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THE GUIJIN THERAPIST AND THE NATURE OF THERAPEUTIC TRUTH: A RELATIONAL PERSPECTIVE

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ABSTRACT: The professional literature is replete with examples of the benefits of the client–clinician dyad being of the same ethnic group. Noted advantages include a perceived implicit understanding of the client's subjective experience and a furthering of the therapist's personal and professional growth as a result of the therapeutic interaction. This paper suggests that there are also benefits to the clinician being considered a *guijin* or "outsider" to the client's culture of origin. Utilizing a relational perspective with an emphasis on multiple self-state theory, this paper will discuss the advantages of being perceived as an outsider when working with an Asian bicultural client.

KEY WORDS: bicultural; cross-cultural; multiple self-states; relational theory.

INTRODUCTION

Whether you describe yourself as a clinical social worker, a psychotherapist, or a psychoanalyst, our therapeutic profession is a truth-seeking one. The nature of the truth we seek depends largely on our theoretical orientation and psychological makeup. In classical analysis,

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the therapist strives to discover the historical truth or seminal events that account for a patient's symptoms. In this one-person psychology model of treatment, the clinician functions as an archeologist by uncovering and reconstructing the patient's past. In order to accomplish this goal, the therapist analyzes the patient's defenses, which serve as selflies and which reflect the psychic need not to knowledge the truth.

By contrast, a therapist in the relational tradition prefers the narrative construction of the patient's subjective truth. Through the therapist's "empathic immersion" (Kohut, 1977, 1984) into the patient's world, the therapist attends to the patient's subjective truth. Intersubjectivity, a two-person psychology, grew predominantly out of the self psychology movement and elaborates Kohut's recognition that the patient's experience of the clinician is determined by both the patient's archaic interpersonal relationships and the clinician's actual reactions to the patient. As articulated by Stolorow, Brandshaft, and Atwood (1987, 1994), intersubjectivity involves the interplay between differently organized subjective worlds of the therapist and patient. Analytic neutrality becomes essentially impossible as both participants are interdependent and are changed in the therapeutic process. From this perspective, there is no absolute truth or reality, only interpretations of it created by each person according to his or her own unique system of internalized self and object representations which, in turn, are constructed out of a combination of actual events and unconscious fantasy.

Rather than reconstructions of the past, the therapist and patient construct a story such that what is created by the patient and between the patient and therapist is different from the actual events. This approach requires a "not knowing" (Anderson & Golishian, 1992) stance on the part of the therapist, one which stresses openness to the patient's stories. As we come to understand how patients construct their interpersonal and intrapsychic worlds, we simultaneously attend to how we create our constructions based on our own subjectivities. The therapist's narrative is viewed as another story, not the definitive one. As proposed by Spence (1982), narrative truth, the truth which patients and therapists create, accept, and remember, becomes the new reality and an integral part of the psychoanalytic process.

How does the narrative truth develop in the cross-cultural dyad particularly when the patient's own cultural narrative is a mosaic of contradictory experiences, values, and ancestral imperatives? While considerable work has been done to advance our understanding of the transference–countertransference matrix in cross-cultural treatment (Altman, 1993, 1995; Foster, 1992, 1996; Yi, 1995, 1998), there still persists a general belief that it is preferable for a patient to work with a clinician from the same cultural or racial background. Not sufficiently

addressed in the professional literature are the instances when it is beneficial to be a *guijin* therapist; that is, a clinician who is outside the client's culture of origin. Guijin is a common Japanese term used to describe a foreigner to one's culture, and it was a term my client employed to describe how she viewed me as her therapist, and at times how she viewed herself in relation to her family. The present paper addresses the advantages of being a guijin or outsider when working with patients who themselves feel like outsiders in their own country of origin. Relational theories of self development will be used to elucidate the richness and complexity of the narrative truth which emerges in such cross-cultural therapeutic dyads.

RELATIONAL PERSPECTIVES ON SELF-DEVELOPMENT

Defined broadly, the relational perspective is comprised of many of the major post-classical schools of analytic thought, including British object relations, self-psychology, interpersonal psychoanalysis, intersubjectivity, social constructivism, and multiplicity of self-state theory. Common to many of these latter postmodern viewpoints is the underlying assumption that there is no one objective reality but only perceptions of reality which reflect our own unique subjectivities. Theoretical developments, for instance, are not objective, but rather express the subjectivities of their respective authors (Stolorow & Atwood, 1979). In this way, knowledge can be viewed as a social construction. For the present purpose, consideration will be given to contemporary relational perspectives on the self, namely those of Mitchell (1993), Bromberg (1998), and Davies (1996). These viewpoints, I believe, can best explain the complexity of bicultural self-development and the multiple truths which emerge in the cross-cultural therapeutic interaction.

The postmodern view of the self is one which is decentered and disunified. Mitchell (1993) proposes that the relational notion of self maintains the dialectical tension between multiplicity and integrity, in this way allowing for a functional coherence, while also remaining open to contradictory experience and change. Observing that patients develop different versions of themselves in different relationships, as well as different versions of themselves in the same relationship under different circumstances, Mitchell suggests that a multiplicity of selves-in-relation can account for these various self perceptions and self constructions.

In essence, the relational self is a paradox consisting of contradictory realities which need to be balanced and prioritized but not necessarily integrated. Bromberg (1998) maintains that the healthy mind

possesses the capacity to bridge this paradox. Writing about the normative multiple self, Bromberg views mental health as the ability to stand in the spaces between these realties without losing sight of any of them. Put another way, the person has the ability to make room at any given moment for a subjective reality that is not easily contained by the self which is experienced as "me" at the moment. He further suggests that there are self-states which enact their experience because they are not cognitively experienced in the here-and-now of a given moment. Difficulties arise when such self-states are experienced as "not me" and are not congruent with other modes of defining the self.

In the normative multiplicity of self-states, healthy dissociation serves as the basis for such necessary functions as creativity, illusion, and playing. Healthy dissociation needs to be distinguished from defensive dissociation often found in dissociative identity disorder and other dissociative states. According to Bromberg, the difference lies in the severity of the paradox and the extent to which the self-states can bridge this paradox. Pizer (1996) offers an example from everyday life which illustrates this common phenomenon. When a child's feelings are hurt by someone, the child will turn to the mother for comfort, even when it is the mother herself who offended the child. In this way, the child is demonstrating a capacity to hold the maternal relationship in a paradoxical space, recognizing both conflict and interest within self and mother. If, however, the paradox becomes too great, such as when the mother repeatedly and brutally abuses her child, then defensive dissociation in employed.

Along with her colleague (Davies & Frawley, 1992, 1994), Davies (1996) has written extensively about this type of defensive dissociative process in her treatment of survivors of childhood sexual abuse. She posits that dissociative identity disorder common with this patient population reflects a fragmenting of self into multiple subselves without the ability to maintain a background awareness of multiple self-states and their dynamic interplay. When trauma is excessive, overstimulating, and intense, the capacity for self-reflection is extremely compromised in order to preserve selfhood and identity. Dissociative unlinking of self-states occurs, each with its own firm boundary between self and not self, resulting in a rigidified dissociative mental structure. Each self has an established pattern of interpersonal engagement and its own truth to tell.

Davies (1996) suggests that this quality of fragmenting dissociation is the antithesis of healthy multiplicity of self-states which allows for the simultaneous holding of alternative self-other configurations in the background. Under normal conditions, dissociation helps self-states to function optimally, not just defensively, when immersed in a given

reality. The "relational unconscious," according to Davies, is not one unconscious but many levels of consciousness and unconsciousness, "a multiply organized, associationally linked network of meaning attribution and understanding. Within such an interactive, dynamic system, past experience infuses the present, and present experience evokes state-dependent memories of fornative interactive representations" (1996, p. 562). She further elaborates that each representational system includes self and object representations along with a predominant affective tone, experience of a somatic body self, and mental sophistication of the internalized self-other configuration. This developmentally structured schemata becomes the lens through which new experience is viewed, organized, and ultimately integrated. New interpersonal experiences, such as the therapist-patient encounter and fresh insights into established maladaptive patterns, have the potential to alter the nature of the relational unconscious through which experience is interpreted.

Davies, along with Mitchell, Bromberg, and other proponents of relational psychoanalysis, asserts that the notion of an integrated internal world is a necessary illusion. When applying these relational theorists' views to a discussion of bicultural development and inculcation, one can appreciate the intensity of the internalized and irreconcilable aspects of self-other interaction that comprise the individual's self-experience. As an example, consider the case of Nancy.

CLINICAL VIGNETTE

Nancy, a vivacious and engaging young Asian woman in her early twenties, was referred to me following an attempted suicide. When first meeting her, I found it difficult to reconcile her heart-wrenching story with the attractive, nonchalant-mannered woman sitting in my office. With great detail, she described the circumstances surrounding her first and only suicide attempt several months earlier. Nancy had been attending a prominent Midwest university, but was expelled after two years for "partying too much." She did not inform her parents or her classmates about the dismissal. Instead, for two additional years she resided in off-campus housing and pretended to go to classes. Since her parents resided in Japan she found it surprisingly easy to lie to them; that is, until they arrived on the expected graduation date. Terrified of how they would react and unable to contain her deep-felt shame, Nancy impulsively ingested a partially filled bottle of non-prescription sleeping pills. When her proud parents arrived with flowers in hand, she nearly collapsed into her mother's arms.

In that instance, her incompatible and competing relational worlds collided. She could not tolerate the shame and disgrace she brought on her family by her indulgent and rebellious Westernized ways. Although her parents were unaware that she had an abortion while attending school, Nancy had difficulty

living with that memory, along with the others which would bring humiliation to the family name. Reared to respect and care for one's body and to conduct one's self in such a way that brings honor to the family, she believed that she brought the ultimate disgrace to the family name by failing, lying, and receiving an abortion. Her parents' presence served as a painful reminder of her dissociated self-state, the "failure." Prior to their arrival at the college, she assured herself that her self-indulgence was a well-deserved "vacation" from parental overprotection and expectation. Now the paradox was too great for her contradictory self-states to contain.

Although Nancy was born and spent her early childhood years in Japan, her family moved to New York when she was twelve years old. Her father accepted a lucrative position which necessitated frequent business trips, often back to Japan. As a result, the family maintained homes in Japan and in New York. Consistent with Japanese tradition, her mother assumed the bulk of the caretaking and other parenting responsibilities. Nancy perceived and internalized the contrary dimensions of her mother's parenting style. On the one hand, her mother was a warm, sensitive caregiver who anticipated and indulged many of her desires and needs, while on the other hand her mother was a stern disciplinarian who exerted excessive pressure on Nancy to succeed in school. Nancy was provided with many material possessions, all of which she viewed as anticipated rewards for academic success. She was purposefully spoiled materially but also expected to be diligent, obedient, and self-disciplined.

Nancy consciously sought out a bicultural lifestyle and unconsciously strove to develop an internal schema to provide coherence and meaning to the growing variety of seemingly contradictory experiences. Raised in the collectivistic culture of Japan, she readily adopted many of the individualistic values of the United States. Her parents shunned much of the Western emphasis on individualism, preferring instead to remain dependent on and close to family and kinship support. Interdependence was clearly valued over independence, and Nancy recognized the extent to which her mother's sense of self was fused with her own. Nancy's accomplishments became those of her mother and her failures were her mother's responsibility. Such interdependence reinforces a culturally-based mental schema of self and other as fundamentally interconnected to each other.

Nancy revered her father and respected his strong work ethic. When she ingested those pills, it was the image of disappointing her father that was in the forefront of her mind. Her relationship to her father was more formal than that with her mother and the thought of shaming him was intolerable. He implicitly trusted her to perform successfully in college and to be a significant contributor to the family's success and happiness. Instead, Nancy proved herself unable to handle the independence in the way her family required. Unsupervised and physically and emotionally distanced from her parents and their demands, she was at high risk to enact a dissociated self-state experience which reflected her parents' neglect of her social and emotional developmental needs in favor of academic performance and excellence. Nancy was caught in the dilemma of her conflicting heritage and the host culture which she had now embodied.

In the analytic relationship I came to know her multiple constructed realities and the complexity of her bicultural narrative. There was a dutiful daughter who was overwhelmed with shame and grief for having disgraced her family; a rebellious and impish girl who found her parents views harsh and

unforgiving, but who would consider no other future except the one prescribed by them; and the needy young child who longed for recognition and acceptance of her individuality, not punishment for self-expression.

In treatment she recounted horrific stories of being punished by her mother for less than stellar grades. When disappointed with her school performance, her mother would require her to kneel backward for an hour, placing her toes inward. She found the physical pain excruciating, but the mental torture too humiliating to bear. She felt that at these times, her mother was particularly punishing her for her interest in dancing. (Nancy had taken ballet lessons in New York and continued this pursuit throughout high school and college.) Her mother viewed this activity as selfish and self-indulgent, something which hampered Nancy's academic performance. In one therapy session, as she was demonstrating the position to ensure that I understood her experience, she was flooded with emotions of sorrow, shame, and anger.

In this instance, an emerging piece of previously unconscious self-other experience was in the foreground of our analytic work. She was eager to educate her guijin therapist about the perils of self-expression, when she found herself reacting in a way for which she was unprepared. I encouraged her to experience and express this dissociated aspect of self-experience, as I too allowed myself to be open to the experience of the moment. Davies (1996) refers to this transference–countertransference moment as "therapeutic dissociation," a therapeutic experience which allows for the dynamic interaction of multiple self-organizations to unfold and to reveal their historic roots within the safe confines of the therapeutic relationship. She experienced herself as if kneeling before her mother, shame-ridden and humiliated, while simultaneously expressing the anger that she previously could not express to her mother. It was a moment filled with both palpable pain and welcome relief.

On one occasion, she spoke a Japanese word which defied precise translation, but which expressed a deep shaming of generations of ancestors. As she repeated the word, she assumed a kneeling posture to indicate what was expected of her when she did something perceived by her mother as being disrespectful. Nancy found herself again overwhelmed with emotion, similar to the kneeling incident described earlier. This time, however, the intensity of her shame and despair filled the therapeutic space in a way that neither of us had experienced earlier.

Countertransferentially, I found it nearly impossible to tolerate her kneeling, but I knew intuitively that important work was taking place. While she was reliving an old relational pattern in the safety of treatment, paradoxically, I was feeling shame and guilt for having her assume such a subservient position. I was acutely aware of the embarrassment and discomfort I was experiencing in reaction to the power I assumed in her narrative. While it was a mutative moment in the treatment, I found myself at a loss for words and merely whispered "I understand."

Somehow we were "standing in the spaces" of this co-constructed narrative, separately and together. Each of her self-states had its reason for existing, each held a single truth and a story to tell, one which I could not write or rewrite to suit my preexisting theoretical beliefs. At once Nancy could recognize the depth of anger she harbored toward her mother for not loving the part of herself she considered so vital. Shortly after this session, Nancy decided to reapply to college, and in doing so, she made reference to her suicide attempt in the application essay. She believed that the essay should reflect both who

she was and who she was striving to become. She felt better able to tolerate the potential rejection than to hide an important truth about her life from others, but more importantly, from herself.

DISCUSSION

Nancy's interpersonal schema involved a rigid, hierarchical relationship between self and other in such a way that the roles, rules, and obligations were well defined within the family and with parent substitutes such as teachers. In regard to the therapeutic relationship, however, she exhibited only some of the stereotypic behavior anticipated in working with an Asian patient. In contrast to Yi's (1995) assumption that Asians prefer direct advice and guidance, and that the therapist is viewed as an authority figure imbued with power and wisdom, I found Nancy to be aware of and open to a more mutual, co-constructed narrative approach. Rather than quiet, dependent, and lacking in assertiveness, Nancy seemed appreciative of the opportunity to present aspects of her self-functioning which she actively hid from her parents. She delighted in finding a therapeutic space which afforded her room for all aspects of her self-functioning, one which permitted room for her multiple truths.

The one way in which her behavior was consistent with the cultural expectation was in her hesitancy to enter treatment. Akin to her parents' beliefs, she too feared that seeking treatment implied that she was mentally ill. It became understandable that she wanted to avoid the stigma of mental illness even though she found herself more depressed and desperately in need of help while in college. At the time she made the suicide attempt, it served as a viable alternative to the disgrace of mental illness and the necessary self-imposed pain of introspection in psychotherapy.

Clinicians are generally cautioned that their culturally-embedded theoretical system and treatment approach may interfere with their ability to gain access to the patient's subjective experiential world. Instead of assuming the perspective of the patient's cultural reference system, therapists may interpret the patient's experience from their own Western cultural vantage point. Contrary to expectation, for Nancy it was vital that her therapist be a guijin in order to appreciate the severe and stifling reality under which her Westernized self-state had to operate. Nancy felt that she could only trust a white therapist to understand her culturally-based Japanese experience from her own guijin perspective. She feared that a Japanese therapist might inform her parents, or those who knew her parents, about her unacceptable

behaviors—dating non-Asian men, her abortion in college, and her blatant rejection of many of the customs her parents and grandparents treasured. She insisted that even an Asian-American therapist could not be trusted with her Western secrets. Such a therapist could be secretly harboring a negative and highly critical opinion of her chosen actions. She believed that only a Western therapist could understand and not judge her actions as disrespectful of her parents.

Nancy could be considered part of the "1.5 generation," a term Kim (1985) used to describe a generation of immigrants born in Asia but who emigrated to the United States before adulthood. Like many of her generation, on the surface she demonstrated a high degree of comfort with bilingualism and biculturalism, yet the disparate ethnic identities were problematic to reconcile internally. Her suicide attempt could be viewed as a negative resolution to the external parental pressure and internal competing self-object configurations. Her self-perceived dilemma involved honoring her heritage culture while enjoying the benefits and freedom which the host culture offered her. She wanted to function effectively in these two seemingly irreconcilable environments, both of which she considered "home."

It is important to note that there are Asian women with experiences similar to those of Nancy who can more readily bridge the paradox of competing culturally constructed self-states. These women did not have to employ defensive dissociation to the extent Nancy did to contend with conflicting cultural mandates and the accompanying internalized shame about the embrace of Western indulgences. On a related note, I have written previously (Tosone, 1999) about Asian women who come to the United States to train in the mental health professions. These women are expected to assimilate rapidly to Western standards of mental health care which often conflict with the values and norms of their respective cultures. These women respond to the competing personal/family and professional identities in a variety of ways which can be categorized along a continuum from those who adhere primarily to their culture of origin to those who assimilate readily into the mainstream American culture. In the middle are those women who are able to effectively negotiate both cultural environments. Viewed from a relational perspective, these women possess the ability to balance and prioritize self-states without losing sight of their totality.

Like many of these women, Nancy maintained a self-state which was loyal and respectful of her parents and her cultural heritage, and she also had a well-developed Westernized self-state which valued creativity and the pursuit of independent happiness. True to Mitchell's observations, Nancy had constructed different versions of herself in different relationships and under different circumstances. However, her

self-states reflected experience grounded in a paradox too great to bridge; that is, she perceived her mother's behavior toward her from the perspective of a liberal, Americanized observer and her acting out behaviors in college through her mother's unforgiving lens. In essence, self-states not cognitively acknowledged in a given moment were enacted in her incongruent patterns of affect, behavior, and cognition.

The therapeutic relationship afforded her the opportunity to hear the necessary voices from her different self-states, each of which held an important truth and had its own alternative reality. Gradually she became better able to maintain opposing realities, or as Bromberg would say better able to "stand in the spaces" of her dissociated self-state experiences. My "whiteness" afforded her a sense of comfort and safety, as ironically did my status as teacher, a revered but feared figure in her cultural tradition. A teacher is someone you respect, but do not approach for help. Her academic difficulties in college were exacerbated by her inability to seek the advice and assistance of her instructors. She could not reveal her ignorance or fear of failure to them. In our therapeutic encounter, her knowledge of my standing as an academician permitted her to explore and reveal previously disavowed aspects of her relational self-other experience.

Since treatment was conducted in her second language, it provided her with a symbolic medium through which she conducted certain relational experiences while also rendering certain areas of intrapsychic experience unavailable for analytic work. Foster (1992) postulates that there is a language bound inner representation of self-states which can be accessed only through the patient's primary language. Nancy's most meaningful moments in treatment occurred when she spoke Japanese, something she occasionally did when she could not convey the affective import of an experience. At such times, order and rationality were suspended as old relational patterns emerged in the transference–countertransference matrix. The two occasions described earlier were the most poignant times in our work together.

CONCLUSION

The goal with Nancy and with other bicultural patients is to help them to better tolerate aspects of their self-experience that have been previously foreclosed. The narrative truth which emerges in such work rests with the unique interplay between clinician and patient in the transference–countertransference experience. For the therapist's part, we need to be mindful that we are not immune to self-deception or to silencing one of the many voices crying for recognition, voices of the

patient and of ourselves. As clinicians, we too need to stand in the spaces of our multiple realities. The paradox of such analytic inquiry is that our profession is founded on truthfulness, yet such truth remains subjective, elusive, and in many ways an unknowable concept.

REFERENCES

Altman, N. (1993). Psychoanalysis and the urban poor. *Psychoanalytic Dialogues*, 3(1), 29–50.

Altman, N. (1995). *The analyst in the inner city: Race, class, and culture through a psychoanalytic lens*. Hillside, NJ: Analytic Press.

Anderson, A & Godishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & H. Godishian (Eds.), *Therapy as a social construction*. Newbury park, CA: Sage Publications.

Bromberg, P. M. (1998). *Standing in the spaces*. Hillsdale, N J: The Analytic Press.

Davies, J. M. (1996). Linking the "pre-analytic" with the postclassical. *Contemporary Psychoanalysis*, *32*, 533–576.

Davies, J. M. & Frawley, M. G. (1992). Dissociative process and transference–countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of childhood sexual abuse. *Psychoanalytic Dialogues*, *2*, 5–36.

Davies, J. M. & Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.

Foster, R. P. (1992). Psychoanalysis and the bilingual patient: Some observations of the influence of language choice on the transference. *Psychoanalytic Psychology, 9*, 61–76.

Foster, R. P. (1996). What is a multicultural perspective for psychoanalysis. In R. P. Foster, M. Moskowitz, & R. A. Javier (Eds.), *Reaching across boundaries of culture and class: Widening the scope of psychotherapy*. Northvale, N J: Jason Aronson, Inc.

Kim, S. (1985). Family therapy for Asian Americans: A strategic structural framework. *Psychotherapy, 22*, 342–356.

Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.

Kohut, H. (1984). In A. Goldberg & P. Stepansky (Eds.), *How does analysis cure?* Chicago: The University of Chicago Press.

Mitchell, S. (1993). *Hope and dread in psychoanalysis*. New York: Basic Books.

Pizer, S.A. (1996). The distributed self. *Contemporary Psychoanalysis*, *32*, 499–507.

Spence, D. (1982) *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: W.W. Norton.

Stolorow, R & Atwood, G. (1979). *Faces in a cloud: Subjectivity in personality theory*. Northvale, N J: Jason Aronson.

Stolorow, R., Brandshaft, B., & Atwood, G. (1987). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, N J: The Analytic Press.

Stolorow, R, Brandshaft, B., & Atwood, G. (1994). *The intersubjective perspective*. Northvale, N J: Jason Aronson.

Tosone, C. (1999). Asian women in the mental health profession: Adapting to the ways of the west. *Psychoanalysis & Psychotherapy*, *16* (2), 299–306.

Yi, K. (1995). Psychoanalytic psychotherapy with Asian clients: Transference and therapeutic considerations. *Psychotherapy, 32*(2), 308–316.

Yi, K. (1998). Transference and race: An intersubjective conceptualization. *Psychoanalytic Psychology*, *15*(2), 245–261.

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