9 Working with Difference

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This chapter was initially written as an essay topic for a Tavistock and University of East London (UK) postgraduate degree in psychoanalytic approaches to working with organisations. Thus the emphasis is on exploring organisational unconscious processes that arise in response to working with clients (patients) who, through the circumstance of their class, race, (dis)ability, gender, age, ethnicity or language, are different from the occupational therapist and/or the social-political 'norm' of that society.

In articulating the complexity which accompanies writing (or talking) about difference, Treacher (2001) wrote:

> *It has become commonplace to begin articles on issues of ethnicity with an apology . . . This is also my starting place but I do not want to make an act of contrition about being on uncertain and shaky ground – indeed, one of the arguments of this article is that this is the only place to be. This is not as a place of retreat or resignation but rather, that we have to hold open a space in which I/we know that we do not know entirely what is going on.*
>
> (p. 325)

What I think she saying is that talking about difference is never easy, and perhaps, it should never be easy. Her writing captures my own sense of discomfit in trying to write about my professional experiences in this area.

The clinical examples used within this work, described from over 10 years ago, remain relevant today as they explore the way institutions and/or professional organisations (e.g., occupational therapists) can use their empathic understanding of 'difference' to promote the rights of people who may be marginalised by unconscious normative processes used in a society. The work follows Menzies Lyth's (1988) seminal study of (unconscious) social defences used by nurses in acute care hospitals. Her hypothesis was that organisations (or professional groups)

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developed unconscious defences against the powerful emotional feelings that were stirred up by their work. This was especially pertinent for the emotionally demanding care work undertaken by staff with vulnerable patients.

> *Nurses face the reality of suffering and death as few lay people do. Their work involves carrying out tasks which by ordinary standards are distasteful, disgusting and frightening. Intimate physical contact with patients arouses libidinal and erotic wishes that may be difficult to control. The work arouses strong feelings: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse those feelings; envy of the care they receive.*
>
> (Menzies Lyth, 1988, p. 440)

Menzies Lyth proposed that the defences used by staff groups and/or organisations to protect themselves from overwhelming anxiety became concretised in the form of routines, roles and procedures in that organisation. These structures could potentially support staff in their work but could become unhelpful when they perpetuated a schism between the care work that nurses wanted to do and the work they found themselves told to perform.

> *. . . Menzies Lyth was able to analyse the procedures undertaken in the hospital both as defending the nurses from anxiety and preventing them from progressing beyond it. She identified various practices that in theory were espoused as poor nursing care, but in practice were commonplace, e.g. splitting the nurse from patient, objectifying patients into conditions and ritualising the performance of tasks to avoid the feeling of emotional responsibility for the clients.*
>
> (Nicholls, 2010, p. 58)

This chapter covers unhelpful processes (unconscious defences) that can be used by staff or services to protect themselves from the painful realities of exclusion for clients who are 'different'. It uses four clinical examples to explore ways in which difference is employed or exploited by the organisation, and offers some suggestions as to how occupational therapists can allow themselves to explore their 'cultural incompetence' (Swartz, 2007, p. 36). This notion of never being able to fully know another is helpful in keeping an open dialogue with all clients. Swartz, like Treacher (2001) in the quote that begins this chapter, believes it is more helpful to say we don't know, and we are sure to make mistakes, rather than to assume we can have a full knowledge of another's experience or ready answers for all situations.

> *. . . if we are serious about cultural competence we have to address the related question of our visceral experiences of cultural incompetence – the difficult, secret silences which can become even more shameful and hard to think about in the context of more and more bells and whistles of practice excellence in the field of cultural competence . . . we need to look for the silences around culture and competence, silences which are hard to hear or see . . . We live these silences out but it takes a particular way of looking, and indeed a particular courage to turn these silences into speech.*
>
> (Swartz, 2007, p. 43)

Note: In all the clinical examples used in this chapter, the names and identifying details of the institutions and individuals within them have been altered to protect their anonymity. In order to incorporate the terms used in psychoanalytic and occupational therapy ~~(OT)~~ literature, I have chosen to use the terms 'patient' and 'client' interchangeably. I have never thought that one term was better (or less discriminatory) than the other, and I hope that the following clinical vignettes, with their analysis and reflections on the organisational work, will speak for themselves.

Learning from the other

Alan Paton, a South African poet, politician and author, wrote the highly acclaimed novel *Cry, the Beloved Country* in 1948, following his 15-year work role of managing a reformatory for black teenagers who had committed crimes. The narrative, which embodies the pain of a country divided by racial conflict, places in juxtaposition the experiences of two fathers, one white and one black. Their encounter (meeting) produces a deep understanding of each other's experience and, thus, a growth within themselves.

In the story, the black man's (Kumalo's) son had killed the white man's (Jarvis's) son. There is a poignant moment when Jarvis, while sheltering from a rainstorm in Kumalo's church, asks if Kumalo's son (who has been caught and prosecuted) has been given a reprieve from the death sentence. He reads the letter handed to him by Kumalo, who is too overcome to speak, and sees that Kumalo's son has not been pardoned. He says that he does not understand anything of what has occurred and at the same time he also understands it all (Paton, 1988).

It is the capacity both not to understand and to understand completely[1] that is the hypothesis of this chapter. The poetic licence of the novel places these two fathers, through circumstance, to meet each other not only through the trauma of the crime, but in their shared love of a rural village in which Kumalo (a priest) has his church. Their interaction, which shifts between anger, shame, remorse and forgiveness, is a declaration that understanding the 'other' can bring about a change in oneself. It is also my hypothesis that because difference provides us with an 'other', it creates a learning opportunity for any person who wishes to explore their inner processes. This may lead to an understanding that extends beyond oneself to the social and political (emotional) realities of others and thereby may create a climate for partnership and change. Gordon (1993), in writing about racism, stated that it exists in two places at the same time. It is part of the real world, frequently supported by those who have political power and/or social status; and it exists in our internal world. It is this existence in our internal fantasy life that is frequently denied by our more conscious liberal selves.

The following clinical vignettes describe how difference is employed, explored or exploited by organisations. Although each example offers a densely textured account of the dynamics within the organisation, I will be drawing from them only certain aspects of how difference is treated by that particular situation, with

[1] I do not believe that any person understands 'completely', but the dramatic language of the novel expresses perhaps the desire to learn and so to understand experiences.

some links to theoretical constructs. 'Difference' covers a wide range of categories, such as race, gender, age, disability, and the roles of 'professional' and 'patient'. The chapter is an attempt to look at some of the consequences and difficulties in working with or ignoring difference as an ongoing dynamic in any organisation.

I do not wish to belie the reality of how difference is imbued with social and political power and that the experience of people who are 'different' can be one of abuse or victimisation. However, the chapter attempts to understand the need for organisations to ignore, exploit or incorporate difference in the service of containing their anxiety. In discussing the 'adoption' of anti-racist policies, Lousada (1994) comments that without the thinking that is required in understanding the dynamics of racism, there may be a temptation to a recourse of moralism, another form of fundamentalism.

> *It is precisely the recourse to moralism that has in my view done such a disservice to the cause of anti-racism inasmuch as it obscures the complexities of both the political and the psychological factors that produce racism, and the variety of actions that might be deployed to fight it.*
>
> (Lousada, 1994, p. 155)

Employing the split position: evoking admiration and/or fear of contamination

The paranoid schizoid position, as first discussed by Melanie Klein (1882–1960), describes the child's capacity to split objects into 'good' and 'bad'. The child does this in response to their internal experience of discomfort, which is projected outwards and into an object that is then felt by the child to possess those particular feelings.

> *Thus the ego has a relationship to two objects; the primary object, the breast being split into two parts, the ideal breast and the persecutory one. . . .. The infant's aim is to try to acquire, to keep inside and to identify with the ideal object, seen as life-giving and protective, and to keep out the bad object and those parts of the self which contain the death instinct.*
>
> (Segal, 1988, p. 26)

Many people in times of stress or illness return to a simplistic (fundamentalist) view of the world and use difference as a container for the bad and 'split-off' parts of themselves.

This could be experienced as fearfulness in racial difference, or difference in age, gender or professional position. The feelings of a patient towards hospital staff can mirror the early experiences of the child towards the mother, who is viewed as a split object: that is, not as a whole object.

This was once very clearly expressed to me by a medical doctor and friend (Richard), who was involved in a motor car accident, sustaining an incomplete lesion of his spinal cord, rendering him paralysed from the neck down. He said that in his first few weeks in hospital he thought the nurses had placed extremely heavy blankets on his body that prevented him from moving his limbs. He was convinced

they were being deliberately cruel and using these weights to torment him. He said that rationally he knew it was not the case and he was distressed at his paranoid response towards their care; after all, he worked with nurses in his professional role. It seemed to me that immediately following the accident Richard could not allow himself to experience the full impact of his disability, and so he imagined that it was the nurses who were preventing him from moving.

These 'split positions', as Menzies Lyth (1988) had discovered in her work with nurses, can unconsciously become part of the institutional culture of a unit. The benefits and concerns of this ingrained dynamic will be explored with the following clinical example.

Admiration as motivation

The Lavender Project, a drug dependency unit, operates at two levels. There is a 'detoxification' (Fennel) ward where patients are placed on an ever-reducing methadone script until they are drug free (known as 'clean'). This ward is physically adjacent to the recovery (Sage) ward, where patients are no longer using any substances (e.g., diazepam or methadone) and are involved in a group programme which allows for ever-increasing freedom in the community with a view to their returning to their homes or moving on to a further rehabilitation unit. Many of the patients on Sage ward have transferred directly from Fennel ward.

The patients from Fennel ward often say they feel better when they can see the patients from Sage ward, as it gives them an optimistic view of what they will be like. They say that Fennel ward is special because it is 'clean' and that the patients there seem more mature and 'sorted out'. The Fennel ward patients ask for increased contact with Sage ward as they 'look up to them' and they say that speaking with the Sage patients gives them 'hope'.

The organisation of the Lavender Project therefore employs the use of segregation to encourage patients on Fennel ward through their admiration of the 'other(s)' in Sage ward to feel more hopeful. The difference between those clients who are still 'using' (i.e., patients on medication) and those who are 'clean' may help to motivate those on Fennel ward to believe they can survive leaving their drug habit behind. The same admiration for those who have remained 'clean' is seen in the language of Narcotics Anonymous (NA) which speaks about a period of time clean, such as '10 years clean'. The premise in this (NA) recovery model is that drugs are given up *forever more*. Maintaining this fundamentalist (i.e.,) position and institutional separation may benefit patients who have had a chaotic drug using lifestyle and for whom real change would require an abstinence period of many years.

However, in situations where there are clear divisions between 'bad' and 'good', the projected material which has been placed in the other can also be feared. What became apparent to me, in working on the wards, was that many staff viewed the

patients in an equally 'split' way, and so feared contamination by the patients. In this NHS-funded unit, the staff had not been recruited from service users or as ex-addicts. The wards often gave explicit messages to the clients that none of them (i.e., the staff) had a history of drug using in their backgrounds. The patients often commented on this, saying they admired the staff who were seen as 'normal' but they would equally verbally attack the staff for not understanding what it (addiction) 'feels like'. Although it is not within the scope of this essay to discuss the complex issues around the social inclusion employment policies of many of the health care trusts to employ 'ex-users', I would like to explore a comment made by a staff member from the Lavender Project in the light of the split between patients and staff. The other side of admiration, which could be seen as placing one's good parts in the 'other', is the difficulty in placing one's 'bad' parts in the other, resulting in fear of retaliation or contamination.

Fear of contamination

The nursing staff, who have a small tearoom on Sage ward, wanted to buy a small fridge for their own use. When I suggested, as an interim measure, they put their lunch bags in one of the large fridges in the patients' self-catering kitchen, one nurse, Stella, said she would never do that 'because you never know what they [the patients] would put into it'.

The Lavender Project seemed to operate on maintaining a split position, but in doing so may have created a fear of the 'other', as experienced in the comment of Stella above. Segal (1988) explained, 'The leading anxiety in the paranoid-schizoid position is that the persecutory object or objects will get inside the ego and overwhelm and annihilate both the ideal object and the self' (p. 26).

I wondered if Stella may have been unconsciously re-enacting the split position, which operated on the wards, by concretely responding to the feeling that patients may indeed 'put things into us'. As Ogden (1979) noted in his description of projective identification, clients put their feelings into us as a primitive form of communication, and it is part of the therapist's work to try and understand what these feelings mean. They do this by thinking about their experience with the client. Bion (1962) called this type of thinking 'containment' – taking in and processing primitive experiences in order to make sense of them, even put them into words.

> *One major tool at the disposal of the therapist in his efforts at containing his patient's projective identifications is his ability to bring understanding to what he is feeling and to what is occurring between himself and his patient. The therapist's theoretical training, his personal analysis, his experience, his psychological mindedness, and his psychological language can all be brought to bear on the experience he is attempting to understand and contain.*
>
> (Ogden, 1979, p. 367)

It seemed that in the Lavender Project this capacity to think about the 'other' was, at times, lost – and as the ward employed the paranoid-schizoid position of functioning, the 'other' was viewed as either 'bad' or 'good' and these differences were encoded in policy and procedure. The fear and anxiety experienced by Stella was expressed as an uncritical thought: in other words, it was an accepted way of viewing and working with the patients. She did not consider that her fear was unfounded; she did not consider that clients could be trusted or enjoyed.

It could be that thinking about the emotional experiences of patients requires an understanding of the introjected material, perhaps feelings of envy, fear or helplessness, as Menzies Lyth (1988) suggested. This thinking about the 'other' would require the staff member to be 'occupied'[2] by the feelings of the patients, described by Bion as the work containment offered to the infant by the mother's capacity for reverie. It may be that this capacity for containment by staff members would have resulted in less dependence on the external boundaries of rule and procedure (e.g., locked doors, urine testing) and more use of therapy groups for exploring the unconscious aspects of the patients' addiction. The Lavender Project made this type of thinking difficult for patients and staff alike as it used the paranoid-schizoid position in the service of a graded (stepped) treatment programme.

Apartheid: the exploitation of difference and the personal price of racism

Holland (1990) in her writing on psychotherapy, oppression and social action asks the reader to consider the fact of racism as a system 'that works' (p. 261). She describes how difference in terms of race has been used by societies as a way of certain groups having access to power, profit and wealth. She states that 'We have to face the fact that racism cannot be eradicated by individual change; it can only be eradicated by in turn eradicating imperialism . . . we must face the fact that racism exists because it works' (Holland, 1990, p. 261).

Apartheid South Africa has symbolised (epitomised) an infamous example of the capacity for a minority group of privileged individuals (white South Africans) to withhold power from a majority population (made of many different racial and ethnic groups in South Africa) by exploiting the notion of racial divisions. As Rustin (1991) wrote: 'race is both an empty category and one of the most destructive and powerful forms of social categorization' (p. 57).

Gordon's (1993) article on 'Psychoanalysis and racism' reinforced this notion of race being an 'empty' category in defining difference. In other words, racial difference is not one that can be based in actual biological or cultural certainty and it may the very nature of this 'empty' category that makes it such an ideal container for split-off parts of the personality. Gordon states that black people in different countries or continents are thought of as being related to each other through the use of uncritical social constructs (e.g., prejudice and power in nation

[2] Bion (1962) speaks about the therapist creating an internal space where the introjected material, also known as the transference, can be experienced (and therefore thought about).

states can perpetuate many forms of exclusion) rather than through biological or genetic evidence.

Holland (1990) uses an explanatory model of how the individual patient may be helped through a process of internal recognition of their early life experiences to their social and political reality of oppression and discrimination. She distinguished between loss and expropriation, the former being an internal experience of the loss of loved objects and the latter being what has been taken or stolen from the individual in terms of their position (role) in society.

The help offered to individuals whose symptoms may be a direct result of the reality of their exclusion from society would do little good in offering explanations of their illness if the care environment perpetrated their experience of this schism in treatment. The next organisational example attempts to explore the difficulties when the patient's early life experiences of exclusion and prejudice are echoed in the institution that offered him healing.

Hate in the transference

In 1986 (before the abolishment of the apartheid regime in South Africa), I was working as an occupational therapist in an alcohol addiction treatment unit in Cape Town, South Africa. This hospital had been established as part of the apartheid treatment facilities for the different population groups in the Western Cape. In other words, there was a treatment facility for white patients who abused alcohol, and another separate hospital to treat 'non-white' patients. The hospital, which was located in a 'coloured'[3] area of the city, had a multidisciplinary team in which the only white staff were the consultant doctor and myself. All other staff members, nursing, secretarial, social workers and domestic staff, were 'coloured', Indian and Black. It was common at that time to have white staff work across all the hospitals, but 'coloured', Indian and Black staff could only work in 'coloured' hospitals, thereby with 'non-white' patients.

A patient, Jim McInnes, was admitted for treatment for his alcohol abuse. He was in his mid-forties and had a fair skin, blond hair and blue eyes. He spoke English with an Afrikaans accent,[4] and was very congenial and somewhat subservient in his manner. He stood out in the patient group, as he appeared white next to their brown skins.

[3] The term 'coloured' refers to a racial group who had been given a particular status in South Africa. It may be referred to as 'mixed race' in the UK. The broad population statistics of the Western Cape area in 1986 were approximately 52% 'coloured', 21% white and 27% black. There have been many debates following the change in government in South Africa about the use of the term 'coloured'. This has not to my knowledge been resolved as yet in a country in which privilege was awarded to individuals whose colour defined their status in society.

[4] An accent associated with the 'coloured' group, who were in the majority Afrikaans speaking.

Jim almost immediately formed an intense ambivalent transference towards me, in which he was outwardly appeasing and deferential towards me, but felt I was hypercritical and withholding from him. In a weekly therapy group, following his making a particularly complimentary remark towards my skill as a staff member on the team, I attempted to explore his underlying feelings towards me. This provoked a sudden emotional outpouring in which he stood up, his face contorted with grief and anger, and said I would never understand how much he hated and feared me.

He then told the group of his birth and experience of growing up in a divided (apartheid) land. He had been born as the only son to a Scottish (white) father and a South African ('coloured') mother. On the day of his birth his father went to the registry office and registered him as white. His mother went the following day and registered him as 'coloured'. And so he had been brought up in a 'coloured' area, attending 'coloured' schools and socialising with 'coloured' friends, but he looked white. He described how, when working as a labourer within a group of 'coloured' men, he would be approached as the 'boss' of the group by the foreman of the company, even though he was not the appointed leader. He had become the object of envy for his friends because of the privileges associated with being 'white'. He said when he was drunk and walking down the street, he would feel ashamed when he saw white people because he would feel he had betrayed his/their white skin.[5]

Jim's painful experiences were a result of a multi-layered violence. Explanations of his psychological trauma could be found in the account of the conflict within the parental couple (who would have been denied a legal marriage during their lifetime), and in the early death of his father who had been a distant and critical figure. However, understanding Jim's alcoholism as resulting from inner psychological processes would belie his lived experience of prejudice and social injustice. Jim's story begs us to consider his experience as both an internal conflict and an external reality.

> *. . . racism also means psychic injury, a fact that is played down or denied even by anti-racism . . . one does not want to add yet another layer of oppression . . . to the conception of black people as victims. But to pretend that there is no psychic price to be paid for everyday discrimination, abuse and violence – or threat of them – seems to me to be a denial of major proportions . . . we may go so far to say that this silence . . . is itself an injury and an injustice, for it is to deny people a part of their reality, psychic reality.*
>
> (Gordon, 1993, p. 65)

[5] The stereotype of the drunk coloured man (a 'klonkie') was in part Jim's way of identifying with his assigned / categorised racial group.

The hospital that offered treatment to Jim in 1986 was not able to consider how it perpetuated the experience of racial hatred and separateness that had been part of his life. It is my belief that in order to engage in some of the thinking about these issues, the staff at that time would have needed to look at their relatedness to each other, as identified by their professional roles and racial groupings. In reflecting on that time, I have wondered about my own difficulty in talking about the pervasive sense of guilt I had as a white therapist working in the 'coloured' hospital. Morgan (1998), in her paper entitled 'Between fear and blindness: The white therapist and the black patient', wrote that pretending there is no emotional dissonance when there is a racial or ethnic difference between the therapist and the client is a form of 'colour blindness' and may represent 'denial' against a painful reality. '[It is] a defence against a complex array of emotions that include anxiety, fear, guilt, shame and envy. No wonder we do our best to avoid the subject' (Morgan, 1998, p. 48).

By avoiding a discussion about our racial difference and thereby keeping the 'other' at a comfortable distance, I may have been defending against my depressive position anxiety. As Kleinian theory states, when an individual moves from a paranoid-schizoid position to a depressive position, they are exposed to their guilt at their destructive impulses and encounter a depressive despair. Added to this was my fear that in talking about my sense of guilt I would expose myself to the full tirade of hate from staff who had been the recipients of such destructive forces throughout their lifetimes: that is, racially oppressive treatment.

> *. . . the mourning and pining for the good object felt as lost and destroyed, and guilt, a characteristic depressive experience which arises from the sense that he has lost the good object through his own destructiveness. At the height of his ambivalence he is exposed to depressive despair . . . His pains are further increased by feelings of persecution, partly because at the height of depressive feelings, some regression will recur, in which bad feelings will again be projected and identified with internal persecutors . . .*
>
> (Segal, 1988, p. 70)

Since 1988 there have no longer been separate institutions to treat the different racial groups in the Western Cape. But the question in my mind is whether the real inequity in Jim's situation was that he may not have been helped when offered treatment in a facility which represented the internal and external reality of the experiences which led him to abuse alcohol in the first place. Holland (1990) states that the point of psychotherapy (with people who have come from backgrounds of racial discrimination) is to help them separate their 'neurotic hostility towards internalized lost objects/persons from the justifiable rage at oppressive treatment by others in the external world' (p. 267).

Avoiding difference: a need for fusion

Organisations that have been created specifically to offer a service to marginalised groups in society run the risk of denying the difference between society and the client group by 'joining' with the client group. This can be made particularly difficult when staff in the organisation are positively recruited as they are seen as

representatives of that difference. When the painfulness of difference cannot be faced, there is a temptation to resort to a manic defence, a denial of the harm experienced by the oppressed individual, and an equally manic reparative drive, which can be omnipotent and essentially patronising in its nature. Lousada (1994), in describing an agency's response to the accusation of racism, writes that it can 'produce a response which, via reaction formation, converts the feelings of persecution (implicit in the accusation) into a thoughtless admiration of the victim . . . Grandiose ambition replaces reality, conflict, discomfort and the modesty of what can be achieved for the client' (p. 157).

The following example comes from a role consultancy (a form of clinical supervision) I undertook at a mental health service established specifically for the needs of deaf clients. There are two illustrations of how this institution managed difference, the one being a manic reparative desire on behalf of the occupational therapist, and the other a fear of difference and need for fusion by an interpreter employed by the service.

Never enough

The occupational therapist, Lucy, did not have a hearing disability and had two years of intensive training in sign language. She was fairly fluent in signing and was both well integrated into the service and respected by her colleagues. Many of the staff (both clinical and clerical) were deaf, and all the meetings were held in sign language. When I visited the unit I was often struck at my sense of being an outsider in a world where people, staff and clients alike, 'spoke' to each other in a language which was both unintelligible to me, and silent.

Lucy was an insightful and sensitive person who was observant of the larger institutional dynamics. She was energetic, conscientious and able to keep modest and achievable goals for her work. However, when returning from a period of leave, she spoke of her great tiredness and difficulty in re-engaging in the unit. She described that when she gets back to work after a break, before she starts to 'cope again', she has a feeling of utter tiredness which comes from the feeling that she can 'not do enough for the clients'. She made an attempt to defend against the feeling and said that 'it always happens when I return from leave and I need to get used to being back'. She then paused and said, 'Sometimes I wonder what I am doing here.'

I wondered if her feeling of tiredness was a result of her getting in touch with the depression that was ever present when working with a group of patients who had a severe disability and whose need to be understood was hampered by both their deafness (lack of speech)[6] and their illness (thought disorder). The positive atmosphere

[6] I am not suggesting that sign language is a deficient language, but that the acquiring of sign language takes significantly longer for the deaf person, and often results in restricted vocational and social choices.

of the institution may have been a manic response to the tremendous difficulty in offering treatment to patients who were already discriminated against in society, whose access to education, work and social engagement was severely restricted.

In Lucy's wondering what she was doing 'here', she may have been trying to make contact with her need to help others, particularly deaf clients, whose experiences did not seem to echo her own life of privilege and purpose. The reparative drive, which is a response to depressive position anxieties, can be the basis for much of the work done with these clients (see Segal, 1988). However Lucy's 'cheerfulness', which following a period of leave threatened to break down, was quickly re-established. Manic reparation (her cheerfulness) denied any anger or guilt in working with these clients.

The atmosphere of the deaf unit was one in which being a deaf person was more highly valued than being a hearing person. Lucy described how, in meetings, hearing people would be criticised for their poor language (signing) skills. It seemed that in this institution you could only be one or the other, but an attempt to be both, a signing hearing person, filled you with a tiredness (sadness) and sense of loss, echoed in Lucy's words: 'I wonder what I am doing here.' It may be this shift from the split (paranoid-schizoid position) to the depressive position of understanding difference that was so hard. In the depressive position, Lucy may have been exposed to her guilt and concern for the lost and damaged phantasy objects, and her response to these feelings may have been to take control and do 'as much as she could', which ironically left her feeling that she could 'never do enough'.

Morgan (1998), in writing of her experience as a white analyst working with a black patient, said the patient, in telling stories of her life, would move between attacks on her therapist's 'whiteness' and self-deprecating remarks about her own 'blackness'. Morgan stated the patient seemed to want her to be black-like-her or remain white and part of the oppressive 'other':

> *Was I allied with these white others or would I join with her in her attack, and become black like her? What was not allowed . . . was our difference . . . D could defend herself against the anxiety of longing to become one with me or the terror of expulsion . . . The pain and frustration of me being different and separate from her could be avoided.*
>
> (Morgan, 1998, p. 58)

It may also be that in recognizing difference, the individual, at a psychic level, experiences the painfulness of his first recognition of his difference from his mother, and that a fusion between them is not possible. Basch-Kahre (1984) suggests this may also be the first experience of the oedipal anxiety where the infant recognises that the father (a different face from the mother) offers a real threat to their mother's undivided attention.

When discussing the transference and countertransference that occurs when the patent and analyst are from different sociocultural backgrounds, Basch-Kahre (1984) wrote:

> *The analyst may become aware of a feeling of loneliness and helplessness which is cut short by a feeling of anxiety and hostility . . . these are transference and countertransference feelings brought about by the*

> *reactivation of a very early childhood experience, namely the feelings of the eight-month-old baby when confronted with a strange face [the father] . . . [This anxiety] is not merely due to the absence of the mother . . . The father, and later his penis, become symbols . . . They symbolize that the mother has other interests than her baby and that symbiosis with her is impossible.*
>
> (Basch-Kahre, 1984, p. 62)

Becoming the 'other'

During a supervision session, Lucy told me that many of the interpreters[7] who worked for the deaf unit were married to deaf partners. She said that some of them, when alone with their partners, would behave as if they were also deaf. For example, they would only answer the door if the light and not the bell were used.

This may be an example of how, in order to avoid the painfulness of separation, and the sense of aloneness, the individual wishes for fusion and then acts as if they are the same as the 'other' (i.e., also deaf).

In these two examples, both Lucy and the interpreter are aware of their difference from the deaf person, but Lucy attempts to remain in touch with her experience of being 'privileged' and pays the price by feeling tired and hopeless at times, whereas the interpreter denies his difference in an attempt to avoid the thinking and experience of inner conflict. It may be this very lack of thinking that can perpetuate discrimination in the realm of diversity.

> *To think critically one must be able to use aggression to break through the limitations of one's own assumptions or challenge the 'squatting rights' of the colonizer within one's own internal world.*
>
> (Hoggett, 1992, p. 29)

In working with institutional change in organisations, the consultant should endeavour to provide a 'thinking space' for the staff group. The challenge of thinking, introducing a third position into the dyad between victim and persecutor, brings with it the territory of uncertainty and ambivalence, and perhaps a real depression (sadness) in the staff for the realities faced by many people with profound and enduring disabilities.

Containing difference: finding oneself in relation to the other

In a paper written for Dr Gordon Lawrence's 60th birthday, entitled 'Satan's return to heaven: The positive aspects of splitting',[8] Evelyn Cleverly sites many

[7] These are individuals who are able to hear, speak and sign, and are used to interpret for deaf staff or patients in 'hearing' meetings.

[8] This paper has never been formally published, but seems to resurface in different organisations and psychoanalytic reading groups.

examples of how the mechanism of splitting and projection allows individuals or organisations an opportunity to recognise the split-off part as being in relation to what is held in opposition. She states: 'Integration of a split is not, therefore, concerned with fusion, a blending together, or a kind of coalition; it is concerned with integrity. By that I mean, wholeness discovered and held in paradox through the acceptance and maintenance of coupling among the many, and duality within the one' (Cleverly, 1994, p. 5).

Cleverly (1994) suggests that it is this boundary of a 'thinking space', where the opposites are held in relation to each other, which creates the possibility of a new thought taking place: that is, the birth of a 'third something'. In describing this thinking space, she considers the need for a container that is robust enough to hold the opposites in relation to each other. One such 'container', she suggests, is an intimate relationship, where 'each is certain enough of their own and the other's capacity for recovery' that there can be an environment where 'shared intolerable anxieties can be related to in their projected and introjected form, modified, relinquished and re-owned' (1994, p. 7).

The robustness required of the container resonates with other articles on difference. Morgan (1998) writes about her work with the black patient as needing to be honest and strong enough for a relationship 'that held the possibility of aggression and hate' (p. 60). Lousada (1994) states that what is hard for the 'caring' professions is not the 'failure' of their caring, 'but the anxiety associated with the hateful feelings which are provoked by the client or their condition' (p. 42).

A consultancy offered to an institution (such as a weekly staff group) can provide a container for the clinical multidisciplinary team (MDT) to examine the splits that operate in the organisation and the defences that they may employ to cope with unmanageable (or unconscious) feelings. As Cleverly writes:

> *In my work with organizations I often experience a sense of wonder at the unconscious processes of splitting that develop to protect from, contain and defend against anxiety, and at the same time draw attention (if one is willing to have one's attention drawn) to those very issues that are the source of anxiety, offering them for exploration and naming.*
>
> (Cleverly, 1994, p. 6)

Victims and perpetrators

In 1996 I was asked to run a staff group with an MDT in a small, semi-urban mental hospital. Prior to starting the group, I had met with the managers of the institution and was assured there were no major staff difficulties and the staff had requested a group for 'support'. However, in my first meeting with the MDT staff it transpired that a senior staff member, 'Bill', had recently been investigated for seemingly inappropriate contact with (i.e., touching) some of the young male patients in the hospital.

The staff were extremely distressed and spoke openly about their experience of initially suspecting him of these actions, attempting to report him to the management and their feeling

of not being believed. The hospital management, who attended the group on a regular basis, spoke of the measures they had taken to discipline Bill, but were also clear that, although they had taken the matter seriously, he could not be dismissed as there was insufficient evidence.

During this time Bill attended some of the groups[9] and he spoke about his shame concerning his actions. He told the group that he needed help and he had made a commitment to the management to undergo therapy for his problems. After a period of 4 months, he decided to resign because he said he realised that 'doing this type of work made him worse'.

What fascinated me during this long and difficult time was that it was not the expulsion of Bill from the staff group which was the dominant topic of concern, but that individual staff members spoke about their own experience of abuse. After Bill's departure from the organisation, a nursing assistant, Geraldine, said that it had been a particularly painful time for her because, she said, 'My father was like him' (meaning Bill), but she said, 'it wasn't until I started working here that I realised there was help for people like him. I am sad that we [our family] didn't know that he could have been helped.'

The temptation in a situation of such stark conflict would have been to see Bill as bad and the patients as victims, but the group demonstrated a capacity to think about the situation, own their projections and hold the sadness of their experiences. Geraldine's humanity and her concern for the other had impressed me as an example of deeply felt reparative work.

Some further thoughts on working with difference

Gordon (1993), in his thoughtful article 'Souls in armour', says that within the experience of racism, black people do not want white people to love them, but to leave them alone, so they can get on with their lives without having to carry the white person's (unconsciously) projected guilt, shame, envy and anger. He says that the work required of the white person is to learn to love themselves: that is, not project their unwanted parts on to a black person and then crave a relationship with them.

Encountering difference provides us with an opportunity to make contact with our split-off parts, providing we can tolerate the painfulness of incorporating a previously hated aspect of ourselves. However, as Cleverly (1994) points out: 'New discovery and learning, is simultaneously experienced as a "finding" and a "losing", and inevitably demands an ambivalent response. We both welcome new knowledge and resist it to the end' (p. 12).

[9] Because of the ward shift system, Bill, like other staff, could not attend all the groups.

I want to return to the book *Cry, the Beloved Country*, where Jarvis again encounters Kumalo late in the evening on the day Kumalo's son is to be executed for the murder of Jarvis's son. Jarvis asks him where he is going and Kumalo cannot speak because he is too overcome with emotion and mumbles that he is walking to the mountains. Again Jarvis states that he can understand Kumalo's position; he may have said this because he too has lost a son. This empathic reaching out to Kumalo allows him to weep openly in Jarvis's presence. Kumalo then tries to thank him for the money he has donated to rebuild his (Kumalo's) church. Jarvis brushes this halting acknowledgement aside and says he wants to thank Kumalo for helping him out from the darkness of his despair (Paton, 1988). And so Jarvis thanks Kumalo for helping him understand the circumstances of his son's death, the racial tension in the country and mostly himself.

Difference, because it is so, cannot easily be ignored. It demands of us to think about the 'other', and thereby to learn about ourselves. Not to do so, as mentioned earlier in the examples of the staff at Jim's hospital and the nurse on Sage ward, carries the risk of, as Jarvis says, living in darkness. But to engage in thinking about difference exposes the individual to the loss of the familiar, and may be difficult to sustain in a social climate of blame and recrimination. Perhaps in modern (UK) culture the immediacy of trying to establish a cause (i.e., the blameworthy individual or group) for a tragic event can be thought of as a social defence against the overwhelming grief that accompanies a loss, but while the grief and sadness remains unacknowledged, it cannot be worked through.

Conclusion

The price and pain of insight (i.e., critical consciousness) is described by Annette Kuhn (1995), who, emerging from a period in her early life of class discrimination and later educational emancipation, writes about no longer being the 'one' or the 'other'. It may be that this is a position of integration, and within it a capacity for depressive position thinking that allows us to mourn what was not possible and may never be achieved. As Khun (1995) wrote: 'Happily, once embarked upon, there is no end to critical consciousness, to the hunger to learn and understand. Though perhaps for those of us who have learned silence through shame, the hardest thing of all is find a voice; not the voice of the monstrous singular ego, but one that, summoning the resources of the place we came from, can speak with eloquence of, and for, that place' (p. 103). What I think she is saying is that it is this critical awareness that allows us to break through the rhetoric of public opinion and cultural assumptions to become ethically reflexive citizens.

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