribbean migration to Britain as the "colonized colonizing the colonizer". Implicit in these notions of exile and "colonization in reverse" was an understanding that the migrants brought with them strengths and weaknesses, which affected how they responded to their experiences in the new country, Britain.

> What a joyful news, Miss Mattie;
> Ah feel like me heart gwine burs-
> Jamaican people colonizing
> Englan in reverse (Bennett, 1982)

The new country provided opportunities as well as threats to the African-Caribbeans' well-being. The major threat was that of racism at the personal and institutional levels; as it was so pervasive that it affected every aspect of a person's life. It affected the whole person. As a result, persons have had to be able to respond to all the major institutions of the society, to ensure the survival of the person, the family and the community.

There are also been the success stories of people who have met or surpassed their goals, completed their studies and raised their children. Some continued on to other destinations like Canada and the United States, and there is now a trend to travel to South and West Africa. Theirs has been a history of migration first forced from Africa, then in search of opportunities in the Americas and now in Europe and Africa. These migrant and diasporic experiences currently exercise the minds of post-modernist thinkers like Hall (1995).

XI. On Ya, Born Ya, Jus come and Come and Go

In thinking about these issues, I developed a classification that related to place of birth and was influenced by the songs of two Jamaican musicians. The songs were called, "My leader born Ya" and "I man born Ya" (Smith, 1989) respectively. These songs coincided with a period of patriotism and nationalism in Jamaica in a very turbulent economic and political epoch in the 1970s. I came up with four categories of Black British. 'All persons are categorized in relation to Britain and they are divided into four groups:

- *'Born Ya'* are people who are born in Britain.

- *'On Ya'* are people who have lived there for long, and are likely to be the parents or grandparents of the *'born ya'.*
- *'Just come'* refers to people who have recently arrived in Britain.
- *'Come and go'* refers to people who commute between Britain and the Caribbean or Africa.

Each group has a different identity although there are many common elements within them, and there is a need to recognize diversity within the African-Caribbean community. There are people who are simultaneously members of more than one of the groups identified as well. The impact of differences will be examined in the conclusions.

Born Ya [4]

This group consists of persons who were born in Britain. There have been some suggestions that there are marked divergences between the grandparents, the parents and the current generation, but James (1992) suggests that the brutal nature of racism has encouraged the development of a consensus. Some members of this group have little concept of life outside of the community in which they live, or Britain for that matter. They seem cut off from their roots and Britain is their only point of reference, and this makes them vulnerable to rejection. This group has the highest rates of mental illness, incarceration and other measures of alienation and social exclusion.

[4] Ya is Jamaican Creole for here.

On Ya

The members of this group were born in the Caribbean, Africa or India and they have been living in Britain since the 1950s and 60s. They are now the grandparents of today's generation. For many 'home' is still the Caribbean. When asked how long they have been in Britain they often say," Too long" and refuse to state the exact duration of their sojourn. Their original intention to return has not for one reason or another.

Just come

The members of this group come from a variety of backgrounds and represent a cross-section of Caribbean society. The numbers are small, but significant to the development of Black British society. This group includes professionals and criminals now known as Yardies.[5] There are many differences between this group and those persons who have long been resident in Britain. Moreover, those who have recently arrived, sometimes fail to understand the impact of racism on people's lives and the difficulties that the pioneering generations experienced in Britain. All of the groups categorized above need to develop an understanding of each other. This classification points out that there is an opportunity for Black people to identify their common heritage, as well as the differences between them. This is not only necessary for their survival, but it is also an important step, which could contribute significantly to the process of healing within the Black community.

[5] Yardie is a description given to a person from Jamaica which is also called 'Yard'. Additionally, there is also an association with criminal activity ascribed by the authorities.

Come and go

Some of these persons live for a number of months in each location and maintain a place of residence or business in both. Then, there is the group that enjoys the best of both worlds. They maintain homes and work in both environments. They exercise choice and sometimes spend six months in the Caribbean or Africa, and six months in Britain. For some this choice has come in retirement, but there are also some young people who have worked creatively and operated in both worlds. There is tremendous freedom for this group of persons who are in a position to capitalize on their dual heritage. Some were born in Britain and their parents educated them in the Caribbean to encourage them to achieve scholastically and in other ways (Reynolds 2000). They were spared the problems facing Black people in the educational system at the secondary and tertiary levels, and they often functioned very effectively in both worlds. This group is both 'born ya' and 'come and go', and they could play a pivotal role in the further development of the Black community.

The presence of these groups identified above underscores the fact that African-Caribbean identities are multiple and varied, and that there are options which people exercise in the construction of their identities. There may be some truth in the view expressed by the psychiatrist and theologian Allen (1989) that part of the identity problem of West Indians is that they constantly search for an identity when they already have one.[6]

The second platform on which this thesis has been developed is that of streams of knowledge and disciplines of healing - primarily Black theology, the psychological, and the psychiatric. As the whole person is affected by racism, there

has to be a response which synthesizes all sources of healing, in other words, a whole or holistic response. This means that those institutions which have traditionally been responsible for healing the society. The church, health care providers, educators and others, must combine their knowledge and skills to use the streams of healing such as theology, psychology and psychiatry. As Lambourne the British psychiatrist and theologian argues:

> No single stream could provide healing which was defined as 'a satisfactory response to the crisis'. (Lambourne 1982, 27)

Lambourne recognized that where the crisis was located in the community, there was need to develop 'community health'. He linked spiritual and physical health to create a holistic concept of health and healing. The combination and the synthesis of the healing streams require a shift in the epistemological terrain. As the African-American feminist scholar Collins (1991) reminds us:

> Epistemology is the study of the philosophical problems in concepts of knowledge and the truth...Investigating the subjugated knowledge of subordinate groups - in this case Black women's standpoint and Black feminist thought – requires more ingenuity than that needed to examine the standpoints of dominant groups (Collins1991,202).

The final platform is that of the coping mechanisms of the African-Caribbean population in the face of racism and other challenges which they encounter in Britain. Some of the mechanisms are adaptive, thereby allowing the population to thrive, while others are maladaptive and result in the many problems experienced by the African-Caribbean population. All African-Caribbean people who live in Britain are members of a minority; most of this population occupy positions at the bottom of the socio-economic ladder and increasing numbers are members of the underclass. Poverty is a significant factor and the British Welfare State has a powerful role within

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[5] Allen has expressed this view about Caribbean identity quite succinctly.

this community. In this context, it is easily possible for some African-Caribbean persons to become dependent on the State. Economic and psychological dependencies are the consequences, which in turn, result in people being robbed of their capacity for self–determination and being at the mercy of the State.

XII. Aims and Hypotheses

This study attempts to fill the lacunae in the literature that addresses the search for healing of mental health problems. In so doing, it seeks to assess the impact of a culturally sensitive African-Caribbean organisation and cultural therapy on the healing and wellness of a group of African-Caribbean persons who have experienced severe and enduring mental illness in Birmingham, England.

The Hypotheses

Two hypotheses have been advanced and they are as follows:

- **Hypothesis on the impact of a culturally sensitive and appropriate African-Caribbean organisation on the healing of African-Caribbean persons with severe and enduring mental illness.**

  H1: A culturally sensitive and appropriate African-Caribbean organisation can have a positive impact on the healing of African-Caribbean persons experiencing severe and enduring mental illness.

- **Hypothesis on the impact of a culturally sensitive and appropriate African-Caribbean cultural therapy on the healing of African-Caribbean persons with severe and enduring mental illness.**

  H2: A culturally sensitive and appropriate African-Caribbean cultural therapy can have a positive impact on the healing of African-Caribbean persons with severe and enduring mental illness.

CHAPTER 2

BEING BLACK AND BRITISH

I. Blackness defined

Many theorists (e.g. Hall, 1992, 252; Gilroy, 1994, 290) use the term 'Black' to connote people with one or both parents from Africa, Asia and the Caribbean. It is used as a political category, coined as a way of referencing the common experience of racism and marginalization in Britain, and came to provide the organizing category of a new politics of resistance amongst groups and communities with, in fact, very different histories, traditions and ethnic identities.

> What has been central to the experience of Black people in Britain has been neither the 'idea' nor the politics of 'racial difference'. Rather it has been racism and other forms of oppression. It is racism that has determined the manner in which their communities' have been policed; it is racism which assaults their humanity in psychiatric hospitals; and it is the effects of racism, too that have been internalised. In short, it is racism against which the struggle has been fought not difference (Harris and James 1992, 3).

This struggle has not only been fought against racism, but also against the discourse about difference that has been developed to counter the impact of racism. The literature is replete with the debate over the significance of racism, as opposed to that of difference. Some see racism in biological or cultural terms:

> A third mediating category is 'racism' which we can define as the organisation of society on the basis of an ideology of inferiority grounded in 'race' or colour (i.e. biological differences) and/ or ethnic difference (i.e. cultural) differences, which then give rise to a distribution of the labour force in certain ways (Lewis 1992, 74).

Lewis, an economist, then goes on to assert that Black people's experience of racism cannot be analyzed only on ideological grounds, but needs to include how cultural and biological factors intersect with underlying economic factors.

Racism has so affected the lives of African-Caribbean people in Britain that there is a crisis both at the individual and corporate levels. Hence there is need for healing in a variety of ways. Indeed, Lambourne is correct when he notes the following:

> Healing is a satisfactory response to a crisis, made by a group of people both individually and corporately. The crisis is a symptom of cosmic disorder and more specifically of a local failure in relations between persons (Lambourne 1982, 27).

Hence healing in the African-Caribbean community requires the synthesis of many streams in response to the crisis of racism. Thus, healing is possible at the individual and the corporate level when cosmic order must be restored, and the failure in relations between persons must be addressed. Being Black and British, being part of the minority culture has created problems of identity in a hostile and racist society. Black people who grow up as part of a minority culture, in societies like the United States and the United Kingdom, where there is racism and open hostility to Black people, have traumatic experiences. The trauma is compounded by the difficulties of defining who is Black and British. The definitions below point to the contradictions and confusion.

According to the 2001 census there are two ethnic monitoring categories, which include Black people of African or African-Caribbean origin. '**Mixed**', which includes White and Caribbean, White and Black African, White and Asian; **Black or Black British** African, Caribbean and any other Black background, which has to be specified. There is an implicit distinction made between persons from Africa, the Caribbean and Britain. These classifications are even more difficult for people of mixed ancestry and for how other Black people classify themselves. Mama (1995, 205) raises the contradictory nature of self-identification. She notes that not all British-raised people with a dark skin colour identify as Black or African, although

some people with light skins do identify themselves as Black. The category' Black other' hardly seems to cover the diverse range of origins of people that might apply here.

These classifications are open to discussion for several reasons including the question of why someone who has one parent who is Black and one who is White is classified as Black or half-caste or even mixed-race. The definitions of race and ethnicity in Britain are extremely problematic. This is especially true within the context of a society so steeped in racism. Thus being 'Black' in Britain is about a state of 'becoming' (racialized); a process of consciousness, when colour becomes the defining factor about who you are. Located through your 'otherness', a 'conscious coalition' emerges: a self-consciously constructed space where identity is not inscribed by natural identification, but a political kinship (Sandoval 1991). Indeed, the whole experience of living in a White racist society has helped to forge a Black identity where it did not exist before (James, 1989, 57).

This identity cannot be British, however, according to Enoch Powell, the controversial Tory Politician who also predicted dire consequences of race mixing in his infamous 1968 speech 'Rivers of Blood'. One must conclude that to be British one must be White and that it is possible to exclude some people from being British on the basis of the Black colour of their skin. However, the confusion about identity has not dimmed the expectations that the migrants and their descendants have brought to Britain.

II. Migration, Racism and the development of African-Caribbean identity

Migration has characterized Caribbean life from the times of African enslavement, European, and Asian indenture and of course, resulted in the mass migration to Britain, the USA and Canada at different times in history. E. Thomas-Hope (1992) in her book *Explanation in Caribbean Migration* and M. Chamberlain (1997) in *Narratives of Exile* advance arguments supporting the pervasiveness of migration in the Caribbean. James (1992) provides a valuable platform for raising issues about Caribbean migration to Britain and the development of identity, especially when he notes the paucity of research on the topic:

> Although much had been written on the forces behind Caribbean migration to Britain, and on the social and economic conditions in which Black people live, precious little work has been done on the nature and ethnic identity of Caribbeans and their descendants here... It is now generally acknowledged that ethnicity and ethnic identity however defined, are not static and eternal in their constitution but are profoundly dynamic, always in the process of being made, unmade and remade. Moreover, it is evident, that the phenomenon of migration and the encountering of new challenges in a new environment quite often accelerates the process of such changes (James 1992, 232).

James provides the foundation for the review in this section from the historical and sociological vantage points, and makes the linkage with history in the following section. This foundation is valuable, as it integrates the historical and sociological aspects of African-Caribbean migration to Britain.

III. Having multiple origins

> My history is of Africa, my past is of the West Indies, my present is of England; and my future is of the world (Martin, 1994).

The words of the poster suggest that to be Black and British is to have multiple origins in Africa, the Caribbean and Britain and that the journey to belong to the world is a work in progress. This reflects the dynamism that James identifies. The poster

describes an ongoing process in which people are actively engaged in creating the future, using the resources of their history, past and present. An appreciation of the journey that has culminated in the emergence of people who are Black and British, is critical to our understanding of their lives in Britain and Europe today. The history of Black Britain will, therefore, be briefly examined in this section.

> When 492 Jamaicans disembarked from the SS Windrush in 1948, they may not have been aware that they had opened a new chapter in history. They were the beginning of the largest mass migration of Black people to come to England. Although to be Black and British is nothing new, since there have been Africans in Britain at least since Roman times (Fryer 1988, 77-81).

The African-Caribbean population has had to grapple with the historical legacy of slavery and colonialism. This is because the majority of Caribbean people were the descendants of African slaves brought to the Americas and the Caribbean between the fifteenth and the nineteenth centuries. The European powers, particularly the British organized the lucrative Slave trade to service the vast colonial enterprises, especially the plantations that produced sugar cane and tobacco among other crops.

> From the beginning of the sixteenth century to the end of the nineteenth century, slavery and the slave trade devastated vast areas of the continent. Some fifteen millions were shipped across the Atlantic to the plantations of the Americas ranging from Brazil to the southern states of the US.
>
> This massive and violent transplantation of peoples damaged Africa's development, encouraging conflict and emptying parts of the continent of its youngest and fittest people. It also created large Black communities on the other side of the Atlantic, in almost every Caribbean Island, in many South American countries and in the American South. Oppressed and exploited as slaves, these people survived the horrors of the plantation and kept alive important elements of their African culture through the generations. With the abolition of slavery in the nineteenth century came social reforms and the hope of a better life, but racism and discrimination persisted. Migration spread the African Diaspora more widely; Black people moved to Europe, to the northern states of the USA and Canada (Watson 1999,6).

The inhumanity and far-reaching consequences of the trade, which robbed Africa of many of its people, is still a matter for discussion and understanding. These Africans in the Diaspora have been citizens of societies that have been built on coercion and oppression, loss and dispossession to which they have responded with resistance. This profound process of adjustment continues to unfold even as we see Africans and their descendants from the Caribbean in Britain struggling to become a part of this society.

IV. Expectations of the Mother Country

Jamaican poet, Louise Bennett aptly expressed the expectations of those who came in the Windrush period. The poem is called 'Colonization in Reverse,' and is written in the Jamaican Creole Language:

What a joyful news, Miss Mattie;
Ah feel like me heart gwine burs-
Jamaican people colonizin
Englan in reverse.

By de hundred , by the tousan,
From country an from town,
By de ship-load, by de plane-load,
Jamaica is Englan boun.

Dem a pour out a Jamaica;
Everybody future plan
Is fi get a big-time job
An settle in de motherlan.

What a islan! What a people!
Man an woman, ole and young
Jussa pack dem bag and baggage
An tun history upside dung!

Some people doan like travel
But fi show dem loyalty
Dem all a open cheap –fare
To Englan agency;

An week by week dem shippin off
Dem countryman like fire
Fi immigrate and populate
De seat a de Empire.

Oonoo see how life is funny,
Oonoo see de tunabout?
Jamaica live fi box bread
Out a English people mout.

For when dem catch a Englan
An start play dem different role
Some will settle down to work
An some will settle fi de dole.
Jane seh de dole is not too bad
Because dem payin she
Two pounds a week fi seek a job
Dat suit her dignity

Me seh Jane will never fine work
At de rate how she dah look
For all day she de pon Aunt Fan couch
An read love story book.

What a devilment a Englan
Dem face war an brave de worse;
But ah wondering how dem gwine stan
Colonizin in Reverse (Bennett, 1982).

This poem illustrates the levels of excitement and expectations of high status jobs and prosperity, with which many Caribbean people came to Britain. With the excitement there was also a sense of caution and concern about the reversal of the historical process that would result in the coloniser being colonised. When the Caribbean migrants who were British subjects came to live in Britain, the seat of the Empire's concerns were felt by those who came and by those who were receiving them. It was one thing to live in the colonies out in the periphery, but quite another matter to come to live in the centre. The audacity and sense of belonging in Britain

of the African-Caribbean migrants was met with horror, hate and fear by their hosts and set the stage for the difficulties which lay ahead.

Hall (1989, 1990, 1992, 1996) Mama (1995) Gilroy (1992) and others have contributed to our understanding of Black British identity. However, there is limited information about the impact of racism on this identity (James 1992). In addition, little information exists to identify the connection between identity, social exclusion and the negative experiences of African-Caribbean people in Britain.

The impact of racism on the development of the identity of African-Caribbean people has been of genuine concern to psychologists, educators, researchers and social workers for decades. Low self-esteem, self-hatred and a negative racial identity have been the characteristics attributed to Black children and adults. A review of the psychological literature shows that there are different perspectives on the identity development question, which has produced contradictory conclusions. One body of research that dominated the psychological literature from the early 1940s and through the 1950s, is the Black self-hatred thesis. This thesis suggests that Black people hate themselves as a result of their experiences of racism and oppression which they have internalised.

Another body of research – developed in the United States focuses on models of psychological nigrescence (i.e. the process an individual goes through in his or her journey toward a secure and confident Black identity (Robinson 1995). Cross (1978) developed a five-stage model of nigrescence as follows: The Pre-Encounter Stage, The Encounter Stage, The Immersion-Emersion Stage, The Internalization Stage and the Internalization-Commitment Stage.

> At the Pre-Encounter Stage the person's worldview is White orientated (Eurocentric). He or she will even deny that racism exists. Interestingly, this

> stage transcends class distinctions. At the Encounter Stage the person now experiences or observes a situation that brings him or her to face racism. This experience is so shattering that it forces the individual to re-interpret his or her world. The Immersion–Emersion stage encompasses the most sensational aspects of Black identity development ... Within this Phase the person struggles to remove all semblance of the old identity while intensifying 'Blackness' In the Internalisation Stage which follows the individual has now managed to separate the old identified self and the new self, thus moving towards a positive Black identity. In the final stage Internationalization – Commitment the person focuses on things other than themselves and their ethnic or racial group (Maxime 1986, 50).

(Robinson 2000, 115) notes that:

> A vast amount of research in the United States has shown that Black (African-American) children may suffer from racial group identification difficulties due to the effects of discrimination and racism (see for example Clark and Clark 1940: Powell-Hopson and Hopson 1988).

Earlier studies of Black adolescents in Britain (Mirza 1992; Modood, Beishon and Virdee 1994) have found that these young people have positive racial identities. However, there is some clinical evidence that a few Black children and adolescents do suffer from severe problems of identity (Small 1986; Maxime 1986).

Researchers in philosophy and theology like Anderson (1995) and Appiah (1992) have raised cautions about the danger of essentialism in the issue of race and identity. Although Anderson and Appiah to a lesser extent, are speaking about the experience of the African–American, nonetheless there are some similarities in the African-Caribbean situation in Britain. In his book *Beyond Ontological Blackness,* Anderson urges us to reject ontological Blackness because it impedes the progress of African-Americans. It locks African-Americans into an essentialized narrative of suffering and analytically stratifies them in a constant negative relation to Whites. In the words of a reviewer (http://www.amazon.com/exec) ontological Blackness is designated as the reification of race in contemporary African-American cultural and religious thinkers. The reviewer repeats Anderson's designation, which for me is a

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very difficult concept to grasp, as it tries to treat with the very being of Black people, by attacking the contribution and ideas of thinkers who have contributed insights into a complex and problematic existence. Ontological Blackness has been a very controversial concept in the USA and the UK.

Although these voices have emanated from the United States, similar discussions have taken place in Britain. Gilroy (1993: 30-1) speaks of the intellectual heritage of Euro-American modernity determining the manner in which nationality is understood within Black political discourse. This legacy fuels the need for acquiring an ostensibly authentic, natural, and stabilized identity, one that is almost always premised on a consciously 'racial' self, whose continuity is derived from national identity.

The complexity of this identity of being "Black and British," especially in terms of African-Caribbean people, poses particular challenges in an anti-Black context like Britain. The very act of declaring oneself "Black and British" often leads to rejection, alienation and brokenness, which leads in turn, to the desperate need for healing that this thesis investigates. This complexity is also paradoxical as Hall (1996, 114) notes:

> I've been puzzled by the fact that young Black people in London today are marginalized, fragmented, unenfranchized, disadvantaged, and dispersed. And yet, they look as if they own the territory. Somehow, they too, in spite of everything, are centered, in place: without much material support, it's true but nevertheless, they occupy a new kind of space at the centre. And I've wondered again and again; what is it about that long discovery-rediscovery of identity among Blacks in this migrant situation that allows them to lay a kind of claim to certain parts of which aren't theirs with quite that certainty?

The identity issue is further complicated by the question of being mixed race in Britain.

> "The topic of racial/ethnic identity in mixed parentage children has received increasing attention in recent years (e.g. Root 1992; Tizard and Phoenix 1993) in (Robinson 2000, 119)

This interest has been spurred by demographic trends that indicate a rapid increase in the mixed–parentage population, and by the acknowledgement that there is little well-defined research and theory in the area. According to Berrington (1995), one in five of all ethnic minority children in Britain under the age of four years is of mixed parentage.

Many of those who have been in Britain for a long time have still maintained a connection with the Caribbean or the West Indies, as they are likely to call it. Some have acquired property there and go back for extended periods or for holidays; those members of the generations born in Britain have a variety of perceptions of the place from which their parents, grandparents or even great grandparents came. Those who are born here in Britain have had to construct their identities or 'subjectivities' (Mama, 1995) in a hostile, racist environment. At best, it is a creative and energising process, but at worst, it is soul destroying. It is that identity that is at the core of a healthy person who is affirmed as being in the likeness and image of God. It is in the difficulties of 'becoming' that healing is needed. In the following section the issue of Black British identity continues to be explored.

> To be Black and British is to be unnamed in official discourse. The construction of a national British identity is built upon the notion of racial belonging, upon a hegemonic White ethnicity that never speaks its presence. We are told that you can either be one or the other, Black or British, but not both. But we live here, many born here, all three million of us 'ethnic minority' people (Safia 1995, 3).

There has been and continues to be conflict about a Black identity. As Stuart Hall suggests:

> Identity is not as transparent or unproblematic as we think. What we say is always positioned in context. We might think of Black Caribbean identities as

> framed by two axes of vectors simultaneously operative; the vector of similarity and continuity; and the vector of difference and rupture (Hall 1996, 223-226).

The issues of identity are complicated by a number of factors including one's place of birth - whether one was born in Britain or elsewhere, whether one resides in the inner-city or the suburbs. Then there is the significance of social class, the nature of employment and level of education. In addition, gender and sexual preferences and one's shade or colour are also important. It is difficult to separate the review concerning migration, racism and identity into psychological and other consequences, but it is necessary that it be attempted nonetheless.

V. Psychological Consequences of Racism

There is a growing body of literature about the psychological consequences of racism on members of ethnic minority groups. The literature was at first generated in the USA, but there is now much more research in the UK. The work of some of these researchers will be outlined in the following section.

> Psychological theory has often suggested that contradictory experiences such as racism are pathogenic... The problem with that theorisation is that it pathologizes the millions of Black people who have lived and continue to live in racist societies(Mama 1995, 111).

> Even where racist contradictions feature a great deal in people's history and experience, the fact that they are responded to by personal change means that they are not omnipresent force acting on passive victims (Mama 1995, 112).

> Low self-esteem, self-hatred, and a negative racial identity have been characteristics traditionally attributed to Black children and adults. A review of the psychological literature shows that there are different perspectives on the identity development question, which have produced contradictory conclusions (Robinson 1997, 89).

Robinson goes on to identify the two bodies of research that are more relevant to the psychological life experiences of Black people in Britain than the traditional psychological theories. The Black self-hatred thesis and the model of psychological nigrescence seem more valuable in understanding the problems of the Black population and providing the directions for solutions. Although it would be understandable for people who are constantly bombarded by negative images of themselves, their communities and their race to be adversely affected, there is also the possibility that there are buffers in the family, community, church and other institutions, which compensate for these problems. As Jaffar Kareem and Roland Littlewood have argued, to be Black in Britain today is to be exposed to a variety of adverse stimuli, which can add up to a serious hazard to mental health (Kareem and Littlewood, 1992). This was a groundbreaking study about Black Mental Health in Britain.

This situation has very serious consequences for the mental health of Black people whose sense of selfhood and personhood is constantly being challenged. Who are you? Where do you belong? This leaves people feeling unwanted, invisible, disconnected and alienated, thereby contributing to a situation of exclusion. Oppression and racism have had a particularly devastating effect on Black people, their mental health and their well-being. African-Caribbean people's struggle to understand themselves and who they are, as opposed to who others say they are, is central to the development of their sense of well-being. The difficulties in achieving this, contribute to the mental health problems described by many researchers (Francis 1992). It is particularly useful to examine the literature about the impact of

racism on the development of identity in Black children, since this is the process of identity development, which starts in childhood.

Speaking of Britain, Francis (1992) notes:

> With regard to race, the school is the object of contradictory yet complementary forces. On the one hand there are the 'anti-racist' positions which target the school as a place of cultural domination (Garrison 1977); and on the other, there are the bureaucratic, administrative interests of race relations which propose an understanding of race that is located in the cultural and the personal. Both positions end up complementing one another and set the stage for the psychologization of Black children in the British school system. (Francis1992, 184)

Francis takes exception to the thesis advanced by Coard (1971) in *How the West Indian Child is Made Educationally Sub-normal in the British School System.* Coard concluded that the IQ test was the single most important indicator used by the educational psychologist to determine that a child was educationally sub-normal. Coard identified three biases, which he held responsible for the over-diagnosis of educational-subnormality in Black children. First is culture, second the 'middle class bias' and the third, is emotional disturbance. He asserts:

> While one would not deny that such phenomena exist, and that they are a factor in the practice and experience of racism, they cannot be held to be principal objects of concern in an analysis of institutional racism in the education system in Britain (Francis 1992, 185).

In the schools there are many problems (Coard, 1978; Safia 1993; Sewell 1996;2004 Duncan 1990) and these include inappropriate pastoral care, labelling and exclusion.

VI. The death of Stephen Lawrence

Black mental health and well-being are also affected by institutional racism in the Police Force. This has been highlighted by the Macpherson Inquiry which

followed the brutal murder of 18-year old Stephen Lawrence, a second-generation African-Caribbean youth.

When Stephen Lawrence was killed in 1993, his family and community mourned his loss. Their loss had been compounded by the unjust outcome of the investigation, the trial and subsequent efforts to seek justice. The alleged killers remained unpunished after a long and painful legal process. It has now been established that the Police who were responsible for undertaking the investigations did not conduct them fairly. As a result of an outcry and the intervention of such powerful persons as Nelson Mandela, a Commission of Enquiry was held. The pattern has been one of racist attacks on African-Caribbean and Asian people followed by unsatisfactory police investigations.

In the Jamaica Observer of June 24, 2002, an Associated Press report quotes Sir David Calvert Smith, Director of Britain's Crown Prosecution as saying:

> British society is institutionally racist ... London's Metropolitan police was branded institutionally racist in an official report on the bungled investigation of the 1993 killing of Black teenager Stephen Lawrence. According to the Macpherson Report "unwitting prejudice, ignorance and thoughtlessness and racist stereotyping and the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin."

Stephen Lawrence's parents made the decision to bury him not in the country of his birth, but in Jamaica where they were born, because they guessed that racists in Britain would never allow him to rest in peace. They were right, as there have been several attempts to desecrate his memory by persons who have spray painted a plaque which has been mounted where he fell after the attack that was to take his life. In Black Britain as in the African context:

> There are many, and often complicated, ceremonies connected with death, burials, funerals, inheritance (Mbiti 1997, 145).

So the death of Stephen Lawrence and many others through racist attacks have created many problems for the African-Caribbean community (Zephaniah 1998). This case is symbolic of the experiences of many Black people in Britain.

VII. The Ambivalence of Exile

The ambivalence felt by many Black British people is directly related to the hostile racist environment in Britain, as well as the contradictory experiences which are part of life in the Caribbean and African settings, where the earlier generations originated. It is, therefore, possible to feel exiled in Britain although one was born here, and also to feel exiled in Africa or the Caribbean.

> In recent years however, many, having been made economically obsolete by a Thatcherite Britain, have become distinctly hostile and bitter about their rapidly deteriorating social condition. Many more than hitherto are returning home. But even more feel 'trapped' within Britain because they are incapable of mobilizing the financial wherewithal to resettle in the Caribbean. 'Trapped in Britain during their lives, a considerable number make detailed plans and get relatives to promise that their bodies will be returned to their native land to be buried as soon as possible after their death... It is also worth noting that a considerable number have returned to the Caribbean and discovered, to their chagrin, that the meagre financial resources which they have scrimped and saved over the years in Britain were not enough to facilitate resettlement – in the land they have loved and romanticized during their painful sojourn in Britain – in circumstances of high unemployment and rampant inflation in the Caribbean (James 1993, 246).

This state of ambivalence is reflected in the writings of many researchers, particularly Mama (1996) and James (1996). There are a variety of responses, and the entire situation poses therapeutic challenges in all of the contexts in which care is provided. In the medical, psychological, social and theological environments, there are many challenges.

Research which has been undertaken in the Caribbean had created a positive feeling and optimism about the capacity to understand, promote and achieve mental health and well-being in Black people, as well as people of other races and ethnic groups. (Hickling and Rodgers-Johnson, 1995)

In Britain there is extreme pessimism and a sense of hopelessness in terms of those who have been socially excluded, many of whom were members of the Black British community. Government policies promoting social inclusion have had very little effect on the homeless, unemployed, mentally ill or incarcerated, as well as those subject to exclusion from school. In some families there are three generations of people who have been unemployed. These persons are deeply immersed in the crippling dependence on the state for Income Support and Disability Allowances among others.

It is possible that some young people have never seen an adult in their homes go to work, or heard the discussions which suggest that people who do the low-paid work which their grandparents or parents did, earn less than those who are on the Dole. There is a very serious problem of dependency that is fostered among vulnerable members of the British society. In looking at the Black British population, one has many concerns about this dependency, which has been fostered in parts of the community. This robs people of their capacity to strive for independence and autonomy, as well as for developing self-respect and self- worth. When one sees the relative prosperity of significant sectors of the British middle and upper classes, one sees the stark contrast with many of those in the lower classes, where many of the Black British community are located. Within this same Black British community there are many people who have achieved their goals, in spite of the many obstacles that

they have had to overcome. These peoples' lives are seldom celebrated, and they are rarely acknowledged in the seemingly unrelenting campaign to pathologize the community through the media and other institutions in the society. If the community can learn from the success of its own people, then there is hope for change and empowerment that can improve the lives of all. As Mama has argued, all of the members of these communities need to acknowledge the diversity that exists, know that they belong to this society and that they are contributing to their own well-being in addition to that of the entire society. (Mama, 1992)

In the words of Mike Phillips and Trevor Phillips in their book, *Windrush The Irresistible Rise of Multicultural Britain;*

> Listening to the survivors of the Windrush, their stories, interwoven as they are with our own experience, reminds us once again that they and their successors are a diverse group of individuals, shaped by a specific and peculiar history, moved by their own needs and ambitions; and linked together by the rich and complex history they now share with the people among whom they came to live (Phillips, 1998, 30).

Many researchers have documented the problems. One described the situation faced by Black people in Britain as 'endless pressure' (Pryce 1970). In this context, it is critical for those persons with pastoral responsibilities in schools, churches and communities, or health and social care to harness their professional and personal resources toward healing the broken-hearted.

CHAPTER 3

HEALING STREAMS

I. The nature of healing

The following quotation taken from Isaiah, was used by Jesus to announce his ministry. Jesus undertook healing as an important part of his ministry and the modern and post-modern church need to continue to undertake the ministry of healing in the world today. (Isaak) 2003 amplifies the point that Jesus was the Model of Healing and that health implied safe integration into the life situation of the society.

> The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor: he hath sent me to heal the broken-hearted, to preach deliverance to the captives, and the recovering of sight to the blind; to set at liberty them that are bruised (St. Luke Chapter 4.verse 18).

Healing the "broken-hearted" in the Black British community is the focus of this section. In this chapter, healing is defined and explored in relation to the needs of the Black British population in Britain. According to the psychiatrist Sashi Sashidharan, the issue of the development of Black identity/ Black identities in the face of racism in Britain, and how this affects people's capacity to be healthy and productive, especially in relation to their mental health, is a central issue in the lives of Black people in Britain particularly as regards their mental health (Sashidharan, 1997).

The review of the literature on healing included the work of eight researchers and practitioners either in the field of healing or concerned with the issue of health. Of these some are European others are African or African-Caribbean. They have been chosen because each brings a unique perspective to the process of healing

and many of these writers have important insights about healing in the African Diaspora. A brief description of these researchers follows.

H. Anthony Allen is a Jamaican psychiatrist and Baptist Minister who has developed a pioneering holistic health and healing ministry in Jamaica. In his book *Caring for the Whole Person* (1995) he integrates his faith with his profession and demonstrates a holistic model.

Robert Anderson is a clergyman and researcher, who has collaborated with Ezra Griffith, a Professor of Psychiatry and in African-American literature in the USA, and written about a model of liaison with clergy, as well as the needs of the mentally ill in the community.

Dannabang Kuwabong is a Ghanaian poet, formerly resident in Canada, now teaching in Puerto Rico, who has researched the language of healing and recovery in the work of four African-Caribbean female poets. His PhD thesis is entitled *An Apocrypha of Nanny's Secrets: the rhetoric of recovery in Africaribbean women's poetry*, in which he develops the concept of Africaribbean.

Lorna Goodison is a Jamaica poet and fine artist who writes extensively about healing in the lives of African-Caribbean people. She has a series of poems about a Jamaican place called Heartease, which is the ultimate place of healing in *Selected Poems,* one of her six published books of poems.

Ezra Griffith is the Professor of Psychiatry and Afro-American Literature at Yale University, and he has written extensively about healing ministries in the Black church in the United States of America and the English-speaking Caribbean. He recently wrote *Race and Excellence,* a biography of Chester Pierce, a pioneering African-American Psychiatrist.

Robert Lambourne was a physician, psychiatrist and theologian who founded the Pastoral Studies programme at the University of Birmingham's Theology Department. He wrote extensively about health and salvation as allied concepts and he has written many books including *Community Church and Healing.*

Emmanuel Lartey is a Ghanaian Professor of Pastoral Care and Counselling who has worked in multicultural settings in Africa, the United Kingdom and now the United States. He is also a theologian and the writer of such books as *In Living Colour* and *The Church and Healing: Echoes from Africa.* He has written extensively about interculturality in pastoral care and counselling.

Malidome Sóme is a shaman and anthropologist who hails from Burkina Faso in West Africa and has written extensively about Africa's contribution to healing the world. He has written books which include *Ritual: Healing and Community* and the *Healing Wisdom of Africa.* He explores the themes of healing using concepts and practices from his African heritage, which are juxtaposed with the knowledge developed in his Western training.

Paul Tournier was a Swiss physician and theologian who explored health and salvation as interchangeable concepts. He has written such books as *The Meaning of Persons* and *Guilt and Grace.*

All of the writers chosen, share an understanding of healing as a multidimensional process which includes the mind, body and spirit. Kuwabong and Goodison use language to convey the processes and imagery to restore a broken people. Sóme draws on the African heritage and culture as a source of healing in his culture, as well as that of people in the West. Similarly, Lartey uses his African theology with pastoral care and counselling concepts drawn from the European

heritage. to address the issues facing people in the multi-cultural settings in which he works. Allen, Anderson and Griffith combine an African-Caribbean theology with medical and psychiatric training. While Tournier and Lambourne combine medicine and theology, using a European cultural framework.

The perspectives explored have agency in a multicultural context where there is a multi-disciplinary focus. The work of the eight authors chosen will be reviewed alongside others who have written in this field. The intention is to build an understanding of the complexity of the issue of healing which the review has revealed especially in the context of the African-Caribbean population in Britain.

In a manual written and prepared by Christian activists and trainers working in the field of racial justice – Naboth Muchopa, Methodist Connexial Secretary for Racial Justice, Sandra Ackroyd, coordinator of the Urban Churches Support Group, United Reform Church (URC), and Marjorie Lewis-Cooper, former Multi-cultural Development Worker of the URC state:

> Churches and community organisations have also developed strategies to help with the healing of Black people and White racist dominant cultures. In the U.K., Black groups established Saturday schools, which provided contexts of high expectations for the academic achievement of Black students and provided inputs of Black history and culture to bolster self-esteem. Black groups of ministers, members and young people in White majority churches, have provided opportunities for Black people to develop their gifts and explore their faith in a way that has enhanced their contribution to the wider church and society. Rituals such as the burial of the Middle passage monument, as a way of honoring those enslaved Africans who died in the Atlantic was one initiative organized by African-Americans. There is a need articulated for the church to develop both its pastoral as well as its prophetic role (Lewis-Cooper et al, 2001, 17).

The above writers draw a valuable composite of the ways the community has tried to heal itself, through education for esteem building, opportunities for the development of the gifts and the faith of young people through the church and

through the process of ritual recovery for the honouring of the enslaved Africans. The repertoire of healing has been expanded beyond that which has been undertaken by the medical and psychological establishment, which is using models that are Eurocentric and steeped in racism. Within this society, the models of healing that are utilized continue to fail the Black population in many ways (Francis 1992).

Medicine has taken the central role in the business of health and healing although there are voices now asking for holistic responses to illness (Allen 1992, Lambourne 1982). Lambourne suggests that it is time for the healing church to emerge again to address the range of issues including racism, which are inimical to the physical, spiritual and psychological well-being of people in Britain (Lambourne 1982).

II. The African and European Christian Heritage

Christianity in the Caribbean has had a contradictory African and European heritage that will be reviewed in this section particularly in relation to the issue of healing. These contradictions continue to be present in the African-Caribbean community in the United Kingdom, where Caribbean theology has been transformed into Black theology. Hence the religion of the African-Caribbean population is based on this contradictory religious heritage. As Barry Chevannes the Caribbean anthropologist explains:

> The best way to understand how African-Caribbeans generally perceive the world is to contrast it to the conception conveyed by European religion. In the latter, there is a material visible world and then there is a spiritual world, preparation for which is made in this life and access is through death. This sort of dualism pervades Biblical and subsequent European theological thought. In African-Caribbean religion; on the other hand these two worlds are really seen as one. The same world in which we live and breathe is the same world inhabited by God, the Spirits and the Ancestors. This belief produces an

> approach towards the world which we might call "this worldly" in contrast to the "other worldly" approach propounded by European religion. (Chevannes, 1995, 66)

There is congruence in the views expressed by Chevannes and the views of the African theologian John Mbiti (1997) who asserts:

> Many societies believe that God heals the sick. For this reason, prayers, sacrifices and offerings are made to God, on behalf of the sick, the barren and those in distress.....When healing comes it is often attributed to God, even if medical agents may play a part in healing process. God is thanked, or His help is otherwise acknowledged...The same ideas are area expressed concerning God's saving work. People take it to be the result of God's help when they are rescued from trouble....Thus God is involved in the affairs of mankind, and people experience this involvement in terms of His continuing to create, sustain , provide, pastor, nurse, heal and save. Most of this functions on the physical and concrete level of being and with special reference to the life of man (Mbiti 1997,43).
>
> It is to be remembered that for many African peoples, God's active part in human history is seen in terms of his supplying them with rain, good harvest, health cattle and children; in healing, delivering and helping them; and in terms of making His presence felt through natural phenomena and objects. The people constantly turn to God in various acts of worship which in effect constitute man's response to God's interest and active part in human affairs. They do not sever God from his total environment, so that in effect human history is cosmic history seen anthropocentrically or microcosmically. God is not divorced from this concept of history: it is his universe. He is active in it and apparent silence may be a feature of his divine activity (Mbiti 1997, 47).

Chevannes and Mbiti provide significant information for African-Caribbean people as we seek to understand ourselves, and our societies. Their views lay a foundation for us to address the historical wounds which we seek to heal in the present; we now know how the two systems or heritages work in concert and in contradiction. The marriage of African and European religion has been achieved by various degrees of syncretism.

Syncretism is "the reconciliation or fusion of differing systems of belief" according to the American researcher Joseph Murphy. His book *Working the Spirit* is described as:

> a valuable guidebook to the enduring and ever-changing African-religious heritage in this hemisphere, as well as a vivid reminder of need for discernment of the spirit - - and spirit—in our midst.(http://www.cocc.edu/ cagatucci/classes/hum211/coursepack /Diaspora Religion.htm.
>
> His study of Revival Zion in Jamaica and North American Black churches reveals different types of religious syncretism, in which Protestant rather than Catholic forms of Christianity serve as vehicles for characteristically African styles of worship. Exit the cult of saints and sacramentals, and enter the cult of the divine word, transmitted by Bible-centered preaching, praising, healing and testifying. (Murphy, 2003) http://www.cocc.edu/classes/hum211/coursepack/DiasporaReligion.htm.

His conclusions are very similar to those of the Australian anthropologist Diane Austin-Broos) who notes that:

> The African heritage has become Creole as well as the heritage of Christian Europe. And if Christianity's hand seems to rest more heavily this fact would fuel a search not only for African connections but also for the uses and forms that have become Creole. The African-cum-Jamaican focus on healing, rather than a disembodied ethic is one such central and enduring form with which the missionaries would continually grapple. Healing often came in conjunction with possession, and this further use of embodied rite was seen as "heathen" in Jamaica until the advent of Christian revival began to redefine its practice (Austin-Broos 1997, 44)

The healing being described by Murphy and Austin-Broos requires not only understanding, but also courage to change the theological orientation in the Caribbean and anywhere else Africans are to be found. As Caribbean theologian Michael Miller reminds us:

> The conditions were right in the Caribbean for the emergence of a new and radical theological orientation. Throughout its history of colonisation and slavery there had been a battle over the religious interpretation of life in the region. The colonisers used Christian scripture with some success to indoctrinate the slaves into accepting their lot. By this means they sought to ensure that the slaves would constitute a hardworking and compliant work

force, which accepted the ideology and manners of Western Christendom as superior and God-given (Miller 2000, 2).

III. Healing in Jamaica

A desire to develop this new orientation was also being felt in the United Church in Jamaica and the Cayman Islands. That was the result of the union of the Presbyterians, Disciples of Christ and the Congregationalists. These denominations have united to overcome some of the divisions that had bedevilled the Christian church in Jamaica. This has been a process of healing in itself. The need for the new theological orientation was also felt in one of the oldest United Churches in Jamaica, St Andrew's Scots Kirk, where I have worshipped for the past 17 years and experienced efforts to create the new orientation.

This Church had been established in 1813, as a place of worship for Scottish merchants and planters resident in the island. The Church was built during the time of slavery, so that the heinous separation of master and slaves prevailed. While the Whites; the planters, merchants and others occupied the pews downstairs; their slaves were forced to worship from the balcony seats above.

There is evidence that a more pragmatic approach has been taken within the churches which came together and that there has been growing ecumenical commitment with the continued development of the Jamaica Council of Churches. Healing is emphasized by the charismatic movement which is growing in Jamaica. Hence this has been a period of expansion and exploration of healing in the Church in Jamaica today.

A church born in the context of slavery and British colonisation, was a church where healing was only possible when the historical wrongs were redressed. In this context a Caribbean theologian declared:

> That within this Caribbean incubator of human depravity, the Europeans set their "God "to work ...That God was to sanction and protect everything that the Europeans had designed and implemented. That God was to vacillate between right and wrong, justice and injustice, humanity and inhumanity, according to the circumstances (Davis 1990, 4).

Davis rejected the European theology that had served to oppress and subjugate the colonized Africans in the Caribbean context. Another Caribbean theologian Noel Erskine, gave a perspective about the need to decolonize theology (1998) and in the Foreword of his book, the African theologian Mercy Amba Oduyoye writes:

> Erskine's work keeps faith with the liberative perspective that theology is rooted in history and in peoples' interactions and actions in history. From the Caribbean experience, Erskine has demonstrated how the oppressed see "concrete political liberation as the fulfilment of promises that Christianity announces" *Decolonizing Theology* is a demonstration of how "eschatological hope for future blessedness" combines with moral witness and political action in the present" (Erskine 1998, xi).

Erskine (1998) also identifies the need for economic justice for the poor and the inadequate role played by missionary theology in this regard in the Caribbean:

> It was not only missionary theology that adopted this hands-off approach regarding economic justice for the poor and the role of mega corporations in our society, but the Evangelical-Pentecostal churches that stood over against the mainline churches. These churches insist on the verbal inerrancy of scripture, the sinlessness of Jesus, and the necessity of affirming the validity of Virgin birth as a basis for salvation. Their emphasis is that right thinking as it regards doctrine is important for salvation, salvation being an other-worldly reality which means in part a denial of reality now in order that we might achieve heaven later (Erskine 1998, xii).

Decolonization then can facilitate the healing that is the focus of this study; this process also results in the decolonization of our minds. Paul J. Isaak (2003) in a

thought-provoking article states that health and healing are a challenge to Christian ethics and the Diaconal Ministry of the Church. In a similar vein, Jamaican theologian Stanley Redwood sees healing as one of the elements of the pastoral role in the European reform tradition. Stanley Redwood in tracing the development of the reform tradition writes:

> The spiritual revolution of the 16th century has been beneficial for the Church in many ways, but it has neglected the psyche of human beings in many regards. The ministry of the priests and the rituals and rites of the Church are primarily psychological curative measures for human feelings of guilt and remorse (Redwood 1999, 78).

To extend this, I would like to suggest that some of the healing rituals and rites that have been removed from the Protestant churches in the Caribbean and in the African-Caribbean churches in Britain and elsewhere, have resulted in serious efforts to bring about a union in the word and the spirit in the reform of Pentecostal and the evangelical traditions. Isaak (2003), a professor of theology and ethics at the University of Namibia provides an explanation about the issue of healing in the Lutheran Church. He notes that "as Lutherans we see ourselves as pastors not healers." This comment came as the Lutherans were preparing for an Assembly in 2003 where the theme was to be *"For the Healing of the World."*

I have recognized that many African-Caribbean and African-American people are seeking to express their faith in a way that synthesises these contradictions. Perhaps healing at the personal, community, racial, ethnic, and national levels, comes with the synthesis. The existence of so many denominations in so many traditions as well as new formations out of old traditions like Rastafari out of Christianity, and the Nation of Islam out of Islam are evidence of this effort at synthesis. Maybe no one tradition in the West or on the African continent is adequate

for the Africans in the continent or in the African Diaspora. Perhaps the African Renaissance championed by South African President Thabo Mbeki (1998) would be facilitated by greater understanding and development of authentic religious expression wherever Africans are.

In this struggle for authentic faith and healing I had cause to think about redemption and rehabilitation. The concept of rehabilitation is well known in a number of fields, including physical and mental health, the criminal justice system and in the physical environment. In every field it refers to the state of someone or something being returned to use.

> Help (a person) to readjust to society after an illness, imprisonment etc; restore to a former position or rank; restore the good reputation of" (Oxford Dictionary, 1997).

Underscoring the notion of rehabilitation are the religious concepts of hope and faith, thus people, who have been ill or who have done wrong can be healed and can change. Then there is the religious concept of redemption, which I suggest in this thesis should be linked to the concept of Emancipation. Lartey (2003) highlights the fact that redemption is linked to notions of personal salvation through the personal acceptance of the death of Jesus Christ. While emancipation, is linked to liberation and has more social and communal implications. Similarly, Deloris Williams the African-American womanist theologian is identified by Mitchem (2003), another womanist theologian as using:

> Black women's experiences to assert the meaning of redemption. Her construction dually honors Black women's experience of suffering from various oppressions as well as ordinary theologies that find salvation in Jesus. Salvation then in womanist construction is not in formulaic answers but in the search for wholeness. Redemption is a journey that begins by daring to care for self in the face of repeated assaults on identity and value. Salvation is born of the struggle to reconcile some assigned "place' in the world with a self-determined identity that springs for hope and is grounded in faith.

> Williams's consideration of right relationships leads to other aspects of salvation: community and social responsibility. Salvation in a womanist view desires transformation of self *and* society. (Mitchem 2003,111)

Bob Marley (1983) wrote Redemption Song to words which have been attributed to Jamaican Pan Africanist and National Hero Marcus Garvey:

> Old Pirates, yes they rob I,
> Sold I to the merchant ships,
> Minutes after they took I
> From the bottomless pit,
> But my hand was made strong
> By the Hand of the Almighty
> To forward in this generation
> Triumphantly.
>
> Won't you help me sing, another song
> Of freedom is all I ever had,
> Redemption Song, Redemption Song
>
> Emancipate yourself from mental slavery,
> None but ourselves can free our minds
> Have no fear for atomic energy,
> None of them can stop the time.
> How long shall they kill our prophets?
> While we stand aside and look
> Some say it's just a part of it
> They've got to fulfill the book
> Won't you help me sing, another song of freedom
> Is all I ever had
> Redemption Song, Redemption Song.

Redemption and emancipation are part of the nexus of healing that this thesis examines in the African-Caribbean community at home and in Britain. People who are free can be redeemed by God in a healthy and life-giving way.

Caribbean theologian Evans (1999) saw that healing:

> required the development and application of a variety of new approaches to healing and helping by those professionals who work in these fields. This also includes revaluing and working with families instead of taking a confrontational view and stance to dealing with them. Not only is it desirable for new approaches to be developed for working with families and individuals but we also need to develop counselling for community change. (Evans 1999, 30)

It has also been recognised that the church has a well-defined pastoral role and it is here that many African-Caribbean people bring their problems and concerns first, or simultaneously with seeking medical and psychological help. Within the congregation, there are ways in which problems are brought especially for and through prayer to a safe place to get comfort, solace and blessing. In addition, ministers of religion meet people on a one-to-one basis to counsel them (Hazle, 2003, 189). The needs of African-Caribbean people expanded with their migration to Britain. However, the Church in Britain was experiencing changing fortunes, which were to have a considerable impact on the African-Caribbean community.

IV. The changing fortunes of the Christian Church in Britain

Christianity in Britain is suffering a change of fortunes as a result of secularisation in the post-modern world. In addition African-Caribbean people are growing away from the traditional church in response to the racism that they have experienced there. The literature on the levels of secularisation as well as the feeling of estrangement of the African-Caribbean community and the concomitant shift to Black-led churches is growing as can be seen from the work of the researchers cited in the following section.

> Christianity is "a religion under siege in Britain", church attendance is falling in the mainline churches, and secularisation has taken over the minds of many. (Brierley 2000, 67)

> Many feel that the church is irrelevant and in the eyes of many the church is as racist as all the other institutions in the society. Many Black people have expressed anger and dismay about their treatment in the Christian churches in the past and in the present (Wood 1998, 113)

> They have been made to feel unwelcome and unwanted. In addition, the churches have not responded to their cries in the face of the racism which

> they suffer at home, at school, at work and in every facet of life in Britain. (Macpherson Report, 1999)

While there are growing numbers of persons attending the Pentecostal and Evangelical churches, particularly in the Black community, there is a sense that the church is not willing to address the issues that the Black community faces. Within the church as well as in terms of the theological underpinnings, there is a growing divergence between Black and White theologies.

V. Black Theology in Britain

The term 'Black theology' arose within the American and South African contexts. The University of Birmingham defines Black Theology in general and particularly in as encompassing:

> all the expressions of faith of Black people in different contexts in which Black people are found. As comprises studies in African theology (within and outside South Africa), African-American theology, African-Caribbean religions and Theology and Theology in Britain (within a European context) (http: //www.theology.bham.ac.uk/postgrad/Black.htm & 710/2003)

Although much can be learned from these countries and contexts, the realities of being Black in Britain have their own peculiar character. Black theologians have contributed to the development of a Black Agenda in Britain. With an expanded view of the role of the Christian in an unjust and racist world, some Black theologians (Wood, 1994, Lartey, 1999, Nwulu, 1999, Erskine, 1998, Hopkins, 1999 Reddie 1999, Beckford 2000, Dixon 2000, Alexander 2000) have postulated theoretical and practical ideas to address the concerns of Black people throughout the world.

In response to the Stephen Lawrence murder and the subsequent Macpherson Inquiry and Report, Lartey (1999) identifies 10 characteristics of Black

British Theology. He suggests that; Black Theology in Britain begins with creation; it is contextual, Black theologians embrace plurality, interfaith interaction and dialogue, and that they work carefully and conscientiously examining and weighing material with attention. Women and men, young and old, work collaboratively on the Black theology projects. Black Theology in Britain is an exercise in liberating praxis, and arises out of the British context. Black theologians seek to enhance authentic and creative approaches to theology, not merely to imitate White western liberal methods.

Lartey also identifies seven items on the Agenda of Black Theology in Britain; there is a Biblical task, a historical task, there is need to address philosophical and cultural education, there are socio-economic, political, psychological and aesthetic dimensions.

Beckford (2000) elucidates a political theology for the Black Church in Britain in his book *Dread and Pentecostal.* While the concept of "dread" and that of Pentecostal seems irreconcilable within the Caribbean context and conceptual framework, Beckford syncretises the concepts in the British context. This enables him to select concepts from Rastafari, one of the African-Caribbean religions, and link it with Pentecostalism (an American religious tradition with deep African-American roots) to address the analysis and understanding of the Black Church and the African-Caribbean Church in Britain. In syncretising these traditions he draws on the widest frame within Black Theology, thereby permitting engagement across denominational and traditional boundaries and enabling Black British people to have the largest possible spiritual armamentarium. It also enables worship and engagement in two traditions simultaneously as suggested by Lartey (2000) who

noted that in Ghana it was quite common for persons to worship in a Methodist church in the morning and attend an evening service in a Pentecostal service.

Black theologians Beckford (2000) and Lartey (1999) have responded to the findings of the Macpherson Report. Lartey's proposals were outlined earlier in this section and they coincide with the following proposals made be Beckford:

> The Black Church must do some soul searching. The Macpherson enquiry was responsible for conscientizing many Black churches. For example, several churches got involved in the campaign, hosted conferences and developed strategies for dealing with racism and racist attacks and began to take seriously the need to find political tools to address racism. The formation of the Black Christian Civic Forum represents this trend (Beckford 2000, 54).

He suggests the need for selfless faith which is outward-looking, prophetic and demands the acknowledgement of White supremacy in English Christianity. This results in the development of processes, attitudes and behaviour which exclude Black and Asian people. He also suggests that:

> There is need in Christian Churches for inclusivity through re-education and retraining. Black British, African-American, Asian and South African liberation theologians have talked about multi-dimensional analysis as a tool for challenging multiple interacting forms of discrimination in Britain (Beckford, 2000, 59).

Then there is need to deal with Black rage constructively, in the face of the renewed anger and depression over the Stephen Lawrence case in Black communities, Beckford (2000). For this he proposes a *Redemptive Vengeance:*

> A way to use positively the rage, anger and frustration stalking all levels of Black Life (Beckford 2000, 60).

Black theologians in Britain have been grappling with the 'principalities and powers' identified above, and as they have been addressing these issues the processes of healing have been at work. Black theologians have had to wrestle with the contradictions of their faith and in the process; they have been trying to heal the

wounds of the African-Caribbean community. There is also tension between the process of healing and the integration of the practice of medicine and the integration of Christian beliefs (Lambourne, 1983).

VI. Healing, Medicine, Psychology and Theology

As Browning (1960) suggests that psychotherapy, theology and medicine are perspectives upon the phenomenon of healing. People who are ill and frequently beset by disease seek help from practitioners of all three disciplines. This is sometimes done simultaneously, as people feel the need for spiritual, physical and psychological relief. Vom Eigen (1992) adapts the model of Eisman to show that in many cultures including Jamaica, people simultaneously or sequentially seek help in three sectors the folk, popular and professional sectors. The conclusion is that the people are whole, and take a holistic view of their health and well-being, while the providers are operating at a primarily narrow sectoral level.

In Britain there has been increasing discussion about the role of medicine, psychology and theology in the healing of people. There are at least three false separations that bedevil the thinking in this field.

1. The false separation and opposition of mind and body, psyche and soma.
2. The false separation and opposition between individual and community.
3. The false separation and opposition between the working and worshipping life of the laity (Lambourne1983, 7).

In their writings, Paul Tournier and Robert Lambourne, both physicians and theologians, have stressed the constant association and interchangeability of the terms "salvation" and "healing" in the Bible. Indeed, the same association occurs in practice among contemporary Christian professionals and congregations. Robert G.

Anderson (1979) has pointed to historical and contemporary examples of the church's mental health ministry. Ezra Griffith (1984), a psychiatric researcher has also demonstrated the therapeutic aspects of church rituals. As a practical outworking of their own salvation or healing, the members of a Christian congregation are called and sent by God to be a healing community through the exercise of mission and evangelism (Allen 1995).

Black people living in Britain are exposed to so much racism and other types of negative experiences that their lives need healing in order for them to live as whole, healthy beings. This would seem to link with recent developments in the British pastoral care scene. Alastair Campbell's statement about pastoral care 'as that aspect of the ministry of the Church, which is concerned with the well-being of individuals and of communities is valid'. Campbell shares the deep concern of other British writers, notably Lambourne, Wilson, and Forrester, that socio-economic and political forces that cause distress need to be addressed in pastoral care (Lartey 1997). Contributing to the discussion on the need for the improvement of pastoral care is Swinton, a Scottish theologian and psychiatric nurse, who has identified the need to "resurrect the person", by examining the role of friendship and the care of people with mental health problems (Swinton 2000).

VII. Other Views of Healing

Although there are many other views about healing, the work of a select group of writers whose work has particular significance to the issue of the healing of the African-Caribbean population is reviewed in the following section.

Kuwabong(1999) identifies four African-Caribbean women writers and poets, Marlene Nourbese, Claire Harris, Lorna Goodison and Cynthia James, who have looked at the issue of healing and restoration of Black people, particularly in the African Diaspora and in Canada.

> Africaribbean literature originates from a desire to recover the Africaribbean personhood from the history of slavery and colonization. I see in Africaribbean literature a search for a rhetoric that can facilitate that recovery. In saying this I do not imply that the concept of recovery originated, nor do I wish to suggest that it is the only preoccupation of Africaribbean writers. Let me state here that the concept of recovery is fundamental to all communities that have undergone dramatic or catalytic change in history. The rhetoric of recovery can take several forms, including literature, language, politics, cultural revivalism, religion and remigration to a homeland from exile...The urgency of rhetoric is proportional to the magnitude of the interruption of the communities' history and patterns of life. Thus a displaced people such as Africaribbeans, who have lost a significant part of the original mother tongue(s) cultural ethos, cosmological space, religion and land, have a great urgency in developing the rhetoric of recovery. Africaribbean people have had their histories distorted, denigrated or denied for so long that there is an urgency in their desire to develop a rhetoric of recovery without the agency of an original mother tongue (Kuwabong 1999, 1-2).

In his thesis entitled *An Apocrypha of Nanny's Secrets*, Kuwabong explores the issue of healing in the African-Caribbean community in Canada. His analyses and conclusions resonate with those of the African-Caribbean in Britain and in other post- colonial settings. The title is a line from Lorna Goodison's poem *We are the Women:*

> "We are the women
> with thread bags
> anchored deep in our bosoms
> containing blood agreements
> silver coins and cloves of garlic
> and an apocrypha
> of Nanny's secrets" (Goodison 1992,34-35)

This speaks of a belief in obeah, an African-Jamaican religion and the use of artefacts, to protect people against evil forces. Lorna Goodison, Jamaican fine artist

and poet, uses the metaphor of a Jamaican place named Heartease in several of her poems. There, people can be safe, healed and restored at the individual, community, national and international levels. Although she is a product of the Jamaican society, her concerns and world-view impact on the lives of Black people throughout the world. She has embraced the concerns of Black people whether they are in Kingston, New York, Brixton or Soweto. She has defined her community as an international one. She has constantly identified how individuals, communities and nations need to acknowledge their hurt and pain and identify and utilize sources for their healing. Speaking of Goodison, Kuwabong (1997, 178) writes:

> In Heartease, she is at the crossroads inviting others on a journey to healing. She examines some of the issues that disturb the psycho-cultural equilibrium of Africaribbean people, and provides points towards the adoption and celebration of Africaribbean women as paradigms and metaphors towards Heartease.
>
> But she believes that while some are recovering the mangled remains of the Africaribbean psyche from Euro-American historiographies, others too must set to nurturing and healing broken souls"(Kuwabong 1997, 165)

Goodison fulfils the artist's role as outlined by Sóme:

> The artist as an artisan of the sacred can cooperate in bringing the sacred birth in this world. Indigenous people believe that without artists, the tribal psyche would wither into death (Sóme 1998, 95).

The artist. especially the writer in the African-American context has an additional role:

> In the absence of psychological literature that adequately describes the African-American psychical experience in terms of the effects of the trauma of racial oppression on the development of the personality; other literary materials in the African-American tradition may serve to provide descriptions (hooks 1990, 225-230).

Hence this is an attempt to draw the parallels with the African-Caribbean in Britain and the African-Canadian community. In Sóme's (1998) view reflected in the statement:

> Today, while most people in the West enjoy material affluence, villagers in Africa suffer hunger and poverty. But here, perhaps, is a case where the material and the spiritual are working independently toward the same end. Africa's material scarcity may be symptomatic of a deeper global problem pertaining to soul and Spirit. While the Third World is experiencing the immediacy of the people's need for healing in the area of physical hunger, the West is awakening to a spiritual hunger so dramatic as to be almost frightening. Like the famished cows in the Pharoah's dream, the modern psyche dangles and zigzags this way and that way with a mighty intent to devour anything that smells ancient and spiritual. The converging paths of these two worlds may ultimately enable material abundance to silence the Third World body's cries for nourishment and the cries of the Westerners hungering soul...
>
> The purpose of this book is not only to promote understanding between Western and indigenous cultures but also to show how the indigenous world and its wisdom might heal many of the spiritual and emotional problems from which Western civilization suffers. Among these ills are the pervasive sense of loneliness and isolation from which many modern people suffer; the absence of a supportive community to help individual weather the storms of life; the feeling of anonymity that results when a culture prohibits the expressing of true emotion; and the distractions of consumerism, which lead people away from focusing on the things that matter most deeply to them (Sóme1998, 15-16).
>
> From an indigenous perspective the individual psyche can be healed only by addressing one's relationships with the visible worlds of nature and community and one's relationships with the invisible forces of the ancestors and Spirit allies (Sóme 1998, 17).

In the British context Black people might have difficulty with this concept. Some members of the community draw solace from the tropical world in which they were born and remember the sunshine and the scenery, the foods and the sea, and the plants. It may be difficult for some to feel an affinity for Britain in the rotting industrial heartlands where the British underclass lives. This underclass includes significant numbers of Black British

people who would not recognize the beautiful pastoral scenes which some know as England. However, what is lost for the African-Caribbean community in nature, in the physical environment, can be reclaimed from the miraculous care and protection offered to and by these communities, in spite of the odds. One graphic example of this is the way people provide support for each other during bereavement. In fact, there has been amazement expressed over the outpouring of grief by Black Britons in response to the death of Princess Diana (Beckford 2000, 49-51).

> *Healing* comes when the individual remembers his or her identity - the purpose chosen in the world of ancestral wisdom - and reconnects with that world of the Spirit. Human beings long for connection, and our sense of usefulness derives from the feeling of connectedness. When we are connected - to our purpose, to the community around and to our spiritual wisdom – we are able to live and act with authentic effectiveness (Sóme, 1998, 36).

Sóme defines healing so that it includes the individual, the community, the ancestors and the spirit. If the purpose is survival and overcoming adversity, then the African-Caribbean can identify within itself, symbols of the sources and of healing at the individual and collective levels.

Through a number of campaigns, legal battles and political action, through the efforts of courageous individuals like the now deceased Member of Parliament, Bernie Grant, and others who agitated for the British Government to build the Maritime Museum in Liverpool to acknowledge the personhood of those Africans who had been enslaved, and their subsequent contribution to the development of the British Empire - healing has been taking place. A concern about healing was not only being voiced and addressed within the African-Caribbean community, but it was

also expressed within the National Health Service and other government departments.

CHAPTER 4

METHODOLOGY

So far, this study has been concerned with mental health and issues of healing in the Black British community. In this chapter the focus moves to the choice of methodological approaches to the fieldwork research which is qualitative; the description of the methodology of qualitative data collection through interviews; participant observation before and during data collection; the review of documents; and focus groups. The Fieldwork Schedule appears as Appendix 1.

I. Choice of Research Method

a) Overview

Due to the nature of the research question in this study: 'What is the impact of African-Caribbean Cultural Therapy in a culturally sensitive and safe African-Caribbean organisation, (Servol) on a group of persons with severe and enduring mental illness?' qualitative approaches to research analysis were used.

> Generally research methodology can be broadly grouped into two camps: qualitative and quantitative (Casley and Kuman 1988, 3)

The distinction between the two is that quantitative methods produce numerical data and qualitative methods result in information which can best be described in words. Hence quantitative methods were not appropriate for this research study as:

> Quantitative research is typically exemplified by the social survey and by experimental investigation (Haralambos and Halbern 1995, 85)

Lincoln (1995) identifies the implications of doing of research in the style or mode of the naturalistic paradigm. Although 14 characteristics were identified using a

naturalist paradigm for doing research (Lincoln, 1995, 39), three of these were most significant for this study; the first is the natural setting:

> The naturalist (N) elects to carry out research in the natural setting or context of the entity for which study is proposed because natural ontology suggests that realities are wholes that that cannot be understood in isolation from their contexts (ibid, 39).

This study was conducted in Birmingham and Coventry in the Midlands, entirely within the natural setting of community residential homes and the supporting surrounding community. Thus the 'natural setting methodology' described by Lincoln seemed to be the most appropriate paradigm for the conduct of this research.

The use of qualitative methods also seemed to be an appropriate model to meet the objectives of this study, as they facilitated the close relationship that had been established between the respondents and myself, prior to the start of this research. The choice of this approach resonated with the principles identified by Lincoln:

> The N elects qualitative methods over quantitative methods because they are more adaptable to dealing with multiple (and less aggregatable) realities; because such methods expose more directly the nature of the transaction between investigator and respondent (or object) and hence make easier an assessment of the extent to which the phenomenon is described in terms of is (biased by) the investigator's own posture; and because qualitative methods are more sensitive to and adaptable to the many mutually shaping influences and value patterns that may be encountered (ibid, 39).

b) Interviews

The pre-data collection phase lasted from September 1997 to April 1998 when preliminary data was collected by reviewing case notes, undertaking participant observation and interviews. The decision to undertake interviews permitted the collection of data from a wide cross-section of individuals that would also facilitate the

development of case studies. It seemed to be the most suitable investigative strategy to test the hypotheses of this study. Taylor and Bogdan (1998) suggest:

> The choice of research methods should be determined by research interests, the circumstances of the setting or people studied and practical constraints faced by the researcher. In-depth interviewing seems especially well suited in the following situations: The research interests are relatively clear and well defined, settings or people are not otherwise available, the researcher has time constraints and the researcher is interested in understanding a broad range of settings or people (Taylor and Bogdan 1998, 91).

However, there are limitations, to the interviewing method. Deutscher *et al* (1993) observed that a person would say and do things in one situation that they would not do in another situation. It is also necessary to observe people in their everyday lives to ensure that the context be understood. Similarly, Glasser and Strauss (1967) in their explanation of the strategy of theoretical sampling, highlighted that it is not the number of persons interviewed, but their potential to aid the researcher in developing theoretical insights into the area of social life being studied.

c) Participant Observation

Introduction

The aim of the study was to identify the impact of African-Caribbean Cultural Therapy in a culturally sensitive and safe African-Caribbean organisation on a group of persons with severe and enduring mental illness. The study took place in Servol in Birmingham, England. In the pre-data collection phase which was carried out three days per week over a nine-month period, case notes were reviewed, in-depth interviews and participant observation were undertaken. The use of this mix of methods was intended to capture as much data as was possible prior to the design of

the study. The study was informed by the data from this phase in terms of the design of the data collection instruments and the conceptual frameworks used.

The setting was the Servol administrative office where the large group cultural therapy activities were organized, a hair salon at Servol, together with the lounge and dining room area. Observation also took place at the Sport centre where the participants and care-givers were engaged in sporting activities one of the three days per week, over the nine-month period. In addition, the four residential facilities where the participants lived and the Camp Lane Centre where they attended computer classes, were also sites for observation.

The role of the observer

My role of observer was complex and dynamic as I played various parts throughout the study. I entered Servol as a part of the Psychotherapy Associates International Team which was implementing the Cultural Therapy Progamme. So I was a practitioner during the pre-fieldwork period. I was also the wife of the African-Caribbean Psychiatrist who had undertaken the review of the clients who were to become participants in my subsequent study. I subsequently became a researcher during my fieldwork. I, therefore, experienced the tension described by the potentially conflictual role of practitioner and researcher.

Then there was the issue of my being an African-Caribbean woman researcher within an African-Caribbean group of participants. It seemed that many of the barriers which might have been raised in the presence of a White researcher were removed in my presence. That was my assessment of the experience. We started the relationship in the pre-fieldwork period with a sense of having a common heritage.

There may have also been limitations imposed by this common ethnicity and these will be explored further in the study. I have, however, tried to maintain the role of participant observer throughout the study as like:

> A number of authors including Bowling (1997), Denscombe(1998) and May (1997), have linked participant observation with an attempt to understand the phenomenon by observing from inside the group , to understand how people including the researcher, interpret various situations . The participant observer uses an unstructured or open approach to data collection (Bell 1993), normally producing qualitative data (Bowling 1997).

The observational process was overt and hybrid, being both structured and unstructured, as this was the most effective way to collect the data.

The Setting

This study was conducted at Servol Community Trust in Birmingham. Servol's administrative office was also the location for the Clubhouse on the Dudley Road which is on the edge of an inner-city area. The clients were persons who had severe and enduring mental illness. They lived at four residential locations belonging to Servol: Strensham Hill, Aston, Gillot Road and a Crisis House on Gillot Road. Servol was located in NHS geographic locality administered by the North Birmingham NHS Mental Health Trust. Servol's partnership with the North Birmingham NHS Mental Health Trust provided a crisis residential home for persons experiencing the acute phase of mental illness, which prevented them from being admitted to a mental hospital. Servol also provided long term residential facilities for patients with severe and enduring mental illness who were managed clinically by the Assertive Outreach Teams of the North Birmingham Mental Health Trust.

Servol's administrative and client activity centre, located on the Dudley Road was easily accessible for the clients. It was a three-storey Victorian House with three large rooms on the top floor. The largest was a meeting room in which the main activities of the Cultural Therapy Programme were conducted. The Director's office, a general office, toilets and a hairdressing salon were located on the second floor. On the ground floor there was a kitchen, a dining room, a lounge where smoking was permitted, and a small tuck-shop. The walls had posters of African-Caribbean persons and motifs; there was Reggae music playing and the smell of African-Caribbean food being prepared. It was a home away from home for the African-Caribbean clients, staff and visitors.

All the data collected was fed into the development of the case studies which are part of this thesis.

d) Case studies

The case study reporting mode augments the interviewing method, underscoring the qualitative research methodology employed in this study. Many authors have identified the strengths of the case study method:

> The Naturalist is likely to prefer the case study reporting mode (over the scientific or technical report) because it is more adapted to a description of multiple realities encountered at any given site: because it is adaptable to demonstrating the investigator's interaction with the site and consequent biases that may result(reflexive reporting); because it provides the basis for both individual "naturalistic generalizations" (Stake,1980) and transferability to other sites (thick description); because it is suited to demonstrating the mutually shaping influences present; and because it can picture the value positions of investigator; substantive theory, methodological paradigm and local context. (Lincoln 1995, 39)

Indeed, Yin (2003) notes:

> As a research strategy, the case study is used in many situations to contribute to our knowledge of the individual, group, organisational, social, political, and related phenomena. (Yin 2003, 1)

Peshkin (1993) also identifies the value of the case study method in qualitative research studies, particularly for the purposes of interpretation.

> They enable the researcher to (a) gain insights about the nature of a particular phenomenon (b) develop new concepts or theoretical perspectives about the phenomenon, and or discover the problems that exist within the phenomenon. (Peshkin 1993, 148)

According to Grbich (1999) the case study has:

Disadvantages:

- Defining a 'case', whether it is established or developing, involves theoretical choices regarding content or framing. The loose application of the term 'case' has often resulted in these aspects being minimised or avoided.
- The researcher's biases need to be clarified, but these are rarely exposed.
- The bounded nature of the cases suggests that, in general, the case study approach favours containment, control and causality (Platt, 1992) rather than the multifaceted complexity, continual change and ongoing interaction in the post modern tradition.

Advantages:

- Case studies, however defined and generated, can provide powerful stories to illustrate particular social contexts. This is generally agreed.
- The holistic approach allows for observation and grounding of a particular phenomenon.
- Continuity and change can be documented.
- This approach permits the generation of theoretical propositions that may be generalisable to other groups (Feagin , Drum and Sjoberg,1991) either naturalistically (Hammersley,1992) or analytically (Yin,1994) in (Grbich 1998, 90)

The powerful stories of the African-Caribbean people who formed the basis of this work, were given voice through the case study method, and became one of the foundations on which this study was built.

e) **Focus groups**

To contextualize the experiences of the mentally ill African-Caribbean people in this study, it was necessary to identify a comparative group of well African-Caribbean people for purposes of triangulation. It proved extremely difficult logistically to access this latter group, and, therefore, it was not possible to utilize the case study method for this phase of the work. The focus group methodology provided the most appropriate means of access to this group, and for the comprehensive collection of comparative data. Gribich (1998) identified the advantages and disadvantages of the focus group qualitative method:

Advantages:

- They are particularly suitable for groups with a strong oral tradition and low levels of formal education.
- They are time efficient. More people can be questioned in the same amount of time as it takes to interview one person.
- The group provides instant verification of data because of inbuilt checks and balances of a variety of viewpoints.
- A skilled facilitator can build on a single response to develop a rich source of data.
- Both the group and the facilitator can benefit when a reciprocal process of information is built into the debriefing section.
- These groups can provide an interesting perspective on the power of group dynamics and the degree of tendency towards consensus on particular topics.

Disadvantages:

- Only a limited number of questions can be addressed.
- Questions cannot be explored in detail, nor can interesting leads be adequately pursued.
- The facilitator needs special skills.
- Two researchers are needed (or one plus a video recorder that can be set up and left to run on its own) are needed.
- Some people do not interview well in group situations, while others tend to dominate. Rather than ten views being collected, only two to three sets of views may be reflected in the data.
- The 'public' rather than the 'private' views of individual tend to be documented (Grbich 1998, 114-115).

The significant difficulties encountered in identifying and capturing the voices of the well African-Caribbean people who were necessary for the triangulation process of this study, were addressed by the use of the focus group method. This investigation recognized that for purposes of this comparison, the advantages of the focus group identified by Gribich significantly outweighed the disadvantages.

f) Qualitative Content Analysis

The case studies provided data from which themes and sub-themes had to be distilled, so qualitative content analysis was selected as the appropriate strategy to cull the data required for this analysis. Bryman (2001) suggests:

> Qualitative content analysis as a strategy for themes in one's data lies at the heart of coding approaches that are often employed in the analysis of qualitative data (Bryman 2001,181).

Qualitative content analysis proved valuable in the coding and interpretation of the case studies in this study.

II. The Study Participants

Three groups of individuals were used in this study:

- respondents with severe and enduring mental illness;
- the care workers; and
- well people.

Respondents with severe and enduring mental illness

Twenty persons with severe and enduring mental illness were interviewed. The mentally ill people who participated in the case study process were initially contacted during the period September 1997 to April 1998, while I was a member of

the team that implemented the Cultural Therapy Programme at Servol. This Programme gave me the opportunity to establish a relationship with these respondents, and to interview and observe them during therapeutic activity.

Care workers

During the Cultural Therapy Programme at Servol I also developed a professional relationship with six care workers who had the responsibility of attending to the clients. They were African-Caribbean, four of whom were born in the UK and the other two in the Caribbean. They had experienced racism and had other difficulties at home and school, as well as in the community and at work. Servol provided them with 'a safe culturally sensitive workplace'. They were between the ages of 30-40 years old, and were undertaking studies in health and social care in order to qualify as care workers. These workers who I interviewed for the triangulation process of the study, proved to be an important cohort.

Well persons

With the help of a male African-Caribbean lecturer at the University of Birmingham, as well as a female postgraduate African-Caribbean student there, I was able to contact 10 African-Caribbean persons who had not suffered mental illness and were successfully pursuing studies, and or working. These persons became part of two focus groups with well persons during 2000. One was with four males and the other with six females. The four males were between ages 25-35 years old; two had been born in Jamaica and two in England. The two born in Jamaica had been educated to high school level there; one had gone on to the

University of the West Indies (Mona campus) and subsequently pursued an MPhil and PhD at Cambridge University on scholarship. He was now on the staff of University of Birmingham as a lecturer and he also provided support and succour for African and African-Caribbean students on the campus. All of the men were single and none were fathers.

There were few Black British students at the University of Birmingham and those Black students who were studying there tended to come from the Caribbean or Africa particularly as postgraduate students. The other Jamaican-born man had done undergraduate and postgraduate work in the USA and had come to the UK to pursue a PhD. One of the two young men born in Britain struggled with the "narrative of underachievement" and was completing his undergraduate programme, while the other had returned to Jamaica where he had been educated to high school level, and then studied at the University of the West Indies. He had later come to England to do postgraduate work. We held the focus group in the Lecturer's office, where we formed a small discussion circle. It was informal and comfortable and the discussions took place in a relaxed environment. Answers came amidst laughter and a mutually encouraging support for the challenge of life in the academy, as well as daily life in Birmingham.

The female postgraduate student who had been born in Jamaica and who had done her undergraduate studies in Coventry and then Birmingham, convened one of the focus groups. She had arranged this focus group to take place at the Osaba African Women's Centre in Coventry. This organisation, where she was a part-time worker, focused on advocacy for women including refugees and women who were victims of domestic violence. She had invited five colleagues: three women who were

born in England, one of whom was the daughter of an African diplomat who had now completed her legal training in the UK. The other two were the daughters of West Indian migrants in Coventry. These two had completed diplomas at a further education college. The other two women had been born outside of the UK in Nigeria and Trinidad respectively. The Nigerian and the Trinidadian had come to the UK to pursue postgraduate degrees. One was single and the other divorced with children. Five of the women were mothers, one married, one divorced and three were single mothers.

d) Access to respondents, care workers and well persons

Access to the three groups of respondents was facilitated by my involvement in the Cultural Therapy Programme in Servol in the first instance, and the assistance of the two focus group conveners who I met at the University of Birmingham. It was very difficult to gain access to the African-Caribbean community in Birmingham as an outsider from Caribbean. Data collection was made even easier, as I was referred by trusted members of the community to the members of the focus groups.

Osaba African-Women's Centre

This was a modern purpose-built two-storey facility at Hillsfields in the heart of an area of tower blocks in Coventry. The area was impoverished, with a reputation for criminal activity, and the facility represented part of an effort of social and community redevelopment that was then being undertaken. There were many meeting rooms and offices that were well decorated, and our focus group meeting took place in a comfortable meeting room on the ground floor.

III. The study period

During the initial Cultural Therapy Programme in 1997, I first met the respondents, and had the opportunity to observe them during their daily activities such as meal preparation and dining; exercising at the nearby community centre; working at the salon; and having their hair groomed. I also was able to observe their involvement in the musical band that had been established during the Cultural Therapy Programme. The band had first performed publicly at the Servol Conference in London, in April 1998.

I conducted the interviews for this research study with the Servol clients at their residences and at a community educational facility Camp Lane that was used extensively by Servol and the African-Caribbean community. The Cultural Therapy Programme had recommended that the Servol clients attend a computer course which was being run at the Camp Lane facility, as part of the clients' vocational training and development. Much of the observational material for this study was collected at the Camp Lane facility during the period of my doctoral research.

Additional data was gathered between October 1998 - May 2000 at the Servol residential homes in Birmingham, as well as at the University of Birmingham and the Osaba Women's Centre in Coventry. I had completed two years of my programme at the University of Birmingham when my husband was offered the position of Professor of Psychiatry at the University of the West Indies and I was offered the position of Lecturer in the Department of Management Studies. Thereafter, I made the decision to return to Jamaica, which meant that my study would be supervised from a distance; via email; and a visit to Birmingham in 2001, just before the departure of my

supervisor Professor Lartey, to Atlanta, the USA. The re-entry process awaited me as I returned to Jamaica at the end of August 2000.

Although promised otherwise, I started teaching at the Mona Campus of the University of the West Indies (UWI), Jamaica, at the beginning of September 2000. The data analysis and the writing up of this thesis has been undertaken in the midst of many challenges, not the least of which is a period of profound change and expansion at UWI as well as in Jamaica and within the Caribbean region. I have become more acutely aware of the impact of migration on peoples lives, this is one of the processes under examination in this study.

IV. Triangulation between the ill and the well

The data collected from the persons who had experienced mental illness in the UK had affected me so profoundly, that I felt that I needed to understand if their experiences were different from other African-Caribbean persons of the same age and experience. Could other persons who had been subject to racism, the disruption of migration and the other social, cultural and psychological experiences identified in this study, remain well in England? What were their "Secrets of Wellness?"

It was necessary to formulate a method of research analysis that would assist in the clarification of the research questions, and also to assist in the analysis and process of conclusion. The research method of triangulation of the data collected from the person's with mental illness and the care workers against data collected from the well African-Caribbeans, seemed to be the most appropriate method. Blaxter, Highes and Tight (1996) define triangulation as:

> the use of more than one method in the main body of research. You may follow up a survey with some interviews in order to get a more detailed

> prospective on some of the issues raised. The telling anecdote may be more revealing and influential than almost any amount of figures. You might follow the reverse process, using interviews in order to identify key issues about which you would then ask questions in your survey. You might compliment interviews within an institution with the analysis of available documents, in order to compare the written and spoken versions. Where two more methods are used in this way to try to verify the validity of the information collected, the process is referred to as triangulation (Blaxter, Highes and Tight 1996, 84).

Interviews and Case studies of respondents

There can be many difficulties in collecting data from persons with disabilities, including mental illness, according to Grbich (1999). These include the matter of gaining their trust; dealing with their suspicion and amazement at the fact that someone would be interested in them and their experiences and the problem of keeping them seated in one place and focused for one and a half hours – the duration of each session. In fact, there were at least two respondents whose care workers had to be interviewed on their behalf, as their illness prevented them from answering directly. As suggested by Grbich (1999) special efforts were made to keep the questions short and clear, to give the respondents extra time to answer, and to maintain a very calm environment.

The respondents might also have had initial difficulties in understanding my accent and expressions, but over the period, we were able to communicate well and even to make jokes about the way we spoke to each other. I took detailed notes, as tape-recording the interviews would have been inhibiting and disruptive for the respondents.

The issues of gender and the conduct of interview research in the African-Caribbean community were of particular significance in the construction and conduct of the interviews with the respondents. The impact of feminism on scholarship is well

documented. The epistemological, as well as political have been highlighted, and the personal, understood to be political (Bryan *et al* 1985, Collins 1990, Jarrett-Macauley 1996). Feminists have mounted a challenge across the world about the nature and definition of knowledge, as well as its generation, ownership and interpretation. Within the feminist movement African-American women have raised questions about the more appropriate nature of womanism (Walker 1984, Mitchem 2002). As a Black woman undertaking research, there were a number of questions that I considered. These included the perception of research and researchers held by my target group. Of particular influence, were the negative and positive past experiences of the respondents on the outcome of the data provided through the interviewing process.

Case studies have been used extensively in this thesis to ensure that the African–Caribbean people who were investigated became visible and were named in the discourse (Sandoval, 1985). Twenty of the case studies provided information about the experiences of Black mentally ill persons in Britain. The case studies were developed from the notes made by a psychiatrist during an assessment of the clients at Servol, and from subsequent observations and interviews. These case studies from Servol provided baseline data on a group of African-Caribbean persons with severe enduring mental illness. These persons were subsequently involved in a Cultural Therapy Programme imported from Jamaica by the Psychotherapy Associates International team, which pioneered and validated the therapy in the UK. These people also provided insight into the psychological impact of racism on African-Caribbean migrants and their families, and the ways in which they searched for healing in England.

Interviews with care workers

Having developed insights into the impact of severe and enduring mental illness on those persons in their care, the care workers were able to provide information that allowed for the triangulation of the data on them. Their relationships with Servol's clients gave them a unique perspective on the way in which they returned to health after bouts of illness. Not only were they working in a safe environment, which was culturally appropriate, but they were also able to engage in therapy which was culturally appropriate.

Focus groups of well persons

At all the focus groups we sat in a circle and I gave each person a copy of the Focus Group Guide (Appendix 3) to read. This Guide contained the 12 questions that I had prepared on the definition of health and healing, and health and cultural issues in the African-Caribbean community. This stimulated a discussion within the group as they answered the questions. The discussions were tape-recorded and then transcribed on to computer. Thereafter, the data were subjected to qualitative content analysis, and the themes and sub-themes identified and analyzed.

The Triangulation Methodology

The 20 baseline case studies were developed during the preliminary phase of the study and the baseline data provided directions for the development of the semi-structured schedule that was administered in the second phase of the study. The results were grouped, using spreadsheets, and manually cross referenced. The care-givers were interviewed to determine the impact of Servol and the Cultural Therapy Programme on the healing and wellness of the clients who were under their care. In

order to triangulate the generalizability of the findings, I undertook two focus groups of well-African-Caribbean people to identify how they navigated life as Black Britons. They were in the same age range as the clients and shared similar educational background and life experiences. The defining difference was that the members of the focus groups had been able to maintain good mental health and had achieved a degree of success in terms of the studies, employment and family life. For purposes of triangulation, there were two focus groups of well African-Caribbean persons in Birmingham and Coventry respectively. The focus groups of well African–Caribbean persons raised adaptive coping issues that allowed for the comparative exploration of the challenges that had been raised by those with severe mental illness.

The process of validation and reliability

In order to ensure the integrity of the research process every effort was made to collect the data and then triangulate it by using focus groups and other interviews. The terms of validity and reliability have, however, come under question Gbrich(1999). She challenged the notion that multiple data sources and a tight design should be valued above the intensive investigation of one person's expert opinion. In this study I, therefore, tried to assess the world of mentally ill persons as accurately as possible, using multiple data sources; interviews, case studies and observations.

Communication

I have learned English as my mother tongue, I also speak Jamaican Creole, which allows me to code-switch between both languages. In addition, from

experience, I am able to recognize a wide variety of Caribbean accents, to correctly determine the mother- tongue of people speaking English as a foreign language, and to decipher the regional accents within Britain. I, therefore, have found that I can engage quickly with people of different ethnicities and socio-economic backgrounds. This allows for the acknowledgement and affirmation of someone's origins and helps to identify a wide diversity in the Black community. People realize that you are listening to them and hearing what they have to say. Language and questions of the modes of discourse are critical to effective communication, which is the bedrock of a successful therapeutic relationship.

The diversity of cultures

Recognition of the diversity of cultures encapsulated within Black communities is also very important for successful data collection and the building of therapeutic relationships and alliances. There is considerable need for knowledge of and sensitivity to different cultures within the Black communities. The 2001 Census in Britain has identified three categories of Black persons for purposes of ethnic monitoring; **Mixed, Asian or Asian British, or Black or Black British.** These categories are inadequate and fail to capture the many nuances of identity, ethnicity and places of origin. Many cultural dimensions such as language, dress, food, religion, and aesthetics must also be recognized by the caregiver in order to provide culturally appropriate care. Where there are differences between the majority and the minority culture as there are in Britain, there is a vital need for caregivers to be committed to cultural sensitivity and appropriateness.

In addition, other issues such as the diversity of family type's in the Black community are important challenges; these include nuclear, extended and one-parent families. A mother may never have been married, so she may have had three children who all had different surnames and she may also have a different surname. A helpful question to solve this problem was: "What is so and so's name?" The research design did not assume that a mother's name was "Mrs." Language and meaning, family types and other issues were considered very carefully in terms of the design of this research. Not only were the traditional research issues like validity and reliability considered with care, but there were also a whole host of cultural issues that were critical for the research design and these were crafted accordingly.

V. The data collection instruments

The Respondent Interview Schedule

Interview Schedule 1 (Appendix 1) is a semi-structured schedule with 25 questions which were administered to the 20 respondents, each schedule took an hour to complete. Based on the experience of conducting the Cultural Therapy Programme, a number of issues arose, and these issues were then translated into the 25 questions on the schedule. The questions included demographic information about the respondent's place of birth and citizenship, levels of education, the skills acquired, work experience and plans for the future. Questions were also asked about difficulties and successes experienced in life and sources of help. The final questions asked were about the impact of Servol and the Cultural Therapy Programme on the lives of the respondents. A number of open-ended questions were raised at each interview, which were often specific to the individual client's experiences and beliefs.

The Care Workers' Interview Schedule

Schedule 2 (Appendix 2) had 15 questions that required a period of one hour for administration. In designing this instrument, care was taken to use descriptive questions as was suggested by Grbich (1998) and I took detailed notes rather than recording the interviews, in order to minimize disruptions. Six caregivers were interviewed of a total of 12 caregivers who worked with Servol. Those interviewed had been with the organisation for a minimum of three years and had at least the first level of training in health and social care. From observation, they seemed to enjoy an excellent rapport with the mentally ill respondents. The care-givers had also experienced some of the same problems as the respondents to whom they gave care: bullying at school, problems with the NHS and Social services, as well as problems with the police - so they understood the respondents' experiences. The schedule explored issues such as their origins; training and experience in health and social care; knowledge about mental health; and observations of clients who had difficulty communicating. Servol's impact on the health of the clients, and the impact of Cultural Therapy Programme were also explored.

The Well Person Focus Group Interview Guide

The well person focus groups were conducted in April and May 2000 respectively. This exercise was facilitated by the two persons who had convened them, who had been able to provide credible information to the participants about me, and the nature of my research. Thus, as suggested by

Gbrich (1999), I stressed anonymity, confidentiality, and the right of each individual to withdraw from the group at any time, without penalty as well as the right not to respond to any question. Twelve pre-tested questions (See Appendix 3) were utilized as a guide during the interviews, and the three-hour sessions were recorded and subsequently transcribed.

VI. Data Analysis

The results were grouped using spreadsheets and the data were cross-referenced. I also developed a thematic framework stemming from the central research questions, which are listed below:

1. *What is it like to be an African-Caribbean person in Britain with severe and enduring mental illness?*[7]
2. *How has being at Servol helped you remain well?*[8]
3. *How has your participation in the Cultural Therapy Programme affected your well-being?*

The core themes were explanations about being Black British and having mental health challenges, in addition to assessments of the impact of Servol and the Cultural Therapy Programme on the maintenance of wellness. These core themes comprised many more sub-themes as well as marginal themes related to the central questions in the interviews, focus groups, and the course of the analysis.

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[7] By "mental illness" I use the term to mean diagnosed by mental health professionals in the NHS, as a result of which one is on Income Support and receiving the Disability Benefit

[8] By "well" I use the term to mean that one does not need to be hospitalized as a result of receiving appropriate care while one is resident in the community. It also means enjoying good health.

VIII. Ethical Considerations

There were significant ethical considerations in undertaking the research for this study.

1. **Privacy:** All persons who were identified in the case studies and elsewhere gave their written permission for the use of the material, and every effort was made to protect their privacy.
2. **Confidentiality:** The issue of confidentiality is always important in a therapeutic relationship such as the one in which I was engaged with these mentally ill persons. As such, when the sample was selected at Servol, we agreed upon some ground rules. These included a commitment to keep the discussions of the group confidential, and all the participants were asked to respect this rule.
3. **Trust:** Trust was, therefore, a critical issue. A lack of trust typifies the relationships that members of ethnic minorities have had with health and other providers of care. Many relationships between care workers and clients of the mental health system were plagued with mistrust, suspicion and fear (Francis 1992). This had disastrous consequences for the effectiveness of the therapy and the quality and efficacy of the care provided, (ibid 1992). I was also aware that many persons, who had experienced mental illness, felt misunderstood, isolated and disrespected.

In order to establish trust, we ensured that all the promises I made to the group were kept. This was done in the following way: I maintained the schedule for the meetings so that even when people arrived late, we were

there waiting. When an individual asked a question privately, there was no mention of this in the larger group without his or her permission. I listened carefully when clients spoke in the Group and made a note on the clipboard for future reference. Where I promised to get information for individuals or the Group, I acted on it. If I provided wrong information or made comments that caused offence, I apologized. I was very conscious of the sensitivities of the clients and as much as possible did all in my power to maintain trust.

4. **Fear of divulging personal information to State Authorities:** The evidence suggests that people sometimes feel it necessary to be less than frank with their doctors and other figures in authority, for fear of possible adverse consequences (Focus Group Coventry, 2000). It is felt that the information shared by the client might be divulged to the Social Services, a person's employers or others who may utilize the information for purposes that are detrimental to them. One result is that of labelling, where Black people are given diagnoses or assessments that have adverse short or long-term consequences (Focus Group Coventry, 2000). These labels connote negative stereotypes of Black people and are often not reflective of the situation which was actually being experienced by the person. Sometimes the health or social caregiver does not hear a word uttered by the client, patient, or help-seeker, instead, he or she allows the thought process to be influenced by the stereotypes.
5. **Ethical Approval:** The study followed on to a consultation undertaken by Professor Frederick Hickling of Psychotherapy Associates International Ltd., at the request of Servol Community Trust. As was noted in the Introduction,

Professor Hickling had been employed on a consultancy to North Birmingham Mental Health Trust, which in collaboration with other service providers for the African-Caribbean population, had requested a proposal to address problems in mental health care in Birmingham. He had sought and received written consent from all Servol's clients for research to be undertaken and published and as such, the study took place under this rubric. It was, therefore, not necessary to seek ethical approval through the North Birmingham Mental Health Trust.

After each Cultural Therapy meeting the participants were asked how they felt about the exercise and they were also reminded if they felt uncomfortable or were no longer willing to participate, they could withdraw.

CHAPTER 5

CULTURAL THERAPY IN A CULTURALLY SENSITIVE AND SAFE ORGANISATION IN BIRMINGHAM

I. The Demographics

Characteristics of the respondents with severe and enduring mental illness

All 20 of these respondents were African-Caribbean, in origin and had severe and enduring mental illnesses. Ten had a diagnosis of schizophrenia, while the other 10 had a manic psychosis, or a psychosis with epilepsy. They were patients of the National Health Service who had experienced mental health problems for a minimum of 16 years and were now resident in Servol's facilities. Observation and interviews were undertaken for the preparation of case studies. The sample included people of at least three generations of African and Caribbean people in Britain; some born in Britain, others in the Caribbean. All off these respondents had been in the mental health system for more than six years and lived in Birmingham.

Ten respondents were male and 10 were female. Fifteen were born in the United Kingdom and five in the Caribbean. Those born in the Caribbean (now British citizen) were the oldest in the group; as they had come to join their parents in the UK in their early adolescence. They had been left in the care of their grandparents or other relatives in the Caribbean before being sent for by parents.

Three of those who were born in the UK had returned with a parent or had been sent to live in the Caribbean with grandparents for periods of one to three years, before returning home. Most of the respondents had never visited the Caribbean although they expressed an interest in doing so.

The oldest participant was 62 years old and the youngest 33 years old. The mean age was 41.8 years. With respect to their education, one completed university

and became an engineer, and two started but did not complete their studies at college as they experienced mental breakdowns. The remaining 17 did not achieve much academic success as many experienced mental health problems and left secondary school without any qualifications. This contributed to their being able to get only low paid jobs in factories and other enterprises for short periods.

At least six of the respondents were parents, although their children were now in the care of the State or adopted by their grandparents, as a result of the problems associated with mental illness. From the socio-demographic profile below, it is clear that these persons have been struggling to maintain their mental and physical health, as well as their well-being. However the sample is so small and non-randomly selected that it is difficult to make claims of reliability of the findings. The life experiences of these persons can, however, give a valid picture of the lives of 20 African-Caribbean persons who have experienced severe and enduring mental illness. Their characteristics are summarized in the following Table 3.1.

Table 3.1

Characteristics of the Respondents with severe and enduring mental illness

Respondents	Characteristics						
	Marital Status/age/gender	**Place of Birth**	**Citizenship**	**Number of Children**	**Length of Time in the Mental Health System**	**Diagnosis**	**Highest level of Education**
Case # 1	Single 34 female	UK	British	3	20 years	Psychosis	Secondary *
Case # 2	Single 40 female	UK	British	n/a	20 years	Epilepsy with psychosis	Secondary
Case # 3	Single 43 female	UK	British	n/a	29 years	Schizophrenia	Secondary
Case # 4	Single 34 female	UK	British	n/a	17 years	Paranoid schizophrenia	Secondary
Case # 5	Single 33 female	UK	British	n/a	lifelong	Epilepsy with psychosis and intellectual disability	Special needs*
Case # 6	Single 41 male	UK	British	n/a	8 years	Epilepsy with	Secondary

						psychosis	
Case # 7	Married (separated) 42 female	UK	British	3	6 years	Puerperal psychosis	Secondary*
Case # 8	Single 49 male	Jamaica	British	n/a	5 years	Paranoid psychosis	University
Case # 9	Single 36 male	UK	British	n/a	21 years	Schizophrenia	College*
Case # 10	Single 59 female	St. Kitts	British	1	31 years	Paranoid schizophrenia	Secondary
Case # 11	Single 45female	UK	British	1	10 years	Schizophrenia	Secondary
Case # 12	Single 35 male	UK	British	n/a	19 years	Schizophrenia	Secondary
Case # 13	Single 49 male	Jamaica	British	4	4 years	Schizophrenia	Secondary*
Case # 14	Single 43 male	Jamaica	British	3	10 years	Schizophrenia	Secondary*
Case # 15	Single 62 male	Jamaica	British	n/a	40 years	Manic psychosis	Secondary*
Case # 16	Single 43 male	Jamaica	British	n/a	10 years	Schizophrenia	Secondary*
Case # 17	Single 38 male	UK	British	n/a	15 years	Schizophrenia	Secondary
Case # 18	Single 33 female	UK	British	n/a	10 years	Manic depressive psychosis	Secondary
Case # 19	Single 42 female	Jamaica	British	1	24 years	Schizophrenia	Secondary
Case # 20	Single 35 male	UK	British	1	18 years	Schizophrenia	College

Characteristics of the care workers

The six care workers who were interviewed were African-Caribbean; two had been born in Jamaica, while the other four were born in the United Kingdom. Three were male and three were female, between the ages of 34 - 40years old. All were British citizens who had completed secondary school and were now at various stages in the completion of the National Vocational Qualification (NVQ) in health and social care. They had worked at Servol for between 2 – 4 years and their characteristics are summarized in Table 3.2.

Table 3.2

Characteristics of the Care workers

Respondents	Marital status/age /gender	Place of birth	Citizenship	Number of children	Length of service at Servol	Highest level of education	Other skills

Careworker #1	Single 34 male	Jamaica	British	3	2 years	Secondary &NVQ	Driving
Careworker #2	Married 36 Female	UK	British	2	3 years	Secondary &NVQ	Hairdressing
Careworker #3	Married 36 female	UK	British	2	2 years	Secondary and NVQ	clerical
Careworker #4	Single 34 male	UK	British	1	2 years	Secondary &NVQ	n/a
Careworker #5	Single 30 male	UK	British	0	2 years	Secondary &NVQ	musician
Careworker #6	Single 40 fem	UK	British	2	4 years	Secondary	cook

Characteristics of well persons

The focus groups consisted of four men and six women: two of the men and two of the women were born in the UK; two of the men and two of the women were born in the Caribbean, while the other two of the women were born in Africa. They ranged in age from 25 – 35 years and were highly educated, one had a PhD, there were two lawyers and a psychologist with postgraduate qualifications, three had bachelors degrees and two had college diplomas. None of the men were married or were fathers, while three of the women were single mothers, one was divorced, while one was married. They were employed in the following fields: university lecturer, centre manager, community and clerical workers.

Table 3.3

Characteristics of well persons

Respondents	Marital status age/gender	Place of birth	Citizenship	No. of children	Highest level of education outside UK	Highest level of education within UK	Nature of employment
#1	Single 25 male	UK	British/Jamaican	n/a	Bachelors	Masters	Lawyer
#2	Single 30 male	UK	British	n/a	n/a	Bachelors	Youth worker
#3	Single 30 male	Jamaica	American/Jamaican	n/a	Masters	Incomplete PhD	Engineer
#4	Single 29 male	Jamaica	British /Jamaican	n/a	Bachelors	PhD	University Lecturer
#5	Single 32 female	Jamaica	British/Jamaican	1	Secondary	Bachelors	Community worker
#6	Divorced 34 Female	Nigeria	British/Nigerian	2	Bachelors	Masters	Centre Manager
#7	Married 32 female	UK	British/Ugandan	2	Bachelors	Masters	Lawyer
#8	Single 32 Female	Trinidad	British/ Trinidad	n/a	Bachelors	Postgraduate Diploma	Psychologist
#9	Single 34 Female	UK	British	1	N/a	College Diploma	Clerical officer
#10	Single 34 female	UK	British	1	N/a	College Diploma	Receptionist

II. The Case Studies of the respondents

Presentation and examination of the case studies of the respondents offer unique information about Black mentally people in the UK. This information is the essence of this study, and provides a foundation and platform for the comparative triangulation process that is at the heart of this analysis. The emerging thematic constructs arising from the case studies are now examined, using particular case

studies to illustrate the relevant themes. The themes also coincided with the findings of the literature, although the person featured in the case study brought his or her story to life in a way that written material cannot.

The meaning of migration

This theme of migration emerged from a number of case studies and interviews. It was not only an issue of the migration of people from the Caribbean to the United Kingdom, but it also disguised issues pertaining to forced slave migration from Africa, and possible return migration to the Caribbean, as well as to Africa. This obscured the experience of continued and repeated loss with each migratory journey, including loss of family, loss of identity, loss of nationality and loss of home.

CASE STUDY #1

> An African-Caribbean female, aged 34, she was born in England and moved to Jamaica at age Seven, where she lived with her mother and sisters. She enjoyed living in Jamaica and did well in school there. She returned to the UK with her family when she was between 11 and 12 years old, but found this move very traumatic. While attendng school where she experienced many problems and soon became pregnant with the first of her three children. She has suffered from severe mental illness for the last 20 years, with the resulting loss of her children into foster care. It was clear from all reports that she had been in a depressed state since the birth of her first child, and that this depression was severely exacerbated by the death of her mother soon after.

She was admitted to Servol in 1997, the staff helped her to remain in contact with her children, and her mental status was satisfactory. In spite of the fact that her illness had been recognized by both her social worker and her general practitioner, she had remained untreated and her condition had not been followed up clinically by the psychiatric service which had been responsible for her care. Her major concern was

for the re-establishment of her family unit - an admittedly complex and difficult task, particularly in the context of African-Caribbean families, where the cultural determinants can be significantly different from those of their European counterparts. Servol has played a major role in her rehabilitation and reunification with her children. She attended the Cultural Therapy Programme at the Clubhouse, and was placed as a part-time receptionist at Servol and continued to acquire vocational skills. Assistance was also provided so that she could access her own accommodation, and receive the critical support in the period when she was trying to re-establish a family unit with her children.

This case study demonstrates some critical issues. This respondent has been affected by the disruption caused by the migration of her family from Britain to Jamaica and back, then the fragmentation of her family between both countries. She enjoyed her life and attending school in Jamaica while she was resident there, and seemed to have felt fairly negative about her life and school experiences in Britain. Her early pregnancy upon return to England and the death of her mother led to the development of mental illness, which was improperly treated for nearly 20 years, in spite of the efforts of her general practitioner and others. She experienced racism at school, in the National Health Service and within the Social Services, which eventually removed her children. Her circumstances and mental health improved as she got the necessary help at Servol, and she was still trying to become reunited with her children with the help of Servol staff, a solicitor and the psychiatrist who provided the necessary support.

CASE STUDY #5

This woman was 33 years old, a second generation African-Caribbean, with a diagnosis of epilepsy with psychosis, and intellectual disability. It is believed that she was born in the UK and taken to Jamaica when she was aged three to be cared for by her grandmother. It would appear that when the grandmother could no longer look after her, she was placed in an institution for older people. She became pregnant at some time in Jamaica and when she returned to England in 1993, she could not relate to her mother's new family, (i.e stepbrothers and stepsisters). Based on concerns about her mental state when she came from Jamaica she was admitted to St. Edward's Hospital, Cheadleton, Leeds and subsequently to the City General Hospital, Stoke-on-Trent. As she was deemed to be learning-disabled, she was referred to the Psychiatrist in Stoke-on-Trent. Her clinical Psychologist attempted to assess her IQ, using the Raven's Matrices, but was unsuccessful due to her lack of co-operation. Her mother has since died. She came to Servol on a high level of medication that interfered with her breathing and led to hospital in-patient care. In addition, she was also thought to be blind or at best, partially sighted. She was also found to need gynaecological treatment.

Since her transfer to Servol, the staff members in her current residential home have been training her in various aspects of self-help skills. (she had limited self-help skills and needed supervision as well as persuasion with most of her personal care and hygiene). She was found to be suffering from epilepsy, with secondary psychosis, and this was complicated by intellectual retardation, probably secondary to brain damage, as a result of long-standing epilepsy. Her level of intellectual and social functioning was very low and she will, therefore, require a high level of clinical and social support for the rest of her life. As such, her rehabilitative potential was limited.

This case demonstrates the impact of migration on this young woman, who required considerable support and care because of her special problems. She seems to have been sent from Britain to Jamaica, then back to Britain where she eventually entered Servol, where the necessary care was available.

CASE STUDY #10

> The 59-year old woman, born in St. Kitts, of Kittitian parents. (She sometimes denied that she was born in St. Kitts). She certainly grew up in St. Kitts with her mother and father and went to England at age 16 to live in Old Telford. Her only son was born in 1963 and when her parents returned to St. Kitts in 1975, she was left to bring him up alone. He was subsequently admitted to care and fostered.
>
> She was initially admitted to Rubery Hill Psychiatric Hospital in 1966 for a six-month period, and has suffered from mental illness since then. During that time she received electro-convulsive therapy. Having lived on her own since 1975, over the years, there had been considerable concern about her deteriorating physical state, poor living conditions and hygiene. Bags of rubbish and mountains of cigarette ends were found on the floor when she was readmitted to Rubery Hill Hospital in 1991. (Summary, 1997)

In 1992, she was admitted into Servol, and had settled in fairly well, with occasional visits from her son. Apart from having a long history of chronic schizophrenia, she suffered from diabetes. She also reported that she heard voices echoing, and people tramping on the pavement. She heard the voices through her ears and not in her head, and heard people talking about their past lives, often in a very irritable manner. She longs to go back to St. Kitts, and plans to do so by the time she is 72. Since, her sojourn at Servol, and her participation in the Clubhouse and Cultural Therapy Programme, she has shown marked improvement.

This case study demonstrates some of the disruptive aspects of migration (for a woman who had been born in St Kitts and brought to England by her parents who subsequently returned to St. Kitts). In addition, her parents' departure from England left her caring for her son without a support system. As her mental health deteriorated she eventually lost her son to the State authorities. After experiencing many difficulties with housing, ill-health and other problems she eventually went to

Servol, where culturally appropriate care was available, and she was able to make considerable progress, and even become reunited with her adult son.

The profound identification with the repetitive cycle of migration for Africans displaced from Africa, forced enslavement in the Caribbean, unwilling entrapment in the United Kingdom and an ambivalent desire to return to Africa in some instances, or to the Caribbean in others, was a major finding emerging from this study. This theme was repeated and compounded in the triangulation process with the care-givers and the well persons that will be discussed in a later section.

Loss of self and family

Continuing the experience of the repeated loss with each migratory journey, is the trauma of loss of family that is mirrored in each of these voices of anguish. The loss of family occurred in moving from the Caribbean to the UK, was compounded by the loss and/or alienation from family there in the UK. The promised victory of the migratory experience was often pyrrhic. Coupled with this, the unstated existential angst of the loss experienced by the generational dislocation of centuries of enforced migration of the slave experience, was a resounding, but muted cry of many of these people.

CASE STUDY # 2

> An African-Caribbean aged 40, was born in England, and in her early years, lived with her mother and father who were both from St. Kitts. At age five she was involved in a serious road accident which resulted in her having brain damage after receiving head injuries. She developed epilepsy as a result and took anti-epileptic medication for that condition. In 1992, she assaulted her mother and arising from this, she was placed in a hostel by the court/probation services. In addition, she had also threatened to kill her grandmother, who also

resided at her mother's home. Thereafter, she was placed at Servol, where for the first three years, she was extremely unstable. Her challenging behaviour, caused conflict in the home and at a nearby shop; and at times other clients feared for their safety because she would terrorize them. This often resulted in fights and she sometimes attacked the staff.

In the spring of 1996, a decision was made by her, in conjunction with the Servol Team, to attend ENTRA, an organisation which specialized in working with people with disabilities, who required further education. After expressing considerable anxiety about the prospects of going to study she successfully completed NVQ Level 1 - Business Studies and went on to pursue the NVQ Level 2. Her family was pleased with her progress, and there were no reports of disruptive behaviour at her mother's home where she visits on weekend. She was well stabilized on medication, but needed self-confidence and training in assertiveness, which is accessible from a group programme. It was also felt the she would benefit from sheltered vocational activities, such as those provided by the Cultural Therapy Programme.

This case study points to the importance of the partnership between the family and the organisation (Servol) in the healing of a client. This client had the benefit of a stable home and the support of her family after an accident in early life had resulted in brain–damage and epilepsy, which caused her to be volatile and unstable. Her entry into Servol provided her with access to the appropriate training and support, from which she subsequently benefited, and was able to improve her relationship with her family.

CASE STUDY # 7

An African-Caribbean, second-generation woman, aged 42 was born in Leeds, England. She went to Jamaica at age five, where she grew up in Santa Cruz, in the parish of St Elizabeth with her mother and step-brother. Her father remained

in Leeds with her brother and she had no contact with them. She attended Lacovia Secondary School and left school at age 17. She had her first child, a son, soon after leaving school and then had another son at age 23. She started working in Kingston as a domestic worker. She was working in Kingston, Jamaica, when she met her husband, an Englishman who looked "White" but was of mixed race and was living on British income support in Jamaica. His father was a Black Jamaican, and his mother, a White English woman. She married him in Jamaica and then returned to England in 1990 at age 29. They lived in Wolverhampton where she had two children with him, who were subsequently put in care. The couple started to have problems while they were living together, and she also reported that he had been very violent and abusive to her in the prior to that. She had never worked in the UK and she had no history of serious physical or mental illness. However, symptoms of depression were noted in a general practitioner's letter in June 1991 when she was pregnant with her daughter. In December 1993, there are notes of outbursts of temper, her breaking a window for no apparent reason, intent listening and talking nonsense. In April 1994 she was found wandering in Coventry in a confused state. It appeared that her husband had obstructed her access to social services and mental health services over these years.

She was hospitalized in an advanced state of pregnancy under Section 2 of the Mental Health Act because of marked self-neglect. She was likely to have been suffering from a post-partum psychosis of a schizophrenic nature, which arose after her last pregnancy. This notwithstanding, she could function quite capably at home doing domestic and related activities and showed a significant degree of resilience and strength. It was felt that her domestic skills could be readily activated and actualized in a work rehabilitation programme, and as such, she should be encouraged to rebuild her life around suitable work activity and a secure emotional relationship.

This case study demonstrates the destabilizing effect of moving between Jamaica and the UK without the appropriate support systems being in place. Hence when this woman was having marital problems and mental health problems associated with her pregnancy, she ran afoul of the state authorities and ended up losing her children. The NHS provided less than adequate service, as she was

misdiagnosed and inappropriately treated. However, at Servol she had made considerable progress and was trying to get her life sorted out.

CASE STUDY # 19

> She was an African-Caribbean woman aged 42, who was born in Portland, Jamaica, and lived with mother while her father had migrated to England. When she was aged 10 she migrated to England with her paternal grandmother, and went to Birmingham to live with her father, stepmother and three brothers. She attended secondary school where she obtained two O' Levels, 7 G.C.S.E.'s and passed the pre-nursing examinations. After leaving school she secured employment in a factory packing motorcar parts. She was aged 18 at the time and worked there for a few weeks, before becoming pregnant. She had a daughter now aged 16, who was brought up by her father and stepmother. Her father and stepmother were divorced in 1989. Her daugther's father did not support the child at all and became mentally ill soon after the birth of the daughter and was admitted to the mother and baby ward of All Saints Hospital, where she had been in and out of hospital for the past 16 years. Her diagnosis was schizophrenia.
>
> She moved to Servol in 1996 and had been fairly well maintained on her medication; she has good social interaction and maintains her personal hygiene. She has also showed considerable progress at the Clubhouse and Cultural Therapy Programme.

This case study provides insight into some of the difficulties occurring in families where migration has taken place. Having joined her parents in the UK, the respondent was relatively successful in school, where she passed her examinations. However she was only able to find factory work, which was not rewarding. She soon became pregnant, after which she suffered a mental breakdown. Her mother and stepfather adopted the baby, however, in time they were divorced. While she had experienced considerable instability and insecurity in her life, Servol provided the stability she needed to improve her circumstances.

Racist and alienating experiences

One of the most devastating experiences faced by the respondents interviewed was that of dealing with racism. The case studies demonstrate how different people dealt with racism and other experiences, which impaired their health and well-being. The voices of this group of African-Caribbean people highlight the pain of their mental illness and their experiences in the mental health system in England. Some of these persons were angry and frustrated:

"Nothing nu wrong with me, is just the Babylonian system fighting me down."

He was a dreadlocked, Rastafarian who refused to admit that he had mental problems. Babylon is the system which oppressed the Children of Israel, with whom he identifies. Others were feeling so much anguish and pain:

> *"The social workers wouldn't give me a break. These people are trying to drive me insane, take away my child, using me as a guinea pig. Thought that if I talked to them and cooperated with them it would be in my interest.*
>
> *After I got sick and then got better, I wanted to go to college and then get a job. The doctor said "You can't cope with stress so just go on the dole." I was just 21years old and I am now 42 years old, sometimes I feel so hopeless.*
>
> *The doctors were just horrible, they kept on telling me what was wrong with me, but I know that they are wrong. I want to get out of the mental health system as soon as possible."*

The reported experiences of the respondents with severe mental illness and the well respondents indicate that doctors, nurses, psychiatrists and other mental health workers have often given up on persons with mental illness and, therefore, have no or low expectations for their healing, or recovery.

> A 58-year-old African-Caribbean male born in Jamaica, who migrated to Britain 40 years ago, has worked in factories in the West Midlands. He was referred to the psychiatrist in our Service by our private GP, after displaying symptoms of severe phobic anxiety and depression and was subsequently treated with the appropriate antidepressant and psychotherapy. He reported major incidents of racism during his stay in Britain and his depressive illness

started some 10 years previously, when his marriage of 30 years broke down. As a result of the many racist experiences at the workplace, he was terrified of seeing the GP with whom he was registered or visiting the mental health services. As a result, he had suffered with his psychological illness for 10 years, until he learned of the existence of our African-Caribbean Health Service and was able to receive the appropriate assistance.

Many African-Caribbean people are terrified and suspicious of the National Health Service, and often refuse to access either medical or mental health services until their condition is 'terminal' (Francis 1992). This too was the case in the respondents interviewed in this study

Others wanted to leave England:

"I just want to leave England; there is nothing here for me. I want to go back to Jamaica to my family and my life there."

"This place (England) does your head in. I did not have a problem when I lived in Jamaica with my grandmother when I was young. Since I have come to this place I have a lot of problems."

CASE STUDY #3

An African-Caribbean woman aged 43 was born in England, in Birmingham. Both of her parents came from rural Jamaica, but she had never been there. She reported that she got on well with her parents in her early years. (Her father was a factory foreman, now retired). She also got on well with her brother, but not her sister. Her brother who used to work in a bank was unemployed at the time of our intervention and she had lost touch with sister. She didn't do well at schoolwork, as she found doing exams very hard, and also found it difficult to think and concentrate. She reported that she got into trouble in school once when a girl called her a prostitute. She hit her and the teacher told her to stand up in a corner. Continuing, she described experiences of racism on a number of occasions especially during the past two to three years when 'women of all different colours were picking on her' based on the colour of her skin. She reported being pregnant in 1984, but her son died not long after birth, and she lived in her own flat between May 1984 and May 1996. She further reported that she had been in and out of hospital all during that time. In retrospect, she recalled that she had problems with her mother from the age of 14, which had resulted in her not going to her mother's house thereafter. However, she had got on well with her father. She did not have a regular boyfriend and she reported that she was often depressed about getting into different situations and not knowing how to cope. Additionally, she used to hear voices in her head

when she was younger. She said that the doctor at Highcroft Hospital diagnosed her with a manic depressive psychosis, which she said she had been having since age 14. Her first admission was to Highcroft in 1977 at the age of 17. Various courses of medication have reduced the distress that this causes, but she reported that it has never stopped completely. Most of the time she said, she was totally swayed by her delusional ideas. Meanwhile, her daughter lived with her parents, but due to continuing conflict with her, (the respondent) her parents have minimized contact.

She was admitted to Servol from Highcroft Hospital in September 1996. Although she still appeared to have delusions about women, it is not to the same extent as in the past, but she related much more readily to men or male members of staff .She handled all aspects of her adult living skills very well, except for her social skills where it took great persuasion to motivate her to interact. She appeared to enjoy communal living so much that she gained a tremendous amount of weight, which she attributed to the fact that she was enjoying life within Servol, compared to when she was on her own. She had become very friendly with one particular male client, although she was always ready to offer support and assistance to the other male service users. While at Servol, she had become involved in an educational programme and her mental state seemed to be stable, she conversed well and there were no obvious problems. She also responded well to the large group and the vocational aspects of the Cultural Therapy Programme that were established.

In this case, there was clear evidence of the impact of racism and bullying at school, on an insecure young woman. She had suffered mental health problems from her early teens when she had been diagnosed at a mental hospital. Added to this, her relationship with her family had hysterically been strained. However, she developed significant life-skills at Servol and was functioning well in the residential home where she lived.

CASE STUDY#12

He was a second-generation African-Caribbean man aged 35, born in Derby in England. He grew up with mother and father, two brothers and a sister. His mother worked as a private nursing assistant, his father as a caretaker. His sister was a nurse, one brother was a teacher and the other an engineer. He himself had never worked. He attended Secondary School until the age of 15 - when he became ill, and it was observed that he was behaving strangely. He was then admitted informally to and was diagnosed with schizophrenia. He remained there for a number of years, and during his stay he received various types of medication and electro-convulsive therapy, which had little effect on his illness. He was eventually transferred to Birmingham and was accommodated by Harambee Housing Association. One of his brothers also suffered from mental illness, but his mother said that there had been no history of mental illness in the family, prior to that of her two sons.

He was transferred to Servol Community Trust on August 3, 1994. On admission he was receiving extremely high doses of psychotropic medication, which had little effect on his auditory hallucinations. He would also dress inappropriately, wearing only Black and White clothing, such as a White shirt and a Black bow tie, Black jacket and trousers. His life skills were underdeveloped, he could not travel on his own, and he, therefore, required full staff support. During his stay at Servol, he became less dependent on staff, and was able to perform most adult living skills unsupervised. He was still unable to travel unaccompanied, however, he had attended a travel-training programme. He no longer dressed inappropriately, and having participated in a behaviour - modification programme, a number of his bizarre behaviour problems have been successfully corrected, as well as his inappropriate responses to his hallucinations. During the period under reference, his medication was reviewed regularly and subsequently decreased. He had a supportive family; his mother and father visited him regularly and took a keen interest in his progress.

He was initially diagnosed as suffering from a schizophrenic illness, as well as having an identity crisis. He grew up in Derbyshire in a small town which had very

few African-Caribbean people, and at his school the teachers and students were predominantly White. He had considerable intellectual capacity and in fact, was quite bright, and he had been doing well at school up until just before he was due to take his final examination. Then he had a breakdown which resulted in him losing his confidence and experiencing considerable deterioration in his interpersonal skills.

Apparently his stay in hospital was counter-productive and the manner in which his illness was treated hampered his progress. His family believed quite strongly that if he had been placed in an environment which had been much more conducive to his cultural background, he would have made a spectacular recovery. He has now made tremendous progress since participating in the Clubhouse and Cultural Therapy Programme.

This case study provides insight into the impact of racism on a young Black man in Britain. His was one of a few Black families in Derby, so he grew up in a nearly all-white school. Here he experienced racism in many forms, which contributed to his experiencing severe identity crisis and a mental breakdown in his early adolescence. The care of the NHS was so inadequate that he remained in the mental health system for a long time. Servol provided culturally safe and appropriate care, which has led to considerable improvement in his life.

Failure in school

Most of the mentally ill respondents had negative experiences at school in the UK. These ranged from bullying, low levels of expectation from teachers, and underachievement, which laid the foundation for low-level menial employment on leaving school.

CASE STUDY #6

This man was a 41-year old second-generation African-Caribbean. He was born in Northampton, where he lived until the age of 16. He was the eldest of four children and never knew his father. He lived in Northampton with his grandparents with whom he did not get on well. His grandfather was a gardener and his grandmother was a caterer in a hospital. He attended school in Birmingham and he did not enjoy it, as people continually picked on him. He was, therefore, a very lonely child and missed a great deal of school because of his epilepsy. In secondary school he had no friends, was bullied and teased, and recalls being treated as an "idiot person". He left school at age 16 without qualifications and worked as a welder/soldered for one year. Thereafter, he was made redundant and has never worked since that time. His mother took him away from his grandparents at the age of 16 in order to get him better treatment for his epilepsy and to help him to live on his own. He lived with a girlfriend for nine years, after which he left her, and stayed on his own for two years. He had epilepsy since childhood and had been admitted and assessed at All Saints Hospital on the August 22, 1989, (around June 1989) after developing an insidious paranoid psychosis. He was generally very worried about people knowing about him and the fact that he had epilepsy. At times, he felt that people in Birmingham were interfering with him, but he was not sure in what way. Just prior to admission in August 1989, he presented himself at the out-patients department of the All Saint Hospital, saying he thought he was becoming mentally ill, but no formal diagnosis was made at that stage. On examination when he was admitted, he expressed bizarre ideas about his epilepsy, he had a flattened affect, was displaying strange signs of paranoia, and had visual hallucinations. He said he saw himself as a ghost at times, due to his epilepsy, and also that he wanted to stop his excessive smiling. Nonetheless, he was insightful, and his cognitive functions and orientation were normal.

During the two-year period when he lived on his own, he gradually began to neglect himself, to the point where it was deemed unsafe for him to continue independent living, and he was, therefore, admitted to Servol Community Trust. Since his placement within Servol it was confirmed that he had a low intelligence level which had been highlighted in psychometric testing done in 1981, at All Saints Hospital. He found it difficult to comprehend ideas in English as well as patois, although these were the languages with which he grew up. However, he was reasonable at reading and writing.

It was observed the he would spend long periods staring into space and had a tendency to smile and laugh inappropriately during conversation. Some of these more bizarre tendencies have subsided and he became less concerned about his epilepsy, performed most of his adult life skills fairly well, requiring prompting and staff support. He also became socially active and was able to travel independently. The interaction at Servol has been successful in confidence-building and there was marked improvement in his internal state. A full-time educational programme was also put in place to try to correct his verbal communication skills. This, together with his improved domestic life skills and the confidence-building exercises, were aimed at equipping him to return to semi-independent living. However, he continued to hear voices talking to him. He thought that they were the voices of his mother and father, telling him what to do.

He had not experienced racist incidents or attacks. The psychiatrist thought that he was suffering from a schizopheniform psychosis, secondary to long-standing epilepsy. Nonetheless, he had a good skill base and some experience, and he would respond favourably to a Cultural Therapy Programme.

This case study provides insights into the impact of bullying at school on an insecure and isolated young man. He had lost contact with his family and required the kind of care and support that Servol provided. The experience at Servol helped to improve his psychosocial functioning and reintegrate him into the community.

Image and identity

The experience of mental illness is exacerbated by identity crises and conflicts as reflected in the lives of some of the respondents interviewed. As a result, the

study showed that there were many persons who became careless of their appearance, wearing ill-fitting clothes, and becoming generally unkempt.

CASE STUDY # 8

This man, aged 49, was born in Fairfield district, St. Catherine Jamaica. He came to England at the age of nine, in 1964. He left school at the age of 17 with some GCSEs, and after a few short-term jobs, attended College. At the age of 20, he attended University and graduated in Mechanical Engineering in 1979. A large car manufacturing company employed him for about three years, and he was subsequently made redundant. He had no close relatives or friends, and his mother lived in Jamaica. He saw his three half-brothers occasionally when they came to visit him. He also visited one brother at his home on occasion. His mother communicated with one of his brothers and he read her letters, but he did not communicate with her directly. From all indications, he seemed to have lived a reclusive life after he had been made redundant and concerns had been raised about his mental health only after it was reported to the police that he had made an unprovoked attack on a neighbour. No previous history of violence or mental illness was known.

Social Services, however, were aware of a two-year history of self-neglect, failure to pay bills and the fact that he was facing an eviction order. He was also reported to be verbally abusive to his neighbours and would sometimes spit on them. There were further reports that he had told the Jamaican High Commission that he thought he was being persecuted and that people were trying to kill him. His hospital assessment diagnosed paranoid schizophrenia mainly characterized by negative symptoms, i.e. lack of drive, motivation, volition and blunted affect. He was not found to be forthcoming and concealed many of his personal concerns.

He moved to Servol in 1994 and at the time he was in complete denial of his illness and lacked motivation, to the extent that staff had to attend to his every need. However, he was diagnosed as depressed and took anti-depressant medication, which resulted in a marked improvement in his health. He spent most of his time at the library and tried to keep abreast of developments with the latest computer technology. He also applied to do post graduate studies, then the teachers' qualification, so that he might become a lecturer.

This respondent was diagnosed as suffering from a depressive psychosis resulting in severe identity problem and personality disorder, which made him feel

superior to his fellow clients and deny his Black racial identity. It was suggested that he had a classical "Roast Breadfruit Psychosis," which is a psychosis developing in persons who deny their Black identity and are faced with severe social stressors of racism and prejudice (Hickling and Hutchinson, 2000).

This is a case study, which depicts the mental health problems of a bright, educated young man who lost his job and found himself unable to cope with the pressures of life. His situation was exacerbated by his isolation from his family and the identity problems which he experienced. He had also had racist experiences, which affected him deeply. In addition, he was struggling with problems of racial identity and seemed to be ambivalent about his Blackness.

CASE STUDY # 9

He was a 36-year-old second-generation man born in London of a father aged 18 at the time of his birth. His father was apparently unwilling to acknowledge that he was indeed the father. The respondent expressed open hostility and anger toward his father. He said that he had only wanted to have sex with his mother also, aged 18, and then ditched her. He had spent the first few months of his life in care, after which his mother removed him from the residential nursery in London and brought him to her own mother. According to his medical records, she had little further contact with him and he was legally adopted by his grandparents at the age of five. His grandparents had lived in Birmingham at that time, and his birth mother returned to her family home in St. Kitts, so he did not have the opportunity to know her. He saw his father very rarely, therefore, they did not have a close relationship. His grandmother was proud of the fact that he was reasonably bright and expected that he would enter a good profession as all of the other children had done. From age seven to the age of twelve he lived in Jamaica, and was educated there. He had gone to live with his great grandmother in Jamaica at age seven, and felt that if he had lived with her from the start, it would have been better for him. For one thing, she did not beat him everyday as his grandmother had done.

He returned to school in England and gained six GCSEs. He also gained a place at a College to study computer and electrical engineering, but did not manage to complete the course. He had very few friends at school and tended to be very shy and withdrawn.

In his interview he reported that, his paternal Grandmother, who had brought him up, verbally and physically abused him every day. He said that she

would lash him with her slippers and bits of leather. He felt that all she did was beat him. "Bend the tree from when it young," he reported her as saying. However, she was now dead. He further reported that he had a stepmother who also used to beat him. He said his mother didn't want him and as a consequence, he had never met her. From age 11 he reported, his grandmother, aunt and father set up on him to destroy his life. "All I had from age 12 was school".

His concentration, he recalled, was affected by the physical abuse he received, for instance, if he got a puzzle to do at school, he could decipher it in his mind, but couldn't complete it. They called him a bastard and he reported that he had a cousin who was treated better than he was, and that his grandmother used to spit in his tea. He said that he was quite artistic but was never allowed to do anything with his art. He could write poetry and draw well, "but his mind wouldn't let him do anything now". In retrospect, he believed that he was also malnourished while growing up in England.

He became ill at age 15, having been diagnosed with Schizoaffective disorder, and has been hospitalized several times since then. During that period, he experienced considerable conflict with his consultant psychiatrist, as well as the community team which cared for him. He also expressed concerns about racism. From time to time, he would discharge himself from the hospital before he was fully stabilized and this would result in his having relapses. (He had lived in a semi-independent unit, but was unable to care himself adequately).

He moved into Servol on the 23rd of September 1996, where he was to have access to the support he needed. There, he also experienced conflict with the staff who tried to motivate him to comply with his care plan. Over time, the conflict decreased. However, he continued to be isolated, as he had no friends and had had only one visit from a relative since his placement. He was assessed to be a very intelligent young man whose talents and abilities had never been released or exploited. There is no doubt that he had had severe psychotic illness, perhaps not a classical schizophrenic psychosis, but "Roast Breadfruit psychosis", (Hickling and Hutchinson 1999) with a bizarre psychotic response to his own racial identity, which was triggered by the physical abuse he may have experienced in his family.

This case provides insight into many of the problematic issues in the lives of African-Caribbean people in Britain. These issues include the structure of some

families, where young people in visiting relationships become parents too early in their youth. The result is that the son in this case, was moved from the maternal to the paternal grandparents and even spent time with a great-grandparent in Jamaica. He felt unloved and unwanted by his parents and was subject to severe physical and verbal abuse by some members of his family. In fact, he suggested that the best years of his life were those spent in Jamaica.

Another issue which was underscored was the negative impact of his early life on his educational achievement. Although he had the potential to achieve his goals, he was unable to complete his studies at college as a result of his mental health problems. To complicate matters, he had experienced severe racial and sexual identity crisis and his efforts to live independently were thwarted as he grew more and more isolated in his community. His mental health deteriorated and the care provided by the NHS was not completely successful. As a result, he entered Servol and having received the necessary support and care, he was eventually able to relate to other clients and staff, as well as to access the Befriending Service.

The impact of the culturally sensitive organisation

None of the clients of Servol had lived in an African-Caribbean facility before. Instead, they had lived in white-run statutory or voluntary facilities. The group of caregivers will supplement the comments of the Servol clients, who were the respondents in the study, in order to triangulate the findings.

Clients of Servol identified the value of the support they received and the way in which it helped them to remain well. They highlighted the fact that they were able

to develop friendships and seek to "put their lives together again". Below are comments made by respondents about the impact of Servol on their lives.

Support and self-confidence

> *I have received a level of support in Servol that I have not received elsewhere. The staff and clients are brilliant and I plan to write about this tremendous support. If there had been a Crisis House before, I may not have been sectioned on three previous occasions. The group has given me support for my problems, has allowed me to make friends with other clients, and helped me to understand myself and make changes for the future. I am truly grateful.*
>
> *I am regaining my self-confidence as Jane, (the manager of the residential home) helped me to save my money so that I could prepare to liveon my own or in a warden-run flat. She also helped me to by some clothes that made me look better. In addition, she fixed my hair as she is a hairdresser and I feel and look much better. A lot of people have complimented me on how good I look. I was also able to get a part-time job as a receptionist at Servol.*

West Indian food

> *I am learning to cook West Indian food so I have just got a recipe book. I love to eat curry goat, rice and peas and chicken. The smell of the food is so yummy, lots of pepper and other seasoning. It reminds me of the food that my grandmother used to cook for me in Jamaica.*

Anger management

> *I have learned to control my temper since I went to anger-management class. When I feel upset they help me to calm down. Since I have been feeling calmer, I have been going to visit my family every month.*

Repaired relationships with family

> *I went to a wedding with my son. (He had been in care for many years, but the staff at Servol helped to mend the relationship. They helped me to get new clothes and a new hairstyle so I could go to the wedding looking good.*

To be treated as a normal person

> *We used to go shopping, go to the movies, go out on the bus, we even went on a trip to Dublin, I felt just like a normal person. I learned how to wash and iron my clothes, comb my hair, clean my room and lots of other things.*

Servol is safe place for Black people where we can be ourselves without any body bothering us. I am glad that Black people are taking care of me here and that they are in charge. I am so tired of being bullied by White people.

I was able to learn how to do macramé and embroidery and to put my work on display. I was happy to show off my work to friends and visitors to Servol.

CASE STUDY #4

An African-Caribbean woman aged 34, she was born in Birmingham, who grew with her mother and father was the respondent. Her mother was from Kingston, Jamaica, and her father was from St. Catherine, Jamaica. She was the youngest of four siblings, and she went to Jamaica between the ages of 11 and 13. She liked Jamaica and found the people kind and friendly, and the atmosphere pleasant. Although she reported no problems of racism or prejudice, she did not maintain contact with African and Caribbean culture. She started taking medication for mental illness since age 17. She was admitted to Hollymoor Hospital with a diagnosis of paranoid schizophrenia in 1986, at age 18, because of the auditory hallucinations she had been having. Prior to 1992, she had been placed at Servol and left to take up a work placement in Clothes Design and to live independently. It would appear that she became isolated in the community and did not maintain contact with the mental health service. She returned to Servol in 1992, following her release from Highcroft Hospital where she had been admitted in October of that year on an informal basis. At the time of her admission she was subdued and preoccupied with auditory hallucinations. Her former flat had been severely damaged by fire, which she had started after being instructed by voices she was hearing (Summary, 1997).

Throughout her involvement with Servol, she had made significant improvement. She had initially lived at the Dudley Road unit but moved to Strensham Hill into a flat with a view to learning to live independently, improve her budgeting, cooking and domestic skills – all of which she has achieved. She tended to be socially isolated, but had become more receptive to others, outgoing, friendly, helpful and interested in new ideas. Her budgeting skills were excellent; she had cleared her past debts and was pleased with herself. However, she had made occasional suicide attempts, and sustained superficial cuts to her wrists as a result. She had been involved with the Employment Training Needs Training Agency. She enjoyed this experience and achieved a RSA Diploma in Business Administration level 1 and 2.

She had been working part-time as a receptionist/secretary at Servol for the past two years, which really motivated her. She actively participated in all events and was appointed chairperson at weekly residents' meeting held at Strensham Hill. She presented herself quite well, her hygiene was excellent, and she also enjoyed wearing the latest fashions, which resulted in her frequently saving for her purchases. Her mental health was quite stable and she continued to improve. She was also involved with a few Housing Associations, with a view to living independently; having expressed her wish to do so and discussed it with the staff and management of Servol. She has even started buying things for the new accommodation she hopes to move into. Her wish is to reside somewhere that is warden-controlled or where she would probably share communal areas, but still have her own space.

This case study demonstrates the importance of the support provided by Servol for this client, who had become isolated from her own familial support system. Her most recent relapse had been largely due to her isolation in the community and the inadequacy of the support by the NHS. However, with appropriate support, care planning, she was able to improve to the point where she was seeking to live independently or in a warden-controlled flat, having become the part-time receptionist at Servol.

CASE STUDY 11

> She was a 45-year old woman of mixed race with an English mother and a Jamaican father, who had been diagnosed as Schizophrenic. She had come to Servol after being in several mental hospitals and then living in residential homes. Servol was the first African-Caribbean residential facility that she had lived in. During a period of relatively good health she had lived on her own and had worked in a pub. However, she fell ill and had to be re-hospitalised.

She had had a daughter when she was 20 years old and the daughter had been taken into care. However, they had maintained a good relationship and her daughter would visit her while she was at Servol. When she entered Servol she was overweight and dishevelled looking. Her clothing did not fit well and she tended to remain by herself all the time. She hardly spoke or participated in any activities.

After a month at Servol she was encouraged to try a new hairstyle and some new clothes. Her appearance improved tremendously, and she smiled as she got compliments about her appearance. During the Cultural Therapy sessions she became more engaged and began to talk about her experiences; her work in the pub; and how she was feeling at any given time. She later became more outgoing and more aware of her appearance, and ultimately become so confident that she was going out more often. She admitted, however, that she would not normally be leaving her home and going anywhere.

CASE STUDY#13

He was a 49-year-old man, born in Jamaica in the parish of Westmoreland. He grew with his grandmother who is now dead and he came to England at age 11, when his mother sent for him. He had four sisters and two brothers. He had regular contact with one of his brothers and his mother and sister also continued to take a keen interest in him. His father and other brother lived in Jamaica and he had a keen desire to return to Jamaica to live with his family. He subsequently had two children with whom he had no contact.

He had been admitted informally to All Saints Hospital in December 1993, where he said he had three previous admissions. He also has a forensic history, which dated back to 1971, where he had spent time in prison for burglary and wounding in 1974. He had eight previous convictions and was a regular user of cannabis. Prior to moving into Servol he had a flat, which he neglected badly. The kitchen and hallway were flooded with water, the garbage was not disposed of, and the general condition of the flat was very poor. He also neglected himself, and at the time, his dreadlocks were infested with lice. It was clear the he did not have the capacity to cope independently.

On admission to Servol he, therefore, needed support in all areas of his life. Initially, he was usually very quiet and withdrawn. As his life skills improved, so too

did his general appearance and he no longer wore dreadlocks. Since leaving school at the age at 16, he had only had short-term jobs and had not worked for many years. His mother reported that as a child he had been 'spoilt', and was waited on by the rest of his family, which she thought had contributed to his being unable to cope, and subsequently to his developing mental illness. He was quite intelligent and communicated competently. During his period at Servol he successfully improved his life skills, to the extent where he could wash, clean, cook, iron and dress himself appropriately. There, he had also been engaged in a work education programme. Despite the fact that he had been diagnosed with a schizophrenic illness, he did well in the programme in Servol.

This is a case study of a man who experienced the disruptive impact of migration. He was left with his grandmother in Jamaica while his parents went to the UK, where he joined them at age 11. Whereas he was able to maintain contact with some family members, he lost contact with others. Some currently live in the UK while others live in Jamaica. He continued to express the desire to return to live in Jamaica, and in the interim he had many difficulties, including being incarcerated, severe mental illness and also separation from his own children, as a result. At Servol he made considerable improvement and is now able to take better care of himself, and has decided that he would like to live independently.

CASE STUDY # 17

> He was an African-Caribbean man aged 38: he was born in London to Jamaican parents; his grandmother adopted him after the death of his mother and the disappearance of his father. He went to school in Birmingham, until the age of 13 and he first worked as a mechanic's assistant at the airport. Little information was available about the development of his mental illness, however

he spent some years in All Saints Hospital, and was maintained on neuroleptic medication.

He moved from All Saints Hospital to Servol in 1996, having had several placements before, all of which had broken down. He had not been happy about his Servol placement and had been making efforts to leave. He had very poor interpersonal and social skills, and functioned at a very low level. He required a great deal of help in reading, writing and budgeting skills, and displayed very low levels of personal hygiene. Staff also found it difficult to engage with and work with him. As a result of the severity of his illness, it was difficult for him to participate in the Clubhouse and Cultural Therapy Programme.

This is the case study of an African-Caribbean man who was adopted by his grandmother after the death of his mother and the disappearance of his father. Little is known about his mental illness except that he had spent a considerable number of years in a mental hospital and that his interpersonal skills were quite inadequate. His time at Servol was very difficult for the staff, however, he has made progress. Although he has had a history of unsuccessful placements in various organisations, he remained at Servol.

CASE STUDY #16

He was an African-Caribbean man aged 43: he was born in Birmingham and grew up with his father who was a factory worker at British Leyland, and his mother who was a cleaner. His parents were both from St. Kitts, however, he had never visited St. Kitts. He also had a brother and sister who both lived in Birmingham, but who he had never seen. He still had contact with his parents, and his father came to see him occasionally. He left school at age 15 and worked in a variety of jobs.

The workers at Servol reported that he used to be an extremely well dressed and prosperous man who owned a sound system, and used to travel around

the world fairly extensively on business. Some years ago he went to the Soviet Union and after nine months was brought back to England by alleged agents of the KGB. He had apparently become mentally ill in the Soviet Union. On his return, he was admitted to All Saints Hospital with auditory hallucinations and grandiose delusions. He spent some years there before being transferred to Servol. He also suffered from severe skin eczema, which made him almost reclusive, as he was unable to have appropriate social relations.

At Servol he benefited from the Clubhouse and Cultural Therapy Programmes and subsequently expressed an interest in making contact with his family in St. Kitts. This is a case study of an African-Caribbean man who had enjoyed a successful life until he experienced a traumatic mental breakdown while overseas on business. In the aftermath, he received the support of those members of his family, with whom he had maintained contact, while he was in a mental hospital in Birmingham. Subsequently he went to live at Servol where he improved considerably.

CASE STUDY# 18

She was an African-Caribbean woman aged 33: she was born in Birmingham and lived with her father and mother. Her father originated from St. Kitts, and her mother from Antigua. Her father was the first to migrate to England, and worked for a long time at a factory as a labourer. Her mother migrated after he did, and had worked as a power press machinist, and also in a brewery. Her mother, as well as one brother and sister were now dead. She had one sister and one brother alive. The respondent attended secondary school in Birmingham. After leaving school she had worked as a domestic worker and also took care of babies at a nursery. She denied ever having been to the psychiatric hospital. However, she had in fact been admitted to All Saints Hospital, where she had been treated for what appeared to be a manic depressive illness.

She had been with Servol since 1996. The staff reported that she could be extremely difficult to manage at times when she became aggressive and abusive, but would apologize for her behaviour when she became quiet. She also drank fairly heavily, and spent a fair portion of her time and money at pubs and nightclubs. She did

not participate in the Cultural Therapy Programme regularly, but when she did, she seemed to have made some progress.

This is a case study of an African-Caribbean woman who had been diagnosed with a manic-depressive illness and hospitalized on several occasions. As various members of her family had died, she had become more isolated and this situation was made worse by her tendency to drink heavily. Servol provided stability and support for this woman and she continued to improve.

The impact of Cultural Therapy

Working with longitudinal research protocols to evaluate the outcome of clients and interventions used, the Cultural Therapy Team collaborated with Dr. Gerard Hutchinson, a Trinidadian-born, African-Caribbean psychiatrist at the Maudsley in London who undertook the evaluation of the clients' progress, using the Verona Scales. Preliminary data confirmed our observations that the patients were improving, although this data has not yet been reported (Hutchinson, personal communication). However, the case studies of some of the respondents illustrates their progress.

CASE STUDY# 14

> He was an African-Caribbean man aged 43, born in Rocky Point, Clarendon, Jamaica. His parents left him when he was two months old with his maternal grandmother, brother and sister. He came to the England at age 12 and had lived in Birmingham since that time. He was not in touch with his grandmother at the time of the interview. He attended primary and secondary school in Jamaica and later came to Birmingham to live with his father who was a mechanic, and his mother who was a housewife. He had three brothers and one sister living in Birmingham, however, he had not been in contact with his family for the past five years. He was a Rastafarian who wore dreadlocks, and he had

had serious conflicts with his family about this issue. The conflict started with his parents at age 15 when he refused to do what they wanted him to do.

He went to school in Birmingham until he was age 15, as he claimed to find girls, as he said he was not into education. He did not like school in England, and felt that the school system there could not teach him anything, as he had learned all that they were trying to teach him when he was at school in Jamaica. He also admitted to having a significant criminal record. He started breaking into people's houses and stealing when he could not get any money and he actually admitted to being very good at breaking and entering. He, therefore, got into trouble with the police and had spent time in prison. He also spent time in Reaside Hospital, and then seven years at All Saints Hospital, having been diagnosed with a schizophrenic illness, which caused him to be put on medication for a long time.

However, since he had been at Servol he had hardly taken any medication. He did not think that there was anything wrong with him and felt that the medication did not help him. He worked at Servol from time to time, and was totally capable of taking care of himself. He had been on a Section 37 from the Home Office for a considerable period of time. He had good social skills and maintained a good relationship with his girlfriend. He was also the father of four children ages 20, 18, 16, and 15 from an earlier relationship. He had two children with his present girlfriend whom he had met while he was in All Saints Hospital. The children have subsequently been fostered.

This respondent believed that he was a political prisoner in 'Babylon' and that there was nothing mentally wrong with him. He felt that that he did not have any problem which could not be rectified by having money, and that the British system was designed to keep Black people in slavery and captivity. It was clear the he was extremely articulate and 'street smart' and had considerable intelligence and ability which had never been utilized appropriately. He participated actively in the Cultural Therapy Programme and showed that he could be a productive and creative person.

This case study demonstrates the impact of migration on an adolescent who joined his parents in the UK at age 16. By that time he had difficulty conforming to the ideas of his parents and became a dread locked Rastafarian. He was subsequently incarcerated for crimes he committed. Although he was also hospitalized in a mental hospital, he felt that there was nothing wrong with him and that he was being oppressed by the British State or "Babylon", as he termed it. He was the father of two children conceived with a woman he had met in the mental hospital, but they were now in foster homes. Since he came to Servol his life had stabilized and he had shown considerable improvement.

CASE STUDY# 20

> He was an African-Caribbean man aged 35 who came to Servol after having been in several mental hospitals, and community residential facilities. Servol was the first African-Caribbean facility that he had lived in. He seemed very quiet and hardly spoke until we discussed the use of the computer. He had been doing computer studies at college when he had a mental breakdown at age 17. When he was well he continued to pursue computer studies.
>
> In a weekly sporting activity, part of the Cultural Therapy Programme, he became animated and began to play a vigorous game of table tennis. He later explained that he had been on the junior table tennis team at secondary school until he was in third form. This opportunity brought him to "life".

All of the case studies provide evidence of the psychosocial improvement made by the clients who participated in the Cultural Therapy and Clubhouse Programmes; this improvement indicated that the clients were experiencing healing. They had struggled with many problems including: racism; bullying in school; instability and insecurity; migration between England and the Caribbean; inadequate care in the NHS; loss of loved ones through death and other forms of separation; isolation and limited access to work which most times was menial; unrewarding work in factories

and ultimately, mental illness. The Cultural Therapy Programme enabled the clients at Servol to become more open and willing to express themselves in public; it also allowed their experiences to be validated as they shared in the group. The experience prepared them for reintegration into the society, and they went on to perform a sociodrama they had developed in the Cultural Therapy Programme at the Servol Conference in 1998. They were subsequently enrolled in a specially designed computer course in a community college where they developed a newsletter that was published on three occasions.

The clients developed many skills and insights through the Cultural Therapy Programme as it provided a structured therapeutic experience that was safe and culturally sensitive. It also provided opportunities for persons to claim their Caribbean heritage and explore Caribbean language, history, movement, food, philosophy and aesthetics. It gave them agency to celebrate and create new meaning in their lives, as their comments in the next section illustrate:

Laughter and singing

> *I have not laughed so much in years at jokes about the West Indian accents and the English accents. I have not sung a song or said a poem for years.*

Being taken seriously

> *When we come here we are taken seriously, people listen to us and we can give our opinions. Everyone is trying to do something when they come to this programme.*

Knowing who I am and where I come from

> *I have learned a lot about Black history and about my history, about the Caribbean, about the struggles of my family in England.*

I want to go on a trip to the West Indies now that I have learned about it, I would like to visit my family and go to some new places. I have never travelled abroad.

Being independent

Now that I am 'better' I want to go to live on my own and take care of myself. I have learned that I can do many things with myself.

These themes came out of the analysis of the case studies and interviews.

Development of vocational activities

During the implementation of the Cultural Therapy Programme it became clear that the participants needed to develop outlets for their talent. One possible outlet was that of a magazine, which was quite common in Clubhouses internationally. Simultaneously, there were discussions about the benefits for both the staff and clients developing computer literacy. Some concerns were expressed about the ability of clients to remain focused and to concentrate for considerable periods of time during a computer-training course. Nonetheless, the course was designed and conducted at Camp Lane, an educational facility which focused on some of the training needs of the African-Caribbean population in Birmingham.

In order to participate in the Course, clients and staff had to travel to Camp Lane. Some of the clients described in the case studies before, had to get help from the staff, as they were unable to travel independently. By the end of the exercise, however, they were travelling to the Course independently and on time. Based on the fact that the clients were entering an environment where well people were also attending courses, greater effort was placed on how they dressed and behaved in public. This process resulted in clients behaving 'more normally' as they had to function in a normal environment. Camp Lane selected an experienced computer

trainer to conduct the course, while we provided an orientation about working with mentally ill persons. The Course lasted for 22 weeks and was subsequently evaluated.

Some persons started at the basic level, and they developed good computer skills and successfully completed the examination in word processing in the Royal Society of Arts/Craft. They later went on to work on database development. Their attendance was excellent and their success motivated other clients to develop these skills. One person had prior knowledge of computer skills from his studies at college level and he was able to build on this and to work COBOL programmes with the trainer's support. He was very quiet and concentrated on his work for long periods, thereby displaying the ability to work professionally. The results show that fears about his ability to adapt to a work situation were unfounded, and his attendance was always consistent.

The Camp Lane course was evaluated on August 11, 1998 and a summary of the evaluation of the students and staff who participated in the Computer Classes is detailed below.

Client # 1

She had started with very basic computer skills. During the course she developed good computer skills and successfully completed the examination in word processing in the Royal Society of Arts/Craft. Then she went on to work on database development. Her attendance was excellent after some initial uncertainty about attending the course. Her success motivated other clients to develop computer skills.

Client #2

He had prior computer skills from his studies at college level. He built on this knowledge and was able to work on COBOL programmes with the trainer's support. He was very quiet and concentrated on his work for long periods. He displayed the ability to work professionally, thereby showing that fears about his ability to adapt to a work situation were unfounded and his attendance was very consistent.

Client #3

She had no prior computer knowledge, but she became literate, and could turn on the computer and start an application. She was one of the brighter students and by the end of the course she had improved her English and was also very helpful with other clients.

Client # 4

She missed the first few sessions due to illness, and had no previous computer experience. However, by the end of the course she became 90% computer literate She was motivated by other clients' progress and by the opportunity to participate in the development of the magazine. She expressed her opinions in class openly, she was pleasant and stated that she had enjoyed the classes.

Client #5

He had been consistent and had not missed a session. Though he was introverted, he showed interest in learning when time was spent with him. As such, the trainer had had to try to bring him 'out of his shell.' He made considerable effort to become computer literate, but he needed a great deal of help, as he did not learn as quickly as the other clients. Over the 22-week period, he came 'out of his shell', became more talkative and asked questions. However, he continued to be easily distracted,

and had difficulty concentrating. Despite these challenges, he made valuable input to the magazine.

Client #6

He was consistent and attended classes every week. He participated actively, answered questions quickly and was very open, polite and pleasant. There was some improvement in his English and though he made progress during the course, he said that he felt that he was too old and that he was not sure how this course would help him. Despite his misgivings, he was a contributor to every magazine that was published by the class. He even began to concentrate for long periods once he had gotten over his initial concern about the need for frequent breaks. By the end of the Course he had become about 80% computer literate.

Client #7

She had a perfect attendance record, was consistent, very creative and she wrote moving poetry. She was able to express herself well, although she was not forthright and waited to be asked questions. Nonetheless, she enjoyed using the computer, and by the end of the course, was 80% computer literate.

Client #8

She had no prior computer experience, but was now 85% computer literate and had a good record of attendance. She had been one of the more boisterous students; very talkative and quick to lose her concentration, although she seemed to concentrate on a project when she enjoyed it. At the end of the course she communicated better, and was more polite.

Client #9

She had contributed to the first two and a half issues of the magazine. She was polite, helpful, and very creative, with good English skills. She was keen to learn and when she saw the results of her work, this motivated her.

Client #10

She had stopped participating because of ill health half-way through the course. However, she was quick to learn, a good student and was excellent on the computer.

Client #11

She was not very highly motivated. She had started half-way through the course and only dropped in from time to time, although she worked reasonably well when she was there.

The care-givers also had the opportunity to improve their computer skills, but their primary role was that of supporting and motivating the clients to persevere in the learning process. Some of them also helped to organize the material for publication in the magazine. The fact that both the care workers and the clients were learning together was helpful in the promotion of a healthy learning environment. It provided an opportunity for those who were ill and those who were well to learn from each other. While the trainer had placed little emphasis on mental health problems in the design and conduct of the programme, he had been very patient, person-oriented and provided individual attention for the clients.

One important insight provided by the case studies was the need to give clients the opportunity to work collaboratively, to reintegrate into the community and to rebuild self-esteem and confidence, which had been eroded by their mental illness. An

important area of need identified, was for the development of vocational activities that are described in the following section.

THE SALON

A number of vocational activities were planned, in keeping with the philosophy of the Clubhouse and Cultural Therapy Programme. The activities chosen were dependent on the skills of the staff available and the interests of the clients. Based on this, as one manager had been a hairdresser before working at Servol, she got the resources to establish a salon and employ apprentices. These apprentices came from among the staff members and clients. Visits to the salon transformed many clients who had lost interest in their appearance, and they emerged smiling and feeling beautiful and cared for. This was particularly important for African-Caribbean clients who had difficulty getting appropriate hair care in the mental hospitals and residential institutions, where the White staff did not know how to care for the hair and skin of Black clients. In fact, many Black people in England were in the same position, and as such, wore wigs and make-up which were ill-suited to their skin, in shade and texture. This salon, therefore, resulted in notable improvements in the skills, knowledge and attitudes of both staff and clients.

THE RESTAURANT

The operation of the restaurant at Servol also provided many opportunities for the employment of staff and clients, for the development of many skills including the preparation of nutritious Caribbean food, and for psychosocial reintegration of clients in the community. Some of the second-generation African-Caribbean clients had

spent considerable periods in mental hospitals or residential facilities where they had only been exposed to English cuisine. As such, they decided to use the opportunity at Servol to learn to cook Caribbean food. One of the clients featured in the case studies often expressed pleasure in his culinary adventures, after having bought a Caribbean recipe book and started cooking. He shared this information on several occasions with me individually, and in the large group meeting. It was something positive to report, an achievement.

THE TUCK SHOP

The tuck shop also provided opportunities for work and fellowship, as clients were able to buy various items, as well as to sit in comfort, drinking a cup of tea, or smoking a cigarette in a place where they felt welcome. Visitors from various places were also encouraged to pass by. This served to break down barriers and to reduce the stigma of mixing with people who had experienced mental illness.

CASE STUDY# 15

> He was a first-generation African-Caribbean man aged 62, who was born in Cave Valley, Hanover, Jamaica and grew up with his mother and father, both farmers, who were now dead. He was one of nine children, most of whom are also dead. He had one sister alive in Jamaica and he grew up working on a farm and going to primary school there. He migrated to England when he was 19, as people had told him that there were opportunities in the UK. He first came to Birmingham, but moved to Peterborough after two years in the early 1960s in search of appropriate farming work. In the beginning, the prospects seemed good, but soon started to fall off. After a while, he found himself "making tea for the White man" in a factory in Peterborough. He lived on his own for about a year and one night he fell asleep in his flat and the paraffin heater he was using caught fire and his house burnt down. He woke up in the hospital badly burnt, and from that time he had been in and out of psychiatric

hospitals. He was given electro-convulsive therapy on numerous occasions and a variety of medications.

After living at Servol for five years, he was able to look after himself with some support. He functioned satisfactorily and had fairly good interpersonal skills. Despite his history, he felt that there was nothing wrong with his mind, and that he did not have mental illness. As such, he was very angry about the perception that people have just wanted to lock him away, and that he had spent most of his youthful days in mental hospitals. He would have liked to be able to have a piece of land to farm to live the kind of life he had grown up in. He would also have liked the opportunity to have a holiday in Jamaica. Efforts were made by the staff at Servol for him to develop a farming allotment as part of its rehabilitation programme.

This is a case study of a man of 62 years old, who migrated to England at age 19 in search of opportunities for work. He came from a rural farming background in Jamaica, but was only able to find menial factory work. He soon experienced severe mental health problems, which have persisted throughout his life. Most of his siblings were dead and he had one surviving sister in Jamaica, who he would like to visit. Alone and isolated, he has benefited from the support and care at Servol, where efforts were being made to help him establish an allotment.

The majority of the clients interviewed, initially had inadequate support, and this was an area of concern for service users and providers as well as many people in the community. Independent living was the goal of most clients, however, this depended on good support systems from the statutory sector, families and community organisations like Servol. In the same way that clients had become more motivated and active, communities and care-givers also needed to be encouraged

and supported, as they sought to make the shift towards the new era of care within the community.

The findings of the study were paradoxical and contradictory, on one hand the persons whose stories were told by the case studies had experienced trauma and adversity which the literature did not begin to describe. In spite of their experience, they were hopeful and in the process of healing. My own distress and sense of being overwhelmed had to be measure against what seemed to me as surprising resilience in those who had suffered mental illness.

CHAPTER 6

ADAPTIVE COPING IN WELL AFRICAN-CARIBBEANS

In contrast to the respondents with severe mental illness described in the previous chapter, the group of well African-Caribbeans illustrated that they used many adaptive coping mechanisms to combat the 'ravages' of migration. The central question to be answered must focus on the nature of these adaptive coping mechanisms, and the reasons why the mentally ill African-Caribbeans failed to engage these coping skills.

The need to belong to a community

Perhaps the most resounding finding from the focus groups with the well persons, was the notion that successful African-Caribbean people in the UK grounded their survival in a hostile migrant host country by the creation of African-Caribbean communities that retained the essence of the cultural underpinnings of this racial and ethnic group. This notion is reinforced by the social and economic pressures of the host country, which often demands that young African-Caribbean persons leave the community from which they were raised in order to find a space for their growth and survival in the hostile social environment. This creates another profound sense of loss, compounding the initial sense of loss engendered by migration itself, as the young African-Caribbean person has to lose him or herself to gain success. In a real sense, the young African-Caribbean person has to renounce being Black to become British. Hickling (1991) discussed this notion of "double jeopardy" in African-Caribbean migrants to the UK, and the strong identification of

this conflictual challenge was a major discursive theme in the focus groups with the well African-Caribbean persons.

A male focus group member revealed the conundrum faced by members of the Black community in England:

> *Many young African–Caribbean people are forced to abandon their communities to succeed and yet they needed these communities to support them, give them an identity and promote a sense of health, success and well-being. There is a paradoxical situation in Britain, for an African-Caribbean person to have a sense of well-being he or she must be a part of a community which provides an identity, support, and a place of refuge. It is also a place that one can make a contribution. However when Black people get together in groups in their communities, White people deem them racist and separatist. In order to succeed in the world, Black people are expected to eschew their community. This situation has serious implications for health and healing in the Black community.*

When experiencing problems as a postgraduate student at a University in the Midlands another young man said:

> *I just packed up and left the University and went home to Jamaica. My mother was not expecting me as I did not tell her I was coming... She left me alone when I came home and I overheard her telling a friend "He needs the space to think out his problems".*

He described how he was losing his self-confidence; he was beginning to mumble; as opposed to being the articulate and popular leader he had been in Jamaica at high school and University. For the first time in his life he contemplated suicide. He was also having to come to terms with being a brown-skinned youth, who had been accustomed to enjoying a life of privilege in Jamaica, and was now having to deal with the heavy stereotypes of being, "a stupid, dangerous, mad Black man from Jamaica"

Another participant focussed on his experiences with his father who had spent 17 years in Britain between the 1960s and the 1970s and had returned to their home in rural Jamaica, a broken and melancholy man who recounted stories of having to defend himself against racist Teddy-Boys and skinheads who were trying to harm him and his friends. He often spoke to his son and told him that he did not have anybody to talk to in Britain. Although his father had made some material progress there, and had been able to buy more land and a donkey to transport himself and his goods, he had returned angry and experiencing terrible psychic pain from his sojourn in England. He disrupted the smooth running of the household whose members looked on powerless at his ranting and raving. Sometimes he would run around aimlessly, sometimes he would sit and stare into space. It was a very difficult time for the family. Sometimes his older brother would have to restrain his father so that he would not do any harm. When he died, his son said the members of the household "were relieved".

The next participant had grown up in Jamaica and successfully completed studies at high school and the local polytechnic before going to Washington D.C. to pursue further studies. He was currently pursuing a PhD in Engineering at a University in the Midlands. He commented on the paucity of African-Caribbean or African lecturers and students at the University that he attended and spoke of missing the powerful Black presence he had enjoyed in Washington D.C. Although African-Americans are in the minority in America, they represented 12% of the population, and, therefore, have a much larger power base and impact, than the small African-Caribbean minority in Britain. There are very few role models whom

African-Caribbean youngsters can aspire to emulate, and there are hardly any mentors to encourage African-Caribbean to achieve their goals.

Powerful Black people, Black people of status seemed extremely rare in London and Birmingham where he had been. He found the lecturers in his department unaware of recent developments in the field of study and extremely smug and closed about the need to change aspects of the programme, as well as other aspects of British life. He found that the USA was in his words: "Way ahead". He noted that each year he went " home to Jamaica and also home to Washington to recharge his batteries and saw himself functioning quite effectively in both worlds.

Although all the participants felt the need for culturally sensitive care and support, some people felt ambivalent as they knew that the authorities would punish them for supporting Black people. Health and healing to the participants in the focus groups, included concepts of belonging to a community. This community provided an identity, support and a space for recovery from the ravages of living in a racist country. It provided acceptance and affirmation, and also a place and way of interpreting daily experiences. In addition, the community can help people to identify resources available to meet their needs.

Somehow, the well African-Caribbean person has to overcome this intense challenge in order to ensure his or her survival in Britain. Safia (1995) underscores the challenge:

> To be Black and British is to be unnamed in official discourse. The construction of a national British identity is built upon the notion of racial belonging, upon a hegemonic White ethnicity that never speaks its presence. We are told that you can either be one or the other, Black or British, but not both. But we live here, many born here, all three million of us 'ethnic minority' people (Safia 1995,3).

Notions of the transnational community allow for the benefits of the extended African-Caribbean family that provide vital space for growth, development and indeed, survival. The well African-Caribbeans seem to be able to overcome these challenges, while the mentally ill African-Caribbean people seem to lack the comprehension and recognition of this survival challenge.

Success keeps me well

The members of the focus groups all had noteworthy academic achievements that enabled them to enjoy personal and professional success. They seemed to be achieving their goals. One of the groups consisted of four men who had been educated in Jamaica, the United Kingdom and in one case, the USA. One had a PhD; another was pursuing post-graduate studies in law while the other was pursuing a PhD in Engineering. The fourth was battling with the "narrative of underachievement", so frequently heard in the Black community. This affected so many African-Caribbean people especially young men. This young man had experienced many problems in the educational system and was having more difficulties as he pursued his Bachelors degree. He had experienced racism and all of the other problems identified in the study.

The female focus group members were also academic achievers who were able to enjoy personal and professional success. Of the five, three had Masters degrees in law, psychology and social work respectively, while the other two had a Bachelor's degree and a college diploma respectively. Four of these women were mothers and combined their roles as mothers with those as working women. They suggested that their lives were busy, but fulfilling.

However, this concept of academic success was challenged by one of the African-Caribbean men, as he viewed success for Black people in the UK, especially Black men, in a different way:

> *Firstly I would to challenge the presupposition that I have been through things that others haven't. I would argue that lots of Black men and women "make it", but make it in an illegal manner. The problem is how do we "make it" in Britain? Many Black men I work with in the prison have done a critical analysis and come to the realization that you cannot make it legitimately. So they have decided to make it illegitimately. The price that they pay is incarceration. So for example, a handful of the men that I have worked with, are sitting on thousands of pounds, if not millions of pounds and many of them have been careful with regard to whom they trade the drugs with and who they rob... There is an ethic there, a slave ethic, A 'Robin Hood' ethic, a slave ethic where you do not rob from your own but those who have. Those men would argue that they have made it because the only stigma attached, the only price they have to pay is two years or three years incarceration because they got caught. When they go out they can "go straight", they are set for life.*

He made the comparison of these Black men in prison with the mental, emotional and psychological stresses that Black professional people faced in the UK, who are attempting to hold themselves and their families and together, and fight a path for their people. He suggested that to those men in prison, the life of professional and academic success is failure, and they had made a decision that they could not make it legitimately in British society. However, the conclusion was that 'success', of one form or another was a factor that kept African-Caribbean people well.

God is important in my life

Members of the focus groups identified God as an important part of their lives, and acknowledged that their faith had helped to maintain their health and well-being. Many have had positive experiences in the church that have helped them to cope with the difficulties of life.

I just wanted to say that I could remember when my mum had a tumor and how that affected all of us, her eight children. You know I found that I just couldn't cope until one day I remembered this verse of Scripture and I found that if you do not have faith, you just have to put your trust in the Lord, or you can go right down. Spirituality is important: you just have to understand that there is someone greater than you.

Another member identified the power of his faith:

I have chosen a particular path because of my faith. Because of my faith tradition, being Black Pentecostal, it is first religion then being Black Pentecostal for me. It is to belong to a tradition which says: "you can accomplish anything you will, through the power of God all things are possible". Part of that tradition is a strong demonology, which says that there are good and bad forces working in this world and for me, that meant it was very easy to categorize what's good and what's not good. So that's very important to me in terms of my faith and the demonology.

One of the women in the well person focus group identified the power of God and the spiritual force:

For me it ends up transcending the spirituality as a force... after experiencing that you are not only just body and mind. That you have a soul. When God created me it was with an end in mind. He starts from the end then comes... He just doesn't create and then says what am I going to give [this woman] to do. He already has a purpose [for me], I look at it and that defines how I will deal with my health, whether be it physical, mental or social. The well African-Caribbean people resoundingly concluded that God, religion and spirituality were critical moorings in their lives and in their communities.

The need for African-Caribbean healthcare workers

The well African-Caribbean respondents concurred with the perceptions of the mentally ill respondents, in the need for culturally sensitive health care workers, and the difficulties of communication encountered in the British health services.

There is a serious communication problem. Something happens between most General Practitioners and patients who are African-Caribbean or Asian. You see it quite a lot in the hospital really. Sometimes you will find nurses commenting "he/she doesn't speak a word of English and we just cannot get through to him at all".

A female focus group member, a psychologist, shared her observations of what happened in health care settings:

> *No matter how you explain things to the nurses and doctors they tell you that they don't understand your accent. Even if you speak English, as you open your month and you have got an accent they write you off. Even if you are speaking the Queen's English. " I cannot understand what you are saying".*

The psychologist then pointed out the contradictions of the communication of the same health workers who claimed not to be able to understand the migrant patient, which seemed to be disingenuous.

> *And one of the nurses said to me: " I have just had hand-over Mr. Singh could not speak a word of English and I cannot communicate with him at all. The nurse then heard this person, Mr. Singh, who she had reported couldn't speak a word of English, tell me "I'd like a bowl of cereal".*

She concluded that this was a discriminatory attitude and evidence of institutional racism.

> *Some health professionals ... come with this idea that when they see someone from an ethnic minority they just assume that the person cannot peak English...and that is it, and they don't try any further.*

The issues of trust within the National Health Service were underscored by the comments of another female focus group member who said this while discussing the more general situation of health care in the UK:

> *If my mother is seriously ill I am not going to my General Practitioner who can divulge information about me. Instead, I will go to a private doctor where I am sure that things will remain there. Things will be confidential.*

This African-Caribbean focus group respondent was making explicit the lack of trust that existed between the National Health Service and the migrant community, especially among African-Caribbean people, and was making the further and more profound observation that African-Caribbean people would prefer to pay for culturally

appropriate health care, as they had more confidence in the level of care administered by private, culturally syntonic health care providers.

Congruence with Africans and African-Caribbean people in the UK

The focus group members born in Britain also identified the distrust and suspicion of Black people in the UK. There was a very important discussion about the tension between the Africans and the African–Caribbean people in the UK, which the group attributed to the trauma and dislocation of slavery and colonialism, and the formation of stereotypes held by different ethnic groups, and the competition among racial minorities in Britain over scarce resources, like jobs. The focus group members who had grown up on countries outside of the UK, noted that their experiences outside of Britain, in the Caribbean and in Africa, had given them the confidence and encouragement, as well as the high levels of expectation, which would allow them to overcome these obstacles of intra-racial dissonance experienced in Britain.

The focus groups provided an opportunity for Africans and African-Caribbeans to discuss some of the areas of conflict and misunderstanding between themselves. The presence of Black people from Africa and the Caribbean in Britain has enabled both groups to challenge their stereotypes of each other and to develop higher levels of collaboration, as they face the challenges of life. In confirming the value of support form Black students from Africa and Caribbean one male focus group member declared:

> *My father came back from England mad. He did not have anybody to discuss his problems with while he was there, so he came home to Jamaica angry and mad. He was very isolated. It is very difficult to communicate with people in England so we here at the University have got a group of Black students together, from St. Lucia, Jamaica, Ghana and another African country.*

The challenges of life in the metropolitan settings in England cause divisions between the Africans from the continent and their diasporan relatives in the West, in terms of their capacity to cooperate and live beyond the stereotypes for their collective survival. The need to live together and overcome racism and the many other difficulties identified in this study, therefore, becomes paramount.

Overcoming racism

All of the women discussed the traumatic impact of racism in their lives and the ways in which they tried to deal with it. They also discussed many gender issues relating to their roles in the family, the workplace and the society. They discussed issues like sexuality, their self-image, their relationships with their countries of origin, Jamaica, Trinidad, Nigeria, Zambia and the UK, as well as issues of identity. These focus groups provided insights about the impact of racism in the lives of African and African-Caribbean people in the United Kingdom together with the strategies that individuals employed to maintain their health and well-being.

Those persons born outside of the UK, in Africa or the Caribbean possessed a conceptual and experiential framework that enabled them to believe in themselves and to have self-confidence. The experience of growing up as part of majority Black populations allowed them to withstand the pressures of life as members of a Black minority in Britain They had experienced high expectations at home, at school and subsequently at University. They also had other frames of reference and, therefore, could see beyond Britain and see themselves as people with options. This was in sharp contrast to the persons with chronic and enduring mental illness, who although

expressing the wish to travel "home to the Caribbean" or elsewhere, they were "stuck" and felt trapped in Britain.

An experience of racism and social isolation at University caused one male of mixed race focus group member, who though he had been born in England, had grown up in Jamaica to explain:

> *The more I tried is the more difficult that it became and it just caught up inside and over a period of a year it just got worse. Toward the end of the year I was just losing the plot. Losing the plot completely. My head felt like it was going to burst, I felt like I had no one to turn to. I went to two of my exams in the first year and then I just walked out. I told the faculty that I was leaving that I was pulling out; I got a ticket and went home to Jamaica. My mum didn't even know I was coming home, I just turned up. For days my head was just going like that, I didn't know if I was coming or going. For the first time in my life maybe I started thinking about suicide, something like that , I felt that I had to leave before I did something really drastic... Before I left I had visited some of my cousins in London, they were all Black and I told them and they were surprised. They were saying to me, "You cannot give up and let them beat you. You have to show them that you are better than them .You can rise above whatever they throw your way."*

It would be possible to suggest that the well people had some prophylaxis that protected them in the UK (Burke, 2000). The most important elements are strong African-Caribbean roots and success outside of the UK in terms of education, involvement in the church and the development of a strong and supportive family and community. This allowed young people to have great expectations and to pursue their goals, without the burden of racism. The above involved the development of adaptive coping mechanisms in a society that had low expectations of African-Caribbean people and opportunities for healing in the community.

CHAPTER 7

SEARCHING FOR THE ABSENT GOD

a) Living without Religion

The profound finding of this study was that none of the respondents with severe and enduring mental illness at any time in the process, made mention of religion or suggested that God played a role in their lives. This was deeply surprising, as my experience, and the literature suggests that the African-Caribbean people have vibrant faith traditions, especially in terms of the potency of the Black–led churches which have development in this period of secularization in Britain. This startling finding was made even more stark by the deep profession of faith by the care workers and the well African-Caribbean respondents:

> *Jesus went out into the highways and byways to help prostitutes, the ill and other outcasts. The church must stop waiting for people to come into it, it must go out to the people. We do not realize how much stress people are undergoing on a daily basis. We have to do something (Care worker at Servol 1998).*

My own experience of spiritual and religious enrichment in the Jamaican mental health environment, made this finding in the severe mentally ill respondents in England even more astounding. Should there be an expectation that God be present in the data harvested from a group of African-Caribbean persons? The absence of the mention of God was so profound that it suggests that the Christian church has failed in its mission to these people. It is a serious theological issue, particularly a Practical Theology issue. Is the Christian Church afraid of the mentally ill in Britain? Has the repetitive and scorching sense of loss experienced by these persons through migration, alienation and social isolation, stripped the foundation of this religious faith from a people normally accustomed to spiritual activity?

Where is my God?

This absence is the point of departure to the place of Practical Theology in this study. The South African theologian Muller (2004) in his struggle to engage with persons suffering for HIV-Aids suggests that:

> Practical theological research is not only about description and interpretation. It is also about deconstruction and emancipation. Practical theology is only possible as contextual practical theology. Practical theology cannot function in general. It is always local, concrete and specific. The moment it moves away from the concrete specific context, it regresses into some sort of systematic theology. The very essence of practical theology demands for it to be focused on concrete contexts. It can be argued that the whole theology should be practical and that theology, which is unpractical, is no longer theology. But it is even more the case with practical theology as one of the disciplines of theology. Practical theology should be differentiated from other theological subjects by its truthfulness not only to the context in general,
> but to a very specific context. Furthermore it should not only be truthful to the context, but also truthful to the methodology with a definite and purposeful movement from t he context, or praxis, to theory and backwards. We can refer to that methodological process as the circle of practical wisdom. Muller (2004, 1).

Muller's work in a research project on HIV/AIDS indicated how positive practical theology should be conceived. His work provided a direction that the church in England, particularly in Birmingham, should take in its work with persons with severe and enduring mental illness. There is clearly a need to go into the mental hospitals and the statutory and voluntary community facilities to meet these persons and to include them in the ministries currently served. He had been influenced by the work of Swinton who expanded Fowler's concept of *practical wisdom,* a kind of knowing, 'knowing that guides being and doing'; in his discussion of spiritual care as practical wisdom. Fowler described such practical wisdom as:

> a knowing in which skill and understanding co-operate; a knowing in which experience and critical reflection work in concert; a knowing in which the disciplined improvisation, against a backdrop of reflective wisdom, marks the

virtuosity of the competent practitioner. (Fowler in Ballard 1986, 60) quoted in Swinton(2003,175).

This links with the possibilities for healing identified by Swinton:

> Healing relates to the aspect of care which attends to the deep inner structures of meaning, value and purpose that form the infrastructure to all human experience, irrespective of the presence or absence of distress and illness. Healing is a deeply spiritual task that stretches beyond the boundaries of disease and cure and into the realms of transcendence, purpose, hope and meaning that form the very fabric of human experience and desire. The aims and objectives of healers are to enable a person to find enough meaning in their present struggles to sustain them even in the midst of the most unimaginable storms. The quest for cure of course continues, but the process of enabling healing is a vital and immediate aspect of the daily task of caring (Swinton 2003,56).

The quest for healing in the African-Caribbean respondents in this study should be a part of the task of the caregivers, as well as the churches and other institutions in the community. The church, therefore, has to address the racism and other experiences that have a negative impact on persons with mental illness.

> Experiences such as stigma, social isolation, fear, exclusion from fundamental sources of value, such as work, and the imposition of a negative social identity, frequently mark the experience of people with severe and enduring mental health problems (Swinton 2000, 29).

Religion, particularly Christianity, has played a very important role in the lives of African-Caribbean people in Britain. For many people, religion has provided the support and inspiration to address the many problems faced, although some people feel that religion can also have a negative impact. One of the well African-Caribbean respondents declared:

> *In warlike conditions people have to negotiate the battles, so that is the first thing. The second thing is I have chosen a particular path because of my faith. Because of my faith tradition, being Black Pentecostal, it is first religion then being Black Pentecostal for me. It is to belong to a tradition, which says,you can accomplish anything you will through the power of God all things are possible.*

Although there are Rastafarians and Muslims in the African-Caribbean community, the community is predominantly Christian and the Christians are called to take action in support of the mentally ill.

In search of a mental health theology

Anthony Reddie (1999) has contributed to our understanding of the need for and the development of culturally appropriate contextualized Christian Education for the African-Caribbean child. He reminds us of the critical role of Christian education in all faith traditions and underscored the importance of linkages with the traditional churches and the newer of Black-led Churches. The church is one of the most important institutions in the Black community.

Robert Beckford (2000) asserts that the churches' message of redemption had to be placed in a political context. It had to be about placing that holistic change which we understand redemption to be in a political context and that means it takes on a social quality. So redemption was about the redemption of a whole community not just the individual and redemption has to include justice. The church must be engaged in the life of its community. In this case the issue is health, particularly mental health, and this provides an opportunity for practical theologians to expand their ministry to serve this group.

Conclusions

The impact of racism and other negative experiences on a group of African-Caribbean persons, with severe and enduring mental illness is an enduring finding of this study. In addition, the processes of healing engendered by a culturally sensitive

African-Caribbean organisation Servol, and a culturally sensitive Cultural Therapy Programme for these persons have been clearly demonstrated. From the findings, it has become clear that there is something about the British State and society, which is inherently racist, with the result that the institutions may still be described as "institutionally racist" in the twenty-first century.

While being careful not to take an essentialist stance (Gilroy 1987: Appiah1992) there is recognition of the pervasiveness of racism. It is, therefore, important to identify what are the factors which protect against racism. These adaptive strategies, have allowed people to engage positively with the school, the workplace, the health and social services and the church, in order to achieve their goals. Hence the individual, the family and the community are protected. Burke (2000) identified social and psychological prophylaxis as part of an important adaptive coping strategy. These prophylaxes protect African-Caribbean people against the disease of racism. People develop a positive identity as Black British or African-Caribbean people; they claim their African and African-Caribbean heritage and seek to claim their British heritage. They refuse to be Black or British they claim both and, therefore, situate themselves in their homeland Britain.

On the other hand, there are the maladaptive coping strategies, which result in underachievement, social and educational exclusion, mental illness, and incarceration. Those who had not met their goals have felt like failures, while those who have felt proud of their success. Some of the successful ones have paid a high price. (Group, 1998) In conversations with members of community groups there were hints of traumatic experiences which many had to undergo in terms of violence,

physical and verbal abuse at the work place, harassment by the social services and the police.

Many people have experienced both success and failure and there have been lessons learned in the process. We, therefore, concluded that there were many ways in which the capacity for success could be enhanced. One of the major lessons was that those who migrated to Britain as adults or adolescents seemed to do better. Such persons would have had formative experiences in the place of their birth, and thus had another point of reference. They were aware that an alternative to Britain was possible, so that even if the persons were unable or unwilling to exercise the option to return from whence they came, it still existed. For some of those born in Britain there was no sense of an alternative, thus they felt trapped and in what they perceived, was a hopeless situation.

Those born in Britain suffered the highest rates of mental illness, Harrison *et al* (1988) concluded that African-Caribbeans had rates of schizophrenia 18 times higher than that of native born Whites in Britain. It is likely that the latter group had the greatest attachment to Britain, while experiencing the greatest levels of alienation from the country because of Britain's continued rejection of them. They had the greatest expectations of their country and longed quite legitimately, to have the same rights as all other citizens. They were frequently disappointed in their relationships with all of the institutions of the society. Some observers had noted (Burke, 1998) that those persons of African, Caribbean and to a lesser extent, Asian ancestry born in Britain, seem to lose the protective mechanisms or prophylaxis, which may have provided a psychological buffer for their parents and grandparents to survive and operate successfully in Britain.

Some suggest that whereas their parents or grandparents were prepared to tolerate racism in order to meet their goals, those subsequent generations were challenging this situation. This is a very controversial view, as there is evidence to suggest that the earlier generations struggled in the ways that were available to them, and laid the foundation for today's generation. For some, the foundation might be inadequate, however, it is what they had and they needed to use it as creatively as possible.

A challenge for those born in Britain, therefore, is how to recognize that they are part of an ongoing historical process in which they have a role to play. They are not sure of what this role might be and they sometimes have difficulty in seeing the connections of the past, present and future, as depicted by the poster referred to at the beginning of this chapter. Perhaps they cannot identify the foundations that have been laid by their parents and grandparents and, therefore, have a difficulty in making their contribution to the process. Many such persons display diffidence, frustration, powerlessness and other attributes of alienation, with the result that they do not achieve their goals.

The findings of the study confirmed that the African-Caribbean organisations provided culturally safe and appropriate care for persons with mental illness, however, the British government and the charities continue to starve these organisations of support. There has been an unfortunate history of closures of African-Caribbean organisations, which provide care. These organisations include **Harambee** in Birmingham and **Safoa** in London, among too many others. Many of these organisations have had to constantly seek funds and their programmes have often been short-lived.

Support for the African-Caribbean organisations has also allowed them to provide employment and training for a cadre of African-Caribbean care workers. This also has improved the mental health of the caregivers who have their own problems. Many clients have expressed the view that they had been unable to get culturally safe and appropriate health care in the National Health Service and that they were seeking help independently. Some clients had been receiving care in the National Health Service, but were not satisfied with the care that they received as they did not trust their general practitioners.

There was need for more organisations that developed vocational and other programmes to be established in the communities, in keeping with the needs of the clients. As observed in the Cultural Therapy Programme, clients enjoyed the sessions and were pleased to use the facilities that other citizens used. This encouraged them to behave like "normal" people, no longer separated into mentally ill and mentally well people. This proved to be another way to encourage reintegration of the clients into the community and to reduce the stigma attached to mental illness.

The stigma attached to mental illness constitutes a major problem, as some persons remain in deep denial and do not seek appropriate help until they become chronic and their families in turn, become exhausted and frustrated. The situation is also compounded by the feel that employers and other persons in the society exhibit undue prejudice. In order to combat this prejudice, there is a drive by the World Health Organisation and other organisations to develop campaigns to reduce the stigma against mental illness. The Royal College of Psychiatry in Britain has also undertaken a similar campaign. The campaign, 'Changing Minds', was mounted

against the background of the impact of the diagnosis of mental illness in the Black community which has been devastating, and the targeted reduction of stigma would encourage people to seek help before their conditions became chronic.

During the Cultural Therapy Programme and Clubhouse people from various places were also encouraged to visit, and this had the effect of breaking down barriers and reducing the stigma of socializing with people who had experienced mental illness. If the stigma were reduced, clients would then be able to receive more support at the community level. The majority of the clients had inadequate support, and this was an area of concern for service users and providers, as well as for many people in the community. Independent living was a goal for most clients, however, this depended, for success, on good support systems from the statutory sector, families and community organisations like Servol. In the same way that clients had become more motivated and active, communities and care-givers also needed to be encouraged and supported as they sought to make the shift from institutional care, towards the new era of care in the community.

Various organisations provide services to people with mental illness. These include non-governmental organisations, the National Health Service and Social Services. However, it is important that organisations and individuals engaged in providing services for the African-Caribbean should be working in concert to ensure that the clients received the best care available. While it would seem that there were many organisations which provided services, they were not working in a collaborative manner. These organisations had developed in the community and provided housing, hostels, drop-in services and outreach programmes. However, there was recognition

of the need for special services to be provided in a safe manner, within clearly defined rules and boundaries.

Special attention was given to the clients' need for information about benefits, training in life skills and job seeking. The staff recognized that many clients have had bad experiences with the mental health services in the past, which had resulted in relapses and clients going through the revolving door in the system. The upshot was clients living in isolation and under pressure. Clients had experienced coercion; their lives had been ruined; they had little or no support; and felt alienated. To address this, the staff, service users, and allied professionals had to create an environment where the family, individual and communal identity were nurtured and persons felt welcome. In order to provide the appropriate services, the organisations had to identify the appropriate standards, the legal framework, the resources necessary, effective policies and procedures and communicate more effectively. The evaluation of the services was also very important to ensure that there was continuous improvement and that clients' needs were always being met.

From the findings of the study, there were many problems with the educational system in Britain. The African-Caribbean people interviewed, reported racist experiences, underachievement, and being bullied, among other things, in the educational system.

> The educational system, despite recent cosmetic changes, has been indicted and found guilty time and time again of racism and the undermining of self-confidence of Black children and maligning of the culture of their parents (James 1992, 264).

From the experiences of the persons featured in the case studies, it was clear that school was a place of trauma. (Coard 1971, Duncan1991, Francis 1992 Majors, R

2002) and other researchers agreed that it was traumatic, although they differed about the explanation.

Nonetheless, many parents who themselves had suffered at the hands of the educational system, continued to have tremendous faith in the teachers in the schools to guide their children to achieve their potential. This reflected the sense of powerlessness which many people expressed regarding the difficulties that they were experiencing in trying to transform their lives in Britain. In spite of the valiant efforts of some of the members of earlier generations to address the problems faced by the Black community, many of the problems remained intractable.

Although the findings of this study have highlighted some of the negative aspects of the African-Caribbean experience in Britain, there were also positive aspects. Some African-Caribbean persons have succeeded in Britain. This was borne out by the findings of the two focus groups convened in March and April 2000 respectively where significant issues were explored. One critical issue was that many African-Caribbean people particularly, young men were becoming trapped in a **"narrative of underachievement" (**James, 2000**).** With the experience of racism and the low expectations held by the society, many young people had developed similar problems to those identified in the literature review.

There are too few African-Caribbean lecturers in universities, colleges schools, too few professionals in the health services and elsewhere, too few business persons, too few civic leaders. Where they exist they need to be highlighted and recognized, and many more mentors and role models must be trained to encourage achievement in the community. The success of these persons should not force them to abandon their communities, but instead, they should encourage them

to facilitate growth and development there. Where necessary, linkages should be forged with the Caribbean and Africa to bring successful Black people to the attention of the community. Achievement and success encourage the development of a healthy sense of identity within the individual and the community.

Efforts to maintain old links and to forge new links with the countries from which the migrants came in the Caribbean, and Africa, have been very significant to the well-being of the Black community in Britain. From several of the case studies, it was clear that clients intended to visit the Caribbean or perhaps return to live there one day. Some had parents, siblings or children they had not seen for many years. The literature was replete with stories of people longing to return "home." Some also wanted to be buried in the Caribbean when they died (James 1992).

There was a dire shortage of African-Caribbean nurses, doctors, teachers and other professionals, so there should be active recruitment as was happening with the teachers and nurses. There were only four African-Caribbean consultant psychiatrists in Britain to service the population in the mental health system. A clear need, therefore, existed for mental health professionals to be recruited from the Caribbean. In the case of the teachers, there had been discussions about teacher recruitment and exchanges. Considerable interest had been expressed by members of the African-Caribbean community in the exchanges, as well as other possibilities for helping to raise the levels of African-Caribbean achievement in the schools. The Caribbean could also benefit from the involvement of those persons resident in Britain, not only as returning residents, but also as persons who have skills and other resources to offer to their countries in the region. Clergy were also in short supply and some churches recruited them from the Caribbean.

Britain is a welfare state and, as such, has developed the National Health Service to provide health care, together with Social Services, Education and Employment services, as well as others that have a considerable impact at the community level. There has been disagreement about the British Government's understanding and definition of the African-Caribbean community, which has created problems for the Black community. The community has been defined as being 'imagined', interpretive and a community of 'suffering'. Despite the definitions outlined below, the African-Caribbean, like other Black ethnic minority groups, has been treated very badly by the British government. These communities have experienced high rates of social exclusion as a result of unemployment, substandard health and educational facilities and poor housing, among other factors.

All of the findings of the study highlight the necessity for the British State to address various issues such as institutional racism, which impede the progress of Black people in Britain. At the level of the individual, the family, the organisation, the community and the nation, the State needs to remove all the impediments to progress. In the areas of health, employment, housing, community development, among others, the British government is going to be called upon change policies and practices which have been inimical to the progress of Black people. In the area of mental health, the services provided, must include the provision of funding for culturally safe and appropriate facilities and programmes. The British Government should also recruit the necessary personnel from the Caribbean, especially where Caribbean nationals have been successful in developing culturally appropriate services. Where these have been successful, opportunities should be provided for the service to be implemented in Britain.

At this historical juncture, it is clear that the African-Caribbean community needs leadership which is visionary. These leaders must articulate a new vision for this community which is slipping into despair.

> To understand the roles of both local and national leaders, the need is thus to begin by analysing the organisational and structural contexts in which they emerge, mobilize support, and engage in struggles for communal rights. Rather than simply focusing on 'cultural' or 'political' communities, however, the discussion of ethnic leadership here locates such leaders within four types of mutually constitutive 'communities', defined analytically: 'imagined' communities , 'interpretive' communities, communities of 'suffering' and 'moral' communities (Werbner 1991, 19-20).

The contribution of African-Caribbean women to their community and the nation has been underestimated and undervalued by the State, White feminists and Black men.

From the female focus group, there was unanimity about the traumatic impact of racism in their lives and the ways in which they had tried to deal with it. Some of the gender issues highlighted their roles in the family, the workplace and the society. They discussed issues such as sexuality, their self-image, and their relationships with their countries of origin, Jamaica, Trinidad, Nigeria, Zambia and the UK, as well as issues of identity. They also discussed their hopes and aspirations for the future. Some noted that their experiences outside of Britain had given them confidence and encouragement, coupled with the high level of expectation for achievement. The need for support was identified at several levels, from the personal, to that of the community, in addition to the need for recognition of women's contribution to the society. Carby (1982), Williams (1985) and others identified the devaluation of the contribution of African-Caribbean women and demanded revaluation of their efforts and contribution.

In the literature, exception is also taken to the conceptual framework used by White feminists about race.

(Carby 1982, 82-83) in exploring the existence of female support networks in Britain notes:

> In Britain strong female support networks continue in both West Indian and Asian sex/gender systems, though these are ignored by sociological studies of migrant Black women. This is not to say that these systems remain unchanged with migration. New circumstances require adaptation and new survival strategies have been found....However, the transformations that occur are not merely adaptive; neither is the Black family destroyed in the process of change. Female networks mean that Black women are key figures in the development of survival strategies, both in the past, through periods of slavery and colonialism, and now, facing a racist and authoritarian state.
>
> Historians and contemporary writers on international labour migration have invariably failed to examine the contribution of women to the process of settlement, finding accommodation and employment... Women from the Caribbean in post-war Britain, were instrumental in finding employment, finding accommodation, saving money to 'send home' either to repay the loans which had financed the passage, or for their children or family. Black women also had a high-profile in organizing issues outside of the home: setting up community meeting places; social clubs; community newspapers; and political organisations... Women were in the forefront of campaigns demanding an end to bussing and segregation in State education; in setting up supplementary education; in the campaigns against police harassment; in the fight for union recognition; and support against the racist practices of trade unions and employers. Women's involvement spanned the entire spectrum of concerns affecting the Black community. Within the Black community, women began to: both challenge Black men's sexism and to demand recognition for their crucial contribution to the overall struggle of the community. (Williams 1992: 153)

Mirza (1997) in a more recent work explores Black feminism in Britain around the themes of migration, work, identity politics and imperial feminism. The ideas expressed by Carby still resonate with Black feminists in Britain, as the issues continue to be part of their lives.

The authorities in Britain have pathologized African-Caribbean families; and they have been described as dysfunctional. However, these families have also demonstrated strengths Hill (1972): strong kinship bonds, strong work orientation,

adaptability of family roles, high achievement orientation, and strong religious orientation. Extended families also play a significant role in this community.

Martin and Martin define the Black extended family as follows:

> A multigenerational, interdependent kinship system, which is welded together by a sense of obligation to relatives, strong kinship bonds, strong work orientation, adaptability of family roles, high achievement orientation, and strong religious orientation. (Martin and Martin 1978, 1)

On the other hand, a woman who had been interviewed had the opposite experience. Her extended family had played a very positive role; and good pastoral care and counselling had been provided at school, in the family, at church and in the community. As a result of these support systems, she has been able to maintain her health and well-being and lead a very productive life in her community. Her experiences led to her becoming a visionary leader in the Black community, an issue that has already been discussed.

Some of the factors that have engendered health and well-being include the development of a positive identity as a Black person, self-esteem and confidence. The work of Cross (1994), Carter (1997) provided insights into the process of personality development in Black people. Both authors suggested that race had been an aspect of personality, and that most of the therapeutic modalities developed in the mental health arena serve Black people badly as a result.

The family and many other institutions, as well as the individual's personality, and the community, help to define one's identity. African-Caribbean identity is diverse and contradictory; it is affected by rupture and continuity. These characteristics are also visible in the Black family, various networks and neighbourhoods, the popular media, the arts and representation e.g. Carnival, political and cultural organisations,

churches, other religious organisations and State organisations which provide health and many other services.

The findings of this study pointed to many issues such as identity crises and some of the differences with African-Caribbean people. These differences arose from where people were born: in Britain; the Caribbean; Africa; and India; from how long they had been in Britain, as well as other factors. There was a required belief in self that was necessary for those who wanted to be successful and to achieve their goals. Today in Britain, many seem to have become immersed in a sea of self-doubt and caution, to have been bought into the "narrative of underachievement." So many factors conspire to raise doubts about people's capacity to achieve as a result of the pervasive and pernicious impact of racism.

From the findings of the study, it was clear that the issue of self-help was very important. The question of how we take care of ourselves, how proactive we are in terms of our health and healing, as well as the kinds of strategies we use to prevent illness; were all explored. Many African-Caribbean people under-utilize the National Health Service and in the case of the six diseases that plague this community, the results are disastrous. These diseases are certain sexually transmitted diseases, mental illness, sickle cell and thaelesemia, diabetes and stroke. (Centre for Caribbean Medicine, 1999). By the time many African-Caribbean people seek help to address those conditions, they are in an advanced state, and it is too late to help them.

Another issue raised, was that of the difficulties experienced by individuals belonging to ethnic minority groups, with the health services. When the health provider is either European or Asian, the African-Caribbean person can have

difficulty being understood, as well as communicating. The issue of semiotics is critical in this process of effective communication. Like all other British institutions, the National Health Service may also be institutionally racist (Macpherson Report, 1999). An already complex situation has been made all the more complex by racism, communication problems, as well as concerns about who has access to confidential information about a person's health. There is mistrust of the doctors and the government that is in charge of the National Health Service. In Britain there is currently considerable debate about the need for reform of the National Health Service to address a number of issues, including those raised in the African-Caribbean community. There is a critical need for more doctors and nurses, as well as other health care workers, of African and African-Caribbean origin to provide culturally appropriate and sensitive mental health care.

As noted by the (Vom Eigen 1992) people seek healthcare from the three sectors, the folk, the popular and the professional. These sectors also include religious and other personnel, who provide care. In recent years there has been the burgeoning of Alternative or Complementary Medicine to provide health and healing.

The management of the health and healing of the community must be a priority for the leadership of the community, the patients, the health professionals and many others, although the Government must play a critical role. .

All of the conclusions of the study remind us that the African-Caribbean community in Britain is committed to achieving growth and development. In spite of the negative experiences of many, there are also positive experiences in Britain. While the community requires strengthening, it has provided solace and support for its members.

> The healing of the collective Afrikan body, mind and spirit , the expansion of Afrikan consciousness, calls for the accelerated advancement of Afrikan centered historiographic , social and natural sciences , the development of incisive critical disciplines which can make decisive contributions to the establishment of a new world social order in which all humanity are free of oppression and degradation (Wilson, 1993, 4).

This community provided an identity, support and a space for recovery from the ravages of living in a racist country; it has provided acceptance and affirmation and also a place and way of interpreting daily experiences. In addition, the community has helped to identify resources available to meet the needs of persons within it. The community needs accessible locations for places of healing which are not stigmatised, where people can be assured of confidentiality, appropriate care and understanding. It has been very important to identify and develop many different approaches to changing the narrative of underachievement in the African-Caribbean community. Already, there have been many strategies that the African-Caribbean community has developed such as the introduction of Saturday Schools and other types of Supplementary education (Consultation Conference, 1999) to enhance and advance achievement of African-Caribbean youngsters in the United Kingdom.

More strategies need to be developed to ensure the healing of this community. This can mean that people want their remains to be interred, upon their deaths, not in England, but in the Caribbean. It can mean somewhere to have a holiday, own a house and even send one's children to school when they are experiencing problems in the educational system. In Britain there remains a need for the development of services and people to provide counseling, psychotherapy and other talking therapies in traditional, as well as creative ways. There are many persons who have lived in

Britain for a long time, and yet have not been able to debrief and look at their experiences in a therapeutic way. Many such people are in need of healing.
We need to undertake more research to uncover our problems and devise the solutions which will heal us.

None of those persons with severe and enduring mental illness suggested that God played a role in their lives. This seemed surprising, as the literature suggests that the African-Caribbean community has a vibrant faith tradition, especially in the development of Black-led churches at this time of secularization in Britain. The absence of God is the issue which will be discussed in the next section.

The literature raises some of the issues surrounding gender, race and class in Britain. It provides an important critique by Black feminists about the way the problems must be addressed. This would lead logically to the healing that comes from Black women being valued and recognized, in terms of the psychological, social, spiritual and economic aspects of their lives. Their healing has a direct impact on their families and communities of which they are a part.

The authorities in Britain have pathologized African-Caribbean families; they have been described as dysfunctional. However these families have also demonstrated strengths (Hill (1972): strong kinship bonds, strong work orientation, adaptability of family roles, high achievement orientation, and strong religious orientation. Extended families also play a significant role in this community.
Martin and Martin define the Black extended family as follows:

> A multigenerational, interdependent kinship system, which is welded together by a sense of obligation to relatives, strong kinship bonds, strong work orientation, adaptability of family roles, high achievement orientation, and strong religious orientation. (Martin and Martin 1978, 1)

Black families, like families of all ethnic groups have problems, some of which were highlighted in the findings. One of the clients featured in the case studies was born of young parents who did not want him. As such, his care and upbringing were the responsibility of the extended family and the State from the time of his birth. His unsettled life was made more difficult by the frequent movement to different relatives; he even had a good period of care spent in Jamaica with his great-grandmother. Some theorists like John Bowlby would argue that he has suffered from 'maternal deprivation'. This term has been used to cover a number of instances of disruption of an attachment bond that may adversely affect a child.

The adverse effects would include his not being able to trust anyone or be able to establish and sustain relationships. His life has been characterized by rejection, and he has always being an outsider, with a damaged self-concept and self-esteem. In addition, he has suffered both physical and psychological abuse, which has caused him serious psychological damage. The developmental theorists would see delinquency would be a likely outcome, but there was also the likelihood of psychotic mental illness resulting from these experiences, which indeed, happened.

Unfortunately, the respondent did not benefit from pastoral care at school, as he was quiet and withdrawn. As he did not fit the stereotype of the aggressive Black boy he did not warrant much attention. Once he had the breakdown and entered the bleak mental health hospitals, he did not benefit from the pastoral care and counseling of chaplains. Instead, he was left to battle with the racism and other problems so well summarized by Robinson (1997). From all reports he has enjoyed the best care so far at the African-Caribbean Hostel managed by Servol. There, he has become part of a family of African-Caribbean service users and their care-givers

and has begun developing various aspects of African-Caribbean culture, which have enhanced his self-image and esteem.

On the other hand, one of the women who had been interviewed had the opposite experience. Her extended family had played a very positive role; good pastoral care and counseling have been provided at school, in the family, at church and in the community. With this support system she has been able to maintain her health and well-being, and lead a very productive life in her community. As discussed in the previous section on leadership, her experiences led to her becoming a visionary leader in the Black community.

APPENDIX 1

FIELDWORK SCHEDULE

	1997	1998	1999	2000
Jan.		Pre-Fieldwork: 3hrs per week observation, interviews and group work at Servol (Σ=12hrs)	Observational visit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	Interviews with well persons in Birmingham and Coventry (Σ=12hrs)
Feb.		Pre-Fieldwork: 3hrs per week observation, interviews and group work at Servol (Σ=12hrs)	Observational visit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	Transcribed tapes of interviews and organize focus groups (Σ=40hrs)
Mar.		Pre-Fieldwork: 3hrs per week observation, interviews and group work at Servol (Σ=12hrs)	Preliminary data analysis & drafting of case studies (Σ=12hrs).	Conducted focus group in Coventry and transcribe tapes (Σ= 30hrs)
Apr		Pre-Fieldwork: 3hrs per week observation, interviews and group work at Servol (Σ=12hrs)	Preliminary data analysis & drafting of case studies (Σ=12hrs).	Conducted focus group in Birmingham and transcribe tapes (Σ= 30hrs)
May		Preparation of data collection instruments (Σ=24hrs)	Preliminary data analysis & drafting of case studies (Σ=12hrs).	Discussion of focus group findings with organizers (Σ= 8hrs)
Jun		Preparation of data collection instruments (Σ=24hrs)	Made arrangements for visit of psychiatrist to assess the progress of patients (Σ=8hrs).	Refined data analysis and drafted thesis
Jul		Review of case notes	Data analysis and drafting (Σ=24hrs).	Refined data analysis and drafted thesis

Aug	Arrived in Birmingham	Fieldwork preparation: Schedule interviews	Data analysis and drafting (Σ=24hrs).	Refined data analysis and drafted thesis. Returned to Jamaica.
Sept.	Pre-Fieldwork: 3hrs per week observation and group work at Servol (Σ=12hrs). Review case notes.	Observational visit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	Data analysis and drafted thesis (Σ=24hrs).	
Oct	Pre-Fieldwork: 3hrs per week observation and group work at Servol (Σ=12hrs)	Observational visit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	Observational revisit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	
Nov	Pre-Fieldwork: 3hrs per week observation and group work at Servol (Σ=12hrs)	Observational visit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	Made preparations and contacts with well persons for triangulation purposes. (Σ=12hrs).	
Dec	Pre-Fieldwork: 3hrs per week observation, interviews and group work at Servol (Σ=12hrs)	Observational visit to Strensham Hill (2hrs), Aston (2hrs) and Gillot Road (2hrs) – the residential homes and preparation of notes (6hrs)(Σ=12hrs).	Made preparations and contacts with well persons for triangulation purposes. (Σ=12hrs).	

APPENDIX 2

RESPONDENTS' SCHEDULE

Name Age

Place of birth

Place of residence

Have you lived outside the UK? If yes where?

How long have you been at Servol?

How long have you been in the mental health system?

Have you been in a mental hospital? If yes please name?

What is the nature of your mental health problem?

What is your highest level of schooling?

If you did not finish secondary school or college what was the reason?

Describe your relationship with your parents?

Do you have a family of your own? If yes tell me about it.

Are you married, single divorced?

Tell me about the skills that you have?

Describe any jobs that you have done ?

What are your plans for the future?

Describe for me the things that cause the greatest trouble in your life?

Where do you get help when you have problems?

How has Servol helped you?

What have you learned from the Therapy Group?

Have you enjoyed going to classes at Camp Lane?

Tell me about the best time in your life.

APPENDIX 3

CARE WORKERS' SCHEDULE

Name

Age

Place of Birth

Citizenship

Date of Birth

Have you lived outside of the UK? If yes where?

Highest level of education?

How long have you worked at Servol?

What have you learned about mental illness since you have worked at Servol?

Can you identify changes in clients during the time that they have been at Servol?

If yes what kinds of changes?

How can you tell when a client is getting ill?

What kinds of problems do the clients have?

What organisations do you contact to provide support for the clients?

What skills do you have?

APPENDIX 4

FOCUS GROUP GUIDE

TOPIC: HEALTH AND HEALING IN THE BLACK BRITISH COMMUNITY

1. Please comment on the following definition of health, given by the World Health Organisation in the Alma Ata Declaration in 1974.
   "Health is a state of complete physical, mental and social well-being and not merely the absence of infirmity."

2. There are six major diseases which affect the community; can you say anything about these diseases and their causes?

- Certain sexually transmitted diseases
- Sickle cell anaemia
- Hypertension and stroke
- Mental illness
- Diabetes
- Thaelissima

3. Can you suggest ways of preventing any of these diseases?

4. Can you suggest ways of coping with these diseases?

5. Are there cures for dealing with them?

6. Is there a difference between healing and curing these diseases?

7. Do these diseases affect Black men and women differently?

8. What is the impact on the family when a member or members of the family are affected?

9. Where can/do Black people seek help for illness?

10. What can the help givers do?

- The individual
- The family
- The general practitioner
- The church
- Other help/care givers e.g. One Hundred Black Men.

11. Describe an icon which represents "a picture of health"

12. Can you identify a passage, a poem, a song which has healing powers for you?

Appendices 5 & 6 (pages 192-215) have been intentionally excluded from this digitised copy.

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