Severed Identities: Searching for Home and Recognition

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I have been struck by how many of my patients, in some ways, had pointed out similarities they either observed or assumed exist between us. Some periodically return to this issue during our subsequent sessions, insisting on the value and function of these particular similarities for them. Initially, what was even more striking to me about patients' insistence on focusing on perceived similarities between us, was that I am a foreign-born therapist, in America, and my "difference" was quite literally in the room – both visibly and audibly.

However, as I became more curious about what was happening, and why, I noticed a particular kind of similarity that some of my patients highlighted. Broadly stated, it was based on the question of social identity. More, the common thread among those patients who selectively focused on identity-based similarities was that they each suffered from a sense of dislocation or non-normative relationship with one or more of the social identities that they were expected to, or felt that they were supposed to, inhabit. Regardless of whether the pressure to conform came from internal or external sources, they all dealt with a pervasive feeling that something was missing from their own sense of self.

I suggest that for these patients identifying similarities between us, and holding on to them, has been a way to reduce anxiety associated with anticipatory disapproval and rejection, and an unconscious attempt to connect with the missing piece.

Therapist/patient binary

Clinical case presentations typically begin with a statement of the patient's basic demographics, including their age, gender, sexual orientation, racial/ethnic/religious background, marital status and profession. We often hear about these basic demographics even before the patient's stated complaints become clear and before the therapist's initial perceptions shared. The moment we are given this information, the patient is interpellated, automatically located within both the hegemonic structures of society and the structures of our minds. Yet, the patient's relationship with these identities, and their subjective experiences of them, may never even come up in their presentations if the central issue or the problem underlying that treatment seems to be unrelated to their social identities.

We often forget that the analyst and the patient are identities fixed in the hierarchical structures of the fields of psychoanalysis, mental health, and medicine, as well in wider society. The difference between these two subject positions, I would argue, is always the starting place for both parties. Both analyst and patient have no choice but to start by negotiating the analyst/patient binary. Along with this binary, many other identities and cultural associations, stereotypes, assumptions, symbols and signifiers about these identities flood the room.

The challenge for us is to find the following delicate balance. On the one hand, we need to be aware of our own ethnocentrism (negative and positive stereotypes and assumptions we hold about the other) and the danger of cultural determinism that it can inherently produce (by reducing the patient and their issues to "their culture"). On the other hand, we must work not to dismiss the actual shaping

power of identities (as in color-blind and gender-blind ideologies) and their subjective meanings, and not assume these are somehow artificial constructions covering over “the real” person.

Culture, identity and psychoanalytic theory

Harry Stack Sullivan and the first generation of interpersonal psychoanalysts seriously considered the interaction between culture and the person. They believed the process of socialization (enculturation), that is, the influences of the early environment and interpersonal relations, had a significant shaping impact on the person’s self-system and their contemporary experiences (Frie, 2014). As Sullivan succinctly put it, “We all know when we are ‘at fault’ about what we did – an idea which is first learned in childhood from the authority figures” (p. 92). Within the analyst/patient relationship – in any given event, this sense leads patients to shape their narratives if they think they reacted to or behaved in a manner different from what is culturally expected and thereby anticipate criticism from their therapists.

Contemporary psychoanalytic discussions involving culture and culturally-shaped interactions include the analysts’ own formulated and unformulated cultural assumptions about their patients (e.g. Davies, 2011; Dimen, 2011; Kuriloff, 2001; Layton, 2015). However, we also need to focus on how patients understand and experience their relationship with their identities and cultural environments. For many people, their given and chosen identities are a source of anxiety, as either their self-experience does not often match social expectations associated with these identities, or their competing identities cause inner conflict. To be able to observe the ways in which our patients deal with these conflicts, we need to move away from traditional conceptualizations of culture that prioritize shared public patterns and ignore internal inconsistencies, conflicts, and contradictions. Anthropologist Katherine Ewing defines culture as “a style of argument, a process of negotiating a position” (Molino, 2004, p. 86), and argues for a model of culture that “…involves the idea that actions and meanings are highly contextualized, that the decentered subject is operating in terms of multiple cues in the environments” (p. 90). Culture, she suggests, can be seen as Lacan’s Symbolic Order, “a structure of signs in which meaning is based on difference, in the Saussurean sense” (Ewing 1997, p. 28). Lacan’s Symbolic Order, the third and last phase in his developmental model, constitutes the subjects’ acquisition of language. At the same time, severed from the previous Imaginary Order of fantasy (an illusion of wholeness, merger with mother), this subject is left with an unresolved tension based on an impossible desire for recognition (also see Hook and Neill, 2008).

While being critical of Lacan’s single overarching Symbolic Order, Ewing takes the idea of a subject split by its entry into language, “but a language of a particular sort – the signifiers of an ideology that are fixed through the process of domination” (p. 36). She suggests that “[t]his subject may be activated by a desire for recognition that passes through a Symbolic Order” for “[c]oherent ideologies provide an illusory promise of plenitude…” (p. 36). In other words, identities based on hegemonic ideologies (cultural, racial, ethnic, gender, political, religious) are articulated in public discourse and provide a temporary sense of wholeness- a sense of belonging based on group membership. This, in turn, requires sameness among the group members and clear differences from the members of other groups. On the other hand, while being a member of a group promises a sense of belonging – a joyful experience of being recognized based on sameness, one’s personal history of and subjective experience with these identities can vary significantly.

Not feeling at home / Not feeling seen

I will now highlight two cases that I have observed in my clinical work in which the patients’ relationship to their identity had been a source of pervasive anxiety. By focusing on the patients’ search for similarities between us, and the ways in which they utilized these similarities, I aim to show

their complicated and precarious existence in the midst of competing ideologies. Here, I argue that the patients' anxiety stems from the tension between not feeling at home in their national/immigrant and racial identities, respectively, and their desire for recognition; countering that anxiety, in some cases, comes from creating an associational identity link with the analyst.

Masha

Masha, a married woman from an Eastern European country (with strong ties to the former Soviet Union), frequently vents about her American in-laws and their cold, impersonal "American" ways. Being foreign myself, she assumes I feel the same way. She became particularly agitated after one Thanksgiving visit: "And they never clean and never heat the house. I am always cold there. They never have enough food in their fridge. They never prepare enough either. I am used to having left overs! Don't you? It's the same way in your country, isn't it?" Masha talks about childhood summers in her grandparent's village and the country house where any family members could drop by with their children, and there is always room for all. There were plenty of fresh vegetables from the garden that they all tended to together. She asks me if I too find the tomatoes taste like cardboard here in the United States.

As we talk about her memories and explore her fantasies of my similar experiences, Masha's sense that something is always missing comes to the foreground. Her early memories of always feeling hungry and cold also slowly emerge. Masha doesn't know if she felt this way because they were poor and nothing was really available under the Soviet system, or because she was somewhat neglected at home. Probably both, she says. She describes her mother as being very anxious and fearful about the communist government. She describes her father as being mild-mannered, but also absent upon losing his position in the government (and his pension) with the collapse of the Soviet Union. He started drinking.

In the context of this traumatic political history that forced generations to change their social and political identities overnight, I understood Masha's inquiries and fantasies about my culture neither as simply seeking affirmation, nor as an attempt to get me to agree with her about the bad behaviors of her in-laws. Rather, severed from her past identities more than once, she was making an effort to seek recognition and a momentary sense of belonging within the fantasy of our similar experiences of feeling cold and hungry in a foreign country.

Alicia

Another patient, Alicia, self-identifies as bi-racial. She gets frustrated when people insist that she is black and her bi-racial identity is not recognized. "I am not white, but I am not black either; I am bi-racial. Why is this so hard to accept?" She experiences no sense of belonging, and agonizes over being "unseen." Alicia first told me she was glad that I was not an American because then she wouldn't have to worry about offending me by saying something negative about racial identity. She wouldn't have to worry about being politically correct. Later, she told me she thought I understand her experience of not feeling comfortable with either racial identity better because I was bi-cultural. It seemed my different national background positioned me outside the racial ideology and protected both of us from culturally-scripted racial stereotypes, biases, and assumptions.

Alicia grew up with her white mother and went to schools with predominantly white student bodies. Her parents divorced when she was four years old. Growing up, she sided with her mother who had few nice things to say about Alicia's father, and "hated" her father for not being there. As we explored more, it became more evident that Alicia missed her father but could not tell her mother of this, worrying that would upset her. One day at school, peers asked if she was adopted. Alicia expressed

that was the moment she realized she did not look like her mother. She remembers feeling very confused, betrayed and angry. Recently, Alicia found an old picture and brought it to session. The picture was of the three of them together as an intact family and smiling for the camera. She said she could literally see that she was the only link between her parents. “Perhaps that is why it is very important for me to be seen as bi-racial.”

The dislocation these patients felt with severed social identities and the pervasive feeling of not belonging overwhelmed both Masha and Alicia at a younger age. Each projected her unease in a different way, but both sought to alleviate it by establishing some sense of common identity based on their experience with me. With these examples, my goal was to argue that to be able to recognize and explore the ways in which our patients deal with these conflicts we need to consider the connection between social identities articulated in public discourses and negotiated by individuals. This way we also intentionally become co-participants and loosen the analyst/patient binary.

References

Davies, J. (2011). “Cultural Dimensions of Intersubjectivity.” *Psychoanalytic Psychology*, 28 (4): 549-559.

Dimen, M. (2011). *With Culture in Mind*. Routledge.

Ewing, P. K. (1997). *Arguing Sainthood*. Duke University Press.

Frie, R. (2014). “What is Cultural Psychoanalysis?” *Contemporary Psychoanalysis*, 50 (3): 371-394.

Hook, D. and Neill, C. (2008). Perspectives on “Lacanian subjectivities,” *Subjectivity*, 24 (1). pp. 247-255.

Kuriloff, E. (2001). “A Two-Culture Psychology.” *Contemporary Psychoanalysis*, 37: 673-681.

Layton, L. (2015). “Beyond Sameness and Difference” in *Psychology and Other*, D. Goodman and M. Freeman (Eds). Oxford. pp.168-188.

Molino, A. (2004). *Culture Subject Psyche*. Wesleyan University Press.

Sullivan, H.S. (1970). *The Psychiatric Interview*. W.W. Norton & Company.