Mapping the field of psychoanalytic psychosocial practice

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In this paper I make a preliminary sketch of the field of psychoanalytic psychosocial practice. I do this by looking in detail at four accounts of clinical work which claim to be psychosocial. I start by describing one vector of this field which I use to distinguish between the clinical accounts, whether they believe a psychoanalytic psychosocial practice can be done within the existing psychoanalytic framework, or whether a more radical clinical approach is needed which would fundamentally change the way psychoanalysis is practised. In exploring this vector in more detail, other differences between the authors of these clinical accounts emerge: how they understand the connection between psychic and social reality, how they understand neutrality, transference and countertransference, and how they conceive of the aims of psychoanalysis. Further elaboration of the different ways of understanding these elements and their connection with each other would be needed in order to take further this preliminary mapping exercise.

This paper addresses a simple question once put to me by a teaching colleague of mine. We were discussing how to better incorporate the impact of social reality on psychoanalytic practice into the syllabus of our psychoanalytic trainings. We wanted to do this for a number of reasons: because we felt social reality had been relegated to the margins in much psychoanalytic thinking, because our students kept asking for a better understanding of how social forces and dynamics affected their therapeutic work, and because this attention to social and cultural difference is part of the contemporary *Zeitgeist* within the world of counselling and psychotherapy. For instance the 2017 Ethical Framework of the British Association of Counselling and Psychotherapy, the foremost British accrediting body, states: "we will respect our clients as people by providing services that...endeavour to demonstrate equality, value diversity and ensure inclusion for all clients" (BACP, 2017). My colleague said she understood how teaching students ideas, concepts and theoretical frameworks from disciplines other than psychoanalysis – cultural studies, gender studies, critical philosophy, histories of colonization and slavery etc., all of which could be broadly subsumed under the heading "psychosocial studies" - would provide a better social, historical and cultural context to enable our students to establish a clearer and more robust link between psychic and social reality. "But", she said, "I still don't understand how all of this translates into clinical practice."

I have found my colleague's question surprisingly difficult to answer. I had thought that once equipped with this psychosocial knowledge, linked up with personal experience so as to make this knowledge vital and emotionally resonant, our students would find that this teaching in itself would produce a change in their clinical practice. Their eyes would be opened to those aspects of their patient's social reality that they had previously kept out of their awareness. From this point of view, the issue would no longer be "how to bring social reality into my work" but "what do I do to keep it out -how do I find ways of suppressing or diverting my awareness of the everyday reality of my

patient's social identity, particularly in relation to me as therapist?" I think this does provide a partial or preliminary answer to my colleague's question. I have found in my own clinical practice that it is a good discipline to ask myself, every now and then and particularly when the therapeutic relationship with my patient starts to feel a little too comfortable, which aspect of my patient's social reality do I wish to keep out of my clinical thinking? But I am still left with the question of *how* I will do so. In particular, can translating psychosocial thinking and ideas into clinical practice be done using existing psychoanalytic theoretical and clinical frameworks, so this teaching can be fairly easily incorporated into a psychoanalytic syllabus, or does something more substantial and radical need to be taught about how we theorize and how we practice psychoanalysis?

In order to find a more satisfactory way of answering my colleague's question I turned to the psychoanalytic literature which claims to be written from what, broadly speaking, could be termed a psychosocial perspective. I found a large number of papers, many of which contained case studies or clinical vignettes which showed clinicians actively and thoughtfully engaged in linking up psychic and social reality, particularly concerning issues of racial, cultural, gender and sexual identity and differences in class and status between therapist and patient. But no clear picture emerged, at least as far as I could tell, of precisely *how* this work could or should be done. Indeed it was not really clear to me whether to think of these papers as constituting a body of work in their own right. They shared a similar interest in exploring social identity, particularly when these were expressed in visible differences between patient and therapist. But a variety of theoretical and clinical approaches were used, with no obvious agreement or coherence as to what it might mean to be working psychosocially. In other words, if one thinks as "working psychosocially" (or any variant such as "working with difference" or "working in a way that values equality and diversity") as a kind of clinical competence, I could not see from looking at this literature any clear sense of how this competence would be differentiated from any other psychoanalytic competence, and how one

would know whether this competence was being met – and if it was met, how to tell the difference between work in this field that was poor or good.

As my thinking was in danger of getting stuck, I decided to approach my colleague's question from a different angle. I acknowledged I could not provide an answer to her question – at least not yet. But what I could do was to look at how other key writers in the area had answered her question. Here I decided to follow the example of the Working Party on Comparative Clinical Methods set up by the European Psychoanalytic Federation in 1992 which was tasked with comparing the different schools of psychoanalytic clinical practice employed by European analysts. When they started out, the members of the Working Party assumed there was sufficient common ground between the different analytic orientations to begin their task of comparing them. However when they asked their fellow analysts to describe their clinical work in detail to each other, they found that such a common analytical language could not be assumed. Analysts would use the same concepts in very different ways to each other, which made communication between them difficult if not at times impossible. Furthermore the members of the Working Party noticed discrepancies between how analysts claimed they were working, and how they were actually working. The organizers therefore decided that before they could properly begin the task of comparing different clinical approaches, they had first of all to simply map out the field of actual clinical practice. They begun by asking the question: how can we best describe, in their own terms, what analysts actually do, what kinds of clinical interventions do they actually make and how do they justify or explain the function of these interventions? (Tuckett, 2008, Spurling, 2018).

This is the approach I have adopted in this paper. It is clearly too ambitious for one person in one paper to claim to be mapping the whole field of psychoanalytic psychosocial practice, so my aim is to

provide a preliminary sketch of the parts of this field that I have encountered. I have decided to pick four clinical accounts claiming to be examples of psychoanalytic psychosocial work (however differently described by each author). This is obviously a small sample, but would allow some exploration in depth of the clinical approach of each author. I have chosen these accounts because I think they are examples of good clinical writing (Spurling, 2019), in the sense that the clinical approach and description of the actual interventions made is clearly connected to theoretical aims and ideas. Furthermore the papers are written with a high degree of transparency and honesty on the part of the author, which makes it easier for the reader to construct or reconstruct the clinical thinking of the writer. My choice has also been influenced by my own preliminary way of dividing up this field, that one can distinguish between two kinds of clinical writing, those which claim to be operating within existing psychoanalytic frameworks and those that explicitly claim that new ways of thinking and working are needed.

The need to reflexively analyze "the very basis of clinical engagement"

The first paper I have chosen is an example of an approach that seeks to establish a radically different kind of analytic practice. In her paper "Bearing the Cultural in order to Engage in a Process of Witnessing", Katie Gentile starts from the position that the transferences that occur within psychoanalytic work are already shaped by the racial and cultural oppression that is part of our culture, and so in order to try to take account of this the analyst needs to try to reflexively analyse " the very basis of clinical engagement, including how our subjectivities and identities emerge, as products of culture, created through technologies of power and oppression" (Gentile, 2013, p.463). In her paper Gentile describes her work as a white therapist with a female Latino (footnote 1)

patient. Gentile demonstrates how she uses her psychosocial understanding of how "cultural realities" get played out in ordinary interactions, including therapeutic ones, with the aim of counteracting the effect of such ordinary oppression:

> were we not to struggle to find a way to articulate the very real continuous racist and classist violence of privilege in bodies and words, our relationship would have to re-enact, on some level, the myth that the violence in her life emanated from her Latino cultural heritage, while the white, clinical world could emerge, evacuated both of its violence, and thus, of its accountability, even as it would also become the safe space of her healing (p.464)

Gentile describes her clinical conflict over how to work with her Latino patient's disclosure to Gentile of how she had been sexually abused by her Latino father. On the one hand she could see she needed to support her patient's rage, disillusionment and shame in not blaming herself, and facilitate the recognition and acceptance of her anger against her father. On the other hand, by allowing her patient to legitimately blame her father for his abusive act, she could see that she risked trapping her patient further within the powerful social norm that equates the Latino heritage with violence. In order to counteract the effect of these oppressive social myths and norms, Gentile describes how she aimed to create a therapeutic space in which she and the patient could talk together about their impact on the analytic work: "we could discuss how our assumed differences in ethnicity, social class, and privilege impacted on our various ways of engaging with each other and how we saw the world" (p.465). However Gentile also recognized that these collaborative discussions, although an essential part of the work, were also limited in their effect:

> But these discussions felt intellectual, hyperrational, and dissociated from our nonverbal, embodied transference of murky merging and abusive invasion. In this area of relating, we rigidly re-enacted her abuse at the hands of her father and mother (p.465)

In order to free both herself and her patient from this "murky" and "abusive" transference, and so transform the more intellectual discussions between them into more embodied and emotionally resonant experiences, Gentile reminded her patient of a male Latino psychology professor she had previously described as warm and caring, and asked her whether she ever wondered whether he abused his daughter, to which her patient replied no. Gentile writes "together we come up with the observation/meaning that maybe some fathers just somehow know, without their daughters having to tell them, that they shouldn't have sex with their children" (p.464). In her paper she explains this intervention as an attempt to create "a gendered and raced form of triangulation – pulling in a father figure [who was] not just any 'father' but a Latino psychologist [who] could function as a bridge in the moment for both of us, enabling a form of empathy that held, as opposed to split off, some of my culpability as a perpetrator" (pp.465-6).

In Gentile's description of this phase of the analytic work with her patient we can see how her way of working follows from her assumption that psychoanalysis in general and the analyst in particular are so deeply embedded in the racist and classist structure of the society within which both she and her patient are positioned that even the most basic clinical tools such as transference are implicated if not contaminated, and so of doubtful clinical benefit. So Gentile, at least in this phase of the work, has to create a different kind of dialogue, not a transference-based interpretive one which, presumably would risk reinforcing the analyst's social position of superiority, but one based on mutuality and joint exploration of how both patient and analyst position and become positioned in

the analytic relationship in terms of cultural forms of power. Gentile seems to see her analytic role here as taking the lead in such conversations by opening up her own position of white privilege for mutual exploration, a position in which she defines herself as a "perpetrator" of some of the violence and oppression to which her patient, as a working class Latino woman, is routinely subjected.

While seeing such mutual exploration as an essential part of the analysis, Gentile also recognizes its limitation. She acknowledges that intellectual conversation can all too easily be used as a defence against powerful emotional feelings and disturbing thoughts. In order to counteract this tendency, she tries to explore her own more emotional responses to her patient in order to see whether these can be used to inform and give more emotional weight to the analytic exploration with the patient, or whether they are getting in the way of furthering such a process. For instance while her patient was telling her of the details of the sexual abuse by her father, Gentile describes physical reactions so strong that at times she felt unable to breathe: "I would feel an invisible force lying on my body; a pressure on my chest and lap such that each breath was an effort" (p.459). She takes these affects as signs of the crushing weight of social and cultural norms, some of which help her better empathically understand her patient – as a woman she can understand the paralyzing effect on female victims of male violence – but some of which seem to render her unable to think about how to make therapeutic use of her understanding of herself not only as a victim but also as a "perpetrator".

In order to regain her capacity to think Gentile realizes she needs to process these powerful reactions to her patient. This is why she makes the clinical intervention of bringing in the Latino professor, as a way of inaugurating a mutual discussion of what makes good fathering, to give both herself and her patient a breathing and thinking space in order for them to find the most appropriate context for understanding the abuse by her father. Here Gentile can be seen as finding

a form of language in which to explore with her patient the intersection of the social categories of race, gender, age and authority, together with cultural discourses on what it means to be a caring man (or woman). Pitching her understanding of the patient's abuse at the psychosocial level, by creating a form of psychosocial transference, enables her to challenge her patient's shame over her Latino heritage in order to transform it into a potential resource for her. Gentile positions herself as essentially implicated in this exploration, and so seeks a form of clinical intervention that will enable her and her patient to take account of this mutual implication in a therapeutically productive way. Hence she describes the aim of her intervention as creating a form of "triangulation" for both her patient and herself, a "bridge" between categories, in particular those of "perpetrator" and "victim" that might otherwise seem impossible to bring together. Her intervention here could be understood as using an emotionally charged figure in the patient's life to create what Ronald Britton has called a "missing link" or "third position" (Britton, 1989), or what Antonino Ferro calls an "affective hologram" (2009), by which he means how an analyst makes use of an emotionally invested character in the patient's life to represent and contain very powerful and deeply embedded emotions which might otherwise remain unrepresentable. But for Gentile, working from a psychosocial perspective, such clinical terms take on a difference meaning. For her the "missing link" is the link between psychic and social reality, and those repressed or powerful emotions which defy representation are best accessed (at least in this instance) through an exploration of the social norms that normally obscure them. Furthermore as for Gentile, at least in this example, transference is a site of resistance and repetition rather than psychic change, it would be misleading to describe Gentile's way of thinking about and processing her very strong physical and emotional feelings as "countertransference", as that would mean she would think of these reactions as the counterpart in her of the prevailing transference. She uses her emotional reactions to the patient and to the work more as clues as to the kind of link in play between psychic and social reality.

Psychosocial thinking as providing a missing social context

The second account I have chosen also illustrates this kind of more radical thinking about what would constitute a psychoanalytic psychosocial practice. It is in the form of a vignette in a chapter written by Lynne Layton in which she looks back over her long clinical career as having been devoted to developing " a theory of the ways in which cultural inequalities of race, class, sex and gender enter into what happens in the clinic" (Layton, 2018, p.210). She acknowledges that these social categories need to be integrated with the "singularity" of each patient which it is the analytic task to reveal or construct.

> For example, if a patient is a white working class female, I want to know how this particular person has lived and is living both the facilitating and constricting aspects of class, sexuality, gender and race. I think about these categories as existing intersectionally; for example, the way that gender is lived is always marked not only by gender relations but by class, sexual and racial relations (p.210)

Her particular focus is on the ways patients in contemporary Western societies are largely unaware of what seem like free choices – of how to live, who they are and what they can become – are in fact conditioned by social forces beyond their control. But if patients can be shown that their choices are limited in this way, as she puts it "if they come to recognize that their choices were made within particular psychosocial "architectures of choice" (p.228), then they are less likely to blame themselves for their failures. This means finding a way of "supplying the social context" which will give them a more realistic and productive framework within which to make sense of their lives and aspirations.

Her particular way of doing this is by exploring the analyst-patient relationship to see how both parties can so easily fall into ways of thinking that minimize or ignore this social context. She does this through a mutual exploration with her patients of what she calls "normative unconscious processes" (Layton, 2006b), which structure the way we experience our identity and sense of ourselves. These normative unconscious processes can also find expression in political ideologies such as neo-liberalism. When these unconscious processes are powerfully activated, then "cultural inequalities are at times unconsciously and performatively reproduced" in the relationship between analyst and patient (2018, p.210).

Whereas in Gentile's clinical example the analyst had to work hard to bring to light for mutual exploration the operation of these cultural inequalities, Layton gives examples from her clinical work where the analytic task is more to foster the patient's own developing curiosity about the operation of these social forces in their lives. For Layton this means as analyst paying particular attention to any impulse in herself which might deflect from this psychosocial focus. In her 2006 paper, "Attacks on linking: the unconscious pull to dissociate individuals from their social context", (Layton, 2006a) she gives an example of a patient who dreamt of having a political conversation with John Kerry, then American Secretary of State. Layton describes her clinical strategy as one of resisting her own pull towards interpreting this dream in terms of the patient's individual and interpersonal history - "I had the sense that while her passion about what was happening politically might have had multiple psychic sources and motivations, it would be a mistake to understand what she was saying as *mere displacement*" (p.113, italics added). Instead she encouraged the patient to continue this imagined conversation, which then allowed the patient " to go more deeply into what she felt

about the state of the country, evincing a level of passion and state of conviction that I rarely had glimpsed in her" (2006a, p.112). Layton describes this clinical event as an example of her aim in her psychoanalytic work of helping her patient develop a capacity for social awareness and political engagement as well as the capacity to love and to work, an aim which would follow from her conception of psychoanalysis as needing to engage with cultural inequalities. One can also see how this overall conception of psychoanalysis informs her way, at least in this instance, of deepening and furthering the analytic process, as she describes how having the confidence to develop her political awareness becomes the vehicle for the patient to gain access to feelings at a deeper level and thereby discover and develop her own sense of the person she wanted to become.

In her 2018 paper she gives another example of this approach in a brief clinical vignette.

> A middle class white female patient had become ashamed of what she felt her family members condemned as too much desire for attention. When I began seeing her, she was in fact quite constricted. Sometime during our work together I moved into a home office, which I had decorated in higher style than the office I had been renting. In our first meeting in the new office, the theme of entitlement and selfishness arose. The patient spoke about having just read Barbara Ehrenreich's book *Nickel and Dimed*, and said she felt guilty and indulgent about having hired a maid for the first time. I said, 'It's hard to acknowledge that you're privileged". She agreed and held out her hand to show me her nails, which she had recently had done in clear polish. She said, 'I get my nails done, I have a therapist in Brookline in a place like this". My own privilege having been invoked, I think I felt anxious and did not know what to do with the guilt over privilege, hers, mine, ours. I remember having tried to normalize the privilege, saying something like, 'You don't have to feel guilty

> for having nice things'. I think this comment closed down something the patient was trying to say, something that went against the neoliberal grain because it attempted to connect her fortune to the misfortune of others. My first comment had kept the question of privilege open; the second one closed it down. There was something significant to explore here about our mutual discomfort about our privilege and its connection to the lack of privilege all around us, and I would suggest normalizing privilege is perhaps a neoliberalizing practice that keeps class inequality in place. This example illustrates that technical choices that focus on the individual as separate from the social are quite different from those that focus on the individual as psychosocial (p.229)

What is striking about this vignette is how Layton's description of her patient and her own clinical thinking is framed almost entirely in psychosocial terms, that is how she and her patient are positioning themselves in terms of social identity, particularly around aspects of privilege and entitlement. The patient is described in terms of her class, race and gender, and then in terms of her inhabiting and aspiring to particular geographical locations which carry meanings in terms of money and prestige. The more personal qualities of her patient are revealed in how she describes her relationship to other people– the novelist whose book she has read, the maid she has hired, the therapist who has moved to a fancy office. These characters are all located in a social sphere. They are used by Layton as indicators of psychosocial vectors, carriers of social class, status, gender etc., that structure the patient's affective and experiential life. Feelings are treated by Layton not only as personal attributes but also as having a social circulation (Wetherill, 2015). For instance the patient's shame is put into a social context, which allows for the patient to begin to discriminate between shame as a feature of her internal world in which she has continued to construct the world as constricting her, as it did in her childhood, and a shame which is the result of her dawning and painful awareness of her social position as privileged. It is this socially motivated shame that Layton

helps the patient explore, thus helping her to get a handle on her particular "architectures of choice".

Layton's clinical thinking is oriented towards making and evaluating her interventions in terms of whether they open up or close down this psychosocial space. Her first comment "it's hard to acknowledge that you're privileged", can appear to be no more than a simple observation, endorsing her patient's attempt to describe her feelings and thoughts about her growing realization of her position of privilege. But I think its function is more sophisticated: it serves to establish the figure of the maid as an affective hologram of her psychosocial positioning in the analytic discourse, representing the patient's capacity to allow herself to enjoy her life and her money without shame, but in a way that engages her growing sense of social responsibility. The use of the impersonal "it", rather than a more personal statement in the form of "you", can be seen as an intervention designed to help the patient get beyond a tendency to blame herself, and to think only of her internal reality, by locating her actions in a wider social sphere. By saying it is "hard" to make this acknowledgement is an implicit reference to the patient's capacity to identify and challenge the operation of normative unconscious processes.

One can see Layton's judgment that her intervention succeeded in opened up a psychosocial space as implicitly based on her reading of how the patient responded to this intervention. First of all, the patient makes what would seem to be a rather childlike gesture to Layton by showing her nails. This can be seen as the patient wanting to take her exploration of social positioning further, by now bringing in another person, the manicurist who does her nails, perhaps serving as an affective hologram (of privilege? of making herself beautiful without feeling guilty and ashamed? of allowing herself to take pleasure in "forbidden" activities?). At the same time it also seems to signal a

deepening of the relationship with Layton in a way that seems quite complex: positioning herself in a social sphere as someone like Layton, making herself more vulnerable by seeking her approval (showing her nails) and/or fearing disapproval, and maybe also setting up some kind of competitiveness between her and Layton (whose nails are the most beautiful, best manicured?). This is a psychosocial sphere which is not only about the more impersonal categories of social class, gender etc,. but one that is meaningful, alive and rich with potential meaning and affect for the patient.

By contrast Layton judges her second intervention, "you don't have to feel guilty for having nice things", which she recognizes is an intervention borne out of anxiety, as closing down this psychosocial space. Layton bases her judgement on a reading of her own motivation: trying to normalize privilege instead of exploring it, the result of the activation of normative unconscious thinking on her own part to reduce the social to the psychic. Layton's defensive retreat from the patient's exploration of her social responsibility can be seen in the design and construction of her second intervention, which far from following on from the first intervention seems to function as a way of undermining it. So instead of the impersonal "it", which points to a wider, social sphere, Layton directly addresses the patient with the more personal "you", which seems to direct the patient's attention back to the psychic sphere as separate from the social. The content of the intervention – "you don't have to feel guilty" – takes the patient's guilt not as a spur to painful exploration ,which is how the patient's state of mind is taken in Layton's first intervention, but now as a problem and therefore something the patient needs help in overcoming. Even the language she uses in this intervention, as in the blandness of the phrase "having nice things" seems designed to take away from the impact of her first intervention.

In their different interventions, Gentile and Layton use well established psychoanalytic methods and techniques – making use of characters as affective holograms, exploring affects, furthering understanding, exploring and processing their own reactions in the session - in a particular way in order to create and develop what might be called a psychosocial space or a psychosocial form of transference. In so doing, they claim they are radically changing the way psychoanalysis is theorized and practised. By contrast the following two authors I have chosen claim to be working psychosocially but within well established psychoanalytic parameters and principles.

Psychosocial thinking as a deeper engagement with existing psychoanalytic principles

The third clinical description is given by Fakhry Davids, taken from his book *Internal Racism*. In his book he describes how racism is internalized in the normal mind by a certain kind of "pathological organization", based on a form of object relation between a "self" and a "racialised other" (Davids, 2011, p.51) . Davids, who describes himself as a "brown-skinned British immigrant", gives an example from his own practice in which in a session at the beginning of an analysis, after making an interpretation to his white, British patient, the patient became overwhelmed with rage, yelling, swearing and mocking Davids to such an extent that the patient had tears in his eyes. Reflecting after this session on this violent and intense "onslaught", Davids employs his concept of internal racism to identify the patient's overwhelming rage towards him as the activation of a pathological organism in his mind. In seeking confirmation for this theoretical understanding, especially as this incident occurred very early in the analysis making it harder for Davids to draw on other material from the patient, he draws on his own feelings and reactions to the patient's behaviour, and in

particular the sudden and painful coming to mind of some of his own disturbing experiences of having been the victim of a racial attack:

> Feelings associated with racial harassment – of being immobilized in the grip of helpless fury – came flooding back…I realized that these were the very feelings that were alive in me after Mr. A's session, but which I couldn't name at the time: I had *felt* racially attacked (p.24)

In the next session Davids interprets the patient's overwhelming rage directed at him as an "attack", which he links to the patient having noticed that "I was a foreigner of a different race, and that this made him uncomfortable" (p.27). The patient's response – "are you accusing me of having made a racist attack?" – becomes the basis of some very difficult but ultimately productive work in the analysis.

In this clinical account Davids takes the patient's rage and links it explicitly to an aspect of social reality which he tells the patient is in play in the analytic relationship. His intervention is thus clearly a psychosocial one. But it is of a different kind to those described by Gentile and Layton. He positions himself as implicated in the patient's attack on him in the sense of describing himself to the patient as the object of this attack. But he uses his clinical understanding not to initiate the kind of mutual exploration of racism as something in play in the analysis, nor as something co-created by patient and analyst, that we saw in the work of Gentile and Layton. Instead he makes an observation about the patient's experience of him – the patient noticed he was of a different race and this made him uncomfortable. This is an observation which is also an interpretation designed to open up the patient's thinking about the impact of social reality at this point in the analysis, which it succeeds in doing as it is the patient who describes his behaviour as a racist attack.

For Davids the patient's racism is real, a feature common to the experience of both patient and analyst who both live in a racialized society, the features of which Davids explores in his book. But

his clinical focus is not on the patient's racism "out there" in the real world, as a consequence of living in a racialized society, but how it manifests itself in the relationship with the analyst. The aim is to help the patient see his racism as a defence against overwhelming feelings which become activated by certain experiences, in this case by encountering a non-white authority figure in the presence of whom he was starting to feel vulnerable. Davids then works towards helping the patient accept this unwelcome part of his personality by showing him how it is based on feelings and states of mind derived from early experiences which have formed a "template" in his mind, one which is:

> divided sharply between powerful parents and a powerless infant, whose dependency and helplessness are to be exploited, leading to endless resentment and hatred. It is not difficult to see how my Third World appearance presented him with an opportunity to embody the elements of this internal situation in the relationship between us, the infantile side lodged firmly in me" (p.33)

In this example Davids uses his understanding of social reality, in particular how racist and racialized thinking and experiences are formed, in order to deepen his understanding of the nature of the patient's psychic reality in this clinical encounter. He does this by using the normal psychoanalytic tools at his disposal. He makes clear his understanding of what constitutes a psychoanalytic psychosocial practice in a review of Farad Dalal's book on psychoanalysis and racism, which argues that psychoanalysis is incapable of understanding racism as it inevitably reduces social to psychic reality. While acknowledging his debt to Dalal's understanding of racism, which he draws on in his own book, Davids signals his disagreement with Dalal that psychoanalysis is unable to understand racism because of its individualistic bias. He argues that Dalal:

> observes that psychoanalytic practitioners do not give due weight to racist phenomena as they emerge in the consulting room, which he attributes to faulty, reductionist theory. In my view, this assumes too direct a link between clinical phenomena and theory, and I think it more likely that failures to deal adequately with racism in the consulting room reflect defensiveness on the part of the clinician. To understand such difficulties more fully would require a detailed and nuanced understanding of clinical interactions, which would, in turn, require a fuller engagement with psychoanalytic theory (Davids, 2008, p. 1651)

Widening the transference and countertransference

I think Davids' concept of "internal racism", and his use of this idea in his clinical thinking, would constitute a good example of what he might mean by a "fuller engagement with psychoanalytic thinking". In order to employ such a concept he makes use of transference, but in a wider way than in much of the classic psychoanalytic literature. His use of transference can be compared with one of the classic accounts of transference in the psychoanalytic literature, that of Betty Joseph, who took the concept of the "total transference" from Melanie Klein and developed it into a key idea within British object relations. Her basic idea was that of "transference as a framework, in which something is always going on, where there is always involvement and activity" (Joseph, 1985, p.447). In one of her papers she gives an example of what she means by this:

> With one patient it was possible to open up her feelings that I was antagonistic and controlling, that I did not want her to get on in her life or in her career. As we looked at her feelings about my motivation it became clear that in her mind I felt threatened by her, and deeply envious of her as a young intelligent person with her life ahead of her. I would then wish to explore most

> carefully her picture of me, this old, supposedly lonely, rather embittered person, and her quiet conviction of what I was like, and only very slowly and over a long period, hope to explore how much of these ideas might be linked with actual observations of myself or the way I function, how much projected parts of herself, and so on. (Joseph, 1983, p.148).

I would take this as an exemplary description of what "working in the transference" means to many psychoanalytic practitioners (particularly those working within the British Object Relations tradition). Transference is taken as an ever-present background drama, which every now and then takes centre stage. The point is for the analyst or therapist to accept the "reality" of this transference situation – indeed, the analyst needs to find ways of exploring it so as to make it a vibrant and developing drama between patient and analyst. But what is also striking about this account is the absence of social categories and a consideration of how they might affect the transference. Race, ethnicity and culture are simply absent in this description. When it comes to gender, one might wonder why Joseph refers to herself as "this old, supposedly lonely, embittered *person*" rather than *woman*. Social factors such as social class, privilege, access to money and power are implicit, in the background, but not made explicit, so we do not know whether such social realities were actually thought about or addressed in the analysis.

If Davids had made an interpretation to his patient that his rage was a reaction to feeling helpless and dependent on the analyst as a figure of authority, without making reference to his "Third World appearance", he would have followed this more traditional way of thinking about transference that keeps aspects of social reality to the margins. He chooses instead to make explicit reference to his racial identity to enable his patient and himself to engage even more powerfully with the transference, adding layers of complexity and nuance in how the power dynamics of the relationship between analyst and patient, here expressed in terms of attacker/attacked and

dominance/submission, are played out in the analysis. For Davids, the "something" that is always going on within the transference framework is something that crucially involves the formation and negotiation of the patient's deepest sense of his own social identity.

In this example Davids also implicitly acknowledges that the "something" always going on in the transference is constituted to a greater or lesser degree by those aspects of his own sense of social identity which became activated in the analytic encounter. So a key part of Davids' clinical thinking in widening the transference is his use of his countertransference, in particular his recollection of some of his own experiences of being non-white which led him to formulate to himself that in the clinical encounter with his enraged patient he had felt racially attacked. This can be seen as a widening of the concept of countertransference in which the analyst's reactions are taken not only as projections from the patient ("the patient reacted to me in such a way that I felt as if I had been racially attacked") but also as a recognition of his own subjectivity as a non-white person living in a racialized society ("I felt racially attacked because I have been racially attacked and I recognize what it feels like and that is it part of my own subjective experience of someone who is brown skinned working with a white patient"). It may be, then, that Davids brings in more psychosocial thinking than is made explicit by how he constitutes and uses his countertransference. Nevertheless he explicitly positions himself as working "within well-established analytic principles" (2011, p.201).

Psychosocial exploration in the countertransference

The fourth clinical account I have chosen is another example of someone who makes particular use of countertransference in order to work psychosocially. This is a description by Danielle Knafo In her paper, "Anti-Semitism in the Clinical Setting: Transference and Countertransference Dimensions"

(Knafo, 1999) of her work with a patient where the transference became so fixed that for a long time in the analysis it became unavailable as a space which could link together psychic and social reality. Knafo describes her interpretive strategy of unfixing this transference as that of helping the patient experience and then begin to work through in her experience of the analyst particular traumatic events in her childhood. While the transference remained fixed or restricted in this way, for a considerable time in the analysis the only clinical space available for psychosocial thinking was in the analyst's countertransference.

Like Davids, Knafo believes that the lack of psychoanalytic writing on working with patients who are openly anti-Semitic, and the difficulties described when such work is undertaken, is a sign not of the need to change psychoanalysis but of "personal oversensitivity and defensiveness" on the part of analysts, resulting in a silence " which too often is rationalized as analytic neutrality" (1999, pp.38-9). She recounts an experience early in her psychoanalytic career to support this idea, in which she found herself unable to continue working with an anti-Semitic Jewish patient, the son of parents who were concentration camp survivors. This followed a session in which the patient recounted in graphic detail to Knafo his masturbation fantasies of naked women about to die in Nazi gas chambers.

> In the middle of his account – and he became visibly excited in the telling – he looked up at me and included me in the fantasy. I inwardly recoiled in horror and fear and felt I could not work with him…I was unable to process this man's hostility in a therapeutic manner because it was made manifest in the most abhorrent imagery from the Holocaust (p.38)

In trying to make sense of this experience, Knafo starts from the assumption that the analytic relationship is always a social relationship (p.39), and that in this case she felt so threatened by the behaviour of the patient and the content of what he was talking about that she lost her ability to function psychoanalytically, that is interpret the material.

> When this occurs, I believe, anti-Semitic content is treated as an established reality with but one possible meaning, the "as if" quality of the transference is thereby lost, and the analysis loses the fluidity necessary for the exploration and elaboration of the patient's psychic reality and fantasy life. As a result, the analyst, like the rest of society, risks becoming paralyzed and joining in the "conspiracy of silence". In these situations, anti-Semitism becomes a vehicle not for the patient's conflicts and transference, but for conflicts and problems of the analyst. (p.39).

Here we can see Knafo's clinical aim: like Davids, to use the patient's anti-Semitism as a "vehicle" for exploring their innermost conflicts and traumas as they become activated in the transference. In such cases she judges the realm of social reality to be so massive or impermeable, in allowing of only one meaning in an absolute sense, that it becomes therapeutically unavailable for mutual exploration. No productive link between social and psychic reality then becomes possible. In her paper Knafo describes her own development as an analyst in encountering such clinical situations, no longer retreating in the face of her patients' anti-Semitism when it is experienced "as a uniform social phenomenon that is not to be touched" (p.40), but to find a way of working with anti-Semitic sentiments and behaviour by bringing them into the transference.

Knafo illustrates her approach in her description of her five times weekly ongoing analytic work with Ms. C, whose anti-Semitism had become "fixed in the transference" to such an extent that it threatened to overwhelm the patient and derail the analysis. Ms. C asserted that the most important event in her life was the abrupt departure of her Jewish father when she was eight years old. This left her to be looked after by her Catholic mother, whom Ms. C consistently described as psychotic and abusive. This meant that Ms. C "equated Jews with the rejection she had experienced at the hands of her father" (p.47).

Knafo describes how the patient, in her determination to discover or construct her own sense of Jewish identity, became interested to the point of obsession with Knafo's Jewish background and identity. The patient had found out from the referral source that Knafo was Jewish and born in Morocco, and remarked in the initial consultation how "intriguing and exotic" she found these origins. The intensity of Ms. C's feelings towards Knafo reached a climax in a series of sessions in the third year of the analysis, in which Ms. C expressed her envy for what she described as Knafo's "rootedness in Judaism" (p.54). She spoke of wishing but not daring to ask Knafo whether she considered her Jewish – what if she brought Knafo the results of a blood test proving she was her father's daughter, would Knafo then accept her?

> "You probably think, "poor thing., she's deluded about being Jewish!" she exclaimed. I interpreted that she wished for me to be the pretraumatic good father whose closeness guaranteed her Jewishness and all the positive memories associated with it" (p.54)

Here we can see how Knafo interprets the patient's intense wish for her to accept Ms. C as Jewish as the activation of an internal template that equates Knafo with the wished-for or remembered image

of a good and accepting father. This is an example of Knafo's interpretive strategy of working first to develop and enrich the psychic sphere before making any explicit links to social reality. Indeed she actively resists the patient's invitations to actively position herself on how Jewish identity can be defined and conferred. Another example of this is when the patient is described as frequently referring to the difference between Ashkenazi and Sephardic Jews – here would be another opportunity for the analyst to open up a social dimension to the patient's obsessive and self-destructive drive to locate herself as Jewish. But Knafo does not make any explicit reference to such psychosocial thinking. We do not know, for instance, how she responded to the patient describing her Moroccan origins as "intriguing and exotic", which may be a reference to differences in skin colour and/or cultural differences, and could also perhaps be seen as an example of what Edward Said has called "Orientialism," how people in the West conceive of the East (Said, 2003).

We might surmise that a clinical strategy of supplying a missing social context or developing a psychosocial space in the analysis would be seen as premature, serving to divert Knafo's prime clinical task as this point in the analysis as that of unfixing the transference as a psychic space. In fact Knafo goes on to describe how, once this transference crisis has been sufficiently weathered, Ms. C was able to develop a capacity to reflect on herself, and so able to see her anti-Semitic feelings as "reflections primarily of her own self" (p.57). Her clinical strategy seems to be that the patient's defences against experiencing her psychic reality needed to be worked through so that she could develop a richer and more nuanced kind of psychic reality which would be able to be linked up to a sense of social reality no longer so massive and absolute but now allowing for more complexity. Following these sessions Ms. C started to bring dreams in which relationships with other people were no longer experienced in simple and absolute black and white terms. She invented a word, "heteroclite" as the opposite of "orthodox", to describe such relationships, observing: "Until

recently I never thought I had conflicts. I felt one way or the other. Never two things at the same time. That has changed" (p.56).

If Knafo's clinical strategy with this patient at this point in the analysis does not make any explicit links between social and psychic reality, where does Knafo claim to do her psychosocial thinking? The answer is in her personal and private exploration of her own Jewish identity. She recounts that the intensity and extreme nature of Ms.C's transference initially led her to deny she had any personal reactions. But once she started to use her own personal analysis to understand how her own background and personal experiences as a Jew were impacting on her analytic work, she was able to use her own reactions as a resource she could deploy " in the service of the treatment" (p.58), to better understand and empathize with Ms. C's predicament. As Knafo puts it, she had to try to answer the very questions she was posing to Ms. C:

> What kind of Jew was I? Was my Judaism destined to be defined by my parents, or could I find a definition that suited me? And, being an immigrant who came from a very different background, did I not too struggle with bringing together within myself the different sides of what often felt like an irreconcilable cultural rift? (p.53)

In the course of such reflections she was able to recognize that "my Jewishness was clearly a complex matter, one that involved issues of identity, migration, and discrimination on the part of Jews and non-Jews alike" (p.58). This description is clearly rooted in a psychosocial framework. Indeed in describing herself as having to answer the same painfully complex questions about Jewish identity for herself that Ms. C was posing in the analysis, and so having to go through a process not unlike that undergone by her patient, one might wonder whether, rather like Davids, she is implicitly

widening the concept of countertransference to refer to some aspects of her own subjectivity as these were brought into play in the analysis. But, like Davids, she makes no such claim in her work. Instead what is evident is that she considers the fruit of the psychic work on herself to be shown in her ability to work more fully and in a more engaged way with her patient in the transference than she had been able to do with the patient she had encountered early in her career:

> I was once again confronted with a patient who expressed "concern" over her conviction that I had lost my entire family in World War II. This time, rather than respond defensively to her statement, I tried to explore and clarify what personal reasons she might have for killing off all my relatives (p.58).

What kind of comparative framework?

Despite the many limitations of this preliminary mapping of the field of psychosocial thinking within psychoanalysis – the small sample, chosen on personal grounds, without sufficient space for exploration of more work by each clinician to provide a more robust context for the clinical discussion, as well as having to make assumptions about the clinical thinking of each author without being able to discuss this directly with them – a close exploration of the clinical thinking of the authors chosen has led to the identification of some key elements of what might constitute the outline of a comparative framework. I started out with a rather crude assumption that clinical accounts of psychosocial psychoanalytic thinking could be differentiated in terms of whether or not they called for a radical change in the way psychoanalysts theorize and practice. I can now break this differentiating vector down into several differentiating components.

One difference is in how the term "psychosocial" is understood. In the clinical writing of Gentile and Layton it seems clear that for them psychic and social reality are inextricably linked to each other, so

much so that any attempt to conceive of them as separate realms risks producing a version of psychoanalytic practice that at best obscures and at worst perpetuates existing forms of social oppression and inequality. One might say for them that it is psychosocial thinking that is primary, the basic framework of their thinking, and that they view psychoanalytic theorizing and practice as a particular form of psychosocial thinking and practice. Looking at the debate conducted between a number of writers as to the meaning of "psychosocial" in the 2008 edition of the journal "Psychoanalysis, Culture and Society", their conception seems close to the definition given by Lisa Baraitser and Stephen Frosh in their contention that a psychosocial perspective is fundamentally disruptive of normal psychoanalytic practice. They recognize the need in psychoanalytic practice to give value to " personal experience, interconnectedness, intersubjectivity, affect, embodiment, agency and most importantly the impulse to articulate a kind of ethical subject". But their version of the psychosocial serves at the same time to completely disrupt this agenda "through the force of the revelation that there is no human subject, that what we take to be the realm of the personal, including the famous "inner world" of psychoanalysis, is either wavering, fragmentary and lost, or a thoroughly fictional entity" (Frosh and Baraitser, 2008, p.3).

By contrast Paul Hoggett, argues that the "internal and external worlds that make up psychic reality, while overlapping and mutually constituting, are also irreducible to each other".

> Each is governed by its own rules of structure formation. For the inner world these rules are part of what we call our psycho-logic…condensation, repression, projection, identification etc…they are not social constructions. I would go so far as to say that they can be discerned at work in all human societies; they are, in a sense, constitutive of what it means to be human. Similarly I believe the external world would have its own rules of structure formation that govern economy and society" (Hoggett, 2008, p.4)

If one were to develop this difference in how the relationship between psychic and social is understood further as a vector in this field, one might wonder whether it would generate different concepts of intersectionality, for instance whether what would constitute a good psychoanalytic psychosocial account should make reference to a range of different aspects of social identity and how they relate to each other.

In this definition of psychosocial there is room for an exploration of the psychic or social realms to some extent on their own terms, a conception of psychosocial thinking that would seem to support the practice of Davids and Knafo, for whom it might be said that their primary aim is to think and work psychoanalytically, so that any kind of psychosocial thinking would need to be accommodated within existing psychoanalytic principles. If one were to develop this difference in how the relationship between psychic and social is understood further as a vector in this field, one might wonder whether it would generate different concepts of intersectionality, for instance whether what would constitute a good psychoanalytic psychosocial account should make reference to a range of different aspects of social identity and how they relate to each other.

What is also at stake in comparing these difference clinical accounts is not only different ideas of what it means to think psychosocially but different versions of psychoanalysis as well, particularly when it comes to thinking of transference and countertransference. What is striking about the clinical accounts given by Gentile and Layton is the absence of instances of working in or with the transference in a conventional psychoanalytic way. Indeed for them to think and work psychosocially means eschewing a traditional transference interpretation, which for them would mean keeping understanding within the realms of the intra-psychic and interpersonal realms at the expense of social reality. This might render their clinical thinking vulnerable to a reading that could

view their strategy of opening up a psychosocial space as a defence against recognizing the full impact of the transference relationship, for instance one of oedipal rivalry and/or maternal dependence. However both Gentile and Layton argue in the particular clinical situations they describe that interpreting transferentially in this sense would simply lock their patients into a repetition of their original traumatic situation. In these situations making interventions based on the transference would be seen by then as a form of resistance rather than having the potential for change.

By contrast Davids and Knafo work with a conception of transference as the site *par excellence* of psychic change in psychoanalysis, and the way of linking psychic and social reality. Such a view of transference can be seen to draw on one of the ways Freud characterized transference in his papers on technique, where he described transference as " a piece of real experience" but "of a provisional nature" (1914, p.154). By "provisional nature" Freud meant "an intermediate region between illness and real life through which the transition from the one to the other is made" (SE X11 154).

There is a danger here of generalizing from too little clinical data. In Gentile's account of the particular phase of the work with her patient - in which she argues that a psychosocial way of working proved generative in finding a way out of a culturally determined theoretical and clinical *impasse* in which helping her patient recover from violence might be at the cost of reinstating unconscious cultural forms of violence - it may be that she made use of more conventional transference interpretations in other parts of the work. In Layton's case we can find examples in her clinical work elsewhere of more conventional transference interpretations (for example, Layton 2018, p.2 where she makes a direct transference interpretation to her patient concerning a dream

told in the analysis). Indeed Layton acknowledges that in her clinical writing she "doesn't always bother with describing the kinds of things most analysts do and that I do, too, because my work has been aimed at an absence in the literature, at illuminating the psychosocial dimension of subjectivity" (Layton, 2018c).

Nevertheless the differences in how transference is understood and used seems a very important vector in the field, as does the way countertransference is thought of. Whereas Gentile and Layton use their reactions to the patient and to the work as ways of registering the operation of psychosocial norms and structures, what might be called part of a mutual psychosocial transference between analyst and patient, Davids and Knafo write of their countertransference as their "counter" to the patient's transference – even though in their actual use of the term they may be widening the concept to include some conception of themselves as subjects in a psychosocial field.

These differences in how transference and countertransference are conceived can be seen to rest on fundamental differences about the aims of psychoanalysis which would translate into different understandings of what the analyst is trying to do and how to go about doing it. One way of exploring this further would be through an investigation of what each of these authors understands by the analytic concept of "neutrality". Although Davids and Knafo make no explicit reference to this term, in their description of their clinical interventions and interpretations they would seem to operate within a traditional or long established idea of neutrality, as for example defined by Freud in his injunction that the analyst "should be opaque to his patients and, like a mirror, should show them nothing but what us shown to him" (Freud, 1912, p.118). By contrast Gentile and Layton in their writing and in their description of their analytic affiliations could be seen to be operating with a concept of neutrality as described by Owen Renik's description of his analytic stance as one of

"complete analytic symmetry" - by which he means "analyst and analyzand are equally subjective, and both are responsible for full disclosure of their thinking, as they see it relevant to the reality of the psychoanalytic endeavour" (Renik, 1995, p.486). The idea of "full disclosure" of one's thinking can be taken, as it would seem to be by Gentile and Layton, as meaning a mutual exploration with the patient of how each is positioned in social as well as psychic reality.

But for those clinicians operating within a more traditional notion of analytic neutrality, such a view would be in danger of confusing analysing with moralizing. For instance in Winnicott's classic account of how Freud created the setting which allowed analytic work to be done he asserts that it is "well known" that the analyst "keeps moral judgment out of the relationship, has no wish to intrude with details of the analyst's personal life and ideas, and the analyst does not wish to take sides in the persecutory systems even when these appear in the form of real shared situations, local, political, etc." (1954, p.284). So if we are to use neutrality as one of the vectors in this field of psychoanalytic psychosocial practice, we would need a much deeper exploration of how different writers understand the relationship between analysis, morality and politics. Even in Winnicott's formulation, we might wonder what he means by "persecutory systems" which might appear in the form of "real shared situations". He does go on to say that in some social situations, such as "if the king dies" the analyst should be "not unaware". What has happened, then, within the analytic community as a whole, is that Winnicott's attitude of being "not unaware" has changed into one of needing to be aware, or being more explicitly aware, creating a relatively new field of psychoanalytic psychosocial practice which now needs to be mapped.

Footnote

1. In my discussion of Gentile's work I have followed her usage of the term "Latino" which seems to refer to someone of either sex who is identified or identifies as a member of the "Latino" ethnic/cultural group.

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