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Cultural Aspects of Transference and Countertransference Revisited**

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This article is an update of the paper of the same title that was presented at the annual meeting of the Academy in 1958 (Spiegel 1959). The assignment id challenging, for it imposes upon me the obligation to answer at least three questions: 1) What did I say in 1958 that makes it worthwhile to take another look at the subject matter, which was concerned with the influence of cultural values in the treatment of working-class ethnic groups? 2) In what ways have the turbulent social changes of the last decade altered perceptions of ethnicity, and how is the new climate of opinion reflected in the professional literature and in professional practice? And 3) what changes have taken place in my own thinking in the interim?

In the original, 1958 paper, I was attempting to report some aspects of work being carried on at the Children's Medical Center in Boston, and in the Department of Social Relations at Harvard, in the study of ethnic families. With Florence Kluckhohn, whose skills combined sociology and anthropology, and with the cooperation of an interdisciplinary team of psychiatrists, psychiatric social workers, clinical psychologists and sociologists, the investigation focused on transactions in Irish-American, Italian-American, and Yankee families, all at the working-class level.

We were interested in distinguishing the effects of acculturation stress in ethnic families from the more general effects of working-class membership in a society dominated by middle-class values. This was the reason for comparing working-class families of recent

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Irish and Italian origin with working-class Yankees, who, presumably, would not be subjected to the stress of acculturation. In the 1958 paper, however, I did not emphasize this distinction, a point to which I shall return later in this article.

For the sake of making the necessary comparisons, we utilized the theory of variations in cultural value orientations which had been developed and previously tested by Kluckhohn (1961). The 1958 paper used the categories of this theory to locate the significant disparities we had found between Irish-American and middle-class American values. Since both the theoretical approach and our findings take a long time to describe and have been reported elsewhere (Papajohn and Spiegel 1975), I shall only mention in a shorthand fashion those discrepancies which we found to be a source of strain, omitting the technical terminology on which the theory is constructed. As previously, I shall not, for the moment, attempt to distinguish between the ethnic and the class factors involved in the dissimilarities.

American middle-class values emphasize planning for a far-flung future and for perpetual change to a degree that seems excessive when compared with other nations, even the most industrialized societies of the Western world. Tracking time in little books and calendars, remembering appointments, and arriving on time are of the greatest significance since there is always something important to do in the next hour, day, or week — and woe to those who stand up their dates. Irish-American working-class families live in a present-time perspective, showing great respect for the past and a relatively fearful attitude toward the future and especially toward change. Aside from well-learned work routines, keeping new appointments at the right time and the right place is not something highly valued. There will always be a next time.

The American middle-class places great significance on the development of independence and autonomy for all family members, and are not too surprised (if not always delighted) when the children develop ideas and social standards that differ from their parents'. Irish-American stress dependence on the extended family, respect for authority, and conformity among children to parental standards. Great pride is taken in being Irish, creating a strong, positive group identity. Sex roles are strictly segregated and women are expected to accept a rather subdued position. Nevertheless, because of historical factors which have tended to weaken the competence of Irish males, Irish women frequently had to take responsibility for running the family. This was accomplished

by the wife's “ruling from behind the throne” while trying to make her husband look good in public — a strain that the children, and often the neighborhood, were well aware of.

American middle-class values emphasize the importance of success in schooling and in occupational roles, building achievement forcefully into the sense of identity. Showing one's real feeling impulsively toward others should be modified in favor of the technical requirements of one's job, whether as a parent or at work. Irish-Americans stress spontaneity. The job is important for income maintenance but is not felt to be of major significance to one's identity. Holding back feelings is regarded as having something to conceal, probably something shameful. Declaring one's independence from the extended family for the sake of achievement is viewed as both risky and disloyal, and is likely to evoke the sentiment, “He (or she) will be sorry. They'll come crawling back on their knees some day!”

Middle-class Americans take a rather relaxed and pragmatic view of ethics and morals. In a well-adjusted family, children will learn ethical principles through gentle suasion and by identifying with parents' conduct. Moral standards tend to change and have to be judged on a case-by-case basis, usually in terms of avoiding harm to others. Irish-Americans hold to a strict, often harsh, sense of morality, assuming that the capacity for sinful, evil conduct is inherent in human nature and has to be crushed (I'm tempted to say “exorcised”) whenever it threatens to appear in conduct. Temptation is always around the corner. Children are consistently badgered about misconduct. Because of the prevalence of mischief, one does not openly reveal one's feelings to strangers. The spontaneity I spoke of previously is to be exhibited mainly with family members and close associates. Basic trust takes a long time to develop among a people whose experience has been that the world is not too trustworthy. For parents, the harsh moral system becomes especially prominent in the area of sexual behavior, more so for daughters than sons. Daughters must remain chaste till marriage and even then sex is for the sake of having children, not for pleasure. The fear is that daughters will be taken advantage of or give way to temptation. In either event, they must be closely watched, warned and lectured to.

I would not wish to leave the impression that the constellation of Irish-American cultural values and practices just described is, in and of itself, any more stressful than similar constellations among other ethnic groups in middle-class American families. Cultural

values always display a double face. On the one hand they have grown out of, and have been adapted to, the ecological conditions of particular social systems over time. On the other hand, they are always somewhat anachronistic and ill-fitting at a particular point in time, posing problems with which individuals and cultural institutions like the family must cope. In any event, our study was concerned less with the conflicts engendered by the traditional system of ethnic values than with the strains produced when family members in ethnic groups attempted to accommodate to mainstream, middle-class American values.

In this connection, the 1958 paper focused on the strains which developed when middle-class American therapists — namely, the members of our research teams — attempted to establish a psycho-therapeutic relationship with members of Irish-American families. Organized around the concept of transference and countertransference relations, the paper pointed out the similarity between the professional values and goals of psychoanalytically trained therapists — practicing, to be sure, a relationship type of therapy rather than formal psychoanalysis — and the values of the American middle-class. Like good middle-class Americans, we psychoanalytically trained therapists expected our patients to be able to look forward to change in the future and if a patient did not arrive on time or forgot his appointment, this was registered as "resistence." We thought our patients ought to resolve fixations and aim for increasing ego autonomy, in the process developing relative independence from their families and from other pressures for conformity or the need to please others at the sacrifice of self-interest and achievement. We valued our "benevolent neutrality" in the domain of morals and hoped to release our patients from their tyrannical superego pressures, whether conscious or unconscious. We expected our patients to talk about their thoughts, attitudes, and feelings but, in accordance with our technical job training, were reluctant to talk much about ourselves. And we hoped that, whatever the degree of divergence from our values and goals at the beginning, as therapy progressed and the relationship deepened, our patients would identify with and accept our goals and values. If this did not happen, then we would clearly have to discontinue therapy, or — and this is what actually happened — change our own value orientations as applied to therapy.

Since our patients did not arrive on time consistently, did not value change, could not reveal their feelings if we concealed ours, kept expecting us to tell them how to solve their problems, were

unable to aim for autonomy and independence from the family, and, finally and most importantly, could only make the smallest changes in their strict moral sensibilities, we clearly had to modify our goals and procedures, or else abandon our research and accept failure.

Motivated by our middle-class drive for success and guided by our deepening understanding of the legitimacy, on both sides, of the value differences, we made changes. We saw some of the fathers in the families in bars, trucks, near their place of work, or wherever was convenient, and we made frequent home visits. We began to disclose certain aspects of our personal lives, accepting questions about the health of our children, for example, without evasion or "interpretation." We revealed our feelings about moral or political issues, when asked, while recognizing the validity of varying views of such matters. We accepted the limitations on autonomy and independence within the general framework of the Irish family and made ourselves visible within the neighborhood in order to reduce the wariness of the untrustworthy stranger. In a way, we became "adopted" by the Irish-American network, just as anthropologists are adopted by their native tribes and middle-class "shrinks" are taken for granted by middle-class consumers. None of these modifications seemed to interfere with our ability to help the families focus on their problems. In fact, the changes seemed to help the process along. But they gave us a great deal of internal turmoil.

The remainder of the 1958 paper was devoted to an account of the "resistance" displayed by Irish-Americans toward taking the "good" patient role in terms of transference, and of the "resistance" displayed by the therapists toward modifying their traditional therapeutic roles in terms of countertransference. Although in part motivated by conscious beliefs and recent training (or environmental experiences), the reluctance or inability to change on both sides was, I proposed, also the result of unconscious, archaic ego-superego conflicts connected with childhood experiences and fantasies reactivated by the challenge of change. Although I still believe in the validity of these generalizations, I now think that the formulation in terms of "transference and countertransference" was imprecise, and I welcome the opportunity to propose a somewhat different formulation.

Before turning to that task, I would like to go back to the second question proposed at the outset: In what ways have events occurring in our society since 1958 changed the perception of ethnic

groups and cultural values and how have such changes been reflected in the professional literature?

I'm certain that the reader hardly needs to be reminded of the degree to which the Black Power and Civil Rights movements of the 60s and early 70s challenged the “melting pot” concept which, during the complacent 50s, had largely been taken for granted. The destructive effects of racial discrimination and stereotyping were brought powerfully to everyone's attention through the riots and civil disorders of those tumultuous times. Such ringing slogans as “We Shall Overcome” and “Black is Beautiful” changed, almost overnight it seemed, a negative ethnic identity for Afro-Americans into a positive definition, at least at the symbolic level. Further dramatic exposures of the hypocrisy concealed behind our assumed egalitarian values followed in rapid order. The Antiwar movement challenged the right of a remote federal bureaucracy to impose its will on the nation by involving its youth in an unjust war, while the Youth movement carried the struggle against an elitist establishment onto college campuses, political conventions, and into the streets. The Women's Liberation movement opened another chapter in its long historic campaign to abolish the numerous manifestations of a presumed male superiority. All of these efforts added up to a massive attack on the cultural value conflicts which permitted a self-advertised democratic society to exclude so many subcultural groups from social participation and political power (Papajohn and Spiegel 1975b).

As the struggle to clarify the conflict between participatory and elitist values proceeded, a trend became evident. Following the lead of the Blacks, other ethnic groups began to assert themselves in terms of the distinctiveness and value of their cultural heritage. Mexican-Americans began to talk about Brown Power. The Chicano movement, first organized around Caesar Chavez's leadership of migrant farmworkers, soon took on a more comprehensive character in the form of open assertation of pride in Mexican-Americans traditions. American Indians began to talk about Red Power in the effort to overcome the long-endured injustices of life on the reservation. With the formation of the American Indian Movement (AIM) the cause of Indian rights was reaffirmed on the basis of Native American history and culture. Even the Orientals, that “most silent minority” (Ho 1976), in their customary unobtrusive fashion, created The National Coalition of Asian-Americans and Pacific Island Peoples for Human Services and Action, which subsequently became The Pacific/Asian Coalition (PAC). Choosing not

to engage in overt protest, this organization works quietly behind the scenes to develop research and services to the wide variety of Asian and Pacific populations seeking to survive in a Western culture.

The latest to join the trend are the white ethnics — the Italians, Irish, Greeks, Poles, and Jews — who have not recently suffered so intensely from discrimination, and who had attained pockets of political power in various cities and states. Nevertheless, the sudden outbreak of activity represents the surfacing of long-festering resentments against a broad, WASP, middle-class social system that has tended to devalue the white ethnic's traditional cultural background (Novak 1971). In New York City, the Italian-American Fraternal Society was founded to combat prejudicial stereotyping of Italian gangsters in the public media, and to affirm the contributions of Italians to American society. Polish-American cultural organizations have begun to take aggressive stands against the media for stereotyping ethnic groups, though they have so far been unable to stamp out the sting of the Polish joke (Novak 1976). Second and third generation Greek-Americans established the Greek Orthodox Youth of America (GOYA), to underscore their sense of Greek consciousness and identity. The ethnic consciousness of the Jews, stimulated over the centuries by anti-semitic persecutions, was brought to a fever pitch by Middle-Eastern threats to the existence of Israel. Similarly, Puerto Ricans, with their native soil only a few hours away by plane, needed no urging to make their bid for community control and political power. Clearly, both the "visible"* minorities, and the "invisible" minorities were making it increasingly evident that the metaphor for a pluralistic America was not a melting pot but a mosaic — a patchwork of ethnic groups erasing and reestablishing boundaries in the process of social change and competition for political and economic power.

The growth of ethnicity did not go unnoticed by social scientists. Glazer and Moynihan's (1970) studies of Puerto Ricans, Jews, Irish, and Italians in New York City in *Beyond the Melting Pot*, and Gans's (1962) *The Urban Villagers* called attention to the life styles of white ethnics living in the cities. Other publications

*I owe the "visible-invisible" distinction to Yamamoto, James, and Palley (1968). I myself prefer "official" versus "unofficial" minorities, since federal policies and census statistics are routinely concerned with Blacks, Spanish-speaking, Orientals, and Native Americans, and are silent about the "white ethnics."

focused on Mexican-Americans (Farge 1975; Madson 1965), Greek-Americans (Saloutos 1964), Puerto Ricans (Lopez 1973; Rodriguez 1973), Native Americans

(Symposium of American Psychiatric Association 1967), Asian-Americans in general (Sue and Wagner (1973), Filipinos (Aquino 1974), and Japanese-Americans (Kitano 1969). These books describe the values, customs, family life, and problems of adaptation to middle-class American culture of the various ethnic groups in considerable detail. Meanwhile, publications on Black ghettos, Black identity, racism and race relations, and violent Black-White confrontations reached mammoth proportions. The changed social scene, so different from the old integration-assimilation assumptions, and the accompanying sociological literature, led to several attempts to frame new, overall theories of ethnic persistence and conflict in the United States (Schermerhorn 1970; van den Berghe 1970). In commenting on the importance of this change, Glazer and Moynihan (1975) recently noted that a shift has occurred in our understanding of ethnic groups:

> *"Formerly seen as survivals [emphasis the authors'] from an earlier age, to be treated variously with annoyance, toleration or mild celebration, we now have a growing sense that they may be forms of social life that are capable of renewing and transforming themselves. As such, perhaps the hope of doing without ethnicity in a society as its subgroups assimilate to the majority group may be as utopian and questionable an enterprise as the hope of doing without social classes in a society."*

Now we may ask, how has the mental health literature, in general, and writings on transference and countertransference, in particular, kept pace with these new developments? The answer is, unfortunately, not very well. Of 63 citations in *Psychological Abstracts* listed under "transference" or "countertransference" for the last five years, plus a review of the first six months of this year, I could find only four journal articles dealing with cultural, social, or ethnic aspects of transference-countertransference relationships. Two were concerned with Black patients and white therapists or vice versa (Carter and Haizlip 1972; Fisher 1972), one with the problems of an urban analyst who had moved to a rural area (Ordway 1976) and one on general aspects of the effects of contemporary social change on patients' attitudes and behavior (Rangell 1975). Because Rangell represents a traditional point of view, his way of dealing with cultural value conflicts through

superego analysis is pertinent to our interests today and is worth quoting:

> *"The inclusion of ego-superego conflicts as a central point of interest within the intra-psychic world adds now what has always been*

pressed for, but to the exclusion of the equal pressures of the inner world. The social frame and cultural demands are now added, but within and including the inner psyche of man.... With the field of vision enlarged to these new fronts, the method of analysis and the role of the analyst remains the same. Value choices, decision-making and social action, while analyzed whenever elements become known and understood, are left ultimately and completely to the patient..."

The gist of this is that although value conflicts accompanying social change may produce new problems for patients and different alignments of intrapsychic structures, the analyst can handle such situations through a slight broadening of focus to include the value conflicts, but without any fundamental change in procedure.

Although it meets the challenge of social change in a generally adaptive fashion, this statement is open to question on two grounds. The first has to do with the statement "While analyzed whenever elements [such as value conflicts] become known and understood ...." Stimulated by the dawning awareness of the significance of ethnic differences, the literature is beginning to contain warnings on the limits of the ability of the analyst to "know and understand," associated with the social distance between analyst and patient. For example, Wallerstein (1973), in an article on the problem of reality in psychoanalysis, states, "It is an important analytic task to face the fact that our customary and ordinary assumption that we can empathically intuit the realities of ethnically different patients' lives is not necessarily so." Countertransference errors and mistakes in the perception of reality have cropped up in other contexts, for example, when the analyst has emigrated from a foreign country (Ticho 1971).

Many analysts believe, however, that if the patient is otherwise suitable for analysis in terms of intelligence, ability to articulate feelings, capacity to develop an observing ego function and the other standard prerequisites, then the difficulties imposed by cultured or ethnic divergence can be surmounted. This depends on the analyst's dedication to maintaining a watchful eye on countertransference responses, and caution in drawing conclusions about the relation between the patient's behavior and his social

milieu.* In cases of interracial analysis there is a small collection of articles demonstrating the transference uses to which patients put their fears of prejudice and stereotyping and the analyst's ability to dissolve such obstacles through interpretation and confrontation (Bernard 1953; Jackson 1970; Waite

1968; Schacter and Butts 1968; Calnek 1970; Carter and Haizlip 1972; Fisher 1972). Nevertheless, there is evidence that overcoming the obstacles is associated with a minimum difference in class level and social distance (Oberndorf 1954). It also requires a certain openness, flexibility, curiousity, and empathy for cultural differences in the personality of the therapist — something of which not all therapists are capable (Sager, Brayberg, and Waxenberg 1972), and which I shall refer to later.

The second objection to Rangell's position about dealing with social values in classical analysis concerns the phrasing: "Value choices ... are left ultimately and completely to the patient ..." There is a substantial literature in regard to the limits of so sweeping a generalization (Wallerstein and Smelser 1969; Halleck 1971; Tseng and McDermott 1975). Even the insistence on leaving decision-making and value choice completely up to the patient represents an emphasis on the value of autonomy with which the patient must identify. There is also the matter of the "lessons in constructive living" that are sneaked in through the back door of "working through," and that obviously represent the analyst's own values (Strupp 1975). The significance of the implicit value placed by analysts on "future" versus "present time" orientations, discussed in my 1958 paper, has received some attention in terms of the lack of importance placed by Latin American patients on arriving at any appointment on time, keeping to the 50-minute hour, and taking commitments and personal promises for future behavior seriously (Ticho 1971; Jackson 1970). Conflicts between the "future time" and "individualistic" values of psychoanalysis, and the veneration for the past and loyalty to the extended family incorporated into Chinese (Fong 1968) and Japanese (Doi 1964) ethnic values have also received some attention. Of further interest

*This problem was first pointed out by Freud (1953) in his one and only notice of cultural differences. In commenting on the difficulties of writing up the case of the "Wolf Man," who was of Russian background, Freud wrote, "Personal peculiarities in the patient and a national character different from ours made the task of feeling one's way into his mind a laborious one."

is the value placed by Japanese and other Asians on formality and fine-tuning of facial and body messages in contrast to the informality and unawareness with which Americans engage in nonverbal communication (Johnson, Marsella, and Johnson 1974). This gives rise to a good deal of miscommunication, and is in need of systematic research (Spiegel and Machotka 1974).

In the broader area of mental health service delivery, with the exception of Blacks, there has again been very little attention given to ethnicity. Using a large sample, Yamamoto and his coworkers (1968) have done a series of studies in Los Angeles on mental health services delivered to Mexican-Americans, Orientals, Blacks, and Caucasians in a public outpatient clinic. With class level held constant, more Caucasians were accepted for psychotherapy and were seen for a longer series of visits than was the case for the minority groups. Since all the therapists were Caucasians, a study of ethnocentrism was carried out, using the Bogardus Social Distance Scale. As was hypothesized, therapists low on ethnocentrism more often saw patients from minority ethnic groups than those with stronger ethnocentric feelings (Yamamoto, James, Bloombaum, and Hattem 1967). Underutilization of services by Asian-Americans has been noted by others (Sue and McKinney 1975). It is usually attributed to a combination of staff attitudes ("They have no problems"), and Asian values opposed to self-assertion, open expression of feelings, or seeking help outside of the boundaries of the group (Ho 1976). Native Americans also receive fewer follow-up outpatient appointments because of negative staff attitudes toward the response to treatment (Hendrie and Hanson 1972).

As far as white ethnics are concerned, with the exception of the book by Papajohn and myself (1975), *Transactions in Families*, which deals with Greeks and Italians, and Ann Parsons's (1969) study of Southern Italians in Italy and in the United States, the mental health literature is silent. For example, there are apparently no studies of the variety of Eastern European nationality groups of Slavic origin, (Russians, Poles, Estonians, etc.,) of Scandinavians, of the French (with the exception of Canada where there is a growing literature), nor of the Portuguese who have been pouring into eastern seaboard cities.

In contrast to this trickle of publications on ethnic factors, the literature devoted to the economic and social class factors involved

in treatment is voluminous.* It would seem that interest in the effects of poverty on "the disadvantaged" has been so overwhelming that ethnicity has simply not been systematically studied, or has been included in an undifferentiated fashion among the problems of the poor. The reasons for the lack of salience of the broad range of ethnic factors are not clear. That the "War on Poverty" initiated by the Johnson Administration happened to coincide with the growth of the community mental health movement is one possible factor. Fear of stereotyping and of expressing other form of bias toward ethnic groups (Offer and Sabshin 1975; Cohen 1974) has probably played a role.† Conceptual

support for such ethnic “blind spots” has been drawn from Lewis's (1959, 1965) work on *The Culture of Poverty*, and Riessman's (1964) on *The Mental Health of the Poor*. To be sure, the large number of epidemiological studies of the inverse relation between social class and serious mental illness has given strong support to the perception of urban poverty as a major source of stress (Dohrenwend 1969; Dohrenwend and Dohrenwend 1974a). However, the effort to distinguish what kind of stresses — material deprivations such as overcrowding, social structural conditions such as unemployment, or cultural and psychological attitudes such as ethnic stereotyping and discrimination — are associated with psychopathology has run into serious methodological problems (Dohrenwend and Dohrenwend 1974b). In any event, the fact remains that stereotyping and discrimination are much more likely to exert an influence when ethnicity is held at an implicit level than when an ethnic group is made a specific object of research and service, with the cooperation of members of the ethnic group (Callan 1973).

Because the literature on the cultural aspects of social class membership is now so massive, no attempt will be made here to refer to it in any detail. In a general, nonspecific fashion this task has already been performed by Goldstein (1973) in his typically

*For example, the second edition of the Comprehensive Textbook of Psychiatry does not list “ethnic” or “ethnicity” in the index, and the new edition of the American Handbook of Psychiatry contains only a few, minor passing references. Both texts, however, contain numerous entires for “social class” and “poverty.”

†Cohen (1974) has described this problem succinctly: “During diagnosis and treatment there is a remarkable lack of direct attention given to ethnicity, race, subcultural identity, and bilingualism by mental health practitioners. There may be a conscious or unconscious avoidance of the reality of ethnic differences stemming from a hypersensitivity and liberal concern not to be ‘discriminating’ or to show ‘prejudice’ in the clinical setting.”

entitled monograph, *Structured Learning Therapy: Toward a Psychotherapy for the Poor*. The book, containing a bibliography of over 700 items,* summarizes the findings with respect to psychotherapy succinctly at the outset:

> *“The implications of a patient's social class for his psychotherapeutic treatment destiny are numerous, pervasive, and enduring. If the patient is lower class, all such implications are decidedly and uniformly negative. In comparison with patients at*

higher social class levels, the lower class patient or patient-candidate seeking psychotherapeutic assistance in an outpatient setting is significantly more likely to: (1) be found unacceptable for treatment; (2) spend considerable time on the clinic's waiting list; (3) drop out (or be dropped out) after initial screening; (4) receive a socially less desriable formal diagnosis; (5) be assigned to the least experienced staff members; (6) hold prognostic and role expectations incongruent with those held by his therapist; (8) terminate or be terminated earlier; and, (9) improve significantly less from his own and his therapist's perspective."

According to Goldstein, all attempts to avoid these negative outcomes through modifications of psychoanalytically based therapeutic techniques are doomed to fail. Decreasing social distance through the therapist's adoption of more active or directive methods of treatment, employing more concrete language, crisis intervention and other interventions that have been proposed simply don't work. His solution is to employ a "prescriptive therapy" designed to help lower class patients overcome their psychological and social inadequacies so that they can cope more successfully with the social stresses under which they labor. Using a variety of behavior modification techniques such as modeling, role-playing, and social reinforcement, the therapist attempts to increase the repertoire of specific social, interpersonal, and personal skills at the disposal of the patient. The book reports a series of well-controlled experiments to achieve these ends which are only partially successful, but which the author regards as promising.

It is difficult to disagree with so dedicated a student of social class differences, but disagree I must. Unless I misinterpret the author's intent, the effort consists of teaching working-class people

*Because Goldstein is interested in learning theory, linguistic abilities, and a number of other processes related to psychotherapy, not all the items in his bibliography are directly related to social class and other cultural factors in the therapist-patient relationship; but there is very little in this area that he has missed.

the middle-class virtues of self-disclosure, empathy, articulation of feeling in a self-observing fashion, identification with others, and the like, by means of a packaged technology. One is reminded of Professor 'enry 'iggen's male chauvinist lament in "My Fair Lady": "Why can't a woman be more like a man?" No effort is required of the therapist to identify with or learn more about the

values and perceptions of the working-class patient, since his cultural background is already assumed to be responsible for his emotional difficulties. The author apparently considers middle-class values and behavior the royal road to mental health.

This one-sided approach to cultural differences ignores the fairly good results reported by others using a more collaborative approach. For example, in his often cited paper, “Dr. Strangeclass: Or How I Stopped Worrying About the Theory and Began Treating the Blue Collar Worker,” Gould (1967) began the initial interviews with some instruction to the patient regarding the value of talking about himself, but he also modified his own behavior, adopting an easy give-and-take manner, discussing sports, and in other ways adapting to working-class styles in order to decrease social distance. Others have reported on the value of brief instructions to the patient regarding what to expect in treatment (Jacobs, Charles, Jacobs, Weinstein, and Mann 1972; Hoen-Saric, Frank, Imber, Nash, Stone, and Battle 1964), choosing treatment goals in accordance with the patient's cultural standards (Dragan 1974), and maintaining flexibility of technique (Moore 1974).

One reason for the standard package approach involved in the learning theory employed by Goldstein derives from the assumption of invariance embedded in *The Culture of Poverty* and *The Mental Health of the Poor* conceptualization. Unless they live in chaotic families, in which case they are all but hopelessly disorganized and damaged (Pavenstedt [Ed.] 1967), working-class families are assumed to have the same values and perspectives on life, across the board. This view is, in my opinion, clearly unrealistic. It fails to take into account the tremendous range of variability in values, roles, and cultural perspectives associated with ethnic background. It neglects the degree to which ethnic families may get caught in conflicting values as they undergo social mobility and social change. And it ignores the idiosyncratic situation of the individual's position in his family and the interplay of biological, psychological, and social systems involved in his particular personality structure — in short, his developmental history and current environmental problems (Papajohn and Spiegel 1975).

It may well turn out that it is this failure to take appropriate account of cultural variation that is associated with some of the negative treatment outcomes reported in the literature. When ethnicity is combined with social class variation, the therapist must be something of an anthropologist. He should be aware of what it is like to have a foot in each of two cultures, to get confused

about how to proceed, and not to recognize the origin of the confusion. He should familiarize himself with the childrearing customs and family relationships of the relevant ethnic group — doubly so if the patient is the product of a mixed marriage or involved in one. And he should be able to perceive the degree to which the patient's behavior may be bizarre, deviant, or conforming — not just to American middle-class standards — but primarily to the values of his social class, ethnic group, and geographical setting.

The problem of conformity brings me to the last question that was raised at the beginning of this presentation: changes in my own thinking about transference and countertransference as applied to cultural differences.

It seems to me, now, that the distortion arising from unconscious childhood object relations and fantasies, and manifested in transference or countertransference responses can only be detected when played against a fixed point of reference, in respect to which they appear bizarre or out of place. In classical analysis the fixed reference point consists of the minimal activity of the analyst and the appropriateness of his interpretations to the meaning of the patient's productions. But what can this fixed reference point consist of if, in order to decrease social distance and increase the patient's ability to identify with him, the therapist displays a variety of active behaviors and a carefully chosen repertoire of social roles?

A solution to this problem may be found in the distinction proposed by Greenson and Wexler (1969) between the transference, especially the positive transference, the therapeutic alliance, and the nontransference, or real, aspects of the therapist as a person (Namnum 1976). I would suggest that in psychotherapy with lower class ethnics, “visible” or “invisible,” the therapeutic alliance has to be carefully constructed in a collaborative fashion in accordance with the known values of the patient's major group affiliations. This means, for example, that if the patient comes from a cultural background that emphasizes obediance to authority, then the therapist has to be prepared to give guidance and advice — when, and if, he knows what advice to give on the basis of

prior exploration of the patient's conflicts. If the patient's ethnic group maintains fixed prejudices and stereotypes toward another ethnic group, to which the patient openly adheres, then the person of the therapist should be considered. He should not be a member of the target ethnic group, and may possibly have to be a member of the patient's ethnic group. If prestige is important to the hierarchical values of the group, then the therapist, no matter what his actual rank or title may be, must be presented in a prestigeful way to

the patient or his family. Finally, the construction of the therapeutic alliance requires a careful, mutual consideration of the goals of therapy in line with the cultural value orientations of the patient and his ethnic group.

Because ethnicity has been given such a low priority in research and practice, we lack the experience and the case examples needed for illustration. It is clear, however, that this approach entails a major value shift. The emphasis on individualism and autonomy traditionally endorsed by American psychotherapy is replaced by horizontal, collaborative decision-making. This gives the patient the "breathing space" to opt for either individualistic or authoritarian human relations, and for other value splits, depending upon how he sorts out his conflicts. It also requires a 180-degree shift in our traditional "blindness" toward the person of the therapist. His color, his sex, his age, the shape of his body, face, and hair, his name, his accent, his capacity for nonverbal communication, his costume, his ethnic background, above all, his degree of ethnocentrism — pro or anti his own and other ethnic groups — all these become matters to be given the most serious attention in the construction of the therapeutic alliance.

Once these connections between the person of the therapist, the person of the patient, and the goals and procedures of the therapeutic alliance have been worked out,* then the fixed point of reference mentioned above is set in place. There will be a generally positive tone in the relationship against which transference and countertransference responses can be detected. For example, if the patient who values obedience to authority and has accepted the

*Such matters are given consideration in the "match-making" that occurs at points of referral of patients in private practice or assignments of therapists in clinics. However, attempts to line up patients with therapists who will work out well are not given systematic attention in private practice and only selected features, such as Yamamoto's (1967) study of ethnocentrism, are subjected to research in clinic practice.

therapist as a prestigeful authority figure suddenly rebels against or criticizes him, then an identity conflict, probably connected with childhood object relations outside of his awareness may be about to break into consciousness. At this point, however, the therapist must give careful thought to the possibility that he has inadvertently violated some other cultural standard important to the patient, such as the sensitivity to the prevalence of sin and temptation characteristic of the Irish-Americans. This would not be counted as a countertransference error but as a matter of cultural learning requiring

correction. On the other hand, the therapist may have misinterpreted as prejudice a bid by the patient for love and acceptance based on his own personal history but outside his awareness.* Such countertransference errors require even-handed explanation or apology. The open-minded therapist should have little difficulty distinguishing between cultural misconceptions and personal misinterpretations.

Some important aspects of cultural impacts on transference and countertransference have not been discussed in this article, due to a lack of space. Some of these are: the women's movement (Chesler 1971; Sherman 1976), the Gay Liberation movement (Davison 1976), or the alternative life-styles involved in the youth movement (Allen 1971). Nor have we been able to consider the importance of family therapy to the delivery of services in the context of social change and cultural values (Spiegel 1974). Even our discussion of ethnicity has been very incomplete, and our materials scanty. In the future, the activity of such organizations as the American Jewish Committee's Institute on Pluralism and Group Identity (Giordano 1974a, b; Levine 1975), the newly funded Asian-American Mental Health Research Center (Lin and Yamada 1976) in San Diego, and the Spanish-Speaking Mental Health Research Center in Los Angeles, and the American Psychiatric Association's Minority Fellowship Program (1975a, b), and its Task Force on Transcultural Psychiatry to Study Ethnocentricity, will help to develop the needed resources. Until then, we can hope that the sheer force of events will raise the consciousness of mental health workers to the point that our national heritage of cultural diversity is appropriately cared for.

*A striking example of such a countertransference error is provided by Tycho (1971), an Austrian analyst, in her response to an adolescent black girl's comment about a German schoolmate. The analyst took to be a slur what was actually a compliment.

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