

Racism and Similarity: Paranoid-Schizoid Structures

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SUMMARY. This paper attempts to examine the importance of exploring and interpreting in the transference the unconscious dynamics of racism as present in psychotherapeutic work; in particular, the primitive defences employed against the unfolding of racist feelings when therapist and patient are from different racial groupings. In this specific context, unless these feelings can be brought into light via transference interpretations, the therapist/patient relationship becomes stuck and very little growth can take place.

Introduction

In 'Race and transference in psychoanalysis and psychotherapy', Dorothy Evans Holmes, an American psychoanalyst, writes (1992, p. 1):

Several issues have been suggested to account for the frequently observed tendency to not fully interpret intrapsychic conflicts in the face of racial explanations offered by therapy patients. These issues include white therapist guilt, black therapist over-identification with the down-trodden (a particular form of countertransference problem), and warded-off aggression in patients and therapists. These limitations in therapy intervention have occurred when the patient explains a problem in its racial aspects alone, and the therapist does not seek ways to expand the patient's understanding once the racial component has been acknowledged.

This paper attempts to look at defences employed by patients which make it very difficult for therapists to focus on the transference relationship. In particular, it concentrates on the use of similarity as a defence against the painful feelings of difference.

Racism is an inability to accept and acknowledge difference without attempting to control and dominate the object that is felt to be different and separate. The control and domination aim to re-enforce the phantasy that the quality of separateness does not exist. To put it another way, the object is perceived to be similar, leading to a distorted omnipotent feeling of similarity. The creation of similarity in this way is based on infantile phantasies of introjective controlling of the object as well as projective identification with it (Klein 1946, Bion 1959, 1962). Because this is such a primitive and omnipotent infantile level of functioning, development is often obstructed in this area.

If these defences are successful in their employment, the difference is destroyed and there is no dis-similarity. It is almost the form of a disturbance resting on primitive defences of the paranoid schizoid position. This is so often seen in racial conflicts when clear rational thinking becomes impossible, and extreme hatred and violence are used in an attempt to wipe out any source of difference. Difference serves as a constant reminder of the painful early infantile experience of impending loss of the 'good breast', which for some infants is unbearable. In this sense, the source of difference has

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to be denigrated, perhaps annihilated, or made similar, in order to control the threat of painful acknowledgement of dependency needs.

In the clinical setting, the awareness of the difference between therapist and patient has then to be brought about and worked through so that progress can begin to be made. Where therapist and patient are from different racial backgrounds, the bringing about of this difference becomes crucial as cultural and racial differences are such fertile and receptive areas for projections.

Psychotherapy is about human relationships and as such both patient and therapist bring with them their own prejudices from their respective cultures, each unconsciously responding to the other in ways which could affect the outcome of the therapy. As a person from another culture living and working in a predominantly white/English society, I more often than not have to negotiate myself through the maze of covert and sometimes overt prejudices and discriminations of a white society. The experience of these prejudices, which may be real or imagined via projection or projective identification, leads to an inability to assess the situation realistically. An ability to contain and make sense of these feelings away from the immediacy of anxieties is essential to rational functioning. This is even more so when faced with racist feelings from patients. It is not easy, however, to get away from the immediate pressure of racist material from patients so as to be able to think with clarity. It is not a luxury afforded to the therapist faced with such infantile/primitive functioning when everything is felt to be immediate and concrete.

As a psychotherapist working here, I have to face this situation in the clinical setting in almost every case, whether the patient is from the indigenous population or from one of the many ethnic communities living here. Unlike the external world, the prejudices of the patients have to be explored as they are the very defences which prevent the patient from benefiting from treatment. There is an added dimension in that sometimes I do not get the opportunity to work with this area of conflict with patients, as I am rejected out of hand by the patient because I am both foreign and not white, making it possible for the prospective patient to cling to these defences. The reason most often given is that, due to the sensitive and intimate nature of the treatment, a therapist from another culture could not/might not be able to understand the patient's feelings. Although we can grant a limited validity to this claim, there is also a fundamental problem which lies in the inappropriate attitude to differences. The issues arising out of this single act of rejection are boundless for the therapist-to-be. I would therefore stress the importance of the transference in this context from the beginning of contact.

Roland Littlewood in his paper 'Towards an inter-cultural psychotherapy' writes (1988, p. 16):

As a White I am frequently approached by White patients who in the past have had a Black therapist or doctor, and who immediately told me how good it is that I am White, that I thereby had the ability and the knowledge to help them. They are puzzled by my returning to the assumption, which they see as tacit, but which I see as one aspect of their current inability to deal with their problems, whilst they see the past therapy and the Black therapist as a transient difficulty now passed.

I think that what Littlewood is referring to is the problem of identification which operates by creating similarity to the object. In *A Dictionary of Kleinian Thought*, Hinshelwood writes of identification (1989, pp. 315-316):

Identification concerns the relating to an object on the basis of perceived similarities with the ego. ... The simple recognition of a similarity with some other external object that is recognized as having its own existence is a sophisticated achievement. At the primitive level of phantasy, objects that are similar are regarded as the same, and this omnipotent form of phantasy gives rise to a confusion between self and object.... These primitive processes occurring very early in development when there is little distinction between activity, phantasy and reality. Phantasy 'is' reality, and phantasy constructs the reality of the internal world on the basis of these primitive forms of introjective and projective identifications.

This is at the root of making racist feelings an issue in the therapeutic process where both therapist and patient are from the same racial grouping. The assumed similarity is based on perceived reality, especially so when the therapist may be having countertransference feelings in this area of the patient's pathology. The white patients to which Littlewood refers may not have been referred to suitable black/foreign therapists who were aware of these racial difficulties. Any assessment had probably ignored this possible problematic transference. All this emphasises the importance of race awareness if the patient seeking help for his psychological difficulties is to be fairly and appropriately served. Inappropriate referrals in this context could amount to exploitation of the patient arising from the assessor's ignorance - at worse a disregard for significant aspects of the patient.

This paper then is about the primary problem of the disposal of differences. Whilst differences cover a host of situations including that of gender and class between therapist and patient, I believe racial difference is the latest addition, given that we now live in a multi-racial society. Racial difference in the transference is an essential tool to be taken up and made use of in the resolution of the patient's emotional conflicts, a tool to be used via transference interpretations.

This paper puts forward three main points:

- (1) Unconscious racist feelings exist especially when therapist and patient are from different racial backgrounds.
- (2) Racism is a defence against growth in the therapeutic relationship, and it is lodged at a primitive (infantile) level of the paranoid-schizoid position.
- (3) It is imperative that racist feelings are interpreted in the transference.

I will try to show how racist attitudes and feelings are present and brought into the therapeutic relationship and, secondly, when transference interpretations are made, how the transference is deepened in the service of a working through of the patient's problems.

I would add that I think historical implications of colonisation are influential in shaping the minds of both parties, particularly those of the colonised people. I feel that historical influences help to crystallise a distorted sense of superiority on the one hand, and inferiority and persecutory anxieties on the other. Because this paper focuses on racism as a defence against growth, the clinical material presented is necessarily selective to illustrate the points I am making. Other ramifications of defences present are therefore not taken up here.

Clinical Material

Patient A

Patient A is a white community worker whose work brings him in constant contact with members of the Asian community. He places emphasis on being a racially aware

person and would readily speak up in defence of the rights of the ethnic minorities in this country. He has a brother who lives in the country, to whom he very often refers as having provincial values and whom he sees as rather ignorant in blaming the immigrants as being responsible for his unemployment, and the decline of English values generally. Indeed his whole family maintains this attitude which he himself despises. He presented for treatment because he was having difficulties in his relationship with his girlfriend who was on the point of leaving him.

He feels however that, as a therapist, I must be just as racially aware and openminded as he is and that the obvious racial difference between us is not an issue. His coming to me, a foreign and non-white therapist for treatment, gives him a sense of validity for the job that he does and reinforces his denial of any racial feelings in him. Also my being in the 'helping profession', as he sees it, allows him to feel somewhat similar to me. These two feelings created for him an ideal space for his projections into me of unwanted parts of himself. This allows him to focus on the idea that we were similarly doing something positive and constructive, thereby denying the devalued and rejected parts of himself which are extremely painful for him. After one of his fairly regular reportings of his day's work with his Asian and black clients in a rather excited way, I said to him that he felt somewhat excited as if we were doing the same thing, and that we were similar. He agreed with surprise and excitement as if this was a new discovery. This theme that we were of 'like minds' (as part of his job, he occasionally ran race awareness groups) and therefore feeling positive in the treatment with me continued for some time.

However, halfway through the second year of treatment the patient started to complain of being stuck in his work and indeed his therapy, and was contemplating stopping therapy as it was 'not doing him any good'. He felt frustrated with his work primarily because he felt that he was made to feel helpless and useless by his clients who had a quite different approach to life, and very often could not really understand his suggestions because of their lack of understanding of the English language and way of life. This complaint paralleled my countertransference feelings as I was feeling extremely frustrated, and made to feel useless by his fairly regular boasting of how aware he was of racial problems and how effective he was in this area of work (Davids 1988). I felt that he was telling me that my 'lack of understanding of the English language' was a reference to my inability to understand his unconscious communication in the transference and was therefore feeling stuck like him with his clients. After gathering my thoughts and feelings together, I was able to show him that he was feeling hostile towards me and that his boasting was in fact an attack to disarm me from doing him any good, and that, furthermore, he was only able to maintain me by feeling superior because I, like his clients, was not white. This reflects the way he dealt with his clients by seeing them with contempt and inferiority, the unbearable painful parts of himself. In particular, it was very difficult for him to accept help from me (who is foreign, inferior and his client in phantasy) as this would make him feel inferior which he found intolerable. The intensity of his feeling in this regard was amplified by my saying to him that he was polite towards me in an 'obsequious' way and, as such, was in fact secreting his contemptuous feelings towards me. This threw him into a state of anxiety because I had used a word which he did not understand, i.e. obsequious. He had often told me of his interest in literature and that he spent his time writing and hoped to be published one day. He had a particular liking and respect for a celebrated English author and his use of words. During these times, I would find myself being

over-cautious with my choice of words, with an overriding feeling of inadequacy and inferiority in the use of the English language. I was surprised, therefore, when he reported to me in the next session that his being unfamiliar with the word had caused him so much shame and anger that he had rushed home to look up the meaning of the word. Furthermore, he had become slightly paranoid by saying that he felt I had chosen a difficult word in the knowledge that he was unlikely to understand and, in this respect, it was an attack on him. At this point it was touch and go as to whether he would be able to carry on with therapy as he felt extremely persecuted and pained by his intense feelings of inadequacy and inferiority. I had caused him to feel insignificant and depressed and these feelings were immediately warded off by paranoid phantasies to enable him to survive. He felt that I was poised to attack him with words which were foreign to him and which increased his paranoia.

My interpretation had made him consciously aware of the difference between us which he could not face. He had, prior to this episode, been engrossed in the struggle for equality between us, and on many occasions expressed the feeling that we were similar - in particular his feeling that we were doing the same kind of work of helping others. The feeling of undifferentiatedness enabled him to ward off any feelings of envy and missing me between sessions and during the holidays. I was not perceived as a separate person/object. The very obvious difference of being from different cultures and its implications for him were omnipotently denied, and I was therefore under his control. This awareness of differences between us gave him the opportunity to acknowledge me as being in possession of some goodness in having the ability to contain his projections without being damaged, either by collapsing into a heap or retaliating with hostility. These were the very anxieties which he experienced within himself. These polarised feelings of omnipotence on the one hand, and total helplessness on the other, prevented him from being able to see that there was perhaps an alternative/middle option both in his actions and his responses to me.

Having somewhat cleared his clouded thinking by using racist feelings as a defence, he now had to face his depressive anxieties. Had he damaged the relationship with me and had he the necessary resources to repair the damage? This became evident when he refused to leave in the last session before the Christmas break. He was very concerned that something would happen to me during the break, that the situation between us would be different and I would not be here for him. He was anxious both about his ability to keep me in his mind, and his hostile feelings of wanting to wipe me out, so as not to have any painful feelings of separation nor experience his immense need of me. The ambivalence was almost unbearable for him. I had to remind him of the date and day of resumption of sessions. On his return, he told me that he was extremely anxious and had sped the 130 miles (he had spent Christmas with his family in the country) to keep his first appointment with me. There are, of course, various implications about his having driven perhaps dangerously to keep his appointment with me, but I will not discuss these here.

Soon after this period, he told me for the first time that the girlfriend he was having difficulties with at the time of coming into therapy (she had by now left him) was in fact from South East Asia. When we discussed this omission on his part, he said he did not think it important to tell me at the time! This omission was partly due to my own lack of awareness of racist feelings (that the patient and I were obviously from different cultures) and was therefore unclear in my own thought processes and feelings in the counter-transference. This awareness has led me to emphasise the very special

transference present from the point of contact when the patient and therapist are from different racial groupings.

Patient B

B is a white European social worker who works in the UK. She often complained that she could not hear me nor understood what I had said to her because of my accent. She herself spoke English with a heavy accent and was not conversant with the use of idiomatic English. She did not hear her own accent when speaking and was therefore surprised, when talking with friends one day, to learn that they had at times found her difficult to listen to. In her own mind, she spoke near-perfect English and felt equal in this respect to her friends and colleagues. She had mentioned on numerous occasions that she had done wonderful assessments and would go on to say that she was taking in a lot from me. She then acknowledged with astonishment that she felt equal to the task at hand and felt somewhat similar to me. In the transference, however, she was secretly feeling superior to me and furthermore was patronising me in coming to see me as her therapist.

This came to light when she told me she had two close black friends, a man and a woman. On one occasion, when she had gone out for a meal with her black man friend, she was feeling vaguely rather special and proud at being seen publicly with a black man, giving the impression that she was a liberated and intelligent white woman. She felt good about being able to portray this 'nice' part of herself. She had always said to me rather proudly that she was able to treat her (non-white) clients with equality and that the terms black and white were only significant in the political sense as if this had no bearing on one's personal life. In her sessions, she had expressed feeling satisfied about having a non-white therapist and yet there was always the struggle for equality as if my words and presence were persecutory to her. On establishing that there was a difference between us as therapist and patient, and as different people from different cultural backgrounds, she was able to acknowledge that she felt ashamed that I had a better command of English than she did. This was primarily because she felt that as a European she should have a closer affinity to the English. Although this may be true in that the European factor gives her a closer cultural link with the English, it is nevertheless an assumption on her part (phantasy) that my being non-European should therefore mean a lesser understanding and command of the language. Her inability to experience a relational difference between us led her to not being able to think and see me and herself clearly. This acknowledgement of difference between us allows for the very painful taking back of the disowned and devalued parts of herself (which hitherto had been constantly projected into me) resulting in a more integrated self. She was then more able to relate to me as a whole person. She was also then able to admit (painfully) that she always had racist feelings without feeling too threatened by them. The working through of this very particular defence enabled her to think and see herself more clearly and she was finally beginning to get in touch with the pain of having abused herself in her relationships, more able to feel positive and constructive about her ambitions. This more positive approach towards herself took the form of her being able to feel more of a sense of who she was; that she was foreign and not some pseudo-English person that she perceived herself to be for a long time. (She had come to England in her early twenties.) The omnipotent denial of the pain and attacks on the maternal introject became more realised, and the anguish of her own infantile needs

from a mother who was quite unable to fulfil her demands became less threatening. She had begun to feel less responsible for her mother's depressive illness, and in the transference I was experienced as less fragile and damaged.

This unfolding of racist feelings led her to speak of her mother's severe depression and how it had affected the patient in her early life. In particular she spoke of painful and angry feelings of being shut out by a mother who could not bear her own depression, causing the patient to experience a sense of deep isolation and loss. She also recalled how, years before coming into therapy, she had got herself almost thrown out by a black friend of hers when, in discussing racism, she had admitted to having racist feelings. She was very anxious that I would be just as racist as she was and, in this way, would be affected by her just like her friend, and like her mother by her own depression.

Patient C

Patient C is an Eurasian in his mid-thirties with a white overbearing and controlling mother and a somewhat weak but rational Asian father who aims to keep the peace in the household at all costs. He presented with extreme anxieties of being attacked by white racist youths, fear of living on his own and of being generally incapacitated. He has held a steady job for some years but has been passed over for promotion yearly and his life revolves around going to work each morning and coming home to his parents' house where he resides, although he has had his own flat for a number of years. In the transference he presented negative narcissistic traits akin to those described by Rosenfeld (1987):

In studying narcissism in some detail it seemed to me essential to differentiate between its libidinal and destructive aspects.... When considering narcissism from the destructive aspect, we find that the self-idealization again plays a central role, but now it is the omnipotent destructive parts of the self that are idealised. They are directed against both any positive libidinal object relationship and any libidinal part of the self which experiences the need for an object and the desire to depend on it.

The patient felt that he could be anything or anyone he wanted to be. At these times he became alive and fairly manic. It was interesting to note that he felt he could be Pavarotti, who is white, or John Barnes, a black footballer. At other times he became totally flat and dead in the sessions. These omnipotent phantasies which he described were most marked after a positive transference interpretation of his need of me which allowed him a fleeting feeling of dependency (Steiner 1979, Klein 1935,1940). He could be totally white or totally black. In being white he was identifying with the Westernised part of me (and the treatment) and would respond with his intellectual and analytical thoughts creating an atmosphere of similarly felt superiority thereby destroying any difference between us. In being black, he was identifying with the foreign me which was felt to be similarly inferior so that we could both wallow in our sense of uselessness and despair. This way of relating in the sessions put me firmly in his control and prevented him from having any sense of experiencing me as having anything which could be beneficial for him as a separate object. Furthermore the extent of his denigration of me were clearly illustrated in his dreams. In one of these, he dreamed of some boat people struggling through heavy seas trying to get to the safety of land. Although he felt sorry for these people, he was nevertheless not involved as a participant in the dream but as a bystander looking at this picture of others' misery and strife. When talking of his

thoughts about the dream he immediately related me to the boat people as I was assumed, correctly, to be from the same part of the world. He also went on to say that really it did not touch him at all as these events happened on the other side of the world (emphasising the split) and did not directly affect his own existence.

I believe the dream described his feelings about me from the bystander's viewpoint. He was unfeeling watching me and my struggles with what he had put into me and my feeling lost as to what to do with this confusion. It was as if he had an unconscious knowledge of my own struggles with my foreignness and the 'mother country' which I had always thought this land to be. The Vietnam war and the killing of babies against a mediaeval backdrop were frequent images in his dreams. In the war dreams I was always portrayed as a 'gook' (as the foreign part of him was felt as vague and ghostlike) and the latter dreams would suggest the primitive nature of his disturbance of a very early infantile nature. In himself he was ambivalent about whether to marry a white or an Asian woman. The former presented him with immense difficulties as he felt that he did not have the social grace to meet a white woman, which is what is felt as good and desired, and the latter was an easy option for this could be arranged by his parents as is the norm within his culture. This denigration of Asian culture as inferior, undesirable and beneath him allows him to feel trapped between 'the foreign bad bits' and 'the white good bits' of himself.

He is particular about being punctual for his sessions and would get extremely distressed when his lateness was caused by unreliable underground transport. On such occasions, he would feel that the whole session was then spoiled, and practically nothing would be associated in these sessions except for a series of agitated violent phantasied attacks on the underground employees, who were perceived as useless, lazy, black immigrants who could not do a simple job of running the trains on time. He could not see that some of the underground workers were white when he was in this mood: 'They should go back to their own country if they were not willing or able to work in a country where the expectations were higher'. One could see from this material how he denigrates the foreign/Asian part of himself and of me thereby feeling not in possession of inner resources to rise up to his aspirations and blaming it for his predicament. In this way, it was as if the good (white) part of himself was held at ransom by the bad/destructive (foreign/black) part, making it a vital necessity for him to make use of splitting processes to survive. With regards to his father he was at times able to acknowledge that he had always given him (the patient) good advice, but he would not 'give in' to his father by taking his advice as this would be tantamount to taking back his split-off foreign/bad bits which would spoil the good white bits in him. In the transference I was seen in the same way. It was through a variation of interpretations regarding his racist feelings towards me, and therefore towards the Asian part of himself and his rubbishing of what he had taken from me in the transference over a period of time, that he came to realise that what I had given him was felt as second-rate - indeed the way he felt about himself. In this way we were felt to be similarly inferior (both being non-whites) and this inferiority and similarity were controlled by his omnipotent attacks and devaluation of my abilities which he desired. This realisation led him to be able to recover some Asian parts of himself which in turn enabled him to acknowledge some modicum of goodness within my possession. He was also able to live in his own flat intermittently. He was beginning to feel a slight sense of depression, a taking back of devalued/inadequate parts of himself, and was more able to reside in my mind with a lessened fear of destroying me.

An Example from a Group Supervision Session

In my supervision group which consisted of white supervisees, a student was presenting for supervision a recent session with a half European, half English woman married to a foreign/non-white man. The woman had some months ago told the student that her husband was planning to return to his country of origin and that she would have to go with him. The implications of this material were not taken up at the time in supervision by me. The student had expressed the feeling that it was not all that serious an issue and the group and myself as supervisor were lulled into this belief. The patient now said that a date was set for them to leave England and that she was ambivalent about the prospect of having to live in this particular foreign country with its stereotyped image of treating women as mere possessions. The student had then voiced her concerns as to how her patient was going to cope with this strange culture and was indeed fearful for her patient's survival. The other members in turn became increasingly concerned for the plight of the student's patient in this respect. How was she going to survive in a country which was so authoritarian and persecutory? The discussion became lightly peppered with racist overtones directed at the husband and his culture. All sense of the ability to think clearly was taken over by the anxiety this case aroused. Neither the group nor myself were able to see at this point how the student herself had been treating her patient as her possession, by focusing on the plight of the patient in this way, and why the patient had chosen to marry this foreign man in the first place, which was now felt to be a problem. The need to rescue her from her predicament became the focus of the group.

For my part, I was in turn treating my supervisee as my possession by being swept along with this trend of thought. It was not until I became aware of the parallel process taking place and pointing this out to the group that the 'spell' was broken (Searles 1955, Caligor 1984, Doehrman 1976).

The group's dependence on me was felt to be persecutory and deskilling, in particular to the student who was presenting. This persecutory anxiety was taken up by the other members of the group and projected into the patient's husband, splitting and externalising this felt persecutory anxiety in an attempt to keep the group together by avoiding the very obvious difference between them and me and its implications for them. I have to mention that the group was fairly new at this stage in that the members had been with a different (white) supervisor before. The fact that I was foreign and not white was difficult to acknowledge. They had also found my emphasis on the transference as central to psychodynamic work difficult to understand and accept and was therefore persecutory. These persecutory anxieties were projected into the patient's husband and the obvious difficulties facing the group were thereby evaded. In this sense, I had become their persecutor and they the victims, just as they felt the woman patient had become the victim of her non-white husband. The two situations had become similar and confused because it was felt that if these differences were explored, the group would disintegrate. The student had identified with her patient to such an extent that she could not separate out the difference between them. In trying to rescue her, she was attempting to avoid losing a training case which was felt as some sort of disintegration within herself. It was this particular aspect of her work with her patient in the transference that was being avoided, as it was for a short while by the group (Mattinson 1975).

Conclusion

It can be seen from the cases above that the path to creating similarity is varied. Both patients A and B tried to achieve similarity through identification and idealisation of the good parts of the therapist via their omnipotence. By contrast, patient C used destructive omnipotence to break down the good parts of the therapist in order to achieve a similar inferiority to prevent any progress from being made. Racism then is an inability to accept and acknowledge difference without attempting to control and dominate the party (object) that is felt to be different and separate. In the atmosphere of racial conflicts, one then has to destroy the difference in order to preserve the survival of the self. The good bits are always under threat of being expelled due to excessive projection, and in the living situation one fears one's quality of life would be eroded due to the presence of a different people. Racism seen in this light is a defence firmly lodged in the paranoid-schizoid position.

I contend that for those who profess not to have racist feelings, there is always present the feeling of uncertainty and ambivalence about another of a different race. These are people who have attained a minimal degree of tolerance of the depressive position.

In my opinion, it is vital that psychoanalytic psychotherapists have the ability to examine their own unconscious feelings and phantasies about racial difference, so as to be less influenced by their own omnipotence and, in turn, by that of the patient. I believe this to be the first obstacle for us to be aware of before any growth can begin to germinate, especially when therapist and patient are from different racial groupings.

I hope I have been able to demonstrate the importance of maintaining and working with the transference in bringing about acknowledgement of difference between therapist and patient, thereby enriching the therapeutic relationship. It is always more comfortable to deny that difference exists. I would like to end with a quote from Davids' paper on this issue (1988):

I also think that we must recognise that we, like our patients, are human and are subject to the same societal pressures to turn a blind eye to uncomfortable aspects of ourselves. In the area of racial difference we are very susceptible to persuasion that 'differences don't matter', i.e. that that they do not have real psychological meaning or impact on our professional work. Of course when we are so persuaded we spare ourselves a painful struggle, something that is both understandable and human. However, in so doing we also undermine our therapeutic efficacy.

ACKNOWLEDGEMENTS

Acknowledgements to Dr Alberto Hahn and M Fakhry Davids for going through the draft with me and making invaluable comments; and to Dr R D Hinshelwood for first bringing awareness of this area of conflict to my mind. Thanks also to M Lodrick.

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