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Pepperdine University
Graduate School of Education and Psychology

WORKING IN THE TRANSFERENCE AS A MULTICULTURAL INTERVENTION

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Goni Hary Bissell

October, 2011

Shelly P. Harrell, Ph.D.—Dissertation Chairperson

This clinical dissertation, written by

Goni Hary Bissell

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

The purpose of this dissertation is to use a critical review of the literature to provide a framework for working psychodynamically/psychoanalytically with clients that is informed by developments in multicultural psychology. The psychoanalytic technique of working in the transference from a contemporary Kleinian perspective is discussed and analyzed from the perspective of multicultural psychology. The history of multicultural psychology is discussed with a focus on events that led to the formulation of principles of multicultural competence. The history of the concept of transference from the perspective of Freud and Klein is described in order to introduce the writings of contemporary Kleinian authors on the technique of working the transference. The technique of working in the transference is critiqued from a multicultural perspective and suggestions are provided to contemporary Kleinian therapists who are interested in adding a multicultural component to their clinical work.

Chapter 1: Introduction and Background Literature

The purpose of this dissertation is to provide a framework for working psychoanalytically with clients that is informed by developments in multicultural psychology. In order to limit the scope of the project, a specific psychoanalytic technique, that of working in the transference from a contemporary Kleinian perspective, will be discussed and analyzed from the perspective of multicultural psychology. The goal of this project is to more clearly delineate how psychoanalytic techniques can be effectively integrated with multicultural awareness to both deepen the therapeutic relationship and provide more effective treatment to patients in today's multicultural society.

The current chapter presents a summary of the preliminary literature review in order to provide the background and foundation for the integrative tasks described above. One of the important principles of multicultural psychology, first elucidated by Fanon (1952/2008), is the fact that individuals cannot be understood outside of the context in which they exist—that we are not just products of intrapsychic dynamics, but “an object among other objects” (p. 89). Therefore, any study of psychoanalysis should begin with a discussion of its context within Victorian Austria and the unique cultural milieu of its founder, Sigmund Freud. As this dissertation project is being written in the United States, the emigration of psychoanalysis to the U.S. will also be described. As a first step in illustrating the importance of a multicultural analysis, this history of the assimilation of psychoanalysis into U.S. culture will be described with a view to illustrating the role of sociocultural factors in shaping psychoanalytic theory. Finally, some initial commonalities and differences between psychoanalytic theory and multicultural theory

will be discussed with the goal of illustrating the dynamic chemistry between the two fields both historically and for the future.

Introduction to the Literature Review

It is hard to underestimate the impact of history on who we are. Whether it is the chemical history of our genetic makeup or the traditions of our family, we all grow up within a specific, albeit multi-faceted context. From a postmodern research paradigm, the researcher's history and lens are important to identify and assess in terms of their impact on how the literature is interpreted (Fine, 1998). For this author, psychoanalysis is part of my history on both a personal and cultural level. Personally, because of being raised by a mother with a lifelong interest in psychoanalysis, and culturally because of the history of psychoanalysis as developed by a Jewish man and initially embraced by his fellow Jews. Many years in psychoanalytic psychotherapy and the decision to become a psychotherapist have cemented my connection to this tradition. However, another important aspect of my identity is that of being an outsider and a minority both religiously and culturally. Having immigrated to the United States from Israel but maintaining a foot in both cultures, I have always been painfully aware that the dominant narratives of my adopted country were not stories about me or my ancestors. Therefore, as a therapist, I am acutely aware that the theories I use to understand my clients as well as the techniques I use to communicate, are the result of my history and preferences rather than a universal reality. Yet, aware of my subjectivity, I seek to find common ground with my patients—to use who I am and what I know to connect with people who, inevitably, are very different from me. Initially, it was the principles of critical theory which helped shape my understanding of intercultural dynamics. As a therapist, I now

rely on research in multicultural psychology to guide me in addressing the needs of my patients.

Just as history is important to understanding individuals, it is also vital to understanding theory. Therefore, an analysis of the development of psychoanalysis and its relationship to Sigmund Freud's individual history is important. Putting psychoanalysis in context, essentially seeing it from a multicultural perspective, yields important insights about why it arose within a specific cultural moment and the way in which its principles were shaped not only by the life of Freud, but also by the tumult of two World Wars. The fruits of a multicultural analysis only multiply when we consider the manner in which psychoanalysis became assimilated into the mainstream medical culture of the United States. We will see how forces such as existing U.S. values as well as the impact of religious persecution on those who imported psychoanalysis, came to shape the field into the elitist and largely irrelevant discipline it is popularly regarded as today in the U.S.

It is possible to critique psychoanalysis as engaging in *ethnocentric monoculturalism* (Sue, Bingham, Porché-Burke, & Vasquez, 1999), which results in a lack of consciousness about the subjective nature of a psychoanalytic worldview, the tendency to pathologize based on European American standards of normalcy, the value of certain professional practices as being culturally-based, as well as the culturally encapsulated nature of psychoanalysis' system of ethics. The critique of ethnocentric monoculturalism helps to highlight points at which psychoanalytic theory and practice can benefit from multicultural awareness. One goal of this project is to look back on the values that influenced the development of psychoanalysis to see how a system of thought

initially developed by religious and ethnic minorities in Europe was tailored to suit the value systems of cultural elites in the United States. This investigation suggests the possibility that psychoanalytic theory can also be used to reflect other value systems and may not be essentially flawed as a system of thought.

In contrast to the view of psychoanalysis as elitist and irrelevant is the overlap between psychoanalysis and multicultural psychology both historically and in the present. Both fields were developed and shaped primarily by persons who were cultural minorities (Hale, 1971; 1995; Ridley & Kleiner, 2003) and both were developed in part as a response to perceived social ills (Comas-Díaz, 1992; 2000; Moskowitz, 1996). For example, psychoanalysis has long been associated with social critique (Moskowitz, 1996). Freud himself believed that part of the problem of his patients was the fact that they were living in an oppressive Victorian society which had unrealistic expectations of human beings (Gay, 2006). In terms of an historical overlap, Freud's followers established organizations such as the Frankfurt School to examine the social oppression of authoritarian regimes (Moskowitz, 1996; Rasmussen & Salhani, 2010). The Frankfurt Institute for Social Research was founded in the 1920s in Germany by (mostly) Jewish intellectuals including sociologist-philosophers such as Horkheimer, Adorno and Marcuse as well as psychoanalysts Reich and Fenichel, with the goal of "understanding the unconscious meaning of social processes and institutions, particularly domination, oppression, and the failure of revolutions" (Moskowitz, 1996, p. 25). Their work was later used by others to critique cultural and social inequalities from a psychoanalytic perspective; using the theory to explain how and why social inequalities arise and are perpetuated (Fanon, 1952/2008; Greedharry, 2008; Treacher, 2000).

The idea of psychoanalysis as a tool for understanding dynamics of difference and diversity has only recently recaptured the attention of psychoanalysts, in spite of the fact that it has been used as such since its inception by other fields of study (Greedharry, 2008; Treacher, 2000). While the threads of social critique were present in psychoanalysis at its inception, the cultural revolutions of the 1960s led to a rise in interest in the overlap between psychoanalytic theory, Marxism and social justice (Kimball, 1997). It is reasonable to guess that some of the individuals who were later to become major figures in the field of multicultural psychology in the 1980s and beyond were the students engaging these theories around social change in the 1960s and 1970s.

Comas-Díaz (1992; 2000), is one of many multicultural psychologists who point out the need not only for psychotherapy to address diversity issues, but for clinicians to integrate sociocultural awareness as a value in their daily lives. Comas-Díaz (1992) looks at the shift in demographics in the United States towards greater diversity to suggest that a process of increased pluralism in theory and practice in psychotherapy is inevitable. She delineates a two phase process of change in psychotherapy that will be influenced by the demographic shift in the U.S. towards people of color. The first phase is one of integrating therapies or therapies designed for specific groups. The second phase, pluralism, involves opening up the values behind psychotherapy to include the beliefs and values of people of color. Comas-Díaz provides examples relating to seeing the self as part of a larger whole in a familial, spiritual and global sense as well as definitions of mental health that include integration. In another essay, Comas-Díaz (2000) discusses the values that define a clinician who aims to bring sociopolitical awareness to both her work and her life, regardless of theoretical modality: "Ethnopolitical psychologists

transform reality by promoting racial equity and social justice, safeguarding peaceful, respectful, and democratic processes, fostering a safe place and a good enough society to live in, developing social identity and solidarity, and encouraging global consciousness" (p. 1323). I find Comas-Díaz's values to be relevant to my own process of integrating psychology with multicultural values. I believe that my work benefits from being informed by sociopolitical awareness and a commitment to acknowledging and addressing issues of social justice. I see myself as one of the psychologists who is seeking, with this project, to open up the values behind psychoanalytic theory to be more inclusive of the beliefs and values of marginalized groups.

In terms of potential meeting points, both psychoanalytic and multicultural theories aim to facilitate growth in the individual and society by challenging repressive aspects of self and culture and promoting supportive interdependence. The difference is that while all multicultural psychologies include these aims as primary, not all psychoanalytic theories lend themselves to collectivist aims. One reason for this is the way in which psychoanalytic theory was embraced and assimilated by different countries. In the United States, psychoanalysis underwent a number of changes that served to deemphasize theories of sex and aggression as well as its progressivism (Hale, 1971; 1995). As American Ego Psychology, psychoanalysis in the United States became a reflection of the dominant culture in American medicine with its white, Northern European, Protestant value system. In Europe where countries were attempting to rebuild and make sense of the two World Wars, psychoanalytic theory took a different turn with an emphasis on aggression and the importance of mothers in England (Rustin, 1984; 2006), and the dynamics of injustice as evidenced by language in France.

Multicultural psychologists have made specific advances in the understanding of how to work with diverse clients as well as how to be a therapist who works for social justice outside of the consulting room. This dissertation aims to understand the current trends in multicultural clinical psychology that are relevant to case conceptualization: What are some current clinical perspectives that hold diversity as central to their understanding of human beings? In addition, this dissertation seeks to use these clinical perspectives to critique psychoanalytic theory with the goal of integrating psychoanalytic and multicultural awareness in order to address unexplored diversity-related aspects of the therapeutic relationship. What follows are some considerations about the relationship between psychoanalysis, social critique and multicultural psychology in an effort to set the stage for the research objectives of this dissertation.

Psychoanalysis in Context

Freud's milieu. The birth of psychoanalysis in Victorian Austria is synonymous with Sigmund Freud's development into the first psychoanalyst. Freud's birth as the first psychoanalyst was influenced by a number of historical factors such as the evolving political climate in Vienna, Freud's social status as an upper middle class, urban Jewish man, the impact of Freud's mentors, and the influential scientific theories of the time (Gay, 2006; Marcus; 1984).

Between 1848 and 1885, Austria experienced a shift away from the ruling classes and towards a spirit of progressivism that paved the way for the entry of Jews into Austrian professional and political life (Gay, 2006). Between 1848 and 1867, a number of reforms were enacted that swept aside long-standing obstacles for ambitious Jewish families. These reforms included legalizing Jewish religious services, an abolishing of

the so-called “Jewish Tax” which required Jewish families to pay extra taxes due to their religious affiliation, a revision of ownership laws to enable Jews to own property outright, and a repeal of the law barring Jews and Gentiles from working for one another (Gay, 2006). These changes, which occurred at the beginning of Freud’s academic career, gave Jewish men the opportunity to hold political office and enter any profession they wished for the first time. Freud’s biographer, Peter Gay (2006), describes a sense of hopefulness which characterized this time in Austrian Jewish history. For Freud, who was always hardworking and academically ambitious, the possibility of making an impact outside the ghetto was both new and real.

Freud’s Jewish identity is an important issue in the context of psychoanalysis in that this study of the mind, of neurosis, and of the *talking cure*, was developed by a social and religious minority figure within the larger context of the ebb and flow of anti-Semitism that characterized the historical period between world wars and into the Second World War (Aron, 2007; Bergmann, 1995; Bergstein, 2003; Brunner, 1991; Frosh, 2004a; 2004b). Psychoanalysis is sometimes seen as a tool of the oppressor, but it may be more accurate to adopt a Freireian (1970/1993) attitude and say that it developed as a tool of the oppressed in an effort to identify with and assimilate into the dominant culture. Friere suggests that when a binary, oppressor/oppressed dynamic exists in a society, the oppressed often do not seek social justice but seek to become the oppressors. The binary nature of the dynamic limits an individual’s role to two options, thus, the oppressed individual seeks the more preferable option. Similarly, Altman (2004) suggests that Jewish analysts immigrating to the United States took advantage of their new status as “whites” to transition from oppressed to oppressors by “adopt[ing] unreflectively a

Northern European value system and... seek[ing] upper-class social status” (p. 808). As a result, psychoanalytic theory in the United States took on the character of the individuals in power at the time—white, Northern European, Protestant, medical professionals.

One aspect of the oppressor/oppressed dynamic played out in Freud’s relationship with his mentor, Jean Martin Charcot. Charcot was a French Catholic physician whose fame was well-established by the time Freud came to study with him in 1885. Freud’s few months in France marked a turning point in his career trajectory in that he was persuaded to abandon a career in research neurology in pursuit of a physiological psychology (Aguayo, 1986; Gay 2006). In spite of Charcot’s patronage of Freud, there seems to have existed a social distance between them that Freud could not bridge. For example, when Freud wrote a warm letter to Charcot telling him that he named his first son Jean Martin after Charcot, he received only a cordial response of good wishes with a reference to St. Martin for whom Charcot himself was no doubt named. In the letter, Charcot assumes that Freud will understand this reference without explanation; Charcot marginalizes Freud by ignoring his Jewish identity. In his admiration, and due to a history of similar experiences, Freud endeavored to pursue his career goals without reference to his religion and culture, opting instead to see himself as a European physician, a scientist, like his mentor.

Another important influence in the development of both psychoanalysis and psychology that had profound implications for oppressed and diverse groups was the presence of positivism (Aguayo, 1986) and the rise of Darwinism in scientific thought (Guthrie, 2004). Both theories privileged scientific rationalism as practiced by white

Christian Europeans as the apex of human achievement, thus marginalizing other cultures and ethnic groups as inferior.

Scientific positivists viewed “history and society as a series of linear progressive stages involving an evolution from the darkness of religious dogma to the light of rational scientific thinking” (Aguayo, 1986, p. 229). Again, one is reminded of Freire’s account of the oppressed becoming the oppressor as Freud adopts a scientific outlook that sees his people as inferior due to their religious views as well as their perceived racial origins.

After the publication of *Origin of the Species*, many scientific disciplines including psychology integrated evolutionary theories into their ontologies. For Freud, Darwin’s ideas became the driving force behind his early scientific investigations; Freud and his teachers were determined to lend credence to a theory that placed man in the realm of the animal kingdom and described his emergence in secular terms (Gay, 2006). Freud continued this work in *Totem and Taboo* (1913), where he posited the evolution of religion and the Oedipal complex in evolutionary terms (Gay, 2006). In addition, Freud structured his investigations into the mind in terms of tracking the variations in form and structure of various aspects of the mind as well as aspects of mental illnesses such as hysteria (Marcus, 1984). It may be that Freud’s attraction to Darwinism was in part a factor of his image of himself as a secularist—a person who sought to transcend the limitations of his religious affiliation and live in the broader world of his Christian scientific community. Unfortunately, the product of this identification with the broader scientific community in general and Darwinism in particular was a psychology of individual pathologies (as opposed to social dynamics) and a membership in a social

ethos that had identified a (so-called) scientific basis for the superiority of white Christian Europeans over other ethnic groups (Guthrie, 2004).

Psychoanalysis: Demographics and applicability. While there has been some debate in the past about the demographics of Freud's patients (Brody, 1970; 1976; Trosman, 1970), these debates limited themselves to the question of how many members of each economic class and gender Freud himself treated. What is more interesting is Freud's direct involvement in the development of free clinics across Europe where anyone was entitled to receive psychoanalysis free of charge. The social liberalism that was responsible for giving Austrian Jews new social and political freedoms (Gay, 2006) also imbued Freud with a sense of social justice and civic responsibility (Danto, 1998; 2005). Freud believed that psychoanalysis should be available to all people, regardless of social class.

Freud's belief in the applicability of psychoanalysis to all people establishes a vein of social responsibility and social justice in the psychoanalytic movement. The status of psychoanalysis as an outsider, "Jewish science" (Gilman, 1993, p. 31) further underscores the position of early psychoanalysis as a response to oppression rather than a tool of oppression. These factors may have set the stage for the use of psychoanalytic theory as a critique of social hegemonies and also contributes to the richness of psychoanalytic theory as a basis for working with culturally diverse clients.

Psychoanalysis becomes a naturalized U.S. citizen. How and why did psychoanalysis find fertile soil in the United States? Bergmann (1993) suggests, "Psychoanalysis prospered because after World War II a generation of Americans believed they were entitled to the pursuit of happiness and a life that was better than that

of their parents” (p. 943). Writings from the period (Alexander, 1938; Brown, 1940) echo the sentiment that psychoanalytic thinking gained momentum in the United States at the outset of World War II both due to the influx of refugees from Europe and the growing interest in Freudian thinking in academic and experimental psychology in the United States. Hale (1970; 1995) traces the history of Freudian psychoanalysis in the U.S., beginning with Freud’s first and only lecture in the U.S. in 1909 through to the state of psychoanalysis in the 1980s. Hale outlines the cultural beliefs which shaped the reception and subsequent interpretation of psychoanalysis in the U.S. and how this American psychoanalysis gained momentum and then lost it during the last century. Hale (1970) suggests that, “[t]he Americans modified psychoanalysis to solve a conflict between the radical implications of Freud’s views and the pulls of American culture” (p. 332). However, the very alterations and emphases Americans made to Freud’s theories between 1910 and 1940 became the elements that brought about its loss of popularity. In attempting to understand how psychoanalysis went from being a “Jewish Science” in turn of the century Vienna to becoming a force for oppression in the U.S., Altman (2004) echoes Friere (1970/1993) in postulating that the oppressed became oppressors as a way (in Altman’s thesis) of splitting off the traumatized and victimized aspects of their experience by participating in the marginalization of traumatized and victimized groups in the U.S. such as African Americans. Altman cites the rise of Ego Psychology within the field of psychiatry as well as American capitalism as forces that shaped the way we commonly see psychoanalysis today—as a field that ignores and is irrelevant to the experiences of culturally diverse clients.

It is difficult to summarize the diverse threads that formed American scholarship and popular culture into which Freud's theories wove themselves at the turn of the 20th century. Many schools of thought prevailed including, at one end, E.B. Titchener the experimental psychologist and at the other, Emma Goldman, the anarchist and free-love proponent (Hale, 1970). Freud's ideas began to gain popularity amidst this complicated American tapestry with his first and only visit to the United States in September of 1909. Freud was invited, along with Jung and Ferenczi, to give a series of five lectures at Clark University in Worcester, Massachusetts which were intended to introduce his basic theories to professionals and laypeople alike. Hale describes a mixed reception from psychologists and the public that, over time, resulted in the gradual acceptance even of Freud's most controversial theories such as that of infantile sexuality. However, Freud's ideas were understood through the lens of the prevailing cultural milieu in the United States which resulted in a number of important differences between Freud's European and American followers. The American brand of psychoanalysis that reached its heyday in the 1950's was shaped by cultural dynamics that were unique to the United States.

Before psychoanalysis, there were other treatments for mental conditions. Hale (1970) labels the prevailing school of thought of the period between 1895 and 1910 as "The Somatic Style," (p. 47) in which mental illness was conceptualized as the result of physical deformities such as lesions on the brain and treatment consisted of schedules of bed rest, exercise, healthy meals and massage. The apparent incongruity between theory and practice as well as the lack of evidence for the theories (such as the lack of brain lesions in the presence of all mental illness) made way for the introduction of psychoanalysis as an alternative conceptualization.

Alexander (1938) notes that, unlike its lukewarm reception in Europe, by the 1930's psychoanalysis was being seen as part of the medical and scientific establishment in the United States. Psychoanalysis as a therapy was considered the purview of psychiatry, and as it dealt with human behavior was considered a relevant part of the social sciences. Brown (1940) observes that by the 1930s, textbooks on psychology had shifted drastically in emphasis, introducing their tomes with discussions of unconscious motivations rather than theories of and experiments on human perception. This shift of psychoanalysis from an outsider Jewish science in Europe to a mainstream medical theory in the U.S. is relevant to Altman's (2004) thesis that a possible unconscious motivation behind this shift was a disowned experience of racism and discrimination by émigré psychoanalysts.

Altman (2004) suggests that Jewish analysts who immigrated to the United States unconsciously adapted to its endemic racism by "becoming white" (p. 808); that is, by adopting an unquestioning attitude towards the Northern European value system and seeking upper class status. Altman too notes the incongruity between the "Jewish science" (Gilman, 1993, p. 31) of psychoanalysis becoming a hegemonic force in the United States, suggesting that, like Irish immigrants to the U.S., Jewish analysts were able to shed their minority status by identifying with and becoming a part of the cultural, white majority in part by participating in the oppression of other racial minorities such as African Americans. In the case of the Jewish analysts, this oppression may have been accomplished by excluding the voices of culture and political dynamics from psychoanalytic thinking in the U.S. and thereby participating in a status quo that oppressed minority groups. Specifically, Altman (1994) cites the adoption of ego

psychology (with its emphasis on frustration tolerance and inaction as well as on a one-person psychology) by the American medical profession which placed psychoanalysis in the category of a “high-priced medical specialty” (p. 810) thus “turning away from the social context of people’s lives” (p. 811). It is interesting to note that, as late as 1995, ego psychology was still regarded as the dominant theoretical framework in the U.S. (Paniagua, 1995).

Hale (1970) describes a climate of American “civilized morality” (p. 24) at the turn of the 20th century into which Freud’s ideas were simplified with a de-emphasis on sexuality and aggression with a concomitant focus on the importance of social conformity. The doctrine of repression and the need for talk therapy was embraced on the grounds that vices were the cause of repressed sexual fantasies and repressed aggression that simply needed to be talked about in therapy. The idea that discussing *forbidden* wishes and desires will help a person accept and not act out on them remains with psychodynamic interventions to this day. Psychoanalysis was also adopted as the new language of morality with those values previously considered *good* now labeled *mature, adult* or *conscious*, while *bad* became, *childish, primitive, unconscious* (Hale, 1970).

It is interesting to note that Freud himself felt that his ideas were poorly understood by his American followers (Warner, 1991). He felt that “psychoanalysis was accepted in America because it met the psychological needs of individual Americans. But, it had to be modified gradually to fit in better with American ways” (p. 149). In Freud’s (1930) own words, “It seems to me that the popularity of the name of psychoanalysis in America signifies neither a friendly attitude to the thing itself nor any

specially wide or deep knowledge of it” (p. 254). Freud took issue with the requirement that prospective psychoanalysts be medically trained psychiatrists (Hale, 1994). He also disagreed with the idea that psychoanalysis was an ethical pursuit and, in a way, an exercise intended to bring errant individuals back into the fold of productivity and therefore normalcy.

Hale’s second volume outlines the manner in which four major shifts came to dethrone psychoanalysis both in popular culture and in scientific circles. The fact that psychoanalysis came to be identified with medicine became a liability when medical science shifted to a more positivist, empirical model of experimentation. As a result of this shift, psychoanalytic techniques could no longer be proven in an empirical sense. Psychoanalysis was further discredited by the rise of a new somatic psychology in behaviorism. In addition to receiving criticism from medical and psychological establishments, psychoanalysis also came under fire from women and minority groups during the counter-culture movements of the 1960s and beyond. One example is the attack on psychoanalytic views of the role of women in society launched in popular culture by magazines such as *Ms.* (Hale, 1994). It is interesting to note that, as in the case of medicalization of psychoanalysis in the U.S., its identification with morality became a liability when definitions of the status quo were challenged by women and other minority groups such as gays. Finally, the proliferation of alternative psychotherapies began to edge out psychoanalysis, an additional reason for this being the fact that treatment times went from one to two years in analysis to ten years or more.

It appears that a number of historical threads came together to shape the “Rise and Crisis” (Hale, 1994, p. 1) of psychoanalysis in the United States. Freud’s marginalized

Jewish science eventually found a welcoming reception in the U.S. where somatically based theories of psychopathology were on the wane while a culture of “civilized morality” (Hale, 1970, p. 24) sought to downplay the role of sexuality and aggression and emphasize the importance of social conformity. By 1940, psychoanalytic theory was the focus of “conservative” (Brown, 1940, p. 289) psychology textbooks, Freudian theories of human behavior were of interest to experimental psychologists, and psychoanalysis was a specialized branch of psychiatry (Altman, 1994). However, over the years, the exact influences that made psychoanalysis the interest of mainstream society began to be seen as sources of oppression to culturally diverse groups gaining a voice in the 1960s and beyond. As a result, psychoanalysis began to be seen as irrelevant to clinicians interested in working with culturally diverse clients and, by the 1980s was often perceived to be an arcane branch of psychotherapy whose theories were more relevant to academics studying literary criticism and history than clinical psychotherapists.

Psychoanalysis, Cultural Studies and Clinical Practice

Psychoanalysis as a lens. Freud used his psychoanalytic theories not only for the analysis of individuals, but for the analyses of cultures and history (Freud, 1913; 1939), with the goal of creating a universal theory of human nature. In this way, he illustrated that the purview of psychoanalytic theory includes fields such as anthropology, history, biography and even literary criticism. Subsequent theorists in many fields of study applied psychoanalytic theory to the understanding of human endeavor, the result of which was often the use of psychoanalytic theory to critique states of inequality between people. It is perhaps no surprise to note that in his own explorations, Freud revealed most starkly his cultural biases and prejudices (Gordon, 2001; Person, 1983), perhaps because

his lack of knowledge of actual facts allowed him to project himself onto people in faraway lands and throughout history. While the justification for using psychoanalysis to analyze culture appears convincing, Freud's Totem and Taboo (1913) is just one example of the manner in which this process can go awry; reducing human desire for something transcendent to a product of the Oedipus complex and suggesting that non-European peoples collectively suffer from psychopathology. Yet almost from its inception, other psychoanalysts such as Wilhelm Reich were attempting to use psychoanalytic theory along with Marxism to undermine traditional biases (Kimball, 1997), while anthropologists such as Malinowski critiqued psychoanalysis for being ethnocentric (Walton, 1995). Thirty years later, Fanon wrote his seminal book, Black Skin, White Masks (1952/2008) which was to become the touchstone for a generation of thinkers who sought to use psychoanalytic theory to critique unequal power dynamics such as racism and colonization.

Serious critiques of psychoanalysis began in the 1960s and 1970s with the rise of feminist and homosexual activism (Hale, 1994). Each of these groups took issue with aspects of psychoanalytic theory that seemed to unnecessarily pathologize them. As a result, psychoanalysis went from being a darling of popular culture to a symbol of the *establishment*. However, in the midst of psychoanalysis' identification with oppression in popular culture, scholars like Fanon made use of psychoanalytic theory to critique the very structures of power it was considered by others to represent. Some authors (Gordon, 2001; Kimball 1997) suggest that this trend gained momentum in the 1970s and beyond when Marxist radicals, disappointed with the "defeat of the emancipatory political projects begun in the 1960s" (Gordon, p. 18) turned to psychoanalytic theory as a way to

understand the relationship between groups with unequal power and to suggest how such an analysis can support sociopolitical resistance and activism. Fanon's (1952/2008) work is an early example of what later became known as the field of Cultural Studies and the discipline of postcolonial theory. Postcolonial studies as a field is concerned with the impact of colonization on cultures (Burgess, 2001). Cultural studies is a more diffuse discipline which seeks to "challenge hegemonic knowledges" (Gibson, 1999, p. 97) by engaging in interdisciplinary research within the fields of sociology, literature, and psychoanalysis with a focus on poststructural, postcolonial and Marxist theories of epistemology and power (Gibson, 1999).

Fanon was born in 1925 in the then French colony of Martinique (Macey, 2001). He was born to a lower middle class family and served in the French army during World War II. After the war, Fanon studied psychiatry in France and was posted to Algeria, also a French colony, in 1953. However, his involvement in the Front de Libération Nationale (FLN), a group advocating violent resistance to colonizing influences in Africa, necessitated him to flee the country three years later. He continued to practice psychiatry as well as work as a spokesperson for the FLN until his death from leukemia in 1961. Fanon's work is important because he was the first to point out that one cannot understand the psyche of a person from a strictly individual perspective devoid of culture. Fanon used psychoanalytic theory to explain "how the black man experiences his life in the wake of racist myths that degrade, devalue and make the black man a fearful object in society" (Greedharry, 2008, p. 136). Until his work, pioneering critiques of bias in psychoanalysis involved themselves with the othering of women in reference to a norm of maleness. Fanon discussed the othering of blacks both in Europe and in colonized

Africa (Walton, 1995). In other words, in addition to understanding how the black man experiences life, Fanon also focused on the psychological processes influencing white peoples' fantasies about blacks (Treacher, 2000).

While psychoanalytic theory may have been used by Freud and others to justify cultural biases, psychoanalysis was also used to examine biases and critique dynamics of power and attitudes that were previously taken for granted. Scholars like Fanon introduced a tradition of using psychoanalytic theory to understand and challenge the products of European colonialism. There are a number of important clinical applications that can be gleaned from the ongoing encounter between cultural studies and psychoanalysis. There is the idea that while psychoanalysis has been used to colonize the other, it can also help the clinician think more carefully about the experience of injustice in clients' lives. Psychoanalytic theory informed by cultural studies can also help the clinician reflect on the transference and counter-transference implications of political and social difference. It also reminds clinicians who work psychoanalytically that psychoanalytic theory is in a constant state of tension in the consulting room as it both illuminates and obscures the life experiences of its clients. In the next section, the focus will be on examining the manner in which work in the field of cultural studies has allowed psychoanalysts to reconnect with a spirit of social critique and progressivism that was present in the field at its inception.

Psychoanalytic theory and the spirit of progressivism in treatment.

Moskowitz (1996) describes a rift created between clinical psychoanalysis and psychoanalytically influenced social theory that was exacerbated by the political shifts that took place in psychoanalysis upon its taking root in the United States. Moskowitz

outlines the progressive strains of psychoanalytic theory beginning with Freud's liberalism and discussing the cosmopolitan values that influenced the creation of The Frankfurt School and its work using psychoanalytic theory to understand social injustice and authoritarianism. Upon the instantiation of psychoanalysis as a force within United States psychiatry, efforts were made stateside to divorce psychoanalysis from its progressive roots for reasons discussed earlier such as the unconscious ambition to legitimate a "Jewish science" (Gilman, 1993, p. 31) by appealing to the cultural values of Northern European white Protestant males. In the meantime, psychoanalytically based social theory went on to become more robustly developed by theorists working in the fields of critical theory, postcolonial studies and cultural studies. Coupled with other social and cultural forces including the multicultural movement within psychology, clinical psychoanalysis in the United States has been reconnecting with its social theory roots in an effort to breathe progressive life into the way both analysts and psychodynamic psychotherapists work with diverse clients (Altman, 2004; Comas-Díaz, 1992, 2000; Eng & Han, 2000; Pérez Foster, Moskowitz, & Javier, 1996). These resuscitations include a reexamination of the role and function of psychoanalytic theory in case conceptualization and providing a structure for considering cultural and sociopolitical issues in treatment and in life.

It is interesting to note that psychoanalysis did not have the same drastic rise and fall in Europe compared with the United States (Rustin, 1984; 2006). In fact, Rustin argues that in Britain, the focus of the psychoanalytic theories of Klein, Bion and the British school were an effort to make sense of the tremendous destruction and trauma wrought in peoples' lives by the First and Second World Wars. His theory is that this

difference of focus allowed psychoanalytic theory to continue to be what it was for Freud, “a response... to problems located in a particular social order” (Rustin, 2006, p. 337). Rustin contends that psychoanalysis in Britain has remained focused on clinical issues in part because of its inclusion in Britain’s National Health system, but also because of the emphasis placed on interdependence in general and mother-infant interactions in particular. Rustin believes that the development of British psychoanalysis came to a “here and now” (p. 344) focus on what was happening in the room between patient and analyst without the conflicts associated with the hegemony of American Ego psychology that necessitated a radical break with traditional psychoanalytic theory in the United States by clinicians interested in providing more relevant services to diverse clients. Rustin argues that British object relations theory is solid basis for generating ideas about social justice and he illustrates this with examples of psychoanalytically influenced interventions implemented by Britain’s National Health Service through the Tavistock Clinic. However, British psychoanalysis as a clinical practice suffers from some of the same critiques of American psychoanalysis in that it remains a time-consuming practice, relegated to major urban centers, that is therefore limited to a fortunate few (Rustin, 1984).

In the United States, efforts to make psychoanalysis and psychotherapy more relevant to diverse clients has been primarily influenced by socially conscious clinicians who are members of historically oppressed groups. These individuals have sought to impugn the universalizing tendencies of psychoanalytic theory by emphasizing the importance of context in the consulting room and sociopolitical awareness in general. As Pérez Foster and her colleagues (1996) put it; one of the challenges of applying

psychodynamic theory to work with diverse populations is “the inescapable human tendency toward constructing meaning from the centerpoint of one’s own experience, and in the inevitable societal tendency toward selectively enforcing the meaning systems of those in power” (p. 1). Clinicians are faced with the dilemma of recognizing our biases while at the same time being honest with ourselves that in order to connect empathically with another person, we must be dealing with some commonalities, numinous (Kant, 1781/1996) though they may be. The following are some ideas about how to soften the impact of our meaning systems and those of psychoanalytic theory without throwing the baby away with the bathwater.

Pérez Foster points out that it is the “the interpretive metapsychological side—that is so rooted in the assumptions, beliefs, and expectations of one’s personal, environmental, and cultural surround” (Pérez Foster, 1996, p. 9). The abstract theories of psychoanalysis are developed and interpreted by clinicians who inevitably vary (many times, widely) from the “assumptions, beliefs, and expectations” (p. 9) of their clients. She argues that the problem is not in the theories themselves, but in “placing the prime focus [in treatment] on the intellectual interpretive power of metapsychological theory” (p. 12). Pérez Foster suggests that instead, the information gained in the dyadic interaction should be empirically privileged because of the cultural biases inherent in the theories used. For example, she discusses a case of a boy who recently immigrated to the U.S. from a rural village in the Dominican Republic. The boy displayed problems with defecating in public which were eagerly interpreted by clinicians as anal aggression. Upon further questioning, it was revealed that children commonly defecated in public in a place with no running water or plumbing. Instead of being an act of anal aggression,

Pérez Foster and the boy came to the understanding that he continued to defecate in public because he was homesick and wished to rekindle memories of his previous life and beloved family. Pérez Foster refers to this interaction as an example of “refocusing on the processes that emerge under the conditions of direct therapeutic relatedness” (p. 18). We can see in this example how an awareness of the biases in psychoanalytic theory can help us to hold theory more gingerly without giving up entirely on the ability of psychotherapy to enable connection and insight with our clients.

A more abstract approach to countering the universalizing tendency in psychoanalytic theory is offered by Roland (1996), who suggests that it is not the problem of universals that undermines our work but the way in which universal categories are assumed to contain the same specific contents. Roland suggests that an example of a universal concept, inherent in all cultures, is the idea of a sense of self. He draws from his research in India and Japan to give examples of what a healthy sense of self would look like from the perspective of each culture. In this respect, he offers a “comparative psychoanalysis” (p. 85) where universal concepts are “decontextualized” (p. 86) by removing value judgments and making attributions of psychopathology based on cultural norms. One example of this kind of comparative psychoanalysis can be found in the work of Eng & Han (2000) who work with the Freudian concept of melancholia. Eng & Han take Freud’s idea of melancholia as “unresolved grief” (p. 669) and apply it to “registers of loss and depression attendant to both psychic and material processes of assimilation” (Eng & Han, 2000, p. 669) which they label, “racial melancholia” (p.668). In this case, the category is unresolved grief, a long-standing experience of sadness that may be applicable to many cultural groups. However, while Freudian melancholia is

considered an illness, Eng & Han believe that racial melancholia can be a normative experience for people of color living in a white-dominated society. Of course, Roland's notion of a comparative psychoanalysis that decontextualizes universal concepts is complicated by the nature of diversity as gender, sexuality, nationality, culture, ethnicity and age-based (to name a few) so that each subcategory would have to be individually normed and then considered in context with others. However, his idea that there is something we can take from psychoanalytic concepts and apply to work with our clients is a hopeful one—that there are some aspects of what we learn about and how we individually interpret psychoanalytic theory that we can gently compare with our clients' experience and come to some helpful understandings.

The tension between psychoanalytic theory and sociocultural progressivism has been shaped by the history of psychoanalysis in the United States as well as threads of progressivism in the theory itself and the push from historically oppressed groups to address the needs of diverse clients (Moskowitz, 1996). It is possible that the unique history of psychoanalysis in the United States has contributed to a sense of the field as inherently discriminatory in spite of the fact that, in other parts of the world, psychoanalysis has maintained a more progressive stance on issues of social justice and diversity. In addition, academics in other fields have used psychoanalytic theory to understand the relationship between groups with unequal power and to suggest how such an analysis can support sociopolitical resistance and activism (Bhabha, 1997; Greedharry, 2008; Treacher, 2000). In a similar way, clinicians such as Altman, Roland, and Pérez-Foster have engaged with psychoanalytic theory to develop interventions and strategies that address the needs of a wider variety of people. In both cases, an emphasis is placed

on the importance of context in terms of both understanding the various influences (social, historical, economic) on individuals as well as the necessity of employing theory informed by context rather than the other way around. These strategies pave the way for looking more closely at how specific psychoanalytic concepts can be opened up and made relevant to psychoanalytically/psychodynamically oriented clinicians and clients from diverse and (inevitably) differing backgrounds.

Summary and Rationale for the Proposed Research

The purpose of this dissertation project is to explore the manner in which insights from multicultural psychology can inform psychoanalytic theory and technique. The goal of this integration of psychoanalytic theory and multicultural awareness is to address unexplored diversity-related aspects of the therapeutic relationship. The contemporary Kleinian approach of working in the transference will be used as the technical framework for addressing the therapeutic relationship with patients in session.

There are three specific objectives for the proposed research:

1. To contextualize the development of psychoanalysis from a historical and cultural context
2. To identify and explore issues, considerations, and recommendations relevant to working in the transference within the multicultural literature.
3. To analyze the contemporary Kleinian technique of working in the transference from a multicultural perspective.
4. To offer a framework for working in the transference informed by both psychoanalytic and multicultural literatures.

Definition of Terms

Contemporary Kleinians are psychoanalysts who have developed the theories of Melanie Klein by focusing on the here-and-now relationship in the therapeutic encounter in order to understand how a patient's unconscious phantasy influences behavior in the room as well as illustrating underlying anxieties (Hinshelwood, 1991). These theories developed originally out of Klein's play therapy with children and were expanded upon based on Klein and later theorists' work with schizophrenics. Both groups helped develop the concept of the primitive defense mechanisms—splitting and projective identification. Contemporary Kleinians are distinguished by their here-and-now focus in the room where the goal is to understand “the way these processes [splitting and projective identification] in the analytic setting defend against the patient's experience of dependency and envy” (p. 23).

Culture: The Encyclopedia of Multicultural Psychology defines culture as: “The embodiment of a worldview learned and transmitted through beliefs, values, and practices... an orientation for a person's way of feeling, thinking, and being in the world” (Moodley & Curling, 2006, p. 130). For the purposes of this project, the term “culture” is intended to be an inclusive one, describing not only one's geographic origins, but the combined influences of one's race, ethnicity, gender, sexual orientation, sociopolitical milieu, socioeconomic status, family of origin, etc. In other words, the term *culture* represents the unique background of an individual, a person's contextual fingerprint and the manner in which this fingerprint shapes an individual's perspective and interpretations.

Diversity refers to the pluralistic nature of our society where individuals of different backgrounds and asymmetrical power interact with one another. Issues of *diversity* refer to the inevitable differences—some equally valued, most not—between individuals who compete for resources in a shared physical space such as a city, a neighborhood, a family or a therapeutic dyad. According to The Encyclopedia of Multicultural Psychology (Moodley & Curling, 2006), diversity is considered a more inclusive term than multicultural in that it “includes other disadvantaged communities, including those from the European American community” (p. 325).

Multiculturalism as a movement is a response to a Eurocentrism and seeks to foreground the plurality of races, ethnicities and cultures that make up the U.S. population. As a movement within psychology, it has been criticized for being descriptive rather than radical; for discussing difference without discussing inequality, injustice and social responsibility (Moodley & Curling, 2006). Ideally, multicultural psychology seeks to understand “the dynamic, reciprocal relationship between intrapsychic forces and environmental influences” (p. 325) To that end, it involves a process on the part of psychologists of exploring their own relationship to difference, celebrating their own unique backgrounds, understanding discrimination as a social process, and being informed not just by principles of professional ethics, but also by a spirit of equality for all human beings (Moodley & Curling, 2006).

Transference is a psychoanalytic concept that “refers to the patient’s transfer of feelings, wishes and reactions experienced toward an important figure from his or her childhood (usually a parental figure) onto the analyst” (Skelton, 2006, p. 462). Transference may be analyzed in therapy, but it is a process that is thought to occur in

many contexts both between individuals and between individuals and groups or institutions. Kleinians have expounded upon this definition to include “an understanding of the transference as an expression of unconscious phantasy, active right here and now in the moment of the analysis” (Hinshelwood, 2006, p. 465). The idea being that unconscious phantasy (differentiated from everyday *fantasies* by the use of the *ph*), which is a process of hypothesizing about experience, begins very early in life and tends to shape subsequent experiences. While we are engaged in unconscious phantasy all the time, it is those early phantasies that form the substrate of our current understanding like the foundation of a building. While we may not be able to go into the cellar and look at the foundation, analyzing transference in therapy is like visiting the building and generating theories as to what lies below the surface and how it is holding everything else up.

Chapter 2: Review and Analysis Plan

The dissertation aims to offer a framework for working in the transference informed by both psychoanalytic and multicultural literatures. The overarching goal of this critical review and analysis is to integrate psychoanalytic and multicultural awareness to address unexplored diversity-related aspects of the therapeutic relationship. This dissertation involves a critical review of existing literature on multicultural psychology, specifically multicultural competence, and multicultural critiques of psychoanalytic theory as they relate to contemporary Kleinian writings on working in the transference. The psychoanalytic concepts that will be examined are transference and countertransference from a contemporary Kleinian perspective. Multicultural issues that will be researched within the context of transference include the history of the multicultural movement in psychology, the development of the concept of multicultural competence, features of multiculturally-informed psychotherapy, and multiculturally informed critiques of psychoanalytic theory and practice.

The dissertation applies the principles of multicultural competence researched therein to the practice of psychoanalytic psychotherapy from a contemporary Kleinian perspective. In addition to examining the literature on multicultural competence, this dissertation will also analyze the writing of multiculturally-oriented clinicians working within the psychoanalytic modality. This process will serve two purposes: It will aid in developing a critique of psychoanalytic psychotherapy from a multicultural perspective as well as identify and explore issues, considerations, and recommendations relevant to psychotherapy within the multicultural literature.

An additional task of the literature review will be to introduce the concept of transference, then collect and summarize the specific contemporary Kleinian formulation of transference and the technique of working with the transference in the therapeutic encounter. The goal of this part of the project will be to paint a picture of the current application of this technique and its aims as a therapeutic intervention.

The purpose of the proposed critical review will be to develop a framework that integrates psychoanalytic technique and multicultural awareness to address unexplored diversity-related aspects of the therapeutic relationship. In other words, in addition to using the transference relationship to elucidate intrapsychic dynamics in general, the goal is to provide a template for more consciously grappling with intrapsychic conflicts around race, ethnicity, sociopolitical inequalities, and sexuality (to name a few) in order to further the ultimate aim of treatment—to facilitate growth in the individual (and, by extension, society) by challenging repressive aspects of self and culture and to promote supportive interdependence.

Inclusion/Exclusion Criteria

Topic areas. The general topic areas included in this comprehensive, critical literature review are the history of multicultural psychology, multicultural competence in psychology, the psychoanalytic concept of transference, the history of the concept of transference, contemporary Kleinian technique, multicultural critiques of psychoanalytic theory, multicultural applications of psychoanalytic theory and therapy.

Dates of publication and databases. The dates of publication within which literature was accessed ranged from approximately 1870 to the present since this critical review includes a historical dimension and thus makes use of primary sources relevant to

the development of psychoanalysis. The literature reviewed and analyzed will be located through the computer search of databases including, but not limited to (a) The Psychoanalytic Electronic Publishing (PEP Web), Archive 1, Version 10, covering the years 1871-2007, (b) EBSCO Web, which includes indices such as Academic Search Elite which contains full text for more than 2,100 journals spanning 1985 to the present; and (c) PsychInfo, the American Psychological Association's resource for abstracts of scholarly journal articles, book chapters, books, and dissertations spanning the 1800s to the present.

Types of documents. The focus was placed on documents written from a psychoanalytic perspective as well as documents discussing the history and application of multicultural awareness in clinical psychology. Types of documents included historical analyses, theoretical papers, and clinical papers that include case studies, as well as any relevant empirical studies.

The following key words were used in the literature review search process: Bion, Contemporary Kleinian, cross-cultural competence, countertransference, culture, diversity, dynamics of difference, Freud, Klein, multicultural competence, multicultural psychology, multicultural psychology history, projective identification, psychic change, psychoanalysis, D.W. Sue, and transference,.

Critical analysis process. The critical analysis will include an integration of the literature on multicultural psychology and psychoanalytic theory. The following topics will be discussed then integrated: the history of multicultural psychology, multicultural competence in clinical psychology, multicultural critiques of psychoanalytic theory, transference, and contemporary Kleinian technique. This critical analysis will aim to

develop a framework for integrating issues of diversity into psychoanalytically informed clinical practice. Specifically, the analysis will inform how developing multicultural competence can enhance one's thinking about the transference and make for more effective encounters with diverse clients while maintaining a psychoanalytic treatment frame.

Chapter 3: Multicultural Psychology

Introduction

This chapter will discuss the history of the multicultural movement in psychology as it relates to the establishment of guidelines for multiculturally competent therapists. There is still a lack of consensus as to the definition of the term “multicultural competence” (Ridley, Baker, & Hill, 2001; Ridley & Kleiner, 2003). *The Encyclopedia of Multicultural Psychology* (Buhin, 2006) defines “multicultural competence” as: “skills that counselors and other mental health professionals possess and continually expand that enable them to work effectively with clients who are culturally different from themselves” (p. 318). The goal of models of multicultural competence is to provide “a way of relating to or interacting with others cross-culturally... as a way of enhancing therapy” (Ridley, Baker, & Hill, 2001, p. 824). Multicultural competence is framed currently in terms of the APA’s (2003) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* which deals with only one aspect of cross-cultural therapy, that of race and ethnicity. Rather than discussing the APA document in great detail, I have chosen to discuss and critique Sue et al. (1982) and Sue, Arrendondo, and McDavis’ (1992) formulation of cross-cultural competence as it relates to differences of race and ethnicity. Sue and colleagues’ (1982; 1992) formulation is the model that established and continues to influence the ongoing conversation about multicultural competence and it represents a major contribution to the development of the APA document (Arrendondo & Perez, 2006). The ultimate goal will be to later apply the principles of multicultural competence to a discussion of the contemporary Kleinian technique of working in the transference.

History of Multicultural Psychology

Sue et al. (1992) document the shift in thinking about diversity that defines the multicultural movement. They describe historical psychological views on “minorities” (p. 479) as taking one of three unhelpful and discriminatory perspectives. The earliest views involved seeing non-whites as lower on the evolutionary scale and therefore inferior to and inherently more pathological than whites. The genetic view posited that non-whites in general and blacks in particular were lacking in desirable genes especially relating to intelligence (Sue et al., 1982). Finally, the cultural view, which was posited by seemingly well-meaning but nevertheless culturally encapsulated white social scientists (Sue et al., 1992) was that minorities are culturally deprived and thus incapable of achieving the same levels of success as whites. In contrast, Sue et al. (1992) describe the assumptions of the multicultural model as affirming of the value of cultural differences and considering disadvantages in light of sociopolitical dynamics rather than cultural deficiencies. Specifically, Sue et al. outline four assumptions of this new model: First, that cultural difference cannot be reduced to deviance or pathology. Second, that it is important to acknowledge the status of racial and ethnic minorities as bicultural; i.e. having a foot in both the mainstream and their individual cultures. Third, that bicultural status is an asset rather than a hindrance in that it “enriches the full range of human potential” (p. 480). And finally, that individuals should be understood in relation to the sociopolitical realities of their environment, rather than having their cultural background blamed as the source of their struggles.

The development of the multicultural movement in psychology was also catalyzed by other historical forces in the lives of its advocates. Franklin (2009) cites the Civil

Rights Movement as a major force of empowerment in the lives of racial and ethnic minorities which subsequently lead (among other important changes) to an “immersion into our ethnic and cultural history that led many into greater advocacy for understanding behavior within our cultural context and the passion to bring about change in the discipline [of psychology]” (p. 417). Holliday (2009) discusses the impetus in the 1970’s for students of color seeking a greater voice in the profession to organize into ethnic student psychological associations. In addition, there was a perceived need to form ethnic professional organizations in response to inequalities in society at large. For example, the impetus for the formation of the Association for Black Psychologists in 1968 was in part to address the fact that too many black students were being placed in special education classes as the result of biases both in standardized testing as well as on the part of school personnel (Holliday, 2009). Franklin (2009) notes that: “The path to contemporary multiculturalism as a distinct area of psychology is directly related to the early accomplishments of each of the ethnic psychology associations” (p. 416).

The multicultural movement in psychology is indebted to the efforts of psychologists who sought to make a place for historically oppressed ethnic groups in the United States within the field of psychology. Therefore, the history of the multicultural movement in psychology is, in large part, the history of efforts by African American, Asian, Latino and Native American psychologists to achieve equal representation at all levels of the psychological community. What follows is a brief chronology of their efforts to advocate for issues of diversity within the structure of the American Psychological Association (APA).

The American Psychological Association's Vail Conference of 1974 is cited by many as the inaugural event in the continuing conversation about the importance of cultural diversity to the practices of mainstream psychology (Holliday, 2009; Ridley & Kleiner, 2003; Sue, et al., 1999). The Vail Conference was convened to discuss issues with training programs in psychology in general, and the concerns of minorities, women and of social justice in particular (Korman, 1974). The recommendations generated by the conference included the importance both professionally and ethically of multicultural training for all students and the value of linking with community organizations to "drive home ...the extent to which psychological distress and social dysfunction are intertwined" (p. 449).

Four years later, in 1978, a smaller conference was convened at Dulles International Airport in order to "urge APA to take responsibility for providing a substantial place for ethnic minority issues within its organizational and governance structure" (Jones, 1998, p. 205). Specifically, the recommendation of the Dulles Conference was that APA create an Office of Ethnic Minority Affairs and a Board of Ethnic Minority Affairs.

In 1986, APA's Division 45, the Society for the Psychological Study of Ethnic Minority Issues was established. Four years later, at APA's 98th Annual National Convention, the *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (1990) was approved by APA's Council of Representatives.

In 1992, the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests was established which "began an aggressive pattern of

advocacy and pressure on APA, extending the civil rights activism for social justice of the 1960s to the central governance of APA” (Jones, 1998, p. 207). Two years later, in 1994, the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association acknowledged the importance of considering culture, race, and gender in the formulation of mental disorders. In 1998, the inaugural issue of the official journal of Division 45, *Cultural Diversity and Ethnic Minority Psychology* was published. Early the following year, the National Multicultural Conference and Summit (NMCS) was convened in Newport Beach, California. NMCS resulted in three important resolutions: “[to] (a) directly challenge the monocultural basis of psychological practice, education and training, and research; (b) make specific recommendations on needed changes in the profession; and (c) propose a set of well-defined multicultural competencies” (Sue et al., 1999, p. 1062)

The values behind all of these efforts relate to the vital importance of acknowledging the diverse nature of the U.S. population by working to address the inequalities inherent in psychological theories, training programs and research that were originally developed by and for white Americans. In the words of Jones (1998):

Cultural differences matter because they summarize the collective and cumulative bodies of experience that distinguish our pasts, inform our presents, and predict our futures. When those differences are trapped within disparities of power, they may be pathologized and soon rationalized as the flawed capacities of a people.

(p. 210)

Multicultural Competence

One important aim of the conferences and organizations discussed has been to provide psychologists with methodologies to guide their work with culturally diverse clients. These “cross-cultural counseling competencies” (Sue et al., 1982, p. 48) seek to establish a set of guidelines on how to work effectively with culturally diverse clients. Many models of multicultural competence have been proposed (Mollen, Ridley & Hill, 2003). In fact, Sue (2001) believes that “differences over defining cultural competence” (p. 790) have contributed to resistance in the profession towards adopting such standards. Multicultural competence is framed currently in terms of the APA’s *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (2003).

APA’s (2003) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* relies heavily on the framework established by Sue and colleagues (1982; 1992) over the past two decades. Therefore, the theory and model of Sue and colleagues’ (1982, 1992) formulation on cultural competence is important to detail in that it forms the historical context and conceptual basis for the APA’s (2003) formulation on cultural competence. In addition, Sue et al.’s (1982; 1992) formulations of cross-cultural counseling competencies are regarded by many as a landmark papers (Mollen, Ridley, & Hill, 2003; Ridley & Kleiner, 2003). Sue et al.’s formulation forms the basis for the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests’ guide to *Psychological Treatment of Ethnic Minority Populations* (Association of Black Psychologists, 2003) which is distributed by APA’s Office of Ethnic Minority Affairs and Sue et al.’s (1992)

paper is in part based on APA's (1990) *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*. The goal of this section will be to describe and critique Sue et al.'s formulation and suggest some points that will be of future relevance to the discussion of the interplay between working in the transference and working multiculturally.

Multicultural competence is framed currently in terms of the APA's (2003) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*. This policy document is divided into six guidelines which are introduced in the beginning of the document by contextualizing the importance of multicultural awareness and defining terms such as culture, race and ethnicity. Of reference to clinical work are Guidelines 1, 2 and 5 which relate directly to Sue et al.'s (1982; 1992) tripartite formulation of cultural competence as consisting of an understanding of the beliefs and attitudes, knowledge, and skills relevant to working as a culturally competent practitioner.

Each of Sue and colleagues (1982; 1992) formulations came about as the result of advocacy within APA and the American Counseling Association (ACA) by proponents of multicultural psychology within each organization (Arrendondo & Perez, 2006). In 1981, D.W. Sue was president of APA's Professional Standards Committee. This committee was commissioned by the president of APA Division 17 (Counseling Psychology) to create a report addressing cross-cultural issues. The result was Sue and colleagues' (1982) paper, *Position Paper: Cross-Cultural Counseling Competencies* in which Sue et al. outlined a tripartite model of cultural competence consisting of beliefs and attitudes, knowledge and skills. Ten years later, the president of the Association of

Multicultural Counseling and Development commissioned the Professional Standards Committee to elaborate upon the 1982 document which Sue et al. (1992) did by elucidating three characteristics of cross-cultural counseling competencies that each consist of the three dimensions listed above, yielding a 3 X 3 matrix of competencies. The three characteristics are: (a) “counselor awareness of own assumptions, values and biases” (p. 482); (b) “understanding the values of the culturally different client” (p. 482); and (c) “developing appropriate intervention strategies and techniques” (p. 482). Each characteristic is elaborated by the dimensions of beliefs and attitudes, knowledge and skills. What follows is a brief sketch of Sue et al.’s formulation.

The first characteristic that is critical to multicultural competence is awareness on the part of therapists as to their own assumptions, values and biases. One can become aware of beliefs and attitudes by exploring how one’s own cultural heritage results in certain attitudes and biases with regard to psychological processes. Part of the process of becoming aware of one’s beliefs and attitudes involves learning to tolerate differences in culture, attitudes, and beliefs as well as discovering areas where one has still more to explore. Developing knowledge about one’s assumptions, values and beliefs is a process of understanding one’s specific racial heritage as well as the personal impact of oppression and discrimination. On the other side of the coin, one must also understand and anticipate the impact one has on others in the social realm, especially in relation to the dynamics of power and privilege that may be at play in the therapeutic dyad. For example, a straight Latino therapist and a white lesbian client exist in a complicated sociopolitical relationship to one another. The therapist has experiences of discrimination related to his ethnicity, but participates in the privileges afforded to heterosexuals and

males in the U.S. culture. Conversely, his client, while benefiting from the power associated with being white in the U.S., nonetheless suffers inequalities as the result of being female and gay. In this example, the therapist would benefit from understanding how his ethnicity, gender and sexuality all impact his relationship with his client. These skills of self-awareness must be constantly enhanced by further training experiences, consultation, and supervision.

The second characteristic of multicultural competence involves understanding the worldviews of culturally different clients. In this context, attitudes and beliefs are important as they relate to understanding negative reactions and stereotypes one is experiencing towards actual clients. Gaining specific knowledge about the “life experiences, cultural heritage, and historical background” (Sue et al., 1992, p. 482) of a variety of people is important to establishing a baseline of information about clients that can be researched more fully as needed. Of particular importance to this dimension of knowledge is an understanding of the various racial identity development models as well as the sociopolitical milieu of different groups as it impacts both their daily lives and their potential relationship with psychotherapy. Sociopolitical factors include “immigration issues, poverty, racism, stereotyping, and powerlessness” (p. 482). Understanding culturally different clients relies on a constant process of skill enhancement through keeping up with research as well as personal involvement outside the consulting room with “minority individuals” (p. 482) so that one’s “perspective of minorities is more than an academic or helping exercise” (p. 482).

The third characteristic of multicultural competence has to do with the development of appropriate intervention strategies and techniques. Critical to this

characteristic is an attitude of acceptance towards clients' religious and spiritual beliefs and "values about physical and mental functioning" (Sue et al., 1992, p. 482), as well as a respect for indigenous healing practices and a value for bilingualism. The knowledge dimension of this characteristic has to do with achieving an understanding of how the mental health profession can clash with cultural values, deter individuals from seeking treatment, and contain inherent biases that invalidate assessment tools. It is also important to have knowledge of community resources available to clients from different ethnic groups as well as how "discriminatory practices at the social and community level... may be affecting [their] psychological welfare" (p. 483). There are a number of skills required of the culturally competent therapist relating to knowledge of appropriate intervention strategies and techniques. Therapists must develop a wider repertoire of verbal and non-verbal communication skills in order to account for and address cultural differences in communication and not be limited by "one method or approach" (p. 483). Culturally skilled therapists should be able to help clients "determine whether a 'problem' stems from racism and bias in others" (p. 483) and be open about the strategies and limitations of their chosen psychological interventions. In addition, culturally skilled therapists should be working to address issues of social justice such as bias, prejudice and discriminatory practices as they relate to the exercise of their profession. Finally, culturally skilled therapists should be sensitive to requests by clients to have therapy in the language of their choice.

Mollen et al. (2003) provide a critique of Sue et al.'s (1982; 1992) model on the basis of six criteria they developed to assess models of multicultural competence. They argue that Sue et al.'s model is unclear with regards to the definition of terms such as

culturally skilled, culturally competent, and expertise which yields confusion when these terms are used interchangeably. Adding to this confusion is Mollen et al.'s (2003) critique that Sue et al.'s (1982; 1992) model is descriptive without being proscriptive; it supplies aspirational values but does not sufficiently elucidate their practical application. For the purposes of this project, these characteristics of Sue et al.'s model are actually assets in that they make room for a more liberal interpretation of cultural competence which can in turn be used to think creatively about more traditional interventions such as psychoanalytic therapy. In essence, this is the rationale for discussing how working in the transference can constitute a multicultural intervention.

Mollen et al. (2003) also critique Sue et al.'s (1992) decision to limit the scope of their model to ethnicity, in spite Sue et al.'s acknowledgement that "all forms of counseling are cross-cultural" (p. 478). Mollen et al. (2003) point out that there are other important aspects of one's identity such as gender or religion that "may be just as critical as ethnicity" (p. 25). Ridley et al. (2001) make a similar argument when they say that a model of multicultural competence, "must address multiple social identities and their unique intersection for each individual, organization, and society" (p. 830). These critiques are relevant to this project in that I propose to look at culture from the perspective of "multiple social identities" (p. 830) rather than strictly from the perspective of race and ethnicity. Nevertheless, Sue et al.'s (1982; 1992) model can be generalized to include other dimensions of identity such as gender, religion, sexuality, age and socioeconomic status, just to name a few.

Greene (2007) contends that psychology has not figured out what to do with people who fall into more than one disadvantaged category. Her critique can extend to

Sue et al's (1982; 1992) model in that even culturally aware therapists may continue to universalize experience and decrease awareness of differences between client and therapist due to an excessively taxonomic knowledge of other cultural groups. This problem arises when cultural factors are considered in the absence of awareness that cultural identities are interdependent and contextual—that an individual forms a temporal nexus of cultural identities. Membership in “multiply marginalized groups” (Greene, 2007, p. 49); for example, being African American and lesbian, is one important example of how multiple cultural identities can create a unique experience of injustice and discrimination that cannot be encapsulated by a simple description of the struggles of one particular ethnic group.

Conclusion

The impetus behind the multicultural movement in psychology was the desire of various oppressed groups to achieve representation and equality with regards to the definition and dissemination of mental health services. To this end, ethnic minorities formed professional organizations in order to lobby the APA to include multicultural considerations within its policies and procedures. One important consideration for clinicians is what constitutes multicultural competence—how to work cross-culturally given that every individual varies from every other to some degree and that the greater the level of variation, the greater the challenge to forming a therapeutic alliance and effecting psychological healing. To this end, many psychologists have provided models of multicultural competence. At the forefront of this movement is the work of D.W. Sue and his colleagues. Sue et al. (1982; 1992) developed a 3 X 3 matrix of multicultural competence characteristics and dimensions that continue to frame the profession's

conversations about multicultural competence. Multicultural competence involves the ongoing processing of one's beliefs, knowledge and skills as they relate to personal, client and interventional aspects of cultural diversity and the sociopolitical impact of inequality. These considerations are vital to any psychological intervention as they can increase the applicability and utility of traditionally limited techniques.

Chapter 4: Transference

Introduction

In the same way that we have put Freud in context, it is possible to put the concept of transference in an historical context. The idea of transference, like most ideas, is not a static one. It developed out of a history of debate around Freud's first treatment intervention—hypnotism (Makari, 1992). Freud then refined the concept of transference to address his changing beliefs about the purpose of analysis: Was analysis simply a process of uncovering actual traumatic and thus repressed memories, or did distressing and thus repressed wishes also play a part in symptom formation? Klein took up the notion of transference and used it to explore “the deep layers of the unconscious” (Klein, 1952, p. 437) by focusing on the transference relationship in session and emphasizing the importance of interpreting negative as well as positive transference.

Freud

Freud's biographer, Peter Gay, gives a general definition of transference: “The transference is the patient's way, sometimes subtle, and often blatant, of endowing the analyst with qualities that properly belong to a beloved (or hated) person, past or present, in the ‘real’ world” (Gay, 2006, p. 253). Freud initially conceptualized transference as a tendency in hysterics to make false connections between disassociated ideas, and then thought about it as a replacement for symptom formation—as a form of repressing disturbing fantasies by imagining that they are felt towards the analyst rather than the original person. The idea of transference as a form of resistance was more robustly developed in *Dynamics of Transference* (Freud, 1912). However, alongside the idea of

transference as a form of resistance, was Freud's contention that it was "also the necessary (and troublesome) vehicle conveying unconscious material into the field of analytic operation" (Friedman, 1991, p. 576). Friedman suggests this contradiction was the result of Freud's effort to integrate two models of treatment; an earlier model based on uncovering memories and a new one based on uncovering repressed wishes: "Freud is finding a way to think in terms of the earlier theory of treatment (ventilating memories) while heading toward the new treatment goal (the integrating of freshly enlivened wishes)" (p. 583).

Freud's first musings on the topic of transference took place in *Studies on Hysteria* (1893) and included the following definition of transference:

the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. This is a frequent, and indeed in some analyses a regular, occurrence. Transference on to the physician takes place through a false connection. (Freud, 1893, p. 302)

Makari (1992) traces this notion of a "false connection" (p. 416) to Freud's involvement with the hypnosis community and their debate around how hypnosis worked to cure hysterics. On the one hand, there was Charcot and his followers, who believed that hysterics had a tendency to convince themselves of false beliefs (auto-suggestion) and were thus more open to suggestion during hypnosis. On the other, were the followers of Hippolyte Bernheim in Nancy, France who believed that the power of suggestion was at work all the time and that all individuals were equally susceptible to auto-suggestion, i.e., convincing themselves of ideas based on emotion rather than logic. Freud came down on the side of Charcot, believing that auto-suggestion was a quality inherent in the thought

process of hysterics that caused their symptoms as well as resulted in their propensity for certain types of cure. At this point, the concept of transference “was like Charcot's concept of inherent suggestibility, an intrapsychic distortion firmly rooted in the hysterical subject” (Makari, 1992, p. 429). Makari suggests that one of the advantages of seeing transference as a product of the hysteric’s distorted way of thinking was that it answered Freud’s critics’ assertions that he was making patients more ill or that he was seducing them.

From a theoretical perspective, Freud’s (1893) theory of transference in *Studies on Hysteria* relates to his view at the time that analysis was a process whereby traumatic repressed memories are uncovered. This was a time in Freud’s work before he abandoned the seduction theory (the theory that all hysterics have somehow been sexually abused) so that mental illness was a response to an actual trauma. Therefore, transference was simply the product of the hysteric’s tendency to make connections between ideas that aren’t related, in an effort to obscure the true cause of anxiety which was a repressed memory. During the process of analysis, some of the ideas that were mistakenly associated in the hysteric’s mind become mistakenly associated with the person of the analyst and resulted in transference; feelings toward the analyst that are properly feelings towards some other important person. Freud came to realize that these transferences happened quite often in treatment and were, according to the model of uncovering true memories of the past, a serious impediment to treatment.

By the time Freud (1905) came to publish *Fragment of an Analysis of a Case of Hysteria*, his conception of transference was becoming more complicated in that he was

seeing it both as an impediment to treatment and as a way of understanding what was happening in the patient's unconscious. In that paper, Freud defines transference as,

new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. (Freud, 1905, p. 116).

Freud theorized that during treatment, symptom formation takes a back seat to the development of transference feelings as a way of expressing what is going on in the unconscious. However, both transference and symptom formation represent strategies to avoid becoming directly conscious of the feelings stirred up by traumatic repressed memories. Symptom formation replaces a repressed memory with a physical disturbance while transference feelings interfere with the process of free association that is necessary to the treatment. Friedman (1991) suggests that there was an ambivalent shift taking place for Freud at this time between the repressed memory theory of illness (seduction theory) and the idea that repressed wishes and fantasies were the source of symptoms. Friedman theorizes that this shift was the source of the tension between the notion of transference as simple resistance and transference as a window into a patient's unconscious. The shift from memory to wish dealt specifically with memories/wishes of parental seduction and was thus called the "revised theory of seduction."

The tension between the two functions of transference becomes more obvious in Freud's (1912) paper, *The Dynamics of Transference*. In this paper, Freud simultaneously describes transference as a form of resistance as well as a way of gaining insight into the unconscious fantasies of the patient. On the one hand, he describes

transference as way of making up reasons not to continue the process of free association. On the other, Freud talks about the importance of transference to understanding the longings and wishes a patient has been repressing. Freud says: “But it should not be forgotten that it is precisely [the transferences] that do us the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest” (Freud, 1912, p. 108). Friedman (1991) describes a shift in Freud’s thinking about transference that was the result of a shift in his understanding of treatment from an uncovering of repressed memories to the uncovering of repressed wishes. These wishes are most clearly in evidence in cases of erotic transference towards the analyst. As Gabbard (1994) puts it:

Freud had come to recognize that the passionate demand inherent in transference love presented the analyst with an in vivo glimpse of the powerful longings and wishes from childhood toward parental figures. In other words, Freud discovered that it is the ‘real’ nature of the feelings in the analytic setting that makes them so useful to the analytic enterprise and that helps the patient see their relevance and applicability to other extra-transference relationships. (p. 389)

At this point in the history of transference, countertransference—feelings of the analyst towards the patient—was regarded as an impediment to treatment.

Countertransference is defined as “an affect arising in the psychoanalyst through the patient’s influence on the analyst’s unconscious feelings” (Gay, 2006, p. 253). Freud felt that countertransference was an obstacle to neutrality and needed to be mastered in one’s own training analysis: “We have become aware of the ‘counter-transference’, which arises in [the analyst] as a result of the patient's influence on his unconscious feelings,

and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it” (Freud, 1910, p. 144-145)

Klein

Klein (1927; 1946; 1952; 1975) expanded on Freud’s ideas about transference by widening the application of the concept and discussing in detail the techniques involved in working with transference. In order to understand Klein’s development of transference, it is important to discuss her theories on early development; specifically, the presence of early object relations and the role of primitive defense mechanisms such as splitting and projective identification. It will then be possible to see that, for Klein (1946), transference was the key to understanding the deepest parts of an individual and that analysis of negative transference specifically was important to achieving this understanding and, by extension, psychic change.

Klein distinguished herself from Anna Freud by asserting that both she and Sigmund Freud believed that object relations—internalized relationships with mental representations of the people in one’s life—operate from the beginning of life (Klein, 1927). The interactions between these internalized mental representations are collectively labeled *phantasies*. *Phantasy* is an important concept in that it describes, with its special spelling, the contents of the unconscious mind as opposed to *fantasies* which are more in the order of conscious daydreams (Isaacs, 1948). More specifically, phantasies are the “first mental processes, the psychic representatives of bodily impulses and feelings, i.e. of libidinal and destructive instincts” (p. 82). In other words, phantasies are the bridge between somatic experiences and intellectual processes—they are narratives in the form of emotions and images that attempt to understand what is happening both

inside and outside ourselves. To quote Isaacs: “The world of phantasy shows the same protean and kaleidoscopic changes as the contents of a dream. These changes occur partly in response to external stimulation and partly as a result of the interplay between the primary instinctual urges themselves” (p. 82).

The idea that object relations and phantasy are in play from the very beginnings of life came about through Klein’s (1927) work with very young children. Through her work, Klein came to believe that the Oedipus complex occurs much earlier in a child’s development; in infancy. An earlier Oedipus complex makes it theoretically possible for young children to develop transference since the original feelings and phantasies around this seminal developmental event have already undergone repression:

The analysis of very young children has shewn me that even a three-year-old child has left behind him the most important part of the development of his Oedipus complex. Consequently he is already far removed, through repression and feelings of guilt, from the objects whom he originally desired. His relations to them have undergone distortion and transformation so that the present love-objects are now imagos of the original objects. (p. 352)

Klein emphasizes the destructive nature of the infant’s mind and his use of *primitive defenses*, such as splitting. In describing the infant’s emotional life, Klein delineates a series of dichotomous relations; love and hate, external and internal states of affairs, perceptions of reality and interpretations of those perceptions, in order to illustrate the experience of splitting whole people or experiences into good and bad entities. One important dichotomy in the infant’s emotional life is characterized by shifts between persecutory anxiety and idealization.

Persecutory anxiety is the sensation that forces are conspiring to destroy oneself. For Klein, this anxiety was primarily the result of the death instinct—that collection of impulses in the human being that are focused on destruction rather than creation; on surrender rather than perseverance. Klein also alluded to external influences on persecutory anxiety such as the trauma of the birth experience as well as prenatal complications (Klein, 1975). Persecutory anxiety is experienced as inimical to the self and thus must somehow be defended against in order to achieve a more preferable state of calm.

The corollary of persecutory anxiety is idealization; the feeling that all is well with the world and one is in a state of perfect satisfaction. These states influence early object relations in that feelings of anxiety and idealization are externalized and seen as belonging to separate entities—in the first instance, to the breast (or primary feeding mechanism) which is considered good when it satisfies the infant and a bad separate breast when it frustrates the infant. Klein relies on bodily terminology because she believes that the infant's first experiences are of parts of objects rather than whole people (Brown, 2010).

In addition to splitting and idealization, projective identification is a primitive defense mechanism used to ward off bad feelings as well as invest external objects with good feelings. Joseph (1988) describes projective identification: “Klein described the fantasy of splitting off and projecting impulses and parts of the self into objects, as projective identification, insofar as the object then becomes identified with the parts of the self that have been projected into it” (p. 628). Through projective identification, the infant seeks to discharge emotions and phantasies, this time by externalizing them. The

result is that the infant imagines the caregiver to be experiencing the emotion rather than himself. Another goal of projective identification is to avoid the disturbing reality that the infant is separate from and thus unable to control his caregiver's behavior. Klein introduced this concept in 1946 and it was taken up with much elaboration by her followers over the years. Klein's conception of projective identification went on to shape the way analysts work in the transference and the specific developments of that technique will be described in the next section.

Klein describes the next stage in an infant's emotional development:

The ego's growing capacity for integration and synthesis ...gives rise to the second form of anxiety—depressive anxiety—for the infant's aggressive impulses and desires towards the bad breast (mother) are now felt to be a danger to the good breast (mother) as well. (Klein, 1952, p. 434).

These anxieties and the defenses against them are collectively labeled the *depressive position* where good and bad entities become integrated to the extent that angry feelings towards what was previously seen as the bad breast or bad mother threaten to damage or overwhelm the loving feelings towards the good breast/mother. Having realized that his angry and destructive feelings are aimed at the good as well as at the bad mother, the infant experiences depressive anxiety and guilt which feel very uncomfortable (Klein, 1975). The primary way of dealing with these unpleasant feelings is to resort once again to splitting—this time to put the bad feelings outside onto others and try and keep the good feelings inside and imagine that they are the sole contents of one's heart.

Even though an infant usually has only a few actual people in his life, each person is initially not seen as a complex whole but as many individual people corresponding to

different aspects of an individual. If the infant has already internalized and is relating (through phantasy) to mental representations of his caregivers (objects), it is now possible to analyze these mental representations through analysis of the transference because, “transference originates in the same processes which in the earliest stages determine object-relations” (Klein, 1952, p. 436). In other words, the infant already has rudimentary notions or hypotheses (phantasies) about others and it is these notions and hypotheses that go on to form the basis for an individual’s understanding of himself and others. This understanding can be discovered by exploring how an individual understands his relationship with the analyst—i.e. by exploring the transference.

Klein (1952) asserted that before her work, transference was limited to obvious references to the analyst in the patient’s material. In contrast, Klein believed that the presence of object relations from the very beginnings of life, coupled with defenses against persecutory anxiety suggested that even the young infant was operating from a basis in phantasy rather than reacting to what we would normally consider *real* events. These early phantasies went on to form the basis of a person’s way of relating to others which can be elucidated by analysis of transference. Therefore, transference was not simply object relations transferred to the analyst, but a clue as to the most basic inner workings of an individual’s unconscious. The corollary to this conclusion, which was the basis of Klein’s technique, is that the analysis itself, which is analysis of an individual’s unconscious phantasies, is a way of understanding the transference. In Klein’s own words:

My conception of transference as rooted in the earliest stages of development and in deep layers of the unconscious is much wider and entails a technique by which

from the whole material presented the unconscious elements of the transference are deduced. (p. 437)

Perhaps the most important contribution Klein made to psychoanalytic technique is in the emphasis on the importance of analyzing the negative transference from the outset of treatment. Just as splitting is a defense against seeing a whole, positive and negative transference are two halves of a whole experience of the analyst. Therefore, both must be uncovered and understood in order to effect psychic change. In fact, Klein believed that “analysis of the negative transference, which had received relatively little attention in psycho-analytic technique, is a precondition for analysing the deeper layers of the mind” (Klein, 1952, p. 436)

In summary, Klein’s work with young children enabled her to develop more specific theories about the *infantile*, *early*, or *primitive* state of mind. Klein’s observations led to her conclusion that object relations are at play from infancy and that infants attempt to cope with phantasies about their objects through the defense mechanisms of splitting and projective identification. In this context, transference takes on a new importance in that those early phantasies about internal objects become the basis for a person’s current ideas about their own and other’s motivations and states of mind. These current ideas and their antecedents are most clearly discovered through the transference and specifically through analysis of negative transference.

Chapter 5: Working in the Transference

Introduction

This chapter will provide an overview of the contemporary Kleinian technique of working in the transference, followed by a critique of this technique from a multicultural perspective. As specifically Kleinian critiques are few in number, the section on critiques will begin with relevant sociocultural critiques of psychoanalytic therapy in general and transference in general, followed by an application of these critiques to the contemporary Kleinian model.

Contemporary Kleinian Theory

Subsequent followers of Klein, who for the purposes of this study will be collectively referred to as contemporary Kleinians, did much to explain and expound upon her theories (Spillius, 1983). Spillius elegantly summarizes the important aspects of Klein's work that went on to influence her followers:

What Klein did, in my view, was to add depth and meaning to Freud's concept of projection by emphasizing that one cannot project impulses without projecting part of the ego, which involves splitting, and, further, that impulses do not just vanish when projected; they go into an object, and they distort the perception of the object. (p. 322)

Contemporary Kleinians developed a more detailed picture of the origins and function of transference as a key to the unconscious. They highlighted how the primary goal of therapy, to make the unconscious conscious was accomplished by working in the transference through analyzing splitting and projective identification. Contemporary

Kleinians emphasized the importance of countertransference in the context of projective identification as a nodal point of communication between analyst and patient. Finally, with developments in the understanding of projective identification, they began to discuss the pressure on the analyst to join with the patient in acting out in the transference. The general trend to these contributions is an “‘interactive’ model of psychoanalysis, where the emphasis is on the significance of the analyst's own subjective experiences in his understanding of and his method of responding to his patient” (Feldman, 1997, p.228).

How the mind works. Heimann (1950; 1956) and Joseph (1985; 1988) provide two examples of Kleinian analysts describing the workings of the mind. What the two perspectives have in common is their emphasis on the importance of unconscious phantasy. Heimann, who was a contemporary of Klein, relies on a more classically Freudian understanding of the structural model to explain the role of the ego in mental illness and treatment. However, she expands this understanding with Klein’s ideas about transference and how working in the transference accomplishes the goal of strengthening the ego. For Joseph, the early infantile states of mind as developed by Klein provide the framework for understanding mental illness and treatment. Joseph then further develops Klein’s work on transference to illustrate its role in helping to mediate the impact of infantile mental states on unconscious phantasy. Ultimately, both analysts share the goal of working in the transference to help patients become more conscious of and better able to tolerate the challenges of living and loving in the world.

Heimann (1956) emphasizes the importance of strengthening the ego in order to help it manage unconscious conflicts. Heimann references Freud in asserting that mental illness is the result of unconscious conflicts around the tension between the pleasure

principle (what feels good) and the reality principle (what is possible given the rules of society). It is the function of the ego to mediate between these forces using perception—the act of consciously interpreting and processing sensory input in order to make sense of both the inner and outer world. The act of perception is what initiates contact between an individual and her caregiver, the goal of perceiving the caregiver is to obtain “satisfaction and protection” (p. 303). Heimann sees the analyst as an auxiliary ego in the sense that the analyst uses his perceptive faculties in conjunction with the patient’s to facilitate becoming conscious of the patient’s internal processes—to help the patient make the unconscious conscious.

In discussing her theory of how the mind works, Joseph references Klein’s paranoid-schizoid and depressive positions. In effect, Joseph is referring to Klein’s elucidation of the process of perception: The ego, the perceiving part of the individual, is initially capable of a certain kind of perception, that of the paranoid-schizoid position which is characterized by splitting, idealization and projective identification. The phantasies that result from this early state of mind can become toxic and destructive to the self when internal or external traumas overwhelm an individual’s ability to cope. As a result, an individual can be left with varying degrees of unbearable thoughts and feelings which must be dealt with through symptom formation. The goal of therapy is to strengthen the good internal objects so that the individual becomes more capable of tolerating the pain of becoming conscious of these toxic and destructive phantasies.

Transference. Heimann (1956) uses the language of object relations to explain transference: “On account of unconscious phantasy the patient treats his own ideas, his memories of past events, his wishes and fears, etc. as personified entities localized within

himself, and he transfers these internal objects as well on to the analyst” (p. 305). According to Heimann, what is being transferred are an individual’s internal objects which he then imagines are identical with those of his analyst. Heimann explains that the vehicle for making the unconscious conscious is the transference interpretation: “the transference interpretation enables the patient's ego to perceive its emotional experiences, its impulses and their vicissitudes, makes them conscious, at the moment when they are actively roused in a direct and immediate relationship with their object” (p. 305). In other words, rather than discussing the past in a literal manner, the goal of the analyst should be to remain aware of how the patient is acting out past perceptions in the room by making assumptions about his analyst; what she thinks, what she means, how she is feeling, etc. It is in that moment when a patient is actively experiencing a state of mind in relation to the analyst, that he is most able (in conjunction with a well-timed interpretation) to connect with and understand how his past relationships are influencing his current state of mind.

Joseph is most well-known for elaborating on Klein’s notion of transference not just as feelings related to the analyst, but to the total situation of the analysis: “what the patient says, in itself of course extremely important, has to be seen within the framework of what the patient does” (Joseph, 1988, p. 630). Another important elucidation Joseph provides is the notion that transference is a constantly shifting process whereby a patient is communicating her current state of mind. This conception influences Joseph’s work in that she works in the transference with the goal of gaining insight into the nature of being as an ever-shifting process rather than a vehicle to discover discreet truths about an individual. Spillius (1983) elegantly summarizes Joseph’s perspective on the nature of

transference and how it is communicated, saying, it is “not expressed in the representational content of words but through the use of words to carry out actions, to do something to the analyst or to put subtle pressure on the analyst to do something to the patient” (p. 326).

Feldman (1997) encapsulates the rationale for why working with transference is preferable to primarily exploring external object relationships: “Of course, it is not difficult to see the advantages of projection into a hallucinatory, delusional or absent object. Since it is an omnipotent process, there is no doubt about the object's receptivity, and the consequent transformation” (p. 231). In other words, when patients talk about people in their lives during sessions, they are creating a picture that is, to quote Pick (1992), “partly accurate, partly coloured by emotions, and partly by the relationships we made in the past” (p. 27). However, the analyst is hard-pressed to sort out the details of this picture as its artist is the unconscious part of the patient. By working in the here-and-now through the transference, the analyst is able to become part of a living process with the patient as they work together to chart hidden and sometimes dangerous waters.

Working in the transference: Technical considerations. Some important technical considerations emerge when exploring the most effective way of working with the transference in session. These considerations will also be relevant for later discussion of the manner in which this technique is relevant to working in a multiculturally competent manner. These considerations include ways of facilitating the transference relationship, questions to ask oneself when doing the work, the analytic stance and how to make interpretations. In general, working in the transference involves paying attention to the way a patient is experiencing his therapist. There are many avenues for

discovering the transference since asking a patient directly about transference reactions does little to uncover the phantasies of which he is initially unconscious.

Efforts to facilitate the transference involve the proper role of the analyst in treatment where the goal is to prevent, as much as is possible, imposing one's own values and needs onto the patient. As Heimann (1956) states, the goal of analysis is to enable the patient to make contact with his own unconscious: "He becomes conscious through the interpretative work of what he had forgotten; he also becomes capable of thinking consecutively and finds conclusions where earlier his line of thought was blocked" (p. 308). To this end, the well-known principles of the psychoanalytic frame become a set of guidelines on how to initiate a certain specialized type of conversation, rather than a set of rules to which we must slavishly adhere. For example, the injunction against revealing personal information and opinions is important not because of some wish to be cold and dispassionate, but because "the analyst has to consider the reciprocal fact that his own personality, no matter how much he controls its expression, is perceived and reacted to by the patient" (p. 307). In other words, it is inevitable that we will reveal ourselves to our patients in many subtle ways so that consciously doing so is both unnecessary and distracting from the goal of the work, which is to introduce the patient to his own experience. In addition: "The patient's tendency to short-circuit his painful labours by accepting his analyst as a saviour and mentor makes it necessary for the analyst to avoid authoritative attitudes" (p. 308). Seeing the analyst as a savior is simply one potential aspect of a transference relationships and marks the beginning of the analytic work, rather than an end in itself. In summary, facilitating the transference involves efforts to remain

conscious of one's impact on one's patients with the goal of making better contact with patients' unconscious phantasies.

It can be helpful to have some questions in mind when listening to clinical material so that one remains focused on thinking symbolically rather than getting lost in the concrete details of a story. Heimann (1956) suggests asking, "Why is the patient now doing what to whom?' The answer to this question constitutes the transference interpretation" (p. 307) Rather than attempting to get clarity on the facts of a story, Heimann is suggesting that what needs clarification is the way unconscious phantasy is influencing the timing and content of a given statement with the goal of understanding the connection between the current statement and what has transpired in the treatment previously. By framing the question in general terms, Heimann provides a way of feeding clinical material into a structure designed to help the analyst consider multiple interpretations of a concrete story—the story may begin as a story about a patient's intrusive sister-in-law, but it may also be a story about an intrusive aspect of the therapist's last interpretation or a story about an intrusive experience of the therapist generally. Pick (1992) couches her questions in object relations terms: "This is a good opportunity to raise the question: what sort of object am I for her, and what sort of anxiety was she escaping from?" (p. 29). In this case, Pick is asking, what inner person/object is the patient speaking to when she tells a story and how does this story told in this way insulate the patient from feared psychic pain. Pick also asks: "Who is the analyst at times of need, or indeed who is the analyst when he addresses the patient with an interpretation?" (p. 33). Her point is that, "if the analyst is experienced as the patient's internal object he may not be experienced as much help" (p. 33). In other words, the

answer to questions about the transference may be that the patient is in a space where the therapist is experienced as unhelpful or even attacking—an important insight when attempting to account for how our best intentions are often not received in the spirit in which (we think) they are given.

Given the uncertain reception of a therapist's observations, some guidelines for how to make relevant and thoughtful interpretations becomes important. In discussing interpretation, Joseph (1985) in agreement with Pick that: "everything that the analyst is or says is likely to be responded to according to the patient's own psychic make-up, rather than the analyst's intentions and the meaning he gives to his interpretations" (p. 454). To that end, Joseph (1992) suggests that it is vital to interpret the experience the patient is having of the therapist's comments since any other interpretation may seem adequate on the surface but will only serve to create an emotional distance. We can see in this case how a transference interpretation will be able to address the manner in which what the therapist is saying is being used for some internal purpose by the patient, rather than to further understanding. One of Joseph's (1985) important contributions to contemporary Kleinian theory is her assertion that: "If one sees transference and interpretations as basically living, experiencing and shifting—as movement—then our interpretations have to express this" (p. 449). Therefore, it is not just important to make transference interpretations, but these interpretations must be dynamic—they must reflect the ever-shifting nature of the unconscious and the relationship transpiring between therapist and patient. Ultimately, the goal of timely transference interpretations is to: "bring alive again feelings within a relationship that have been deeply defended against or only

fleetingly experienced, and [to] enable them to get firmer roots in the transference” (p. 452).

The technique of working in the transference is dependent upon a therapeutic stance that facilitates the transference by creating an environment that allows for both patient and therapist to better contact the patient’s unconscious material. Working in the transference involves a focus on the here-and-now relationship by asking oneself questions that shift the focus of a patient’s statements from their surface content to their symbolic content. Finally, working in the transference is a function of interpretations that attempt to address the patient’s emotional experience of the therapist in a way that reflects the panoply of characters (objects) in the patient’s unconscious.

Projective identification. Working in the transference is a sophisticated technique that relies heavily on the use of countertransference and Klein’s concept of projective identification. Like splitting, projective identification is an early defense mechanism used, in part, to cope with persecutory anxiety by projecting bad feelings into external objects. It is also used to project loving feelings, which in healthy people forms the basis of good object relations (Klein, 1946). Contemporary Kleinians further developed the concept of projective identification when they observed that this form of projection often results in strong countertransference feelings being stirred up in the analyst. As a result, projective identification began to also be understood as an infantile form of communication (Bion, 1962; Rosenfeld, 1983) that allows mother to feel what baby feels and ideally to respond appropriately. In a similar manner, “The patient gets the analyst (or other external object) to understand what he feels by subjecting him to the experience that the patient himself undergoes” (Spillius, 1983, p. 321)—what is being

stirred up in the analyst are feelings that the patient cannot yet verbalize or understand. This process of using countertransference to access the patient's unconscious is an important aspect of the technique of working in the transference. Rosenfeld (1987) describes this process: "projective identification makes it possible for the analyst to feel and understand the patient's experiences, and so to try and help him face them and make better sense of them" (p. 161). In essence, the patient is relying on the analyst to be able to tolerate the feelings he is projecting so that the analyst can think about them and open up a conversation about them. Rosenfeld's work builds on the principle that the analyst acts as the patient's auxiliary ego in that it is the role of the analyst to maintain her ability to think in the face of overwhelming feelings even when the patient loses that ability.

Bion, alpha-function and enactments. The process of interpreting projective identification was discussed in detail by Bion (1962) using a specialized terminology that was later adopted by most contemporary Kleinians; that of alpha-function and beta-elements. He introduced these terms to describe both the early developmental and the analytic process and made it possible for subsequent analysts to conceptualize the parallels between early life and analysis in greater detail. The related concepts of container/contained and maternal reverie (Bion, 1962) are other ways of describing what is happening between a mother/baby dyad or an analyst/patient dyad. One consequence of Bion's terminology was that it enabled other analysts to begin to formulate theories about how the patient's material affects the analyst and can even result in pressure to act out the transference with the patient during session.

Bion discusses Freud's (1911) thoughts on attention in a similar way to Heimann's (1956) discussion of perception mentioned above. All three analysts

distinguish between the raw data of sense impressions and emotions and the act of perceiving and drawing conclusions about that data. Bion adopts a specialized language, akin to mathematical language, in order to better control associations to the words he chooses to use. To that end, Bion (1962) labels this raw data of sense impressions and emotions, beta-elements. The process of perception or attention, he calls alpha-function and the results of alpha-function are alpha-elements. Bion explains the distinction: “Beta-elements are stored but differ from alpha-elements in that they are not so much memories as undigested facts, whereas the alpha-elements have been digested by alpha-function and thus made available for thought” (p. 7). Another important fact about beta-elements is that they are “suited for use in projective identification... [and] influential in producing acting-out” (p. 6). The role of the infant’s primary caregiver as well as the role of the analyst is to take in an individual’s beta-elements, “digest” (p. 7) them and thereby transform the beta-elements into alpha-elements. In other words, the infant/patient is making use of the caregiver/analyst’s alpha function in the same way as Heimann (1956) might describe a patient making use of the analyst as an auxiliary ego.

Maternal reverie is a product of a mother’s alpha-function and defined by Bion as that “state of mind which is open to the reception of any ‘objects’ from the loved object and is therefore capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad” (1962, p. 36). In a similar fashion, the analyst is making use of alpha-function when he is in a state of receptivity to his patient’s material, maintaining a capacity to think in the face of intense emotional states on the part of the patient experienced by the analyst in the form of projective identification. In this respect, the analyst’s reverie, a product of his alpha-function, is performing the function of

“containing” (p. 102) the raw materials (beta-elements) of the patient’s unconscious which the patient experiences as unverbilized sense impressions and overwhelming states of emotion. Bion’s terms container/contained illustrate that quality of the therapeutic relationship wherein the analyst acts as a container for the patient’s projections; taking them in and thinking about them and thereby lending his alpha-function to the patient as the patient learns to develop his own capacity for reverie.

The concept of container/contained also relates to the idea of projective identification leading to enactments. As Steiner (1984) describes it, “patients act out their internal conflicts and anxieties in the transference and ... by projecting parts of themselves and of their internal objects onto the analyst, they act on us and try to recruit us to act out with them” (p. 444). There are moments when the analyst’s containing function falters and her capacity for reverie is replaced with her own acting out in response to her patient’s projective identifications. These enactments are regarded as inevitable to some degree, and therefore as opportunities to go back and reflect with the patient upon the failure of containment and the role the analyst was playing in the patient’s intrapsychic theater.

Summary. In conclusion, the contemporary Kleinian technique of working in the transference is an effort to use the therapeutic relationship as the vehicle for accomplishing the goal of treatment: To make the unconscious conscious and thereby facilitate psychic change. Another way of saying this would be: Observing and working with the dynamic nature of the therapeutic relationship is a way of helping patients become aware of states of mind that interfere with the formation and maintenance of their relationships with self and others. The process of working in the transference is an

interactive one in that therapists make use of their countertransference to understand their patients as well as considering the impact of their own unconscious on that of their patients. It is my belief that this technique lends itself to working with culturally diverse clients. However, before we can examine this belief in more detail, it is important to understand how the concept of transference, which is rooted in a White, European value system, is used by and critiqued by therapists interested in multicultural theory.

Transference and Multicultural Theory

The concept of transference is of course subject to numerous critiques. Of relevance to this project are critiques of transference from a multicultural perspective—from a vantage point of the impact of sociocultural dynamics on the therapeutic encounter. From a sociocultural perspective, it is possible to draw the entire enterprise of psychotherapy into question. Among these critiques are examinations of the unequal power dynamics in the room (Foucault, 1978; Hook, 2003), the hegemonic influence of theory (Carignan & Iseman, 2004), and the challenges of separating personal from professional (Hook, 2003). Some critiques of the concept of transference then follow directly from general critiques of psychoanalytic therapies (Carignan & Iseman, 2004; Hook, 2003; Shlien, 1984). Others seek to use sociocultural theories (multicultural theories) to highlight the pitfalls of disregarding culture when using the concept of transference (Altman, 2004; Basch-Kahre, 1984; Bernardez, 1994; Yi, 1998).

In *The History of Sexuality*, Foucault (1978) outlines the process whereby deviant sexualities (including homosexuality) were categorized and “medicalized” (p. 44) in order to bring human sexuality under social control from the 17th century onward. Foucault discusses the establishment of a “confessional” (p. 38) relationship between

doctor and patient in which these perversions are brought to light in a way that sexualizes the power dynamic and gives way to “spirals of power and pleasure” (p. 45) as new secrets and sins are revealed. Foucault’s analysis is relevant to this project in that it brings up a number of issues regarding the relationship between sociocultural dynamics and the enterprise of psychoanalysis.

Regarding pleasure, there is the potentially voyeuristic nature of psychotherapy, elaborated upon by Hook (2003) where the analyst “may be gratified by the content of sessions, or transference activity, in a personal capacity” (p. 206). Regarding power, the other aspect of Foucault’s spiral, we can see how the very system for assessing illness is culturally based and controlled by the values of those in power. In microcosm, this can be also said of the therapeutic encounter where the therapist’s own culture as well as the culture of psychoanalysis (Cabaniss, Oquendo, & Singer, 1994) can become the standard by which to pathologize and then treat/sanitize a patient. Another consequence of the unequal power dynamic is the potential manipulative power of analytic theory (Carignan & Iseman, 2004). One critique that is endemic to the psychoanalytic therapies is the fact that theory can give an analyst a deep sense of conviction as to his aims and, by extension, the analysis can become the process whereby a patient is forced to comply with (at worst) or be inculcated (at best) into the analyst’s theoretical culture. Both the pleasure- and power-based critiques of analysis have implications for critiques of transference.

Hook (2003) argues that it is the pleasure of the analyst which is gratified by the transference relationship, most obviously in cases of erotic transference. He goes as far as to suggest that erotic transference is caused by the analytic relationship: “If it were the

case that we have a potentially causative relationship on our hands, between the structuring of the psychotherapeutic relationship and the occurrence of erotic transference, then the ethical imperative behind these questions assumes a new importance” (p. 205). Hook’s argument is based on the notion that therapy represents a power imbalance and therefore the patient is incredibly vulnerable to abuses of power by the therapist and that these abuses of power are perpetuated in the transference dynamic (by stirring up forbidden desires) and carried out in the countertransference behavior. According to this argument, the technique of working in the transference would be seen tempting a therapist to abuses of power.

Greene (2007) contends that “there is the potential for the normative social power relationship characterized by dominance and subordination to be reenacted” (p. 56) in therapy. Altman (2004) observes in detail how the “social history of psychoanalysis played itself out” (p. 811) with a particular patient. Altman elaborates this thesis to propose that, “additionally, history on the large-scale level may be reenacted on the small-scale level of the individual or the dyad” (p. 807). From this perspective, enactments are not only influenced by intrapsychic factors but also by sociopolitical dynamics that become internalized by both patient and therapist so that historical power dynamics in the world (for example between a white male therapist and an African American female patient or in a dyad where the therapist has a high socioeconomic status (SES) and the patient a low one) at large can get played out in session.

There is also the associated danger of using our countertransference when working in the transference in that it may be our own negative feelings we are experiencing towards the differences we perceive between ourselves and our patients.

Schlien (1984) makes this point in a general sense, suggesting that therapists take pleasure in identifying transference because it allows us to hide our own reactions behind a label. Our feelings and behaviors remain hidden and the patient bears full responsibility for what transpires in session.

Another difficulty with the technique of working in the transference specifically is that a contemporary Kleinian analyst speaks to the patient “as though there had been an agreement to talk about the patient’s internal world, whereas from the patient’s perspective there was no such agreement” (Carignan & Iseman, 2004, p. 1258). Cabaniss et al. (1994) point out that it is not only the patient and therapist’s cultures that are at odds in the room, but also the culture of psychoanalysis. Relying on a heavily theoretical technique with intellectual roots in European philosophy, working in the transference represents a very different way of relating to another person that is probably outside the cultural norms of both patient and therapist. This third culture has a privileged position in the room, as it is being promulgated by the person who holds an unequal share of power.

However, the therapist’s effectiveness in offering a specific technique based in psychoanalytic culture is undermined by the fact that the very assessment of transference is culturally bound. Basch-Kahre (1984) points out that: “Socio-cultural peculiarities of behaviour make the evaluation of transference and counter-transference difficult” (p. 61). Basch-Kahre describes how both patient and therapist can “misinterpret the other’s pattern of non-verbal communication in terms of the pattern in his own culture” (p. 62) leading not only to difficulties understanding transference but a potential impasse in the treatment in general.

A related critique of transference is that it obscures a therapist's subjectivity, making him appear all-knowing and without faults. Bernardez (1994) makes the point that abuses of power can be caused by biases on the part of the therapist regarding sociocultural factors such as gender, ethnicity or sexuality. She states that the therapeutic situation is determined by: "an interactive process that uses certain characteristics of the patient's transference combined with the dynamic history, personality, gender, culture, and theoretical frame of reference of the analyst" (p. 520). Further, the transference itself is influenced by the limitations of the therapist as what the patient decides to reveal is related to the behavior of the analyst:

What is disclosed as well as what is hidden, what flourishes and unfolds in the patient's transference is in direct relation to the ability of the analyst to perceive those aspects and to understand them, is inhibited by his or her urge to reject them or misinterpret them. (p. 519)

Stolorow, Brandchaft, and Atwood (1987) go a step further with their critique of the concept of projective identification which, like the concept of transference, can be used to obscure the analyst's subjectivity. This critique applies to the view of projective identification as a defensive function of putting feelings and ideas "into" the analyst which Stolorow et al. argue, can be used by the analyst to deny his own idiosyncratic and personal responses to a patient's material. Stolorow and his colleagues' critique essentially argue that the concept of projective identification can be used to blame the patient for the therapist's negative responses to her. Yi (1998) elaborates upon this theme from a multicultural perspective, discussing the possibility that "strong countertransference feelings of helplessness and insecurity" (p. 251) experienced on the

part of an Asian therapist who works in a Kleinian modality, results in the assumption, “that the White client was looking for a ready opportunity to unload his dark, hostile impulses” (p. 251). Yi argues that the Kleinian’s “dark vision of human nature” (p. 249) coupled with persecutory feelings on the part of the therapist can result in “abusive attack[s] on the patient” (p. 251). These attacks can feel abusive to a patient if the focus on a dark vision of human nature “obscure[s] the developmental dimensions underlying one’s attitudes and feelings toward members of other races” (p. 249). In other words, the Kleinian focus on anxiety and primitive defense mechanisms can undermine the therapeutic alliance when sensitive issues such as cultural differences are strictly viewed as loci for defensive enactments rather than as serving both defensive and developmental functions.

Critiques of psychoanalytic therapy revolve around the pitfalls associated with the unequal balance of power between patient and therapist as well as the potential for impasses as the result of difference. Specific critiques of transference extend the analysis of power and impasse dynamics as well as highlighting the strong impact of both the therapist’s unacknowledged biases and the culture of psychoanalysis itself. Critiques of the contemporary Kleinian technique of working in the transference assert that excessive focus on cultural themes as defense mechanisms and a propensity to attack patients due to unacknowledged biases on the part of the therapist can undermine the therapeutic relationship. Each of these critiques illustrates the vulnerable position of the patient in therapy and the urgent need for a greater understanding of the impact of cultural biases on the part of the therapist as well as the relationship between culture and psychoanalytic therapy from a clinical perspective.

Chapter Six: Synthesis

Transference and Multiculturalism in Dialogue

This final chapter seeks to provide some ideas as to how a dialogue between working in the transference and the values of multicultural competence can enhance clinical practice. This chapter begins with a review of what others in the field have proposed in terms of integrating the two concepts. I end the chapter with my own thoughts on the relationship between transference and multiculturalism both for multiculturally responsive clinicians in general and psychoanalytically oriented clinicians in particular.

Integrating Transference and Issues of Diversity

Based on multicultural critiques of transference, various authors propose ways to integrate culture and transference. One school presents cultural issues as (to varying degrees) reducible to intrapsychic dynamics (Fischer, 1971; Holmes, 1992; Ticho, 1971) while the other provides models for conceptualizing transference as inextricably linked to culture (Basch-Kahre, 1984; Bonovitz; 2005; Comas-Díaz & Jacobsen, 1991; Cabaniss et al., 1994; Grey; 2001; Pérez Foster, 1992, Taketomo, 1989; Yi, 1995;1998).

It is possible to roughly divide writings on the relationship between transference and culture into two schools of thought. The first is united by the assumption that, to varying degrees, cultural issues in the transference can be reduced to intrapsychic dynamics. In contrast, the second school conceptualizes culture and transference as inextricably linked. The most popularly cited articles belonging to the first school are those by Schachter & Butts (1968), Ticho (1971), Fischer (1971) and Holmes (1992).

Each author discusses analyses taking place between racially different dyads, usually Blacks and Whites (in the roles of both analyst and patient). Each author is clear on the vital importance of discussing differences between analyst and patient during treatment and each cautions that neglecting to address these differences will prevent therapeutic success.

Schachter & Butts (1968) draw a distinction between stereotypes and transference that is inherited by subsequent authors: “These stereotypes do not reflect a transferring of feelings from earlier significant figures onto the therapist. They provide the structure upon which a problem can be hung” (p. 804). They suggest that: “If the stereotype and the developing transference are both reflections of the analysand's personal difficulties, this confluence of transference and stereotype will facilitate the analysis” (p. 804). The distinction between stereotypes and transference paves the way for seeing dynamics of difference in the room as opportunities to address “core problems” (p. 793), suggesting that perceptions of differences such as racial difference are surface problems that are potentially the result of these deeper, core problems. This trend is continued in the work of Fischer (1971) who states that: “the black-white difference between the analysand and analyst is a significant, contributing, and visible structure upon which the more basic and dynamic infantile fantasies are projected” (p. 736). Essentially, cultural dynamics form a manifest structure upon which latent intrapsychic dynamics unfold. Ticho (1971) states that: “Stereotypes can be used not only to cloud the transference but also to avoid looking at individual problems” (p. 316). Her argument is that cultural differences play a part in analysis, but that it is the patient who is unconsciously choosing which differences to emphasize and that this choice is based on “his pathology, individual needs and,

concomitantly, with the development of the transference neurosis” (p. 315). Therefore, analysis of intrapsychic dynamics is relevant since it is the patient’s individual history which determines how he responds to difference. Holmes (1992) also describes issues of diversity in terms of intrapsychic dynamics, and makes the point that race can be useful to the transference rather than just a hindrance; “race can be a useful vehicle for the expression and elaboration of transferences of defence, of drive derivative and of object ties” (p. 10). While all of the authors mentioned discuss the importance of exploring the reality of dynamics of difference in treatment, it is Holmes who observes that the mental health profession tends to focus efforts around the challenge of prejudice and injustice using “educative, advocacy and community mental health approaches” (p. 2) rather than in the context of individual therapy. This observation is perhaps an attempt to account for the extent to which each of the authors discussed nonetheless reduce issues of difference to intrapsychic dynamics during sessions.

There are other psychoanalysts who attempt to conceptualize the relationship of transference to culture in a way that does not reduce one to the other. One way of discussing the overlap between psychodynamic concepts and culture is through the notion of ethnotransference. Comas-Díaz and Jacobsen (1991) describe the concept of ethnotransference when discussing “the relevance and validity of ethnocultural factors in transference and countertransference” (p. 393). They discuss the various ways in which transference based on ethnocultural differences can range from “overcompliance and friendliness to suspicion and hostility” (p 393) and suggest that the process of exploring these reactions can lead to insight into patients’ unconscious feelings and the discussion of potential areas of impasse between therapist and patient. Grey (2001) addresses the

issue of sociocultural differences manifesting in the transference by distinguishing between transference, which he describes as a reaction to the other that is “idiosyncratic, even within one’s own group” (p. 685), and *ethnotransference*; reactions that he describes as, “reasonable to members of one’s own culture, but not to those belonging to the context in which they are expressed” (p. 685). In this way, Grey creates a space for thinking about the manner in which transference is a communication on many different levels—transference reactions do not just express individual psychopathology or personality but also ways of relating to another that are culturally bound. The fact that Grey still labels these reactions as transference helps us keep these reactions within a conceptual context of a communication to the therapist; in the case of ethnotransference, it is a communication that has greater potential for misinterpretation, which makes the case for the importance of acknowledging the impact of sociocultural differences in therapeutic dyads.

The actual practice of acknowledging the impact of sociocultural differences in therapy involves some key themes. Among these themes are the relationship between culture and individual (Bonovitz, 2005; Taketomo, 1989), the possible impact of language on an individual (Basch-Kahre, 1984; Rodriguez, Cabaniss, Arbuckle, & Oquendo, 2008), the importance of understanding the interrelationship between an individuals and their sociocultural milieu (Grey, 2001), and the role of extratherapeutic education on the part of the therapist (Cabaniss et al., 1994; Yi, 1995, 1998). The ultimate goal of these considerations is to provide suggestions as to how to work psychoanalytically within a cultural context.

Both Bonovitz (2005) and Taketomo (1989) point out that culture is both a function of group and individual dynamics in that the group dynamics of culture are internalized through each and every interaction with others, beginning with mother. As a result, “race and culture cannot be separated from the internal objects that reside in our unconscious” (Bonovitz, 2005, p. 71), because culture is what makes up the substance of our internal objects. In a similar vein, Taketomo (1989) suggests that, “the influence of culture can emerge in the search for individual personal meaning” (p. 428). In other words, just as individual meaning is made of cultural issues as discussed by the authors such as Schachter & Butts (1968), cultural meanings and understanding can be gained in the process of seeking individual meaning. In fact, Taketomo (1989) suggests that this is one way in which culture and diversity can be discussed in therapy: “Culture is not to be ignored, but it must be looked at through the individual's experience. Indeed, in a strict sense, one might say that every psychoanalytic psychotherapy is transcultural” (p. 428). Every therapy is transcultural in the sense that each member of the therapeutic dyad exists within a unique matrix of cultural experiences that form an individual. Bonovitz (2005) echoes this sentiment when he says: “Culture colors the internal world of objects and, not only influences, but participates in constituting the psychoanalytic dyad” (p. 72).

Basch-Kahre (1984), Pérez Foster (1992), and Rodriguez et al. (2008) discuss the impact of bilingualism on therapy, holding the view that being able to process experiences in one's mother tongue is vital to facilitating psychic change. Basch-Kahre (1984) points out that an experience cannot be worked through and has to be repressed when the caregiver cannot link emotional experience with symbols and words. In part, this inability is culturally based, for example, the inability to openly discuss sexual

matters with children in certain Western cultures leads to repression around the primal scene (witnessing intercourse or sexual matters at a young age). In a similar fashion, early learning of a new language and refusal to speak the mother tongue is a common strategy adopted by ethnic minorities when attempting to adapt to a host culture through assimilation (Organista, 2006). However, this creates a split between the language of emotional understanding and language as a concrete system of communication. The result in analysis can be that all the right words are being said, but there is no emotional connection and instead the emotions are acted out, often psychosomatically (Basch-Kahre, 1984). In discussing a bilingual psychoanalysis, Pérez Foster (1992) concludes that, “when both languages are used in treatment, language switching can trigger powerful shifts in transference phenomena, as affective experiences and early object relations are uniquely revived in the language in which they were lived” (p. 61). Also on the subject of bilingualism in treatment, Rodriguez et al. (2008) points out that both therapist and patient can make use of the split between the languages of head and heart in a defensive manner when they share both English and their mother tongue. She discusses the case of a patient where: “The patient and I took refuge in the less intimate English language and American culture as a way of creating a safe ‘distance’” (p. 1403).

Sue et al. (1982; 1992) have clearly established the importance of acknowledging the impact of sociopolitical dynamics on the individual. One way of conceptualizing the various influences on an individual is by applying the concept of multiple levels of analysis in the manner of ecological systems theory (Bronfenbrenner, 1977; Darling, 2007). Bronfenbrenner (1977) outlines a set of “nested and interconnected structures” (p. 199) that impact the development of an individual from the individual familial

(microsystem) to the larger sociocultural context (macrosystem). Grey (2001) evokes ecological systems theory by referencing research on the impact of the economy on mental health as well as the impact of sociocultural disparities on mental health. Grey traces the tendency to emphasize intrapsychic dynamics in treatment to the North American value of personal independence. Sue's (1978) discussion of internal versus external loci of control is also relevant here in that individuals from Western cultures tend to view the sources of their problems and the solutions to these problems from an internal perspective, emphasizing the importance of personal choice over external causes. Therefore, not only are there multiple layers of influence on an individual, but culture affects where one places the emphasis in understanding that influence. The task of relating individual experience to sociopolitical dynamics is important to every therapy (APA, 2003). However, a client's receptivity to this process is also culturally mediated.

In addition to the education in diversity clinicians receive from individual clients, it is important that clinicians also seek education and training regarding both the values and cultural practices of various groups as well as the culture-bound nature of psychoanalytic constructs (Yi, 1995). Cabaniss et al. (1994) point out that not only are the cultures of therapist and patient present in the consulting room, but also the culture of psychoanalysis. They propose three routes to help deepen awareness of the cultural tides in the therapeutic dyad: "[F]irst, through a fuller understanding of the cultures of our patients, second, through a thorough examination of our own psychoanalytic values and cultural beliefs, and third, through vigilance as the transference and countertransference develop" (p. 619). In other words, one route to developing an understanding of the

meeting between our own and our patients' cultural values is through an awareness of the vicissitudes of the transference. In the words of Cabaniss et al.:

The emphasis on the need to understand the patient's cultural values and the therapist's psychoanalytic values in no way minimizes the importance of the therapist's exploration of the relationship of these values to the patient's intrapsychic conflict. In fact, understanding the patient's cultural values clarifies the patient's psychodynamics. (pp. 618-619)

A review of the literature on the connection between transference and culture reveals a shift away from reducing one to the other in favor of understanding the two as inextricably linked. Bonovitz (2005) and Taketomo (1989) illustrate the view that culture is not a surface phenomenon that is reducible to individual intrapsychic dynamics, rather culture is both a force that interpenetrates individuals as well as the substance that makes up the contents of the unconscious. The observations of Basch-Kahre (1984) and Rodriguez et al. (2008) show us that just as culture makes up the contents of the unconscious, one's mother tongue is the language that is closest to the emotional experiences in the unconscious. The multiple levels of analysis (Bronfenbrenner, 1977; Darling, 2007) of ecological systems theory can give clinicians a template for thinking about the multiple influences on individuals that is analogous to the multiple levels of analysis that clinicians can perform on unconscious material. From a contemporary Kleinian perspective, the most effective way to access the unconscious material is through working in the transference—through a conversation in the here and now about how patients experience treatment and view their therapist. Given this author's perspective, the accounts of the interconnectedness of culture and intrapsychic dynamics

seem most valuable due to both the dynamic nature of the concepts themselves as well as of the human self as it exists on multiple levels of being—individual, familial, societal, cultural and temporal.

Working in the Transference as a Multicultural Intervention

The contemporary Kleinian technique of working the transference provides a methodology for exploring the therapeutic relationship that can be helpful to any clinician interested in deepening their work with transference. The principles of multicultural competence also provide a way of thinking about transference that can be helpful to facilitating cross-cultural work both in general and from a specifically contemporary Kleinian perspective. Basically, if working in the transference relies heavily on the therapist's sense of what is happening in the room, then culturally responsible training is vital to working in the transference (since all therapy is cross-cultural to some extent). The corollary to this statement is that some of the components of cultural competence can manifest in transference, which is something any multicultural therapist can be watching out for. What follows is a discussion of the ways in which transference work can be informed by multicultural considerations. I have elected to divide this section into two parts: (a) How working in the transference can benefit from multicultural competence and (b) General applications of transference work for multiculturally competent therapies.

What transference can learn from multiculturalism. This section will be organized into Sue et al.'s (1982) model of beliefs and attitudes, knowledge and skills that are important to gaining multicultural competence. There are aspects of working in the transference that can be deepened by working with each dimension of multicultural competence with the ultimate goal of better addressing client needs given that “all forms

of counseling are cross-cultural” (Sue et al., 1992, p. 478). Furthermore, the analyst’s alpha function or capacity for “reverie” (Bion, 1962, p. 36), which allows her to provide containment to her patients, can only be enhanced by developing the ability to reflect upon sociopolitical, cultural, and historical themes as they relate to the content of sessions. The goal of the following suggestions is to address the critiques outlined in the previous chapter which have to do with the danger of abuses of power in the transference relationship. Specifically, integrating multicultural concerns with working in the transference helps to foreground the strong element of subjectivity present in cross cultural encounters as well as the cultural impact of the technique itself. This is particularly important with a technique such as working in the transference in that it is based in the metaphor of the therapist as mother and thus relies heavily on the therapist’s subjective understanding of the patient’s communications.

Just as psychoanalysts use their own analysis as a tool for developing insight and getting important applied training, they would benefit from an analysis of how their cultural heritage affects bias, how they may have been impacted by discrimination and stereotyping, and how they impact others from a sociopolitical perspective. This *cultural analysis* has implications for improving the analytic frame and deepening the analyst’s capacity for reverie. One’s cultural value system, which also resides in the unconscious, is just as deeply rooted as one’s personal values, so that a part of the frame should become being conscious of one’s attitudes and beliefs in the same way that one is conscious through personal therapy of personal issues that, unchecked, could adversely impact treatment. In terms of contemporary Kleinian work, the suggestion of a cultural self-analysis is intended to touch more than just a surface level of biases or stereotypes.

A successful training analysis is intended to give the analysand the opportunity to experience both her own unmetabolized early emotions and phantasies (beta elements) as well as the experience of having these beta elements digested and fed back to her by her training analyst. In a similar fashion, the experience of encountering and thinking about one's most visceral and deeply ingrained beliefs about culture and difference can prepare an analyst to sense her patient's struggle with these issues without losing herself in the chaos that strong feelings around difference can engender and getting drawn into enactments around culture. An example of this process could be the manner in which a cultural self-analysis yields insight into the complicated nature of prejudice as both a fear and a hatred of another person or group. An analyst can take this felt experience (through projective identification) of prejudice and use it to listen for prejudice in an encounter with her patient where she may feel her patient's sense of hatred and fear as both directed at some external group but also towards herself. She can avoid the dangers of either indulging or censoring her patient's emerging material and instead use her cultural self-analysis to contain both her own and her patient's feelings, thereby opening up a conversation about culture rather than retreating from strong emotions or reducing them to a universal intrapsychic experience and avoiding the importance of the impact of prejudice in her patient's life.

It is important for analysts to be aware of the specific cultural heritage, historical background and life experiences of their patients. Each of these factors impact the transference in that the work of the psychoanalysis is to help the patient transform painful unverbilized states of mind (beta elements) into alpha elements that can be thought about and constructively acted upon. In order to be able to think about these feelings in an

informed manner, the analyst should have an understanding of possible sociopolitical impacts on a given client as well as an understanding of sociopolitical dynamics in the U.S. in general and the culture-bound nature of analysis itself. Analysts can benefit from knowledge of possible sociopolitical factors impacting a patient the same way analytic training allows them to maintain an awareness of the intrapsychic issues—through knowledge of analytic theory—that may be at play when a patient is in distress. For example, patients' destructive states of mind can become overwhelming in response to external events. These triggering events may include both obvious events (such as hate crimes) and subtle sociopolitical dynamics (such as being the only parent at a PTA meeting whose son is attending school on a scholarship) at play in a patient's life. Another benefit of understanding a patient's sociopolitical milieu is that strong unconscious feelings around discrimination and injustice can become sources of anxiety. Part of the goal of the therapeutic work is to bring those feelings into conscious awareness so that the person has a chance to think about them rather than being controlled by them and reacting to them in a self-destructive manner. An example of this type of therapeutic work around discrimination is a situation where working in the transference suggests to the therapist that his patient is experiencing him as sexist. Rather than reducing this experience to the intrapsychic issue of persecutory anxiety, the analyst may choose to examine the sociopolitical realities of the therapeutic dyad such as (in this particular example) the difference in gender. Using his patient's communication through projective identification, the analyst can make contact with the felt experience of his patient's feelings around sexism. Feelings such as powerlessness and anger can be discussed in an effort to open a conversation about how even an unconscious sense of

others as sexist is impacting this patient's behavior and perhaps causing her to become overwhelmed by emotions and therefore unable to think about the possibility that she can empower herself. The goal of the work in this case is not to tell the patient that she can become empowered, rather, it is to bring to conscious awareness the emotions that are roiling under the surface so that the possibility of changing those disturbing states of mind and thus empowering herself can develop in the patient.

In their discussion of cultural competence, Sue et al. (1982) discuss the importance of developing skills in sending and receiving a variety of verbal and non-verbal responses. The concept of transference as the *total situation* in the room can be a pathway to honing verbal and non-verbal communication skills in the service of a multiculturally informed contemporary Kleinian therapy. If transference is the total situation of verbal and non-verbal interactions between patient and analyst, it is important for analysts to have a working understanding of the culture-bound nature of both verbal and non-verbal communication in order to be able to reflect on the various levels of meaning and facets of the transference being communicated. The goal of developing this skill is to multiply the possible avenues of reflection available to the analyst in response to patient communications. For example, a patient may have a tendency to lean forward at certain times during a session. Every time he does this, his analyst feels the desire to lean away from him. In addition to the individual dynamics represented by this encounter, a knowledge of the cultural vicissitudes of non-verbal communication could give the analyst a number of other ways of thinking about this encounter including issues around personal space preferences, and the meaning of leaning forward as indicating interest for one person and aggression for another. Another aspect of the skill of

understanding a variety of verbal and non-verbal communications relates to projective identification and the idea that words are being used “to carry out actions, to do something to the analyst or to put subtle pressure on the analyst to do something to the patient” (Spillius, 1983, p. 326). This is an important point for cross-cultural analyses in that words are not being used to just understand what someone is saying, but a conversation is happening in analysis about how words represent expectations and pressures on the analyst that are not directly verbalized. These expectations and pressures are simultaneously individual and culture-bound as illustrated by discussions of sociocultural dynamics playing out in the therapeutic dyad (Altman, 1994; Greene, 2007). For example, pressures on the analyst to enact situations with a patient may not be simply individual communications, but cultural communications as well. A patient may be bringing a feeling of disgust into the room where he is alternatively disgusting to and disgusted by his analyst. A contemporary Kleinian interpretation of this feeling of disgust may be that the patient was neglected in his early life and the goal of the work would be to help the patient connect to that feeling of neglect. However, this feeling of disgust may have been amplified and exacerbated by other factors in the patient’s life that also need to be connected to, factors that relate to sociocultural issues such as the experience of being poor and African American in urban Los Angeles. The possible transference implications of the therapeutic dyad then multiply in that this patient could be treating his analyst like his neglectful mother, his miserly grandmother or his indifferent white teachers. Each of these experiences hold a kernel of the emotional suffering that, according to contemporary Kleinian theory, is important to experience and understand in order to facilitate psychic change.

The contemporary Kleinian technique of working in the transference can benefit from the application of multicultural awareness around analyst beliefs and attitudes, knowledge, and skills with the goal of increasing the analyst's capacity for reverie and containment, and addressing the fact that the unconscious is a culture-bound entity. To this end, analysts can benefit from doing their own work around cultural and sociopolitical experiences, seeking ongoing training in the histories of many different groups as well as training in the culture-bound nature of analysis itself, and from further developing skills in using and interpreting verbal and non-verbal communication. The goal of this additional training would be to find ways to enrich contemporary Kleinian theory so that it addresses patient needs at the level of intrapsychic as well as cross-cultural dynamics.

General applications of transference work for multiculturally competent therapists. This section deals with how to use a multicultural interpretation of transference work to explore cross-cultural themes that may be developing between a client and a therapist. The techniques discussed involve thinking about a client's content from a symbolic perspective that facilitates multiple levels of analysis in order to help clients manage painful experiences and become empowered to effect both psychic and social change.

Working with transference can be seen as an alternative to exploring external object relationships which can be useful from a social justice and empowerment perspective. On a certain level, what limits people are internalized injustices—an acceptance of the status-quo that limits creativity and the ability to imagine positive change. By becoming familiar with the states of mind that get triggered in the face of

external injustice, one is able to remain creative and open to opportunities for action rather than becoming overwhelmed and paralyzed by anger or despair.

One way of applying multiple levels of analysis to client material is to consider multiple interpretations of a concrete story by asking general questions of the material such as, “Why is the patient now doing what to whom?” (Heimann, 1956, p. 307).

Heimann’s general question can be used to think about sociopolitical interpretations of a patient’s material as it relates to transference. To extend the example from earlier about a client discussing her intrusive sister-in-law: We phrase this situation as the client experiencing a relationship, not of her own choosing, that is intrusive. This general statement could be used to think about institutional-level or society-level experiences of intrusion such as possible feelings about having to see the therapist at a community clinic or the attitudes of others towards one’s homosexuality. Another important transference-based technique that can inform multicultural practice is that of interpreting the client’s experience of his therapist’s comments. Opening up a discussion about how therapist interpretations are being received is another way of having a conversation about cultural difference and the experience of being understood or misunderstood by one’s therapist. One advantage of this kind of conversation is that it gives the patient an opportunity to educate the therapist about his verbal and non-verbal responses which further fosters understanding.

According to a transference model, themes relating to issues of diversity (like all content in treatment) are best explored during moments when they are most emotionally alive in session. An actively experienced state of mind can then be thought about at many different levels in a moment when it is most emotionally alive for the patient. This

technique has the two-fold advantage of talking about something the patient clearly has strong feelings about, something that is relevant, as well as engaging in an exercise of thinking about painful emotional experience, thus processing it.

Finally, the perspective of transference work as gaining insight into the nature of being as an ever-shifting process is helpful when thinking about how to introduce clients to the vicissitudes of their own minds as well as helping them withstand the constant state of change that is the reality of human existence.

In summary, elements of the technique of working in the transference can benefit any therapy that is multiculturally aware by giving access to a client's experiences of difference in the therapeutic dyad. Applying the concept of multiple levels of analysis to client material is one way of thinking about how sociopolitical dynamics can overlay the manifest content of sessions. Checking in with clients about how interpretations are being received is another way of fostering a dialogue about possible differences in communication that are culturally-based. The idea of talking about the therapeutic relationship because it is something active in the present moment allows the client to become comfortable thinking about intense feelings that may have been overwhelming in the past. Finally, participating with the client in the dynamic and complicated process of encountering and thinking about shifting states of mind and multiple levels of relating helps clients become more comfortable with the dynamic and complicated nature of existing within a framework of multiple realities.

Issues for further research

This project represents the beginning of many possible avenues of research into the relationship between contemporary Kleinian psychoanalytic theory and the values of

multicultural psychology. A number of issues that have been hinted at in the course of this investigation would benefit from continued exploration. These issues include the relationship between contemporary Kleinian ideas about psychic change and the multicultural and politically liberal belief in the value of social justice as well as research into the implications of culture-bound nature of contemporary Kleinian thinking on working with clients from diverse backgrounds.

The notions of alpha-function and containment also have implications for the social justice element present in the values espoused by the psychological community (APA, 2003) and how it can inform a contemporary Kleinian perspective. Joseph (1992) broadly defines the goal of psychic change to be “deeper and fuller relationships with people” (p. 238) and an ability to “tolerate ambivalent feelings towards them,” (p. 238) which appears to have little to do with social change. Yet an argument can be made that injustices get represented intrapsychically, and while there are real social injustices and discriminatory practices that exist in the world, working in the transference ultimately can help patients deal effectively with the injustices in external reality by increasing their capacity for containment. The task of such a project would be to present the arguments from community psychology and multicultural perspectives and try to reconcile those with the psychoanalytic frame of contemporary Kleinian theory. The goal of such a project might be to show that working through internal conflicts can enable a person to become active fighting against worldly oppression and that without that working through, these real sociopolitical dynamics get represented in a way that is not empowering. In other words, to make the argument that, if you are overwhelmed by emotions and pain, then you don't have the resources to take care of yourself in the real world.

Another possible avenue for further research is the status of contemporary Kleinian theory as both culture-bound—existing within the matrix of the history of European values and philosophies—as well as appealing to groups throughout the world. This study could examine the theoretical similarities and differences between Kleinian communities in the United States, Britain, South America and Japan. A related study could look at the worldview of Kleinian theory and how it overlaps with the worldviews of other cultural groups, making it effective in some cross-cultural dyads but less effective in others.

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