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### COMMENTARY

# Management of race in psychotherapy and supervision

**Publish date:** June 22, 2020

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On the Friday evening after the public execution of George Floyd, we were painfully reminded of the urgency to address the inadequate management of race, racism, and anti-blackness in medical education, residency training, and postgraduate continuing medical education.



Dr. Constance E. Dunlap

The reminder did not originate from the rioting that was occurring around the globe, though we could feel the ground shifting beneath our feet as civic protests began to spread globally. Instead, it occurred during a webinar we were hosting for psychiatry residents focused on techniques for eliminating blind spots in the management of race in clinical psychotherapy supervision. (Dr. Jessica Isom chaired the webinar, Dr. Flavia DeSouza and Dr. Myra Mathis comoderated, and Dr. Ebony Dennis and Dr. Constance E. Dunlap served as discussants.)

Our panel had presented an ambitious agenda that included reviewing how the disavowal of bias, race, racism, and anti-blackness contributes to ineffective psychotherapy, undermines the quality of medical care, and perpetuates mental health disparities. We spent some time exploring how unacknowledged and unexamined conscious and unconscious racial stereotypes affect interpersonal relationships, the psychotherapeutic process, and the supervisory experience. Our presentation included a clinical vignette demonstrating how racism, colorism, and anti-blackness have global impact, influencing the self-esteem, identity formation, and identity consolidation of immigrants as they grapple with the unique form of racism that exists in America. Other clinical vignettes demonstrated blind spots that were retroactively identified though omitted in supervisory discussions. We also discussed alternative interventions and interpretations of the material presented.<sup>1-5</sup>



Dr. Ebony Dennis

Because 21st-century trainees are generally psychologically astute and committed to social justice, we did two things. First, before the webinar, we provided them access to a prerecorded explanation of [object relations theorist Melanie Klein](https://melanie-klein-trust.org.uk/theory/) <<https://melanie-klein-trust.org.uk/theory/>> 's paranoid-schizoid and depressive positions concepts, which were applied to theoretically explain the development of race, specifically the defenses used by early colonists that contributed to the development of "whiteness" and "blackness" as social constructs, and their influence on the development of the U.S. psyche. For example, as early colonists attempted to develop new and improved identities distinct from those they had in their homelands, they used enslaved black people (and other vulnerable groups) to "other." What we mean here by othering is the process of using an other to project one's badness into in order to relieve the self of

uncomfortable aspects and feelings originating within the self. If this other accepts the projection (which is often the case with vulnerable parties), the self recognizes, that is, identifies (locates) the bad they just projected in the other, who is now experienced as a bad-other. This is projection in action. If the other accepts the projection and behaves accordingly, for example, in a manner that reflects badness, this becomes projective identification. Conversely, if the other does not accept these projections, the self (who projects) is left to cope with aspects of the self s/he might not have the capacity to manage. By capacity, we are speaking of the Bionian <<https://psychoanalysis.org.uk/our-authors-and-theorists/wilfred-bion>> idea of the ability to experience an extreme emotion while also being able to think. Without the ego strength to cope with bad aspects of the self, the ego either collapses (and is unable to think) or further projection is attempted.<sup>6-8</sup>

We have seen this latter dynamic play out repeatedly when police officers fatally shoot black citizens and then claim that they feared for their lives; these same officers have been exonerated by juries by continuing to portray the deceased victims as threatening, dangerous objects not worthy of living. We are also seeing a global movement of black and nonblack people who are in touch with a justified rage that has motivated them to return these projections by collectively protesting, and in some cases, by rioting.



Dr. Flavia DeSouza

## Back to the webinar

In anticipating the residents' curiosity, impatience, and anger about the lack of progress, the second thing we did was to show a segment from the "Black Psychoanalysts Speak" trailer. In the clip played, senior

psychoanalyst [Kirkland C. Vaughans, PhD](https://apsa.org/apsaa-publications/vol50no3-TOC/html/vol50no3_04.xhtml) <[https://apsa.org/apsaa-publications/vol50no3-TOC/html/vol50no3\\_04.xhtml](https://apsa.org/apsaa-publications/vol50no3-TOC/html/vol50no3_04.xhtml)> , shares: "The issue of race so prompts excessive anxiety that it blocks off our ability to think."

We showed this clip to validate the trainees' frustrations about the difficulty the broader establishment has had with addressing this serious, longstanding public health problem. We wanted these young psychiatrists to know that there are psychoanalysts, psychiatrists, psychologists, and social workers who have been committed to this work, even though the contributions of this diverse group have curiously been omitted from education and training curricula.<sup>9</sup>

So, what happened? What was the painful reminder? After the formal panel presentations, a black male psychiatry resident recounted his experience in a clinical supervision meeting that had occurred several days after the murder of George Floyd. In short, a patient had shared his reactions to yet another incident of fatal police use of force and paused to ask how the resident physician, Dr. A., was doing. The question was experienced as sincere concern about the psychiatrist's mental well-being. The resident was not sure how to answer this question since it was a matter of self-disclosure, which was a reasonable and thoughtful consideration for a seasoned clinician and, certainly, for a novice therapist. The supervisor, Dr. B., seemingly eager to move on, to not think about this, responded to the resident by saying: "Now tell me about the patient." In other words, what had just been shared by the resident – material that featured a patient's reaction to another killing of a black man by police and the patient's expressed concern for his black psychiatrist, and this resident physician appropriately seeking space in supervision to process and receive guidance about how to respond – all of this was considered separate (split off from) and extraneous to the patient's treatment and the resident's training. This is a problem. And, unfortunately, this problem or some variation of it is not rare.



Dr. Jessica Isom

Why is this still the state of affairs when we have identified racism as a major health concern and our patients and our trainees are asking for help?

## Rethinking a metaphor

Despite calls to action over the last 50 years to encourage medicine to effectively address race and racism, deficits remain in didactic education, clinical rotations, and supervisory experiences of trainees of those learning how to do psychodynamic psychotherapy.<sup>8-10</sup> Earlier that evening, we used the metaphor of a vehicular blind spot to capture what we believe occurs in supervision. Like drivers, supervisors generally have the ability to see. However, there are places (times) and positions (stances) that block their vision (awareness). Racism – whether institutionalized, interpersonally mediated, or internalized – also contributes to this blindness.



Dr. Myra Mathis

As is true of drivers managing a blind spot, what is required is for the drivers – the supervisors – to lean forward or reposition themselves so as to avoid collisions, maintain safety, and continue on course. We use this metaphor because it is understood that any clinician providing psychodynamic supervision to psychiatry residents, regardless of professional discipline, has the requisite skills and training.<sup>10-13</sup>

Until May 25, we thought eliminating blind spots would be effective. But, in the aftermath of the police killing of George Floyd, our eyes have been opened.

We are encouraged by the global protests and initial actions to reform law enforcement, but we realize that medicine is in need of reform. Hiding behind the blue wall of silence is an establishment that has looked the other way while black and brown women, men, and children have come to live in fear as a result of the state-sanctioned violence that repeatedly occurs across the nation. Excessive police use of force is a public health issue of crisis magnitude. However, the house of medicine, like many other established structures in society, has colluded with the societal constructs that have supported law enforcement by remaining willfully blind, often neutral, and by refusing to make the necessary adjustments, including connecting the dots between police violence and physical and mental health.

For example, racism has never been listed even in the index of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders.<sup>14</sup> Being the victim of police use of force is not generally regarded as an adverse childhood experience, even though communities that are heavily policed experience harassment by law enforcement on a regular basis. The 12 causes of trauma listed on the website<sup>15</sup> of the National Child Traumatic Stress Network – bullying, community violence, complex trauma, disasters, early childhood trauma, intimate partner violence, medical trauma, physical abuse, refugee trauma, sexual abuse, terrorism and violence, and traumatic grief – do not include maltreatment, abuse, or trauma resulting from interactions with members of law enforcement. Much of the adverse childhood experiences literature focuses on white, upper middle class children and on experiences within the home. When community level experiences, such as discrimination based on race or ethnicity, are included, as in the Philadelphia ACES study,<sup>16</sup> as many as 40% reported ACE scores of greater than 4 for community level exposures.

As psychiatrists, we recognize the psychic underpinnings and parallels between the psychic projections onto black and brown people and the actual bullets pumped into the bodies of black and brown people; there is a lurid propensity to use these others as repositories. Those who have the privilege of being protected by law enforcement and the ability to avoid being used as containers for the psychic projections and bullets of some police officers also have the privilege of compartmentalizing and looking the other way when excessive acts of force – projections and projectiles – are used on other human beings. This partly explains why the injuries and deaths of black and brown people caused by police officers' excessive use of force have continued even though these unjustified deaths are widely televised and disseminated via various social media platforms.

Prior to the death of George Floyd on May 25, other than the [American Public Health Association <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>](https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence), the National Medical Association (NMA) was the only major medical organization to issue a call to consider police use of force as a public health issue. In its July 2016 press release, provided in the aftermath of the death of Freddie Gray while in the custody of Baltimore police officers, the NMA

summarized the scope of injuries citizens sustain during “the pre-custody (commission of a crime, during a fight, chase, and apprehension, during a siege or hostage situation, or during restraint or submission), custody (soon after being admitted to jail, during interrogation, during incarceration, or legal execution), and post-custody (revenge by police or rival criminals or after reentry into the community)” periods. It is noteworthy that the scope of these injuries is comparable to those encountered in a combat zone.<sup>17,18</sup>

According to the NMA:

*“Injuries sustained by civilians at the hands of law enforcement include gunshot wounds, skull fractures, cervical spine injuries, facial fractures, broken legs, blunt trauma orbital floor fractures, laryngeal cartilage fractures, shoulder dislocations, cuts and bruises, concussions, hemorrhage, choking (positional or due to upper body holds), abdominal trauma, hemothorax, and pneumothorax. Complications of such injuries include posttraumatic brain swelling, infections following open fractures and lacerations, hydrocephalus due to blood or infection, as well as subdural and epidural hematomas and, in the most severe cases, death.”*

In addition, there are multiple emotional and psychiatric sequelae of these injuries for the victims, families, upstanders, bystanders, and those viewing these images via various social media platforms. Increasingly, many are experiencing retraumatization each time a new death is reported. How do we explain that we are turning away from this as physicians and trainers of physicians? Seeing and not seeing – all of the methods used to avert one’s gaze and look the other way (to protect the psyches of nonmarginalized members of society from being disturbed and possibly traumatized) – these key defense mechanisms creep into consulting rooms and become fertile ground for the enactment described above.

Yet, there is reason to believe in change. It’s not simply because we are mental health professionals and that’s what we do. With the posting of position statements issued by major corporations and a growing number of medical organizations, many of us are experiencing a mixture of hope, anger, and sadness. Hope that widespread awareness will continue to tilt the axis of our country in a manner that opens eyes – and hearts – so that real work can be done; and anger and sadness because it has taken 400 years to receive even this level of validation.

In the meantime, we are encouraged by a joint position statement recently issued by the APA and the NMA, the first joint effort by these two medical organizations to partner and advocate for criminal justice reform. We mention this statement because the NMA has been committed to the needs of the black community since its inception in 1895, and the APA has as its mission a commitment to serve “the needs of evolving, diverse, underrepresented, and underserved patient populations” ... and the resources to do so. This is the kind of partnership that could transform words into meaningful action.<sup>19,20</sup>

Of course, resident psychiatrist Dr. A. had begun supervision with the discussion of his dyadic experience with his patient, which is set in the context of a global coronavirus pandemic that is disproportionately affecting black and brown people. And, while his peers are marching in protest, he and his fellow trainees deserve our support as they deal with their own psychic pain and prepare to steady themselves. For these psychiatrists will be called to provide care to those who will consult them once they begin to grapple with the experiences and, in some cases, traumas that have compelled them to take action and literally risk their safety and lives while protesting.

That evening, the residents were hungry for methods to fill the gaps in their training and supervision. In some cases, we provided scripts to be taken back to supervision. For example, the following is a potential scripted response for the supervisor in the enactment described above:

*Resident speaking to supervisor: This is a black patient who, like many others, is affected by the chronic, repeated televised images of black men killed by police. I am also a black man.*

*I think what I have shared is pertinent to the patient’s care and my experience as a black male psychiatrist who will need to learn how*

*to address this in my patients who are black and for other racialized groups, as well as with whites who might have rarely been cared for by a black man. Can we discuss this?*

We also anticipated that some residents would need to exercise their right to request reassignment to another supervisor. And, until we do better at listening, seeing, and deepening our understanding, outside and inside the consulting room and in supervision, more residents might need to steer around those who have the potential to undermine training and adversely affect treatment. But, as a professional medical community in crisis, do we really want to proceed in such an *ad hoc* fashion?

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*Dr. Mathis is an addictions fellow in the department of psychiatry at Yale University and former programwide chief resident at Yale. Her interests include the intersection of racial justice and mental health, health equity, and spirituality. She has no disclosures.*

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