

A composite case

Thinking with ‘BME’ categories in UK mental health care

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Abstract

In this think piece, I discuss a composite category – Black and Minority Ethnic (BME) – that has emerged and expanded to incorporate race, ethnicity, and now also immigration status, in a somewhat clumsy meeting of political narratives and sanitised public health-speak. I look at how this category has been interrogated and put to work in a particular UK mental health setting, one that is committed to improving access and inclusion for ethnic and cultural minorities. Using the analytical tool of ‘thinking with’, I explore how the category was used in relation to an absent majority or mainstream, and consider what such a category might show ‘us’ in all its glaring imperfection. I ask: Is it possible to push forward anthropological thinking by paying attention to these composite, unwieldy categories? Might this be one way to embrace the clumsy conspicuousness of our proverbial elephant in the room?

Keywords

mental health, BME, categories, relationality, ‘thinking with’



Figure 1. Noah Purifoy's *The Kirby Express*, 1994–96. Outdoor Desert Art Museum of Assemblage Sculpture, Joshua Tree. Image courtesy of Noah Purifoy Foundation © 2019.

I'm sitting in a small circle of inwards-facing chairs in a psychotherapy centre in London. We're in a therapy room, but this evening, the space is not being used for clinical work, which has all finished for the day. The therapists – after-hours, under cool panel lighting – are talking politics. Someone in the circle is holding her arm out and showing her pale olive skin: 'It's not this that makes me different', she says, in a heavy Iranian accent, 'it's the way I speak'. Another therapist, who has been here since the centre was founded, tells us that, in the beginning, most of the staff members identified as black: 'political Blackness', it was called. As they go on to discuss different signifiers of sameness and difference that are used to describe both clients and staff here at the centre, I think of the official acronym that is used in the contracts and policy documents to describe whom this service is for: 'BME' for

Black and Minority Ethnic, which was expanded to 'BAME', adding an 'A' for Asian, and then further expanded by adding 'R' for refugee, resulting in 'BAMER'. These official acronyms are not the subject of today's discussion; I'd be more likely to find them in policy documents about representation or inclusion in public services. And yet, the ever-expanding string of letters tells an important story of the somewhat clumsy meeting of the politicised narratives I am hearing here and the more sanitised public health-speak that is concerned with 'access' and 'pathways to care'. It is this meeting point, at the intersection of politics, public health, and the psy-disciplines,¹ that I am interested in: how this composite category of ethnic and cultural identity relates to eligibility criteria and notions of mental health need.

In this think piece, I draw on the sense of accumulation, composition, and extension through time that is evoked by Noah Purifoy's assemblage sculpture, pictured above. An artist who has charted African American history through its physical debris and other found objects, Purifoy has also used his body of work as a tool for social change. In working with a different kind of historical debris, I want to 'stay with the trouble' of the imperfect and unwieldy category of BME and its various extensions (Haraway 2016). I seek to expose the BME/BAME/BAMER category's increasingly untechnical mix-and-matching of ethnicity, race, and migration status, at best an odd by-product of pragmatism and at worst a harmful yoking together of ethnic and cultural differences. Yet, I do not only want to trouble or be troubled by the category (as we often take Donna Haraway's famous maxim to mean), but rather, to make a 'critical and joyful fuss' of the matter as I encountered it in the field (Haraway 2016, 31).

In the reflexive spirit of this series, I delve into my own uncomfortable sense making of this composite category, in light of received knowledge and expectations from the disciplines of transcultural psychiatry and anthropology itself. I propose that the way it was put to work in this fieldwork setting was productive, and worth us (as anthropologists) attending to, instead of jumping to the conclusion that the category is ethically (as well as technically) 'bad'. I ask: is it possible to push forward anthropological thinking by paying attention to these composite, unruly categories? Building on what we have learned from science studies scholars in the 1990s, what happens when we look beyond singular categories that tend to harden, become naturalised, and disappear from sight (Bowker and Star 1999)? Might this be one way to embrace the clumsy conspicuousness of this proverbial elephant in the room?

1 In my title, I have played with the term 'composite case': a device often used by psychotherapists (and sometimes anthropologists) to protect the anonymity of clients by merging the identifying details of individuals. The intention is that the case ceases to refer to any single person and becomes a composite of many.

In order to respond to these questions, I use the analytical tool of ‘thinking with’ the category as I encountered it in my fieldwork and the academic literature (Harding 1996; Puig de La Bellacasa 2017). ‘Thinking with’ a category does not imply its straightforward support or rejection but rather close attention to what it does for those invested in its definition or use. Three aspects of this tool are useful for me as I move through my account of how the BME category came into being and expanded as it was put to use. Firstly, it is a ‘relational way of thinking’ (Puig de La Bellacasa 2017, 72): here it attends to the way this composite category is made up of common ground between several ethnocultural categories, in relation to an absent majority or mainstream that is imbued with whiteness. Secondly, ‘thinking with’ insists that it matters how categories relate and in which situations. I ask the reader to bear with me as I move through the sometimes-conflicting narratives of my concerns, observations, and speculations of how this category relates to those associated with the mainstream mental health system. Finally, I pick up on a reflexive thread that speaks to the collectivity of ‘thinking with’, responding to the guest editors’ call to attend to the ‘complex dynamics of obviousness and invisibilization’ invoked by our proverbial elephant. We anthropologists are in our element looking for ‘blind spots’: what ‘they’ may have ignored or invisibilised. But in this piece, I count myself as one of many knowledge-makers who might consider what such a category might show ‘us’ in all its glaring imperfection.

When I came into contact with the voluntary psychotherapy clinic in which the scene above took place, it had been providing its mental health service to diverse religious, cultural, and ethnic communities in London for some three decades. The service providers at the clinic (which I will call Culture in Mind) have always been brought together by shared ideas about cultural difference, and by the ethnic minority status of both clients and therapists. But the terms and classifications they have used (or that have been made available to them) have changed over the years. The early momentum to found an explicitly antiracist clinic was driven largely by unifying notions, spoken of in the vignette above, of political Blackness.² They went on to deploy the notion of a service for minority communities, using the words ‘ethnic’ or ‘cultural’ minority almost interchangeably. The BME category and its various successors tell something of a potted history of how different markers of ethnic minority status have become important in this context: each letter marking a different political moment. These letters also tell us of how voluntary organisations have mobilised attention and resources towards different communities and concerns in health care.³ In my research, I

2 See Bourne (2003) for a contextualised review of how this term was employed to address common experiences of racial oppression.

3 Whilst fully charting such a history is beyond the scope of this piece, details of the category’s use in the UK’s policy and history can be found in Craig and colleagues’ (2012) book *Understanding ‘Race’ and Ethnicity: Theory, History, Policy, Practice*.

attended primarily to the most recent addition of 'R' for refugee, which speaks to the current global 'turn' to migration in public health, as well as the academy (Andersson 2018). What is most striking for this conversation, however, is that strange 'mix-and-matching' of ethnicity, race, and immigration status in these new composite categories.

This mix-and-match critique of the acronym stands up on its own, regardless of what context it is applied to (you'll find it in UK policy and research on diversity in education, employment, and the arts, to name a few) but if I am to move beyond the name and stick with my commitment to a 'relational way of thinking', I need look at how it operates in situ. For publically accessible, free services in the United Kingdom, the way in to services is via a clinical assessment of need, usually based on diagnostic classifications of mental unwellness (depression, or generalised anxiety disorder, for example). The mainstream provision of talking therapy is now based overwhelmingly around cognitive behavioural therapy (CBT). Although CBT is described as 'transdiagnostic' (not specific to individual disorder categories), the Euro-American system of classifying and measuring distress remains hardwired into the assessments for this treatment (Turner et al. 2015). This bias towards Euro-American frameworks for understanding and naming mental health needs is one explanation for the persistent patterns of unequal access and provision of mental health care for so-called BAMER communities.

It was against this backdrop that my research looked for alternative, non-diagnostic ways of producing eligibility for therapy. As one of several voluntary organisations I worked with, the Culture in Mind clinic was constantly working to break with the diagnostic system of assessing mental health need. Their aim was to redress some of the white and Eurocentric biases in mental health access and care: being Black, Asian, Minority, Ethnic, or a Refugee was part of what made someone eligible for the service and legitimised alternative articulations of need. In the clinical intake meetings I observed, referrals made by mainstream professionals on the basis of diagnoses such as posttraumatic stress disorder or depression might be reformulated as responses to racial violence or cultural dislocation, in a process I called doing 'need' differently, in my ethnography (Brenman 2019).

If this concern with culture and critique of all things medical sounds familiarly anthropological, it is for good reason: at play here is the product of what Moyer (this special section) describes as anthropologists' role in 'reordering' categories. The Culture in Mind clinic has been pushing back against Eurocentric conceptualisations of mental health and illness since its establishment, which was galvanised by the 'cultural critique' of diagnosis from the disciplinary field of 'transcultural psychiatry'. This subdiscipline, largely born out of ideas from medical anthropology, was concerned with social and cultural determinants of psychopathology and psychosocial treatment of disorders (Littlewood 1980; Kleinman

1988). As such, universalist approaches to assessing mental distress and disorder came to be treated with deep scepticism by academics and clinicians who align themselves with transcultural psychiatry and medical anthropology alike (Kirmayer 2005). In a similar vein, these transcultural psychiatrists exposed traditional psychodynamic psychotherapy as overwhelmingly white, with its accessibility often limited to the middle and upper classes (Lipsedge and Littlewood 2005; Kirmayer 2007).

These forays into the recent history of thinking about culture, race, and ethnicity in the UK's mental health context tell a decidedly politicised story of how the BAMER category came to be deployed in care settings. But there's another story of depoliticisation that I could just as easily tell. It is true to say that the United Kingdom has adopted a perhaps uncharacteristic level of openness in the debate about problems of racial inequality in the health system (compared to discussion around class, for example). The result is a sometimes-baffling preoccupation with recording and categorising ethnicity in intake forms and assessments within health care in general. For better or worse, this stands in stark contrast to, say, the French system's (legally imposed) colour and culture blindness (Fassin and Rechtman 2005). Keeping an eye on these larger scales is important if we want to understand how marginal or minority categories relate to wider (mental) health care structures, and how they may be in danger of being depoliticised and neutralised if they are subsumed into these structures.

At this point, I return to my own position as an ethnographer, sitting in that small voluntary clinic, informed and slightly overwhelmed by these established bodies of knowledge. How to make sense of these conflicting stories of the political and the bureaucratic? My concern was about the use of categories altogether in these contexts, even as they enabled this cultural model to be funded and put into practice. But there was another, more immediate problem on my mind: if transcultural psychiatry had the 'cultural critique' of diagnostic categories covered, what then was the role of the visiting ethnographer? I was there, I supposed, to point out 'blind spots' and 'unintended consequences' of health care provision. If I am honest, I think I had already half decided on the 'blind spot' I wanted to uncover. 'BAMER' was still a category, however inclusive and eclectic its aspirations were. Moreover, the acronym was, and continues to be, critiqued in public debates (see, for example, the *Guardian's* 'Is it time to ditch the term "Black, Asian and Minority Ethnic" (BAME)?' [2015]; and Jeffrey Boakye's recent book, *Black, Listed* [2019]). I was suspicious of the way it was used by commissioners and funders of care services wanting to define their 'client groups'. My worry was that this catch-all category of ethnic or cultural 'Other' would simply supplant one problematic system of categorisation with another. Was the psychiatric system of classifying eligibility through diagnoses being replaced with these (technically dubious) categories of ethnocultural difference?

Whilst my concerns were (and remain) valid, the point I want to move towards is not about which categories were present or which classification system was ‘worse’, but how they relate and can be put to good use. Soon after I started, one of the senior therapists suggested a book club be set up, to stimulate critical thinking amongst staff, particularly those who (like her) had been educated in countries where political discussion was discouraged or explicitly restricted. She suggested that in the first week we discuss the text that the organisation’s therapeutic model was founded on. She insisted we needed to talk about the fact that the client group had extended far beyond the Commonwealth communities of South Asian, African, and Caribbean background. These communities had been by far the most visible ethnic and cultural minorities when they started their work, because of Britain’s colonial history and the migration patterns that followed. These groups were also, then, the focus of critical postcolonial thinking and projects such as this one. But this had changed, and my interlocutors were navigating their way through London’s now ‘super-diverse’ sociocultural landscape (Vertovec 2007; Hall 2013). Far from disappearing from sight, the composite categories of BME/BAME/BAMER entered into these discussions, both explicitly and implicitly in how the new client group reflected or challenged the original ideas about whom the service was for. Where did whiteness come in? Or different experiences of blackness? What about the increased number of (Eastern) European people coming with their own very different migration experiences? Yes, this service relied upon a messy and imperfect category, but it was precisely this messiness that allowed them to keep such debates alive and to keep such inclusion criteria open to revision.

Perhaps yet more interesting in terms of my worries about ‘pitting one set of categories against another’ (the replacement of diagnostic categories with ethnocultural ones) was the multiple ways that the category was put to work in order to disrupt the diagnostic model. In the clinical meetings I observed for over a year, ‘BME’, ‘BAME’, and ‘BAMER’ were used interchangeably and almost never treated as a fixed set of inclusion criteria. For each referral, the case would be made for eligibility, not solely on minority status, but in how this status related to clinical decisions, assessments, and interactions within the UK system of health and social care. In each case, how a potential client’s ‘Otherness’ (self-identified or imposed) interfered with mainstream understandings of mental health and illness was what mattered. Had they been labelled with a particular pathology because of associations with a particular racialised identity? Was his or her trauma being overmedicalised, due to under-recognition of their overall migration experience? Was there a linguistic barrier or dearth of shared vocabulary to adequately describe the presenting problem in a mainstream English-speaking clinic? Crucial to these discussions was the way such Otherness was put to work vis-à-vis mainstream models of mental health care. This work treated mainstream models not as culturally or ethnically neutral but as distinctly Eurocentric and white.

I have been describing a process by which, after being scooped up into one acronym for the purposes of administration and funding bids, the category was disaggregated in clinical practice. It is at this point that the ‘thinking with’ tool becomes generative. Indeed, the category itself becomes ‘good to think with’ (Harding 1996). By this, I mean that the acronym bore so many potential threads of contestation or disruption, waiting to be spelled out, that it easily became a conduit for productive discussion and thought. It also invited me to trace how the category came into being in relation to other systems of sorting and classifying throughout the lifetime of the clinic and its mental health context. I have described the different ways that BME categories were put to work by therapists, and how Otherness was explicitly named and negotiated in mental health care. As such, the eclectic mix of letters makes it an unlikely candidate for reification, or becoming a naturalised ‘thing’ that may disappear from view. The ontological politics (Mol 1999; Jasanoff 2012) of what each version of the category ‘is’, is hard to get to without considering what the category does and how it came into being. This doesn’t make it a ‘good’ category, per se, but it does make it one that is, in its essence, constantly in-the-making and subject to change.

‘Thinking with’ categories is not to argue for or against them; it is to participate in the processes by which we come to know and produce certain categories. It can also be to contribute to conversations about how categories can be put to better use, how they can be ‘done’ better. In this think piece, I have tried to think with a particular form of composite category, whose unwieldy acronym tells a potted history of various actors’ efforts to name and work with marginality in health care. The incorporation of race, ethnicity, and immigration status has resulted in an assembly of letters that (unlike more familiar and singular categories) is so self-conscious and unwieldy it is hard to miss: an ‘elephant in room’, indeed. I would argue that as health care provision becomes increasingly self-conscious of heterogeneity within its categories, it is useful for anthropologists to keep these cases in view and interrogate them (as I have been doing) in situ. No doubt the discussion would look very different if we turned our attention to, for example, the LGBTQIA+ or RMNCAH⁴ categories, let alone the myriad ways in which they get put to work in health care settings. But engaging with their histories, extensions, and applications offers a way to think along the poor coherence and inadequacy of these terms, rather than against them. This entails exposing where they succeed or fail to address marginality or where components should be added or taken away, thinking always about how they relate to the absent mainstream or majority. This case reminds us that categories are *always* composite and

4 The better-known ‘LGBT’, with its more recent additions of Q, I, A, and + stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and the ‘+’ for everything else that may not (yet) have a name. The lesser-known ‘RMNCAH’ is a product of the professional world of global health and stands for Reproductive, Maternal, Neonatal, Child, and Adolescent Health.

relational, and that refining, splicing, or splitting them is unlikely to make them better or more accurate. To think with this unwieldiness might help us to keep categories in sight, in motion, and incomplete.

About the author

Natassia Brenman is a medical anthropologist with a focus on mental health and care. Her PhD thesis, 'Place, Need and Precarity in UK Mental Health Care: An Ethnography of Access' critically reflects on the problem of access to psychotherapeutic care in the voluntary sector. Her work more generally uses ethnography and creative methodologies to generate new modes of engagement with taken-for-granted concepts in mental health, such as diagnosis, need, and in/exclusion. She is currently working on a new project at the University of Cambridge on vitality and temporality in the field of neurodegenerative disease.

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