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The cultural influences which motivate countertransference for the collectivist-oriented clinician working with clients in the United States

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ABSTRACT

This theoretical thesis explores the phenomenon of the collectivist-oriented clinician and

the cultural influences that motivate countertransference while working with clients in the United

States. This project explores the cultural influence of difference in the cultural orientations of the

clinician, and the clients' in two internship placements as contexts of the work in the United

States. The cultural experiences in the dyad are related to differences in the issues of sense of

self, differentiation, separation-individuation, autonomy, and self-determination. In particular,

these influencing cultural differences are analyzed through structural drive theory and relational

theory. Ethnocultural countertransference literature (Comas-Diaz & Jacobsen) informing the

influencing experiences of ethnicity and culture on diverse dyads is also discussed. Additionally,

cultural differences are discussed through the literature on the individualism-collectivism

orientation framework. Through this exploration and analysis, drive theory and relational

theory's concept of intersubjectivity are offered as important in informing clinical work for the

collectivist-oriented clinicians practicing in the United States. An adaptive idea of horizontal

individualism as a compromise, from which collectivist-orientated clinicians may practice while

embracing their bicultural identities, is offered. Implications for clinical social work practice

concerning the need to increase social work students' cultural competence are presented.

THE CULTURAL INFLUENCES WHICH MOTIVATE COUNTERTRANSFERENCE

FOR THE COLLECTIVIST-ORIENTED CLINICIAN WORKING WITH CLIENTS IN

THE UNITED STATES

A project based on an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

Culture influences every aspect of therapy with clients, and it informs the way some clinicians view themselves, their clients and their clinical practice (Comas-Díaz, 2012). Clinicians from collectivist-oriented cultures who work in the United States (U.S) specifically experience cultural differences between their original cultural orientation, and that of their U.S.-born clients. These cultural differences have an important impact on clinical practice. I theorize that clinicians from collectivist cultures confront ethnic and cultural (ethocultural) experiences that inform their work in meaningful ways (Comas-Diaz and Jacobsen (1991). This study will explore the phenomenon over over-identification (Comas-Diaz and Jacobsen, 1991) and how it intersects with client-clinician experiences of sense of self, differentiation, autonomy, separation-individuation and self-determination. My analysis of this phenomenon will be influenced by a careful examination of the applications of drive theory and relational theory. I will also explore how collectivism and individualism represent influencing frameworks with an emphasis on my own experience in a collectivist culture. I will explore my own cultural frameworks and use this analysis to reflect upon my clinical experiences during two internships. I believe using my own experience as scaffolding for theoretical analysis has the potential to make a meaningful contribution to social work literature on cultural competence.

In chapter II I will provide a thorough explanation of these statements, including the rationale for use of these cultural concepts. Chapters III and IV will focus on drive theory and relational theory respectively. I will weave my analysis of relevant theoretical models with my personal experience working as a clinical social work intern at two mental health agencies in the Northeastern United States. I believe my own clinical practice is an important lens through which to explore this topic, because my practice was challenged by the need to prioritize both my cultural self-concept with my clients' as well as responsibility to the professional requirements of clinical work via the NASW Code of Ethics. These challenges demonstrate the need for cultural competence in clinical social work.

Review of Relevant Literature

Clinicians from collectivist-oriented cultures, particularly those that are foreign-born, experience unique, culturally influenced countertransference in their clinical work in the United States. There is a significant gap in the literature concerning this phenomenon. Most of the research about cultural countertransference is limited to the discussion of U.S. born clinicians' perspectives of cross-cultural therapy, and much of it focuses on the native-to-the U.S white – black and clinicians of color dyads. Comas-Diaz & Jacobsen (1991) highlight the complexity of this phenomenon, but fail to appreciate the culturally orientated differences that influence countertransference, especially for those born outside the United States. Their research focuses on the ethnocultural factors that influence ethnocultural countertransference in all their complexity, within different dyads. Their work also illustrates the complexity of ethnocultural countertransference in a myriad therapeutic dyads (intraethnic and interethnic). Comas-Diaz and Jacobsen (1991) use the expression "ethnocultural countertransference" to highlight the factors or experiences that influence culturally oriented work within therapeutic dyads. Comas-Diaz and

Jacobsen (1991) view denial as a prevalent form of ethnocultural countertransference in therapeutic dyads. Clinicians in these dyads unconsciously (and sometimes consciously) refuse to acknowledge and manage their countertransference in the therapeutic process. They may insist on fairness, sameness, and the need to stay above the fray of the cultural and political issues of the dominant society in which they find themselves.

Similarly, "the clinical anthropologist syndrome" can be prevalent within this therapeutic relationship. This ethnocultural countertransference leads clinicians to over-explore in a way that may derail the clinical process. In this situation, there is too much emphasis on aspects of the client's attributes, which leaves little room for treatment. Guilt as ethnocultural countertransference can also be present in similar dyads. This manifests when the dyad's ethnocultural background is designated as lower or antagonistic by the dominant sociopolitical processes.

On a related note, pity as a form of ethnocultural countertransference closely related to guilt that can lead to paralyzing and unhelpful over-identification on the part of the clinician toward the client. According to Comas-Diaz and Jacobsen (1991), ethnocultural countertransference such as aggression can become entangled with the clinician's guilt. The clinician may become angry with the client for experiences the clinician perceives as off-putting, diminishing, and unrepresentative of the client's ethnocultural identity. Sometimes this anger may be seen an extreme version of ambivalence toward a client's experiences that trigger the clinician's own unresolved cultural issues within that context.

Ambivalence is also recognized as an ethnocultural countertransference experience. Clinicians may experience ethnic and cultural ambivalence as a result of unresolved issues in the process of acculturating or assimilating. Comas-Diaz and Jacobsen (1991) give an example of

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clinicians who embrace the dominant lifestyle and cultural values, thus transcending similar ethnocultural values with their clients. The dynamic of survivor's guilt can also arise and is common among clinicians identifying as ethnic minorities and immigrants with less advantaged socioeconomic backgrounds compared to the dominant group. Clinicians experience this in their zeal to escape such origins, which leads them to higher education and higher income levels. As a result, these clinicians may be riddled with conflict and guilt for their survival among relatives or fellow immigrants who were not able to leave poverty behind.

Comas-Diaz and Jacobsen (1991) also suggest that phenomena like survivor's guilt can impede professional growth due to the clinician's inability to focus on the client's real problems. As a reverse form of the clinician's conflict-within the guilt, clinicians who share a similar ethnocultural constellation with their client may experience both hope and despair because they escaped poverty, but they harbor no guilty feelings for their success and survival. Therefore, working with clients in challenging socioeconomic situations, clinicians alternate between experiences of despair and hope as they work to improve their clients' lives, and the larger community from which they originated.

According to Comas-Diaz and Jacobsen (1991), clinicians, especially those who identify as collectivist and similar to their clients, may over-identify with their clients. That tension is brought about by an unconscious sense of sameness in the process of treatment, especially around ethnic and cultural identity issues. Mishne (2002) elucidates that cultural orientations and worldviews may include cultural disconnection and re-connection, or self-identity development, for both clinician and client.

According to Comas-Diaz and Jacobsen (1991), the extreme version of over-identification is the "us and them" countertransference where similar dyads also identify as an

ethnic minority. When clients identify within groups with a history of lower socioeconomic status and oppression, the clinicians may harbor the attitudes of their clients and thus over-identify in a common victimization state of being. The authors observe that such clinicians may be over-sensitized to racial overtones based on a shared interpretation of the dominant context as oppressive. They may choose to over-identify and over-protect their clients against racial overtones thus avoiding the confrontation of their client's intrapsychic issues. These clinicians may also over-identify by over-emphasizing policy and social change to confront issues of racism and, in the process, neglect to deal with the clients' real issues (Comas-Diaz and Jacobsen (1991). Over-identification may challenge clinicians in many ways such as in the under-diagnosis of existing psychopathology (Mishne (2002); Comas-Diaz and Jacobsen (1991).

Although the literature also doesn't specifically mention dyads made of clinicians from collectivist cultures, it nonetheless, shows the relationship between culture, and the interpersonal context of the diverse therapeutic relationships (Comas-Diaz & Jacobsen, 1991). It could have benefited this research more to show the specific culturally oriented dimensions of the influencing differences within the different dyads.

Comas-Diaz and Jacobsen (1991) represent a contribution to the literature that is important, and almost unique in the field of cultural competence, however, there are certain gaps in their research that are worth addressing. In particular, the dimensions within the cultural orientations of individualism and collectivism are worth studying to illustrate the innate and unconscious cultural differences that may affect therapeutic work. While there is limited literature available on this topic, subsequent sections of this thesis will review what is available in order to highlight the importance of these themes to social work practice.

Individualism versus Collectivism

One of the salient themes in considering the experiences of foreign-born clinicians with their U.S.-born clients is the impact of collectivist versus individualist ideologies. Markus and Kitayama (1991) researched the individualism-collectivism link in their U.S. versus Asian social psychology research and explored the differences in independence versus interdependence with respect to aspects of self within cultures. Most individualism-collectivism literature has focused on such differences in Western cultures (e.g. U.S and Britain), Middle Eastern (e.g. Israel), and the Far East. Literature on collectivism primarily addressed cultures in Korea, China, Japan, Malaysia, India, and Hong Kong (Eaton and Louw (2000).

While many African cultures can be considered collectivist as well (Triandis, 1989; Eaton and Louw, 2000), there has been very little research that focuses on the African continent. For the purposes of this research, the United States will be considered individualistic. Kim (1994) asserts that the political philosophies, and the social underpinnings of liberalism are hallmarks of the United States's individualism. Other cross-cultural researchers (e.g. Hofstede, 1980; Triandis, 1994) confirm the U.S.'s position on the individualism-collectivist dimension.

Triandis (1994, 1995) stated that individualism is the opposite of collectivism. Individualism as a cultural pattern stresses individual autonomy and independence of self. He elaborated that in vertical individualist cultures (e.g., US corporate cultures) competitiveness is high, and one must be "the best" in order to climb the hierarchy. In horizontal individualist cultures (e.g., U.S, Australia, Sweden) hierarchical differentiation is de-emphasized, and the emphasis is on self-reliance, independence from others, and uniqueness (Triandis and Gelfand, 1998).

Individualism-collectivism within the context of the United States was found to vary region-to-region and state-to-state. Through research that covered the Deep South, Mountain West and Great Plains of the United States, Vandello and Cohen (1999) found that Hawaii for its Asian and North American influences, ranked highest in collectivism, while Montana ranked as the most individualistic. The Northeast U.S ranked below the half mark between Hawaii and Montana with the exception of New York and New Jersey. In their research, communities with distinct ethnic immigrants managed to upset their individualism-collectivism scale due to the foreign-born tendency to integrate within their in-groups. They found that while the South was relatively collective, the Great Plains and Mountain West were maximally individualistic. They found that the Northeast (where this thesis work was based) had started out relatively collectivist but became more individualist as the region become commercial and industrial.

The distinction between collectivism and individualism is important because of the potential impact on relationships. Collectivist cultures are commonly believed to be more concerned with interdependence and relationships. For example, Ohbuchi et al. (1999) showed that collectivists in conflict situations are primarily concerned with maintaining relationships with others, whereas individualists are primarily concerned with achieving justice. Thus, collectivists prefer methods of conflict resolution that do not destroy relationships (e.g., mediation), whereas individualists are willing to go to court to settle disputes (Leung 1997). Triandis (1994, 1995) elaborated that collectivist cultures are simple and tight. In collectivist cultures people are interdependent with their in-groups (family, tribe, nation, etc.), give priority to the goals of their in-groups, they shape their behavior primarily on the basis of in-group norms, and behave in communal ways.

Triandis (1994, 1995) also stated that there are all kinds of collectivist cultures with worthwhile distinctions, such as those existing between vertical (e.g., India) and horizontal (e.g., the Israeli Kibbutz) collectivist cultures. Vertical cultures are traditionalist and emphasize in-group cohesion, respect for in-group norms, and the directives of authorities. Vertical collectivism correlates positively with age and religiosity, and negatively with education and exposure to diverse persons. Horizontal collectivist cultures emphasize empathy, sociability, and cooperation (Triandis and Gelfand, 1998). Conversely, Gabriel and Gardner (1999) also found another variation of collectivism between genders. According to their research, male collectivism is derived from group memberships (e.g., "I am an American"); female collectivism is derived from specific relationships (e.g., "I am Amanda's best friend").

According to (Triandis et al. 1985) individualism-collectivism also involves idiocentrism and allocentrism. They found that idiocentrism and allocentrism are personality attributes that are often well referred to in this phenomenon. Idiocentrics emphasize self-reliance, competition, uniqueness, hedonism, and emotional distance from in-groups. Allocentrics emphasize interdependence, sociability, and family integrity; they take into account the needs and wishes of in-group members, feel close in their relationships to their in-group, and appear to others as responsive to their needs and concerns (Cross et al. 2000). They found it is possible for individuals to be high or low on both allocentrism and idiocentrism.

In all cultures there are both idiocentrics and allocentrics, in different proportions (Triandis et al. 2001). In agreement, Greenfield (1999) suggested that the individualism-collectivism contrast corresponds to the "deep structure" of cultural differences. The research found that generally speaking, in collectivist cultures there are about 60% allocentrics and in individualist cultures about 60% idiocentrics. The allocentrics in individualist cultures are more

likely than the idiocentrics to join groups—gangs, communes, unions, etc. The idiocentrics in collectivist cultures are more likely than the allocentrics to feel oppressed by their culture and to seek to leave it.

Further more, in terms of self-concept, Eaton and Louw (2000) posited that people from collectivist cultures might be experienced as more concrete and interdependent than people from individualist cultures. Singelis and Brown (1995) stated that individualistic cultures directly encourage predominantly independent self-constructs, while collectivist cultures are characterized by interdependent self-constructs. Members of collectivist cultures usually describe themselves in specific and contextualized ways. They see relationships with others as fundamental in self-construction, which influences the ways they concretely define themselves within each specific social relationship. Individualist cultures abstractly define the self as inner, stable, and self-determinant.

According to the literature, individualist cultural contexts and collectivist cultural contexts can be specified as vertical (social hierarchy in relationships) and horizontal (social equality in relationships). These contexts experience cultural values differently and express the dynamic between relationships to self and other differently. In addition, within both individualistic and collectivistic contexts, individuals may inhabit traits of the opposite orientation, causing conflict or the drive (motivations and influences) to seek the other.

According to Gushue and Constantine (2003), having bicultural status enables foreign-born individuals express both individualistic and collectivistic patterns, within the U.S context. Toldson and Toldson (2001) believe that horizontal individualism worldviews (U.S agencies and society) represent this blend of the two cultural orientations. The U.S context for having a capitalist society worldview is democratic and prizes individual freedom (winner takes it all

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mentality). Seeing that the U.S bases value on individual uniqueness, freedom, and social status through competition, it has horizontal individualism according to these researchers. The opposite of that is horizontal collectivism, which represents a culture that views people as more alike than not. In horizontal collectivist cultures, there are common goals, interdependence, and resistance to authority where decisions are taken by and for the group.

Other authors have also examined cultural influences in therapeutic relationships using countertransference as a product of culture (Bonovitz, 2005). They have shown that culture permeates aspects of difference in culturally influenced work, in the form of countertransference. Bonovitz (2005) attempts to explain that the cultural influences of countertransference have intrapsychic origins in the form of internalized self-object relations (people or things that represent earlier relationships [cultural]). He elaborates that these influences are more often the manifestation of sociocultural roots and cultural heritage, including relationships to the dominant group--(the dominant group could be the culture a new clinical intern from a collectivist culture is entering).

Mishne (2002) also attempts to show cultural influences on therapeutic work by addressing matched racial minority dyads, and the countertransference of over-identification that occurs (an unconscious or conscious state of feeling affiliation or connection to familiar others). Comas-Diaz & Jacobsen (1991) note that over-identification (Comas-Diaz & Jacobsen, 1991) is especially prevalent in ethnoculturally-influenced therapeutic dyads (dyads whose ethnic and cultural backgrounds are assumed as similar or different). In this research, the therapeutic experiences for this and similar clinicians were indeed culturally influenced in both conscious and unconscious ways based on their ethnic and cultural background. Kelly and Boyd-Franklin (2005) speak of the common threads that culturally bring people together in therapeutic work.

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They speak of such cultural influences like racial similarities, cultural strengths and values balanced with coping within the cultural expectations of dominant society (U.S dominant society). They show that cultural influences can be instinctual and unconscious while people interact with others, Mattei (2008) adds to this argument. She explains that Freud believed humans as inevitably shaped by a fundamental, inherent antagonism between their wishes (culturally influenced biases] and societal prohibitions (also culturally influenced]. Finally, according to Fong (2014), ethnic and cultural experiences within countertransference can be complex, yet valuable in offering opportunities for client and clinician to both negotiate and reorganize clinical meaning within the clinical relationship.

Based on the limited literature above, this phenomenon that explores the cultural experiences within the therapeutic work of collectivist oriented clinicians and their U.S born clients, merits further social work research. It is important that the clinical social work field in the United States understands both the clinical and cultural experiences of clinicians from collectivist cultures, as they work and integrate within the U.S culture. Currently one in eight U.S. residents are foreign-born.(U.S.C Bureau, 2010). With the growth in the foreign-born population, it is likely that many clinicians, who may also be from collectivist cultures outside the United States, work in community agencies serving differently oriented U.S born clients. This exploration of culturally oriented differences and their influences in clinical work may contribute to the general social work cultural competence pedagogy.

For a better understanding of this phenomenon's contribution to clinical social work research and practice, in succeeding chapters I provide a theoretical base for using drive theory and relational theory including the concept of intersubjectivity. Chapter II introduces the methodology and the two theories that frame this thesis. Chapter III offers an in-depth

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discussion of the cultural influences derived from a collectivist culturally orientated background and example. In Chapter IV, I discuss drive theory's perspectives of the mind. In Chapter V, I discuss relational theory and the concept of intersubjectivity as it informs my cultural influences through countertransference. In Chapter VI, I conclude with an examination of how these two theories merge to provide a deeper understanding of clinical work that is culturally influenced . Finally I offer implications and suggestions for clinical work practice for clinicians from collectivist cultures on the helpful ways to work within the U.S culture.

CHAPTER II

Conceptualization and Methodology

Culture influences every aspect of therapy. This chapter introduces key concepts and theories to be used in this thesis. I begin with a description of my methodology and then move into describing my theoretical orientation, outlining both drive theory and relational theory including the concept of intersubjectivity and how they relate to the thesis phenomenon.

Methodology

In the following chapters I describe my ethnic and cultural experiences with clients at the clinical internships as the phenomenon. It is through these experiences that I use drive and relational theories to examine the ethnic and cultural countertransference in the client-clinician therapeutic work in the U.S. context. The chapters in this thesis focus on my feelings and reactions in response to clients as influencing experiences within the cultural contexts of the clinical placements.

Below I explain how I perceive the experiences as ethnocultural countertransference in order to justify the use of drive theory's unconscious structures of the mind. I also explain how relational theory and the concept of intersubjectivity shaped how I understood the ethnocultural countertransference in my clinical work.

In essence even though we were different or similar in therapy, my clients experienced me through their own cultural orientations as I did through mine, within the context of the U.S where our clinical encounters occurred.

Theoretical Formulation

This section will provide an overview of both drive theory and relational theory including the concept of intersubjectivity, and briefly explain how each applies to this research phenomenon. I begin by describing drive theory, its origins, and its clinical applications. I then move on to discuss relational theory and the concept of intersubjectivity..

Application of drive theory. Drive theory was first formulated by Freud (1905, 1913, 1917, 1925, 1933, 1963); it attempts to explain human behavior, as influenced by innate instinctual needs or drives. Freud, over many years of work (1905, 1913, 1917, 1925, 1933, 1963), conceptualized it as the theory where the drives (motivations or instincts of a person) are the forces toward life or death, love or hate, sexuality or aggression, and aim toward the satisfaction of the person's sense of self (ego). Freud's drive theory today can be understood on the basis of ego psychology by our conceptualizing the psyche or mind as made up of three parts: the Id (inhabited by instinctual or motivational drives), the Superego (inhabited by societal norms and prohibitions, and the Ego (a moderating force that is often thought of as the "Self"). In this conceptualization I will focus on the structure called the Id, where aggressive (death or self-destructive instincts) and the libidinal drives (towards pleasure and connection with others) are thought to exist.

Through this theory's structures of the mind, Freud promoted the concept of the unconscious drives (instinctually sexually and aggressively motivated) of a person that operate in a constant state of satisfaction and dissatisfaction, depending on their particular objectives.

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Freud promoted the concept of the unconscious drives arguing that the conflict of that motivational or instinctual energy (also the libido) manifests as urgent needs that seek to be resolved or released lest they become "fixated" (a sense of feeling stuck or in collusion with).

Freud believed that the drives toward pleasure such as love or connection to others (libidinal drives) were developed through stages of psychosexual development in childhood. These psychosexual development stages, namely the oral, anal, phallic, latency, and genital stages, could be points of fixation when libidinal drives were not sufficiently satisfied or were overly satisfied by primary caregivers [or clinicians as caregivers in a therapeutic relationship] (Freud (1963).

Drive theory is used in practice as a guide in understanding how ego defenses (also repression) and behavior in an individual may be linked to their fixation and/or their internal conflict. When using classical drive theory in most cases, clinicians focus on the psychosexual development and psychological make-up of the client. In the classical application of drive theory, little focus is usually placed on the clinician in the practical application of drive theory; in fact, the clinician is encouraged to be as much as possible, a "blank screen".

Drive theory applies to my clinical work by helping to understand the clinician's own unconscious contribution to the experiences in the therapeutic dyad. The unconscious instincts and motivations influenced by the cultural orientation's regard for interpersonal relationships can shape the countertransference in therapy. My clinical work was influenced by repressed id impulses in my mind, and by my ego drives, in order to understand, to love, to help, and to liberate clients. While my superego worked to ensure I adhered to the required and appropriate reactions concerning professional social work. Countertransference arose because my ego and superego, which were operating within the U.S cultural orientation of the therapeutic work, were

actively in conflict with my id impulses that were highly influenced by my original cultural orientation.

Application of Relational theory and the Concept of Intersubjectivity. The move from drive theory to relational theories in psychoanalytic thought has been called the move from a one-person psychology to a two-person psychology. In contrast to drive theory's instinctual influences, relational theory and the concept of intersubjectivity focuses on relationships in therapeutic work. They advocate for the importance of recognizing and understanding the valuable contributions of the clinician, client and their unconscious impulses as they interact in any clinical encounter (Berzoff, Flanagan, and Hertz (2011).

These relational theories emphasize that countertransference can only be understood as an interactional process that occurs between the clinician and client. They hold that clinicians are more similar to their clients than different in any therapeutic relationship. They also propose that countertransference between clinicians and clients is part of the transactional need to be understood. Countertransference as an interactional need is communicated non-verbally or through as experiences in the therapeutic context. These non-verbal communications (countertransference) are expressions or experiences of the unconscious for the clinician as well as the client.

Relational theory and the concept of intersubjectivity, therefore, challenges drive theory's notion of the "blank screen" and state of neutrality in culturally influenced therapeutic work. Instead, relational theory through the concept of intersubjectivity highlights the subjectivities (selves) of the two persons' experiences of their unconscious defenses (distortions, projections, displacements) or unconscious selves (egos) experienced as strong feelings in the intersubjective relationship (Berzoff et al., 2011).

In practice, clinicians using relational theory and the concept of intersubjectivity to reflect on their own experiences of the clinical encounter and make use of the countertransference that occurs. Countertransference especially that which is ethnically and culturally motivated may appear as emotional clinical moments. The clinician may notice non-verbal reactions from clients and sense that something important has been communicated. The concept of intersubjectivity that operates within relational theory is especially known to be helpful in mediating and regulating the unconscious emotional expressions within a co-created space. Schore J.R and Schore A.N (2008) write that during psychotherapy, relational theory's intersubjectivity is more than explicit cognitions—it is also a co-constructed field by two individuals who share an attachment bond of emotional communication and interactive regulation.

Relational theory and the concept of intersubjectivity resonate with my clinical experiences. While communicating with clients during the internship, I sometimes sensed the unconscious non-verbal expressions that manifested in the clinical process. My sense and understanding of client communication and responses was expressed as reactions that depicted my automatic responses and perception (countertransference) of their expressed experiences. This lens of work with clients necessitated openness, closeness, and a vulnerable stance to enable myself as a clinician to actually hear (be attuned to) clients speaking of their trauma and pain. Yet it was also crucial to "not know" (Berzoff et al. (2011)) and to be willing to experience the clients' apathy and dysregulated emotions, in order to meet their needs in therapy.

Terminology

Many terms used in this paper may be understood in a variety of ways in different contexts. In this section I hope to provide an overview of terms and the specific ways that I will

be using them through the paper. The American Community Survey (ACS 2010) reported

foreign-born as referring to people originating in broad geographic regions, including Africa,

Asia, Europe, Latin America and the Caribbean, North America, and Oceania. The U. S. Census

Bureau (2010), in line with the ACS, uses the term foreign-born for anyone who is not a U.S.

citizen at birth. This includes naturalized citizens, lawful permanent residents, temporary

immigrants, humanitarian immigrants (such as refugees), and undocumented immigrants. I use

the term foreign-born in relation to clinicians from collectivist cultures sparingly because I

recognize that not all foreign-born come from collectivist cultural orientations. In

acknowledgment of that, I maintain that the clinicians from collectivist cultures in this thesis are

born and raised outside the United States. This definition also takes into consideration the

clinicians from collectivist cultures as immigrants, different or "foreign-other" based on the

American historical binary discourse of citizen/immigrant (Kang (2010). Of note, the foreign-

born clinicians from collectivist cultures that I consider in this thesis have had educational and

professional opportunities that advantaged them since coming to the United States.

In this paper I condense the terms "ethnic" and "cultural reactions" (Comas-Diaz and

Jacobsen (1991) into ethnocultural, encompassing the influences of ethnicity and culture on the

countertransference within the therapeutic relationship. Here, those terms are used to explain the

nature of countertransference reactions within different or similar dyads. Those reactions may

include separation-individuation, denial of ethnicity and culture, mistrust, ambivalence,

idealization, survivor guilt, pity, "us and them," over-identification, distancing, and devaluation.

In this thesis, I will discuss over-identification as a major ethnocultural

countertransference experience. This definition also states that to the clinician from a collectivist

culture as a foreign-born, race as an ethnic and cultural marker in mainstream America is to

some extent a limiting concept. It is limiting because for most, culturally oriented therapists, family status, gender, formal and informal education, and nationality, as well as geographic location, explain their ethnic and cultural experiences before they were immigrants. These ethnocultural experiences can be influencing and motivating during clinical work with their clients.

According to Fernando (2010) ethnocultural identity can be characterized thus:

	Characterized by	Perceived as	Assumed to be	In reality
Race	Physical appearance	Physical, permanent	Genetically determined	Socially constructed
Culture	Behavior, attitudes, etc.	Social changeable	Passed down by parents/parent substitutes	Variable and changeable blue-print for living
Ethnicity	Sense of belonging	Psychosocial, partially changeable	How people see themselves in terms of background and parentage	Culture-race mixture
Identity	Sensitive feelings	Psycho-personal, several parts, each fairly fixed once formed	Formed through upbringing and experience	Feelings about heritage; personal choice

Ethnicity acknowledges the place of history, language and culture in the construction of subjectivity and identity as contextually positioned. Ethnicity may also overlap in meaning with both race and culture, where it encompasses both in different contexts. Also, subjective feelings may be represented as a sense of belonging to an ethnic group or a group per se with racial, cultural markers, real or imagined; yet this sense of belonging may arise also, not because of self-perception but because of the way contextual society or the cultural context [U.S context] perceives a person. The relationally interactive experiences during clinical work with clients provide ethnoculturally-motivated experiences within the cultural contexts of the clinician, and that of the United States.

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To review, before exploring the clinician's countertransference from drive theory and relational theory's intersubjectivity perspectives in chapter VI, I explore the cultural orientation frameworks and their differences in Chapter III for the purposes of the phenomenon. The cultural orientation differences influence the ethnocultural countertransference in this thesis.

Study Biases and Limitations

The methodology of this thesis is primarily based in my own experience and notions as a clinician from a collectivist culture working with clients in the United States. My personal experiences of cultural difference and immigration, weighed down with notions of loss, disconnection, success, connection, self-identity formation is biased. Yet these experiences enriched both the focus of my thesis and my perspective on the issues my clients experienced, as I remember them—this is fine. A major limitation of this thesis is that my analysis of the literature and myself as the case, does not provide as rich a level of research as an empirical study involving interviews with other foreign-born clinicians from collectivist cultures would have. The difficulty lay in a lack of time identifying enough subjects from other countries with sufficient experience as practicing clinicians. However, these limitations shouldn't take away from the strength of the phenomenon and theoretical approaches. The theoretical approach offers a relevant discussion of this phenomenon using two facets of psychoanalytic theory This approach may help to increase positive experiences for clinicians from collectivist cultures born outside of the U.S and practicing clinical social work in the U.S. It may also increase clinical social work students' cultural competence in the cultural context of the U.S.

Summary of Conceptualization

Within this chapter, I introduced my methodological formulation and why I experienced my clinical internships as phenomenological experiences that needed to be explored further. I

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then expressed my theoretical formulation of the two theories used in Chapters IV, V, and VI. I also explained essential terminology, including the population to which this thesis is directed: the clinician born outside the U.S and from collectivist cultures, the clinical social work community, community mental health agencies, and any human services agencies working with immigrant populations as clinicians and clients. I then explained the biases and limitations of the thesis, and concluded to transition to my phenomenon and cultural orientation position in chapter III. The chapters that follow will encompass and elaborate my cultural orientation position as presented in Chapter III.

CHAPTER III

Phenomenon

Corbin (2012) states that clinical internships (domestic and international) can strengthen students' knowledge about cultures, cultural orientations, and global perspectives on social work, social justice, and social policy. They can also increase social work students' capacity to work competently across cultures. Moreover, they can also transform life experiences for the interns. During these clinical social work internships, interns often encounter worldviews, cultural practices, and standards of living that are different from their own.

As a clinical social work intern, born and raised outside the United States, I embodied my own culturally oriented differences. The cultural orientation differences I encountered in the U.S cultural context challenged my innate beliefs and norms, producing major reactions in my clinical practice, but also increasing my awareness of the values and cultures in which my northeastern U.S placements were embedded—this is ok as is.

Chapter III will briefly describe the background of my placements and my country of origin. Then I describe my culturally influenced countertransference within the U.S context. Lastly, I describe the ethnic and culturally influenced experiences of working within a collectivist cultural orientation to support clients during placement. The discussion of these theoretically based cultural orientated differences is needed here because I should frame the

contexts of the cultural differences that influence and motivate the countertransference in the therapeutic work.

Background

I spent nine months at a K-8 school that was predominately Latino and Puerto Rican in culture and ethnicity. The student body of more than 800 children was between ages five and sixteen. The location city, an old Irish-rooted industrial city was predominantly low-income but had been economically revived the last few years. The primary languages were strongly Spanish and English. Most students resided in public housing around the city, while others lived in homeless shelters around the city. My clients' persistent concerns were trauma-related struggles with immigration, poverty, family, peers, teachers, and the community.

My other nine-month placement was an academically well regarded, influential, and prestigious women's college in northeastern United States. The student body was both domestic and international, and very diverse in race, culture and ethnicity, as well as nationalities. The 18-21 years old student body was comprised of very well to do, and moderately lower means clients, whom the school accommodated and catered to adequately. The school also offered an all-inclusive prestigious fellowship that catered to older students (23-60) seeking their first undergraduate degrees. The languages spoken were strongly English but many students spoke other languages. Most students resided at the school, home, and personal rentals around the safe community of the location city. My experience of the clients revealed a wide range of clinical challenges including but not limited to traumatic experiences, school adjustment, separation-individuation, anxiety disorders, and mood disorders.

My sub-Saharan country of origin is located in eastern Africa, and is bordered by various countries linked collectively as the East African community for regional cooperation. The

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community is comprised of Sudan, South Sudan, Kenya, Tanzania, Burundi, Rwanda, Uganda and the Democratic Republic of the Congo. The country's population of about 32 million has a life expectancy of 53 years irrespective of gender. The country's economy is highly agricultural based, and in the past few years, a revived industry and service has contributed to the developing economic base.

The collective population of this sub-Saharan country is largely rural with a small percentage of urban dwellers.   People are traditional and religious in beliefs and practices. Collective religious activities are highly integrated within cultural and traditional African spiritual practices. People gather daily for such collective activities as prayer, religious ceremonies, cultural rites of passage like circumcision, and sociopolitical activities such as welcoming local leaders into villages, or leaders of other countries like presidents, the Queen, and the Pope.

Daily life within any family and community is communal with regards to trading, gathering, raising families, eating, and education, among other things. The ethnic and cultural groups in the general region of eastern Africa comprise of clans within tribes. The cultural orientation of all these tribes is predominantly collectivist, and specific tribes speak specific languages and also endorse specific clan rituals and totemic customs. Within these specific tribes however, all peoples regardless of tribe speak and conduct national education and business in English and Swahili as official languages.

The influence of the cultural orientation of collectivism on the ethnocultural countertransference within the diverse therapeutic dyads in my clinical internships is important to note in this In this section, I describe some collectivist, culturally-oriented motivations that influenced the countertransference experienced within therapeutic work with various clients. To

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illustrate, I draw on Comas-Diaz and Jacobsen's (1991, 1995) cultural (inter-ethnic and intra-ethnic) research on ethnocultural countertransference within therapeutic dyads in chapter I. They posit that inter-ethnic and intra-ethnic dyads are therapeutic relationships in which the clinicians and clients have similar (inter-ethnic) or different (intra-ethnic) racial, ethnic, and cultural backgrounds.

In their research, Comas-Diaz and Jacobsen (1991, 1995) discuss countertransference as inevitable in different or similar culturally- oriented dyads due to the influencing reactions between clients and clinicians. Basically the clinician's ethnoculturally-motivated feelings, fantasies, and unconscious reactions trigger earlier memories similar to the client's experience. For example, as a collectivist oriented clinician working with similarly oriented clients; I am most likely to experience reactions to our similarities that may influence my work. Comas-Diaz and Jacobsen (1991) state that in such dyads, ethnocultural countertransference is prevalent and may be both facilitative and impeding to the work. Based on the formulation that collectivist oriented clinicians experience clients through reactions that influence ethnocultural countertransference, I describe some influencing experiences here.

In my experience, my over-identification with one client came from my motivation support her through shared vulnerabilities, and experiences in earlier times. This client and I shared many difficult experiences, including earlier political wars, experience around significant diseases, and experiences of oppressive rites of passage, familial expectations, and earlier life in Africa.

While over-identification may sometimes be the driving force for clinicians to avoid closeness, I reacted to my client by getting closer to knowing her and supporting her family.. Yet at the same time, I worked to adhere to cultural and clinical social work values in the context of

my work. On the other hand, too much closeness as a result of the clinicians' cultural myopia can lead to unconscious collusion because of the danger of cultural blindness within a dyad of similar ethnicity and culture (Comas-Diaz and Jacobsen (1991).

Mishne (2002) however argues that similar dyads enables a strong alliance in therapeutic work. For example, my client who was going through cultural identity issues after immigration gained a stronger sense of self through attuned and engaged interactions, and modeling in therapy.

My countertransferential experiences with clients were collectivist culturally influenced and I felt it hard to support them without over-identifying with them. Crow (1994) believes that clinicians' emotional reactions to clients are ever-present and cannot be avoided, just as clients' reactions to clinicians are. At my first placement, I took advantage of the fluid boundaries of the collectivist oriented Latino-majority school. I checked on my clients every day, peeking through their doors to check on them, and asking their friendly teachers about their wellbeing. I impressed upon them my open door policy and could provide food and clothing I got from the local Survival Center if their families needed help. I believed that I was establishing a co-created therapeutic frame (Segal (2012) for our work.

Sharing my thoughts in supervision about my tendency to over-identify or over-involve within relationships helped me recognize that I relied on my collectivist cultural orientation unconsciously. While the fear of over-identification can sometimes be a driving force for clinicians working to avoid closeness, according to Comas-Diaz and Jacobsen (1991), my over-identification influenced positive work with one client who had endured extreme trauma. For example, without knowing the collectivist norms of that client's culture, her peers, teachers, and even school social worker were criticizing her grooming behaviors. They were culturally limited in their understanding of her grooming behaviors, dress, affect, and speech. By making the

teachers and social worker aware of the cultural norms in the client's country and her current process of acculturation in this new context, I provided context for her to be understood.

Many times, my awareness of the client's collectivist orientation increased my over-identification with them. Although I didn't experience the extreme version of over-identification that Comas-Diaz and Jacobsen (1991) refer to, the "us and them" countertransferential dynamic, I was protective of young clients who were particularly culturally oriented and born outside the U.S. In classic countertransference, critics might say, I could have used our similarities and differences in treatment by critically examining my projective identification (my experience of non-verbal, unconscious feelings) throughout my work. I could argue that in many ways I was examining the countertransference involved in the ways I culturally identified in the U.S context.

For the next chapter, through the lens of the ethnocultural nature of countertransference with diverse clients, I discuss the perspective of drive theory.

CHAPTER IV

Drive Theory

Drive theory is one of the original aspects of psychoanalytic thinking outlined by Freud (1923). Drive theory presents a structural model of the psyche and describes how conflict between competing drives shape individual development and psychological organization. The structural aspects of drive theory postulate that the psyche is made of three parts: the ego, super ego, and the id.

While using structural-drive theory, psychodynamic clinicians conceptualize clients' symptoms as manifestations of unconscious drives and conflicts within the intra-psychic realm. They conceptualize the conflicts between client's desires for gratification and societal restraints as the context within which psychological symptoms manifest. In this model the client basically attempts through symptomatology and defenses to find ways to deal with intrapsychic conflicts and achieve homeostasis or equilibrium.

Drive theory constitutes Freud's tripartite model of the mind. In Freud's model, the id, ego, and superego all play different roles and manage different aspects of the psyche. When compromise cannot be made between conflicting structures, psychological defenses are formed to moderate anxiety (Magnavita, 2008).

The superego is the psychic system that enforces and passes on the group's rules. This part of the psyche maintains the internalized value system of society in the form of parental

attachments and sociocultural influences. As an agent within, the superego is typically in conflict with our beastly desires (id), which then mobilizes a mediator (ego) to achieve a compromise.

The id, in the structural model of drive theory is seen as a "cauldron" full of seething motivational forces fueled and filled by our past. Magnavita (2008) writes that the id harbors our instinctual organization (sexual and aggressive impulses, drives, wishes) and what Freud termed primary process.

The ego is the part of the psyche most commonly seen as the self. It plays the role of mediator between instincts and social norms, creating compromises and mobilizing psychological defenses (Magnavita, 2008).

Drive theory singles out two irreducible impulses in human development: the sexual drive and the aggressive drive. These forces, particularly sexuality or libidinal strivings, enter into a lifelong conflict with the demands of a socialized existence. Development—and pathology—is seen as the compromised results of a series of conflicts fought in a sequential progression of bodily battlegrounds. The progression of bodily experiences and functions leads an individual through developmental or psychosexual stages. When anxieties are introduced at different development stages it may lead to fixations and regressions. The fixations and regressions come to be represented in symptoms, character traits, and in compromises of the person (Mattei, 2011, p. 264).

For this thesis drive theory's structural model is central for understanding the phenomenon of clinical work between a clinician from a collectivist oriented culture and a clinician from an individualist oriented culture. I also incorporate the early psychoanalytic concept of countertransference to understand how culture and drive combine for the clinicians from collectivist cultures.

Background

  Freud and his drive theory are considered one of the most influential characters of the twentieth century (Magnavita, 2008). Freud's theory emerged from the cultural, scientific, and historical events of Vienna where he created and refined his drive theory and its structural therapeutic approach. Due to the repressive times [as compared to today] in which he was raised, sexual expression in post-Victorian society and bourgeoisie sensibilities was strictly prohibited. Therefore, because of those sexual expression restrictions, his society never openly discussed or examined the natural expressions of sexuality. Freud recognized during his practice, which women visited, the continuous repressed suffering of his female clients. Freud through his talking cure, articulated and explained the repression and outbreaks of forbidden impulses as defenses against the expression of the sexual conflicts associated with sexual trauma, an idea that later became his trauma theory.

  Much criticism of his work followed and was referred to as generalization by theoretical critiques. Many debunked his theories while others followed him loyally. Many leading psychoanalysts followed him into America during the turmoil of World War II, including Melanie Klein, Anna Freud, Karen Horney, Wilhelm Reich, Frank Alexander, Helene Deustch, Heinz Hartmann, Otto Rank, Erik Erikson, and Heinz Kohut. Their flow into North America greatly influenced the development of theory and practice of psychoanalysis.

  Drive theory's biologically based limitations and devaluing views ignited challenges and criticism. Critics argued that Freud's views about girls and women had been constructed by the society in which he lived. Berzoff et al., (2011) confirmed that Karen Horney challenged Freud to show the ways society's misconceptions about women's sexual conflicts were attributed to their unconscious minds, reinforcing challenging gender inequalities. In the same way, Melanie

Klein also challenged Freud's views of women as his being afraid of their power over men, and challenged Freud's idea that women were powerless. She maintained that women were powerful because they had the capacity to provide boys and men their first love object, and to provide or withhold love.

Later in the second wave (1960s to 1980s] of the feminist critique of Freud, Irene Fast (Berzoff et al., 2011) argued that the envies of the penis and womb were pathologizing because cognitively children wouldn't know the difference before age six. When they were cognitive of their differences, however, they envied what they didn't have between the genders. Some Neo-Freudian psychoanalysts challenged Freud along cultural lines, such as, Harry Stack Sullivan. He first agreed with Freud's issue of infant conflicts and neurosis but thought Freud was narrow on the influence of culture and interpersonal relationships in psychotherapy.

Today postmodern theorists according to Berzoff et al., (2011) critique drive theory as too narrow on the issues of cultural identity. The authors write that women and men negotiate identity categories continuously and fluidly based on culture, cultural orientations, religion, social conditions, and social contexts. This argument, which carried through to today's psychodynamic theories, does stress the clients' self-realization and capacity to be who they are. This view influences today's push for the cultural understanding of the client as a cultural being.

Drive theory and the culturally oriented clinician's ethnocultural countertransference Freud's drive theory informed what clinicians today refer to as the exploration of unconsciously buried and forbidden childhood impulses. These impulses are said to give rise to unwanted behaviors and relationships that we consciously cannot seem to explain. When those buried impulses get uncovered in the countertransference, clinicians get the chance to examine them consciously and change the course of their behaviors. Through the process of uncovering the

unconscious, Freud warns, we encounter a painful process of terror and punishment. The process is met with resistance, which Freud refers to as unconscious blocking of the flow of memories during the therapeutic hour. Within this exchange and uncovering, inevitable influences such as countertransference happen. Clinicians who inspire positive spaces, hope, and trust through empathy, warmth and genuineness are known to facilitate a peaceful process of uncovering according to Freud.

Drive theory imagined that the biological realm (drives and impulses) of human beings was all fixed, inevitable and immutable. Mattei (2011) writes that according to Freud, our biological dimensions were in opposition to our psychological life, and thus unable to mix. The development of drive theory shows that though all humans are motivated by sexual and aggressive drives, the way these drives manifest and present in the world is inevitably shaped by culture. Freudian work however paid limited attention to cultural and societal influences on psychological development. Mattei (2011) however notes that today, psychodynamic theories have diversified to include new ways of understating the relational person and the cultural influences involved in society.

Through countertransference, psychodynamic theory rectifies Freud's narrow focus on culture by going beyond drive theory's notion of the unconscious mind. Psychodynamic theory today embraces the complex unconscious influences of cultural orientations on race, affect/impulse, defense, and over-identification in countertransference.

Freud first confirmed that countertransference was inevitable as the difficulty for a clinician to act indifferently to their client. Indeed, Freud (1923) later noted that the clinician's personality (affected by his or her cultural orientation) played a part in countertransference. He also pointed out the dangers inherent in countertransference, such as the narcissist and sadist

tendencies of the clinician (fixated in the ego and libido development stages). He also assumed personal problems on the clinician's part, where the clinician re-experiences the client's aggressive and sexual transference narcissistically, depending on their stage of fixation in development.

Moreover, according to Freud, countertransferential experiences would be understood as reactions to the client's transferential experiences. Freud envisioned therapeutic work as passive, inscrutable, and one-dimensional—the therapist sitting quietly with the client—so the expressions of libidinal energy toward clients through countertransference were seen as the client's own doing. Many years later, he redefined the concept to remove responsibility from the client. In fact, Freud (1910) predicted the potential of the client's influence on the clinician's unconscious, and strongly urged clinicians to disavow these feelings and deepen their self-analysis.

Drive theory showed that inasmuch as countertransference is about the mirroring of a client's transference, clinicians use it best when they facilitate the client's transference. Collectivist oriented clinicians are challenged to reconsider Freud's views, that a clinician must be unfeeling and detached to understand and work with transference. The countertransference arguments show that clinicians have reactions in therapy and, when used insightfully, these countertransference reactions benefit clients as they do clinicians.

The next chapter, Chapter V, will discuss relational theory and the concept of intersubjectivity to address some missing pieces in drive theory as it pertains to the phenomenon. Empirical studies on unconscious cognitive processes (Westen; 1998; Greenwald, 1992; Kihlstrom, 1987; Schacter, 1992) recognize that Freud (1926) was the one who first offered a dynamic and structural theory of unconscious processes. Westen (1998) notes that Freud's drive

theory advanced fundamental propositions that once controversial and new to psychoanalysis, have stood the test of time through empirical verification. He further writes that experimental investigation of human mental life and behavior and the theories that drive and derive from it have been informed by Freud's drive theory. The Freudian model focuses on innate drives and impulses as motivators of all human behavior.

Whereas Freud emphasized sexual and aggressive drives as primary processes rooted in our biology, it was contemporary psychodynamic theorists that proposed aspects of culture and experience as motivators of human behavior as well. For that matter, drive theory is criticized for its ethnocentric and colonist reductionism, according to Mattei (2008). Indeed, drive theory reduces cultural and related psychological experiences by immigrants including this clinicians', as challenges of libidinal longings or conflicts. It must be said though that Freud's ideas were based on nineteenth-century European concerns of "civilized" society (Mattei, 2008). According to Westen (1998) drive theory view of aggression was too mechanistic, as the instinct untenable, and highly focused on sexuality. Object relations' theorists, self-psychology theorists, and relational theorists focus on the aspects of human culture and relationships to address the gaps in drive theory that didn't address vital psychosocial aspects of cultural development (Aron, 1996; Fairbairn, 1952; Greenberg & Mitchell, 1983; Kernberg, 1975; Kohut, 1977; Sullivan, 1953).

CHAPTER V

Relational Theory

Spencer (2000) asserts that the study of relationships cannot be separated from the study of human development; many theorists agree that relationships are important in forming cultures, identities, and societies. Indeed, relational theories have maintained that the self and relationship aren't separate entities in development and psychological experience.

Theorists who focused their work on addressing gaps in the Freudian model pioneered relational theories in the late 1930s. These theorists expanded the perspective of human development to show the vital role of psychosocial dynamics in development, as opposed to instinctual or innate drives and impulses as the force behind life's motivations. In an exposition of relational theory, Mitchell (1988) elucidated that relational theory focuses on the aspects of the self, the other, and the space between the two. Without either the self or the object as "other," no meaningful therapeutic interaction could occur.

In this chapter, I describe relational theory, the historical trends, key features, and concepts and orientations of the theory, as well as the concept of intersubjectivity as an extension of the theory. I further explore supportive and contradictory empirical studies on relational theory, relative to my cultural orientation and phenomenon. I also review some studies for which intersubjectivity was developed and for what purpose. The chapter closes with a summary

of key points of the phenomenon as it relates to relational theory's intersubjectivity perspective and a transition to Chapter VI.

Background

Many early relational theorists and psychologists focusing on human development studies, such as Baldwin (1913), Mead (1934), and Ferenczi (1933), helped conceive of the interplay between the self and society. However, succeeding years saw a clearer articulation of the relational aspects of psychological development. As a result, many theorists were able to focus on aspects of human relational processes as the backdrop of psychology and psychoanalysis.

Relational theories helped advance earlier work in feminist psychology (e.g., Gilligan 1977, 1982; Miller 1979), in psychoanalysis (Mitchell 1988, Stolorow, Brandshaft, and Atwood 1987), and in infant development research (Stern 1986; Tronick 1989; Trevarthen 1979). For example, in the late 1960s and early 1970s, infancy studies recognized observations of mother-infant interactions by focusing on mother-infant [clinician-client] empirical research. These researchers recognized that infants are born with an innate motivation to know and engage with their mothers. In other words, they have a subjectivity or sense of self that is based on motivation to communicate with their caregivers—later called intersubjectivity (Spencer, 2000). This empirical evidence of the clinician and client's innate bi-directional communication was also recognized in the Mutual Regulation Model (MRM) (Spencer (2000). MRM research confirmed that normal development was indeed dependent on both children and their caregivers to relate using innate abilities for affect regulation and communication. When caregivers are willing and able to respond, frustrate, and scaffold for children in their interactive display of emotions, the mutual regulation of one another's emotions, expressed both verbally and non-

verbally, serves the healthy development of the child's affective core. These MRM researchers also recognized that reciprocity and the successful resolution of frustrations and mismatches is central to the development of many growth functions in infants and children – as it would in clients' healing and growth.

While relying on relational theory in their feminist theory research on women's psychology and girls' development, Miller (1976) and Gilligan (1982) asserted that women and culture were vital to the better understanding of psychological and human development theory. These researchers maintained that the central theme of relationships in psychological development focuses on connections of one's self to others. Through their relational model work, feminist psychology literature grew to include the Stone Center Relational/Cultural Model (Spencer, 2000). In this model, psychological development is understood to take place in complex relationships. While psychological health is understood as a function of participation in relation with others where mutual and empowering cultural connections, disconnections, and reconnections occur and lead to the development of core relational processes. This model particularly emphasized mutual empathy and mutual engagement as vital to development processes (Miller and Striver 1997, as cited in Spencer 2000).

Similarly, feminist development theory emerged as a relational model of psychological development. This feminist relational model grew out of research on adolescent girls' development (Brown 1998; Brown and Gilligan 1992; Gilligan 1990, 1996; Gilligan et al. 1991). The researchers found that authentic relationships that allowed the expression of a wide range of feelings and experiences, including the cultural contexts within which girls lived, led to healthy psychological development; later this informed research on boys' and men's lives, as well (Gilligan 1996; Way 1997). This entire body of research concluded that psychological

development—and development in itself—was framed not as a linear progression of stages, but as a process of relationships and cultural connections of an individual to others in society. Many more theorists helped advance relational theories, and their variations have been used for research since the early twentieth century. Employing a rich history of relational psychoanalytic theory, theorists and researchers such as Sándor Ferenczi, Melanie Klein, H.S. Sullivan, and D.W Winnicott, among many others, integrated interpersonal relationships in their understanding of psychological development and developmental health and distress [in general]. Greenberg and Mitchell (1983) asserted that a common factor in psychoanalysis today consists of the increasing focus on people's (clients] interactions with others. While Aron (1996) declared that the relational matrix indicates that our psychological reality is best understood as operating within both intrapsychic and interpersonal realms of the self, object, and the interpersonal space between self and other. Mitchell (1988) later concurred that cultural experiences are understood to be experienced within, and explained through, the context of one's relational matrix. Therefore, development both psychological and physically is an intrapsychic and interpersonal experience for each of us, and for others in society.

According to Greenberg and Mitchell (1983), relational psychoanalytic theory replaced Freudian biological drive theory as a dichotomous solution to Freud's drives structure. Drive theory states that we have a structured mind and instinctual or innate forces drive one's relationships and self-agency. These theorists recognized that drive theories and relational theories were incompatible in concept, and therefore hard for psychoanalysts to choose between them.

Of critical note, when relational theory's early advances by Greenberg and Mitchell (1983) provided gradual shifts away from Freud's concepts of the drive model, their theory

didn't provide adequate alternatives to Freud's instinctual and one-person psychology. Other theorists such as Modell (1984, 1995) argued for relational theory as an addition to Freudian theory in his critique of relational theory's separation from Freud's work.

Relational theories have been advancing and evolving over many years and should not be thought of as new or better than other theories, such as Freudian drive theory. Indeed Modell (1995) argued for psychoanalysis to maintain a pluralistic position on both theories because they both embody the internal and external determinants of human development.
Therefore, clinicians and psychoanalysts who use relational theory today maintain a two-person psychology of the mind while opposing a one-person and instinctual psychology. They maintain that the mind fundamentally seeks to interact, contact, engage, and is dyadic in nature [not individualistic] (Mitchell 1988). Relational psychoanalysts are influenced by the belief in a dyadic and interactive mind that is always seeking connection with other minds in an inter-subjective (one with others in context) manner.

Relational theories acknowledge that clinicians and clients exert mutual influence on one another. For example, according to Berzoff, et al. (2011), Sándor Ferenczi understood the importance of mutuality in the therapeutic process when addressing trauma in therapy. He believed that clinicians needed to feel "in their bones" the clients' unconsciously conveyed traumatic experiences, so that the clinician could live through and face the trauma inter-subjectively with the client. Melanie Klein, through her establishment of "projective identification" as a way to induce in another what is being felt but not spoken, showed how a child's projections and distortions of its mother help shape the child's internal and interpersonal worlds.

Berzoff et al. (2011) continues that H.S. Sullivan showed that clinicians have to be fully engaged with each client as a real person. She observes that as clinicians, carefully observing clients and asking about their experiences in the therapeutic relationship assists in understanding the client's inner and outer worlds. Other relational theorists, such as Stephen Mitchell, also emphasized the person as better understood within relationships with others. Paul Wachtel focuses on the relational field as created by interactions of the client's internal life or mind with the clinician's internal life or mind. Last but not least, D. W. Winnicott insisted that there is no such thing as a therapist or a client by himself or herself, but instead, a therapeutic dyad (Berzoff et al., 2011).

As shown above, the conceptualizations central to relational theory help to emphasize perspectives of mutuality and intersubjectivity in therapeutic relationships. These concepts include transference and countertransference, which are seen as inseparable (and thus interactional) through the process of intersubjectivity. Countertransference as experience inherent in the therapeutic dyad is experienced through known cultural orientations and emotionally complex interpersonal exchanges (Berzoff, et al. 2008, 2011; Segal 2013). For example collectivist-oriented clinicians may encounter emotionally charged therapeutic interactions with similar clients, primarily due to similarities in ethnicity and culture as intersubjective links. As historical and empirical studies show, these dynamics are based on both parties' experiences in, and out of the dyad, and these dynamics, have the potential to impact therapeutic work in major ways.

In relational theory, the concept of enactment is also unavoidable and hence vital in therapeutic relationships. It shows, minds colliding and playing out therapeutic situations. Furthermore, in the therapeutic process, the clinician's reflections and associations become part

of the therapeutic experience, and are considered major concepts of relational theory. Another vital concept, self-disclosure, is key in relational theory; it needs to be used appropriately in order to open dialogue and avoid an impasse in therapeutic work. The concept of self-disclosure shows that the clinician's subjectivity cannot be reduced or withheld from the client.

In the past years, countertransference as a concept of relational theory has been studied in conjunction with transference. In this thesis, this concept (countertransference) is used to show the foreign-born clinician's tensions due to their cultural vulnerability in contexts of work. Atwood and Stolorow (1984) write about the relational intersubjective matrix as created by the dialogue and interactive space between the subjective worlds of client and clinician. They show thus, a creating of reactions and tensions within the psychological space where personal conflicts and interpretations play out as transference and countertransference. In such inevitable therapeutic situations, these theorists urge the clinicians to be willing to stay baffled, confounded, and discouraged, not knowing the answers to therapeutic dilemmas, yet remaining open. That way, the clinician is expected to be able to verbally express that, which is unspoken for the client in the therapeutic relationship.

Countertransference is dialectic and interactional between the clinician's subjectivity and the client's subjectivity. Through this process (countertransference), intersubjectivity as the analytic third or third space—a space that is co-created, in which clinicians and clients reflect upon each other—is created (Berzoff, et al. 2011). While working in a racially influenced white-black therapeutic dyad, Suchet (2004) also agrees with Berzoff, et al. (2011) and Stolorow, et al. (1987) that, the intersubjective space mutually influences both the client and clinician through transference and countertransference. The cultural experiences of countertransference are therefore central to the relational theory perspective of intersubjectivity.

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Relational theory's intersubjectivity informs collectivist oriented clinician experiences in

therapeutic work

According to Berzoff, et al. (2011), relational psychoanalytic theorists and practitioners

reached their pinnacle in the middle of the post-modern age of the late 1980s, and embraced the

intersubjectivity perspective. By conceiving of the well-developed relational psychoanalytic

theory perspective of intersubjectivity, theorists Atwood and Stolorow (1984, 1987, 1992)

posited their post-modern work to challenge the individualistic paradigms of earlier years. Post-

modernism critiques the positivist and objectivity of many disciplines that privilege some, while

excluding others. This postmodern era also takes the stance that truth is never absolute,

observable, or knowable. It suggests that the knower cannot be separated from the known, and

that, as they work with clients, clinicians ought to be cognizant of which client is relegated to the

margins.

The authors stated that in the intersubjectivist view, the field, or intersection of two

subjectivities, is the key to understanding psychological health, distress, and healing. These

theorists were in agreement with the infant researchers and showed that intersubjectivities are

both interested in affect and the regulation of affect in the context of the relationship, such as that

which happens in the infant/child-mother relationship (Stolorow, Brandshaft, and Atwood,

1987).

Therefore, when working in intersubjectivity, clinicians for whom this theory is

developed such as this writer need to examine their own subjectivities that intersect or interlock

with situations of cultural orientation, power, privilege, class, race, and ethnicity, among others.

Intersubjectivity urges clinicians to hold the complexities of what it is to be human. They must

be able to tolerate uncertainty, ambiguity, and paradox within the therapeutic relationship. This

perspective also urges clinicians to make the power dynamics in the relationship as transparent as possible, to show the inherent inequality between clinician and client. Intersubjectivity urges clinicians to practice with restraint, to listen and learn, and to know where the client "is" (Berzoff et al. 2011).

Collectively, the literature studied here helps show that, within the phenomenon (cultural influences of ethnic and cultural countertransference for collectivist clinicians) discussed in this thesis, neutrality of the clinician is not possible in any given therapeutic dyad. More specifically, the collectivist clinician experiences ethnocultural countertransference while working with clients with cultural orientations that are similar or different from theirs. In that case, the literature on intersubjectivity shows that the intrapsychic and interactional space within which the therapy occurs is very important to support understanding and growth for the dyad. The ethnocultural countertransference experienced through the intersubjective field supports the process of cultural understanding and growth. Through the interactions that occur within a culturally orientated space, the intersubjectivity within that space leads to ethnocultural countertransference. For example, a good fit of dyads based on similar ethnic and cultural backgrounds forms an intersubjective field or system of reciprocal mutual influence (Stolorow 1991). The influence of countertransference through the intersubjectivity perspective, therefore, helps clinicians to be full of knowledge, yet empty at the same time, remaining open to the unknown, the complex, and the paradoxical.

Above all, for this phenomenon relational theory's concept of intersubjectivity creates a new reality and a new space for better reflection on the reactions and motivations in the collectivist clinician's work with clients in the U.S context.

In the final chapter, Chapter VI, I recap with major points of the drive and relational theories' influence on the phenomenon (ethnocultural countertransference caused by cultural influences aS motivations for collectivist clinicians) in therapeutic work. I bring together the discussion of the phenomenon in Chapter III and present a new way of understanding this phenomenon. I also identify the strengths and weaknesses of the methodology as a summary. I then consider the implications of this thesis for social work practice, policy or research, and conclude this thesis.

CHAPTER VI

Discussion

In this final chapter, I offer through synthesizing, a new way of understanding the phenomenon of the cultural experiences that influence countertransference for the collectivist-oriented clinician. Then I offer an analysis that involves the theories of drive and relational and the concept of intersubjectivity in relation to the phenomenon. I also identify strengths and weaknesses of the methodology. Then I consider some implications for social work practice, policy or research, and finally conclude the thesis.

Developing a Bicultural Identity

Clinician cultural experiences that influence countertransference may be understood better within a biculturally orientated way of thinking. As a clinician with a collectivist orientation, I perform my clinical work within that lens, but my new cultural identity is based on my immigration to the U.S also. I argue that my new cultural identity based on my acculturation in the U.S accords me a horizontal individualist orientation. I wrote about the vertical aspect of culture as oriented toward the individual, while a horizontal culture as oriented towards the collective group within any cultural orientation in Chapter III. Although my default cultural orientation as African hence foreign-born and collectivist, I have adopted aspects of the individualist orientation, creating a bicultural identity, which flexibly orients from individual to group depending on the context.

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My research found that indeed for some people, like foreign-born, and collectivist-oriented clinicians, having self-identity and group-identity is possible in horizontal individualist societies. People, specifically those who are foreign-born, can have both personal (individual) and group (collective) identities that allow them to maintain a sense of their individual cultural self while, at the same time, remain connected to vital cultural contexts (Gushue & Constantine, 2003).

Gushue and Constantine (2003) found that adapting to horizontal individualism is one of the ways foreign-born collectivist individuals manage to adapt to self-developmental tasks such as differentiation and professionalism within a dominant society with an individualist orientation. Academic environments and U.S internship settings are both examples of sites where this process of integrating horizontal and vertical prongs of the two cultural orientations can occur.

As a clinical intern working to promote optimal mental health for my clients in both my school placements (discussed in Chapter III), I relied on understanding my clients' cultural orientations and levels of differentiation to perform my work. Working to understand their values and cultural orientation was essential as we reconstructed their struggles and moved towards their goals. This reliance on their input enhanced the ethnocultural countertransference, but also successfully opened a path for both our psychological and developmental wellness.

Through this reliant or interdependent process of reconstruction, many reactions and experiences ensued as both of us negotiated the processes of fitting into the contexts we found ourselves in. For me it was the challenging process of navigating U.S professional culture, including social work ethics and the internship placements. For my clients, it was the developmental tasks of self-definition and maturation as they battled various traumatic developmental experiences.

Just as I had moved away from my country of origin and was now considered a foreign-born clinical intern, my clients were students transitioning to early adolescence or young adulthood within academic communities. In both cases, there were moves from close families, increased autonomy, and the development of new identities within the contexts of the U.S, rigorous academics, and racialized communities.

Through my cultural orientation of collectivism, I understood myself as intertwined within the U.S-context cultural orientation. To understand my self, and my clients as well as the cultural experiences that influenced the countertransference, it necessitated tremendous reflection. This reflection is what I put forward as a new way to think about my phenomenon.

Through self-reflection and the use of Drive and Relational theories I have learned to adaptively use collectivist and individualist cultural orientations in varied contexts with clients. During periods of stress and pressures for some clients like adjusting to school life, I relied on the individualistic cultural lens to support specific unique traits for their adjusting, their social, and academic goals. I learned to use the collectivist stance to underline the importance of connection and community as they negotiated moving away from home into a residential college environment.

Having the ability to maintain and construct clinical work within two worldviews was important for my growth although the countertransference was at times unbearable. Many times during the clinical placements, it was inevitable that I would respond emotionally and reactively to some cultural misunderstandings that ensued. It was hard to remain well defined, and at those times, I relied on my collectivist worldview to maintain my sense of self frequently.

Challenging experiences showed that as a collectivist oriented clinician, I had to reconstruct myself constantly in order to perform as myself within the intertwined contexts of

clinical social work, and placements. With some practice, I learned that I could perform both collectivist and individualist cultural orientations within the contexts of my clinical work, developing a bicultural clinical identity. In such situations, my bicultural competence enhanced my ability to do challenging clinical work in challenging moments with clients in both placements.

Within the more competitive and horizontal individualistic culture of my last (the women's college) placement, the pressure to adapt was overwhelming. I needed to adjust to the predominantly individualist system of work in the placement. While at the middle school placement, the year before, I performed a collectivist ethic that felt consistent with the cultural orientation of the predominantly Puerto Rican population I was working with. I explored individual situations through the collectivistic emphasis of maintaining harmony within the community.

In collectivist-oriented cultures, professional marriages, like all marriages are a joining together of people, families and clans that support the social and economic needs of the agency or family. I felt an obligation of duty and adherence to the rules. I felt very committed to support the placement as a whole and provide group stability. In my last placement (the women's college) the need to accommodate an individualistic stance was more pressing and challenged me to delve further into the development of a bicultural identity.

In both placements, however, I needed to understand and pay attention to the usually subtle behavioral shifts in the cultural worldviews of my clients. Many of my clients, specifically in the last (the women's college) placement, through their own transference, demanded my adherence to their presumed cultural ideas about themselves and me as the clinician. I was easily influenced and motivated by client beliefs, attitudes, and values within my contexts of clinical

internships but worked to keep my work within the confines of social work ethics. Reliance on

social work ethics and existing cultural worldviews was necessary for both my professional

survival and the survival of self.

The NASW Code of Ethics (2008) embodies the values and ethics of the social work

profession in the United States. Those specific to my work were the ethical values of service,

social justice, dignity and worth of the person, importance of human relationships, integrity, and

competence. Through the code, I was able to feel grounded due to my collectivist tendency to

adhere to set rules. Social workers are also urged to be aware of how their personal values,

beliefs, and cultural orientations affect their perspectives about their clients (NASW, 2008).

Based on that, for some foreign-born clinicians in the U.S. cultural context, client and placement

values and beliefs may create cultural tension and dilemmas due to the differences. However, the

guidance of the code of ethics necessitates them to stand by their clients ethically.

For the next section, through the lens of cultural experiences that influence ethnocultural

countertransference for clinicians, I discuss the perspective of drive theory. I formulate that my

unconscious or instinctual drives ignited by my reactions to clients. These reactions were due to

my internalized wishes and lived realities that collided with what the clients experienced as well.

I negotiated my conflicts or wishes within the cultural contexts of the placement and the clients I

encountered.

Drive Theory Perspective on the Phenomenon

Freud's drive theory is interesting to apply to the phenomenon I discuss in this thesis

because of how my psychic structure interacted with my ethnocultural countertransference

experience. My collectivist superego encouraged a close identification with my clients, which

was helpful in joining, but inhibited my ability to offer some objectivity.

Applying this model to my work with past clients, I argue that I was expressing my unconscious conflicts through over-identifying with my clients' relational struggles. I feel that my collectivist orientation prevented me from properly differentiating myself from my clients, so that in my early work, their struggles felt like my struggles. Using a bicultural identity I have been better able to distinguish between my clients' feelings and mine.

In my work with clients from individualistic cultures I often noticed my internal reactions to how they related to others in their lives, particularly family members. Many of the clients I worked with were dealing with issues related to separation and individuation, and I found my internal narrative leaning often towards reinforcing connection to others. I felt myself mentally emphasizing the mother's role and right to influence and determine the life of her children. This was problematic when my client was the child, and I found myself internally contradicting my client's viewpoint.

My superego developed in the context of a collectivist culture, which greatly values and emphasizes connection to others and maintaining group norms. In my work with clients from individualist oriented cultures in issues of separation-individuation, self determination, and autonomy; I found myself opposed to my clients' need to create boundaries that would support their developmental processes. I was operating within a collectivist oriented view point.

Drive theory also points to the motivation of libidinal and aggressive energy that is inherent in the human psyche (Freud, 1923, 1926). I experienced my libidinal and aggressive conflicts through cultural experiences in therapy that were at times similar and dissimilar with my clients'. My libidinal drives specifically manifested in my motivation to bond, to over-identify, to get closer to, and to comprehend the world for my clients. My aggressive drives were evident in the frustration and introjected anger I experienced when I recognized a misattunement

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in therapy that I felt was culturally based. Once, I felt out of attunement or sync with a client because I was frustrated at myself for "failing" her. I was supporting her process to be angry with her caregiver. My collectivist oriented cultural sense recognized her frustration as toward me, but didn't recognize it was the caregiver she was angry and frustrated with. My clients of course also contributed their own drive conflicts and psychic structure. Consequently, how the internal experiences I described above manifested differed with each client. With one other client, I felt that her aggressive instinct was projected onto me through transference, and my identification with that aggression caused significant countertransferential reactions for me.

As I allowed my unconscious or libidinal energy to manifest in my work with clients, I aimed to resolve my early conflicts within the therapeutic relationship. Using my urgently felt needs for connection and my anxiety about the felt ethnocultural countertransference, I channeled my libidinal tension toward them by over-identifying with them. Here Freud (1963) would say that the resolution or work-through helped me to avoid fixation of the instinctual energy within me. I channeled my converged libidinal instincts into meaningful and earnest expressions of love and support for my client.

In the preceding chapter III, I showed that ethnic and cultural experiences were influential in my over-identification, which at the time, was advantageous to the work. I perceived the process of joining as advantageous because it provided a glimpse into the clients' internal processes. It was also problematic in that at times I was too close. Using an individualistic stance as a horizontal collectivist orientation in the context of the U.S was useful. It was to especially help me gain some separation from my clients. It was a positive shift for me, helping me to feel that I had options for relating to clients. For me, the process of adapting an

individualistic oriented cultural stance enabled mourning and a cultural self-identity reconstruction within the professional contexts of the agencies where I interned.

Relational Theory's Intersubjectivity Perspective on the Phenomenon

Thus far, I have discussed drive theory's perspective on the collectivist-oriented clinician's experiences that influence ethnocultural countertransference with clients in therapeutic work. I now discuss the relational theory and intersubjectivity perspective on the phenomenon.

Migrating from the country of origin disrupts one's cultural identity. The experience of supporting similar or different others (early adolescent and young adult clients) through their developmental and transitional challenges occurs within a mutually influenced therapeutic environment. Relational theory's concept of intersubjectivity provides a space to explore the developmental and transitional processes the self must endure. As Stolorow (2002) elaborates, affectivity or emotional experience (in transitional challenges and identity development) is a product not of isolated intrapsychic mechanisms but of the client-clinician system of mutual affect or emotional regulation.

I argue that the collectivist-oriented clinician's ethnocultural countertransference is informed within the relational theory's intersubjectivity idea of the two-subjective cultural experiences. I discuss that the experiences of the ethnocultural countertransference and show that both client and clinician are mutually interacting within the context of the cultural orientation of the therapeutic situation.

Relational theory and intersubjectivity clearly articulate the mutuality in therapeutic relationships. This mutuality is also closely related to the collectivistic values of non-Western societies that emphasize indigenous models of therapy based on mutual familial participation.

Atwood (1992) writes of traditional healing among some indigenous communities as more social and spiritual.

Intersubjectivity theory is called the meta-theory of psychoanalysis because it examines two people in the space they create and emerge. It implies that people's contexts of psychological and developmental needs should be considered within their own cultural worldviews.

Through intersubjectivity, I supported clients to investigate and interpret their experiences and academic expectations. Stolorow (1993) speaks of attuned responsiveness that holds, and eventually alleviates, the client's painful emotional reactions to experiences of self-object failures. Clients gain increased confidence when they experience their therapists as able to receive and contain their painful reactions.

During my clinical internship some client experiences intersected with my own, this created a space where my undisclosed experiences were integrated into our work. Without probing that which was too traumatic for them to retell, I integrated what I knew of their trauma to create a safe space for them to reconstruct new states of self.

For one client, in spite of my status as an older person, her earlier strong object relations with caregivers enabled rapport and attachment in our combined intersubjective field. Intersubjectivity takes into account the co-created experiences of both the foreign-born collectivist oriented clinician and the client in the supportive psychodynamic work they do together. While one client was psychologically able to develop her sense of self and new cultural identity within the context of the K-8 school placement, I developed as well, because of mutuality in the relationship.

Furthermore, from the intersubjective perspective, the interplay of the clinician's countertransference complemented by the client's similarities and differences sometimes facilitate and impede therapeutic work. Stolorow (1995) writes that clinicians who shared childhood histories with their clients revived archaic states and developmental longings. He elaborates that when the clinician's empathy is equal to the client's ideal of optimal human responsiveness, the countertransference dilemma occurs. This dilemma could include the clinician's zeal to provide the client with an unbroken self-object experience uncontaminated by the painful experiences of the client and clinician's past childhood traumas. For example, in sessions with one client, I zealously inquired about earlier good memories, and it became clear that recalling that history was hard for this client.

For foreign-born as collectivist oriented clinicians as immigrants, leaving past lives for their new countries can have many meanings. Moreover, making contact with other immigrants whose stories intersect with their own calls into play myriad advantageous and disadvantageous tensions and dilemmas. When those clinicians and similar clients embrace bicultural orientation in the host country, confusing expectations occur as one reconstructs a new cultural orientation to fit the context. Before one adapts that which could be unintentionally imposed upon the subjective experiences of any foreign-born immigrant is usually unknown. For the host country, the existing cultural orientation imposed upon the immigrant is the normal constructed socio-narrative that must be adhered to. Some clients come to mental health agencies after traumatic experiences, and using intersubjectivity enables clinicians to engage such clients authentically as they work to understand the familiar trauma clients face. The attachment and attuned response between the client and clinician in contained and modulated intersubjective spaces can be helpful to both.

Relational theorists offer ways to conceptualize present experiences as influenced by early relationship experiences. They offer that conflicts in early experiences could be interrupted to offset their painful reactions to early traumatic experiences. They also develop and defend the notion that participation and engaging in interplay between two people (subjectivities) with new relational experiences could facilitate healing, growth, and reconstruction of psychological difficulties (Berzoff et al., 2011).

Intersubjectivity conceives of self, other, and the clinical situation (Berzoff et al. ,2011). There is a call for clinicians to be cognizant of their own point of view in order to fight for those clients who are relegated to the margins. Berzoff et al., (2011) explain that power constructions that are maintained within cultural and political systems of dominance and subordination create urgency for the clinician to have a cultural standpoint.

The relational theorist's advancement of the intersubjective perspective created a field in which the complexities of people's subjectivities of cultural values, beliefs, power, privilege, and multiple identities get encountered, investigated, and interpreted. Clinicians come with their own issues and needs, as do the clients they serve in the therapeutic relationship. Intersubjectivity attends to the psychological and developmental needs of these two subjectivities in the therapeutic relationship, and how each one of them interacts and intersects within the dynamics of power, privilege, culture, class, and gender.

Relational theories and the intersubjectivity perspective capture what is human about each one of us. Working with other people who seem similar and different within new cultural systems can be complex and contradictory. On one hand, the foreign-born collectivist oriented clinician needs to follow set boundaries of the code of ethics, and on the other, supporting clients in a fashion tailored to their cultural needs is also morally justifiable. It is imperative that

foreign-born collectivist oriented clinicians tolerate the uncertainty, ambiguities, and paradoxes of working within cultural orientations that are different such as the U.S.

However, being aware of the slippery slope of using relational theory and intersubjectivity out of context is also part of the learning curve. This includes the tendency to forget the code of ethics discipline and take the similarities or differences within a therapeutic relationship as a given to disclose information through over-identification.. Berzoff et al. (2011) elaborated that sometimes in being authentic, one could burden clients unnecessarily and hence impede their advancement in therapy. Therefore, remaining aware of the risks inherent in intersubjective therapeutic work and the tension of ethnocultural countertransference is important. As foreign-born and collectivist oriented clinicians, we are implored by the authors not to focus on our own subjectivities at the expense of the client's subjective experience, but rather to consider the two-subjective experiences.

Intersubjectivity challenges collectivist oriented clinicians to embrace new knowledge, including theoretical and cultural knowledge, yet simultaneously maintain an open and empty stance. Being knowledgeable of one's own power and privilege and being able to recognize the way these intersect within the therapeutic relationship is important. It is important because it forces the foreign-born clinician to interrupt and deconstruct the ways they view or could use the power and privilege they have to facilitate or impede clients' growth. Intersubjectivity enables foreign-born clinicians to understand the ways in which interacting with clients, shapes their new realities and enables a mutual space that influences change within both individuals.

As seen above, I have discussed drive theory and relational theory's intersubjectivity perspectives on the collectivist-oriented clinician experiences that cause ethnocultural

countertransference in therapeutic work. I discuss below suggestions within the theories that would enable these clinicians to work within these theories in mutual ways.

Collectivist-oriented Clinicians can Practice Clinical Work with Both Theories

These theories are based upon human relationships; yet by nature, human beings are complex. Through these psychoanalytic theoretical positions, the complex clients are uniquely their own beings, and clinicians' assumed differences or similarities to them are the clinicians' own interpretations within cultural contexts of the work.

Therefore, learning to practice with restraint and remaining attuned to listen and watch for where the client is may reduce the danger of simplistic solutions, such as assumed equality and closeness between client and clinician. That said, in consideration of the challenges that immigration bestows upon most immigrants' psychological and cultural development, collectivist oriented clinicians' clinical work with clients should facilitate the union of common tasks of development and transition within the proposed horizontal individualist oriented culture.

Relationships that support emotional reconnections validate and invigorate new relational contexts (Alvarez (1999). I argue that sometimes foreign-born collectivist oriented clinicians are addressing cultural and clinical tensions in their transitional and psychological tasks as they acculturate, as do their clients. I suggest that these clinicians consciously combine aspects of structural drive theory and relational theory's intersubjectivity perspectives in their work to understand themselves and their clients in the context of the United States.

According to Freud (1963), the superego functions together with the ego to support people as they interact with the outside world. This notion was what other theorists, such as Fairbairn, extended as the concept of internalized objects that are representative of relationships with other people. Drive theory does operate within the unconscious, but influences the

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psychosocial aspects of relationships that happen in conscious realms. This adds to the tension

and occurrence of over-identification ethnocultural countertransference that collectivist oriented

clinicians feel toward their clients. If one's innate conflicts and wishes, and developmental

structures generate the clinician's reactions within the relationship, then to an extent relational

theory's intersubjectivity embraces Freud's classic drive theory by paying attention to the mutual

processes.

It is possible for the more biologically and structurally oriented drive theory and the more

dynamically oriented relational theory's intersubjectivity to support collectivist oriented clinician

therapeutic work within new cultural orientations. Modell (1995) argued that both drive theory

and relational theory are fundamentally complementary of each other, as they all lead to

intersubjectivity spaces, even though intersubjectivity has differing assumptions. Modell (1995)

posited that today few psychoanalysts would argue that the psychoanalytic process started by

Freud is intersubjective in nature. Classic theorists equated countertransference with unresolved

aspects of the clinician's neurosis, yet today most clinicians view it as an instrument (Modell

1995). Mishne (2002) suggests that culturally knowledgeable and competent placements that

adapt to diverse relational dynamics make such complexities less daunting for clinicians

including the collectivist oriented and foreign-born clinicians.

As expressed above, collectivist-oriented clinicians who experience tensions that cause

ethnocultural countertransference, could practice using drive and relational theories'

intersubjectivity perspectives. For these clinicians, both theoretical approaches may help advance

their sense of self, new-bicultural identity and overall self-realization. Drive theory would help

these clinicians to gain an understanding of their motivations and experiences in relation to the

contexts in which they work. Relational theory's intersubjectivity supports more relational

processes that converge with collectivist cultural orientations of most foreign-born individuals.

Writing this thesis enabled me to understand the ways that drive theory provoked the

intellectual advancements that led to relational theory's concept of intersubjectivity. Through

this, I feel that foreign-born collectivist oriented clinicians involved in theoretically based

clinical work can be open to the multiple modalities that accommodate multiple cultural

identities of clients and societies.

Conclusion

In this Chapter VI, I have written about drive theory and relational theory's

intersubjectivity perspective. My hope is that the reader will recognize my effort to show how

culture and unconscious drives influence ethnocultural countertransference for the collectivist-

oriented and also foreign-born, clinician. Both theories help to show experiences or motivations

that cause ethnocultural countertransference within clinical work. Sometimes the use of terms

like foreign-born, and ethnocountertransference were necessary to state the cultural identity of

the clinician's cultural orientation before and after migration. I have shown the motivational and

experiential nature of the ethnocultural countertransference for the foreign-born clinician, but

also the limiting aspects of performing collectivist-oriented culture in therapy within context in

the U.S. I have demonstrated through some clinical internship placement examples that

ethnocultural countertransference facilitated the therapeutic work and supported clients into

gaining more integrated selves.

Finally, as indicated in the exploration of biases in Chapter II, I emphasize that this thesis

is a formulation created theoretically. The ideas I have presented were informed by my own

clinical experiences within internship placements in the Northeastern U.S. However, the major

limitation of this thesis is the subjective experience of me, the author, as foreign-born and collectivist oriented. This paper could have benefited from incorporating the perspectives of other foreign-born clinicians who may have experienced similar tensions and dilemmas.

Empirical research might explore some of this study's statements, formulations, concepts, and questions. For example, using quantitative methods, this study might investigate foreign-born clinicians' professional experiences with a bicultural orientation lens in the U.S. These foreign-born clinicians could offer their views of working within newly constructed perspectives and the impact of these experiences on their personalities. Further research could discuss the ways more foreign-born cultural values and beliefs could be incorporated within the U.S NASW code of ethics.

This thesis has aimed to provide foreign-born collectivist-oriented clinicians—and all clinicians—with a little understanding of the dilemma involved in situating one's self within new cultures, and the tensions that ensue. As these clinicians re-construct their lives after immigration, they must also contend with new cultural disconnections, connections, societal values and beliefs, knowledge constructions, and professional expectations of their work.

References

Alvarez, M. (1999). The experience of migration: A relational approach in therapy. *Journal of Feminist Family Therapy: An International Forum, 11*(1), 1-29. doi: 10.1300/J086v11n01_01

Berzoff, J., Flanagan, L. M., & Hertz, P. (Eds.). (2011). *Inside Out and Outside In* (3rd ed.). Lanham, MD: Rowman and Littlefield.

Bonovitz, C. (2005). Locating Culture in the Psychic Field: Transference and Countertransference as Cultural Products. *Contemp. Psychoanal., 41*(1), 55-76.

Bureau, U. S. C. (2010). The foreign- born population in the United States. http://www.census.gov/newsroom/pdf/cspan_fb_slides.pdf

Comas-Díaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. Washington, DC US: American Psychological Association.

Comas-Diaz, L., & Jacobsen, F. M. (1991). Ethnocultural Transference And Countertransference In The Therapeutic Dyad. *Amer. J, Orthopsychial, 61*(3), 392-402.

Comas-Díaz, L., & Jacobsen, F. M. (1995). The therapist of color and the White patient dyad:Contradictions and recognitions. *Cultural Diversity and Mental Health, 1*(2), 93-106. doi: 10.1037/1099-9809.1.2.93

Crow, J. F. (1994). Relational concepts in psychoanalysis: An integration, by Stephen A. Mitchell. *Journal of Clinical Psychoanalysis, 3*(1), 15-24.

Erikson, E. H. (1945). Childhood and Tradition in Two American Indian Tribes— A Comparative Abstract, with Conclusions. *Psychoanal. Study Child, 1*, 319-350.

Fernando, S. (2010). *Mental health, race and culture* (3rd ed.). New York, NY: Palgrave Macmillan.

Fong, B. Y.-Y. (2014). *The death drive revisited: A reexamination of psychoanalytic drive theory and its implications for critical theory.* (74), ProQuest Information & Learning, US. Retrieved from http://libproxy.smith.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-99031-025&site=eds-live Available from EBSCOhost psyh database.

Freud, S. (1963). *An outline of psychoanalysis*. Oxford England: W. W. Norton.

Kang, H. (2010). *Cultural Citizenship and Immigrant Community Identity: Constructing a Multi-ethnic Asian American Community*. El Paso, TX: LFB Scholarly Publishing.

Kelly, S., & Boyd-Franklin, N. (2005). African American women in client, therapist, and supervisory relationships: The parallel processes of race, culture, and family. In M. Rastogi & E. Wieling (Eds.), *Voices of color: First-person accounts of ethnic minority therapists.* (pp. 67-89). Thousand Oaks, CA US: Sage Publications, Inc.

Mattei, L. (2008). Coloring development: Race and culture in psychodynamic theories. In J. Berzoff, L. M. Flanagan & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts (2nd ed.).* (pp. 245-269). Lanham, MD US: Jason Aronson.

Mishne, J. (2002). *Multiculturalism and the therapeutic process*. New York, NY: Guilford Press.

Modell, A. H. Discussion of articles on relational theory in psychoanalysis. *Psychoanalytic Psychology, 12*(1), 109-114. doi: 10.1037/h0079601

Perez Foster, R. (1999). An Intersubjective Approach To Cross-Cultural Clinical Work. *Smith College Studies in Social Work (Haworth), 69(2).*

Segal, C. (2012). 'We're cool, you and me': A relational approach to clinical social work in the city: Psychodynamic psychotherapy within a homeless shelter for formerly incarcerated women and their children. In J. Berzoff (Ed.), *Falling through the cracks:*

Psychodynamic practice with vulnerable and oppressed populations. (pp. 75-106). New York, NY US: Columbia University Press.

Stolorow, R. D. (1993). An intersubjective view of the therapeutic process. *Bulletin of the Menninger Clinic, 57*(4), 450-457.

Stolorow, R. D. (1995). An intersubjective view of self psychology. *Psychoanalytic Dialogues, 5*(3), 393-399. doi: 10.1080/10481889509539077

Stolorow, R. D. (2002). Impasse, affectivity, and intersubjective systems. *Psychoanalytic Review, 89*(3), 329-337. doi: 10.1521/prev.89.3.329.22075