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Culturally Imposed Trauma: The Sleeping Dog Has Awakened. Will Psychoanalysis Take Heed?

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This paper considers the scant attention psychoanalysis gives to cultural trauma. Three contributions to this deficiency are considered: (a) the continuing identification with our psychoanalytic forefathers' silence regarding cultural trauma, (b) the authoritarian practices in psychoanalytic institutions that keep us overly focused on standard intrapsychic formulations to the near exclusion of cultural trauma, and (c) the fact that work with cultural trauma is difficult. To do this work requires us to "buck the system." If we do so, we expose ourselves to toxic phenomena in a world still rife with cultural trauma. This paper, which includes clinical vignettes, is an invitation to do so.

In "Analysis Terminable and Interminable," Freud (1937) proposed that certain conflicts could not be treated in an otherwise successful analysis because those conflicts were ensconced inaccessibly in the patient's "psychical underworld" (p. 231). If it were possible to unearth them, it would be unethical to do so because "fresh suffering" (p. 232) would be imposed on the patient. To wit, Freud warned, "we should let sleeping dogs lie" (p. 231). Although frustrating to Freud to leave major conflicts unaddressed, he suggested that at some point in the patient's life, fate would wake up the sleeping dogs and make them ripe for analysis. This paper is about the "awakened dog" of culturally imposed trauma—as evidenced in increased awareness and expressed concern by citizens of many nations. From the beginning of the Arab Spring in late 2010 until now, with the fervent cries in many cities of the United States that "Black Lives Matter," there is undeniable demand to stop crimes against humanity. All of us, including psychoanalysts and our patients, hear these demands. If for no other reason, social media 24/7 ensures that we do. The operative question for this paper is, Do we listen?

This paper is focused on understanding how psychoanalysts and psychoanalysis have responded to the greater accessibility of cultural traumas in terms of recognizing and addressing the psychical harm done by culturally imposed trauma. It is my view that we have too often stayed asleep, even though current events call us out of our somnolence, and as a field we have the philosophical, theoretical, and technical tools to address the clinical manifestations of that harm. There is more of a workable surface for psychoanalytic reflection, treatment interventions, and development of institutional best practices concerning these matters than has been acknowledged and utilized. Thus, it is not justifiable to stay asleep as psychoanalysts regarding cultural traumas.

There is indeed a growing psychoanalytic literature on cultural traumas and their impact, from many different cultural angles, providing clear conceptualizations and rich case examples of the clinical significance of acknowledging and working through cultural trauma and history in the nitty-gritty of transference–countertransference interactions—with African Americans (Akhtar, 2012), in relation to those whose multiple diverse identities are important (Nettles & Balter, 2012), as exemplified in working with Jewish patients for whom the Holocaust is critically important clinically (Guralnik & Simeon, 2010), with particular reference to the importance of the analytic therapist witnessing the patient's cultural experiences (Gentile, 2013), and on the necessity for the psychoanalyst to appreciate that living in a diverse society affects us all psychodynamically and affects the psychoanalytic treatment process (Tummala-Narra, 2013). These authors, among others, make clear that and how one's personal history of cultural trauma shapes intrapsychic and interpersonal life, even when the patients' suffering also relates to commonly recognized psychological problems. Psychoanalysts are on familiar and comfortable turf when dealing with individual conflict, family trauma, and family history. Clearly, our aim with respect to these familiar foci is to free our patients from the shackling effects of individual conflict, family trauma, and family history.

In contrast, focusing on cultural traumas is less familiar and is less articulated in our psychoanalytic clinical theories, supervision, and practice in general but common to the publications just noted. In particular, what is less focused on is an acknowledgment and articulation of *the layer within the psyche that contains and secrets crimes of humanity and their history*. It is my view that in general, scholarship and clinical teaching in psychoanalysis continue to take a too narrow view of what history we should focus on when working with our patients and what freedoms we should help them to achieve: Psychoanalysis in general has largely excluded cultural history and its traumas from what it is on which we are to focus. Why? I offer three answers to this question.

THE SILENCE OF OUR FOREFATHERS

Our analytic forefathers were silent in terms of addressing cultural atrocities. We tend to adopt rather than challenge that silence. Freud, for example, knew that the poverty and most likely the anti-Semitism in which he grew up harmed him, including contributing to his success neurosis. He says as much in his 1936 paper explaining his success neurosis symptom, which he called a "disturbance of memory" as he climbed the acropolis in Athens: "It seemed to me beyond the realms of possibility that I should travel so far—that I should go such a long way. This was linked up with the limitations and poverty of our conditions of life in my youth" (p. 247).

Remarkably, stunningly, in the paper just quoted, his statement of those factors seemed almost an afterthought. Rather, he ended up explaining his success neurosis entirely in terms of oedipal conflict. In other writings, Freud dismissed or minimized the influence on him of his Jewishness and anti-Semitism. There have been only a few challenges to this overly narrow view of what contributes to success neurosis, to the exclusion of broader cultural practices and their shaping effect on personal functioning. For example, I (Holmes, 2006) wrote about the wrecking effects of race and class on self and success. I considered pre-Oedipal factors and internalized cultural practices (e.g., self-denigration based on identification with the racist aggressor).

Psychoanalysis, to this day, has acted in concert with Freud by being silent about, minimizing, or disavowing the link between harmful cultural practices and individual functioning, even bypassing or discrediting research that shows a link. A case in point is the Adorno research project most active in the 1940s and early

1950s. Adorno conducted a psychoanalytic research project to study the authoritarian personality and its ramifications, including racism. Moskowitz (1996) reviewed this research thoroughly and reported the following: "Reviewing the more than 1200 studies on authoritarianism conducted through 1983, Meleon and colleagues (1988) concluded that the concept of authoritarianism is valid and that the hypothesized relationships among authoritarianism, racism, … and sexism have been repeatedly confirmed" (p. 27).

How many of us know of this research, recognize it as psychoanalytic, or appreciate its applications to understanding an important aspect of how we and our patients function? It should be noted, too, that Adorno identified authoritarianism of the left and the right in terms of political orientations. My conjecture is that psychoanalysts keep this research at bay, lest we have to recognize that our tendencies as analysts to be authoritarian may be linked to our own deeply embedded prejudices, whether they be left- or right-leaning.

ORGANIZATIONAL CHALLENGES TO ADDRESSING CULTURAL TRAUMAS

I take the view that psychoanalysis has the conceptual frames and clinical tools to do the work of recognizing and properly privileging the important historical and social reality of our patients, including those linked to cultural trauma. Further, I believe we have the tools to do the work of analyzing the symptoms and intrapsychic manifestations that are traceable to historical and/or current crimes of humanity. However, major psychoanalytic organizations in the United States and around the world do not in general embrace crimes against humanity as a principal focus of attention for discovery of their intrapsychic impact and damaging effects on lives our patients live. We are not so focused, even though psychoanalysis is a radical and progressive discipline, meaning that it aims to upset the status quo in order to make room for transformative progress in personal functioning. Rather, psychoanalysts have refrained from articulating our theories and practices in terms of their applicability to cultural trauma. Nowhere in metapsychology, clinical theory, or modes of practice is it writ that any aspect of one's life experience is not to be examined, or is to be relegated to being merely social and therefore not psychoanalytic. As we all know, and Michael Moskowitz (1996) has so beautifully written, psychoanalysis is "our only comprehensive theory of human liberation" (p. 41).

More recently, the same spirited and hopeful view of what psychoanalysis can and needs to offer was captured by Aisenstein (2007), who, in writing about therapeutic action, said,

> *Analysis is uncompromising in relation to other therapies because it, … other than bringing relief from a symptom, aims at aiding our patients to become, or to become again, the principal agents in their own history and thought. Am I too bold in insisting that this is the sole inalienable freedom a human being possesses? (p. 1460)*

Why, then, do we as a discipline give insufficient attention to the social and cultural factors that do grave harm to our patients? First, becoming an analyst does not eliminate the powerful, and I think universal, human tendency to rid ourselves of uncomfortable, inconvenient, and extremely destructive cultural realities of which the Holocaust is a prime example. In regard to

the Holocaust, institutional silence has been profound, as is illustrated by Kuriloff (2014) in her recent book. She has provided an authoritative, compelling account of how analyst émigrés from Nazi Germany and Vienna were psychically impacted and injured by Nazism, and how those injuries were never fully acknowledged by Freud and many other leading psychoanalytic figures of that time. Rather, they were silent about those impacts. The silence was rationalized on the grounds that revelations about the Holocaust horrors would constitute undue subjectivity. It was thought that such subjectivity would interfere with the objectivity necessary for the positivist view of science to which they adhered. But in today's psychoanalytic world, subjectivity is taken as a necessary given in practice. In retrospect, citing subjectivity as a reason not to be open to the wounds of the Holocaust in psychoanalysts and their patients seems strained at best.

It is important to note that the Holocaust is just one example in the history and present state of psychoanalysis showing persistent, witting, or unwitting inattention to important sociocultural issues. For example, Ramos (2012) noted a Fascist-leaning brand of institutional psychoanalysis in Italy, which was prevalent in the first half of the 20th century. It has been documented that analysts were involved in torture in South America (Loewenberg & Thompson, 2011). Wallerstein (2014) discussed this situation and its long-term corrosive effects on organized psychoanalysis in Brazil. He pointed out that the Brazilian Psychoanalytic Association was torn asunder in the years after the military junta's rule of the 1970s by having been in cahoots with the military junta to protect a torturer during the junta's rule. So, in addition to silence about the Holocaust, psychoanalysis has also shown antidemocratic leanings, including some instances of collusion with the perpetration of cultural trauma. Apropos the persistent silence of psychoanalysis about cultural atrocities, Peskin (2012) noted,

> *The scant or doubtful attention to victimization in orthodox psychoanalytic theory, where the late introduction of the destructive instinct favored analysis of the predator, has only underscored the victim's anonymity—a conspicuous short-coming in our time of genocide and crimes against humanity. (p. 190)*

Peskin's point of view is illustrated in the lack of systematic attention in psychoanalytic theory and practice to current-day cultural traumas. In particular I have found that psychoanalysis turns a blind eye to the psychodynamic meanings of being Black in America: The psychologically damaging effects of slavery and its sequels on Blacks and Whites (post-Reconstruction decimation of rights; Jim Crow and its ugly truths, including lynchings; and current-day mass incarceration of Black men) are not typically recognized by psychoanalysts as needing conceptualization and clinical attention. Other cultural traumas are also set aside—dissociated, if you will—by psychoanalysts, for example, the mass forced movement (The Trail of Tears) and massacres of American Indians and the retraumatization of returning veterans of the Vietnam, Iraq, and Afghanistan wars by denying them needed and deserved services.

What are the implications for organized psychoanalysis of the dissociated cultural traumas noted so far? Keeping in mind that there are documented instances in which psychoanalysts have identified with the perpetrators of cultural trauma (e.g., the Brazilian and Italian examples just given), we have to consider the pull on psychoanalysis of dominant cultural trends, even when they are adverse to our transformative, liberating ideals. In that vein, to this day psychoanalytic institutes around the world seem inclined to organize as authoritarian structures and thus framed, to debate endlessly and unresolvedly from extreme "right" and left" authoritarian positions. Such authoritarianism leads to strangleholds being placed on the free thinking necessary to formulate

and to work toward resolution of complex issues, of which cultural trauma is one. Psychoanalysis has limited free thinking in its guild-like professional organizations and educational institutions. This fact leaves the disciple ill-prepared to formulate and promulgate position statements regarding the need to focus on cultural trauma—in terms of larger organizational and institute policies, teaching, supervision, practice, and research.

Whenever we have pains we do not bear to face, we find ways to dispose of them. Institutionally, psychoanalysis has used dissociation, rationalization, silence, and rigid authoritarian organizational structures to limit dissenting voices. We have also used projection and projective identification. For example, I believe that the long and fractious debate over who was suitable to be trained as psychoanalysts fits the frame of projective identification. For years, aspiring analysts from disciplines other than medicine had to submit to a waiver process, meaning that the valorized requirement of medical training would be waived. Many waiver applicants viewed the process as demeaning; as establishing them as second class; and as constraining how they would identify as psychoanalysts, in that the process required that the applicant be strategically placed as an administrator or educator, and more oriented to research than practice. These were additional "qualifications" that physicians did not have to possess. So, at once, waiver applicants felt treated as second class and yet were required to have more qualifications than physicians. The process was confusing and at times discombobulating; ultimately the waiver system was dismantled by force of a lawsuit (Wallerstein, 1998). During the waiver period that lasted to the late 20th century, waiver applicants felt treated as society in general treated Blacks, the LGBT community, and women—as containers for the demons that the dominant groups did not dare to face. In such a paradigm, the demonized groups are related to passionately, but often with contempt and reproach, to wit, the applicability of projective identification. Was the waiver system still another example of the psychoanalytic discipline's entrenched tendency not to embrace "the other" but rather to dissociate the other and to projectively identify into it the discipline's own feelings of unworthiness in relation to multiple past failings toward other groups?

THE DIFFICULTY OF WORKING CLINICALLY WITH CULTURAL TRAUMA

The psychoanalytic work on cultural trauma is difficult and lonely. It is difficult because of the multiple layers of it in and for the patient. Any patient who suffers cultural trauma has internal psychic pain, symptoms, and in a high number of cases somatic problems from the trauma and from the society that allowed or maybe even promoted and imposed it, and then protects itself from any responsibility for the trauma. Another layer of pain is the likely silence within families related to the trauma. Most cultural traumas have multigenerational contributions, also silenced, and thereby expressed in inchoate ways with difficult-to-access, important aspects that are encoded in implicit memory. So the work is made challenging by the silence across generations, the societal disavowal of the trauma, and frail hope for mastery based on few good-enough objects of identification for open expression of trauma-related pain within a family traumatized over generations. Additionally, there are the contributions to the challenge from the therapist's side—with his or her own trauma history, and with the difficulties related to training and institutional support already noted in this paper. Yet, as previously noted, there are now many case examples of good efforts made to do psychoanalytic work on patients' cultural traumas. From my own practice, I now offer two brief vignettes to show how these issues may come up in a treatment and then a longer case presentation of the vicissitudes of doing such work.

CLINICAL SNAPSHOTS OF CULTURAL TRAUMA

Mr. Jones

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The patient was an African American man in his early 30s; he was a civil engineer. He grew up on a farm in the Jim Crow South. In his young adult years, he moved to and settled in the northeast, where his treatment with me occurred. While his move was decades after the Great Migration, it was done in that spirit to pursue better educational and occupational opportunities. He sought analytic treatment with me, an African American analyst, for depression and for some minor but patterned ethical infractions at work in which he did not return to clients small overpayments they were due once his company completed their work and reconciled their accounts. He thought the work-related problem was just due to his carelessness, for which he was being monitored at work. He insisted on waiting 3 months to see me because "you are the only one who can help me." When the treatment started, however, he did not want to pay anything out of pocket. "Just the insurance should be enough," he said. Given his apparent idealization of me, this near refusal to be fully financially responsible for his treatment at first took me aback. However, my acceptance of his feelings about the fee accompanied by an invitation that we be open to what we could discover about his feelings led to the understanding that I owed him something (symbolized in the out-of-pocket part of the fee). He came to see that he likened me to his grandmother, inasmuch as he held her responsible for the shooting death of his father. He was certain that his grandmother knew, or should have known, that the husband of his father's paramour was home when my patient's father went to visit her and was shot dead by his paramour's irate husband. He also idealized this same grandmother, even as he felt cheated by her. She was a wise matron greatly respected in their racist environment for getting along with Whites and Blacks and for holding down racial tensions. Yet "she couldn't save my father." He came to realize that he was trying to hold me responsible by limiting my fee, as he was also doing at work by repeatedly not returning to clients refunds they were due. The linkage of his attempt to cheat me of his out-of-pocket part of my fee to his work situation and to his grandmother was open for exploration early in treatment. The insight he gained enabled him to be able to negotiate with me an out-of-pocket contribution to his fee, which increased substantially over the course of the treatment. This was specific to his transference to me of his experience of having felt cheated by the grandmother, and it was also linked to his transference onto me of the racist South, which he experienced as having cheated him of basic human freedoms. Once these factors were understood and worked through, he no longer needed to hold the fee hostage to them.

Not all culturally relevant material arises early in a treatment. However, it is important to aspire to being open to surprise expressions of such material whenever it arises. Later in this man's treatment a deeper dimension of his concern about being cheated came to the fore, with highly specific cultural meanings. When he observed a White man leaving my suite as he was arriving, discerning correctly that the White man was my previous patient, he angrily demanded to know, "Why do you fraternize with the enemy?!" I chose to address the strength of his anger, asking him if we could make use of it to understand better what went into it. What unfolded, over several sessions, was his view of Whites as cheaters, including in the Jim Crow South where he grew up, and where by cultural practice Jim Crow was enforced with violence as needed, Blacks were cheated of freedom of expression, of freedom to choose where to eat, what

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water to drink, and of the vote. So, his not wanting to pay me was in part an identification with the racist aggressor by whom he had felt cheated. It is reasonable in retrospect to consider that the racist White aggressor, while true to his growing-up experiences, could also have served in effigy for himself and/or me as the aggressor. That possibility did not emerge, and was not considered by me, during the treatment.

Mrs. Stein

This patient is a 70-year-old Jewish widow. She grew up "dirt poor" in a large city in the Northwest. She consulted me because of panic attacks that occurred in relation to her relocation to a Southern city to be near friends. She remembered herself as having always been anxious. Separating from her mother to go to school was always difficult. Her grandparents were Holocaust survivors. She described everybody in the family as tense and anxious, but loving. Both of her parents worked long hours to make ends meet. She experienced her mother's absences to go to work as abandonment. She grew up doubting that she could ever fully take care of herself. She reported that the Holocaust was never discussed in her family. She married early and had three children. Her husband was a schoolteacher and was, like the patient, emotionally vulnerable and needy. Several years into their marriage he became addicted to recreational drugs and had an affair. Without any awareness that my Blackness was significant in her relationship to me, she described her husband's affair, thus: "He had a baby with a Black woman who had no class; she was an addict and a drifter, a slut." The patient seemed totally split off from any awareness that her husband's behavior was like that of his lover, or what she might attribute to me given that I, like the lover, am Black. I told her that I hoped I could show her that I would be open to whatever she might think or feel at any point about me as a Black woman, given that another Black woman had been part of a very painful chapter in her life. She looked at me blankly. As her 2 years of treatment with me progressed, she could slowly tolerate becoming more aware of me as a person. It turned out that my being a woman was more important in her growth in therapy than that I was a *Black* woman. She perceived and used me as a strong woman who could help her gain strength to live in her world without so much anxiety. Building on my perceived strength, and gradually developing her own, she could access fears of abandonment, which she gradually was able to meaningfully link to her family's anxiety-drenched experiences, some of which she came to link to the Holocaust, which had gone unexamined across three generations, and were passed to her. For Mr. Smith and Mrs. Stein, I was important in terms of cultural characteristics, more as a Black woman for Mr. Jones and more as a woman for Mrs. Stein. My point here is that different cultural factors have different weights in different treatments, and at different points in a treatment, in terms of their relevance and impact in each person's character and in the treatment process. That said, a cultural factor not in evidence at a given time or in a given treatment may be being defended against. The therapist is obliged to consider the variety of possibilities.

Before proceeding to a more detailed case presentation, it is important to say that as a psychoanalytic practitioner, teacher, supervisor, and scholar, most of whose scholarship has been on cultural factors, I regularly need to rethink these issues. It is necessary to do so, even though I have been a psychoanalyst in the making for 38 years. My own experience in learning about cultural factors and cultural history has been quite mixed. It started with a traumatic experience in which, in a graduate school environment that was all White except

for me, my first therapy supervisor, who was the most esteemed supervisor in my program, told me that he did not know anything about mixed-race treatment dyads. He advised that I would need to talk to someone else if anything racial came up. It is this kind of dismissal of the subject that contributes to how lonely the work on cultural factors can be. That my revered supervisor did not know anything about how to address race in psychotherapy abruptly disrupted my idealization of him, but I think I could have tolerated that disruption. That he told me to go elsewhere was devastating, but also made that experience and the topic of race in treatment a career-long focus. At the time of the supervisory rupture, my reaction to it was more at an experiential than thoughtful level (hurt, dismay, confusion, disappointment, fear). Over the many years since, I have wished that each of us had been able to engage the challenge better, including recognition of what it meant to each of us to be in a Black–White supervisory dyad. I certainly had not experienced such an arrangement before. Had he? Both of us kept silent in that racially loaded situation. Since then, I have learned to speak up and have encouraged colleagues, students, and supervisors to do the same regarding cultural factors in teaching, supervisory, and practice situations. It taught me that one can learn from traumatic rejection over time, given other healing experiences. Following that early setback, I was fortunate enough to have numerous supervisors along the way, and two psychoanalysts of my own, who supported me and helped me understand race and other cultural factors. Those affirming experiences were very important in my personal and professional development given the slow pace at which psychology and psychoanalysis have embraced these topics in a deep and penetrating way.

I also think that work on cultural factors and trauma is difficult because of the aggression such work unleashes. Institutional psychoanalysis, in largely dissociating from cultural trauma as a primary focus, does not acknowledge this challenge. I have utilized other aspects of psychoanalytic thinking, though, to enlighten and fortify myself for such work. For example, Bird (1972) wrote a compelling paper on how psychoanalysts do not fully address aggression as it comes up in the transference and as it may lurk beneath a positive working alliance. His paper gave encouragement and good example of how to engage aggression in psychoanalytic work. Paul Gray's (1994) view of defense analysis includes that aggression must be analyzed as a precursor to the patient being able to access and trust a capacity to love, lest aggression threaten to destroy the love and the love object. I have been able to use his point of view as scaffolding for working with cultural trauma in the consultation room. By scaffolding I mean two things: First, the fact that Gray had an articulated point of view about the importance of analyzing aggression, by analyzing defenses against it, made the prospect of doing so less scary. Second, in my experience, using Gray's approach to analyze defenses against aggression strengthens the ego, that is, builds scaffolding for it, making the awareness and articulation of aggression more possible. For me this scaffolding is particularly important in working with cultural traumas, because in my experience they carry a heavy load of intense aggression that is defended against. Theories such as Bird's and Gray's that address the defenses against aggression, and the necessity and methods for working with the defenses and aggression, are particularly helpful in working with cultural trauma.

Mr. Smith

This vignette is taken from the twice-weekly exploratory psychotherapy of a White man who, when he first consulted me, was a 37-year-old corporate computer scientist, married, and the father of two boys, ages six and three. What follows is largely taken from my report on this

patient in another publication (Holmes, 2016b). Mr. Smith grew up in a large Southern city in the 1970s. He was cared for by a Black nanny for much of his remembered childhood. He came to treatment having suffered several years of low-grade depression and what he called procrastination. Those features intensified shortly before he consulted me following a freak accident that resulted in his toddler son having fallen from his car seat, without injury, as the patient was trying to take him out of it. A similar occurrence had happened several years before, with his oldest child who was mounted on the patient's shoulders, holding on to his father with one hand and playing with a toy with the other. The patient became aware that something began to fall, perhaps the toy; the patient got discombobulated, let go, and his son fell on his head and suffered a concussion. The patient was mortified in both instances. It was my assessment that both instances with his sons were accidents devoid of hostile intent toward his sons; rather, both instances seemed to reflect his lack of agency and efficacy, about

which he had no understanding at the beginning of treatment. He came across as a ponderous, obsessive, but appealingly gentle man with whom I felt empathy regarding his sadness and sense of weakness and powerlessness, even as in so many ways he was a strong, successful, professional man. I think my empathy was in part based on a sense of him as having, somehow, been disempowered from his dignity. Rather than being filled with a sense of his own prowess and confidence, he acted as if he were puny and nearly worthless in contrast to the protective father he wanted to be. The essence of racism includes the motivation to prevent Blacks from expressing their powerful, efficacious, and dignified selves. Knowing that dehumanizing pressure from my own experiences living in a racist society, I empathized with my patient.

The patient's tendency to get discombobulated came to be understood in ordinary clinical terms and from the vantage point of race. In ordinary terms, it was understood as an identification with a passive, ineffective father and a mother who devalued the father and who herself could not put things together very well. She often hinted to her son that there were more important pieces to the family's puzzle than she wanted to or knew how to share. The patient discovered one of those pieces. Namely, contrary to common family belief, my patient was not his mother's first pregnancy. His mother had had an aborted pregnancy prior to marriage, which he deduced from a close examination of his birth certificate. He never asked her about that fact, saying that he knew the door would be shut to such an inquiry. Perhaps he also did not ask her because of personal pain he experienced in relation to the true family history of his mother having had a disavowed pregnancy before her pregnancy with him. In keeping silent, he secreted his own personal trauma of finding out that he was not his mother's first pregnancy, and he joined her disavowal of an important historical event. For the purposes of this paper, it is important to point out that the family dynamics and cultural history just outlined resided in the patient in terms of a feelings of weakness and lack of efficacy, much as he experienced his father, and his father presented himself and was portrayed by his mother.

The reader may be curious as to how this Southern White man chose me, a Black female psychoanalyst, as his therapist. In stating why he consulted me, he eschewed any cultural/dynamic factor as being important in his decision to consult me, such as a need to refind the Black nanny. Rather, he referred only to my "good reputation" among his referral sources. Nevertheless, important connections to race and social class emerged in the treatment in important ways. *I hope the vignette to follow convinces the reader that it is important for the therapist to be open to possible racial, gender, and class factors in all cases*, recognizing that

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their importance may unfold later rather than sooner in a treatment. In this case, those factors unfolded thus:

As the patient became more trusting in the treatment relationship, in about its sixth month, he began to be able to associate more freely, without fear of an unfortunate accident or disturbing realization. This greater freedom in his mind and trust in our relationship led to an exploration of his difficulties based on race. He told me for the first time that his younger sister by three years was married to an African American man and that they were about to have their first child. He said that his parents disapproved of that marriage. When asked about his own feelings, he said, with some unease, that he was not entirely comfortable himself with his sister's choice of a mate but that he knew he was being irrational and felt ashamed about his feelings about Black people. I asked him what those feelings were. He said he thought of Blacks as powerless, poor, and undesirable. It is important to note here how the patient's racism formed along the fault line central to this paper, that is, with the intention to strip the Black person of dignity. He quickly countered that he knew that was not accurate as a generalization about any group, and especially that his sister's husband was as prosperous and well educated as anyone in his own family. He noted that he also had Black colleagues in high-status positions like his own. He then looked at me very intently, and with a wry smile he said, "and so far, I have not found you deficient." He added, "Alas, I still feel that way about Blacks in general." My own countertransference to this revelation was mixed—I was relieved for the moment to be spared his wrath, but I also experienced some signal anxiety. I knew that the general feeling toward Blacks would become particular to me, if the treatment was to progress. So, I looked forward to that development, but as a Black woman whose blackness was beginning to come more into focus for Mr. Smith, I also felt a sense of danger that I think is inescapable when anger and race are comingled, given that it is a social and for many deeply personal historical and present fact that White anger toward Blacks is often expressed violently. While I knew rationally that Mr. Smith would not perpetrate violence against me, still that scenario was impossible to exclude as a mental representation for me as a Black woman very fully and proudly self-identified as Black. I think that Mr. Smith and I intuited the subjective dangers of our racial difference with his claimed White privilege.

Because I was able to become consciously aware of the tensions just noted, I was able to encourage my patient to continue to be as openly curious as possible about his puzzling discrepancies regarding Blacks—discrepancies among what he felt, what he knew, and what he had personally experienced—so that we could resolve the discrepancies. With this encouragement my patient became very emotional, shedding what seemed to be tears of relief, sadness, and hope. In that period of work he also mentioned for the first time his African American caretaker who had taken care of him from kindergarten through most of elementary school. Mary, as I will call her, was first remembered warmly and as greatly influential in his life, as one who, unlike his mother, answered his questions about feelings. He particularly remembered that he exclaimed to Mary how much he hated girls, and particularly his sister. Calmly, she partially allowed him his feelings, telling him it was okay to not like girls but that he had to love family and that she'd see him at his wedding. In re-experiencing his idealizing and deeply affectionate feelings for Mary, he recalled her as a principled, strong, and dignified woman. Erotic feelings toward Mary and me in the transference began to emerge, which made him anxious and guilty. His discomfort in sharing such feelings was relieved when in a sudden associative shift, he began to speak excitedly about a favorite young, White woman teacher. Thereby, she became a convenient displacement away

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from erotic feelings for Mary and/or me. He resisted understanding the displacement, given the internalized dangers of having erotic feelings for Black women. He protested that neither Mary nor I could have any deep or lasting meaning to him. After all, we were Black, and Mary was a working-class servant. Mary and I became one, and given our low place in society, both in terms of race and class, we could not possibly have power and authority in his eyes or be particularly attractive to him.

This treatment vignette is chock full of meanings. It shows how racial and class issues can emerge quickly, strongly, and obdurately and become an integral part of a psychodynamic treatment, and that by experiencing and processing their transference and countertransference manifestations, therapist and patient can gain access to underlying feelings, issues of dignity, conflict, and underpinnings of same in prior generations. However, the barriers to such work can be built quickly if what is discovered is threatening. In my patient's case, he was threatened by erotic feelings, especially for a Black woman of his past and for me in the transference. As long as the erotic aspects were not conscious, my patient could empathize with and idealize Mary as the dignified and principled person he experienced her to be, and with whom he longed to identify. Mary empathized with the patient around his angry feelings toward girls, but that empathy was eclipsed. As she said to him, you have to love family. I propose to you that Mary's restriction on whom he could hate was in part a projection of her feelings of self-protectiveness and internalized racism, perhaps deriving from one of the pressures of being Black in a racist society, as I elaborate next.

Being hateful as a reaction to being on the receiving end of the hatred inherent in racism feels dangerous for Blacks, especially aimed toward one's own kin. Its dangers include an intensification of what comes one's way from being othered. In being racially othered as a Black person, you are disallowed meaningful expressions of power. To hate is such a power. As a Black person, punishments for such expressions are redoubled and, like other intrapsychic mechanisms, often get extensively generalized. Thus, Mary cautioned her young charge, my patient, that he must not acknowledge or express his hateful feelings in his family. How did I think about and try to work with my patient in terms of race and class? My job in part was to become an even more emboldened Mary, one who did not hasten him to set aside his strongest hostilities, even when they were felt toward his sister. Similarly, tolerance was encouraged when such urges were felt toward displaced objects such as me and Mary once he stripped us of feared retaliative potential by making us powerless and lacking in enduring value and authority. Considerable work was done around his need to protect himself from the hatreds reawakened in the treatment, including the racial ones focused on Mary and me. He was able to see that in part his casting of Mary and me as powerless Black women was a projection into us of the powerlessness he felt, which derived from his weak and devalued internalized parents. He was also derisive toward Mary on account of her being working class, which in his mind stood for moral inferiority. We were able to trace that use of Mary to his own inner feelings of being tainted by having been spawned by a mother who had, in his estimation, shown herself to be lower class and unworthy by becoming pregnant out of wedlock. According to the patient, that fact was the family's "dirty secret."

The patient's aspersions toward the lower class were not fully developed in the treatment in part due to the fact that they arose more vividly near the end of his treatment. Another contribution to that aspect being less developed was my own countertransference limitations in that area. I resisted allowing full use of myself as the impoverished, lower class morally

deficient Mary and mother in the transference. In retrospect, I realize that as regards class, with this patient I wished to cling to a privileged status. In his treatment, this overidentification with privilege was my countertransference vulnerability, which stems from my own personal history of course, and from how psychoanalysis, as the professional place in which I grew up, also clings to privilege in the form of capitalism. Oxford University Press Scholarship Online (2015), in its presentation of Damousi's and Plotkin's (2012) edited book on psychoanalysis and politics, summarized Zaretsky's chapter in that book. Specifically, in their Preview to Zaretsky's chapter, they state that Zaretsy's point is that "American debates over psychoanalysis transformed the notions of authority to maintain as well as to buttress the hegemony of the capitalist class." Had I been more aware of my attraction to the capitalist class in the work with this particular patient, I may have been able to help him recognize more fully the psychodynamics of his need to focus on the poverty of Blacks. Specifically, I believe that need was based on his own disavowed identification with his mother's dark, dirty secret of having become pregnant out of wedlock and on his own dark secret view of himself as a lower class child abuser, given the two accidents with his sons. Had I been more open to his transference of my being the impoverished, lower class person with whom he associated child abuse and pregnancy out of wedlock, he and I may have been able to have rich transference–countertransference interactions that would have gained him insight into this aspect of his dynamics.

I hope that this vignette shows what is possible in terms of working psychodynamically with the cultural factors of race and class that contain elements of trauma and that the vignette shows what is difficult in doing such work in terms of transference and countertransference manifestations. This case example is offered against the backdrop of what the field of psychoanalysis does and does not offer for such work, and how what we do and do not get from living in and being trained as psychoanalysts in our respective cultures is internalized within us. It is my view that the relative ease and/or difficulties in working with cultural factors, including trauma, in treatment derives from the particular dynamics of the participants in the dyad, including the cultural dynamics: We each live in our cultures, which in turn live within us. In addition, how the work goes may be constrained by the silencing general societal and psychoanalytic institutional limitations identified in this paper. To the extent that the work can be done, much may be gained for the patient personally and in relation to the world around him. Specifically, in this case, I think the patient, a White man, rediscovered his more conflict-free love of Mary, a Black woman. The work allowed for his and her dignity to be restored, and his malignant tendency toward othering (of Mary and of me in the transference) was reduced. (I consider the impact of racism on dignity more fully in a recent publication; Holmes, 2016a). Of course, we think of our work in our consultation rooms in largely clinical terms. However, one point of this paper is to show that the cultures we live in also course through us, and are represented in our psyches side by side with the clinical foci that are more familiar to us. So, in the consultation room, we do sometimes have access to cultural factors and can have a healing effect on them, as happened in the case of Mr. Smith, in the sense that treatment helped him to resolve his cultural and intrapsychic tendency to other his nanny, and thereby to restore the love he had for her. Specifically, it was important for my patient to achieve understanding of his various uses of Mary, and of her influences on him. It was particularly important for him to unpack how he had relied self-protectively but damagingly on her warning that he not be angry at family. In that working-through process, my patient reclaimed and worked through his own anger, which, through

owning and taming it, he no longer needed to use it "to other" those racially different from himself, and his resolved anger became a building block in the awakening and consolidation of his own efficacy and dignity.

CONCLUSION

This paper has considered three contributions to the still too scant representation of cultural trauma in psychoanalytic thinking and clinical work. The three contributions to this insufficiency are as follows: (a) Psychoanalysts still maintain individual and institutional identifications with the silence established and promulgated by the founders of psychoanalysis; (b) psychoanalytic institutions maintain defenses against embracing these factors—the defenses include dissociation and projective identification, and (c) it is difficult to work clinically with cultural trauma because of the first two factors just summarized and because most cultures continue to perpetrate and condone crimes against humanity. On all of these accounts, patients, practitioners, teachers, and scholars are handicapped in addressing cultural factors. In our patients and sometimes in their therapists, these issues are sequestered in primal defenses and somatic symptoms. Still, more and more, the sleeping dogs of cultural trauma are awakening. In that more promising light, this paper invites fresh and wide attention to the subject. It also presents some clinical vignettes to illustrate ways of engaging the subject, with reflection and critique to show the possibilities and challenges of doing so.

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