The relevance and validity of ethnocultural factors in transference and countertransference reactions are proposed. Some of those prevalent in dyadic psychotherapy are described, focusing on intra-ethnic and inter-ethnic dyads. Case vignettes are presented to illustrate the ways in which ethnocultural factors serve as catalysts for such major therapeutic issues as trust, ambivalence, anger, and acceptance of disparate parts of the self.

The influences of culture and ethnicity on the psychotherapeutic process have been previously acknowledged (Devereux, 1953; Griffith, 1977; Ticho, 1971), and have recently been recognized as key factors in therapy (Comas-Díaz & Griffith, 1988; Dudley & Rawlins, 1985; Goleman, 1989; McGoldrick, Pearce, & Giordano, 1982). While some of these influences are immediately available to the senses (sights, sounds, smells, etc.), it has been postulated that every culture also has its own unique form of unconscious (Hall, 1981), which may have powerful effects on the process of psychotherapy. Ethnicity and culture can touch deep unconscious feelings in most individuals and may become targets for projection by both patient and therapist, thus becoming more available in therapy. For example, Jones (1985) stated that black patients often evoke more complicated countertransference reactions than white patients since social images of blacks make them easier targets for therapists' projections. Similarly, Spiegel (1965) asserted that working with patients from different cultural backgrounds engenders a very complicated strain within the therapist. Psychotherapy with the ethnoculturally different patient frequently provides more opportunities for empathic and dynamic stumbling blocks, in what might be termed “ethnocultural disorientation.”

In traditional therapeutic orientations, patients’ racial and ethnic remarks in therapy have been attributed to a defensive shift away from underlying conflict, and the therapist’s role has been to interpret them as defense and resistance (Evans, 1985). However, in our own clinical experience we have found that this approach hinders the exploration of conflicts related to ethnicity and culture. By encouraging the elaboration of ethnoculturally-focused devaluing concepts...
and feelings, the therapist can offer patients a richer opportunity to know and resolve their own ethnocultural and racial conflicts (Evans, 1985). For instance, Comas-Diaz and Jacobsen (1987) reported that in cross-cultural psychotherapy, projective identification may be shaped by ethnocultural values. These identifications frequently occur spontaneously, as when the patient attributes to the therapist certain qualities or features characteristic of the patient’s own ethnocultural identity. This process of ethnocultural identification may be facilitated by the fact that identification is one of the chief manifestations of culture (Hall, 1981), as well as a major dynamic force in therapy (Erikson, 1959).

As they do in the traditional psychotherapeutic dyad, transference and countertransference have critical significance for the cross-cultural clinical encounter. The acknowledgment of ethnic and racial factors in the psychotherapeutic relationship often appears to catalyze the transference, leading to a more rapid unfolding of core problems (Schachter & Butts, 1968). However, cultural and ethnic aspects of behavior often make the evaluation of transference and countertransference difficult (Bash-Kahre, 1984; Zaphiropoulos, 1982) and may be a stumbling block to therapeutic progress (Jenkins, 1985), particularly when the therapist fails to acknowledge such differences (Varghese, 1983). Therapists also tend to bring their imprinting of ethnic and racial stereotypes into psychotherapy (Riess, 1971), and these stereotypes frequently play a significant role in the manifestation of transference and countertransference. Countertransference reactions are often complicated by ethnocultural issues such as prejudice, discrimination, and feelings of guilt (Comas-Diaz & Minrath, 1985).

Ethnic and cultural parameters of transference and countertransference may reinforce each other, sometimes developing into a vicious cycle. For instance, Bash-Kahre (1984) asserted that in cross-cultural psychotherapy, transference and countertransference are influenced by a feeling of estrangement that afflicts both therapist and patient as each of them is inclined to misinterpret the other’s nonverbal communication in terms of his or her own cultural reality. However, it is important to remember that factors such as gender, sexual orientation, physical appearance, and personal experience also influence the process of cross-cultural psychotherapy (Jones, 1985). Given the complexity and multiplicity of ethnocultural factors, therapists need an understanding of their own ethnicity and culture as well as of their patients’ so that they can achieve effective cross-cultural psychotherapy (Jacobsen, 1988; Jones, 1984). In order to examine the ethnocultural transference and countertransference in greater detail, it is helpful to explore these processes within the framework of the patient-therapist dyad from both interethnic and intraethnic perspectives.

To illustrate the relevance and validity of ethnocultural factors in transference and countertransference, several of those that are prevalent in dyadic psychotherapy are described in this article, along with the common underlying dynamic themes that characterize them. Case vignettes are used for illustration, with identifying data altered to protect confidentiality.

ETHNOCULTURAL TRANSFERENCE
Interethnic Transference

There are many possible transference reactions within the interethnic dyad, ranging from overcompliance and friendliness to suspiciousness and hostility (Jackson, 1973). Transference reactions can occur at any stage of treatment, although they appear more likely to occur at some than at others.

Overcompliance and friendliness. This type of reaction is frequently observed when there is a societal power differential in the patient-therapist dyad. Perhaps the most common example of such a power differential in the United States is that of a white therapist with a patient from an ethnic mi-
minority. This kind of situation can be seen in the example of a Latino professional woman, accustomed to being assertive in her own professional context, who does not negotiate the scheduling of her appointment with her therapist, even though the offered time is inconvenient for her. Asked why she did not attempt negotiation, she stated: “As a Hispanic professional woman, I did not want to reinforce ethnic stereotypes. I did not want to make waves and was avoiding being labeled as difficult.” Thus, the patient overcomplies with the therapist, compromising the therapeutic alliance.

Notwithstanding such power differentials in our society, the overcompliance and friendliness type of transference reactions can also occur when the therapeutic dyad is of an ethnic minority therapist and a non-minority patient. In such instances, the transference reaction can take the form of concern about being a good patient. For example, a white female said to her Chinese male therapist: “I wish I could speak Cantonese, so I can be like your Chinese patients.”

Denial of ethnicity and culture. This type of reaction involves avoidance by the patient of any issue pertinent to ethnicity or culture. In discussing color blindness among people of color, Greene (1985) suggested that this denial may stem from a fear of confronting racism within the self. She further suggested that some members of oppressed groups may be so afraid of divisiveness that they tend to obscure the differences between themselves and others, thereby avoiding confrontation of their own ethnicity or culture. The following example illustrates this type of reaction:

A Pakistani graduate school student sought treatment for problems in her relationship with her parents. Her therapist in the college counseling clinic was a black male. In response to the therapist’s inquiry about her family ethnic background, she replied: “My parents are Pakistani but that has no relation to my problems.”

Mistrust, suspicion and hostility. Mistrust (or “How can this person understand me?”) is a common transference reaction in the interethnic dyad. Unacknowledged ethnocultural differences promote mistrust and suspicion in the patient. One form this can take is concern on the part of the patient about therapist’s “real” motivations in the therapy. For example, a black patient said to her Hispanic male therapist during the initial interview: “I wonder how good you are if you are working with me in this inner city clinic.” A more extreme example of mistrust and suspicion is provided by the following case of a German therapist-Israeli patient dyad:

After two years of intensive psychotherapy, the patient was still struggling with issues of trust. He was actively fantasizing about his therapist’s possible participation in Nazi military activities. He confronted the therapist, who answered from a classical analytic stance: “You are wondering about my participation in Nazism,” and left it there. Finally, the patient developed a plan to catch the therapist. During a session, he presented his own experiences as an officer in the Sinai war. The therapist’s response implied that he understood the activities of an officer, thereby heightening the patient’s anxiety about the therapist’s possible role in the Holocaust. Shortly thereafter, the patient dropped out of treatment. When discussing this therapy with close friends several years later, the patient stated that his therapy had been disrupted because of his therapist’s refusal to address this issue.

Mistrust and suspicion can eventually lead to hostility, as in the following example:

A Portuguese family was meeting with their daughter’s clinician. The therapist, although culturally identifying himself as being from India, was originally from Goa, an island off the coast of India that was colonized by Portugal. When the patient’s parents asked the therapist where he had learned Portuguese, he told them that he had learned Portuguese, he told them that he had learned it in Goa. The father then said, in a pejorative way, “Ah, you are from one of our colonies.”

Ambivalence. Patients in an interethnic psychotherapy dyad may struggle with negative feelings toward their therapists, while simultaneously developing an attachment to them. Issues of identification and internalization within the interethnic dyad can create ambivalence in the patient. For instance, questions such as “How can an ethnic minority patient living in an inner
city take a white middle-class therapist as a model for identification and subsequent internalizing?" emerge in discussion of transference within this dyad (Comas-Diaz & Minrath, 1985). Another aspect of this transference reaction involves patients' awareness of their own ambivalence. As an illustration, as assertive black patient told his Latino therapist: "I have mixed feelings about you. By you not being white, I can be less suspicious of you. Since you are not black, I can tell you about some negative feelings about being black. However, by you not being black, I am not sure if you can totally understand me."

The question of internalization of the therapist is no less provocative when the patient is white and the therapist is from an ethnic minority. A black female psychiatry resident, writing about issues of race and transference, presented a clinical vignette illustrative of such ambivalence (Harris, 1990). In the vignette a white female patient described to the therapist feelings of persecution by Latino tellers in a bank, who were rude to her. When the therapist raised the question of whether the patient might have feelings about having a black therapist, she replied that even if she had feelings about the therapist's race, she would not bring them up because she "did not want to hurt the therapist." Such a response suggests the existence of transferential ambivalence, in that the patient was experiencing racial feelings, but at the same time, due to her attachment to her therapist, she did not want to hurt her by discussing them.

Intraethnic Transference

The omniscient-omnipotent therapist. This type of transference involves a complete idealization of the therapist and the fantasy of reunion with the perfect, all-good parent, facilitated by the ethnic similarity:

A black therapist felt that his work with a black woman was at an impasse. He consulted his supervisor who suggested a conjoint session with the patient. During the conjoint session, the patient expressed her surprise at the need for such a meeting, stating: "I come here and I hardly have to discuss my problems because, by being black, Dr. S knows everything about me. Dr. S is the only good black doctor who can help me." This revelation of the patient's omniscient transference helped the therapist to resolve the impasse.

The omniscient-omnipotent transference reaction can take several forms. One is that of the savior, in which patient and therapist are from a similar ethnocultural minority; because the therapist has been able to survive in the mainstream society, the patient expects the therapist to come back to rescue him or her. This transference reaction frequently reinforces a dependent and passive position. For example, a female Chinese-American patient said to her Chinese male therapist: "We are both Chinese and that helps a lot. You are such a great doctor and a great person, I know that you can make me well, take away the pain, and make things OK for me."

Another version of omniscient-omnipotent transference is that of the folk hero or heroine. This reaction is more predominant among ethnic groups, particularly minorities, that have experienced hardship and oppression within the larger society. In this reaction, the therapist's accomplishments (such as going to graduate school, leaving the ghetto, migrating, and being socially successful) all contribute to the mythology of the ethnic minority person who "made it." Consider the following example:

A Hispanic woman said to her Hispanic female therapist, "I place myself in your hands—you have done so well. I have told everybody in the barrio about you and all the good things that you have done. Pretty soon I will bring my daughters to see you and I know that you will help them." Exploration revealed that the patient had been telling people in the barrio that her therapist was the director of the clinic, when in reality she was in a training position.

The traitor. The converse reaction to idealization of the therapist is the process of devaluation. In this transference reaction, the patient exhibits resentment and envy at the therapist's success, and equates it with betrayal and "selling out" of the therapist's culture, as the following vignette illustrates:
A black male said to his black male therapist: “You have to be an Oreo to be working for the Man. You don’t even live in a black neighborhood anymore and you pretend that you are helping your people by working in this white institution.”

The autoracist. This type of transference is more prevalent among groups that experience racial prejudice accompanied by socioeconomic oppression. Patients with this reaction do not want to work with a therapist of their own ethnocultural group because they experience strong negative feelings toward themselves and project these feelings onto an ethnically similar therapist. Usually these patients experience conflicts in their ethnocultural identities and do not want to be forced to address these conflicts by being in therapy with a member of an ethnoculturally similar group. Working with a therapist from their own ethnic group may signify to them that they are receiving inferior treatment; they prefer a member of the dominant group as a therapist. Consider the following example:

A Latina who has been assigned to a Latina therapist during the initial evaluation tells the therapist: “I don’t want to work with you. I am Latina and I know that Latinos are lazy and like to gossip. I want a white doctor.”

Ambivalence. Questions of identification with and internalization of the therapist can be provocative when raised within an intracultural dyad. Patients in this dyad may feel at once comfortable with the shared ethnocultural background and at the same time fearful of too much psychological closeness. When such closeness occurs in therapy, it may bring to the fore the patients’ unresolved issues about their ethnocultural background. This mix of feelings may lead to a subtle but rather profound ambivalence that can easily be missed or may be confusing to the unsuspecting therapist. For example:

A Latina mental health worker in psychotherapy with a Latina therapist, initially expressed concerns about confidentiality, given their common professional network. Simultaneously, she expressed delight at working with a Latina therapist who could “understand my cultural and gender issues.” She further identified the therapeutic match as providing a positive and corrective experience for her identity. However, as therapy progressed, the patient expressed fears of being too close and of being engulfed by the therapist. Although the patient acknowledged progress in her therapy, she decided to terminate treatment on the grounds of her inability to deal with her strong ambivalence.

ETHNOCULTURAL TRANSFERRENCE

ETHNOCULTURAL COUNTERTRANSFERRENCE

Interethnic Countertransference

Denial of ethnocultural differences. The denial of ethnic or cultural differences, or the belief that “all patients are (or should be treated as if they are) the same,” contributes to a negation of countertransferential influences in the therapeutic process. This type of denial by the therapist may also take the form of feeling that one is (or should be) above the cultural and political influences of the society (Gorkin, 1986). The following case vignette illustrates the effects that such a countertransferential reaction may have:

A Panamanian woman in treatment with a Puerto Rican female therapist had been talking for several sessions about feeling alienated from her mother and family. In response to the patient’s repeated reviews of the reasons for her immigration to the United States, the therapist asked the patient about her feelings regarding the political situation in Panama. The patient then expressed concern about her family’s security in Panama and guilt about being safe herself in the United States. She said that she had not realized that she could talk about politics in therapy, because a previous therapist of hers had apparently taken a position negating the political context of the patient’s clinical presentation. If her current therapist had not addressed the political situation in Panama, the patient’s clinical work would have been seriously compromised.

The clinical anthropologist syndrome. In this reaction, the therapist is overly curious about the patient’s ethnocultural background, and may spend an inordinate amount of time exploring aspects of the patient’s culture at the expense of the patient’s needs (Devereux, 1953). Roughly speaking, this reaction is nearly the opposite of denial of ethnocultural differences just discussed. Such apparent interest by the therapist may superficially be quite grat-
ifying to the patient, who may thus encourage it with a seemingly inexhaustible series of fascinating cultural anecdotes. Such countertransference reactions most frequently serve to derail the therapeutic process, and can even be potentially dangerous, as when the therapist attributes cultural explanations to actual pathology:

A Brazilian male patient regaled his Anglo therapist with colorful tales of partying through the night during Carnival and during almost weekly music-making sessions with friends. Substantial time was spent in therapy discussing the cultural meanings of the patient's intense and somewhat erratic interactions with his friends and of various aspects of Brazilian culture and music. However, certain biological aspects of the patient's experiences, namely hypomanias of a mild bipolar disorder induced by sleep deprivation, were missed.

**Guilt.** This type of reaction can emerge when societal and political realities dictate a lower status for people of certain ethnic and cultural background. For example, in describing the countertransference in a Jewish therapist and Arab patient dyad, Gorkin (1986) asserted that guilt is a recurrent countertransference reaction. Although the pervasive political antagonism between the two ethnic groups may render this particular dyad an extreme one, guilt is also prevalent in relatively less dramatic interethnic dyads, as well. Let us examine the case of a white therapist and Native American patient:

A Native American man was referred to therapy by his employer due to a drinking problem. The therapist, a socially responsible white man, felt guilty, which translated into discussions of relationship problems rather than of the patient's drinking problem. In discussing the case with a colleague, the therapist said, "I feel that all he has left is drinking and we taught them how to anesthetize themselves after ripping them off ."

**Pity.** Within the interethnic clinical encounter, pity is a derivative of guilt or an expression of political impotence within the therapeutic hour. The example of a Jewish therapist and Iranian patient dyad illustrates this issue:

A Jewish therapist was working with an Iranian couple when the Ayatollah Khomeini overthrew the Iranian government. The therapist began to feel considerable pity for the previously well-to-do patients, who began to discuss in therapy all the friends and relatives that they were losing in Iran. Consultation helped the therapist identify his own paralyzing pity and overidentification with the experiences of his own family during World War II.

**Aggression.** According to Gorkin (1986), guilt and aggression can be intertwined in the countertransference reactions of interethnic dyads. He asserted that therapists cannot avoid negative feelings towards patients who repeatedly arouse guilt in them. However, aggressive countertransference reactions are not always associated with guilt, as the following example illustrates:

In working with a Hispanic woman, a Jewish female therapist found herself overly confrontational and active, although her usual therapeutic style was psychodynamic and exploratory. During consultation she identified her patient's passive aggressiveness as the cause of the change in her treatment style. However, further exploration revealed that the patient reminded the therapist of a Spanish singer (Charo) who although competent, portrayed herself as stupid. Consequently, the therapist was very angry with her patient for presenting herself as stupid when, as the therapist knew, the patient was smart; thus, the therapist felt that her patient "was trying to fool her."

**Ambivalence.** In working with ethnic minorities or culturally different patients, therapists carry value and attitudinal conflicts that have an impact on treatment and need to be addressed so that psychotherapy can be effective (Evans, 1985). A therapist's ambivalence toward a patient's culture may originate in an ambivalence toward the therapist's own ethnicity and culture. For instance, Giordano and Giordano (1977) stated that upwardly mobile, middle-class professionals have a personal ambivalence toward ethnicity because they have embraced universalist life-styles and value systems, leaving their own ethnicity behind. The following case example highlights this type of reaction:

An Italian-American therapist working with a black woman began to experience profound ambivalence whenever the patient discussed crime-related incidents in her neighborhood. Her feelings heightened when the patient presented material about a cousin who had been unjustly incarcerated on drug trafficking charges.
During consultation, the therapist was able to identify feelings of ambivalence about her own Italian background. More specifically, she was able to examine her unresolved ethnic shame due to what she called "the societal connection between organized crime (the Mafia) and Italians."

**Intraethnic Countertransference**

**Overidentification.** In the intraethnic dyad, overidentification on the part of the therapist can be detrimental to the continuation and success of psychotherapy (Mays, 1985). For example, some therapists from ethnic minorities may choose activist and supportive therapy approaches for their patients from ethnic minorities because of unconscious fears or of overidentification with the intrapsychic aspects of their patients' problems (Evans, 1985).

**Us and them.** An extreme version of overidentification is that of the "us and them" mentality. This reaction tends to be more prevalent among groups who have a history of oppression and discrimination, and thus a lower societal status, as is the case with many ethnic minorities. The therapist may overidentify with patients in terms of their shared victimization because of racial discrimination and may attribute the patients' problems to their ethnic identity. Therapy may then become a shared fortress against perceived common threats (us against the world), as illustrated in the following vignette:

A Hispanic female patient told her therapist how she was "beating the system" by working full time while receiving disability insurance benefits. The therapist, a Hispanic male, did not confront her with the illegality of her behavior, nor did he discuss its implications. Later on, the patient was fired from work because she was suspected of embezzlement. The therapist sought consultation after the patient admitted that she had indeed embezzled the money. In presenting this case, the therapist was surprised at the consultant's opinion that the therapist had been colluding with the patient and had given her permission to engage in illegal acts. However, upon exploration, the therapist acknowledged the possibility, saying, "Perhaps I colluded with the patient in beating the system because, as a Hispanic, I am also angry at the system." He went on to say that he had not been promoted in the past two years and cited discrimination against his ethnic background as the key factor in his lack of advancement. Colluding with the patient in the us and them attitude prevented him from addressing the patient's dysfunctional and destructive behavior.

**Distancing.** In order to prevent overidentification problems and because of the fear of getting too close, the therapist may affectively distance him or herself from the patient. Consider the following example:

A Hispanic woman was in therapy with a Hispanic female clinician. They were ethnoculturally similar and initially this similarity facilitated the development of a therapeutic alliance. Because she had been reared by her maternal grandparents, the patient was struggling with the issue of feeling rejected by her parents. In addressing this issue, the therapist discussed the rearing by maternal grandparents as a cultural practice among some Hispanic families. The therapist herself had been raised by her grandparents and had struggled between feelings of abandonment and acceptance of this culturally sanctioned practice. By offering the cultural explanation and neglecting to explore the patient's feelings of abandonment and mistrust engendered by her upbringing, the therapist found herself affectively distanced from the clinical situation. Clinical consultation helped her to address the situation properly.

**Cultural myopia.** This involves an inability to see clearly because ethnocultural factors obscure therapy. It can occur when therapist and patient share similar ethnic and cultural backgrounds and is usually accompanied by unconscious collusion. In extreme cases, cultural myopia can reach the proportions of cultural blindness.

An example of cultural myopia was provided by Gottesfeld (1978) who, in discussing countertransference and ethnic similarity, described an Italian therapist/patient dyad in which the therapist's psychological familiarity with the patient developed what she labeled as too much "psychic togetherness." She stated that the characteristically Italian need to hold on to family to the exclusion of outsiders caused this dyad to reinforce each other's positions, and hindered therapeutic progress. The patient withheld family information and the therapist allowed her to retain her family secrets, and thus control the therapy.

**Ambivalence.** In the intraethnic dyad, this can be manifested in the therapist's own ethnic and cultural ambivalence, a situation
which is often more prevalent among ethnic minority individuals. Being an individual of ethnic minority in the United States means facing some inherent cultural conflicts, since ethnic minorities are often bicultural or multicultural (Smith, Burlew, Mosley, & Whitney, 1978). Moreover, many minorities experience oppression and must cope with experiences of racial prejudice and discrimination (Comer, 1980). Working in an intraethnic dyad may intensify these feelings and thereby generate ambivalence toward working with patients from similar ethnic backgrounds. This can lead therapists to overlook their own ethnicity while pursuing a quest for universalist values (Giordano & Giordano, 1977).

The following vignette illustrates this reaction:

A black female therapist complained that she was being assigned too many black cases. When she was asked to expand upon her concerns, she stated that she was “tired of hearing black women complain about their men’s inability to find regular jobs,” thus voicing her profound ambivalence about working with black females. She stated that although she was able to help some of her racial sisters, their problems reminded her of her own personal situation and of the fact that “there were no jobs out there for black men.” By acknowledging her ambivalence she was able to ask for a limitation to be put on the number of black female cases assigned to her.

**Anger.** The ambivalence in an intraethnic dyad can be taken to extremes and converted to anger. Being too close to a patient ethnoculturally may uncover painful intrapsychic issues that are unresolved. The following example illustrates this reaction:

A black male therapist forgot to inform his black female patient about his pending vacation until their last session before it was due to start, although he had remembered to tell all his other patients. This particular patient had a history of being abandoned by black men and this was a recurring theme in therapy. In discussing the case with a colleague, the therapist realized that he did not want to deal with the reactions he anticipated from his patient to the news of his vacation; furthermore, he was angry about them. By forgetting to tell her until their last session, he could minimize the amount of time he would have to spend dealing with her feelings about being abandoned once more by a black man. Further exploration revealed that the therapist’s own father had abandoned his mother and that the therapist had blamed his mother for the situation.

**Survivor’s guilt.** This type of reaction tends to be more prominent among ethnic minority and immigrant therapists from working-class or low socioeconomic status backgrounds. By education, income, or other means, these therapists may have escaped those origins, common to ethnic minorities. In doing so, they may have left family and friends behind, thus generating conflict and guilt. The survivor’s guilt can impede their professional growth and lead to denial of their patients’ real psychological problems (Munoz, 1981), as in the following case:

A black dentistry student presented to therapy with sleeping problems that had no organic basis. Upon exploration, he complained that he was the victim of racial discrimination in his school and cogently presented data to sustain his allegation. The therapist, a black female, had experienced a similar situation when she was in graduate school. Therapy concentrated on helping the patient exert his options and, with the therapist’s support, he filed a formal grievance. However, after this, his symptoms worsened. In discussing the case with a consultant, the therapist realized that she had overlooked the fact that the patient’s mother had remarried and that the patient was extremely angry about her decision. Instead, the therapist’s focus had been on the patient’s racial victimization. She became aware that she was plagued by guilt at having survived the racial discrimination in her own graduate training. She had translated her survival guilt into a politicization of her patient’s clinical situation, failing to explore the intrapsychic and interpersonal elements of his presentation. After the therapist addressed these dynamics, she effectively combined intrapsychic components with the management of reality issues, and the patient progressed.

**Hope and despair.** Alternatively, the ethnic minority therapist may experience despair because of having been able to escape the fate of family and friends without guilt. Such despair may alternate with hope of improving the situation of the patients or of the ethnic community at large (Munoz, 1981). For example:

A black female social work student was working in therapy with a black female therapist. Patient and therapist shared similar socioeconomic backgrounds. The
therapist was initially hopeful about outcome because of the patient’s achievement in getting into graduate school. However, the patient brought to therapy feelings of having abandoned her community by attaining a professional status. This situation evoked feelings of despair in the therapist because of her own lack of guilt about having escaped her own depressed socioeconomic background. After consultation, the therapist was able to address her countertransferential reactions effectively.

IMPLICATIONS

The ethnocultural parameters of transference and countertransference tend to facilitate the uncovering of unconscious feelings and thereby advance the therapeutic process. The clinician’s acknowledgement of these reactions may lead to a more rapid emergence of conflicts underlying major therapeutic issues such as trust, ambivalence, and anger. Let us consider the following example:

A Jewish man working with a Latino therapist identified their shared experience of being outsiders as facilitative in developing a therapeutic alliance. He remarked to his therapist: “You can relate to my experience of being Jewish because, as a Latino, you also are different from the mainstream society.” The patient’s presentation of being the only Jew in a mostly WASP environment was permeated by concerns about his self-image. Initially, he complained that his coworkers and superiors did not trust him, and saw his ethnic identity as the cause for this mistrust. After the therapeutic relationship was cemented, the patient began to make humorous statements about the therapist’s lack of a Spanish accent. When this issue was confronted, the patient was able to admit to his ambivalence about working with a Latino therapist. From this emerged his ambivalence about being Jewish. He said, for example, that he had tried to change his local (Long Island) accent to avoid being singled out as Jewish. The mistrust (both as an object and as a subject) he had perceived as engendered by his ethnicity was re-labeled as mistrust of himself for having become what he called an impostor. Themes of self-image and self-esteem emerged and rapidly unfolded in therapy. This process helped the patient to see that ambivalence was central to his personality structure, regardless of his ethnicity. The patient had used the ethnocultural paradigm as a metaphor for his mistrust and his generalized ambivalence.

Ethnocultural transference and countertransference reactions may emerge at various times during therapy. They can act as catalysts for the acceptance of disparate parts of the self. Monitoring and properly addressing such reactions can advance the therapeutic process and promote growth. Consider the following vignette:

An Anglo-Mexican female, in therapy with an Anglo female, presented depressive symptoms around problems within romantic relationships. She professed to be a “woman who loves too much.” When the therapist raised the issue of their differing ethnic backgrounds, she replied: “It doesn’t matter, I am also half Anglo,” which the therapist interpreted as a denial transference reaction. When the patient’s depressive symptoms subsided, she began to manifest an overcompliant transference reaction; such behavior was inconsistent with the patient’s professional assertive style as a medical student. Upon exploration it was revealed that she perceived the therapist as an authority figure—a member of the dominant society who could not be openly questioned. When this issue was addressed, the patient was able to connect this reaction to her own behavioral style with her Mexican and Hispanic friends. She realized that she often behaved in a rigidly authoritarian style toward them. Such a style appeared to be congruent with her perception of her “Anglo side.” Conversely, she reported being relatively unassertive with her Anglo friends, this being congruent with her “Mexican side.” This realization promoted a discussion by the patient of her ethnic ambivalence. For example, although she was an attractive and petite woman, she felt that the shading of her skin was not light enough, that she was “too Mexican looking.” She stated that as a child she had been blond, and that in Mexico she was called La Gringa.

After this revelation came the unfolding of her feelings about her sense of attractiveness as a female. She had dated both Hispanic and Anglo men and perceived them as always abandoning her for “tall, blond, Anglo women.” She was examining these issues with a tall, blond and Anglo female therapist, however, and her transference reaction turned into mistrust augmented by several derogatory references to the Gringos. The therapist developed a countertransference reaction of pity, and after a consultation, she decided to address the patient’s mistrust transference directly. Examining the patient’s ethnocultural transference facilitated an approach to her ambivalence about her Mexican and Anglo backgrounds. She expressed frustration and said that she sometimes felt like two different people who did not communicate with each other.

In accordance with Chin (in press), who has asserted that splitting is an adaptive defense mechanism among people of color, her apparent splitting was interpreted as part of her adaptive coping style. Although ra-
cial ambivalence is common among individuals of mixed race (Root, in press), the expression of the patient's ambivalence through ethnocultural transference mobilized the unfolding of her anger. She had externalized and dichotomized her expression of anger toward Anglos when she faced her affiliative needs, and toward Mexicans when she dealt with her self-affirmation and assertive needs. The different ethnocultural transference reactions that were emerging were acknowledged by the therapist and connected to the patient's ethnocultural disorientation. By encouraging elaboration of her ethnoculturally-focused devaluing concepts and feelings, the patient was given an opportunity to understand and resolve her own ethnocultural and racial conflicts. Furthermore, these conflicts became tools for the identification of the disparate parts of the patient's self, namely her racial, ethnic, gender, and personal identities, and examination of the ethnocultural issues led to her acceptance of these disparate parts. The ethnocultural context thus acted as a catalytic agent in providing a barometer for the patient's problems with ambivalence, anger, and self esteem.

CONCLUSIONS

Ethnicity, culture, and race can touch deep unconscious feelings in most individuals and may become matters for projection by both patient and therapist, usually in the form of transference and countertransference. Ethnocultural issues constitute key elements in psychotherapy. Acknowledging them does not negate individual uniqueness stemming from developmental, biological, structural, and contextual factors comprising the psychological makeup of each person. As with other relevant variables in psychotherapy, ethnocultural factors in transference and countertransference not only influence individuals' presentations in the clinical discourse, but also significantly affect the process and outcome of psychotherapy. Moreover, they can serve as catalysts for such major therapeutic issues as trust, anger, acknowledgement of ambivalence, and acceptance of disparate parts of the self.

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