Counterspace

Mitigating racial loneliness as transformative psychoanalytic work

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Abstract Racial loneliness is a phenomenon experienced by individuals of color in predominantly white settings, including the predominantly white clinic. This paper identifies key psychoanalytic underpinnings of racial loneliness, drawing upon theory from Klein, Fanon, Layton, Eng and Han, and Okun. In doing so, this paper explores racial loneliness and its treatment implications. Through a deepened understanding of racial loneliness, the isolation and exclusion of clinicians of color within psychoanalysis is interrogated. A clinical vignette is deployed to explore the effects of racial loneliness on treatment, identifying unique challenges in the realms of countertransference, self-disclosure, and identification.
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In a field in which only 5.8% of employed psychologists identify as black, the experience of loneliness might reasonably loom over the training experiences of clinicians of color (U.S. Bureau of Labor Statistics, 2020). As a mixed-race black woman, I was one clinician of color who felt both longing and loneliness during my training. In a psychodynamically-oriented community mental health clinic where I was the lone clinician of color among my intern cohort and supervisory team, my experiences shaped my conscious and unconscious feelings about clinical work with both white-identified patients and patients of color.

This paper will begin to explore the unresolved longings, losses, and loneliness of my second training year through a psychoanalytic lens. By

defining racial loneliness in psychoanalytic terms, it will set the stage for a clinical vignette that demonstrates my encounter with a patient during a moment of intense personal racial loneliness. The paper ultimately argues that personal and sociocultural transformation, and subversion of normative unconscious processes within the field of psychoanalysis, are necessary to address racial loneliness in clinicians of color.

Racial Loneliness and Its Effects on the Therapeutic Dyad

Racial loneliness is an experience that is felt most often and most intensely by people of color who exist in situations where they are, racially speaking, the "only" or the "first." For the "only" or "first," surrounded by whiteness, feelings of ambivalence, grief, or rage in "not belonging" emerge in the individual of color. The paranoid-schizoid position that Klein (1946) describes allows for an elaborated understanding of racial identification in the United States as, fundamentally, a process of collective splitting. Klein describes the primary defense of splitting: processes of projection and introjection allow for internalization of the good object and deflection of the bad object (p. 101). If racialized splitting is what projects goodness onto white individuals and badness onto individuals of color, the minoritized experience of being the only clinician of color in an otherwise white clinic would suggest that the clinician of color often unwillingly takes on all of the badness that is projected from whiteness, which, as the norm, is always presumed to be good. In contexts where all of an individual's colleagues lack experiences of racial oppression, the difficulties of keeping those difficult experiences of "badness" to oneself might be equivalent to the sort of inner loneliness described by Klein (1975), in which it is possible to be lonely "even when among friends or receiving love" (p. 300). This is not the result, it is claimed, of any deficits within the person of color in an all-white environment. Rather, it is the result of a sociocultural way of being that quietly rejects anything and anyone falling outside of the norms of whiteness, leaving the clinician of color with the feeling of being an outsider, even when surrounded by friendly white colleagues and supervisors.

In exploring racial loneliness as an individual and interpersonal process, the sociocultural context of the clinic must be interrogated just as closely as the internal world of the clinician of color. As Fanon (1952/2008) writes, "there is a constellation of postulates, a series of propositions that slowly and subtly – with the help of books, newspapers, schools and their texts, advertisements, films, radio – work their way into one's mind and shape one's view of the world of the group to which one belongs" (p. 118). His work identifies the insidious and inescapable relationship between the social environment of the clinic and the internal world of the clinician. Okun (n.d.) describes characteristics of what she calls "white supremacy culture," noting the ways that the subtle presence of

white supremacist attitudes in organizations can be damaging "because they are used as norms and standards without being pro-actively named or chosen by the group." The valuing of objectivity, individualism, paternalistic treatment of patients, and a sense of urgency are all indicators of a white supremacy culture within an organization or agency. In a clinical setting, the constant interplay of one's internal world with clinical norms might promote unconscious internalization of some of these white supremacist norms.

Given that racial identification and racism are collective processes that can be understood as psychoanalytic and Kleinian in nature, the sociopolitical context in which racial loneliness occurs must be taken into consideration. In addition to Fanon's theoretical work, Layton's (2006a) concept of normative unconscious processes is incredibly useful in contextualizing racial loneliness. The construction of the lone clinician of color is rooted in two sociopolitical realities: first, that of global racism and white supremacy; second, that of exclusion and othering. The individual distress caused by implicit and explicit exclusion of the lone clinician of color is reminiscent of Layton's description of normative unconscious processes as "that aspect of the unconscious that pulls to repeat affect/behavior/cognition patterns that uphold the very social norms that cause psychic distress in the first place" (p. 242). The distress locates itself in the psyche of the lone clinician of color, but it is rooted in macro-level dynamics of white supremacy and racism. As white clinicians and patients alike are drawn to the racial stereotypes, microaggressions, and exclusion that create the conditions of existence for the lone clinician of color, s/he is left in conflict with othering and exclusionary normative unconscious processes.

These conditions are described in terms of survival in the PEP-Web video *Black Psychoanalysts Speak* (Winograd, 2014) where prominent black psychoanalysts sit at a table trading stories about being black in the predominantly white field of psychoanalytic practitioners. Kathleen White asks a series of questions, presumably speaking to the experience of black psychoanalytic trainees:

> Could they survive in this world of […] 90% white people? Could you hold onto your beliefs, and your values, and all like that, if you submit to the work of becoming a psychoanalyst? That is, can you hold onto your identity? Or do you become somebody else? Do you become a white person? (Winograd, 2014)

White's comments about whether it is possible to hold onto one's identity, psychic reality, and beliefs as a black person in a field that is over 90% white are a poignant indicator of the challenges that psychotherapy and psychoanalytic trainees of color may experience in predominantly white agencies and institutes. These comments from black psychoanalysts speak to a sort of unique isolation

that trainees and practitioners of color are forced into in this predominantly white field.

In labeling this kind of loneliness as racial loneliness, there are parallels to Eng and Han's concept of racial melancholia that might be evoked. Racial loneliness parallels racial melancholia as affective experience and as a sociopolitical project. Through their understanding of assimilation as a non-pathological process in which melancholia and mourning might coexist, Eng and Han (2000) allow for the possibility that racial melancholia is "conflict rather than damage" (p. 693). Similarly, the experience of racial loneliness is an affective experience, not a pathological affective state; it is to be expected given the social situation that creates it. Racial loneliness, then, is not a "diagnosis" for an individual – it is a descriptor of a social condition created by white supremacy culture and the normative unconscious processes accompanying it. Racial difference in the clinic setting creates a gap in understanding that equates to an affective experience of Kleinian non-belonging in the clinician of color.

This non-belonging in the clinician of color is the product of individual and interpersonal conflicts about assimilation and otherness. This is why racial loneliness could not be experienced by a lone white clinician in a group of clinicians of color. Racial loneliness is rooted in alterity, the social othering effect that white supremacy has on people of color. Eng and Han (2000) write of "the melancholic's absolute refusal to relinquish the other – to forfeit alterity – at any costs" as politically significant, noting that the working-through of conflicts associated with racial melancholia is productive in individual and political terms (p. 694). The individual products of these socio-political conflicts are often unwanted in white spaces, constituting bad feelings that go against respectable and professional norms set by the white majority. These bad feelings are productively resistant, challenging "internalized refractions of an ecology of whiteness bent on the obliteration of cherished minoritarian subjectivities" (p. 695). If these resistant feelings of rage and ambivalence emerge in racial melancholia, they may also be linked to racial loneliness.

Racial loneliness is the combined result of isolation and racism. To be the only one is to be alone. To be alone is to have lost a community of colleagues, to have lost the potential for shared identity or understanding. This loss is grievable and melancholic. In Freud's (1917/1957) terms, this loss is felt as the shadow of the longed-for object – the opportunity to share non-white identity with colleagues in community – falling upon the lone clinician of color's ego in the face of exclusion from whiteness. If bad feelings from racial loneliness cannot be expressed in predominantly white clinics, where can they be felt?

The therapeutic dyad is an unexplored site in which bad feelings produced from racial loneliness may be acted out. In a clinic setting in which a clinician of color might see a mix of white and non-white patients, racial loneliness has opportunities to emerge – through enactments, identifications, and unspoken

(mis)attunements in the therapeutic dyad. A clinical vignette follows to demonstrate the bad feelings that I internally observed as a result of some parallel process that I experienced with a patient of color during a particularly intense period of personal racial loneliness at the clinic where I was an intern.

Clinical Vignette: An Encounter with Racial Loneliness

This is a clinical vignette with a patient whose information has been disguised, to illustrate the ways in which racial loneliness might operate in the clinical encounter. Hannah (a pseudonym) was a patient that I was able to see twice weekly as part of a free-care clinic at my placement. She was close in age to me, and like me, she was multiracial. Our work spanned several months during my training year at this agency. During one of our early sessions, Hannah began to talk to me, unprompted, about what it was like for her to be a student of color at her predominantly white university. Unknown to my patient was the fact that I, too, had been a student of color at a predominantly white university, and that experience was replicated in my graduate program and my training clinic. Below is some process from the middle of this early session, discussing Hannah's experiences in a class where she was the only student of color. Her racial loneliness and racial melancholia emerge in her discussion of what it feels like to sit in this class – her rage and ambivalence were both palpable affects in the room.

> P: Yeah, okay, so I'm really interested, if you could tell me what you think about all of this, just because you're of color too, like what do you think? [*therapist laughs*] Do you experience this in your life? Do you experience it in school?

In this moment, I felt a strong countertransference temptation to self-disclose. I felt upset that I couldn't fully mitigate her racial loneliness or my own. In her reflections on being an outsider among her white classmates who don't have friends of color, I noticed a strong identification with Hannah forming – perhaps evidence of the ethnocultural transference described by Comas-Díaz and Jacobsen (1991). I deflected Hannah's direct questions, offering a generic statement about the purpose of therapy that sounded to me as though I had lifted it from a graduate school textbook. As I heard myself saying these words, I noticed disappointment in the room; I was not sure if this was my own sense of sadness or hers. Despite the mutually constructed moment at which countertransference temptation emerged between Hannah and me, I left the session feeling ashamed of this temptation to self-disclose, as this was discouraged by my supervisors at my agency (Davis, 2002). In an otherwise all-white setting, my connection to another multiracial person felt precious to me, like something

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to be fostered and protected, and yet I had internalized that I was wrong for even experiencing the temptation. My internalized wrongness, rooted in feeling excluded in my training clinic, had emerged as a constraint on my clinical decision about whether or not to self-disclose.

Or was it the clinic's commitment to certain racial and psychoanalytic practices that prevented me from self-disclosing? Over and over again in training seminars, the idea of "analytic neutrality" was introduced, but never troubled. I now wonder if I had internalized that phrase too rigidly, interpreting it to mean that I was never supposed to share anything about myself with patients. I was expected to mold myself into something resembling a blank screen as closely as possible – I aspired toward the ultimate manifestation of whiteness, despite the fact that my own skin will never be devoid of color. I experienced shame in individual supervision when I mentioned an instance where a patient had learned where I went to college. In individual and group supervision contexts, my questions about race were dismissed as "off-topic," even in discussions about topics ripe with possible racial content, such as projective identification. As Kimberlyn Leary (1997) writes, discussion of race and racial difference with our patients can sometimes lead to insights about our patients' relationship to anxious and vulnerable thoughts and feelings (p. 167). This perspective, however, was thoroughly absent from the way I was supervised and trained in the white spaces of the clinic.

I now understand my response to Hannah's questions as reflective of several different factors: my own insecurities as a young and inexperienced practitioner, white supremacy culture within my clinic, and my own denial of the racial loneliness I was experiencing as an intern. In an attempt to combat the disappointment – maybe mine, maybe Hannah's, maybe shared – I offered a final statement on the therapeutic frame I aspired to create:

> T: And I think it's important that you feel like you can speak freely without worrying about offending me.
>
> P: Yeah, I actually was like really – so, when I first met you, I was like relieved that you weren't white.[*therapist laughs*] Because I was like, oh no, how am I gonna… how am I gonna talk about white supremacy to a white person?

My attempt to re-engage Hannah, expressing my own wish that she feel empowered to "speak freely," is reflective of a personal longing for a community of shared experiences. Even with my knowledge of the importance of boundaries within the therapeutic dyad, my still-unconscious wish for fellowship in being a person of color would not be squashed by my previous attempt to re-assert the therapeutic frame. The kind of loneliness she was speaking to at school paralleled my own experience of loneliness at my internship, sitting in

seminars filled with white social work, psychology, and psychiatry trainees. I felt seen by the experiences she voiced, and this challenged my own capacity to continue making room for *her* in the treatment.

Noticing how flattered I was by our mutual recognition of each other as lone women of color, I unconsciously overreacted in my distancing response as a means of avoiding the countertransference temptation to self-disclose more. This inadvertently upheld the normative unconscious processes described by Layton (2006b), in effect separating elements of the social – in this case, the socially constructed racial – from elements of the psychic in our psychoanalytic treatment. Evidenced clearly in Hannah's statements to me during that session, the norms and practices of a white clinic and a white university were impinging upon the space that I had constructed with Hannah, and my denial of that impingement was a missed opportunity in the treatment.

This clinical encounter was imbued with my own sadness about the constraints of our relationship as therapist and patient – as opposed to friends who might be better able to bond over our shared racial loneliness. This is a particular kind of grief or loss worth acknowledging in discussions of racial loneliness, as it is a mourning of potentiality in the therapy, of what could have been shared between two individuals of color who exist alone in predominantly white spaces. By stopping myself from self-disclosing more about my racial identity or my experience of the world, I was not mitigating Hannah's racial loneliness or my own. I was also choosing to leave a door unopened in the treatment by participating in the normative unconscious processes of the predominantly white clinic. I still wonder about what would have developed in the therapy had I shared something more of myself when asked. Would it have enabled Hannah to feel more personally invested or "safe" in the therapy, by virtue of my own willingness to share a small but vulnerable part of myself? Would it have, as Leary suggests, opened the door to other "risky" topics that our patients tend to avoid? Instead, both therapist and patient remained in a state of inner loneliness, a sense of not-belonging at a mostly-white school and in this mostly-white clinical internship, unmitigated by a self-disclosure that could have communicated the simple sentiment of "Me too."

Implications for Psychoanalytic Theory and Practice

The concept of racial loneliness holds significance for psychoanalysis on macro and micro levels. On a macro level, normative unconscious processes which serve to preserve white supremacy must be identified and interrupted. This means that, as a field, psychoanalysis cannot continue to rely on the white theoretical parents of the field as our only guides. Especially when working with patients of color, *all* psychoanalytic practitioners must begin the personal work of understanding why and how people of color have been subjected to

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dehumanization and harm at the hands of our field (Brickman, 2017). In our past and present use of psychoanalytic theory, where are there biases in favor of racial domination and exclusion? Shifting from normative unconscious processes toward a critical racial consciousness is necessary not only for white clinicians working with patients of color, but also for any clinician seeking to work from a place of sociopolitical awareness. It is the psychoanalytic responsibility of individual practitioners and organizations alike to take on the work of self-education about our field's racist histories, as well as its modern-day practices of racism.

Through advancing an understanding of racial loneliness as a psychoanalytic concept, this paper specifically seeks to influence white clinicians who work and supervise in predominantly white clinics. White clinicians are apt to be more sensitive to the experiences of their colleagues of color in majority-white clinical settings when they make themselves more aware of the inner loneliness that may be brought on for clinicians of color in otherwise all-white clinical settings. In service of clinical self-reflection, it is essential for all members of the psychoanalytic community to consider the cumulative effects of racism on our patients of color, but also our clinicians of color, challenging the white-normative framing of society and the individual that is often presented to us in training literature (Thompson-Miller and Feagin, 2007).

As I consider my clinical encounter from one year ago, I now consider it through the lens of psychoanalytic perfectionism, paternalism, and individualism – all components of what Okun (n.d.) describes as "white supremacy culture." Within my clinical encounter with Hannah, I could not escape from the perfectionist idea that there was only *one* correct way of being with patients – the stance of "analytic neutrality." The paternalistic thinking of my clinic's culture enabled me to feel as though I could make decisions in the interest of Hannah's wellbeing, seeking to maintain a mythic analytic frame instead of expressing curiosity about her interest in knowing men. The rampant individualism of my clinic also contributed to my understanding of Hannah throughout our treatment – whereas I could have conceptualized a number of her neuroses and anxieties in terms of her unresolved racial identifications, I was instead encouraged by supervisors to engage in individualistic and intra-psychic formulations of her. Throughout my training year at this clinic, I internalized and re-enacted normative unconscious processes that were reinforced by the prioritization of psychoanalytic thought at the expense of socially just thought. This false dichotomy negates the work being done right now in our field by psychoanalysts who see inherent connections between individual psychoanalytic healing and the sociopolitical world that interacts with our psyches.

Conclusion

Racial loneliness can be defined as the experience of being the only person of color in an otherwise all-white setting. This experience of racial isolation is constructed through the normative unconscious processes of white supremacy culture, spanning attitudes and practices that prioritize values that are antithetical to the survival and success of people of color as clinicians. As an experience, racial loneliness encompasses rage, grief, and other characteristics of loneliness. Additionally, its parallels with racial melancholia speak to the complexity of the affects associated with being the only or first person of color in otherwise all-white settings. For clinicians of color working in otherwise all-white clinics, racial loneliness is a useful concept for understanding potential transference and countertransference reactions to both white and non-white patients. Understanding racial loneliness as an organizing principle of race in the psychoanalytic encounter enables a more comprehensive exploration of bad feelings about race in the patient and the clinician. Without a consciousness of racial loneliness, racialized enactments will occur and go unaddressed in therapeutic work. Attending to the need for racial solidarity and community – primarily through principled struggle with clinicians' own relationship to white supremacy culture – may mitigate or productively illuminate the effects of racial loneliness on clinical work with patients.

The work of mitigating and preventing racial loneliness is a task that must be taken on by psychoanalysis at a larger scale. In order to respond to the racial loneliness that many trainees of color are forced into at agencies and institutes, white psychoanalysts must critically engage with their own whiteness in order to understand the comfort and community it provides to them. With this more critical understanding of the ways that whiteness feeds the experience of not-belonging in colleagues of color, more holistic and comprehensive efforts at racial equity for clinicians and patients will emerge.

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