A White Therapist, an African American Patient—Shame in the Therapeutic Dyad: Commentary on Paper by Neil Altman

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Neil altman's candid sharing of this daunting case reveals a courage and openness too rarely encountered. It is difficult to talk honestly about race when our feelings depart from "correctness." Such a dialogue is long overdue.

Although some liberal bias may exist in many centers of professional training, the professional, like everyone else, is profoundly shaped by the culture's constructions of reality. A disturbing example of such influence is provided by a recent Georgetown University study. Experimenters (Schulman et al., 1999) sought to determine the role of physician decision-making in race and sex differences found in the treatment of cardiovascular disease. A group of 720 primary care physicians were given simulated patient protocols from which they were to determine need for further cardiac diagnostic procedures. Cardiac catheterization is considered the most sophisticated and useful of these procedures, "the best way to diagnose coronary artery disease and to decide whether to perform cardiac surgery" (Goldstein, 1999, p. A13). Effects of six variables were assessed: patient gender, race, age, level of coronary risk, type of chest pain, and results of an exercise stress test. Interviewed "patients" (videotaped actors) read from identical scripts, wore identical clothes, and had the same symptoms, insurance, occupations, and risk factors.

Catheterization was recommended for blacks (both male and female) 60 percent as often as it was prescribed for whites (male and female).

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Similarly, the procedure was recommended for women (both races) only 60 percent as often as for men (both races). These differences, however, can be attributed to the interaction of race and sex, as black women accounted for both racial and gender differences. African American women were referred for catheterization only 40 percent as frequently as white men. No differences in referral rates were found between white and black men or between white men and white women. Thus, to be black and female was to be referred for cardiac surgery dramatically less often (p = .004) than any other group. Further, the experimenters concluded that problematic beliefs were unconscious, as subjects indicated no overt evidence of racism, sexism, or differences in attribution of personality characteristics across groups.

It is for reasons such as these that Altman brings the person of the professional to his examination of racism. Unlike the physicians, he was aware of racist attitudes and their attendant affects. He also knew that his guilt and shame were distracting.

Shame is central in this case. Shame and shame-rage, motivating much of the patient's behavior, render the treatment problematic. In some measure, it is the therapist's shame about his own racism that obstructs access to the skills he possesses, and it is unanalyzed shame that contributes to a compromised therapeutic alliance. Finally, to a large degree it is both therapist and patient shame that renders what is so powerful in this therapy so difficult to say.

Shame's relative neglect within psychoanalysis reflects in part our subjective experience: Shame feels trivial and childish. We owe much of our present insight about shame to the pioneering work of Helen Block Lewis (1971); this knowledge has been enhanced by the study of narcissism and the psychology of the self. Shame is an experience of the "aware" self (Broucek, 1991).

Tomkins (1963) enumerated the ubiquity and variety of shame experiences:

If I wish to hear your voice but you will not speak to me, I can feel shame. If I wish to speak to you but you will not listen, I am ashamed. ... If I would like to share my ideas, aspirations or my values with you but you do not reciprocate, I am ashamed. If I wish to talk and you wish to talk at the same time, I can become ashamed. If I want to tell you my ideas but you wish to tell me yours, I can become ashamed [quoted in Broucek, 1991, pp. 94-95].

It is a peculiarity of shame that it is often not recognized, either by the person experiencing the affect or by the one who might witness it. According to Lewis (1987), unacknowledged shame is either overt and undifferentiated, or bypassed. Overt and
undifferentiated shame is characterized by acute discomfort and is often accompanied by autonomic activity (e.g., blushing, perspiring); however, ideation is absent, so the source of discomfort or even the nature of the feeling is unclear. In bypassed shame, there is much ideation about a shaming event but little or no affect; thinking and speech have an obsessive, ruminative quality that takes the familiar form of endless repetitions about what “I might have said [or done].” Although we cannot be certain, Mr. A’s shame was probably bypassed, as it never was acknowledged, and as no clinical evidence is reported suggesting undifferentiated shame.

There can be little question that this patient was ashamed. Like his therapist, he had become a member of the professional class, and must have appreciated the fee-for-service expectation. His unwillingness to speak to Altman on the phone and his failure to show up for appointments may well have been shame determined. And his ready offer of cash informs us not only of his wish to be seen as responsible, but also probably of his desire to be responsible.

Perhaps most suggestive of the patient’s shame is his rageful behavior (bounced checks, failure to pay the final bill), for rage is often the clue to the presence of shame. Lewis (1987) thought “humiliated fury” an inevitable consequence of undispelled shame, and proposed a shame-rage cycle in which shame was followed by shame-rage, which in turn produced guilt, often followed by more shame. Both the self and the humiliating other may be targets of shame-rage, though the self experiences the hostility passively, as in depression, and feels paralyzed and overwhelmed.

Shame-rage may, on the other hand, offer an avenue out of shame, and for this reason may be preferable to the internalized agony of the shame state (Olsen, 1996). As Olsen pointed out, however, rage is not an option for many people. Rage itself is shame-producing, and thus is to be avoided. In addition, rage may result in fear of destroying the loved one, guilt, fear of retaliation, and increased anxiety. If shame-rage cannot be directed away from the self, the original shame is severely intensified, now magnified by internality and fueled by rage. Such were the dynamics of Altman’s patient, and of the dyad (to be discussed), that only the most passive hostility was permissible. Should we accept Olsen’s formulation, this man’s shame must have been excruciating.

Altman’s recognition of the patient’s shame may have been obscured by his shame, as shame obliterates reflection. “Shame fences in that field of life that allows creativity to blossom and insight to arise” (Wurmser, 1994, p. 66). When one is ashamed, the world shrinks suddenly to a self simultaneously enlarged (in that one can think of nothing else) and diminished—a self both endangered and in need of protection. Such a self is consumed, and has neither the energy nor capacity for secondary process.

At times, the therapist’s shame reached such paralyzing levels. Altman writes, “In the face of my shame … it was difficult for me to confront Mr. A about the bounced checks … afraid that doing so would expose all these prejudices.” It is the therapist’s shame about “Jewish greed” that leads him to wonder, retrospectively, if the patient thought Altman was putting his needs first in pursuing payment of his fee—a line of thought wide of the mark, I suspect, from where the patient was. When the patient confronts the therapist with either accepting his check or waiting for cash, it is probably the cognitive disruption of shame that does not allow Altman to “freeze the situation in place and reflect on … [what] had developed between [them].”

How are we to understand the patient’s persistent bouncing of checks? As Altman suggests, it may have been an enactment. Perhaps the patient was treating the therapist as his father had treated him—promising money and then reneging. Or, he may have been treating the therapist as he wished to treat his father—ostensibly complying with a demand for money while in fact refusing. The enactment I am suggesting, however, is one with racial implications.

The simultaneous proffering and withholding of money are an attempt to enlist the therapist in the patient’s struggle with a conflicted sense of self—an enactment of his ambivalence. Is he the Ivy League law school graduate, trustworthy (to have gone to such a school must mean something) and responsible (even if disorganized), who has problems, sure, but is essentially okay? Or, is he that wild, Bronx street tough, so bad his own mother extrudes him from their home? Such an interpretation suggests that the patient’s behavior is an attempt to evoke the therapist’s acceptance in the face of his unconscionable performance.

When the therapist confronts Mr. A with the fact that all his checks have bounced, the patient responds that henceforth he will bring cash. The therapist replies that understanding what is happening between them is what is most important, which elicits a puzzling response. “The most important thing,” the patient says, “is that [the therapist’s] needs be taken care of.” This response seems less puzzling if we imagine it the endpoint of reasoning such as the following: “Dr. Altman, your needs should be addressed because you have fulfilled your end of the contract—always in your office awaiting me, listening attentively, providing insight. I, however, have behaved badly. So, of course your needs deserve to be met, and I will pay for missed visits.”

Ostensibly owning his irresponsibility, the patient assumes the persona of the Inferior Other, a persona demanded not simply by his irresponsibility, but by the fact of his blackness. In a racist society, the Good is appropriated by whiteness, and the Other becomes the antithesis of the Good ascribed to the former.
Bracher (1997) explicated such an idea in an editorial on psychoanalysis and racism:

[Racism] provides racists with immediate, direct recognition by the Symbolic Other [e.g., the African American] that they embody certain master signifiers. While non-racists have to perform in order to demonstrate that they embody signifiers like “human,” “intelligent,” “good,” “important,” and “powerful,” a white person in a white racist society embodies these master signifiers not by doing anything but simply by being white [p. 5].

Thus, the patient comes to any encounter with an unknown (and sometimes known) Caucasian with the fact of his socially constructed, inferior status, just as Altman brings the fact of his constructed superiority.

Following the interpretation that the patient is treating the therapist as his father treated him, the patient says he fears he will let their relationship die, as he has done with so many others. “It was only those who didn't give up, who kept calling and calling him, who became lasting friends. … [H]e did not want that to happen between [them].” The therapist is concerned that “pursuing [the patient] for money would be the way [he] would ‘keep calling him’ but would also be the way [he] would be letting him down by putting [his] needs ahead of [the patient’s].” I don't believe the patient is concerned that the therapist is putting his needs first. I believe, rather, that the patient is revealing the wish that the therapist will pursue treatment in spite of his behavior, because he finds him worthy of continued professional commitment.

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The critical moment of the treatment occurs when the therapist must choose between accepting a check or waiting for cash until the next session. The patient places the therapist in an unsolvable bind: If the therapist accepts assurance that the check will be good, he risks going unpaid; if he waits until the patient's next visit (when and if it occurs), he also risks nonpayment. The intersubjective space is filled with the unspoken. At some level, the patient must wonder how the therapist could accept his proposal. The therapist must wonder about the patient's metacommunication: What do the choices signify to him? What do they mean to the therapist? Moreover, the patient must always have anticipated and feared the therapist's judgment if not prejudice, and the therapist, who indeed has had racist thoughts, struggled with his guilt and shame.

The therapist knows that the moment is important in situ, as well as retrospectively: He wishes he had “reflected” on the situation. Indeed, I suspect his sense of “doom” as he accepts the patient's check is the affective component of his preconscious knowledge that he has participated in something crucial, rather than sought their mutual understanding.

**Contextualizing the Patient**

To contextualize this patient, it is insufficient to describe the world in which he presently resides; it is also necessary to delineate historical factors bearing on this present. Such proximal causes as parenting deficits, instances of racism, and poverty can be made to account for the behaviors this man exhibits. However, a richer and therefore truer understanding may be obtained by adding those distal causes that have produced him. The most catastrophic of these were slavery and the personal and institutional racism that survived it.

Slavery has left a void of meaning. This void in our consciousness is due in part to shame. It was shameful to have practiced slavery, shameful to occupy the status of slave, and those qualities used to justify slavery were innately shameful. What was shameful had to be hidden and banished from awareness.

Slavery is not the sole source of the African American's shame, however. To be the victim of human-induced trauma is the ultimate mortification, for there is no abasement as profound as what destroys

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subjectivity, which says through word or action, “What you need, what you desire, and what you feel are of complete and utter insignificance.” There can be little question of the traumatic essence of slavery.

Slavery is peculiarly absent from the trauma literature. Although attention is given the Holocaust, Three Mile Island, the Buffalo Creek Disaster, floods, earthquakes, sexual abuse, rape, even the Depression, except for a brief mention here and there slavery is missing from the canon. For instance, of two highly regarded general texts on trauma, Herman (1992) and Janoff-Bulman (1992), only Herman lists slavery in the index. She does not explicitly mention American slavery, however, and the one sentence that possibly refers to it is found in a discussion devoted to other victims of captivity—battered wives, abused children, and concentration camp inmates. Janoff-Bulman seems not to mention American slavery at all. Further, contributors to Caruth's (1995) lesser known Trauma do not discuss it. In fact, although its place within American history and American studies is assured and vast, it was not, until recently, part of our collective awareness, either as citizens or psychologists.

Trauma leaves a void due in part to the nature of its registration. Van der Kolk (1996) wrote, “The very nature of traumatic memory is to be dissociated” (p. 289). Unlike narrative memory, which incorporates events into preexistent schemas, traumatic memory appears to be stored as sensory and affective fragments that only later acquire linguistic and therefore meaningful components.

**Slavery**
Slavery—the capture of Africans, the Middle Passage, and the institution—was traumatic. Whether we define trauma as “a psychologically distressing event outside the range of usual human experience” (American Psychiatric Association, 1994) or, as the experience that brings to survivors “a jarring awareness of the fact of death” (Lifton quoted in Janoff-Bulman, 1992, p. 57), slavery qualifies.

Slavery imposed a complete and final disruption from the African's land, people, language, and customs. Attachments were violently and finally severed. The sense of one's place in the universe, of continuity with the past, of an expectable future—all were destroyed. Slavery was a condition bestowed for life and passed down to one's progeny. It was a total institution, inescapable, terminable for oneself only through death, but for one's descendants, never. The need to justify slaves’ economic exploitation required destruction of their subjectivity. This annihilation first had to be accomplished in the mind of their oppressors. Then, their own sense of self needed to be extinguished. Slaves should not complain, refute, weep, or rail, because such affect would demonstrate a distinct subjectivity and subvert the system of thought undergirding a vast social and economic structure.

With the Other's subjectivity deleted, no empathy could exist. Laub and Auerhahn (1989) wrote of the empathic failure suffered by Holocaust victims:

In the concentration camps, the sadistic, bureaucratic killing disproved [a] basic expectation [of empathy]. An empathic response was absent not only from the Nazis, but from fellow citizens and Allies as well (i.e., from society at large). When people prove malignant on such a massive scale, the survivor retains the memory of a basic deficit—of a compromise in the empathic dyad. ...

By the failure of empathy, we mean a massive failure of the interpersonal environment to mediate needs. Neither wishes that are an integral part of ... existence ... (e.g., wishes for food, protection, sleep ...) nor wishes that are within reason ... elicit an understanding, appropriate responsiveness. ... It is as if the victim's messages were sent into outer space [pp. 378-379].

What, then, was the psychological impact of slavery on the slave? Janoff-Bulman (1992) asserted that trauma shatters the survivor's internal world. It alters one's basic assumptions about the world's benevolence, changes one's sense that the world is meaningful, that there is justice and control, and alters one's assessment of worth (what kind of person am I that this would happen to me?). Further, Janoff-Bulman noted, “Our research suggests that survivors of human induced victimizations are most apt to hold negative assumptions about themselves and the benevolence of the world” (p. 77).

To address the psychoanalytic question of the effect of slavery and racism, however, we must turn to the personhood of slaves and their descendants and to the shaping of the self by the family. This psychological legacy is comprised of wounds to self and soma, the effects of those wounds on parenting, and the intergenerational transmission of these effects up to the present.

With their efforts to obliterate the slave's subjectivity, both slavers and culture at large (with the exception of abolitionists) were, of course, massively unempathic. A slave's feelings, if one could conceptualize their existence, were meaningless. Grief and anger were explicitly forbidden (see Fleischner, 1996; for general texts on slavery, see Franklin, 1947; Blassingame, 1972; Genovese, 1972).

The failure of empathy is but one prism through which slavery might be viewed, but it is an appealing lens for two reasons: it points to the destruction of subjectivity, about which we need know more, and it reverberates in the parenting practices of too many African American families.

If there is no empathic other to whom the unbearable may be borne, pain must be dissociated, disavowed. Disavowed affects exist but are inaccessible. Disavowal makes modulation impossible: Cognition cannot mediate, the affect cannot be differentiated, and its intensity cannot be diminished, for the selfobject containment that could alter it cannot be applied to an absent affect. Cordoned off from the reality-based components of the personality, such affects cannot profit from the ameliorating effects of experience and are not available as a source of information about the world.

A self thus diminished cannot modulate, soothe, or contain dysphoric affects in a child. Rather, it becomes necessary to prevent them because, unmodulated in the parent's self, they cannot be there contained. Given the centrality of affect to the development of the self, its prohibition will limit and distort that development and constrain the self's vigor, creativity, and harmony. Should the child
express anger toward the parent, it may be necessary to stamp out a subjectivity the parent finds threatening.

The self of such a parent is rarely empowered, rarely robust, besieged as it is from within and without. It cannot and will not tolerate from a child, for instance, anger it was never permitted, either at home or in the world. That would be entirely too much.

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“It was dangerous to be angry,” a black patient of mine reports. “Mother had crude expressions: ‘If you're angry, shove your feelings up your ass and get glad.’ And never stomp up the stairs or slam the door. That was the kiss of death.” After having been beaten, the patient, with her siblings, was not to cry, for anything more than sniffles would earn further assault. To be angry was unthinkable.

“I know you weren't talkin’ to me,” says a mother to a child who has muttered under his breath. Bill Cosby, in one of his early comedy routines, has his father (who is angry with him) say, “I brought you into this world, and I can take you out too.”

Sadness as well must be disavowed. Another patient was taught to manage disappointment by the grandmother with whom she lived. Gently, the grandmother said, “Why honey, you can't cry ‘cause its raining,” the rain having spoiled a long awaited picnic. “That's the Lord's work.” And the patient should not be disappointed over her parents’ divorce, which shattered her five-year-old world, or over her mother's psychosis, which left mother the child and the patient the parent. How could she resent father's passivity, which at times left her without the one parent she had? How could she ask more of him? Why, she should be grateful for all she had!

She did what was expected and became academically and professionally successful. But intimacy eluded her, because it exposed her to feelings she could not manage. She came into treatment baffled by her wish to divorce her husband, “a man of integrity and kindness, the finest man [she] knew.” Yes, she was annoyed at his mismanagement of money and disapproved of his treatment of their children. That his money mismanagement could threaten their financial base, that he was utterly unwilling to give up an unrealistic business venture that she had rescued more than once, that intimacy was so difficult—none of these could account for her inexplicable wish to leave him.

She was relatively unconcerned about her drinking (which was not infrequently solitary and sometimes heavy). At one point, she became concerned about her drug use, but, with her husband's patience and help, she overcame that dependency. She viewed her extreme need for isolation as simply the way she was. In truth, all her symptoms were efforts to protect and repair a schizoid, fragmented self, in large part the result of a proscription of affect that left her empty and numb.

The mother of Altman's patient is familiar to me. I hear her voice in my office. I have seen her in shopping malls, on the streets of my childhood, in my parents' home. It was not simply that Mr. A’s mother

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was mean, though he must have so experienced her. She had raised him the only way she knew, as she had been raised. Given where she lived, what we are told about her, and what I know of the African's American experience, it seems not too speculative to imagine that her life had been difficult. She must have dreamed of what this son might become, and tried to prevent what he must not. It is unlikely that she knew how to seek what he was and affirm it. Urgent parental agendas supercede empathy.

Her lack of empathy was shaming. Who must he be that she so lacked compassion, that she could turn him out of his home? She shamed through objectification (Broucek, 1991), most glaringly when she had the court declare him the kind of child who needed foster care, but probably in other ways as well. It is likely she actively humiliated him (Morrison, 1989, p. 20) given her rage and probable moralistic bent (both parents were described as religious).

Does her shaming not mirror the majority's behavior toward us? What other than an empathic lesion leads a white person to say, “I pulled myself up by my bootstraps; why can't they?” What is more objectifying than saying, “You people …”? Obvious racism is reflected in the fact that, in 1992, the U.S. Public Health Service's Abuse and Mental Health Services Administration estimated that 76 percent of illicit drug users in the United States were white, whereas arrests for drug use in cities throughout the country were overwhelmingly black. (In Baltimore, of 12,965 arrests for drug abuse in 1991, 11,107 were African American males; in Columbus, Ohio where black men accounted for less than 11 percent of the population, they accounted for more than 90 percent of drug arrests [Miller, 1996].) While the repercussions of such patterns are grave and many, shame must be included among them.

**Conclusion**

Altman's patient enters treatment struggling not only with a developmentally based diminished self, but with a culturally constructed inferiority that amplifies and perhaps even symbolizes his shame. I suspect the two become inextricably entwined. Onto this white therapist, who is to look into his soul, he must project an agony of identity—fearing, knowing that this white man, no matter how kind, no matter how liberal, will recognize in him his mother's son.

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But the therapist has also been damaged by racism. There is a way in which he cannot “see” the man who is his patient, a way in which the patient’s Otherness renders him opaque. I suspect it is one reason Altman fails to see the patient’s shame. Or, put another way, it is the therapist’s racism that deprivies him of the chance to ascribe to this man the same motives and affects he would ascribe to someone who is white. If the patient had been white, might this relational therapist have been more likely to share how the repetitive failure to pay had angered him, and might he have wondered if the patient had not felt similarly about his father (Ashmore-Hudson, personal communication, September 13, 1999)?

I want to be clear here: Particular racist thoughts and feelings got in the way of treatment, yes. The more significant problem, however, was the difficulty in extending to this Other a presumption of sameness, the proposition which lies at the heart of racism.

Although I have written here of difference, it is ultimately to argue for psychological identity. It is consignment to the category “different from me” that obscures this patient, that renders him unknowable. The problem is not one of information, for in these matters this therapist was more knowledgeable than most. He chose to work in the poor and black South Bronx (and write about this in The Analyst in the Inner City, 1995), and he is one of the founders of the Social Responsibility Section of the Division of Psychoanalysis (Division 39) of the American Psychological Association. Clearly he has the “identificatory” feelings he writes of, and is committed to action around issues of oppression.

One source of his identification must be his own traumatized ethnic history, a history that created an empathic resonance with African Americans and that, during much of the 20th century, led to an important political alliance between Jews and blacks. It is intriguing to wonder what impact this shared traumatic history may have had. Altman knows the shame of the despised.

Altman writes, “Society is itself not monolithic in its racial attitudes … [and we all] … consciously and unconsciously pick and choose which aspects of that influence of to be shaped by.” Altman’s response to his patient was not monolithic, for while he had racist thoughts he was also admiring and, having met Altman, I am certain had feelings of compassion and probably thoughts identificatory in nature.

Here we come, I believe, to what is so tenacious and powerful about racism: In spite of Altman’s awareness, in spite of his capacity at times to escape the restraints of his own constructed subjectivity, he could not, finally, accord to his patient an essential sameness. “The resistance to finding out that the Other is the same springs out of the reluctance to admit that the same is Other. If the average man could recognize that the Negro was ‘just like him,’ he would have to recognize that he was just like the Negro” (B. Johnson, quoted in Elliot, 1996, p. 68).

The reclaiming of projections is neither a single nor once-and-for-all process. No better proof of this assertion could be offered than that someone as self-aware, socially responsible and compassionate as Altman is still engaged in such “working through.”

References

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