A Transcultural Perspective on Psychodynamic Psychotherapy: Addressing Internal and External Realities

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The paper suggests that just as skin colour plays a significant part in the structuring of society, it also plays a significant rôle in the structuring of the psyche. The argument is built on the hypothesis that the internal object world is colour-coded. The paper looks at how this might come about and explores its consequences. Therapists need to have worked through this area in their training and therapy, otherwise it will reappear as the therapist's transference to confound the therapy.

Key words: colour, counselling, culture, psychoanalysis, race

The paper is based on three premises. First, the current hierarchy of colour, from black to brown to white, came out of the last historical epoch of 400 years or so which saw the colonization of the world by the European. Colour was an important signifier that was used to distinguish the colonizer from the colonized, thus generating the politically real (but perceptually and psychologically hallucinated) categories 'white' and 'black'. Second, this hierarchy is utilized in the structuring of the psyche by 'colour-coding' the internal object world. Third, the attitudes consequent on this exist today in implicit and explicit forms in the theory, practice and practitioners of therapy, whatever their colour. As a reputable white counsellor and group conductor at a counselling centre said to me, he would be happy to work with me because I, as an Indian (brown), was obviously sensitive and intelligent, unlike these 'loud belligerent West Indians' (black).

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I begin by looking at how social values and structures might be internalized. Next, I will look at the consequences of that internalization as it manifests in psychotherapy. It is argued that as the social and the psychological are inextricably entwined, interpretations must straddle both domains — the internal and the external — without necessarily reducing one to the other.

'Therapy' is used here as a generic term to include psychoanalysis, group analysis, psychotherapy and counselling. In order to sharpen the points, I will focus on the dynamics that might arise when the patient is black and the therapist is white, and working in the current British context.

Internalization of Social Values and Structures

Identity is usually thought of in two ways: who I am and where I belong; which is to say that identity belongs to two dichotomies: me/not me and us/them. One way that an us/them divide is created is through the notion of 'race'. However, 'races' are not found in nature, 'race' is an invention that is mistakenly perceived as a biological category. To elaborate, McDougall (1989: 41) says:

> experiences of separation and the recognition of existential differences are the poles around which the sense of self and of individual identity is constructed.

But when a variation (colour for example) is on a continuous dimension and finely graded, then rather than recognize existential difference, the task becomes to 'choose' where to make the cut in order to create a particular difference. The 'choice' is informed by a variety of factors like history, context and so on. The perceived dislocations on the continuum are hallucinated in order to create discrete entities called 'races'. Of course it 'just so happens' that some of the dislocations coincide rather neatly with the colonizer/colonized divide. Difference is used to construct the sense of self, of me/not me and us/them. It is hard to define what is 'me/us'; it is easier to state what is *not* 'me/us'. Colour is one way of defining 'not me'.

To spend a moment on the words 'culture' and 'transcultural'. 'Culture' involves an internal experience of belonging (which might change), whilst 'race' is an external allocation which fixes a person forever. For instance, even though there are no cues otherwise in my dress or accent, it would appear that I am visibly Other to the white Briton as encoded in my name and colour. I am much more likely

than a white person to be asked 'Where are you from?' Yet I may have been born in the UK and have ingested a culture broadly similar to another white. It is the fact of my colour (translated into 'race') that makes and keeps me Other. So when I use the term 'transcultural', I am taking it to mean not only from another culture, but 'visibly perceived to be of a different culture', or even, '*imagined* to be of a different culture' because of certain visual cues.

This gives rise to the conundrum of whether a particular difference exists in reality, or whether it exists in the eye of the beholder. A point to hold in mind is that every time two individuals meet it is a transcultural event in that they each have unique histories, so what is different when Mr Singh and Mr Jones meet, from when Mr Smith and Mr Jones meet?

The Structuring of the Psyche

This section looks at what rôle the social plays in the structuring of the psyche, as this determines to some extent the contents of the transference and countertransference. First, the patients, who are initially introjected in bits and pieces, have already experienced the world and been modified by it. So one could argue that already with these very early introjects the infant takes in (non-verbally) a multitude of values and ways of experiencing the world. In other words, these early introjects are not neutral, value-free entities, but a complex of the social and the psychological.

Second, with the advent of the superego, there is a reshuffling of the earlier introjects. They are now allocated additional and perhaps different meanings and values as encoded within the superego — the nature of which Freud (1933) is very clear about:

> The child's superego is constructed on the model not of its parents but its parents' superego, the contents which fill it are the same and it becomes the vehicle of tradition and of all the time-resisting judgements of value which have propagated themselves in this manner from generation to generation. (SE 22: 67)

With the coming of the superego, the vehicle of tradition, the contents of the psyche are reorganized, and situated in a new relation to each other according to social rules overt and covert, conscious and unconscious, as coded into the superego. As a result of this the organization of the psyche reflects more closely the organization of the social world.

Colour-coding

I propose that the psyche 'marks' its internal objects in order to make sense of the relations between them by allocating them a colour attribute.

To begin obliquely: society concretely and obviously reveals a mapping of the colour hierarchy (black to white) on to the economic and political hierarchy. One only has to walk into a hospital (or any institution) to see this quite starkly, from consultants to porters. Living in this system the black person sees that much of what is valued and given status is white — it appears, even by other blacks. For example the offers of brides and grooms in marriage in Indian newspapers almost always make reference to how fair-skinned they are, this being seen as an asset. The message is clear: to succeed one needs to be white. Fanon (1982: 149) says:

> the [black man] has to choose between his family and European society; in other words, the individual who climbs 'up' into society — white and civilised, tends to reject his family black and savage . . . and the family structure is cast back into the Id.

White society becomes the superego replacing the familial structure.

So the black man and woman in this model repress their own culture and sets of meanings, and could come to feel that 'black' is bad. This view, an intrinsic part of their world schema, will affect the way they handle their own infants. The superego of this child, containing as it does the rules and mores of the dominant culture, will be colour-coded 'white', and as one goes down into the psyche to the id, it will be discovered to be 'black'. The superego will now be doubly ferocious, for it will also persecute the rest of the psyche for not being white. In effect, the psyche has been colonized by something alien, by white society.

The therapeutic task when this person comes into therapy will be dramatically different from the sometimes stated one of softening the ferocity of the superego and strengthening the ego. The therapeutic task is literally to transfer some of the contents of the id to the superego. Tongue-in-cheek we could say that in this instance the therapy is excavation followed by transportation.

Whilst there are truths in the formulation above (which is about recognizing difference), the situation is in fact much more complicated. It should be remembered that Fanon was writing from within the colonial context of French Algeria, where the notion of an

invading alien culture makes sense. But if one were to utilize this formulation exclusively in the context of the modern metropolis, it would lead one to an essentialist model of culture — of being fixed by a particular difference — mistakenly leading one to think that there is something peculiar if a modern metropolitan black person happens to prefer Chopin to reggae. But to say that is not to deny the veracity of the first argument — because to do that would be to deny the significance of difference altogether.

It should be remembered that whilst colour is a trivial, superficial difference — of no importance in itself, what *is* of importance is the significances and meanings attached to it, and the fact that these are interiorized in profound ways. I should add that I am not arguing that it is impossible to have good internal objects colour-coded black, nor that it is inevitable that black people will suffer from low self-esteem; nor am I advocating a psychological zealotry that seeks to purge 'black' psyches of 'white' objects. Each situation needs to be looked at within its particular specificities to be understood.

One other point needs to be made. Because of the exigencies of space I have focused on just one side of the divide and looked mainly at how a black person's psyche might evolve in the current metropolitan context. I should say here that I would argue that a white person's psyche is also similarly colour-coded, with the additional dimension that a white person would consciously or unconsciously experience black people as concrete manifestations of various id projections.

Manifestations in Psychotherapy

Transference and countertransference are ways of experiencing the Other. What will be specific to this experience when patient and therapist perceive each other as 'Other' along the polarities of 'race' or 'culture' as signified by colour?

Transference involves repeating without remembering. It is a pattern around something unresolved, displaced from the past and transferred across to the present. The therapist, by means of interpretation, hopes to reveal the reality behind the transference, the latent content behind the manifest, and so help the patient remember the actual event without the compulsion to repeat it.

The relationship of latent content to manifest content is similar to that of territory to map. The map is territory re-presented in coded form. The dilemma is that we only have access to the 'manifest'

map and not the 'latent' territory (the unconscious). the territory can only be inferred from the map. To take the map/territory metaphor literally: traditionally, the Chinese draw their maps with South at the top. Obviously without knowledge of this fact, one would misconstrue the territory, that is, the interpretation would be a misinterpretation.

The therapist needs to be conscious of what is an acceptable and meaningful way of coding in the patient's particular culture, because although the trauma is coded, the hope is that the code will be broken, in other words, that someone will hear and understand. 'The language of the symptom, although already a form of communication, is autistic. It mumbles to itself secretly, hoping to be overheard . . .' (Foulkes and Anthony, 1965: 259). The therapist needs to ensure that she or he is using the same code-book as the patient, so that 'having overheard' she or he is able to decipher the communication.

Transcultural Transference

I address the notion of transcultural transference with the question: in what manner do the historical relationships between 'races' and cultures re-present themselves in the present? First, some anecdotes:

> Recently I became starkly aware of how an Indian friend of mine (who has spent most of his life in the UK) behaved when he was in India. There he walked down the street with confidence, compared to London, where he is much more subdued and withdrawn. Following that I became aware that when driving he was much more likely to get angry with an Indian than with a white male.

Undoubtedly there are many reasons for my friend's behaviour; but following the model suggested earlier we can say that he behaves differently towards a white male because 'white' occupies a different place in this psyche from 'black'. In attacking the white person he is having to confront his superego, which according to our hypothesis, is colour-coded white. In attacking another Indian, he has no argument from his superego, because he is attacking an inferior aspect of his self; if anything he is likely to get encouragement from his superego. And in the driving situation, the historical relationship between the Indian and the white Briton, incorporated into the psyche, is transferred into the present.

I am not saying that every Indian or every black person is

affected in this particular way and to this extent. I am saying that it is impossible, at this particular point in history, not to be affected some extent by the theme of black and white. How one is affected will depend on a multitude of other factors: social, historical, familial and so on.

Another aspect of transcultural transference is illustrated in the following:

> I was speaking about the theme of colour when my supervisor (white) said that he was not usually aware of the person's 'race' or colour in a session; it was not a significant issue for him. This surprised me as I am often conscious in groups, and in one to one, of my colour in relation to others.

There are several potential explanations for my reaction. (1) I have 'a chip on my shoulder' — this is an interpretation suggesting paranoia; (2) I am displacing material from a more basic issue on to that of colour — suggesting that the issue of colour is a vehicle for other material, perhaps loss. (3) By virtue of their colour, the white person is in the mainstream and near the centre, whilst the black person is marginalized and nearer to the edge. The closer one is to the edge with the resultant danger of going over, the more one is aware of the conditions that put one there — colour. In other words, those at the centre have a vested interest in maintaining the status quo by blanking out the colour dynamic altogether: if it does not exist in the first place, then it cannot be changed.

To return to the theme of transference: let us imagine my Indian friend in therapy, where he is describing feeling intimidated by his white therapist. The feeling of intimidation can be understood as transference, and the therapist might address it in terms of an authority issue. The question now is: what is being transferred? What is contained in the constellation 'authority'?

One component of the transferred is (say) 'Father'. But to stay exclusively with this theme is to be colour-blind and is just part of the story. The other component is that of the Indian's historical relation to the white Briton. But to stay exclusively with this is to be blinded by colour and is also just part of the story. In thinking about how to disentangle the different parts of the story, a patient comes to mind.

> 'A', of Asian parentage, London born, was told by his father that 'we are third class citizens'. Having introjected this message, 'A' became a low-grade clerk. In therapy over some years, he worked through much material to do with his father, and then become painfully aware that he 'had to do three times as much' as his

fellow whites to progress. that is, having thrown off the inner oppression, he still had to address the external reality.

What can the therapist do at this point? If the therapist acknowledges the external reality will she or he be doing something anti-therapeutic? I suggest that this kind of external fact should not always be interpreted in terms of the psyche and the therapeutic relationship. My hypothesis is that at times it is more useful to begin with the acknowledgement of the external, which will then allow the patient to begin working with the internal. To miss out the first step can block therapy.

The External and the Internal

It is a fallacy to assume that in acknowledging the external, one inevitably avoids the internal, and that this is detrimental to the therapy and the patient. It is true that there are conscious and unconscious reasons as to why things are done. The mistake is to think that the unconscious reasons always invalidate the conscious reasons. The model I suggest for these moments, is one of moving from the outside in. In so doing the therapist gives the patient sufficient purchase on the outside world (trust), which then enables the patient to temporarily 'let go' of the external and take the risk of looking at the internal aspects of the *same* reality.

Context and Resistance

The exchanges that occur in the world take place within a social context which determines to some extent what meaning any particular interaction will be given. Utterances will be heard differently depending on who mouths the words and who is doing the listening. The same words can sound precocious when uttered by a child, or meaningful when uttered by an adult, or perhaps as just so much flannel when uttered by a cynical politician.

To take two external facts: the patient who arrives late because of a train delay and the patient who is being victimized for being black. What, if any, is the difference between them? They are similar in that they are both social facts, but different in that context allocates to them differing significances, thus loading each with different types of affect. This difference in attached affect will determine how they will be handled.

The experience of some black people living in Britain today

(context), is that of somehow not quite making it, and when it is attributed to racism there is often a denial that it exists: 'You didn't get the job because the other person was better. It was nothing to do with colour.' The black person's continual experience is of being caught in a powerful pincer movement, one prong of which is racism, and the other the denial of racism. This then is the black person's context, that informs how she or he *might* hear a comment from a white therapist.

Now the train delay, as a social fact, exists to some extent outside the therapist and patient and as such is 'neutral'. Thus an interpretation from the therapist is likely to be heard by the patient and worked with. (Of course the patient might for other reasons resist the interpretation of this fact too.) The other social fact — social oppression — is different from the first, in that both therapist and patient are implicated *in actuality* in the social fact, and, moreover, they are on opposite sides of the fence.

So, how might a black patient hear an interpretation from the white therapist, in this instance, of social oppression, as a reflection of his or her inner dynamic? The black patient is quite likely to view such an interpretation with suspicion, in effect hearing the therapist saying 'You have a chip on your shoulder, and what you experience as the racist edifice does not exist.' In this sense the content of what the patient hears is transference material and the patient's reaction of suspicion can be thought of as a transference resistance; in particular, a resistance to acknowledging a reality which contains within it, amongst other things, the patient's own contribution to the situation, both conscious and unconscious. An interpretation of the resistance at this point is no more likely to succeed than the original interpretation. The patient will entrench him or herself further, experiencing each new interpretation as further attack. This is the benign option. However, at other times it seems that the therapist means precisely that the patient is using a paranoid version of the external to avoid facing a painful internal reality.

Returning to my Indian friend, who has all this time been feeling intimidated by his white therapist, we can summarize what is happening by saying that this Indian's feelings are a transference with two components: one component of the transferred might be Father and is located within a particular personal domain; the other component is that of the Indian's relation to the white Briton, and is located within a larger historical relationship between two groups of people.

I think that it would be true to say that on the whole such material is usually picked up in the former frame and not the latter. Why is this? I suggest that in reducing the external to the internal, the therapist is avoiding something that is painful and unresolved in them involving countertransference.

Countertransference

In my view what is happening in the above scenario is that the white therapist is experiencing to some extent a complementary countertransference of a kind that echoes the feelings of the white overlord. Racker (1985) distinguishes between two types of countertransference: 'concordant', when the feelings of the therapist echo those of the patient, and 'complementary' when they echo those of the object that the patient is projecting on to the therapist. The transference from the black patient might be 'positive' feelings — warm, benign and trusting towards a benevolent despot, or 'negative' feelings — anger, hate and envy. But whatever the case, does the therapist recognize and locate *parts* of the feelings correctly — in this instance in a historical relationship and not in a paternal relationship? Indeed, is he or she capable of recognizing it?

As Freud (1910) put it: 'No analyst goes further than his own complexes and internal resistances permit' (SE11: 144–5). In other words the therapist can only interpret areas she or he has come to recognize through personal therapy and life experience. When material that has not been analysed in the therapist is evoked in the session, it is then the therapist's transference. In other words, it is the therapist repeating without remembering.

If the therapist consistently avoids the issue of the external reality, we have to ask why this is so: is it a resistance? *What is the therapist avoiding remembering*? I suggest that one answer concerns guilt. By virtue of his or her colour, the white person, other things being equal, does have it easier than the black in UK society. To face this is to face guilt and the pain of that. If this area has not been addressed in the therapist's own therapy, then it lies within — too hot to handle. The white therapist in this scenario is avoiding remembering that he or she does occupy a more privileged position than the black patient.

If the material is not worked through in the therapist, then how might he or she address the predicament of 'A', who says he has to do three times as much as white people to progress? How might the

therapist use and understand this comment about the external world?

One possibility is that the therapist will be overwhelmed by guilt and incapacitated by it. The stance is that of being 'blinded by colour', and leads to a colluding with the victim position. What is said is: 'Poor you. Isn't it awful?' Everything is put outside the patient and the patient can only be commiserated with.

Another possibility is that the therapist denies external reality and so avoids facing the guilt, banishing anxiety. The stance is 'colour-blind' and blames the victim. What is said is: 'We are all equal and if you end up there near the bottom of the pile, then it is you and your particular dynamic that have put you there.'

So to answer the question: 'What is being repeated and not remembered?', in the first instance, the therapist is not remembering the patient's autonomy — the internal reality, whilst in the second instance the therapist is not remembering the external reality, but in both what is being repeated is the oppression. However, if the therapist has worked through this area then he or she is able to access and use experiences and is more likely to be able to think, and thus walk the thin line between colluding with a victim position and perpetuating an oppression, without forgetting either.

Authenticity and Essence: 'Race' or 'Culture'?

The whole area of 'race', colour and culture is problematic. How is a black person born in Britain 'to be'? What conditions will this person have to fulfil before he or she is considered to be healthy? The Tarzan stories vividly express the essentialist view — that in the end blood will tell.

> A psychotherapist reported the case of a man, of Chinese parentage, adopted as an infant by a white English couple, and brought up in Britain. The man's internal experience is that he is English. The values that he absorbed were the norms of his immediate society. Now, as an adult, when this man expresses views about 'foreigners' in his place of work and in his therapy, his colleagues and therapist experience an anomaly: here is a Chinese man, going on about foreigners, whilst he himself is foreign.

The patient experiences no contradiction in himself when he talks of foreigners because his conscious internal (cultural) experience *is* of being English. When viewed in this light, the contradiction exists in the observer who 'sees' a Chinese person (race). As it happens, the therapeutic task defined by this particular therapist addressed the

unconscious from an essentialist perspective, saying that there is some sort of true Chinese self that has been lost and needs to be found. The resolution proposed is that there is a lost internal experience in the patient, which when rediscovered, will match the external experience of the therapist, thus resolving the conflict. But the conflict that has been resolved is within the therapist. Here, 'race' overcomes 'culture'.

Presumably the reactions that the patient receives from his work colleagues are not new. Speculating, it is more than likely that he has experienced such reactions all his life, but because of the painful nature of such experiences, he has repressed them. What this patient has 'forgotten' and repressed is not some Chinese essence, but a particular trauma of growing up in Britain, resulting in part from the conflict set up by being perceived and treated as Other.

Is this not exactly the trauma that the therapist replicates by alluding to the patient's alleged Chinese roots? In effect the therapist has populated the patient's unconscious with 'Chinese essence', rather than social conflict. We can speculate that the therapist has avoided taking the second path, because to do so would be to implicate herself within the dynamic. And precisely because the area is unconscious in the therapist, she 'acts' in a way designed to keep her own unresolved material at bay, but in the process repeats — unconsciously — the oppression of keeping the patient Other.

In the end, what remains is that the internal experience of this patient is English, albeit an experience that is different to that of a white person in a similar circumstances. What also remains is that, given the way our thinking is structured, an observer will find it hard to place this person in a 'racial' category other than Chinese. To say that one of these experiences is truer than the other, is to walk into a cul-de-sac. It might be more useful to think in terms of both protagonists having work to do: the patient to allow himself to recall the pain of a lived experience, and the therapist to struggle out of limited ways of experiencing the Other.

Conclusion

The patient is always Other to the therapist. The challenge for the therapist is to engage productively when the patient is Other along the polarities of 'race' and 'culture'. The therapist can avoid engaging with the difference between self and Other in two ways.

One way is by dismissing the difference as pathological, in effect looking down on it. Another way is to elevate the difference into a romantic vision of Otherness, failing to question it, in effect looking up to it. The challenge for the therapist is to stand next to the difference, to engage with it and question it, and in the process risk the transformation of both self and Other.

I end with a quote and a anecdote that draw together the themes explored in this paper. Hewstone and Jaspars (quoted in Tajfel, 1982: 165) say: 'An observer attributes behaviour to an actor not simply on individual characteristics – but also on the basis of the groups to which the actor and observer belong.'

> A while back, in the staff room of a counselling centre, I was heating my lunch in a microwave. A white English woman came in, saw me, smiled, smelt the food and said: 'Hmmm! Smells lovely – I love curry.' The dish was a boeuf bourguignon.

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