

CHAPTER FOUR

Is it coz I'm white?

David Morgan

"Never again shall a single story be told as though it were the only one."

John Berger (2008)

I come from a rather non-diverse background. Indeed, in the rural area I grew up in, the closest I ever came to racial diversity was via the *Black and White Minstrel Show*, the film *The Blackboard Jungle* with Sydney Poitier, B. B. King, Miles Davis, Cassius Clay, and from there to an appreciation of jazz and blues. In fact, it was many years later that I found out that much of the music I was playing on records during my youth was derivative from, or had roots in, black American and Afro-Caribbean culture.

When I trained as a clinical psychologist, psychotherapist, and psychoanalyst, almost all my fellow trainees were white like me, and the trainings at that time hardly touched upon diversity in the clinical setting. This was something I only gradually became aware of as I encountered patients, and, later, supervisees, who confronted me with the confusing experience of difference. This included both sexual orientation and ethnicity. My own analysis and training had not prepared me as much as I thought to encounter this difference, and my patients now made me aware of my own

defensive strategies, which I used to manage this confusion. It is perhaps questionable whether these courses represent tokenism and box-ticking genuflections to a politically correct world, or the beginning of a real change. I think prejudice should be embraced, acknowledged, and explored rather than airbrushed away through well-meaning politically correct conscious-raising exercises.

I did remember hearing about Masud Khan, a psychoanalyst from Pakistan who had a complex reputation. I often wondered whether the difficulties he enacted could have been, at least in part, the result of being the only black person in the analytic village. I wondered how much his analysis had been able to explore this while he was in training. This has since become a question in my mind with other aspects of human diversity: race, sexuality, class, and gender.

At university, many of my colleagues had come from differing backgrounds, which in itself felt like enough of a culture clash for me to manage. This was more a class issue, involving discovering that others had attended private schools and even, to my astonishment, public boarding schools. This was my first exposure to the English upper-middle class, which seemed very foreign to me and owed more in my imagination to the fictional worlds of Jennings (a precursor of Harry Potter without the magic) than to anything I had ever experienced. My own world resembled more a "Just William" story of rather ordinary secondary schools with the odd smattering of "Swallows and Amazons", a sheltered experience undisturbed by any awareness of racial or ethnic difference. As already indicated, during my own psychoanalytic training, race or culture in particular were never really addressed. I knew that my analyst was Jewish and old enough to have been in the shadow of the Holocaust. And I was aware that my own Welsh background, which was important to me, with roots in the South Wales coal-mining industry and North Wales agriculture, seemed at odds with the urban and urbane world of psychoanalysis in London.

So, not having the benefit of any preparation to work with diversity, or even basic equal-opportunities training, I discovered differences through exposure to my patients, travel, and living in a culturally diverse area in London. I also supervised a number of therapists from ethnic and cultural backgrounds that were quite different from my own. I must acknowledge that I have struggled to manage and think about diversity, and at times this was a painful

experience as it exposed prejudice, which I had not anticipated, in areas in myself and in the analytic milieu. To illustrate the struggles I faced and how I grappled to work with them analytically, below are a few reflections of some work with patients from different cultural backgrounds to myself.

Mr A

Mr A was young man who had been in analysis for a few years. He came from a relatively orthodox Jewish family. His original reason for seeking treatment was his inability to make and sustain relationships with women, any women. He was 33 years of age and had not managed any sexual relationships. There was a strong ethical prohibition on sex before marriage from his religious orthodoxy, and Mr A seemed locked into a powerful oedipal dilemma, unable to separate from what seemed to be a rather infantilizing mother. She still cooked his dinners and did his washing although he had at least physically left home and was living in a flat with a friend.

He used to wish that his parents would help him select a wife for him as many of his friends' parents had done for their sons. But he also somehow felt he should be able to do this for himself, something he put down to his ethnically diverse school and the influence of his peers. The idea of arranged marriages was anathema to me, as I imagined with horror the woman my own mother might have chosen for me. In his background up, until his generation, it had been the norm for parents or matchmakers to do the arranging. While it is something I have encountered with several patients from ethnically diverse cultures, to me this is an antiquated idea, one of a number of cultural practices that I struggle with. For instance, a young Sikh woman decided to have her daughter at her mother's home in Birmingham, leaving her British husband in London for the birth and for an indefinite time afterwards. It is difficult for me not to be judgemental at these times. However, in so doing I recognize the need to be open to thinking about the views of those who may have a different perspective. Where is the feminism? Aren't these cultures regressive, using religion and tradition to coerce the next generation for economic and/or social advantages? I could frame a context in which these religious and cultural ideas might have been

regarded as reasonable strategies in difficult times when survival was paramount, but I viewed them as no longer practically necessary in twentieth-century London. But this ethnocentric outlook did not inspire confidence, and I had to recognize that my black-and-white (paranoid-schizoid) thinking was sometimes a way of avoiding other, just as valid, perspectives on the matter.

As Mr A's treatment progressed, he began to meet women via an ethnically focused dating site. He explored his sexuality and eventually met his wife independently. She was someone who was not from an orthodox background but, rather, attended a liberal synagogue and was from a family who seemed more interested in the symbolic manifestations of their rich Jewish heritage than the more concrete, more fundamental interpretation of the Torah.

Looking back, I do wonder how much my unconscious influence, with my ostensibly liberal values and non-religious background, may have influenced my patient's subsequent development.

This conflict between different value systems, his wife's and maybe his analyst's, came to a head later on in his treatment. He married this more liberal Jewish girlfriend, and within a year they gave birth to a male baby. In his analysis, he explored the issue of being a father and how much he wanted his son to adopt his religious and ethnic background. He had by this time—in fact, from the first month, when I betrayed my ignorance of Jewish holy days—realized that I was not of Jewish descent. We had explored throughout his analysis how my ignorance of his ethnicity (religion and culture?) was both a hindrance and in some less obvious ways an advantage. Indeed, I have observed that many Orthodox Jewish patients prefer a “non-frum” analyst to someone who is Jewish.

It inevitably came to pass that the question of circumcision became prominent. He was in no doubt that he would follow tradition and would have his son circumcised. However, his wife was very concerned about the procedure, as she knew of a friend whose son had had complications following the ceremony. In my countertransference, I struggled with my own views—for example, that it was an anachronism, from desert cultures, a position I felt legitimized by Jewish friends, mainly psychoanalysts, who had foregone this procedure. I therefore wondered why anyone should go along unthinkingly with the words of the prophets. However, other friends told me of the dis-identification from the father that non-circumcision represented and how non-circumcised boys often

felt alienated. One story, probably apocryphal, told of children trying to perform their own ritual, so desperate were they to fit in. The immense need to belong, and fear of punishment for forsaking the father, seem to discourage rebellion. I now no longer simply think “why do you listen to the words of the old prophets”—I also think about the real price to be paid by those who do not.

Helping the patient think for himself was threatened by my own prejudices, however rational I thought I was being. My supervisor, who was Jewish, surprised me by stating that there was no issue—because of course the circumcision should be performed. This surprised me, as until then everything had been transference-based in this supervision, but this issue seemed to be beyond psychoanalytic theorizing. I have always been surprised how a number of my colleagues have maintained strong religious beliefs during their training and careers, a testimony, perhaps, to the enduring nature of these ancient regimes or to the importance of ethnicity and cultural belonging over thought and unconscious understanding.

With Mr A, a number of issues soon came into the analysis when he helpfully brought a dream. In the dream, he was standing on a station platform and two trains arrived simultaneously; one was going to Hendon and the other to Hampstead. His associations were that Hendon clearly represented his orthodoxy and Hampstead the home of psychoanalysis. He felt that he was “on the horns of a dilemma” in that he both wanted to be liberal-minded and follow his conscience in relation to his ethnic traditions.

I interpreted that it was important for him that I was able to help him think about decisions like his son's circumcision. The question he posed was, am I able to help him have a mind of his own rather than feel he has to obey orthodoxies, including mine? Of course, this interpretation was redolent with my own belief system, but, as an analyst, how could it not be? Did it enable my patient simply to think for himself, or was it promoting the idea that his having a mind of his own was more important than his rootedness in the ancient value systems based on his ethnic traditional values?

The very practice of analysis flies in the face of orthodoxies and fundamentalist thinking, yet clearly it can become dominated by certainties itself. For instance, within analytic institutions there has been a great deal of psychoanalytic orthodoxy, with each theoretical group having its own leaders and disciples, impeding the processes of creative debate.

When, after a few weeks, the patient decided that he would go ahead with the religious celebration of circumcision, I did feel that the religious value system had exerted its power over him, and yet it was right for this patient to submit, as I saw it, and to assert his right to pursue his own direction independent of me, as he saw it. In the exploration of the dream, I felt there was a struggle for shared ground where two minds and ideas could be considered. The station at least represented a place where choices could be made, and it represented a shift in the patient's previously paralysed condition. It is of interest to note that at the actual ceremony he had been able to contain his mother, who, in an attempt to upstage proceedings and rival the baby, got into an argument with the other mother-in-law. The patient was able to stand up to his mother, pointing out her upstaging of proceedings in a way that she was able to respond too. I felt our exploration of mutual space had allowed something new to happen in the family dynamic.

In my countertransference, I would have to admit that I found the idea of circumcising a small baby disturbing. Yet I had to struggle with, and help my patient feel, that there was space to think with me. I therefore had to struggle with my orthodoxy based on my experience rather than impose it on him. I think this exploration allowed him to decide for himself, his autonomy here being expressed in his ability to stand up to his mother's domination.

Ms B

Ms B was in her forties and was single, with two children. She was from an African background and had come to England ten years previously. Her presenting problem was a need to control her anger, particularly towards Caucasian men. In one case, she had "frighteningly lost control" by attacking a taxi after its driver had mistaken her for a prostitute while walking in the north London suburb where she lived. On the one hand this reprisal on her part seemed reasonable, but on the other her preoccupation and sense of grievance with this tendency in some racist British men left her concerned that one day she would get herself hurt. She was referred to me because I had some experience of working with violent patients.

From the beginning, Ms B criticized me for being a white male. Being Welsh did not in any way mean that I did not represent that British colonialism that had enslaved her country of origin. How could I, she said, hope to understand her experience when our experiences, in terms of both race and gender, were so opposite. I said that I thought she was right to explore with me what sort of analyst I was and whether I had any equipment that could be used to understand her. It was possible that I did not; indeed, she doubted any white man's capacity to truly understand. I said it remained to be seen whether she should continue her analysis or end it because I might be a bigoted racist analyst. She seemed thoughtful about my apparent willingness to be thought about as such an unattractive figure. Clearly the analytic vehicle I was using so far did not deserve the same fate as the taxi her abuser was driving.

She stayed in analytic therapy with me. It transpired that there was a great deal that I did not understand. She hardly knew her parents and had been brought up by her extended family. She seemed to have many aunts and uncles who looked after her. The lack of any real parental couple meant that it felt, at least to me, that a lot of the usual reference points from her past were lost. Did this mean that the childrearing practices of the ethnic group to which she belonged left children without a clear sense of a parental couple, or was I pathologizing a culture just because it was different from my own? In the countertransference I experienced a great deal of confusion as to who I was in relation to the patient. To begin with, it was easy to believe that this represented the patient's own confusion from her extended-family experience—her lack of reference points marking the absence of her parents as primary caregivers. In fact it transpired that with these beliefs, based on a simplistic countertransference response, I nearly missed the subtler message, which was: "Can you, the analyst, bear the confusion in your usual reference points—the couple, the oedipal relationship—without reinforcing your position by pushing your idea of normality back into me?"

I saw her for many years, and her tendency to get into fights reduced, as did my wish to impose my belief system onto her. I came to think that it was this exploration of my fear of loss of purpose, the fear of losing my rootedness in the therapeutic process, as

I understood it, which allowed something other than recrimination to develop. This seemed to be what was required, rather than my need to reinforce those of my own preconceptions that were being challenged by her cultural background. It was hard at times to be made aware of my own judgemental stance.

I have understood this struggle as akin to the power of nationalism, in that when we are under threat we often look for flags that we can stand under to protect our identity from fragmentation. Psychoanalytic theory can also be used this way when patients bring “foreign” experiences into the consulting room; it functions as a form of protection to the analyst whose own normative experiences are put to the test.

In these cases, it is enormously important for the analyst to be discovered as someone who might be able to think about his or her own restricted experience without using psychoanalytic theory defensively, as a psychic retreat. This defensive retreat can include the reduction of ethnic beliefs to psychotic mechanisms, the issue of sexual difference to failures in oedipal development, as well as other forms of reductionism. However, at the same time as bearing all this in mind, it is also extremely important that the analyst, as well as having the ability to be open-minded, is not so open-minded that his brains fall out. This is a difficult task, but it may be the only experience some of our patients have ever had of engaging with diverse thinking. It seems vital, if this process is to have a therapeutic outcome, for the analyst to be aware of the initial impulses in the countertransference to repudiate and pathologize alien experiences. This helps maintain our sense of equilibrium, rather than giving the patient the experience of someone whose theories are less important than he or she is.

Ms C

Ms C, a 25-year-old woman from Nigeria, was admitted to the hospital where I acted as a supervisor of nursing and other clinical staff. Her presenting symptom was a desire to run up to complete strangers in the street and embrace them in a large bear hug. She often chose old women who appeared lonely, and who were then obviously traumatized by this unprovoked gesture of familiarity. Ms C’s history was that she had been studying law with the intent

of earning her living as a lawyer. She had, however, failed her exams and been expelled from her course. Her family had hoped that she would be able to send money home after she qualified, and it seemed that they had been very disappointed. Ms C felt ashamed and expelled from her family. It seemed clear to me that she was reversing her own painful experience of failure and rejection by projecting them into the aged women that she embraced, as if they were indeed her long-lost relatives who she believed had excommunicated her. I was able to share this with staff, who found this explanation of her symptoms helpful. However, unfortunately, I forgot to underline how important it was that this thinking was something to be kept in mind rather than directly communicated to the patient. A staff member shared this interpretation with Ms C, and at the time it appeared that she had been helped by the link it made to her own feelings of loss—loss of family, loss of country, and loss of career. That night she managed to break into a senior hospital manager's house in the grounds of the hospital. He woke up to find her standing over him, just looking at him. Of course, he was extremely shocked by this night apparition. I realized that the patient had also been shocked by a clinical insight that she was unprepared to receive. She had fallen back on her previous ways of managing by projecting her feelings into someone else, and it was they who were to be shocked by her breaking into their homes.

Clearly my failing was to underestimate the importance of ensuring that Ms C's homelessness and alienation was addressed before any understanding could occur. It was a reasonable manic defence that she employed to overcome her own homeless position by choosing to see others as having need of her company. Since then, I have been able to appreciate how difficult it is for those managing in foreign environments to feel safe enough to do analytic work. I might not have any insight into how frightening it is to be in a foreign culture, as I am relatively at home here. The importance with patients from other cultures of appreciating what it might feel like to be in their shoes is therefore of enormous importance. As I have learnt, it is only this appreciation that can begin to allow patients from different backgrounds to feel that they are at first listened to by someone who may have the ability to stand aside, however much prejudice intervenes, from their own experience and be put in touch with something new and unfamiliar.

Psychoanalysis has provided us with an understanding of how we can use the “other”—in particular, their difference—to contain our own anxieties about ourselves. It is important that we recognize that we all have our prejudices, and our patients need to explore our capacities to bear recognizing these in ourselves, if they are to feel understood. We have to be careful in our practice to bear the challenge to our norms that differences confront us with. This includes idealizing difference, which can be as much a defence as pathologizing it.