Psychotherapy: Black and White*

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PART I.

TRADITIONALLY in the United States, text books on psychotherapy only briefly mention the problem of a "culture barrier"[1] between patient and therapist, and they emphasize the problems common in the cultures derived from Western Europe. They have virtually nothing to say about the black American culture. Although more recently there have appeared papers dealing with the latter culture in the context of psychotherapy,[2-10] the conceptual frameworks and practical suggestions that a therapist can apply in the office remain few and far between. This deficiency is a major handicap to any therapist trained, as most are, in a virtually all white University Medical Center and yet treating black patients.

In this paper I shall trace the development of some ideas and techniques that provide a useful framework to me as a black therapist being trained in a white university setting and working with lower income black patients. My emphasis is deliberately on the structure and mechanics of the therapy, rather than the details of the intrapsychic dynamics, because it is the former area which is consistently neglected, and which assumes vital importance in my therapy with lower income black patients. I should not be surprised if many of the concepts applied equally well to any lower income patients, but that is outside my experience and the scope of this paper. Discussion of the extensive ramifications of interracial therapy situations is also omitted.

The mechanics of the treatment system at the University are quite impressive to me because they function smoothly. In essence there is a very efficient mechanism for technically skilled evaluative screening which works around the clock. All patients deemed "unsuitable" are referred elsewhere. The therapist then exercises his own judgment before putting the seal of approval on the "suitable." If I decide to treat, I schedule an hour, arrange for a private office without interruptions, interpret any tardiness, and therapy has begun. This system provides a valuable luxury in training when we need time for reading and seminars and good patients help reaffirm our career decisions.

By contrast, at the O.E.O. sponsored Neighborhood Health Center, there is no selective screening since there can be no referrals for outpatient treatment. The job is specifically defined as treating our entire community. Help! The "book" not only did not cover this, but also specifically excluded it: "Psychotherapy is not for everyone."[1] In spite of this I proceeded to set up appointments, and wait for my unscreened patients. And wait I did, and interpret I did, but just to myself. I was cautious because my interpretations of "tardiness" did not make the same sense here that they did with most of my patients at the University.

The puzzle was the frequent "tardiness" for "no reason" which the patients would candidly admit. The issue was quite distinct from the myriad reality factors preventing low income people in a virtually busless town from getting to an appointment "on time." Patients often call to explain these problems and possibly ask for transportation help. Nonetheless, my patients were almost always from 15 minutes to an hour late. I was quite familiar socially with "C.P. time"* but had never adopted it professionally; for the first time I considered the possibility that it was

* Read at the 76th Annual Convention of the National Medical Association, Aug. 8-12, 1971, Philadelphia, Penn.

* "Colored people's time" usually meaning half an hour or more "late."

an *acceptable* patient cultural value at the Health Center.

This consideration landed me right in the middle of a dilemma. On the one hand, if I accepted this different value of exact timing, what would happen to my appointment schedule? In addition, how was I to distinguish this behavior from resistance to therapy or from unacceptable manipulation by a demanding patient both of which my training instructed me to be wary of? On the other hand, if I refused to incorporate this other time value system into my professional life at the Health Center, I would be making interpretations which reduced my credibility even to myself; and I would be seeing patients for very abbreviated hours and spending the balance of the time waiting in an empty office in the face of a severe manpower shortage.

Initially I tried "education." I explained and insisted on the importance of being prompt. My patients readily agreed and yet continued to come late for "no reason"—overt or covert. I toyed again with the idea of resistance to therapy, but one case provided a glaring example of the limitation of this interpretation. This was a case of severe neurotic depression in a middle aged married mother of four who was invariably "late" for "no reason." However, in the first interview she rapidly accepted me as a source of help for herself, though she had had no previous psychiatric contact, and wasted very little of the remaining therapy time on denial of her own role in her problems. In the second abbreviated interview she easily grasped the concept of internalized anger as a major cause of depression ("Freud's Mourning and Melancholia"). By the third interview she was out of her crippling psychomotor retardation, sleeping well again, eating normally, feeling happier and making plans to cope with the many financial and family difficulties that had overwhelmed her to begin the depression. She returned a fourth time, still "tardy," merely to let me know how well her plans were working out since "you hear so many problems all the time!" In a 13 month follow up she has been coping well, requiring two other series of treatment—one of two sessions and one of one. She remains "tardy." This case and others similar convinced me to accept "C.P. time" as an acceptable patient value, and to adopt it professionally myself.

Surprisingly, my schedule did not turn into chaos. The "tardiness" merely means a see an arrival system with a variable wait for patients. In cases of simultaneous arrival, the sch dule is used to see who will be seen first. This community is well acquainted with the time values of the white culture with which medical services are usually associated in this country, so that when they arrive "late" they are not surprised to find someone else seeing their doctor. They usually wait agreeably because "I know I'm late" or "I know I missed my appointment earlier today."

The number of missed and cancelled appointments almost balances out with my persistent drop-ins: two chronic schizophrenic teenagers, a neglected nine year old with a reading problem, and the informal staff consultations. These patients are frequently excluded as "unreliable[1]" from a system where time is exactly interpreted. In the system I am describing at the Health Center they are fairly easily incorporated and at least one can begin the therapy. To keep this system working smoothly the therapist has to be prepared to work an hour or so beyond his written schedule in order to catch up at the end of the day.

The major problem I find is with the occasional patient who not only knows the exact time system, but also uses it, and arrives promptly. They are usually quite angry about having to wait any length of time and I find that this interferes with the therapy considerably. Keeping such patients waiting is nonverbally telling them that their chosen adoption of the dominant culture's time values is "bad" or "unacceptable" to the therapist. The cultural converse occurs all the time at the University when "unreliable" patients are seen there, but it is frequently misinterpreted as resistance to therapy or an unsuitable candidate. Structurally, I avoid this problem, which I feel is one of personal philosophy rather than effective psychotherapeutic technique. I put these patients first on the schedule if the time is suitable for them. Otherwise it works equally well if they are scheduled last and if the time usually reserved for after the schedule is moved to immediately before their appointment. If I am in doubt about a patient's time values, I assume that they believe promptness is "good'

and schedule accordingly. In this way no one receives unintentional messages. If the patient is late, I utilize the waiting time making chart entries, follow up phone calls, and dictating.

Clearly this problem that I circumvent in scheduling is frequently a pertinent issue within the therapy of any individual patient, black or white. However, I feel that it is more effectively dealt with in the context of the patient's difficulties that bring him to seek help than in the context of a defense of the therapist's own value system with respect to time. In spite of considerable training to aid objectivity and a non-judgemental approach in a therapy situation, a therapist retains and applies personal values much of the time. Many of these, for example those assigned to time, are never questioned. They may not even be recognized in the therapist's own therapy because they are generally accepted by the dominant white culture, from which his therapist probably comes. It may be quite difficult, therefore, for a therapist totally unfamiliar with the ideas I have proposed to adopt all or even part of them when working in a black community in which he might be appropriate.

Adaptation to a new cultural setting is well known for its difficulties. It is particularly difficult when the differences between the cultures are not clearly demarcated, and when it is necessary to make abrupt transitions back and forth from one culture to the other, which is the case in my work. It is my contention that some further investigation of the cultural differences and their application to psychotherapy would greatly aid the task of both white and black patients and therapists.

One aid to compiling such information would be for persons writing papers on this topic to identity carefully, as I have, their cultural affiliation, and therefore bias. This will minimize the misrepresentation of personal values as "objective" criteria. Once understood these cultural assumptions again fade into the background of the therapy, and the therapist is free to concentrate again on the transference and dynamics. If the cultural values are not well known and applied, the therapy may well never have a chance to begin and all the knowledge of transference and intrapsychic dynamics in the world is useless.

PART II

A second important area of cultural difference between the black and white patients I treat is one with many implications for psychotherapy and which concerns another dimension—space. At the University, comfort and privacy without interruptions are easily arranged and increase the enjoyment and productivity of therapy. At the Health Center the therapist frequently answers his own phone calls. Also the room is too hot in summer to have the door closed, yet opens out onto a major patient thoroughfare. Added to this for me is my resemblance to a secretary which invites even more distractions.

It soon became evident that I had to handle these distractions as routine rather than continue my doomed attempts either to minimize them or spend a considerable amount of the therapeutic "hour" apologizing and explaining. As a result patients have become quite accustomed to my abrupt call of "Registration is down the hall there to the end!" in the midst of their description of quite personal material. They continue unperturbed knowing that the bewildered stranger will not actually physically intrude on our "privacy," and cause an even longer interruption. I recognized retrospectively that I am also providing a coping model for my patients. It permits them to see that my emphasis on their own role in their problems, which is the emphasis of psychotherapy, does not come from an ignorance of the multitude of reality problems they have as low income people, but rather in spite of knowing about and dealing with these problems. This technique then lends credence to the idea of personal control over one's situation, and the patient is then willing to give it a try. Whenever a patient interrupts the therapy to greet a passing friend or acquaintance, I make no resistance interpretation. The important factor becomes the number and nature of the friends they have, and the style of their brief interaction with them, and how it compares to their interaction with me.

This approach again demands further education of the therapist. He must include in his mental cataloging system not only the intrapersonal dynamics and the transference, but also the on-going interaction with the environment. This is a difficult task even with an organized system of knowledge at hand. Perhaps a good place

to begin is with the skills learned in Group Therapy, but they must be extended into the less controlled situation such as I described, and such as the patient lives in.

I am certainly not suggesting that psychotherapists throw open their doors and invite confusion and interruptions. Nor am I suggesting that no improvements be made in inadequate facilities such as the ones described. What I am suggesting is that poor facilities do not allow a therapist to ignore the significance of the environment in his therapy, and permit him new views of its influence on a person of which he might otherwise have remained totally ignorant. If further research were done in this area, it might be possible to teach a great deal of this knowledge in a formal seminar. At present it remains in the practical area, to be applied with a trial and error technique.

Home based psychotherapy has a similar advantage to the poor facilities I described. However, it does not permit sufficient scheduling to see as many patients in the time available as one can in the office. I have tried it! In addition I have found that in some home visits the number of environmental factors was so overpowering the individual and family dynamics, and the transference, that I was unable to separate them myself. Small wonder that the family or patient could not see them! Perhaps with more training in this area therapists will find the task less difficult.

At present various social and economic agencies are used in conjunction with psychotherapy in an attempt to deal with the patient's environment. I do not feel that this broadening of the psychotherapy in any way replaces these agencies. The two remain complementary approaches to the problems.

Retrospectively, it is not surprising that this environmental emphasis is absent in traditional teaching of psychotherapy. The environment from which those ideas derive, was one in which the individual exerted considerable control. The exclusion of the environment from the therapist's office, and partially from his mind, is of quite small significance as long as his patients come from the same fortunate and privileged circumstances, and as long as no uncontrollable reality, e.g. death, presents itself. It is of great significance only when the patients are less fortunate and are subjected to many environmental forces such as those imposed by poverty and racial prejudice. In this latter context, detailed understanding of the environmental problems is essential for the therapist to accurately evalute and treat his patient.

SUMMARY

The usage of traditional white university-taught psychotherapy among a low income black community led to the development of two concepts. First, it is essential that the therapist recognize and use in therapy the cultural values of the patients with whom he is working. Time is the variable discussed in this context. Second, an understanding of the environmental factors important to oppressed people must be made an integral part of psychotherapy with as important a meaning as transference phenomena and internal dynamics.

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