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Technical Challenges Faced by the Immigrant Psychoanalyst

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This paper delineates the technical challenges faced by immigrant analysts. These include (i) maintaining cultural neutrality toward "native" patients, (ii) wondering about the patient's motivations for choosing an ethnoculturally different analyst, (iii) scanning the patient's associations for interethnic clues to deeper transferences, (iv) negotiating the dilemmas posed by conducting analysis in a language other than one's mother tongue, and (v) avoiding shared projections, acculturation gaps, and nostalgic collusion in working with homoethnic immigrant analysands. While by no means irrelevant to the clinical work of non-immigrant analysts, these tasks seem to have a greater importance for the immigrant analyst. Brief clinical vignettes are offered to illustrate these propositions and to highlight the tension between the universality of fundamental intrapsychic and relational configurations, on the one hand, and the nuances of cultural and linguistic context, on the other.

> *An analyst living in his own country is less threatened by foreign values than an analyst working in a foreign country where he is deprived of the support of people who share his culture.*
>
> *Ticho 1971, p. 323*

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The founder of psychoanalysis was an immigrant. Born in Freiberg, Sigmund Freud moved at the age of three to Leipzig, and about a year and half later to Vienna. These childhood migrations were not devoid of psychic impact. Freud

“never forgot the forests around Freiberg”; and his “vocal, often reiterated detestation of Vienna” (Gay 1988, pp. 9-10) reflected not only the hardship, solitude, and anti-Semitism he faced there, but perhaps also the fact that Vienna was not Freiberg.

Despite such feelings, when Freud left Vienna for London at age eighty-two, the move was not entirely without pain. In a letter to Max Eitingon in June 1938, he noted that “the feeling of triumph at liberation is mingled too strongly with mourning, for one had still very much loved the prison from which one has been released” (Gay 1988, p. 9). Freud's experiences of migration, however, occurred near the beginning and end of his life, and hardly affected his work as an analyst. The inner world of an immigrant analyst, therefore, did not capture his attention.

However, it is striking that few among the European analysts who fled to the United States and Latin America in the wake of the Second World War wrote about their experiences as immigrant analysts. Perhaps this omission was due to the reluctance of mainstream psychoanalysis to deal with sociological, historical, and cultural factors in adult life, in favor of an exclusive focus upon the intrapsychic residues of early childhood.[1] Perhaps the great excitement these early analysts felt about their nascent discipline also led them to underestimate the cultural hurdles in its universal applicability. The fact that these European analysts were not actually immigrants, but exiles (see Akhtar 1999a for a discussion of the distinctions between the two), might also have contributed to their silence

[1] *Note the skepticism with which early post-Freudian forays into sociocultural realms —such as, e.g., Fromm 1950; Horney 1937; Roheim 1943—were received by the profession. Curiously, this attitude did not take into account the fact that Freud had a deep and abiding interest in the dialectical relationship between the workings of the individual psyche and the nature of social institutions. It was as if applied analysis and sociocultural extensions of theory and technique were deemed only the father's prerogative!*

on this issue. Wanting to forget their traumatic departures from their countries of origin, to deny cultural differences between themselves and their patients, and to become rapidly assimilated at a professional level, they had no desire to draw others' (and their own) attention to their ethnic and national origins. Hence, they wrote little about their experiences in practicing analysis as “foreigners.”

Today the climate is different. Psychoanalysis, especially in the United States, is undergoing a major cultural rejuvenation (Akhtar 1998; Roland 1996). The increase in the number of people migrating from one country to another has resulted in significant shifts in the demographic makeup of industrialized nations, especially the United States and England. Along with an increase in culturally diverse patient clientele, there is also an increase in the number of culturally diverse trainees in psychology, social work, psychiatry, and psychoanalysis. Contemporary theoretical pluralism in the field is yet another factor that makes it possible, even necessary, to openly discuss technical matters of specific concerns with the foreignborn, that is, with the "immigrant" analyst—including, of course, myself.[2]

I will address five such matters in this paper. These include the immigrant analyst's need to (i) maintain cultural neutrality visàvis his "native" patients, (ii) wonder about the patient's choice of him in particular as the analyst, (iii) scan the patient's associations for the interethnic clues to deeper transferences, (iv) negotiate the intrapsychic and interpersonal challenges of conducting analysis in a language other than his mother tongue, and, finally, (v) avoid shared projections, acculturation gaps, and nostalgic collusions when working with homoethnic immigrant analysands. Using abbreviated headings (for didactic ease) and brief clinical vignettes, I will attempt to illustrate these technical dilemmas

[2] *I was born, raised, and medically trained in India. After finishing a psychiatric residency there, I arrived in this country in 1973 and repeated my psychiatric training in Newark, NJ, and Charlottesville, VA. I moved to Philadelphia in 1979 and completed my psychoanalytic training there.*

while underscoring the overlap that such challenges have with those faced by nonimmigrant analysts.[3]

Cultural Neutrality

An immigrant analyst is burdened by the task of maintaining cultural neutrality (Akhtar 1999b) in remaining equidistant from the customary patterns of thought and moral dictates of his own culture and those of the native patient's culture. While such tension also exists in the native analyst-native patient dyad, given that any two individuals can have different moral compasses, its magnitude is potentially greater in the immigrant analyst-native analysand

dyad. This is especially true if the analyst has migrated as an adult (i.e., after stable psychic structuralization) and comes from a country that has pronounced cultural differences with his country of adoption. Thus, an analyst born and raised in Japan or Pakistan who practiced analysis in North America would face greater challenges in this regard than one born and raised in England or France. According to Gedo and Gehrie (1993):

> *The deck is stacked against an analyst's treating someone from an entirely different cultural background with no knowledge of that background. An analyst relies heavily on shared cultural meanings in any analysis, as in any sort of intimate communication. Possibilities for misunderstanding are so broad as to be endless and not correctable solely by reliance on empathy. [pp. 5-6]*

Gedo and Gehrie cite the example of Mahler, who, as a fresh Hungarian Jewish immigrant, experienced considerable difficulty in understanding the cultural context of an upperclass American

[3] *To be sure, immigrant analysts may have to struggle with matters beyond those of technique. For example, they might also experience specific difficulties during their training (in both didactic courses and supervision), and, later on, problems with assimilation and progress in their local and regional psychoanalytic organizations.*

woman analysand. Ticho (1971), a Viennese immigrant analyst practicing (then) in Latin America, described her disbelief that one of her male analysands had been frequenting a brothel and did not feel the necessity to mention it for years in his analysis with her. Ticho also mentioned a South American analyst who “took his patients' tardiness so much for granted, [that] he was somewhat surprised when he started to work in North America that his patients reacted quite strongly to his own lack of punctuality” (p. 317).

Being human and coming from a particular racial, religious, linguistic, and political group, the immigrant analyst undeniably has a cultural dimension to his or her personality, and this is indeed normal and healthy. What one hopes is that internalization of group legacies and repudiated instinctual residues in the analyst's character are not so aggressively charged as to form the substrate of prejudice (or, at least, that they no longer remain so following a personal analysis). That, combined with the mourning-liberation process (Pollock 1961) of immigration and the third individuation (Akhtar 1995) consequent upon it,

should lead to a peaceful coexistence of ethnic facets of identity and heterocultural acceptance within the analyst's character. Studying of the material regarding the interface of social anthropology with clinical work, and leading an open, cosmopolitan life, will also help him avoid excessive culturalization of his analytic ego.

The Patient'S Choice of an Immigrant Analyst

The immigrant analyst needs to be curious about the patient's choice of him as the analyst with whom to undergo treatment. However, asking direct questions in this regard is hardly ever helpful. It can drive significant material (if it does exist) away from consciousness and behind socially appropriate ego defenses. Also, this gentle skepticism regarding the patient's choice should be tempered by the recognition that, at times, such choices have

no “deep” significance at all.[4] At other times, a seemingly mundane, early reference to ethnic matters might be the first hint of major transferences lying in wait.

Case 1

A 40-year-old internist sought consultation with me for phobic anxieties. He came from a suburb and was unfamiliar with downtown Philadelphia. In his first session with me, he said that he was not favorably impressed by the city, and added with a snicker that “too many Vietnamese and Cambodian vendors seem to have moved in here.” When I noted the potential allusion in this remark to me, the patient quickly denied any ethnic anxieties regarding our working together.[5]

Once the patient was well settled in analysis, however, he began to display considerable prejudice against Asians. He regarded Indians as especially incompetent. Still later, he sheepishly revealed that he had deliberately sought an analyst who would be incompetent so that he would not be hurt too much in undergoing analysis. In other words, my expected incompetence would save him from coming to terms with his shame-laden aspects. Projection of his own feelings of being weak and incompetent vis-à-vis his older brother and father were gradually discerned, as were hidden masochistic desires to be mistreated.

While in the beginning, a patiently curious attitude on the part of the analyst is ideal, the demands made by some patients call for limit setting from the outset. Only then can an investigative collaboration be set in motion.

[4] *Only about a third of my patients have revealed significant conscious or unconscious motivations involving my immigrant status in their choice of me as their analyst. Moreover, there are immigrant analysts who are not recognized as such by patients: Canadian, British, Irish, and many European analysts practicing in the United States, for instance, are invisible immigrants (Shanfield 1994) owing to their skin color and their cultural and linguistic proximity to North American culture and language.*

[5] *This was too many years ago, in the sense that my manner of asking then was perhaps too direct, and might have contributed to his defensive withdrawal.*

Case 2

A young Jewish internist, whose father was a Holocaust survivor, called me seeking psychoanalysis. She was well-informed about analysis and had been given my name by an elderly Jewish analyst. While setting an appointment on the phone, she asked me: “Are you an Arab?” I responded by saying that, while I was interested in her question and what lay behind it, I could not answer it on a factual basis. I added that if we were going to undertake any kind of in-depth work together, my real-life situation was less important than what she made of it in her mind. The patient, however, persisted, saying, “Look, I am a devout Jew and an ardent Zionist. I know that if you are an Arab, your sympathies in the Israeli-Palestinian conflict will lie with the Palestinians. And I am not about to give my money to someone who will support terrorism against my own people.”

I was taken aback by this sadomasochistic proclivity under a thin patina of ethnic rationalization. I responded by repeating what I had said, adding that if she found herself willing to tolerate ambiguity and investigate what had already begun to take place, then perhaps we could meet. Otherwise, she might have to go elsewhere. She came for her appointment and entered analysis with me.

In the subsequent six years or so, the patient, who turned out to be neither a devout Jew nor an ardent Zionist, underwent a rather stormy analysis.[6] Provocative limit testing and recall through enactment pervaded the early

phase. Three themes took center stage, in succession, though also intertwined with each other: (1) the Holocaust and her contradictory identifications with her father's survivor guilt (Niederland 1968) and his persecutor's sadism, (2) separation guilt (Modell 1984) involving a depressed mother, and (3) a negative oedipal defense against guiltridden, positive oedipal strivings. These shifts, interestingly, were

[6] *In fact, it was toward the end of her analysis that the patient began to be comfortable with her ethnic identity. For the first time in years, she went to a synagogue, and, during the services, found herself thanking me in her heart!*

associated with changing perceptions of my ethnicity: first, as an Arab (equated in her mind with a Nazi), then as an Indian Muslim (equated in her mind with a Jew, since both represented minorities), and, finally, as a reasonably assimilated, immigrant North American.

The foregoing vignettes illustrate the admixture of defensive and fantasy-based motivations for seeking a culturally different, immigrant analyst. Unconscious hope of finding an important lost object of childhood can also underlie such choice. In my practice, a deep and unmourned attachment to a Chinese housekeeper or a black nanny of formative years has often fueled the patient's choice of analyst. A partial “reunion” with the lost object seems necessary for such individuals to work through the complex feelings attached to the early caretaker, who had often abruptly and prematurely left them.

Patients' Associations to Ethnocultural Differences

Shifting transferences such as those described above, and their corresponding ethnic metaphors, warrant that the analyst constantly scan the associative material for disguised and displaced references to his own ethnicity or race (Abbasi 1997; Holmes 1992; Leary 1995).[7] If the analyst comes from a country or region known to be culturally quite different, and especially if the analyst's skin color is different from the patient's, then he is certainly “more than just a blank screen, and his ... color will pull forth a rich variety

[7] *In a paper striking for its clarity and comprehensiveness, Abbasi (1997), an immigrant Pakistani Muslim analyst, describes her treatment of an immigrant Jewish patient, offering details not only of the transference-countertransference*

material, but also of the analyst's own concurrent analysis, as well as the manner in which this material was handled in her clinical supervision. Sripada (1999), a Hindu psychoanalyst of Indian origin, has also written meaningfully about his experience in cross-cultural supervision during his candidate years.

of projections and stereotypes" (Tang and Gardner 1999, p. 8; see also Ticho 1971). Holmes (1992) notes that such "points of access to a patient's transferences" (p. 8) give rise to rich associations that need to be carefully deciphered. However, this activity should not occur at the cost of sacrificing interest in other meanings of the patient's material. It should be remembered that a seemingly ethnic allusion in the patient's associations can serve as a defense against the emergence of deeper transference configurations.

Case 3

A middle-aged, Jewish exile from Poland was in analysis with an Iranian Muslim, immigrant woman analyst. The patient's family of origin had been devastated by the Holocaust, and his reparative strivings toward his parents were great. He especially ached for the humiliation and suffering of his father during the antiSemitic atrocities perpetrated by the Nazis.

One day, during the third year of his analysis, his analyst announced that she was going to take the following Monday off, thus extending the weekend to a three-day break. The patient responded by saying, "I know why you are taking the day off. It is the holy month of Ramadan and perhaps some important day of prayer coming up." While this was plausible (since it indeed was the month of Ramadan), the analyst felt skeptical about the readiness with which the patient came up with an instinctually "clean" rationale for her day off. There was a defensive quality about it. So she commented, "It's interesting that you thought of a reason that is relatively sanitized, hence excusable." The patient felt uncomfortable in response to this intervention, but could not put his finger on the source of his unease.

In the next session, the patient reported a dream. He was lying on a table and an older man, who was holding a pin in his hand, was about to prick him in the inner side of his thigh. He woke up feeling anxious and puzzled. Associations to the dream revealed that the older man with the pin stood for his tailor father

(who often used pins in his daily trade), and the close proximity of "pin" to "prick" betrayed his dread (and, underneath that, his wish) of being penetrated

by his father's penis. As this material surfaced, the patient's discomfort at the analyst's previous day's intervention came up for consideration. Now it appeared that, when the analyst had questioned the readiness with which he had come up with a relatively sterile reason for her absence, the patient had a passing thought that she was taking time off to spend a long weekend with her husband. Perhaps she would make love with him. This material got repressed but reappeared in the dream, where the patient replaced the female analyst with the idea of being penetrated by an older man (her husband/his father) and also *became* her, as it were, to deny their separation and the anxious fantasies associated with it.

Attention to such overtly ethnic clues to deeper transferences should not make the analyst overlook the fact that not every utterance the patient makes about people of the analyst's ethnicity and race is transferentially significant. A robust tension between skepticism and credulousness must be maintained.

The Analyst's Bilingualism

The burgeoning literature on bilingual psychoanalysis (Akhtar 1995, 1999b; Amati-Mehler, Argentieri, and Canestri 1993; Buxbaum 1949; Foster 1993, 1996; Greenson 1950; Grinberg and Grinberg 1989; Karpf 1955) suggests that words with the same denotative meanings in two languages are often capable of stirring up different associations and affects. Grinberg and Grinberg (1989), for instance, report an Austrian patient who would say, “In German, the word ‘;urinal’ smells of urine” (p. 110). It has also been noted that memories recalled in the actual language of an experience are more affectively charged and vivid than if they are recalled in a different language (Javier and Munoz 1993). Moreover, a bilingual individual's self-expression in his “primary” or first language tends to internally “shift the specific aspect of the self that is speaking and the object ... that is being

spoken to” (Foster 1996, p. 248). All this, combined with Ferenczi's (1911) early observation that obscene words in one's mother tongue carry a much greater affect and drive discharge potential (hence, greater superego admonition) than those in a later acquired language, renders bilingual analyses especially tricky for both analysand and analyst.

However, the literature cited above focuses upon the patient's defensive and expressive play with more than one language. The bilingual analyst's own

language-related inner experience has remained unexplored in the literature. This is surprising, since an immigrant analyst often conducts treatment in a language other than his mother tongue, and this must, from time to time, impact his analytic capacities. For instance, early in his career, and especially if he lacks idiomatic fluency in the patient's language, the analyst might occasionally miss puns, double-entendres, metaphors, or allusions. While the golden rule is “when in doubt, ask,” one hopes that such a need would not arise too frequently, and that when it does, it would not be inappropriately inhibited.

The analyst's requests for clarification should not be restricted, however, to inquiries about unfamiliar words or phrases, but should extend to asking about an abrupt pause in the flow of the patient's speech. Occasionally, this can unmask unexpected anxieties regarding the analyst's ethnicity, and, behind them, deeper transference-based concerns, as illustrated by the following vignette.

Case 4

An attractive, midwestern, Catholic lawyer began an analysis with me to overcome her depressive proclivities and enhance her capacity for deeper heterosexual relationships. During a session in the third month of her analysis, she said: “You know, I used to get depressed on Sundays. I flt so lonely. But nowadays, I don't get depressed at all. In fact, if I feel the slightest feeling of gloom coming over me, I say to myself that I have ...,” and the

patient stopped abruptly in mid-sentence. After a moment's pause, she finished the sentence by saying “... you in my life.”

Noting the hesitation in her manner of speaking, I asked, “What made you pause abruptly? Did you change something in your mind in order to finish the sentence?” The patient then reported that she was about to say that “I say to myself that I have Dr. Akhtar in my life.” She explained that she had changed *Dr. Akhtar* to *you*, adding that saying it that way seemed more direct to her, and made us seem, in her mind, more closely related.

I responded, “Yes. I can see your point. Yet by changing what was coming to your mind and what you do really say to yourself, you might have created distance between us. I also wonder if there were other reasons leading to your switching the words.” The patient then revealed that she had felt anxiety in pronouncing my name in my presence. She feared that if she did not

pronounce it in the “correct” way, I would regard her as different from me, and this would make her feel distant, rejected, and sad. She also wanted to protect me from feeling like a foreigner by her bringing attention to my ethnic-sounding name. In essence, neither of us was to feel rejected by the other. Exploration along these lines led to unearthing of lifelong concerns over feeling unacceptable in her family of origin.

The mention of the immigrant analyst's ethnic-sounding name brings up the larger topic of his mother tongue. The occasional desire of the immigrant analyst to intervene in his mother tongue (when the patient would not understand it) usually has to be met with ego restraint and further grief work regarding the analyst's own feelings about having immigrated.[8] What is also needed at such moments is self-analytic inquiry into the specific transaction that triggered such a wish. In other words, the analyst must ask himself the following questions: What was in the patient communication that made me want to respond in my mother tongue? Did the patient's words or feelings touch something deeply personal

[8] *In a sad commentary upon the long-lasting effects of Western colonialism, analysts from third-world countries seem to experience a greater reluctance about speaking in their respective mother tongues.*

in me? What? And—in a return to a more objective stance—would it be useful to say the idea in my mother tongue and then translate it for the patient? Or should I just offer a translation? What is the advantage of the former? What would be lost by taking the latter route? Would speaking in my mother tongue traumatize the patient or impart genuineness to the relational matrix?

Case 5

My analysand, a young internist, was looking after an elderly, hospitalized man. Both of them were avid gardeners and often exchanged notes about their hobby with each other. In her analysis, the patient told me one day that the old man had given her some seeds that she was planning to plant in her backyard over the weekend. She was excited because the seeds were for a very rare type of flowering plant. Her choice of words such as *old man, backyard, seed*, and *flower* clearly constituted thinly veiled allusions to an oedipal transference fantasy. However, more important for the context, here is what happened the next day.

The patient began sobbing as soon as she entered my office. Her patient had died the previous night. She cried and asked, “What good are those seeds now? I can't tell him how they fared. Did the flowers come out or not? It's all useless now. I'm just going to throw the seeds away.” Listening to this, I was moved. The urge to say the following in Urdu came over me: *Sub kahan, khuch laala-o-gul mein numayan ho gayeen*. This line, from the doyen of Urdu poetry, Mirza Asad-ullah Khan Ghalib (1785-1869), is one of two constituting the couplet:

> *Sub kahan, khuch laala-o-gul mein numayan ho gayeen.*
>
> *Khaak mein kya sooraten hongi, jo pinhan ho gayeen.*
>
> *[Ghalib 1841]*

Roughly translated, these lines mean:

Not all, only a few of the buried ones emerge as flowers:

The earth's bosom hides so many faces, talents, and powers.[9]

[9] *Translation by the author.*

Given my cultural background of an ethnic and familiar tradition of offering rejoinders in the form of a single line of a famous poem, it was the perfect empathic remark to make.[10] It would have conveyed to the listener that I resonated with her pain, helplessness, and sense of loss. However, in the clinical situation, where the patient did not understand my mother tongue, I chose not to speak the words that had come spontaneously to my mind. I realized that uttering these words and then translating them would shift her attention from felt pain to intellectual effort; hearing me speak in a different language might disturb her.[11] A comment intended to be empathic with her mourning would have become just the opposite, a manic defense. So I did not say it. However, in not saying it, I tolerated my helpless feeling that she was not linguistically receptive to me—just as the elderly man was no longer available to her in reality. Like the patient, I also experienced a loss.

Case 6

At another time, however, I did speak in my mother tongue, Urdu, to another patient who, while multilingual, did not know that particular language. This

patient was an intelligent and successful woman in her thirties. Her parents had divorced when she was seven years old, though she had sensed her father's increasing remoteness for a year or two before that. Following the divorce, the patient felt “invisible” to her father, who paid much more attention

[10] *Upon hearing this vignette, a prominent New York analyst said that the idea of reciting poetry in a psychoanalytic session would appear pompous and exhibitionistic to him. The differences in the intellectual and aesthetic traditions that formed our childhoods and our psychostructural backgrounds might account for the difference in what, stylistically, is permissible within our psychoanalytic work egos.*

[11] *During a post-termination contact some five years later, I shared this dilemma with the patient; this time I did utter the words that had been in my mind in Urdu many years earlier. I asked her how she might have responded had I spoken to her in my mother tongue during that particular session. The patient, who had little memory of it, said that she would have been shocked. It was her sense that my decision not to speak to her in my mother tongue was most likely correct.*

to her older sister and brother. The theme of her “invisibility” came up frequently in her analysis and was found to be linked, at its base, to an early maternal depression and a pervasive maternal tendency to invalidate the patient's feelings. It was also related to her father's lack of interest, as well as her own defensive retreat from being “visible” to him, since that stirred up all kinds of longings and desires.

We worked this through, and the patient established a solid romantic partnership with a man. One day, she asked me the word for *daughter* in my mother tongue. I responded by saying that I was curious about what lay behind her question. Fantasies about my having a daughter emerged. The patient expressed curiosity about how I treated my daughter: better than her father treated her, or the same way? Work along these lines led to further oedipal transference material, as well as issues of sibling rivalry (her older sister had been the father's favorite).

However, when, in a similar session a few days later, the patient again asked me the Urdu word for *daughter*, I responded by saying, “I guess you want to hear the word *beti* from me not only to satisfy your intellectual curiosity, but also to see with what tone and feeling I utter it, and so that I can say it not only in front of you, but as if *to* you.”

The patient nodded and began sobbing. I knew that I could have made the same interpretation without the use of the Urdu word, but felt that the patient's hearing it would provide just the right amount of gratification to her against which further mourning of her father's inattention (and her anger about this) could take place. I am aware that some colleagues would argue that this gratification bypassed the analysis of her aggression. I do not agree with that view, as there were plenty of other occasions for her discharging and analyzing aggression, and because I believe that good analytic technique calls for optimal, rather than maximal, frustration in order for the patient to remain in an analyzable mode.

These examples of linguistic dilemmas of the immigrant analyst should not make one overlook the fact that similar dilemmas

are faced by non-immigrant analysts, too. Defensive alterations of language (e.g., from an instinctually charged word to a sanitized expression) happen in monolingual therapeutic dyads as well (Amati-Mehler, Argentieri, and Canestri 1993; Foster 1996).

Homoethnic Immigrant Analysands

A major, perhaps "final" step in the consolidation of an immigrant analyst's work-related identity is constituted by the analyst's treatment of immigrant patients, especially those of similar ethnic, cultural, and linguistic backgrounds to the analyst's own. This brings him face to face with new dilemmas and challenges. The potential for *shared ethnic scotoma* (Shapiro and Pinsker 1973), in which taboo topics remain unexplored, and/or aggression can be displaced onto ethnoculturally different "natives," is now increased. Other types of countertransference collusions can also occur

> *... especially when the therapist identifies closely with the patient's experiences. The therapist may be more tolerant and less confrontational about some instances of acting out. When this identification is strong, the therapist is often tempted to go the extra mile for the patient ... It is a temptation to reach out to such patients, in the sense of being somewhat more didactic and helpful about the process itself. [Tang and Gardner 1999, p. 16]*

Greater than ordinary vigilance might be needed to unmask and interpret *cultural rationalizations* (Akhtar 1999b, p. 122) of intrapsychic conflicts under such circumstances.

Case 7

A married, Indian Muslim law student "accidentally" became pregnant soon after beginning analysis. She felt quite upset about it, and, though she was certain that she did not want a child at this time, she said that she could not have an abortion. When I asked her about this, she retorted that I should know that abortion is prohibited in Islam. Now, having known her for some time, I

knew that she was hardly an observant Muslim. Indeed, she loved to drink, smoked cigarettes, and was defiant of other traditions from her culture of origin. As a result, I was surprised by her using a religious explanation for her hesitation to terminate an unwanted pregnancy.

Bringing this discrepancy to her attention helped the patient see that her reluctance to have an abortion was related to a deeper, personal conflict. On the one hand, having just entered law school, she did not want the burden of having a child; but on the other hand, she was terrified of the surgical intervention of abortion. Exploration of these issues and of the dynamics behind her having gotten pregnant at this time (e.g., filling herself up so that she would not feel orally and erotically needy in the transference) freed her ego to make a relatively remorse-free decision in favor of abortion.

Case 8

In the realm of language, too, new and interesting challenges for the analyst might appear, as exemplified by the case of a 50year-old, Hindu Indian woman, who had been raised by an instinctually repressed (and repressive) family in South Africa. She chose to speak mainly in English during her analysis. As early fears of criticism and rejection were interpretively softened, a devalued self-image emerged. While childhood experiences of prejudice due to skin color were emphasized at first, analysis gradually revealed profound rejection by her mother, a rejection centering upon her being female. Work along these lines relaxed the patient further, and she occasionally began to speak in Hindi, her mother tongue. During one such session, she very hesitantly revealed that she did not know the word for the female genital in Hindi, and felt that it would help her to acquire this knowledge. Issues of maternal transference (such as:

Could the analyst label her body parts for her? Could the analyst know and accept that she had female genitalia? Could the analyst accept "his" female genitalia?, and so on) were clearly evident, and I handled them in the customary analytic fashion.

However, in a later session, the patient quite earnestly asked me to tell her the Hindi word for female genitalia. Suddenly, I found myself experiencing a dual dilemma. One was purely technical—i.e., what would be the process-related pros and cons of telling her the word versus inquiring why she wanted to know it from me, and so on. The other dilemma that caught me by surprise involved my personal morality, as it were. Could I even utter the word in my mother tongue (given that spoken Hindi and Urdu have the same word for the female genital) in the presence of a woman? Experiencing the inhibition outlined nearly a century ago by Ferenczi (1911), I became for a moment tongue-tied.[12]

Then, working through my inner block and in the spirit of "developmental work" (Pine 1999) that includes occasionally providing patients with words for what is hard for them to express, I decided to tell her that it was called *choot*. I was aware of the potential transference gratifications in this intervention, but the subsequent flow of our work confirmed my hunch that letting her hear the word from me would facilitate and not impede our access to that material.

Case 9

In contrast to the situation mentioned immediately above, an analyst who has been an immigrant longer than the patient might have lost proficiency in their shared mother tongue. Listening to the richer vocabulary of the patient might stir up powerful inner affects (e.g., envy, shame) in the analyst. Kogan (1999), a Romanian immigrant analyst living in Israel, gives a poignant account of such a situation during the analysis of a Romanian woman who had recently arrived in Israel:

[12] *Recently, a young Iranian analytic candidate said to me: "I will die if I have to say the words for sex and genitals in Persian to a patient." I smiled and encouraged her to explore this issue further on her own, as well as in her analysis. I also reassured her that she was not alone in experiencing such anxieties, adding that even Freud lapsed into the Latin matrem nudam when describing in a letter to Fliess, at age forty-one, his childhood memory of having seen his mother naked (Masson 1985, p. 268).*

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> *Anna spoke to me in Romanian; her use of language seemed to me to be very elaborate and beautiful. Using my mother tongue ... had a strong emotional impact upon me. I felt excited and somewhat intimidated. My mastery of the Romanian language is relatively good, so I am often told. But relative to whom?, I now asked myself, listening to Anna. My intimidation stemmed from a very deep and personal experience, which echoed in me a world of purely private experiences.... Nothing was more distant from my professional occupation than the language of my childhood and adolescence. Was I able at all to do analysis in this language, so cut off from my professional career?*
>
> *Moreover, my simple, not very elaborated language put me in the position of a child, especially when confronted with the beautiful language of my "grown-up" patient. I began to wonder if this special situation, in which the therapist finds himself linguistically disadvantaged, with all its emotional implications, may not have a disruptive effect on the treatment. [pp. 3-4]*

In such analyses, patients' nostalgia is also hard to handle. This is because the lost objects, evoked in an idealized way, are from a culture that is shared by patient and analyst. On the one hand, this allows the analyst to have a finer and more intuitive empathy with the patient's experience. On the other hand, it also makes him vulnerable to a *nostalgic collusion*, in which the defensive functions of waxing eloquent about lost places and things are left unanalyzed (Akhtar 1995, 1999a, 1999b; Freedman 1956; Sterba 1934; Werman 1977). Tensions of this sort bring the immigrant analyst one step closer to native-born colleagues who are exposed to such technical challenges on a daily basis.

Case 10

Finally, in working with homoethnic immigrant analysands, the analyst must negotiate the *acculturation gap* (Prathikanti 1997) that at times exists between the two parties. This was highlighted for me in my work with the following patient.

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A Muslim Indian woman announced, during analysis, that she was seriously thinking of getting engaged and married to a man whom she had met only twice. One of these meetings was in the presence of their families, who

“arranged” the encounter. The other was exclusive, consisting of a lunch and a stroll in the park. She said that the next step should be engagement, followed by marriage.

My immediate reaction to this was to feel shocked. How could she think of marrying someone whom she had met just twice? Shouldn't she know him better? Shouldn't she have sex with him before thinking of getting married to him? However, I kept all this private and allowed myself time to think. Then it occurred to me that there was much difference in our value systems in this regard, and, at least in some ways, this difference was due to our contrasting migration histories. She had been in the United States for only two years, and I for nearly thirty years. Her ways were consonant with her original cultural background; they were conflict free. My response reflected my Westernization and my postmigration superego and ego changes. Recognizing this difference between us permitted me to resume a peaceful and unintrusive stance toward her.

Clearly, the immigrant analyst is faced with clinical pitfalls and technical challenges in working with both “native” and fellow immigrant patients. Work with each brings its own challenges, and yet, when all is said and done, it all boils down to conducting an analysis, no matter what the hues and colors of the dialogue might be.

Conclusion

The central message of this paper is two pronged. On the one hand, it delineates the specific technical challenges faced by immigrant analysts. On the other hand, it upholds the essential similarity of human beings across races and cultures and the applicability of the psychoanalytic method to all psychologically minded individuals, regardless of racial, ethnic, or religious background.

The analyst's personal analysis and mourning over immigration determines his capacity to work peacefully with individuals of diverse cultures. Continuing work on both these fronts—i.e., ongoing self-analysis and mourning—also matters a great deal.

The analyst's ability to maintain optimal distance (Akhtar 1992; Bouvet 1958; Escoll 1992; Mahler, Pine, and Bergman 1975) between his own hybrid identity and his native patient's monolithic one, and his homoethnic immigrant

patient's differently acculturated one, is critical. Ultimately, the analyst's deep conviction of the universality of fundamental psychic configurations and the ubiquity of human conflicts will help him hear and understand (both within himself and his patients) “voices that are not necessarily unified and not unifiable” (Amati-Mehler, Argentieri, and Canestri 1993, p. 283), while continuing his analytic work.

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