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Psychodynamic Work, Community Mental Health and Multicultural Sensitivity

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Introduction

It is a commonly held misconception that psychodynamic theory and therapy have nothing to do with community mental health and are inapplicable to ethnic minorities. Many consider psychodynamic psychotherapists as rigid, arrogant, reductive, sterile, sexist and racist. Though I feel no need to defend unprofessional therapists who fit this stereotype, I will, in this brief article, attempt to articulate the difference between the negative caricatures of psychodynamic psychotherapy and what I believe is a more accurate representation of solid psychodynamic work and its application to community mental health and multicultural sensitivity.

Psychodynamic Work

Students often ask me, 'If psychodynamic work isn't inherently rigid, arrogant, reductive, sterile, sexist, authoritarian, and racist, what is it? To answer this question I must first make my way through the cobwebs of popular media representations of psychodynamic work as well as the stories of real analysts and therapists who, for whatever reasons, actually approximate some of these representations. I then recall the subversive and creative psychoanalytic spirit which has always been a part of this work and only then do I prepare to deliver my answer. My simplified and abbreviated answer is that psychodynamic work begins with the notion that 1) behavior is motivated by impulses and ideas of which we are partially or fully unaware, 2) symptomatic behavior, like depression, anxiety, and persistent interpersonal problems are recognized as unconsciously motivated, 3) therapy is about making the unconscious conscious and learning to keep as few "secrets" from oneself as possible, and 4) when the compulsion to repeat symptomatic behavior is diminished by the recognition of the previously unconscious motives that it served, the person is in a position to make better choices in his/her life.

We say that through the symbolic function, the child's organization of the world is constellated around various maturationally determined zones and functions of the body and that a person's world view is as much a function of identifications as it is a function of disavowals and repudiations. The forbidden impulses and ideas are exiled into unconsciousness through various behavior strategies such as sublimation,

intellectualization, rationalization, isolation of affect, denial, negation, acting out, substance abuse, splitting, primitive idealization, devaluation, projection, delusional thinking, and so on. To the extent that these strategies are limited, brittle or cause problems in living, they may result in symptoms or relationship problems that become the focus of a psychotherapy. In therapy, depending upon the patient's level of organization and the amount of time allotted for the treatment, we may invite the patient to speak in a free and uncensored fashion or address a particular concern in a more focused fashion. As the patient speaks, we attend not only to what the patient says but also to the ways in which he/she is reluctant to speak, the things the patient doesn't say, and how he/she doesn't say them. As the patient speaks we remain emotionally present while maintaining a neutral stance. This neutrality does not mean being sterile or cold or rigid. It simply means that the therapist attempts to limit the extent to which he/she gets in the way of the patient. The therapist tries to get out of the patient's way and allow the patient to speak. Neutrality is an impossible goal but the therapist attempts to get out of the way of the patient to the extent possible and take a nonjudgemental and nondirective approach to the patient. And when the therapist inadvertently, and often inevitably, intrudes he/she deals with it clinically.

As the patient speaks, the therapist attends to the patient's pull on him or her noting the role into which the patient attempts to recruit the therapist. The therapist may see the patient as an experience looking for an event and a relationship looking for an other. With these views, the therapist construes the patient, not as an embattled hero, survivor, victim, etc. but as a conflict between desires and inhibitions. In viewing the patient as a conflict and examining the strategies the patient uses to conceal the associated but forbidden impulses and ideas, the patient is afforded the opportunity to examine previously unexamined thoughts, memories, fantasies, etc. As these are encountered, the patient finds new ways to organize the world, has a new and fuller experience of him/herself and finds new ways of dealing with familiar problems. Thus a batterer learns to refrain from hitting, endure his feelings of vulnerability and powerlessness and deal with the warded off experiences more directly. The alcoholic refrains from drinking and confronts the experience that the alcohol formerly held in check. The intellectualizer learns to speak the unspeakable and the denier admits the formerly unacceptable.

Psychodynamic work requires that the therapist assume a down to earth, understanding, and compassionate stance. To the extent that a psychodynamic psychotherapy fails in this regard, it fails to live up to its name. Sexism, racism, arrogance, and the pejorative use of psychopathological terminology are all unprofessional stances. Psychodynamic work, on the other hand, is inherently radical and subversive. It is aimed at overturning established psychic structures. Thus, there is no room in psychodynamic work for sexism, racism, arrogance or the pejorative use of psychopathological terminology.

While not everyone can pay for, or even use, four or five sessions a week of psychoanalysis, the schematized approach to psychodynamic work described above is modifiable to a wide range of patients and settings including community mental health outreach programs, out-patient clinics, and crisis clinics. In these settings therapists can

use psychodynamic principles to understand any patient's conflict while intervening with an appropriate ratio of analytic strategies to counseling strategies.

Analytic strategies can raise anxieties and unravel or *pull the psyche apart*, so to speak, to help the patient *understand* the motivations behind his/her behavior and *change* psychic structure. These strategies include the maintenance of a neutral stance, the interpretation of resistance and transference, the use of free association, a focus on exploring the patient's personal construction of reality, clarification, confrontation, linking, recognition of repetitive behavior patterns and a focus on impulses, fantasies, dreams, relationships and experiences. Counseling strategies *put people together*, in a sense, to help them *cope and adjust*. These strategies include the maintenance of a directive stance, a problem focussed discussion, education, limit setting, reassurance, referral, case management, explanation, advice giving, and a focus on adjusting to a consensually agreed upon external reality of objects and events (as opposed to relationships and experiences). From a counseling perspective we see two people in the consultation room - a person who needs help and a person who gives help. From an analytic perspective there are at least three people in the room the patient, the patient's other, and the therapist. The patient's other is who the patient tries to turn the therapist into. This transference of a previous object relation onto the person of the therapist is made possible by the therapists neutral stance.

Every psychodynamic psychotherapy is comprised of a ratio of analytic to counseling strategies. The ratio of analytic to counseling strategies will be dependent upon the ability of the therapist, the therapist's counter-transference, the frequency of sessions, the social support needed and available to the patient, the defensive strategies of the patient, and the level of crisis at any given point in the treatment. Doing psychodynamic work does not mean putting everyone on the couch. Psychodynamic work is a way of interacting. It is a way of listening, a way of thinking, and may include a set of interventions to be incorporated, to varying degrees, into a balanced and reasonable treatment plan. Doing short term psychodynamic work is entirely possible provided we establish attainable short term analytic goals.

Community Mental Health

In Europe, after World War I, Siegfried Bernfeld established a home and school for Jewish war orphans where psychoanalytic principles were integrated. Anna Freud and Dorothy Burlingham did a similar sort of work with children in England during World War II. In the late 1930s and early 1940s the Mental Hygiene Society of Northern California engaged in a wide range of social work and educational activities in the Bay Area using psychoanalytic principles as their theoretical basis and drawing on the services and support of many in the psychoanalytic community. During World War II many of the San Francisco psychoanalysts devoted much of their time to the returning war veterans at Mt. Zion's Veteran's Rehabilitation Clinic where the analysts experimented with new therapeutic techniques such as group therapy, recreation therapy and brief psychodynamic psychotherapy. One of San Francisco's early analysts was a woman, named Portia Bell Hume, who is sometimes referred to as the Mother of Community Mental Health in California, owing to all the work she did in this area. In the

1940s R. Nevitt Sanford, Daniel Levinson, Else Frenkel-Brunswik and Theodore Adorno studied the "authoritarian personality" in an attempt to better understand anti-semitism, racism and other manifestations of social intolerance and the impulse to control a rejected other (Adorno, et al, 1950). Bernard Diamond, Emanuel Windholz, and Nathan Adler did psychodynamic work in the prisons and mental hospitals, and Norman Reider was famous for his Saturday Clinic where he saw indigent psychiatric patients at no charge. In fact, the entire community mental health system in the Bay Area owes its existence to the intertwined social work and psychoanalytic communities of the 1930s and '40s. Furthermore, the influence of psychodynamic theory, therapists, and analysts continues in community mental health throughout the San Francisco Bay Area to this day. Nonetheless, people continue to cling to their pejorative stereotypes of psychodynamic theory and therapy and use them as excuses to avoid reading the psychodynamic literature and to avoid examining their own countertransference desires to simply soothe and fix.

Multicultural Sensitivity

Another common misconception is that psychodynamic work isn't applicable to ethnic minorities. This assertion is made in spite of the fact that the founding fathers and mothers of psychoanalysis were, for the most part, members of a horribly oppressed minority. I am speaking, of course, of Freud and the vast majority of early Freudians who were Jews in anti-semitic Austria and Germany. By the 1930s and '40s psychoanalytic groups were being established all around the world. There are currently recognized psychoanalytic institutes and study groups throughout Europe, the United States, Canada, Mexico, South America, Israel, India, Japan, Russia and Australia.

It is difficult, for example, to know what to say to those who think psychodynamic work does not apply to Latinos. There are at least eighteen psychoanalytic associations, study groups and societies in Mexico, Chile, Argentina, Venezuela, Peru, Brazil, Colombia, Uruguay and so on. The Kleinians and Lacanians are said to be particularly popular in these countries. Furthermore, the president of the International Psychoanalytic Association from 1993-97 was Horacio Etchegoyen, an Argentinian from Buenos Aires. And the current (1998) president is Otto Kernberg who was raised in Chile.

Psychodynamic theory is currently being applied at clinics throughout the Bay Area such as La Familia Counseling Service, West Coast Children's Center, Ann Martin's Children's Center, California Pacific Medical Center Out-Patient Psychiatry Department, Mt. Zion Hospital's Out Patient Psychiatry Department, the Infant Parent Program at San Francisco General Hospital, Westside Crisis and Outpatient Clinic and many more. In my lectures, teaching and supervisory capacities I speak in rebuttal to the current anthropological and sociological trend of teaching the students what each of the different ethnic groups are like and how they should be treated. Instead I focus on the psychological view of cultural experience. I am not opposed to the acquisition of knowledge about the anthropological and sociological realities of different ethnic groups and in fact I find this information not only useful for those that are uninitiated to various ethnic groups but the treatment suggestions that this perspective generates are often very useful in planning counseling

interventions, community interventions, and other kinds of social work strategies. But for psychodynamic psychotherapy we need to study another set of questions that pertain to:

- 1) the difference between identity and identifications
- 2) the encoding of personal conflicts in cultural conflicts
- 3) the encoding of cultural conflicts in personal conflicts
- 4) the internalization of cultural difference
- 5) the role of language in the construction of subjectivities
- 6) the management of transference and countertransference reactions that get encoded in social terms
- 7) the sensitive handling of the intersection between family values and psychotherapy values
- 8) the vicissitudes of emigration
- 9) the differential encoding of experience along linguistic lines in bilingual and polyglot patients
- 10) the vicissitudes of identity formation in transracial adoptees, biracial or multiracial persons, emigrants, biracial couples, etc.

Other equally rich avenues of exploration are the ways in which the power associated with minority status is lost when one rises up in class structure. How do education and wealth and the position of the therapist leave the ethnic minority psychotherapist still a victim of racism and yet regarded with suspicion for having become "white?" How does the ethnic minority therapist's guilt associated with oedipal victory get displaced into the guilt of financial and professional success in society? and how is this guilt surcharged by social ostracism for doing well? How is it that Freud's psychology, born in the mind of a Jew in the virulently anti-semitic Vienna, has come to be seen as an American white middle-class bourgeoisie treatment aimed at maintaining the status quo? Why is Freud, who wrote *Totem and Taboo*, *The Future of an Illusion*, *Civilization and Its Discontents*, and *Group Psychology and the Analysis of the Ego*, commonly said to have ignored culture?

When I was Director of Training at La Familia Counseling Service (1993-1996) we did not talk about Latinos by giving a list of stereotyped characteristics to describe such an extraordinarily large group of people. No, we taught the basic psychodynamic principles of psychotherapy and examined in supervision and case conferences the issues raised by immigration, religion, language, and the internal representations of culture. From this vantage point we became curious about the vicissitudes of the transference in a mixed race therapeutic dyad, wondered about the intrapsychic and interpersonal power dynamics generated by shifts in social status as a function of immigration, and became mindful of the equally turbulent countertransference reactions.

Being multiculturally sensitive means never taking words at face value but rather unpacking them to understand their meaning for the individual. This basic psychodynamic principle has particular significance for bilingual patients in therapy with a therapist conducting the therapy in the patient's second language. These issues have been addressed in a number of fascinating articles by Buxbaum (1949), Greenson (1950),

Marcos & Alpert (1976), Marcos, Eisma & Guimon (1977), Perez-Foster (1992) Jacqueline Amati-Mehler, Simona Argentieri, and Jorge Canestri (1993) just to name a few. Other interesting issues pertain to the patient's view of the therapist's role which may be as priest, mystic healer, pill dispenser, confidant, or what have you. It is important to understand the context in which the patient is coming to see the therapist, to clarify for the patient what it is the therapist really offers and refer the patient out if necessary. Furthermore, while some patients will definitely benefit from a psychodynamic psychotherapy, others, particularly those in crisis, may benefit, more immediately, from a reabsorption into the values, customs, and community of their primary cultural identification.

Psychodynamic work with African Americans has been eloquently addressed by Andy Curry (1964), Kimberlyn Leary (1995), Carmen Gloria Da Conceicao Dias and Wilson De Lyra Chebabi (1987), Enrico Jones (1982), and Dorothy Evans Holmes (1992). Anti-semitism has been addressed by Ernst Simmel (1946), Bernhard Berliner (1946) and Michael Vannoy Adams and Jay Sherry (1991). Emigration has been addressed by Leon Grinberg and Rebeca Grinberg (1989) and by Daniel Lieberfeld and Judith Sanders (1994 or 1995). Acculturation has been addressed by Ricardo Ainslie (1994). These are obviously not exhaustive lists. Furthermore in recent years entire journals have emerged that are devoted or receptive to articles on the psychology of cultural issues in psychodynamic psychotherapy. These include *Mind and Human Interaction: An International and Interdisciplinary Journal* published by the Center for the Study of Mind and Human Interaction at the University of Virginia and the *Journal for the Psychoanalysis of Culture and Society*.

In my current work as Director of Training at the Nevitt Sanford Community Service and Research Initiative we are following in the tradition of Nevitt Sanford by applying psychological insight to social action. In the first year of our collaborative work with Youth and Family Services in Solano County, California we have sent three pre-doctoral students into the Solano County Jail to provide counseling and psychotherapy to incarcerated men and women. During this year the students have had to confront clinical challenges to confidentiality, the frame of therapy, and the multiple psychological entanglements of race, class, legal status, and education level as they get configured in the psychotherapeutic relationship. We have mused on the relationship between a holding environment and a holding cell. We have considered the limitations of the clinical context. We have appreciated the ways in which many correctional officers, often with completely different world views, have in fact been very supportive, collaborative, and made our work possible. We have recognized the ways in which the jail environment has been supportive and functioned as an organizing force for some inmates and been psychologically crushing for others. We have lamented and been challenged by some of the working conditions such as conducting therapy in a glass walled room in full view of jail guards, not to mention the video camera in the corner! And it became commonplace to conduct therapy at a table in a very public room. One therapist lamented the frustration of doing therapy in a hallway while a group of inmates filed by and one fell to the ground in front of the therapist and patient in an epileptic seizure. We have been dismayed at the extraordinary number of inmates from ethnic minorities and lower socio-economic strata

for whom incarceration has become a normative part of the life cycle. How have these inmates internalized the oppression of the culture and been recruited to do its bidding by engaging in self-destructive behavior and self-sabotage? How have the conflicts of the cultural surround been internalized as psychic structure?

Multicultural sensitivity means recognizing that culture is not a set of "stereotyped variables" that exist "out there" in "those types of people" but a set of internal representations of relationships and experiences. Thus, the therapist is always interested in learning about the conflicts and alliances between internal representations in the person's introjected culture. This view of multicultural sensitivity carried to its natural conclusion leads us to recognize that the therapist must remain multiculturally sensitive with anyone, regardless of his/her cultural background - even if the therapist and patient share the same ethnic, cultural, and racial background. Intrapsychic conflicts are often clothed in the vestments of sexual, religious, political, racial, and cultural conflicts. Thus, it is important to remember that the relationship between intrapsychic and cultural conflicts is always dialectical.

Recognizing that the salient features of a person's culture are his/her introjected experiences of that culture, we can begin to see the insidiousness of prejudice in society when it re-emerges as self hate - as in the misogynist woman, the anti-semitic Jew or any other self oppressing member of a racial or ethnic minority. In these situations the oppressor and the oppressed, out there in the world, are internalized where the race war continues intrapsychically and one's subjectivity may change masks from one to the other from moment to moment. Thus our multicultural world gives rise to a multicultural psyche where cultural and personal conflicts merge, wage war on the battlefield of the mind and negotiate resolutions through intrapsychic diplomacy. When psychodynamic psychotherapy provides us, for example, with an opportunity to renegotiate intrapsychic racial tensions, it frees us to see other people more clearly, and in doing so enables us to more effectively attend to the political, social, and interpersonal conflicts of the day. An analytic psychotherapy does not end in self absorption but rather in object relatedness and a vital engagement with the community and the world.

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