THIS IS ~~NOT~~ SAFE SPACE:
Creating Human Connection in a World That Often Fails to Hear

By

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About the Author

Abi Canepa-Anson is a psychodynamic psychotherapist, writer, and activist with more than 16 years of clinical experience. Committed to demystifying therapy and making it genuinely accessible, particularly to those marginalised by race, culture, and systemic inequality, her work bridges psychological insight with lived experience across individual, couple, and group settings, and extends into clinical supervision.

Trained at WPF – (Westminster Pastoral Foundation), Birkbeck, and Roehampton Universities, with additional training in relationship, psychosexual, and group supervision, Abi explores psychotherapy through a racialised lens, illuminating both its transformative potential and its limitations. Her writing and teaching examine adoption, diasporic histories, and the psychological tensions between inherited faith and modern therapy.

Alongside her clinical and literary work, Abi is a mixed-media artist whose work has been exhibited across London.

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Contents

Part II: Clinical Stories

Tasha: Where Diagnosis Replaces Understanding

Training as a psychotherapist, I took a job as a clinical support worker in a rehabilitation centre, knowing it would be challenging. What I hadn't fully anticipated was how broken the system itself would be. Patients, many diagnosed with borderline personality disorder, bipolar disorder, or schizophrenia, were routinely reduced to their diagnoses, their legitimate complaints dismissed as symptoms. Staff, underpaid and overstretched, burned out quickly, retreating behind locked office doors to survive their shifts. The atmosphere was one of mutual fear: "us" versus "them." It troubled me deeply that places designed to heal could so easily make things worse.

It was in this environment that I met Tasha.

She was extremely late to our first session and arrived seeming surprised to find me waiting. She looked me over carefully, not much conveyed, but clearly assessing my suitability.

> *"I don't want to be here," she said, by way of explaining the lateness.*

Tasha was a Black British patient admitted for delusional disorder with co-occurring addiction to drugs and alcohol. Before admission, she had lived in the heart of the city, housed in a local centre where she still felt part of a community. That sense of belonging disappeared when she was transferred to our ward. As the only other Black person on the unit, she took an immediate interest in me.

> *"What do you think could make this place better for you?" I asked, hoping to draw her in.*
>
> *"I just don't belong here," she answered, hesitantly.*

I repeated her words back to her — so she knew I had heard them — and kept things open-ended.

> *"Yeah. I just don't think this is helping. I'm not crazy or anything… What's the point?"*
>
> *"I don't think you're crazy. So, what can we do about it?"*

People who have long felt unheard tend to be acutely vigilant about how they're received. Their willingness to stay depends on it. Tasha's response was guarded but honest, vulnerable, faintly frustrated, and wary of being misunderstood. What she

needed most was to be listened to without judgment, without being rushed toward a fix. I believe that's what began to earn her trust.

Over the following weeks, a rapport developed. Early on, Tasha avoided eye contact, arms crossed, body angled away, a posture of self-protection. Gradually, her shoulders loosened. She began meeting my gaze. She started asking where I sourced my hair and skin products; the hospital-issued toiletries did not cater to her needs as a Black woman. There was a clear identification with me, and I engaged with it carefully, mindful not to provoke envy among other patients.

From early in life, positive identification, the process through which we model ourselves on others, adopting their traits and values as our own, plays a central role in self-development. Our first experience of this is typically with a parent or caregiver: our first point of relating when we enter the world. Identification is, at its root, bound up with love. Some people come to therapy because this process was disrupted or unavailable, and Tasha's early life, as I would come to understand, had been deeply disrupted.

I realised she lacked basic self-care skills, with personal hygiene, with laundry, with replacing things she had outgrown. By simply being receptive to these needs, I was signalling that she mattered, and that her feelings were safe. This was the foundation on which our relationship was built.

Traditionally, patients with histories of early trauma are considered poor candidates for long-term psychotherapy, seen as too dysregulated, too dependent, or too prone to entrenched patterns. They are more commonly offered short-term, structured interventions: CBT (cognitive behavioural therapy) or DBT. (dialectic behavioural therapy) Under-resourced services favour these approaches because they are time-limited, measurable, and cost-effective. All types of therapy have value — but none can be one-size-fits-all.

Tasha could not sit in a consulting room for fifty minutes. She found enclosed spaces uncomfortable and claustrophobic. She couldn't follow the "rules." Instead, we would snatch ten minutes in the kitchen, then the corridor, then her room. She sometimes cried on my shoulder, gestures that spoke not only to immediate distress but to a deeper, long-unmet need for connection and safety. I offered something more accessible: a presence she could reach. After each session, I made notes and shared relevant details with staff during debriefs, and I made Tasha aware of this practice as part of maintaining clear professional boundaries.

Several months in, she spoke about her toddler son, Ross, who lived with her older sister. When she first became pregnant, Tasha had hoped for a council house and a new start. Her boyfriend of one year disappeared without explanation. The pregnancy that was supposed to anchor her future instead sent her into a spiral.

Unable to manage daily responsibilities, caring for Ross, sustaining work, she fell into depression. Substance use escalated, becoming, as she described it, a way of getting through each day from the moment she woke. Her life unravelled steadily: employment gone, her relationship with her son strained, her sense of herself as a capable person eroding.

> *"I was expecting supported accommodation," she told me at one point. "This is more like the rehab centre I just left. I want to be able to go out whenever I like. I want to be around people."*

Rehabilitation centers inevitably restrict personal freedoms, and for Tasha, this loss of autonomy was hard to bear. The imposed structure was nonetheless protective: when unsupervised, she acted impulsively, leaving without informing and placing herself in situations that were unsafe. It was clear she needed long-term therapeutic intervention, to address the accumulated losses, to develop insight into the patterns driving her addiction, and to build a more stable relationship with herself.

Psychoeducation formed part of this — helping her understand the connections between her thoughts, feelings, and choices, and recognise behaviours that were no longer serving her. DBT, with its balance of acceptance and change, was also available on the ward. But I was working irregular shifts, and I was acutely aware of how much this limited what I could offer. There is only so much one person can do within a system that lacks the structural support to sustain meaningful care.

> *"Do you feel truly ready for full independence?" I asked her once. "That requires being able to look after yourself. Perhaps you can start practising here, we can work towards it together."*
>
> *"Perhaps," she said, looking at her feet. She lost interest in the conversation not long after.*

A few weeks later, I escorted her into town. It wasn't the freedom she wanted, I still had to be there for her safety but it was a beginning.

> *"I only know people back in the city centre. Even my nail salon," she said as we walked.*
>
> *"Does that make you want to return?"*
>
> *"Yeah. But what I really want is to take care of Ross. That's not going to happen. I'm stuck here." She kicked at a bottle on the pavement.*
>
> *"I hope it can happen. I'll let the site manager know that's your goal."*

She talked about missing Ross, wanting to be back with him, while accepting it could only be for short visits. Something held her back from saying why. Eventually, I found out: in her view, Ross was better off in her sister's care, for now. What pained

her most was that he no longer remembered her. When he cried, he wanted his aunt. She feared he might never feel safe with her again.

It was hard to hear, but it was also something. She was taking responsibility, acknowledging her limitations, allowing the possibility of change. There was hope there, driven by love for her son. It seemed important to hold onto that. A goal, however distant, can be something to move toward.

Tasha had one possible route out: a friend, Mia, with whom she hoped to live after discharge. But she feared Mia's door might be closed to her, Mia had witnessed the lies, the relapses, and had warned her more than once. Tasha's other option, her sister, was not available.

> *"Why can't you live with your sister?"*
>
> *"I just can't," she said, firmly.*

I stayed quiet.

At our next session, she explained. Her sister had often worked night shifts as a nurse. Her sister's partner at the time used to hold parties while she was away — drink, drugs, and people she didn't know filling the house. On one occasion, the partner had come onto Tasha. When she described what had happened through tears, her sister didn't believe her.

> *"I couldn't believe she didn't believe me. She's meant to be there for me. I was upset — but mainly just angry." Her shoulders rose. Tension returned to her body, making her seem suddenly guarded.*

I had come to understand that posture. It was a shell, the same one that made staff afraid of her. The irony was that it appeared precisely because she was afraid of them. It was protective. Tasha was tired, she told me, of being misread and blamed — tired of being cast as just another angry Black woman.

After that episode with her sister, Tasha had stopped looking for safety at home and started seeking validation elsewhere, particularly from men. That search, for a paternal figure who would see her, fed the lifestyle that came to consume her. She dropped out of college. Nobody noticed, let alone intervened. Her parents hadn't gone to college; her friends had similarly drifted away. No one had modelled responsibility. No one had taught her to regulate her emotions or set goals. Her choices weren't random, they were patterned, shaped by an environment where very little had been stable or attentive.

Through all of it, Tasha had carried the feeling that she was not understood — by her parents, her teachers, her sister, the staff, and her fellow patients. Where she had hoped for sympathy, she found condemnation. Eventually, she stopped trying. All of this compounded her isolation.

She felt, she told me, that there was no way to be heard.

She could talk openly with me, and she didn't want to lose that. This sometimes led to contradictions, painting a more favourable picture than was accurate. She had been involved with several men and was uncertain about who had fathered Ross, yet maintained that the father might visit any day. She had told one possible father, Jamal, that she was getting her life together. He had said he might visit. Might want to be involved. She wanted to be taken seriously, to be believed as a mother, as someone who could love and protect someone more innocent than she had ever been allowed to be.

Eight months in, I was reducing my hours as my training intensified. Ending a shift, Tasha caught me on the way out.

"When will you be in next?"

I couldn't share my timetable, the ward had a policy against it, precisely because of the competition it could trigger between patients. Self-harm on the unit had taken on a contagious quality: when one patient hurt themselves, others followed. Incidents escalated and spread. A teenager severely injured herself in the toilets; after that, staff accompanied patients more closely. Yet every precaution seemed like firefighting. Patients always found new ways. Self-harm had become a means of seeking the attention that was otherwise so absent. The centre, rather than offering recovery, had inadvertently become part of the problem.

Tasha herself had an aggressive streak, colleagues had reported it to me, though I hadn't personally witnessed it. When she was kept waiting or felt disrespected, she would kick the office door. Staff found her unpredictable. She had struck a staff member once.

"I was being treated like an idiot," she told me, when asked.

She had always defended herself. I could have taken her behaviour at face value and agreed with the prevailing view, that she was simply volatile. But I understood there was legitimate grievance beneath the surface.

There was also the question of Phoebe. Phoebe was the most feared patient on the ward, she had been there the longest, self-harmed the most, and held an outsider's kind of influence. She was also known for directing racial slurs at staff and patients alike. She and Tasha clashed.

"Phoebe accused me of staring at her. I accused her of staring at me."

I understood the dynamics without needing a detailed account. Phoebe did not respond well to new arrivals, and Tasha was still considered new. Phoebe was guarded, middle-class, white, her accent clipped and controlled. Tasha was Black British, from south London, expressive, sharp-tongued, unwilling to diminish herself

for anyone's comfort. Phoebe knew that staff could not retaliate against her slurs. Tasha was not bound by the same rules and had no interest in pretending otherwise.

Phoebe mocked Tasha's hair. Tasha responded with confrontation, which was precisely what Phoebe wanted, giving her grounds to call the nurses.

Tasha's experience on the ward took little account of what it meant to be the only Black woman in that space. No one named it. No one asked how she felt carrying it. Yet she felt it daily, in the lingering looks when she entered a room, in the shift in atmosphere her presence caused, in the way her emotions were read before she had spoken.

Her distress was routinely misread as aggression. Her intensity, her refusal to soften herself, was filtered through a racialised lens that left no room for nuance. Even the most mundane aspects of daily life reinforced her sense of non-belonging: hair products that didn't suit her, comments about her appearance framed as jokes but landing as something more corrosive. These were not incidental details. They were central to her experience — evidence that the space had not been built with her in mind.

Recovery, as the ward offered it, arrived in one language and assumed a shared starting point. It treated everyone as though they had broken in the same way and needed the same repair. But Tasha had not grown up with therapeutic vocabulary, or environments where feelings were negotiated gently. Her traumas had been shaped by race, class, and a generational absence of support. The ward was not equipped to hold that complexity.

I found myself increasingly convinced that she needed to leave. Not to be discharged into nothing, but to be moved somewhere more attuned, somewhere that could offer long-term individual work: space to understand the forces driving her addiction, to sit with the complicated grief of her relationship with her sister, to be seen in her full context rather than managed as a problem.

That provision did not exist. The centre managed people; it did not change them. Patients were patched up and released. Most returned within a year. The cycle did not end.

A year after starting, I left the institution, reluctantly, but I could no longer hold both commitments without compromising each. Working irregular shifts, exhausted by the gap between what was needed and what I could offer, I recognised that overextending myself would only add to the problem.

I found out through a colleague that Tasha had eventually been transferred back to the city centre, which was what she had wanted. She was glad to return to familiar faces, to her community, to more opportunities to see friends, family, and Ross. In that environment, she was no longer the only one in the room. She didn't have to translate herself. I was not confident that her underlying problems would be

addressed there any better than they had been with us. But I hoped the context would at least stop making things worse.

This early experience opened my eyes to something fundamental: the traditional therapeutic setup, two chairs in a contained room, fifty minutes, a clear framework, does not serve everyone. For some, that structure is containing. For others, it is alienating: too clinical, too hierarchical, too reminiscent of authority and surveillance. The snatched conversations in kitchens and corridors were not failures of method. They were adaptations, ways of meeting Tasha where she was, rather than requiring her to come to a place she couldn't reach.

Organisations benefit from group reflection, adequate supervision, and ongoing training. Understanding patients is not enough, we also need to understand the cultures of the institutions we work within, and the unconscious processes that prevent people from offering their best.

Tasha's lack of support was not a departure from her life. It was an extension of it. If we begin to see that people's distress does not emerge in a vacuum, that it is shaped by environment, history, race, class, and accumulated experience, we might assess them differently and offer care that is genuinely responsive. We might reach those at the margins, who are so often the most in need and the least well served.

For now, this vision of mental health provision remains largely aspirational. Government cuts have left the most exposed with the least access to long-term therapy, the very people who need it most.

Tasha's story illustrates what is lost when diagnosis replaces understanding. Her hypervigilance, her apparent unpredictability, her outbursts, these were survival strategies, shaped by a lifetime of not being safe. Progress was never linear. The environment continuously tested her capacity to engage. But in the fragile accumulations of trust, moments when she allowed connection, stayed present, and risked being seen, her resilience was visible.

Working with her demanded that I confront the limits of the system, the assumptions held by those within it, and the quiet but real power of sustained human attention. Real care depends on relationship and context. It requires listening and bearing witness, rather than labelling or categorising.

Tasha deserved more than the system could offer. But in the time, we had, I hope she felt, perhaps for the first time — seen.