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From the Other Side: Countertransference in Spanish-Speaking Dyads

Rebeca Chamorro

In her work on psychoanalysis with bilingual patients, Perez-Foster draws attention to the process of doing therapy in both English and Spanish. She describes patients' access to early object-relations and powerful shifts in the transference as a result of language choice, specifically the greater possibility for transference enactments which might not otherwise occur or take longer in the secondary language. While she states that both patient and analyst are changed by this particular medium—i.e., use of the primary language—more focus is placed on the patient and less is mentioned about the subjective or countertransferential experience of the analyst.

This paper will focus on the tensions and choices presented to the therapist as a result of the Spanish-speaking therapeutic coupling. Specifically, issues regarding the debate on the therapist's self-disclosure, both inherent and at other times purposeful, will be illustrated. Thereafter, I will share the personal dimensions of doing this work and its interface with cultural dilemmas. Finally, the paper concludes with a clinical example that highlights the fluidity of word meanings and potential for and use of countertransferential enactments.

TO REVEAL OR NOT TO REVEAL: IS THIS REALLY THE QUESTION?

Psychodynamic psychotherapy, as practiced by native Spanish-speakers in the United States, provides a particular platform for treatment. Mainstream US culture homogenizes Spanish-speaking peoples into one ethnic group: "Latinos." Yet such a group involves dozens of different countries, each with particular socio-political histories and unique versions of the Spanish language. In the consultation room, distinct nationalities, boundaries and regions are communicated, as dialects, accents and intonations can "give away"—or, at least, provide

clues—to the therapist's and patient's origins. Other stimuli, such as the treater's race and gender are also immediately available without so much as a verbal exchange, as are approximations to class and age. As described by Aron, "Self revelation is not an option; it is an inevitability" (40). Some of these accents are more distinct to country of origin, as in Argentina or Spain; other accents are associated to regions such as Central America or the Caribbean. Regardless, the Spanish-speaking patient will often ask the therapist: "¿y de donde es usted? (and where are you from?)." The question is a query but also a statement that both patient and therapist are foreigners and, as such, upon meeting, the dictate is to specify origin.

This, however, butts heads with another set of cultural norms, those of psychodynamic theory and technique, in which ideally the therapist is the receptacle of fantasy and projection and becomes the vehicle for understanding transferential enactments. Personal questions asked by the patient, or what Ghent calls "object probing," create a choice for the therapist between a position of mutuality/to disclose, or asymmetry/to not disclose (Burke). To disclose or not to disclose is an age-old question that still is debated today. Freud cautioned against self-revelation, for he felt it would inhibit the patient's free associations. The alternate view by Ferenczi is that anonymity is a myth, since everything the analyst does is revealing (cited in Greenberg). As with any fork in the road, to make or not to make a disclosure is determined by many factors and will inevitably have an effect on the process. As described by Greenberg, there is no "one-size fits all technical prescription" (197). To assume so would be to assume what Burke calls a "predesigned strategy formulated outside of the clinical moment" (264).

The debate on mutuality and asymmetry is a complex one that is made all the more so when superim-

posed onto Spanish-speaking dyads. I believe that a degree of mutuality is not “chosen” but is inherent, as mentioned above, when accents can reveal geographic origins. Also moving the dyad in the direction of mutuality is the fact that the patient and therapist are co-participants in a treatment using a language that is not reflective of the mainstream. As a result many subvocal messages are conveyed. Among these, the patient may assume that the therapist is an immigrant, or has a migratory past—i.e., is also far from “home.” If this is a primary language for both, then patient and therapist are speaking in a pre-Oedipal tongue, which is the language of intimacy and attachment. Also relevant to the therapeutic context is the fact that in the United States Spanish is not a valued language, despite its growing prevalence—it lacks the veneer and cache of French, which is perceived to be an “educated language.” Conducting a treatment in Spanish may be viewed as a collective identification with disempowerment. This may be the case for some patients, perhaps not all.

From a theoretical and technical standpoint a position of asymmetry discourages direct disclosure. Thus, the therapist remains in a position of observation with the focus of inquiry on the patient. As a Spanish-speaking therapist with a predominantly Castilian accent, anonymity and the choice for disclosure is rhetorical, for patients can recognize my origin immediately and not have to ask. For those patients who do ask—“and where are you from?”—the question seems to reflect polite etiquette rather than true disorientation. When I ask patients for their possible speculations about my origin, they evince little uncertainty about my being from Spain. Given that my work as a therapist has been with Latin-American patients, what does the knowledge of my origin, once confirmed, set up in the treatment? To answer this question the focus must shift from the patient to the relationship (Burke).

Slochower cautions that there might be an idealization of mutuality in contemporary theory and that movement toward mutuality should only occur when the patient has attained “object usage,” i.e. can tolerate difference; otherwise some patients can find it quite upsetting to know something about their treater. However, questions about the therapist’s origins arise early in the treatment of Spanish-speaking patients and prior to attaining true object usage. I do agree with

Slochower that such knowledge may prove premature, even burdensome, for it sets up a reality of difference. Indeed, I have found that patients will respond in quite predetermined ways to diminish this sense of difference, for example, by looking to their ancestry so as to create a link to me. They will say: “my great-grandmother was from Barcelona,” or “I still have relatives that live in Spain.”

I must also add that such a phenomenon happens with my English-speaking patients when the same question is asked, not because of an accent on my part, but because my name highlights a potential difference. After the fantasies are explored the most persistent patients will still press on for the answer to “so, what kind of name is Chamorro?” Here too, with the answer provided, the patient will make incredible efforts to find a link: a very fair, blond, blue-eyed patient of Irish-American heritage said “oh, you wouldn’t believe this by looking at me, but there’s black Irish in my family and my siblings have your coloring.” Another patient, of Italian descent and in treatment to deal with her divorce, responded to my heritage by saying: “oh, that makes you Spanish-American, you’re a mix, like me—Italian-American,” and she chose not to link me to her estranged Mexican-American husband. It seems that at the onset of treatment the eagerness to be understood and bridge the gap of alienation can propel patients to vigorously locate identifications with their therapist.

THE PERSONAL DIMENSION OF DOING THIS WORK

The relationship of the Americas with Spain has historically been interconnected and, at times, has been painful. Upon knowing this part of my lineage, or hearing my Castilian accent, Spanish-speaking patients will often smile and say “Ah, la madre-patria” (Oh, the mother-country) and adopt a subservient and pleasing style, cautious and respectful: a transference to authority. At times I find myself quite uncomfortable with the deference on the part of such patients and notice subtle alterations in my Castilian. I begin to create sounds that are more rhythmic, melodic, softer, Caribbean in nature, which—unbeknownst to my patients—are also a part of my heritage, as my mother is Dominican and my father Spanish.

My conscious intention at these moments is to

create a link to such patients in hopes of reducing their genuflection. Unconsciously the countertransferential motivations are many and probably include: my own discomfort with being treated transferentially in a way that is alien to my self-experience (Adler and Bachant); alternatively, a possible discomfort with any unconscious authoritarian ambitions I may have; a wish to deny difference borne out of compensatory guilt (Comas-Díaz and Jacobson) for a challenging historical past between Spain and the Americas; and, related, what Holmes describes as a countertransferential reaction formation which serves to quiet the patient's affective expressions of rage.

I have worked hard to become more cognizant of the inclination to adjust my accent, especially since I can appreciate the developmental and psychological need to express and examine the anger and repudiation felt in reaction to authority. Such work is often done transferentially by the patient with the doctor/therapist but can also be done in response to other cultural symbols such as the "madre-patria." In fact, associations to the "madre-patria" can be a useful means of discussing areas of conflict with the original authorities in the patients' lives—their parents. In this way, cultural metaphors can become a means of encoding and discussing personal conflicts. This is especially helpful with Latino patients who have often been socialized to respect authority and not question its conclusions. To ask such patients to do so head-on in treatment will likely be met with resistance. Thus, listening for indirect means of defiance is important.

On a more personal level, my movement and adjustment of accents reminds me of when I was younger and used this tactic to show loyalty at different points in time to ingratiate myself with one parent over the other. Nonetheless, the amalgamation of the Dominican and Castilian is a truer representation of my background, part of the "Hyphenated Identity" described by Salman Akhtar. In fact, many Latinos are often a blend of different races, regions, and religions such that there really is no simple answer to the question: "and where are you from?"

CLINICAL CASE

Just as accents are fluid constructions, so, too, the choice of words and their meanings are relative to con-

text (Rendon). To illustrate this concept I will present a clinical example. I once worked with a woman from Argentina. We conducted the therapy in Spanish, but particular words have different meanings in her lexicon. In Spain, and other Spanish speaking countries, the word "coger" means to seize/catch. In Argentina, however, the word "coger" means to seize/catch but with a sexual connotation: literally, "to fuck." During a particular point in the treatment the patient was working through memories of sexual abuse and was searching for the image of her faceless perpetrator. She was about to return to Argentina after a four-year exile in the United States. She would often shake with fear that she would soon see her physically abusive brother. This brother was once part of a subversive political movement in Argentina, and he made the patient the recipient of his war games as he would play with guns and lock her in the closet.

Her biggest fear at returning home was that she would find herself alone with her brother and he would begin his unrelenting political tirades at her expense. I said to her: "you are afraid he will catch you alone without escape or reprieve" ("tienes miedo de que te *coga* sola sin escape ni alivio"). Thereafter my patient's flashbacks to her rape and sodomy accelerated in frequency as did her fear of her brother. Only weeks later was I able to realize that my use of the verb "coger" may have been heard in a sexual context and potentially triggered her associations. I have always known that "coger" is a sexual term in Argentina, but when I spoke it in the session I did so unawares—at least consciously. My rationalization for this lapse is that it can be tedious to remember when to switch terms depending on which Spanish-speaking patient is in the room. Unconsciously I think I wondered all along if her uncontained brother was her sexual as well as her physical perpetrator—a question I then "forced" upon my patient. As described by Renik "awareness of countertransference is always retrospective, preceded by countertransference enactment" (556). I would also add that certain countertransference enactments that might otherwise remain concealed in the secondary language are revealed in the primary language.

My countertransference, inadvertently posed to my patient, caused her pain and repulsion; it also stimulated her curiosity, anger and self-investigation

(Renik). I, too, was in pain and wondered about my motivations: had I been protective, aggressive or both? Through supervision I realized that my eagerness to keep the patient out of harm's way and to define the faceless perpetrator probably led to my linguistic leak. Also, in a couple of months I was to leave the practicum site where I saw the patient to take up my internship on the East Coast. My guilt about this departure and the premature ending that I was imposing on our work together led to an unsavory identification with others who had hurt this patient in the past. A fruitful component of our remaining sessions, however, was the patient's exploration of feeling left in a vulnerable state and how to access protective supports: both in terms of her visit home as well as in terms of her ongoing treatment plans. As stated by Ehrenberg: "The question at hand, therefore, is not what response is 'right' or 'wrong' but how to use whatever occurs to greatest analytic advantage" (226).

CONCLUSION

As clinicians our work involves asking and deciphering *where the patient is from*. When this question is posed to us, it feels like an odd reversal and calls upon us to examine our purpose, motivations, exclusionary defenses and blind spots. Yes, Spanish-speaking patients will be curious about the treater's geographic origin, but beyond this they are trying to locate us on their relational map as a means of understanding the "other" as well as expressing merger fantasies of being understood by the "other." The patient will ask "and where are you from?" as a means of preparing for the next question, "and where are we going?"

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