to sustain social inequalities but also to do so via vicious circles of relational wounding and counter-wounding.

In what follows, I draw on examples both from the clinic and from an academic field that has emerged in the United Kingdom and Europe in the past 10 years: the field of psychosocial studies (a founding text is Hollway & Jefferson, 2000; see also Psychoanalysis, Culture & Society, 2008, Vol. 13). This field is unfortunately very underrepresented and undertheorized in the United States, which I imagine has largely to do with the fact that the United States is probably the country that practices the most radical separation between our conceptions of the social and the psychological. It is no secret that sociology in the United States is very antagonistic to psychology, and psychology generally operates as though, at best, culture is an add-on to what we know of as universal psychic structures.

To begin, I offer five connected thoughts about identity formation:

1. We construct our identities in particular social and political circumstances, within particular power arrangements. Social norms that positively value some ways of being human and devalue other ways condition the process of identity-formation while never fully determining its outcome (Bhabha, 1994; Butler, 1993, 1997; Hall, 1987/1996; Henriques et al., 1984).

2. Identities are intersectional. By this I mean that genders, for example, are always raced, classed, and sexed (Anzaldúa, 1990; Higginbotham, 1992; Williams, 1997; Yuval-Davis, 2006). Norms that mandate what it means to be a “proper” white working-class female differ from norms that mandate what it means to be a “proper” white middle-class female.

3. Although, to continue the example, the ideal white middle-class and white working-class female identities may differ, even differ radically, they are related: We build our identities in relation to whatever other identity constructs are circulating in the particular cultural moment in which we find ourselves. Members of minority subcultures might envy and/or repudiate attributes highly valued in the cultural group that holds most power—and vice versa—but all of us take up some psychic relationship to the ideals both of our subcultures and of dominant white middle-class culture—and
these may be contradictory and thus cause conflict (Bourdieu, 1984; Connell, 1995; Crenshaw, 1992; Friedman, 1995; Gates, 1996; Layton, 2004a/1998).

4. The different ways that basic psychological constructs are lived—constructs such as dependency, agency, emotionality, vulnerability, and shame—are inextricably interwoven with class, gender, race, and other identity positionings; they are not add-ons. Thus, although we all experience some version of these human capacities and attributes, we live them differently depending on where we locate ourselves along various identity dimensions—for example, social norms for proper upper-class white females include a version of dependency and a valuation of being dependent that differ from the ways white upper-class male norms figure and value dependency. As suggested, assuming these identity positions is no neutral process: The process occurs within relationships and within cultural hierarchies that differentially value particular psychological states. Thus, processes of identity formation often demand the splitting off of attributes, emotions, states of being that are not valued or are considered shameful for a particular subgroup (Altman, 1995; Benjamin, 1988; Chodorow, 1978; Corbett, 2009; Dimen, 2003; Domenici & Lesser, 1995; Goldner, 1991; Harris, 2005; Layton, 2004a/1998).

What complicates this further psychologically are historical processes of intergenerational transmission, which often create conflict in the way we live our identities and thus can create resistances to personal and cultural change (Aarseth et al., forthcoming). For example, my way of living dependency was shaped by the cultural norms for what it meant to be a proper white middle-class woman in my mother’s era (Breines, 1992; May, 1988); my mother was a good girl and she feels to this day that a woman ought to subordinate her autonomous strivings to those of her husband. By the time I was a young adult, those norms had changed dramatically. In fact, in my heterosexual white subculture in college, women had begun to deem it dangerous and weak to be dependent on a man both financially and emotionally. The norms that I began to embrace consciously were in fact in dramatic conflict with what I had taken in unconsciously, and

the conflict over how dependency and autonomy were to be lived led to particular psychological symptoms. This propelled me eventually into treatment, where I tried to work through the inherited norms that had radically split connection and dependence from what it meant to be autonomous.

5. Because of all this, it seems to me that beyond difference and sameness there is another issue to which we must attend, and that issue involves understanding the ways that living our identities implicate us in each other’s histories (see Altman, 2000; Bhabha, 1994; Davoine & Gaudillière, 2004; Grand, 2007; Pratt, 1984; Scanlon & Adlam, 2013; Straker, 2007; Suchet, 2010; Walkerdine & Jimenez, 2012; Walkerdine et al., 2013; Williams, 1997). I offer an example of the complexities of this relational view of identities from the field of psychosocial studies. In her book, Formations of Class and Gender: Becoming Respectable (1997), Beverley Skeggs studied the way a group of white British working-class women who sought upward mobility by enrolling in caregiving training programs created their identities in opposition to the upper-class women for whom they worked, claiming a kind of respectability for themselves based on what they considered to be their superior capacities to give care, capacities they found wanting in their self-absorbed, always busy female employers who “shop out their kids” (p. 71). At the same time, for Skeggs’s subjects, becoming respectable also meant disidentifying with the ways the female white working-class subject is typically figured in upper-class valuations—as slutty, less moral in general, and wanting in sophistication and taste. In the norms of dominant culture, it is the middle-class white female who holds the claim on respectability that this particular group of working-class females covet, appropriate for themselves, and attempt to redefine in their favor. Yet, as Skeggs shows, in a world in which the middle class has more social and economic capital than the working class, these women never do quite feel securely respectable. Thus are such psychological structures as respectability, dependency, reason, vulnerability, and emotion gendered, raced, classed, sexed, and subject to other dimensions of unequal power relations. Jockeying against each other to attain the precious
necessarily coercive and oppressive (e.g., Butler, 1990), that no version of racial or gender identity is healthy. But because power hierarchies do pull for defensive splitting, and because too often psychoanalytic theory ignores the psychic effects of the power hierarchies in which we live, it seems imperative to me that we put some thought into the ways the regressive and foreclosing uses of identity categories operate. As my examples illustrate, of primary psychological importance is the fact that cultural hierarchies, which confer power and exist for the benefit of those with power, not only tend to idealize certain subject positions and devalue others but also tend to do so by splitting human capacities and attributes and giving them class or race or gender assignments. To be proper subjects worthy of love and esteem, members of a dominant group are psychosocially encouraged to split off what the norm disavows and project it onto abject subordinate groups. And, as the examples also suggest, abject groups often make a virtue of the psychic space they are left to inhabit, and they find ways to distinguish themselves as superior both to the powerful and to those they deem inferior (Bourdieu, 1984).

As my autobiographical gender vignette suggests, norms are rarely internalized without conflict, and everyone’s unique way of making meaning tweaks norms such that, as Butler (1993) suggests, they will not necessarily be performed in the way power hierarchies expect them to be—this accounts for the diverse ways that gender, for example, is performed. Butler (1990, 1993) roots the diversity in the instability of language, whereas I would root it in history, where people constantly have to negotiate the conflicts that emerge when one set of internalized historical norms meets a new set or when we have to make something of the multiple and potentially contradictory relational matrices in which we live, or when we are subject to the intersectionality of potentially conflicting identity norms (e.g., where norms for what it means to be a valuable member of middle-class society conflict with gender or class norms). Importantly, however, as Butler (1993) has also argued, not all performances are possible; cultural norms pull for particular performances, and those whose performances do not accord with the norm are vulnerable to rejection and humiliation. But even the privileged, those whose performances do accord with the white middle-class norm and do receive social approval, face the psychological problems that result from splitting off part of what it means to be human. Power hierarchies that sustain class, gender, race, and sexual inequality make certain aspects of what it means to be human shameful—for example, dependence, need for the other, or, in my own gender case, assertion and aggression. Because the hierarchies split and categorize human attributes and capacities, we find in the clinic and in our lives unceasing conflict between those unconscious processes that seek to maintain the splits and those that refuse them.

I call the ones that seek to maintain the splits “normative unconscious processes” (Layton, 2002, 2004b, 2006a, 2006b, 2013)—that is, processes that pull us to repeat affect/behavior/cognition patterns that uphold the very social norms that cause psychic distress in the first place. They are one of the psychic forces that push us to consolidate the “right” kind of identity as they obstruct awareness of the workings of unequal power hierarchies. They thus protect the psychic splits that cultural norms mandate, and they do so because the risk of contesting them is often loss of love, social approval, and social privilege. But as my examples have shown, the result of the splitting intended to make a part of the self “other” in fact always keeps what has been split off near. Repetition compulsions are the very place where the struggle between coercive normative unconscious processes and counter-normative unconscious processes are enacted. And these repetitions are stirred up and played out in relation, particularly at moments of heightened vulnerability. In the clinic, then, we are likely to find patient and analyst engaging all the time in enactments of normative unconscious processes, in which the therapist is either unconsciously pulled by the same norms as those pulling the patient or herself pulled by oppressive norms.

Now I add another layer of complexity to these thoughts about normative unconscious processes. Because the result of splitting is to keep what has been split off near, because we project what we repudiate onto others, the ways we have been wounded will often stir up the wounds of those with whom we seek intimate contact.

Because identities are intersectional and constructed in relation to other identities, I think that to counter the splitting that power hierarchies mandate, and to understand how we replicate in the clinic and
elsewhere norms that sustain social inequality, we have to become conscious of the ways in which we defensively use our own investments in class, race, sexual, and gender hierarchies to distinguish ourselves as superior to others. We need to become more aware of how, in becoming who we are, we inadvertently and unconsciously can contribute to the pain of others, particularly those in less privileged positions. And in the clinic, of course, therapists are always in the position of privilege.

Distinction, the use of identity to establish superiority, is generally sought when trying to defend against the possibility of being hurt and humiliated, when trying to defend against exposing shameful vulnerabilities that you fear will at some point be used against you. In the clinical material that follows, I discuss examples of normative unconscious processes that involve relational repetition compulsions in which one or both parties take refuge in distinction. In most of these examples, we can see how shameful vulnerabilities that emerge as the price of inhabiting certain identity positions are split off and return in enactments that sustain inequality and obscure awareness of the ways we can become implicated in each other's suffering. I do not offer these as examples of analytic "mistakes." Rather, I offer them as examples of how all of us, in performing identity, unconsciously get caught up in sustaining our own and others' suffering.

My first example is a case I commented on awhile ago that shows the way in which sexist norms of proper white masculinity and femininity are enacted and sometimes sustained in the clinic (Layton & Bertone, 1998). This vignette begins when a white male analyst reports that, in early September, he knew he would have to be out of town in November (Gerson, 1996). He told all of his patients in a timely manner, save one, Ms. A, a white heterosexual female. Just 2 days before he was to leave, he communicated to her that an emergency had come up and he would have to be away for a few days. In their one remaining session, the patient free associated to a number of crises that might have come up for her analyst. The analyst felt guilty, not only for having lied but also for having caused further worry. He decided he would tell her that he had lied and ask her why she thinks he might have done so. He had thought he had not told her because of her characteristic hostile-dependent response.

But she says she thinks he did not tell her because he liked her and did not want to leave her. This leads to a reverie on his part, and he recalls that "in early September" she had learned of a possible job promotion in June that would have led to her moving and ending the analysis (note the repeat of "in early September," suggesting an unconscious connection between this information and the time when he first knew he had to be away). Her potential departure had not been taken up much in the analysis. Suddenly he is aware of how fond he is of her and that he will miss her. In this reverie, he acknowledges his dependence on her. "I thought to myself that I had reversed the role not to avoid her anger at my departure but rather to be consoled by her for the loss I would feel upon her departure" (p. 638). But when he speaks next, he says, "Just as you wish to be dependent on me, I too can have a wish to keep you dependent on me" (p. 638). While to himself the therapist could acknowledge being dependent on this less powerful female, to her he could only express a wish that he presumed each of them shared—to have her remain dependent on him. At first, the patient is flattered; she finds it touching. On the next day, there are references to "her ambivalent feelings about her possible departure" (p. 638). But during the next several sessions, she gets more depressed and

the predominant theme once again became her difficulties in imagining and maintaining a positive feeling about herself as a woman. In various ways we came back to the theme of how hard it was for her to imagine being the object of someone else's desire. (p. 638)

What struck me was the possibility that unconsciously patient and therapist were colluding in an enactment of both traditional gender splitting, in which the male is autonomous and not dependent, the female dependent and not autonomous, as well as an enactment of compulsory heterosexuality. Somehow the issue had shifted from her autonomous possible departure to whether or not she was desirable to a man. I wondered what might have happened if he had told her that his enactment had to do with his dependency on her, with his conflict about her autonomy, and if he had made it clear that that conflict was his problem, not hers? And what might have happened
had he considered the possibility that the question of sexual desirability might be a defensive reaction on both of their parts, a theme she and he retreated to when something else was at stake, in this case, her autonomy? We can see here how living sexist identity norms for proper masculinity, norms that make dependency feelings shameful and risky, might inhibit the male analyst and sustain suffering in the female patient.

My second set of vignettes is from a case I explored more fully in a 2006 issue of Psychoanalytic Quarterly devoted to race and ethnicity (Layton, 2006a). In a prolonged enactment, I realized only over time that my gay, male, Asian-American patient had ascribed whiteness and all the desirable attributes that went with whiteness to me. It is not so much that he was actively idealizing me, but that he was idealizing whiteness and I was feeling very securely white. When something I read about minority attempts to inhabit a fictive whiteness made me finally realize that I had assumed that position in the treatment, I began to explore what whiteness meant to him and, lo and behold, what it seemed to signify was a position of invulnerability, which, had he possessed it, would have guaranteed that he never have to feel the pain of humiliation again. As long as I was putting myself in that place, I must have been acting somewhat superior, which probably enabled me to tolerate his envy and idealization and to empathize with his feelings of inferiority. But I did not realize that I was in some ways re-enacting the very scene of humiliation by sustaining a superior stance. Indeed, although I well know intellectually that “whiteness” is a fiction, a cultural ideal created by repudiating undesirable attributes labeled non-white, I unconsciously held onto the privileged position because it enabled me to keep a certain distance both from my own ethnic vulnerabilities and from the pain caused this man by racism, not to mention homophobia. In doing so, however, I was in fact enacting the humiliation of racism and the projection of vulnerability that underlies it.

At another moment, I thought that I was being empathic with my patient’s difficulty knowing whether or not he was too deferential to others or, alternately, whether he was adhering to an ethic of politeness that was a norm of his culture. As he saw it, being polite was superior to the norms of a more selfish Western culture. Yet, the situations he described often reminded me of Benjamin’s (1988) analysis of domination and submission in gender relations. I told him this and said that if he were a female describing the situations he described to me, I would have thought that he might be conflicted about his assertive strivings and that it might feel safer to assume a submissive position. I did add that the difference in our cultural norms made me more perplexed about whether this was indeed submission or something else. What I was not conscious of until I tried to understand why he responded with a hostile zinger aimed right at the heart of my femininity, however, was that the very mention of a female submissive position was to this gay Asian male a wounding white cultural stereotype. Why had I framed it in those terms? Was I perhaps unconsciously enacting my own dissociated racism and homophobia? Was I imposing my own struggle with sexism, a vulnerable area for me, on his painful struggle with Orientalism and homophobia? What did it stir up for me to sit with a man who did not assert himself in ways I associate with masculinity?

A third example involves an upper middle-class African-American couple I saw for a short while. As in all couples’ therapies, one task of the therapist is to empathize with each member of the couple, but in this case feeling empathy was complicated by their very different and perhaps gendered ways of experiencing the wounds of racism and sexism. He was in a profession that was largely white and highly demanding. Although both were well educated, over time they had fallen into inhabiting traditional split gender roles in which he was the breadwinner and she the keeper of the home. He needed her to bolster his self-esteem, which repeatedly was battered by what they both felt was racism at work. She supported him, but at the same time she expressed the pain she felt at having so little time with him not by asking for time, which she thought would have gone nowhere because he felt he had to work as much as he did, but by giving moralizing lectures about how various aspects of his character were deficient, the ostensible purpose of which was to help him be more successful at work. One thing that struck me was how this relational pattern revealed the very different ways they experienced the wounds of racism—he felt that those moments in which he was not included or promoted at work had to do with racism and that there was nothing a black man could do to be rewarded in the way he felt he deserved to have been. She agreed
that there was racism at work, but she felt that his frequent lateness for meetings and his disorganization gave fuel to the racism, and that if he corrected his behavior, he would be more respected—she believed that a black man could succeed—if he was extra good. In the end, he felt unappreciated not only at work but also at home.

What was difficult for me was that, at times, to empathize with her was to empathize with a version of internalized racism in which she validated the norms of white success and seemed to suggest that color-blindness is possible. To empathize with him was to empathize with a version of cultural and personal sexism that had really harmed both of them, the splitting of roles into breadwinner and relationship-tender. To point to what that had done to her felt unempathic to him, as though I too did not really get how much time and effort a black man has to spend in the workplace in order to find acceptance. When she described his lax behavior and harshness toward her, she appealed to me as a woman fed up with selfish male behavior.

To complicate the situation further, in several early sessions he brought his resumes and monographs to show me. He brought them to me as the white professional woman who has the power to confer worth. His appeal to me to confer worth embroiled us in an old historical pattern in black/white relations, the one in which the black male repudiates the black female by seeking white female recognition, and in which the white female herself may well have unconscious desires propelling her toward protecting or desiring the black male. Historically, this pattern has set white women up against black women and has frequently interfered with the development of black/white female political solidarity. I think my female patient often felt I was too indulgent toward her husband, and when I presented the case at a conference in which there were many women of color present, it was clear that they, too, felt angry that I had not challenged what he was doing in turning to me for validation.

Although these examples are brief, I hope they help demonstrate that treaters and patients alike have formed their identities in larger histories of class, race, gender, and sexual inequalities, and that this can radically complicate our notions of what exactly is “other” and what exactly is good treatment.

NORMALIZATION AND OTHERNESS

A left-wing, academic, white working-class patient railed at me and at therapy for several years for what she perceived as my intention, conscious or unconscious, to “normalize” her. Indeed, there is currently a large literature, inspired by Foucault, on what sociologists have referred to as the normalizing function of the psychological sciences and professions (e.g., see Rose, 1989). What they mean by this is that at the heart of these professions lies an unconscious project to make middle-class white behaviors and values the standard of normalcy and to pathologize whatever is “Other” in relation to dominant norms.

One of the U.S. middle-class values that has been universalized as normal and as necessary for civilized society to function is the capacity for self-control, which involves, among other things, being reasonable and keeping emotional displays under control. I suggest that the capacity for self-control is increasingly necessary in a neoliberal society in which individuals are more responsible for taking on the kinds of caretaking functions formerly performed by our never very generous welfare state (Layton, 2009). And I think the effects turn up in various ways in the clinic. For example, a colleague recently presented her work with a college student who oscillates semester to semester between a high-achieving perfectionism that requires an extraordinary amount of discipline and self-control and a collapse into alcoholism and anorexia. The presentation was notable for the pull the analyst felt to make sure the student turned her papers in on time and did not flunk out. The pull is understandable, but I suggest that it can also be seen as a collusion with the perverse pole of non-caretaking and self-sufficient omnipotence to which so many of us have submitted ourselves in this age of free market fundamentalism.

In attempting to diminish the harshness of my middle-class patients’ punitive supererogos, I often find myself making interventions designed to help them feel less guilty and less bad about enjoying their privilege, but in so doing, I fear that I consciously and unconsciously collude with neoliberal norms that encourage the privileged not to look at the connection between their fortunate status and the unfortunate status of less privileged others.
I see a 60-something African-American female patient who has what she calls an “anger problem.” One reason she medicates herself with an antidepressant is so her feelings of being slighted do not lead her to getting out of control—she is much quicker to anger when she is not taking her Celexa. One day, she was telling me about a cancer awareness conference she attended at which the white specialist in charge was lecturing about random sample studies that show that the age for first screening for this cancer should be raised. My patient knew two crucial pieces of information not mentioned by the specialist: First, the so-called “random sample” is almost all white, and second, African-Americans are more often diagnosed at younger ages with this cancer than are whites. She was livid and did what she later labeled the “inappropriate” thing: She first asked about the random sample issue but then began delivering an angry lecture, thereby soon losing the sympathy of the nearly all-white audience and angering the speaker. She and I agreed that her anger was not the problem, but we also both know that in a white, middle-class public, venting it is only going to make her the pathologized one. This is a kind of situation that gives me the heebie-jeebies in relation to the work I do: What is my job here? Is it to help her be able to express anger in a way that will enable the anger to be heard? Can we do this without at the same time normalizing this process under rubrics such as those described in the dialectical behavior therapy manual as the need to moderate emotions, or as described in Bionian terms as helping her tolerate frustration so she can think? She can think perfectly well, but the fact is that any display of rageful discourse, unless wielded by the largely white and middle-class tea party, of course, is quickly pathologized and not heard. Anger at being slighted and invisible is a legacy of her family history to be sure, but her family history is also inflected by the BIG history of which I, too, am a part: the legacy of white racism and responses to it.

My work with the African-American couple and with this patient put me in mind of something Cornel West said and Anna Deavere Smith cites in her play, Twilight: Los Angeles (Levin, 2000). Speaking about racism in America, West says,

I think ... I think ... if white folks were to experience black sadness it would be too overwhelmin' for 'em. Very few whites could take seriously black sadness and still live the lives that they livin'. Livin' in denial ... oh, couldn't be that bad ... and they got their own form of sadness ... tends to be linked to the American dream. But it's a very different kind of sadness.

When I heard these words in the context of Smith's play, I thought that West was correct about whites living in denial but perhaps not quite correct in insisting on such a radical distinction between the two kinds of sadness. For I believe that the white form of sadness, the one linked to the American Dream and to the dominance of middle-class norms of behavior, has a lot to do with both black upper- and lower-class sadness, and work with patients such as those I mentioned has taught me a great deal about that connection. What the privileged split off to sustain white privilege has a lot to do both with white sadness and with black sadness. And black sadness is sustained not only by continuing inequalities but also by living out the result of what they had to split off to become “proper” black subjects in a white world that casts them as the inferior “Other.”

I conclude with one further example, a dream that one of my patients had a week or so after Hurricane Katrina, a dream that I think again reveals the unconscious ways our identity formation in conditions of inequality implicates us in each other’s suffering and each other’s histories. Like many of my patients, she had not mentioned Hurricane Katrina at all in sessions immediately following the event. Here is the dream:

I'm watching this dream unfold: There's a black woman who feels ill. She seems to get progressively worse. Her friends dig up a pit in the dirt and with water make it into a mud bath. They have her in it, rolling her around, back and forth, making more mud all the while. I'm worrying that they might be intending to put her under water. I don't want to be watching and not doing anything; I have to hope they have her best interests at heart and that they know what they're doing. The woman is in a delirium. When just her head is visible, her daughter, who has been watching, cries out, "That's my mama," and rushes closer to her to hug her. I don't remember seeing her submerged or getting better.

In the next scene, however, there's a whole crew of people escorting her to a TV show where she was supposed to be going on, but they were filling in for her because of her illness. Not only had she recovered, she
looked absolutely stunning, glamorous: reminiscent of Oprah. Her friends were rushing ahead and there was commotion as they were letting the TV people know that she was coming and to plan for her to come on.

When I asked for her associations, she first said that it seemed to her the dream was about the personal transformation that she was undergoing, one that held great excitement and promise but also great risks and anxiety. And then she said, “I don’t know why the people were black.” I asked what came to mind. She said it made her think of Hurricane Katrina and all the poor, black people. She said she was very upset about what was going on and then went on to speak disparagingly about “them,” those horrible people in the Bush administration and in New Orleans who did not think about how poor people without cars were going to get out. I was struck by the part of the dream where she says, “I don’t want to be watching and not doing anything,” and where she hopes the people in charge know what they are doing but fears they do not. So I asked her if she perhaps felt complicit in some way. She said she did not; she would never let such a thing happen.

Shame had set in, and I realized only later that addressing the complicity rather than the helplessness had likely suggested my own refusal of complicity, as though I somehow was able to stand outside as the curious, but not helpless, onlooker. And I think this prevented me from finding a way to explore with her the richness of this dream, a richness that goes beyond its obvious transferential aspects. I might have drawn on a pact this patient had made with her parents, who were quite critical and quite sure their way was the right way. The silent pact she had made was to do what they told her to do but to take no responsibility for any outcome, positive or negative. We might have talked about her hope that people in charge on all levels, including me, know what they are doing, and the fear they do not—and what do you do when you are pretty sure they do not? We might have talked about her associations to the daughter who cries out, “That’s my mama.” Perhaps then we would have been able to connect emotionally to the way that the dream and associations suggest a relational unconscious in which we are all interimplicated and interdependent—“that’s my mama”—while they simultaneously point to a contemporary social reality whose discourses deny interdependence and therefore deny complicity. In the United States, social discourses and norms pull for us to think of the psychic and the social as separate, and for the individual to see himself or herself as responsible only for the self and not for others. Because there is very little left of a social safety net in this country, most people literally feel that they are on their own and responsible for either sinking or swimming.

The dream struck me as perhaps revealing something important about the effects of these social circumstances on the unconscious, for it ends just as every U.S. disaster movie and Oprah show end. Her unconscious turned a tragedy of which we were all a part—a tragedy of class, race, and the indifference to human vulnerability manifest in neoconservative foreign policies and neoliberal monetary and domestic policies—into a spectacle, a story of personal triumph over adversity. Indeed, the magical reincarnation of the Oprah show is the very thing that cultural authorities offer in lieu of taking responsibility for the welfare of their citizens. My sense is that this abandonment is breeding a resentment and helplessness that shape some of the kinds of conflicts we see in the clinic. Just as the patient’s pact with her parents made her simultaneously too responsible and not responsible, so the government’s and corporate culture’s pact with its citizens makes us too responsible and not responsible enough for either ourselves or others.

CONCLUSION

As my examples have suggested, in a frame that assumes that our identities emerge from what we make of the numerous concordant, conflicting, and contradictory relational matrices in which we find ourselves—a frame that, while taking account of power differentials, is yet not a determinist frame—mutual interdependence emerges as a fact of being human. The full acknowledgment of that fact and its implications, however, is quite difficult to achieve, both in the clinic and in the culture, for to do so we must consistently work to integrate into ourselves what we have made “Other”—that is, what we have split off to become who we are, what we split off to become less vulnerable
to hurt and humiliation, what we split off in order to maintain privilege, and what we split off to sustain the individualist norm that insists we are not mutually implicated in each other’s lives and losses. I have argued that there is a way that all of our forms of collective sadness are interconnected. Although it is no easy task to unsettle those aspects of identity and identifications wrought from conditions of cultural inequality, I believe that the best we, as clinicians and citizens, can do for ourselves and our others is to work toward acknowledging how our defenses of distinction obstruct our awareness of the ways in which we are different, similar, and mutually interdependent.

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Commentary on Layton: Beyond Sameness and Difference; Some Transnational Perspectives

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Lynne Layton’s chapter can be understood as a critical intervention in two arenas of clinical literature and practice: (1) multicultural attempts to negotiate sameness and difference in ethically responsible and therapeutically effective ways, and (2) psychosocial studies as an academic field that is woefully “undertheorized” in the United States in contrast to Great Britain and Europe. Layton’s articulation of “the intersection of culture and psyche” thus aims to correct what she describes as a mutual antagonism in the United States between psychology and sociology, on the one hand, and to encourage practicing clinicians to understand culture as something more than a mere “add-on to what we know of as universal psychic structures,” on the other hand. Social norms and cultural formations, in other words, become key to a fundamental form of interdependence between patient and therapist. Beyond this, Layton suggests, active engagement with this form of interdependence will allow clinicians to move beyond mere acknowledgment of sameness and difference in the therapeutic setting in order to treat psychic conflicts more effectively. Interlaced conflicts and identities present themselves in this setting in terms of what she calls “normative unconscious processes and our mutual implication in each other’s suffering,” especially around internalized