DOROTHY EVANS HOLMES

RACE AND COUNTER-TRANSFERENCE:

TWO "BLIND SPOTS" IN PSYCHOANALYTIC PERCEPTION

The Psychoanalytic Century

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Dorothy Evans Holmes

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Table of Contents

Race and Countertransference: Two "Blind Spots" in Psychoanalytic Perception[1]

In this paper I propose an approach for the evocative use and resolution of racial and countertransferential manifestations in the treatment situation. When addressed with the interest they warrant, these phenomena can become powerful tools for the advancement of the treatment, rather than "blind spots." The therapist's own treatment is offered as the most likely means through which the evocative and pernicious effects of race and countertransference can be mastered.

Responses to race and countertransference reactions encompass complex cognition and emotion; both are likely to have highly conflicted components, and to mobilize defense. It is my position that race—whether in same-or cross-race dyads—and countertransference magnify each other's effects, can interfere with the ego resourcefulness of the therapist, and consequently, can limit the effectiveness of the treatment. These dire effects are not inevitable, however, and in my view, occur only when race and countertransference are not recognized to be the rich sources of therapy enhancing material that they are. What is likely to bar this recognition? In our culture, race continues to be a container for disavowed urges, a vehicle for distorted representations of those urges, and of the racial group onto whom they are cast. While a more open attitude towards countertransference is standard in training and practice now, recommendations on how to make optimal use of it in the treatment situation are still emerging and the topic remains controversial.

Alas, in my view, we are still faced with limiting effects of race and countertransference in most treatments. In our culture, race is ubiquitously linked to the worst of prejudices. That is, it is an all too familiar fact that one racial group (for example, African Americans) is often used by members of another racial group to fend off their own intolerable characteristics. As Mahon (1991) stated: "The tendency to . . . project one's instincts onto the scapegoated group suggests that it is more popular to use a group for id disposal and superego-disposal than to use a group . . ." (p. 373) for adaptive ego purposes. When a patient or a therapist is affected by rigid defenses against recognition of racial prejudice, he or she is limited in the ego resources necessary for psychotherapeutic work. As Mahon (1991) noted: "When a prejudiced person hates a [member of a] group without challenging his own self-deception, . . . [he] . . . engages in . . . [an] affective, conflictual, defensive mind-set that obscures [his] error" (p. 377). Hence, when such an "error" occurs in a therapist towards his patient, his ego functioning is restricted, his effectiveness is reduced. It bears noting that race-based errors occur in same-race dyads, as a vignette presented later will show.

Regarding countertransference, Freud stressed its limiting effects. A good example of his point of view is found in his reference to Stekel. "There can be no reasonable doubt about the disqualifying effect of . . . [unrecognized countertransference] in the doctor; every unresolved repression in him constitutes what has been aptly described by Stekel as a 'blind spot in analytic

perception'" (Freud 1912, p. 116). Careful reading of Freud clarifies that his cautions were directed to the *unconscious* influences of countertransference, *not* to its utility in *the therapist's mind* when conscious. More recent writings on countertransference, whether from a classical (Abend 1986) or inter-subjectivist school (Hoffman 1994) hold in common, albeit with different emphases, that contributions to the therapist's subjective reactions, including countertransference, come from the therapist and patient. Still, there is much debate about how to make use of countertransference and enactments of it in the treatment situation (Gabbard 1995). Currently, no particular emphasis is placed on the therapist's own treatment as the primary experience in which the therapist consolidates awareness, understanding, and mastery of her countertransference potentials.

What has psychoanalysis offered to date about the relationship between countertransference and race? Writings in this area are sparse and most are dated. Schachter and Butts (1968) presented two case reports—one of a black male patient with a white female analyst and one of a white man treated by a black male analyst. They emphasized that race may have catalytic and evocative effects on transference and countertransference, but seemed to eschew the primacy of race to stir these reactions. In a richly textured paper, in which she discussed two cross-cultural cases of her own, Ticho (1971) demurred with Schachter and Butts by pointing out that race (that is, racial stereotypes) may have primacy in determining transferences and

countertransferences. Bernard (1953) and Fischer (1971) focused on the difficulties *(and necessity)* of maintaining an analytic stance in the face of race prejudice, cultural biases, and countertransference reactions. Boyer (1977) and Boyer and Boyer (1979) explicitly stated that their countertransference contributions to impasse in conducting analyses with culturally-different patients were reduced through becoming familiar with culturally dissimilar patients by reading about their cultures and through their extensive field work as psychoanalytic ethnographers.

Most recent papers on culture and countertransference come from the psychodynamic psychotherapy literature and have focused on descriptions of the phenomenology of racial and countertransference effects (for example, Comas-Diaz and Jacobsen 1991), and on the utility of a process model of supervision in redressing interferences from such effects (Remington and Da Costa 1989). In an earlier paper (Holmes 1992), I raised the role of a countertransference identification with the patient as a limiting factor in an African-American female patient's gaining access to the links between her fear of becoming rageful and race. She came to treatment because she feared she would lose control of her rage in the race riots going on in her city when she sought treatment. In a recent paper by Leary (1997), postmodern perspectives and self-disclosure are discussed as helpful in freeing patients and therapists from barriers to effective therapy process linked to race. She aptly pointed out that silence in the face of race (such as allusions to race or

unacknowledged racial difference) is not neutral. Leary presented the case of a married white woman who was given to outbursts of rage towards her husband and who suffered from identity diffusion. Leary's selective use of self-disclosure seemed to have the impact of stabilizing the working alliance with the patient, but the case material is ambiguous on the question of the impact of self-disclosure on gaining access to and resolving the patient's proneness to hostility and rage. In particular, the hostile, intrusive motivations for the patient's race-linked and non-race-linked questions (for example, the possibility that the patient was turning her passive experience of having been on the receiving end of her mother's intrusive-ness into an active stance) did not seem relieved by Leary's answers. Nor was it clear how the therapist's answers clarified bases other than race itself for the patient's hostility. My present approach to working with race-linked expressions of drive derivatives—including questions the patient may ask me in which a social answer seems to be what is being demanded—emphasizes the utility of giving the patient ample opportunity to elaborate his feelings and thoughts as a foundation for eventual processing of them with the analyst, or to demonstrate to the patient that deflections away from continuing their race-linked associations occurred when unpleasurable affects arose signaling the danger of doing so towards me. An example of the recommended approach is given later in this paper, including the role of the therapist's systematic examination of her countertransference and race-based conflicts in her own

therapy as a way of understanding the motivations for enactments. Leary's paper is silent on the value of such an examination.

The most frequently recommended approaches to race and countertransference have been didactic or post-treatment efforts (for example, self-analysis). I think the following discussions will show that neither is sufficient when addressing the complexities of race and countertransference.

DIDACTIC REDRESS OF RACIAL AND COUNTERTRANSFERENCE REACTIONS

Increased Minority Representation and Culturally Sensitive Teaching Materials

No data exist on attempts to formalize the challenges related to race and countertransference into the curricula of psychoanalytic training programs. The most systematic data are available for clinical psychology. In a 1994 survey, Bernal and Bernal found that numbers of minorities and minority-focused curriculum offerings have significantly increased in mental-health training programs in the past fifteen years. However, in Cancio et al.'s recent comment on that survey (1995), it was pointed out that, "the results of the study did not convincingly provide evidence that graduates of culturally competent training programs are prepared for service and research with ethnic minorities" (p. 800). Relatedly, in my review of Dillard's book (1983)

on multicultural counseling (Evans 1985), I pointed out the psychodynamic power of race to overcome the influence of education in the treatment situation. Specifically, Dillard provided useful information on the personal characteristics and socio-cultural problems particular to seven ethnically diverse groups of Americans. Such information did not, however, prevent certain insensitivities later in the book, such as repeated references to children born out of wedlock as illegitimate and the routine reference to adult patients by their first names.

Supervision

Case One: A Latin American Trainee Treating a Patient from a Rival Latin American Country

> The insight-oriented psychotherapy supervisee was a young woman from a Latin American country who was treating a female patient from a neighboring country. I was the supervisor, and the supervision and psychotherapy took place in an urban, predominantly African-American university hospital. The therapy was conducted in the non-English language shared by patient and therapist since the patient had not learned English, even though she had graduated from college in her native land, and she had lived in the United States for seven years.
>
> Early in the psychotherapy, the therapist began to express impatience towards the patient whose dependency conflicts were manifested in her not being able to move about the city on her own, a fact that contributed to her being erratic in her attendance to therapy. The therapist seemed to be at a loss to find an approachable surface to the patient's problems. Even though the patient's inability to read street signs played a role in her manifest problems, I noticed that the therapist showed little curiosity

about her patient's lack of English fluency. When I brought this to her attention, at first she passed it off as a culturally-based personality characteristic, that is, as an aspect of dependency typical of women from the patient's country. In our discussions, partly for my own learning, and partly to stimulate thinking in the trainee about what I suspected were prejudices in her views, I asked her to inform me about the patient's culture. This supervisee's observing ego capacities came to life; she realized she was relying on a stereotype out of competitive feelings towards the patient's country of origin and towards the patient. She became better able to explore defensive aspects of the patient's dependency and identity problems that the patient had externalized onto her new country. That is, the patient's superego prohibitions against her own ambitions and liveliness had been attributed to her new country which she viewed as hostilely unwelcoming and demanding.

Case Two: A Black Trainee in a White and Then a Predominantly Black University Hospital

The training situation involved a trainee in a large, predominantly black university hospital where I was a training program director. In his admission interview for residency training, Dr. Smith informed me that he had received his prior professional education in a virtually all-white setting. Also, he told me that his enthusiasm about coming to a minority-focused program was based on the feelings of isolation he had experienced at the university where he had received his professional degree. He wanted the experience of having black supervisors. When asked why this was particularly important to him, he recalled a painful experience with his first psychotherapy supervisor who was white, and who told him that he did not know anything about cross-racial therapy. I asked the applicant if the supervisor's admitted ignorance might have been promising. The prospective trainee countered that *that* possibility had been eliminated because the supervisor had hastened to suggest that he talk to somebody else about it. This young man was greatly offended by this; he felt that the supervisor had not been interested in him because he was black—unknown and unknowable. In that early formative experience, he was discouraged from thinking about the relevance of race in the treatment

situation and supervision. He had taken a certain pride in deflecting what he felt was a kind of racial provocation from his supervisor; he thought he had contained the pain of that experience, and looked forward to the new training situation. He said that he was particularly drawn to it because I and others on staff were psychoanalysts.

It became clear early in the trainee's experience that his conscious aims were significantly undermined by unrecognized countertransferences and racial conflicts. For example, when a highly repressed young black woman was presented in a case conference, I noticed that Dr. Smith was frowning when the patient's failure to remember any specifics of an appendectomy at age six was described as repression. When he was queried, he offhandedly said that he thought the patient must have been lying. He was contemptuous and deeply mistrustful of her account. He took her coyness and playful allure to be signs of a "get over" mentality he described as "typical in the ghetto she had come from." ("Get over" refers to seeking an advance on a non-earned basis.) Multiple subsequent training experiences showed Dr. Smith to be quite strained by an attitude of open inquiry concerning the interplay between psychopathology, race, and social-class background. He often slept in seminars and missed many training exercises. When these problems were confronted, he expressed disappointment in himself and dismay, inasmuch as he had not experienced these problems in a more racially repressed setting from which he had come. Clearly, the earlier supervisor's attitudes had buttressed Dr. Smith's own defensive tendency to deflect pain associated with race and countertransference. Consequently, in the new training situation that discouraged such a defense, he showed contempt for a patient whose dynamics he misconstrued in terms of his own "get over" tendencies. Also, he did not recognize his countertransference reactions to her hysterical features, and miscast the patient's dynamics into a racially prejudiced sociological portrait of her.

Given that Dr. Smith and his former supervisor "agreed" that race was not knowable between them, any value of such knowledge was lost, and Dr. Smith's own aversion to various meanings of his and his first patient's different races increased. The possibilities for accurate perception of, and associated acquisition of knowledge about the role of his blackness in his

early psychotherapy training were subverted, and his faulty perception was extended to the new training situation and to a patient *of the same race.* In addition, his own prohibitions against reflection and introspection regarding race in relation to his work were reinforced in his earlier training and seemed to generalize to and augment a hostile and suspicious countertransference reaction to the hysterical features of his new patient.

The portrait of the misguided first supervisor and the mental-health trainee just reported is not to conclude that training is not helpful in addressing the interaction of countertransference and race. Both of the training experiences described led to a necessary crisis in his career. However, I think the vignette illustrates that supervision alone, no matter how "culturally competent," does not have the full power to relieve and make positive use of race and countertransference, since typically, both involve strong and complex defenses against one's most conflicted impulses. The various meanings of race are especially difficult to reach in supervision since internal prohibitions to learning about thoughts and urges connected to race are reinforced by a generalized cultural bar to becoming aware of the meanings of race. Supervision is not powerful enough to overcome this factor. Also, the irreducible superego factor necessarily involved in a supervisory process is another limiting influence in supervision in terms of definitively reaching conflicted issues having to do with race and to some extent, countertransference. In both of these supervisions, one might wonder whether the cultural attributes cited by the supervisees (such as a "get over" attitude) represented important cultural values to be understood in their own right. Surely so; at the same time, 1 believe the examples illustrate that the supervisees adopted them in a defensive way that had limiting effects on their work. In Case One, when the supervisee had the opportunity to reflect upon her patient's use of the cultural value of dependency, the supervisee went beyond a reflexive and defensive reliance on that value.

SELF-ANALYSIS

Published accounts of Freud's responses to his Jewishness, and of his

countertransference responses to patients and to colleagues, are instructive with respect to the limitations of self-analysis. He is known to have thought of his Jewishness as a boon to his work. For example, Freud wrote to Ernest Jones:

> The first piece of work that it fell to psychoanalysis to perform was the discovery of the instincts that are common to all men living today—and not only to those living today but to those of ancient and of prehistoric times. It calls for no great effort, therefore, for psychoanalysis to *ignore the differences* [italics added] that arise among inhabitants of the earth owing to the multiplicity of races, languages, and countries. [1929, p. 249]

Freud is also said to have commented to an analysand: "My background as a Jew helped me to stand being criticized, being isolated, working alone" (Blanton 1971, p. 43). Thus, Freud disavowed any vulnerability as a therapist on account of his Jewishness. His point of view is illustrated in Iwasaki's (1971) quote of Freud as saying in 1919: "I have been able to help people with whom I had nothing in common, neither nationality, education, social position nor outlook upon life in general" (p. 334). Freud's view of himself as racially neutral stands in contrast to Jones's recorded recollection of Freud's initial reaction to him, which revealed Freud's *unanalyzed* racial feelings. Jones (1955) reported that Freud said, "from the shape of my head . . . I [Jones] could not be English and must be Welsh. [Jones added:] It astonished me, first because it is uncommon for anyone on the Continent to know of the existence of my native country, and then because I had suspected my

dolichocephalic skull might as well be Teutonic as Celtic" (pp. 42-43). There is ample irony here in Jones's own bent toward a language of racial biology.

Pointedly, Freud's conscious aspirations to be a racially neutral psychoanalyst was in some measure defeated by unconscious forces strong enough for him to have enacted a feeling of "racial strangeness" towards Jones when they first met (McGuire 1974). The examples already cited from Freud's life warn us of the potential for race and countertransference to interact harmfully. Another, more vivid example can be taken from Jones's challenge to Freud over whether he had thoroughly analyzed the resistances of his daughter, Anna. The challenge arose as part of a criticism of Anna Freud's technical approach to the analysis of children, which Jones and others thought was too superficial. Antagonized by Jones's criticism, Freud wrote to Jones in 1927: "Who, then, has ever been sufficiently analyzed? I can assure you that Anna has been more deeply and thoroughly analyzed than, for instance, yourself' (Freud 1927). Sometime later, while still reeling from Jones's adverse comments, Freud wrote to Max Eitingon, "I don't believe that Jones is consciously ill-intentioned; but he is a disagreeable person, who wants to display himself in ruling, angering and agitating, and for this his Welsh dishonesty . . . serves him well" (Freud 1960). In this correspondence, there is clear evidence of a confluence of racial and countertransference feeling which resulted in an enactment of ethnic disparagement. Such enactments may have had ramifications for Freud's theory construction. This

possibility was proffered by Gilman in his discussion of the impact of the racist Viennese scientific community in which Freud worked. Specifically, Gilman (1993) pointed out that Freud was repeatedly faced with virulent racism in Vienna in the late nineteenth century; in that milieu, Jews were defined as an inferior race. How did Freud resolve or otherwise dispose of the sense of inferiority his adopted community sought to impose on him? Freud's response was to argue that race was of tangential importance. Apparently, such minimization was Freud's way of coping with the racist scientific community of his time, a community in which he defined himself. Gilman (1993) has suggested that there was a self-deluding element in Freud's minimization of race; and he has proffered that the errors and distortions in Freud's theories of female psychology represented a displacement from race to women and a projection of Freud's own conflicted feelings about his Jewishness. Clearly, self-analysis alone is not the answer.

RACE, COUNTERTRANSFERENCE, AND THE TREATMENT SITUATION

Having reviewed the opportunities and limitations associated with didactic approaches and self-analysis in making productive use of race and countertransference, I will turn to the treatment situation itself as the source of the greatest opportunities for full positive utilization of race and countertransference. How does the therapist achieve the capacity to aid patients with conflicts expressed in racial terms? The obvious but least

explored means is through the therapist's own therapy. Therapists who achieve conscious, voluntary management of racially conflicted affects and drive derivatives are optimally suited to help patients who express their conflicts in racial terms.

Dias and Chebabi (1987), in their elegant paper concerning psychoanalysis and blacks in Brazil, frankly discuss the failure of analytic therapies to address the impact of race in the treatment situation. They particularly noted the inescapable and inevitable importance of race in the conduct of every analysis in that culture. Their wisdom is ours to heed, as there are many parallels between the Brazilian situation and the United States in terms of racial issues. As they noted:

> Making the unconscious conscious in Brazil means being able at a deep level to acknowledge racial prejudice as a phobia related to one's own instinctuality. . . . This will require the institution of a new dialectic . . . in place of the *master-slave* dialectic. . . . This [maturation of psychoanalysis] will enable us to overcome the narcissistic formula whereby strangers are stamped as enemies, [as] put forward by Freud. . . . [p. 200]

It is important to remember that when race enters into the therapy process, it often involves projected hostility or sexuality. The therapist's own discomfort, influenced by countertransference and race, may too quickly lead him or her to interpret the patient's defensive uses of race. I caution that to interpret defensive use of racial comments or allusions *early on* may defeat the purpose of defense analysis, which is to enlarge the ego's capacity to

know and to voluntarily control that which has threatened its functioning. Demonstration to a patient of his or her defenses against awareness of the meanings of racial feelings needs to await the fullest possible elaboration of those feelings, or allusions to them, lest the defenses be redoubled (Evans 1985), often by the use of superego prohibitions. That is, patients and therapists are quick to be influenced by guilt or shame in the face of their racial feelings, since, on a conscious basis, most patients and therapists find their racial feelings unacceptable. As Gray (1994) has richly described, the primary threat to adaptive ego functioning comes from the superego, and patients re-externalize threatening superego activity onto the person of the analyst. Thus, the therapist's attempts to highlight the defensive aspects of racial comments or allusions may miscarry if they occur before the patient experiences a full opportunity to express racially-loaded thoughts and affects. For example, a therapist-to-be-patient may approach his or her prospective analyst or therapist with the expectation that he or she will not be helpful and —let us assume that the two are of different races—expresses the wariness in terms of the racial difference between them. In such a case, the therapist has the challenge—and I think the responsibility—to convey that he or she will not judge, or seek to persuade, the patient against such feelings. Rather, should the prospective therapist-patient decide to give the work a chance, he or she and the therapist will learn together how the expectations weight out over the course of the work. This kind of message lets the patient know that

he or she will have the opportunity to express racial feelings and fears fully, and this approach minimizes the excitation of inhibiting superego forces. Thus, the therapist's own forbearance and open-ended curiosity in these matters will aid therapists in training to resolve their own racial conflicts and thereby, in work with their own patients, to show necessary patience and tolerance when race or other somewhat similarly affecting factors (for example, gender and class) come to the fore.

Case Three: A White Woman in Psychoanalysis with a Black Female Psychoanalytic Candidate

> This case was previously reported by me in a paper focused on race and transference (Holmes 1992). The patient entered analysis at age 31 because of difficulty deciding to marry her live-in boyfriend of several years. Similarly, she had not resolved conflicts over choice of career. Having graduated from college, she was working in a part-time business with her boyfriend and as a part-time concert violinist. Ms. Elliot grew up in a circumstance of privilege, with two professional parents and a brother who was 2-years older; yet, she took great pride in living a meager existence. Initially, in relation to her self-imposed impecunious state, my blackness seemed to appeal to her because, as she said, "Well, uh, as a black woman, I thought you would understand about low income." My awareness of some discomfort about this emerging transference to me, into which she incorporated my race, led me to ask her to expand on her impression. I commented thus, "I will try to understand, but right now, you do not make it clear why either one of us should be pleased with such low pay." What emerged over time is that Ms. Elliot used altruism to buttress masochistic tendencies to hold herself back. By the midpoint of her nearly five years of analysis, and after she guiltily acknowledged that she had been fascinated with the Civil War Confederacy during adolescence, Ms. Elliot expressed dread that she might express hostility in racist attitudes.

My countertransferences and racial responses toward Ms. Elliot came to light in the following way: Ms. Elliot noted with pleasure that frequently when I came to the waiting room to get her, I was humming, which she liked. She surmised that I must have a lovely singing voice, and she took my humming to mean that I was in a happy mood and glad to see her. In fact, until she brought the humming to my attention, I had not been aware of it, which led me to discuss it with my analyst. What I came to understand was that my humming represented a countertransference wish to be praised by the patient—a very accomplished musician. I wanted her to be a substitute for the musically talented members of my family who were critical of my extremely modest singing ability. In addition, I believe I began to hum at the time this patient began to anxiously link her hostile feelings to race. Since humming in my family represented a quasi-religious ritual for "calming the demons," I came to know that I was also using humming to quell my own anxiety about working with the patient's racial conflicts. Coming to understand my uses of race enabled me to make my blackness more available to the patient for the associative and projective uses to which she needed to put it. She became freer to express herself in racial terms, and thereby, to better understand her defenses against hatred, the origins of which had to do with her mother suppressing her ambition in favor of the patient's brother. The following exchange shows how this more forthright work began:

Ms. Elliot: (The patient began by speaking of a black professor teaching her in graduate school.) Professor Jones, well—should I say this?—he just is not very good; nothing like you, of course. I mean you're excellent at what you do. I, uh . . .

Analyst: You seem to strain to protect me from any possible criticism you have of me.

Ms. Elliot: If **I** speak in racial terms, I'll be out on a limb. I'll fall off. You'll criticize me. I'll say the wrong thing and boom! In recent years I have been a champion of poor people and blacks. I don't want to recognize how angry I am, and it's still hard for me to believe that I can criticize anybody I want to in here. . . . If I cling to my love of the poor and blacks, and get you to join me, I don't have to face those feelings.

Analyst: So, the "boom" is an alarming way of being aware of angry feelings you don't want to have. Fearing my objection to those feelings, is it easier to focus on blacks other than me and to remind me that you champion the rights of blacks and the poor?

This case presentation was offered as a way one's own treatment can and optimally should work to be sensitive to and useful in the resolution of racial and countertransference feelings such that the therapist becomes more usefully available to patients in their conflicts expressed in racial terms. In terms of my countertransference toward Ms. Elliot, I came to realize that I had enacted a fantasy of using her to elicit a favorable review of my meager musical ability, and with respect to race, I had been incomplete in analyzing her aggressive conflicts because I, at first, unknowingly shared with her a dread of race used as a vehicle to express hostility. My own analysis during training became the effective vehicle in which I could address these issues.

CONCLUSION

This paper was written to demonstrate the power of race to organize defenses against awareness of drive derivatives and to show how race and countertransference operate similarly and synergistically. Both may impede treatment, but when either is made available for the therapist's reflection and analysis, the therapist will be better able to assist the patient to grapple with his or her own racially expressed issues. It is my position that racial reactions are more potent and potentially more destructive of therapy than countertransference reactions in general since responses to race are determined and reinforced externally, that is, in the culture at large and intra-psychically. Given the ego-distorting effects which stem from the ubiquitous

use of race for primitive defensive purposes, I have argued that neither didactic approaches nor self-analysis *alone* are likely to gain the therapist-or analyst-to-be sufficient mastery over racial "blind spots." The therapist's own therapy is likely to be the most effective means by which to resolve such conflicts. Since racial reactions are so heavily and universally relied on to fend off one's own instinctuality—as Dias and Chebabi (1987) and Mahon (1991) have previously pointed out—the resolution of racial reactions may serve as a prototype for the resolution of other "blind spots" in the therapist, such as those which may develop from countertransference feelings.

Heretofore, when race has been considered as a factor in psychoanalysis and psychotherapy, the emphasis has been on the phenomenology of it in terms of transference, and to a lesser extent, countertransference. Its unique role and its relationship to other variables such as countertransference have not been explored in depth previously in the United States, nor has the technique of how to analyze it as an important influence on the therapist been previously probed.

It needs to be highlighted that people in general, including therapists and patients, use racial groups to flee from the "bad" internal darkness of their instinctuality. In the United States, and in many other places, blacks serve this purpose. That is, through the use of externalizing defenses, blacks become a marginalized and impersonalized group onto whom unwanted

urges are cast. In this paper, I have proposed a way for therapists to address such mechanisms so that race can be transformed from an "ambiguous, abyssal blackness . . . [into a conscious] container of insight, enlightenment and hope" (Tien 1993, p. 17). I think that it is within the analytic therapist's capacities and obligation to explore this realm in his own treatment and thereby, to gain the courage, sensitivities, and skill to be alert to and ready to work with its inevitable emergence in the treatments she conducts. It is a difficult but necessary calling.

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Notes

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