THE IMPACT OF CULTURAL SIMILARITIES ON THE INITIAL TRANSFERENCE IN THE EARLY PRASE OF PSYCHOTHERAPY OF ISRAELI PATIENTS WITH AN ISRAELI THERAPIST

Lili Pila Hodis

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by

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the Clinical Research Project

The Impact of Cultural Similarities on the Initial Transference and Psychotherapy in the Early Phase of Treatment of Israeli Patients with an Israeli Therapist

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ABSTRACT

The purpose of this study was to examine the impact of cultural similarity between Israeli patients and an Israeli therapist on the therapeutic process in the early phase of treatment.

Corollary issues studied are:

1. Some unique manifestations occur during this phase which enhance treatment.

2. There is a tendency to see the therapist as an omnipotent all-good mother, and because of it, the patients exhibit minimal initial resistance.

3. The patients are extremely open, and early childhood material emerges right from the start.

4. The patients expect great empathic responses, and instant understanding by the therapist.

Another major purpose of the study was to collect and present a modal Israeli personality.

In order to validate the hypothesis, a literature review was conducted; cultural similarity and dissimilarity studies from the wider population, and studies on ethnicity and mental health, social class, race, and sex were examined.

A review of the material pertaining to the Israeli's character, modal personality, and the condition of Israelis in the U.S. were also summarized.

A population of six patients from this therapist's private practice was used. All these patients are Yordim (Israeli immigrants), i.e., three of them were long-term cases, and three were short-term cases. These cases were examined by looking at the frequency of their responses to analyze if the phenomena presented in the hypothesis were valid.

The data were obtained from this therapist's private practice records which were taken during every session. The responses were made by these patients during the first six sessions which were called the early phase of therapy.

Demographic data were obtained from the records, and social class was determined by using the Hollingshead Scale (1958).

Positive, negative/ambivalent statements which were made by these patients for six sessions were counted per patient, per session.

Discussion of early childhood material was numbered per patient, per session, and statements made by patients expecting empathy and instant understanding from the therapist, per patient, per session, were counted also. Graphs were made per patient, per session, so that there

would be a visual view of these patients' expectations of empathy and understanding of the therapist.

In general, this study provided the following findings: Overall, these patients are in their late twenties. There are more females than males, and there are more single than married patients. These patients come from an average of middle and upper middle classes, and have all come to Los Angeles from Israel in the last 10 years. It was found that due to the cultural similarity between patients and therapist, these patients were able to enter into therapy being very open, and have minimal resistance. They seem to idealize the therapist, and are capable of creating a bond and a "working alliance" (Greenson, 1967b) which enhances treatment. They are able to speak about early childhood material, and expect the therapist to be available, empathic, and to have a clear and instant understanding of them and their problems.

It was also found that these patients experience a great rejection by the State of Israel--their Motherland--and most have experienced similar rejections and withdrawal from their mothers, which create in them an unresolved difficulty in the area of separation-individuation. These patients, when they enter treatment, re-enact their unresolved difficulties, enter into a state of unity with the therapist, and are able to understand them and work towards resolving them due to the cultural similarity.

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CHAPTER I

INTRODUCTION

Reason for Study

This study began in my office. Although my practice includes a cross-section of native and foreign-born Los Angeles residents, a significant and growing portion has been Israeli immigrants, drawn to me, no doubt, because I too am Israeli. What has become clear through working with this group is that in the beginning phase of treatment, a certain process seems to unfold.

Initially, the patients call up and start speaking in rather formal English. However, in the middle of the conversation, they invariably inquire, with a happy little giggle: "At medaberet Ivrit?" (Do you speak Hebrew?). This question marks a distinct shift in the conversation. When I reply that yes, I do, the tone shifts, and they begin to speak to me with a sense of great familiarity and ease. Although for a long time I was not aware of this, the unity, the attachment and bonding to the therapist starts at this precise moment in the initial telephone contact.

It took a few experiences of this before I began to notice just how informal, even familiar, the first

phone conversations with Israeli patients are, and how uniquely different they are from such first encounters with patients of other population groups. In fact, I began noticing that this ease and familiarity with the therapist seemed to continue throughout the entire beginning phases of treatment--a phenomenon which distinguished them in my mind from any other patients I had ever treated. They were so easily engaged, so open. I began to feel a bit omnipotent, attributing this success solely to my skill as a therapist, thus giving myself all kinds of undue credit.

To say the least, their bond with me was very unusual. Although confused, I was intrigued, and started asking myself a lot of questions. It had now become something of a challenge to me. What, I asked myself, makes therapy with these patients so different? Why are they bonding with me so quickly and so closely? These and other questions prompted me to look more deeply and with great curiosity into this phenomenon. This study is a result of that curiosity.

Purpose and Hypothesis

This study will examine the impact of cultural similarity between Israeli patients and an Israeli therapist on the therapeutic process in the early phase of treatment.

Corollary issues studied are: (1) unique transference manifestations occur during the early phase of treatment; (2) there is a tendency to see the therapist as an omnipotent, all-good mother; (3) because of this, in the early phase of treatment, the patients present minimal, if any, resistance; (4) because of this minimal resistance, the patients are extremely open, early childhood material emerges right from the start; (5) due to the cultural similarity, the patients also expect great empathic responses and exhibit a tremendous desire to be understood instantly by the therapist.

A lesser but equally important goal of this study is to present a modal personality--a collected overview of a summarized dynamic and sociological understanding of the Israeli character (in Israel and the U.S.A.), and the treatment issues related to these patients' emigration and re-acculturation struggles.

Significance

Cultural issues surrounding treatment of foreign-born population groups in the United States have been poorly integrated in social work theory and practice and in clinical practice in general. The literature reveals a paucity of research in this area. A careful review of the literature revealed that very few theorists, for instance, talk about the interplay between cultural issues

and personality dynamics in treatment. Further, there is almost no material concerning what goes on dynamically in practice should the therapist be of the same ethnic background as the patient. Although the literature is full of studies about other cultures, particularly primitive cultures in other countries, ethnopsychiatry seems to have a paucity of research in this area.

Hopefully, by opening up long neglected areas of inquiry, this study will facilitate projections and interpretations concerning other cultural groups, minority groups, gender groups (i.e., blacks, women, Mexican-Americans, etc.) and provide conclusions for diagnosis, treatment, and further research.

Of more significance, however, and what is addressed directly in this study, are the clinical problems surrounding work with Israeli patients in the United States. There are currently 400,000 Israelis in the United States (JTA Daily News Bulletin, Jerusalem, May 11, 1978), and their numbers are growing. In Los Angeles alone, there are around 150,000 Israelis (Tafnit, November 1980). These people represent a cross-cultural picture of Israelis from all walks of life. Most of them have had problems in the past which they brought with them to the U.S. Along with these problems other problems peculiar to the acculturation process, namely feelings of isolation and

alienation, have also surfaced. Because of this, persons of this population group seem to need a special and specific type of treatment (Tafnit-Israeli Division, November 1980).

It appears that many Israeli patients would rather receive treatment from private practitioners than from any other health service agencies. The general feeling is that they can get better treatment in a private rather than in a public setting. Due to the general alienation they feel (Tafnit, November 1980) from the Jewish Community, they exhibit hostile behavior toward available agencies and show a reluctance to ask anyone in these settings for help.*

The other side of that problem, I feel, is that agency workers, American or Jewish, don't understand the "Israeli character," and are not prepared to deal with them. It is hoped that this project will be helpful in alleviating that problem by identifying and clarifying the "Israeli character," and the treatment style necessary with these patients. It is felt that this information can be of special importance to social workers because these professionals in particular treat patients from all walks of life, many of them immigrants, from a multitude of diverse countries, and representing a wide variety of cultural backgrounds.

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*Information gathered from my patients, other professionals and friends.

According to Vasquez (1976) and others, it is most unfortuante that cultural issues are kept separate from dynamics in practice and in the literature. The result is that minority patients too often do not receive adequate or effective treatment. Most of the literature shows that a high percentage of dropouts is among patients whose culture is different from the therapist (Jones & Seagull, 1977). Dr. Frances Wellsing (1976), former chairperson of the Department of Psychiatry at Howard University Medical School, related in a personal interview that minority individuals are angered and dissatisfied by school and agency counselors, psychologists, social workers, psychiatrists, and other "helpers." She stated that the "turned off and turned out" state was a direct result of cultural insensitivity and inappropriate actions on the part of the helping professionals.

CHAPTER II

LITERATURE REVIEW

Cultural Similarity is Relevant in the Therapeutic Relationship

Studies of cultural similarity point to two diverse conclusions. Most of the literature suggests that "optimum effectiveness occurs when therapist and patient come from the same background" (Lesse, 1968). A small amount of literature found it not to be significant. Most of the literature, especially if it is psychiatric, points out that "similarities in culture and values can foster alliance formation, differentiation of psychopathology and therapeutic intervention, but may also interfere when therapy abuts culturally shared blind spots" (Borus, Anastasi, Casoni, Russo, Dimascio, Fusco, Rubenstein & Snyder, 1979).

Studies from Israel show that ethnic similarity promotes good results even though the therapist might not be academically trained (Aleksandrowicz, 1972).

Almost all of the Mexican-American cultural and social class studies show that "patient-therapist matching is most conducive to establishing a reliable therapeutic

relationship with low income bilingual Mexican-American clients" (Herrera, 1979).

In a study of relationships between patients of different social classes and upper-class therapists, Hollingshead and Redlich (1958) suggested that the most positive helping relationships exist in situations where social class similarities are shared by client and helper. Similar inferences are made by Kaplan, Kurtz and Clements (1968). Cole, Hardin, Hand and Allison (1962) have further substantiated how shared language, cultural and moral values of the therapist and patient add a feeling of comfort in the relationship. Perceived racial similarity was also found to influence a positive relationship (Graff, Kenig & Radolf, 1972). Taylor (1971) found that when professional training and sociological characteristics of counselors were equal, race of the counselor was the factor that most influenced the therapeutic relationship.

Henriette Tolson (1972) has implied that similarities between client and therapist and the ability of the counselor to be empathic are the essential ingredients of a positive counseling relationship. Tolson (p. 738) further described a movement by individuals to seek therapists who "share a background of experiences similar to their own." Supporting Tolson's contention, Bryde (1971, p. 55), indicating the relevance for similarities in the counseling

relationship stated that: "The ideal counselor for Indian students would be Indian, since no one can talk to an Indian like an Indian. There is instant rapport and no jockeying about for mutual understanding."

Fiedler (1951) discovered "assumed similarity" as the factor influencing the therapist's liking of his client. He has described this as the degree to which the counselor perceives a resemblance between his personal characteristics and those of his client. Other studies found that empathic feelings are communicated when the counselor perceives shared similarities between himself and the client (Hunt, Ewing, LaFarge & Gilbert, 1959; Rogers, 1959).

As one of his research findings, Taylor (1971, p. 3282A) learned that "When professional training and sociological characteristics of counselors are equal, racial similarity between counselors and counselees is the factor that affects the individual counseling relationship." A similar study by Grantham (1971) with black college students and their progress in counseling substantiates Taylor's findings. Grantham found that black college students preferred black counselors to a significantly greater degree than white counselors. The same study also found that female counselors were preferred by blacks to a significantly greater degree than male counselors. William Gardner (1971, p. 5763) further found that:

"Black counselors will be seen by black college student counselees as able to function at higher facilitative levels with black students than white counselors."

Cohen (1974) talks about the "Borderline Personality Syndrome." She says that the syndrome can be defined as a fluctuating clinical picture involving episodic emergence of aberrant deviant behavior patterns. Because aberrant or deviant patterns are often defined differently in different cultures, complications in diagnosis and treatment arise when therapist and patient have different cultural backgrounds. For example, particular behavioral responses might be seen as symptoms of illness in one culture and not in another. Or patients' reactions to the same symptom might vary from culture to culture.

Cultural stereotypes that patients and therapists have about each other can alter the transference and interfere with therapy. She suggests that the therapist dealing with a patient from another culture must develop a great deal of self-awareness and, in addition, learn everything that he/she can about the patient's culture (Cohen, 1974).

Agostini's (1977) study of undergraduate students showed that Latin students favored Latin therapists, blacks preferred blacks, while whites preferred whites or blacks but not Latins. These findings suggest that clinicians must be aware of the role of ethnicity, since human

behavior needs to be understood not only through intrapsychic forces, but also through interactional and centextual qualities of the therapist-patient dyad.

Furlong's (1979) study on the "effects of counselor ethnicity and attitudinal similarity on Chicano students' perceptions of counselors' credibility and attractiveness" showed that students who perceived their attitudes as similar to the counselor rated the counselor's credibility and attractiveness as more favorable than did students who perceived their attitudes as not similar to the counselor.

Vasquez's (1976) study at New York University with Puerto Rican college students suggested that students who knew the counselors' various ethnic backgrounds were more likely to bring their problems to one who was a member of the same ethnic group and with a similar degree of ethnic orientation than one who was not.

Cultural Similarity-Ethnicity is Not Relevant in the Therapeutic Relationship

Carkhuff (1972), one of the leading researchers involved in interpersonal relationships between blacks and whites, recognized the existence of differential effects of the counselor's ethnic background, when the counselor's skills were not as good as they should have been. He felt, however, that the counselor's ethnic background had

no bearing on a counseling relationship if the skills and counseling responses were good. Further, Carkhuff felt that systematic training was an important factor to overcome the ethnic differential caused by inadequate counseling. Vontress (1969) supported Carkhuff's contention, but included cultural awareness as a necessary condition for successful counseling of psychotherapy.

Roark (1974) suggests that counseling minority groups is no different from counseling other people. Based on the author's experience as a bilingual counselor, he states that there are mixed results of research in the area of counselor and client similarity, i.e., problems in trust, communication, openness and transference, and identity conflicts resulting from belonging to the two referent groups.

In another study by Furlong, Atkinson and Cases (1979), it was stated that counselor ethnicity and positive attitude alone were not found to be related to ratings assigned to the counselor.

In the area of counselor-client dissimilarity, Kinzie (1979) finds a solution in the use of the medical model. He states that cross-cultural experiences and data indicate that there are several effective technical components to psychotherapy that can be employed when therapist and patient come from different cultural backgrounds. These include the appropriate use of the medical model,

the recognition of nonverbal communication and universal expression of emotions, and sensitivity to the subjective phenomenological aspects of the patient's life. The lessons learned by the author from cross-cultural psychotherapy provide useful approaches for a psychiatrist working with American patients from diverse subcultural and socioeconomic backgrounds. For these methods to be effective, however, therapists should have awareness of their own values, should gain information on the social background of their patients, and develop flexibility in their approach to patients. It is hoped that by developing these methods of treatment, effective psychiatric services can be delivered to a greater number of suffering people.

A study that examined the relationship between black and white counselors and clients and the level of understanding demonstrated in the counseling relationships, indicated that client race was not a significant factor influencing the degree of understanding between client and counselor (Bryson & Cody, 1973). A similar study was done on black junior college students' attitudes toward counselors. Three hundred black students who had been at the college at least one year and who had seen a counselor one or more times were interviewed to obtain a sample N of 80. Although two of the counselors at the college were black, none of the subjects in the sample had prior professional

or formal contact with either of the black counselors. The subjects were ranked by GPA into high and low achiever categories. A Likert-type scale to items drawn from the Counselor Evaluation Inventory was used to measure client attitudes. No significant differences were found in attitudes to counselors due to race (Brown, Frey & Crapo, 1972).

Gamboa, Tosi and Riccio (1973) investigated the effects of counselor-counselee race and counselor warmth with respect to counselor preferences demonstrated by delinquent girls. The selections were made by the subjects from audio-visual tapes made by a white male and a black male actor. Each actor recorded a counselor-client exchange. Results indicated no significant difference in the choices of counselors made by the subjects.

A review of most counseling theories, discussions, and materials utilized in counselor training programs usually does not include the subject of ethnicity as a factor to be considered and/or included in successful counseling. Most theorists such as Rogers, Adler, and Ellis, in addition to the most popular theories in use today such as Psychoanalytic Transactional Analysis, Gestalt, and Rational Behavior Therapy assume adherence to the theoretical model and the high skill level of the counselor to be the important preconditions of successful counseling. The exclusion of discussion regarding the various theories

relative to different ethnic groups seems to imply that the theories work for everyone, providing the skills and techniques are good.

Similar Research

Similar research was done by Dale Gilsdorf (1974) for a doctoral dissertation in Educational Psychology at Texas A & M University. His study was prefaced by a pilot study that dealt with client's choice of a counselor with regard to the ethnic background of both client and counselor. Both studies were done at McLennan Community College in Waco, Texas.

Gilsdorf's (1976) pilot study reported in "Minority Counselors" Are They Really Needed?" included all male students from a stratified random sample of 60 students with 20 students representing the Mexican-American, black and white populations in the school. Photographs of six males designated as professional counselors were shown to the subjects. The photographs represented counselors from the three ethnic groups comprising the population of the school. The pictures were validated by student judges as to the ethnic representation of the photographs. Two counseling problems were used for selection: the first problem was an administrative matter regarding obtaining a loan from the school and the second problem dealt with a personal problem.

Race was found to be a significant factor in counselor selection in the population used (Gilsdorf, 1976, p. 5).

> This was especially true for Mexican-American and Black students. White students also expressed a preference for a counselor of their race when faced with a personal problem but not significantly for the administrative problem. As might be expected, students in general, wanted to speak with a counselor of their same race more for the personal than the administrative situations. Although this was quite clear for Blacks and Whites, the Mexican-American student chose a counselor of his race despite the type of problem.

Gilsdorf further stated that the Mexican-American student had the strongest preference for a counselor of his ethnic background.

Gilsdorf (1974, p. 82) used basically the same research procedures in his pilot study and his dissertation with exceptions: Women were used in order to test the sex variable in the selection of a counselor; slides instead of pictures were used; and only a personal problem situation was presented to the subjects. A summary of the findings supporting the results of the pilot study found that:

> Mexican-American, Black and White students, when provided an opportunity to talk with counselors of various ethnicities, preferred a counselor of their same ethnicity; that when a choice was provided between a male or female counselor, male students preferred the male counselor and female students preferred the female counselor; and that, of male and female counselors, the female was more often selected.

Alonzo Spang, Sr. (1971, p. 102), regarding the plight of Native Americans in the counseling situation, stated that: "The greatest problem that Indians have with non-Indians is their total failure to understand, accept, and treat the Indian as a human being." In an interview by Spang (1971, p. 102) with several Native American individuals, one of the participants stated that:

> Indian people don't have to go through sensitivity training like university counselors. I think it's ironic. I see in the counseling situation that White counselors have difficulty understanding the student's viewpoint. The White point of view is that you have to feel important about yourself, and you know this is onesided. The Indian self includes his own people and this is a point that non-Indian counselors aren't aware of, and can't deal with.

In an effort to explain why counseling Native Americans is different, Bryde (1971, p. 1) stated that:

> . . . many a counselor, often with advanced degrees and accomplished in all the skills of his profession, has been completely stumped in his initial and continuing face-to-face counseling sessions with Indian students. It quickly dawns upon such a counselor that there is something different about Indian students and that many of the ordinary counseling techniques that work so well with most student do not work at all with Indian students.

Vontress (1971, p. 15) made strong implications throughout Counseling Negroes that blacks have been disillusioned with counselors. The following statement may, perhaps, be an explanation of the causative effect of the disillusionment.

> The counseling of Negro students presents more challenging problems than the counseling of White students, because of the factors of race, deprivation, and lack of academic skills prerequisite to success in schools which are geared in the main to meet the needs of middle-class White students. Thus, counseling ethnically different youngsters is not easy for anyone. When the factor of racial difference is added to the already existing variables, the White counselor may be presented with a more difficult task that he would have if he were counseling White students . . . .

Significance of the Problem

In his client-centered approach to counseling, Carl Rogers (1961) feels that acceptance, congruence, understanding, and the ability to communicate these characteristics by a skilled counselor are the most significant ingredients in a positive helping relationship. Rogers continues to state that the "desire" of the counselor to understand is what the client accepts as understanding. Communication of this "desire" creates an atmosphere in which progress can be made by the client.

Carkhuff (1971) simplifies Rogers' model into what appears to be a personalized perceptual model based primarily on empathy. Carkhuff defines empathy as "the ability to see the world through the other person's eyes" (p. 170), or the ability to see and feel the world from another's frame of reference. In other words, the counselor must possess the ability to experience situations and feelings

just as the client experiences them. Carkhuff extends his concept further to include an ability to communicate this empathy. If the counselor cannot communicate empathy sufficiently, what other skills the counselor may have or direction the counselor may take are meaningless.

Helping professions must evaluate relationships that exist solely on the basis of empathy, understanding and congruence. This suggested need for re-evaluation of necessary counseling ingredients represents a deviation from most theoretical models upon which helper training programs are built. Evidence presented in preceding paragraphs seems to imply that the assumed core conditions of counseling as seen by Rogers, Carkhuff and others are not always sufficient when dealing with the culturally different. By Carkhuff's definition, it seems that empathy cannot be realized if experiences, values, attitudes and frames of reference are sufficiently different between counselor and client. The commonly used adage, "worlds apart," has significant implications in a situation where client and counselor have no insights and/or experience in each other's worlds. When counselors lack cultural sensitivity, any attempt at empathic helping can be blocked, thus creating a relationship filled with frustration, hostility and/or indifference.

The literature presented here is mostly from the area of counseling. It is interesting that most of the literature available on cultural similarity is to be found in counseling and not in psychotherapeutic or psychoanalytic literature. Psychoanalytic literature deals mostly with the issues and problems caused by dissimilarity between patient and therapist (Seward, Wolberg, Turner, etc.). It seems that the counseling literature deals mainly with sociological and concrete external process developments in therapy, while psychoanalytic literature deals with internal process transference, countertransference, and resisance issues. Regardless of this difference, the counseling literature seems to be dealing with the basic and practical issue of effective patient functioning and describes different methods of intervention and treatment in a language which is unique unto itself and does not concern itself with intrapsychic material, i.e., transference and resistance.

Social Work Literature Review

A review of the social work literature reveals that unfortunately not much has been written on cultural similarity or dissimilarity problems in treatment.

Block (1962) suggested that even when there is a white worker and a Negro client involved in the psychotherapeutic process, countertransference issues must be

dealt with. She stated that the worker might be identified with white middle class values which could be projected to the client. Further, individual symbolism, unconscious cultural stereotypes, and also guilt, might be attached to the Negro client, resulting in a distortion of the client's psychodynamics, coping mechanisms, and basic ego strengths. She suggests that such countertransference will strongly influence therapy unless the white worker is willing to sort out his/her feelings towards the Negro clients on a cultural and individual basis, and seek supervision, if needed.

Man Keung and McDowell (1973) state in their article, "The Black Worker - White Client Relationship," that like most of the population, the black worker is part of a race-conscious society. He undoubtedly will hold deeply ingrained feelings about the effects of racial differences. However, the black who places himself in the position of a professional helper must make an effort to understand his cross-racial feelings and their social and cultural antecedents. Further, he must recognize the possibility of contamination of his hard-won neutral attitudes toward white clients. Therefore, his effectiveness in working with white clients will depend to a considerable degree upon his ability to be aware of his true feelings and to separate these feelings from his therapeutic encounters with individual clients.

One black worker of considerable experience stated that: "People who are in need do not care who their benefactors are." In most encounters with clients, he is able to accept the individual as another human being rather than a person of color. However, he remains aware that:

> There must be deepseated, unresolved feelings that I possess which result from injustices experienced as a black person. These may have a carry over and therefore affect decisions I constantly make in everyday life. I must try to be aware of any personal biases that would influence my ability to relate to a white client or which would cause a difference in treatment between black or white clients in similar situations.

Only when the black worker is secure in his position, when he regards himself positively in relation to other human beings, can he expect to accept the white client with the absence of conditionality mentioned by Rogers (1961). Open acceptance of client whiteness, as well as one's own blackness, instead of past tendencies to avoid recognition of racial differences, is imperative.

Ultimately, the success of the black worker in establishing positive relationships with white clients rests upon his ability to communicate genuine and common concern for all individuals as human beings, as individuals, and as members of racial groups. He must confirm for himself that people, no matter who they are, have common needs, and that if blacks were "depigmented" and whites "pigmented," their needs would remain virtually the same.

Siegel (1974), on the other hand, found little empirical evidence to suggest that black patients do better with a black rather than a white clinician.

Barrett and Perlmutter (1972) state that competence and understanding of the client's problems are viewed as crucial variables and not race. Race ranked as less important by the trainees and counselors that were studied.

Kodushin (1972) claims that opinions differ about whether racial differences between the social worker and the client create insurmountable obstacles to the casework relationship. He discusses numerous studies that have been conducted on this complex subject. Although empathic understanding is most easily achieved if the worker shares the client's world, white workers can work and have worked effectively with nonwhite clients. Data suggest that when the interviewer and client are closely matched, other difficulties arise. The optimum relationship is one of moderate social distance between interview participants. The attitude and competence of the worker are more significant factors than race in determining the outcome of the interview.

Mary Gottesfeld (1978) has treated a patient whose ethnicity is similar to her own (Italian) and recounted her experience in an article titled, "Countertransference and Ethnic Similarity." She claims that the therapist's

sense of psychological familiarity with the client, usually so helpful with borderline patients became a situation which produced too much psychic togetherness.

Josef Giordano's (1974) words summarize the state of knowledge from a cultural and ethnic perspective:

> Numerous studies have suggested that ethnicity has at least as powerful an influence on mental health and mental illness as socio-economic status. The influence of ethnicity becomes particularly significant in those studies where social class is held constant. Yet, while professionals have readily accepted socio-economic differentials, ethnic variation is still often ignored or, worse, denied outright.
>
> The studies reviewed here underscore the need for new models of treatment, as well as serious research on the values and attitudes of ethnic groups and their implications for health and illness. Studies such as "Black Rage" (Cobb and Grier, 1968) and "The Mental Health of the Poor" (Reissman and Pearl, 1964), for example, have already influenced the development of new models and treatment programs. It is becoming increasingly clear that it takes different methods and programs to reach the varied groups within our society, and that we will have to reshape our current mental health policies and programs to make access to services easy for all of them.

To summarize this review, then, the significant issue is that neither psychoanalytic nor social work literature has concentrated on the issues of cultural similarity between therapist and patient and its dynamics in treatment. Although most of the literature concedes that cultural and ethnic similarity enhances treatment and creates a special therapeutic environment, some of the literature

asserts that there is no difference between cultural similarity and dissimilarity between patient and therapist so long as the therapist remains aware of the cultural issues at hand.

In this study, this author strongly maintains that cultural similarity between patient and therapist makes a great deal of difference in the therapeutic process and, in fact, enhances treatment a great deal. Moreover, it will be the purpose of this dissertation to show just how profoundly cultural similarity between patient and therapist can affect the therapeutic process in the early phase of treatment.

CHAPTER III

OPERATIONAL TERMS

1. Cultural similarity. This term refers to patient and therapist coming from the same country and similar upbringing. When patient and therapist share a language, a similar value system, similar super ego training, and beliefs, and a similar outlook and belief about their heritage and roots.

2. Initial phase. After reviewing the literature thoroughly, the author has discovered that no one will commit themselves to a set amount of sessions, i.e., no theorist will assert that the initial phase of treatment amounts to X amount of sessions. Most theorists write about this phase simply in terms of what occurs or is likely to occur during this period. Perlman (1957) discusses the Beginning Phase in terms of the person, the problems and the place-process scheme. She describes the contents of this initial phase as consisting of: (1) the nature of the presenting problem, (2) the significance of the problem, (3) the causes and precipitants of the problem, (4) the efforts made to cope with problem-solving, (5) the nature of the solution or ends sought from the

case work agency, and so on (p. 115).

Florence Hollis (1964) also discusses the initial phase under the title "Diagnosis" (p. 178), and basically talks about using this phase for assessment exploration of the problems and eventually arriving at a diagnosis and treatment plan.

Ruth Smally (Roberts & Nee, 1970), who is a representative of the Functional School of Thought in Casework, discusses the initial phase as a process as characteristic of all of life--a beginning. She says:

> Perhaps most essential of all is the worker's sensitivity to what the other is experiencing in the beginning and his response to that feeling, in a way appropriate to the particular situation so that the other is freed to move through and beyond feelings . . . . (p. 120)

Taking Ruth Smally's point further, it became clear that in order for the author to find how long the initial phase (the beginning) lasted, it was necessary to look through my cases very closely. After such an examination, it became clear that until the sixth session the patient is in a very special state of identification and/or in an idealized transference, similar to the early phase of symbiosis (Mahler, 1975). Around the sixth session, a shift occurs. This shift creates a crisis in treatment when there is an entry into the next stage of treatment. Therefore, for the purpose of this research the initial

phase of treatment will be considered as the first six sessions in treatment.

3. Long term treatment. For the sake of this research, treatment which took place over eight months, in which issues of transference, countertransference, and resistance are dealt with, where early material and early conflicts become issues of treatment, and where unconscious material was dealt with and interpreted, will be considered as long term.

4. Short term treatment. For the sake of this research, treatment which took place up to six months is considered short term. This short term treatment was not planned as a treatment modality. Patients terminated prematurely due to various reasons. This treatment started in the same way as did the long term treatment, but was cut off prematurely. The only short term planned case was the crisis case where length of time and treatment plan was set from the onset of treatment.

5. Crisis case (Intervention). A definition from the Encyclopedia of Social Work states that:

> Crisis intervention, viewed within a spectrum of casework and other preventative and remedial mental health endeavors, is a process for actively influencing the psychosocial functioning of individuals during a period of disequilibrium. Its goals are (1) to evaluate the immediate impact of disruptive stressful events, and (2) to help mobilize the manifest and latent psychological capabilities and

social resources of those directly affected for coping with the effects of stress adaptively. (Dr. Howard Parad, 1971, p. 196)

6. Ashkenazi. An Israeli who immigrated (or his parents immigrated) to Israel from Europe or the U.S. Another definition is: a non-Arabic speaking Israeli (M. Z. Segal, Dictionary and Hebrew Encyclopedia, 1976).

7. Sefardi. An Israeli who immigrated (or his parents immigrated) to Israel from an Arabic or Spanish speaking country, i.e., Middle East, Asia or Africa, Spain, South America, etc. (M. Z. Segal, Dictionary and Hebrew Encyclopedia, 1976).

8. "Yored" or "Yordim."

Yored - singular

Yordim - plural

Yored - a derogatory term used by Israelis in Israel to describe the ones who left the country. The one who went down--a deserter.

Yerida - another word for emigration or the going down movement.

This term will be used interchangeably with Israelis in the U.S., or Israeli patients throughout this study.

9. Diaspora. Any dispersion of a people having a common heritage--specifically used in this paper, it refers to Jews living outside the State of Israel.

CHAPTER IV

STUDIES ON ISRAELIS

The Israeli Character--A Modal Personality

Much has been written about the "Israeli character," especially how it is viewed by outsiders, Europeans and Americans. The stereotype seems to be that the Israeli-born or Sabra has specific characteristics which are unique. According to Professor Arnnon Rubinstein of Tel-Aviv University, the male Sabra is popularly regarded as a tall, strong, suntanned man with an aggressive approach to life and people, conceited and kind-hearted with an appreciation of humour and with few manners. This description is a generalization, not only of a Sabra, but of the Israeli in general.

Ruth Bandy (1969) claims that the Israeli male carries around the character of the region, he is the proprietor of the harem who likes to keep his women on the go between sink and bed. There is some truth to this wry feminine comment concerning the Israeli woman. A popular foreign conception is that the Israeli woman is nubile, full figured, and of course sun-browned, easy to know, alert in mind and body, eager to marry and have children, and yet

whole-heartedly feminist. There is much more to Israeli women than this, but it might serve as a basis on which to build a convincing description.

To get a most accurate picture of an Israeli male, one might have to look from two different angles. One is how the Israeli sees himself and the other is how a non-Jewish observer sees him.

An Israeli man sees himself not in the same way as the Jew in the Diaspora. He sees himself not as Jewish but as Israeli, but he would probably agree that Jewishness is part of his identity. Jewishness is no longer defined in terms of a minority group or culture in Israel. The problems, uncertainties and anxieties of being a Jew in the Diaspora do not affect the Israeli. He is a member of a nation and has a collective identity.

In a survey described by Katz and Gurevitch (1976), several thousand members of the general public were asked to identify which of 22 possible different traits of Israeli people they considered "very characteristic." Heading the list was "concern over peace among the nations," followed by self-sacrifice for the ideals of people (for the common good), and "attitude of sanctity towards human life"--"a nation that doesn't rely on others" "emphasis on the importance of family life." Rather surprisingly, "ability to laugh at ourselves" is lowest on the list of

22 characteristics. Many observers would put it higher on the list.

Not on the list at all is a trait which is apparent to the foreign observer--acute sensitivity to criticism and slights. Most Israelis sometimes see unfriendliness where none is intended.

Israelis have been called "aggressive." The term "aggressive" is applied by both Israelis and foreigners but each mean such different things that a dictionary entry might appear like this:

> Aggressive. 1. (Israeli) Self reliant, disinclination to be "pushed around," confident, determined to the point of forcefulness.
>
> 2. (Foreign) Intransigent, abrasive, belligerent, inclined to ride roughshod over other people's feelings.

Perhaps when Israelis are abroad, by their confident bearing, they give an impression of aggressiveness which outsiders assume to be a national characteristic. Mostly they are direct in manner and speech. They are at times painfully, even embarrassingly, direct. They are not given to euphemisms and circumlocutous speech, even among politicians (Laffin, 1979).

On first meeting, an Israeli can also seem not just direct but abrupt or even rude. Appearances can be deceptive. The fact is, Israelis are among the least subservient

people in the world and many of them are not aware of the forms of ritual politeness. Laffin (1979) observes correctly that the Israeli is reluctant to say "I don't know." Contrary to some places abroad, the Israeli does not have a free-living, free-loving, free-wheeling personality. Israeli society has in fact been described as Puritan and this may not be too wide of the mark--though the yardstick is not that of religion but of work. Few people in Israel question the value of work; it is an accepted value (Dicks, 1975).

Israelis hold human life and human relationships in very high regard, but it is possible that their lofty ideas have been tempered by the stark reality of prolonged war or near war. It would be surprising if prolonged war has not made people less sensitive, thus decreasing their respect for their own lives and the lives of others.

Nearly all Israeli men and a good many women, psychologists claim, are afraid to be afraid. They feel, according to Eisenstadt (1967) and Dicks (1975) that it is weak to show fear, unmanly, decided un-Israeli, and unfair to the team. Emotions embarrass the upper-class Israeli--except where Israel and its right to exist is concerned. Displays of deep emotion are seen as an unpardonable indulgence, a weakness impossible to tolerate, an instability that will preclude the person concerned from any real

responsibility; he is not the man you would want next to you in an emergency for "he is not being a man."

Market research and psychological studies are Israeli commonplaces but not until 1976 did anybody think to commission a report into the status of Israeli women. It must be understood that the pioneer Jewish women who helped found the Yishuv (the original settlement) at the turn of the century saw themselves as worker-units rather than as wives and mothers to be protected. In a way, they played the parts of men because of their worker roles; they asked for no favors (Russcal & Benain, 1970) or privileges and no task on the kibbutz was too heavy or unpleasant for them. As mates to their husbands under the arduous conditions imposed by heavy pioneering labor, hostile climate and raiding Arabs, they developed the type of backbone common among the early settlers in the American West, Australia and New Zealand. Their men knew that these women could be counted on to the death.

Today's Israeli women are no less independent, no less courageous, but they rate their femininity high. According to most literature on Israeli women, it is evident that she is able to bear the burdens of life as capably as her grandmother did, but she is more concerned with her appearance and she does not want to act in mannish ways. She joins the army and wears the plain uniform because the

country has not enough men, but she retains her interest in things feminine.

The younger Israeli woman is liberated, but only to a point. In a way she has a split personality forced on her by the time in which she lives. As an Israeli she must have some masculine attributes; as herself, she must and wants to be feminine.

Israeli men expect from their women pretty much what most Western men expect. She must basically be "feminine" which as the men see it means not too independent, not too intelligent or articulate either, not too obtrusive when men are talking. As a sexual partner, the man expects his mate to be vigorous and voluptuous but not to take the lead.

While in public life, the Israeli woman is positive, even authoritative; in private life she is passive even at times submissive. Lesley Hazelton (1978), a British-born Israeli who has studied the role of women in Israeli society says that sexism--or male chauvinism--is "strangling Israeli women as surely as our foremothers were stifled into silence in the ghettos of the Diaspora." Ms. Hazelton claims that a triad of liberation, security and religion governs the lives of Israeli women. She says, "Until we confront the myth of our liberation, the power of religious tradition, and the effects of our national security/

insecurity, we resign ourselves to the role assigned us by the male-oriented society." Although her language is a little strong, her comments in general are basically true.

After two years' study on the status of women, the government-sponsored Namir Committee presented its report, "Status of Women in Israel" in 1978, headed by Mrs. Ora Namir, a Knesset (Parliament) member. The committee was comprised of 92 men and 2 women, a disproportion some people might find disturbing, considering the nature of the report. In this report, Mrs. Namir and her colleagues admit that Israel is a male-oriented society, a fact illustrated by example and by statistics. For instance, of 700 types of jobs in the Israel defense forces, only 200 are open to women.

The lot of the career woman at the top of the socio-economic scale is not satisfactory, Mrs. Namir's report states. Husband and wife may be equally educated and both may work outside the home. "Yet the husband comes home and expects to relax and find everything ready for him," says the report. A lot of archaic (Biblical) rules and laws still govern marriage and divorce which make it specifically hard for women to remarry. But the Citizens' Right Movement, headed by Shulamit Aloni, Knesset member, is always fighting to circumvent laws which discriminate against women and it is widely held that sooner or later

their archaic judaic prohibitions will crumble.

Despite certain equalities granted to women by law, they have not escaped from the traditional female jobs and obligations. Indeed, women seem to have surrendered some of the privileges which they won at such great cost and have gone back to the kitchen sink. Somehow they have shown to the man that they can do it all.

On the other hand, the Israeli feminists vigorously fight the old traditional roles, especially the traditional male terminology associated with the Divine Person and have proposed a glossary of substitutes for such words as "Father," "Master," and "Lord."

As must be evident, the Israeli is a worried person. The unavoidable stresses of life, the constant threat of war, the general lack of money, the great and constant inflation which affects every household in the State, create extreme tensions which Israelis must face on a daily basis. But the Israelis are resilient, and are accustomed to quick fiscal and mental adjustments.

It is felt that there is a danger that Israel is producing fewer independent thinkers than in the days of the Yishuv or in the early days of the State. This is the result of the school system and a social pattern based on a security above all attitude. The emphasis is on conformity, for in Israel's precarious situation, deviance

is an "un-Israeli activity." And yet deviance, original and lateral thinking and independence of outlook, are essential to a country which must have its collective wits about it (Becker, 1973; Eisenstadt, 1955).

Problems of Migration and Reacculturation

Migration from one state to another and from country to country is as old as time itself. It is a known phrase to call the Jew a "wandering Jew" as he has always wandered from country to country, never having a homeland of his own. But in the mid-forties of the 20th century, the State of Israel was reborn. Migration to Israel continued and was looked upon as a virtue by all Jews over the Diaspora. But Israelis don't only go in. They also get out.

The phenomenon of migration is characterized by a movement of individuals or groups from one geographic area to another. It also generally involves other shifts, mainly in the psycho-social arena and from one social stratum to another.

Israeli and Jewish theorists have addressed the problem of migration from Israel. Writers like Dekel (1977), Feran (1977), Handleman and Kurshman (1977), and especially the Israeli sociologist Eisenstadt (1955), have discussed the reasons for the migration, which might range from psychological problems to socio-economic problems or other

insecurities and frustrations. It is the fantasy of success in the new country that draws the emigrant to make the decision to leave. The major issue seems to be insecurity and conflicts, and a wish to change one's conditions.

Discussions as to the reasons for leaving the homeland have been going on as long as there have been "Yordim." Friends and family who have emigrated from Israel to the U.S. have encouraged their relatives in Israel to do likewise. The chronically strained economic situation in Israel provides further motivation for persons to leave. The Israelis are among the highest taxed peoples in the world. Israeli money provides very little buying power. For the Israeli citizen who is highly motivated to work and makes a success out of himself, the United States seems like a veritable paradise--a place where "the American Dream" can still become a reality. In addition, and weighing even more heavily on the Israeli, is the constant pressure of war, or the constant foreboding threat of upcoming war. For every able-bodied citizen, the military service (Miluiium) requires two to three months a year away from family and business. The threat of death is always hovering over their heads.

Despite these strong and certainly understandable reasons for emigration, even before he departs the country,

the Israeli who decides to leave is called a "Yored" (someone who went down), and it is not a term which can be borne easily.

The actual application to leave bears with it tremendous procedural and bureaucratic difficulties. For this reason, and for other deeper psychological reasons, many Israelis who decide to emigrate claim that they only intend to be tourists or students, even if it is their real intention to stay in the adopted country for good. Those who openly declare their intention to stay in the U.S. must prove that they have family/blood relationships or they must encounter the quota system, and face possible denial of passport to the new environment.

The very act of "Yerida" (emigration) is inextricably linked in the Israeli mentality with pain and guilt. The "Yored" is considered by the Israeli society to be a deviant, in fact, something of a traitor. To become a "Yored" is a non-conformist and profoundly non-Israeli act.

Some of the "Yordim" are people who were considered deviant in the Israeli culture; some had had problems with the law, with the IRS, and desired to leave their problems behind them. But regardless of the real or imagined transgression, most who have emigrated to this country seem to suffer guilt or shame for being away from the "Mother Land."

These "Yordim" are not respected by their fellow Israelis in Israel and are not welcomed by the Jewish community in the U.S. Prime Minister Rabin, in his speech in 1977, called the "Yordim" "Nipolet shel nemoshot"--or the drippings of the lowest of the low, and added that they are "hahalashim shebahalashim" or the weakest of the weak, and James Feron (1977), quoted Rabin as saying, "I see no justification come what may for anyone born in this country (Israel) or living here to get up and say 'I'm deserting the battlefield.'"

These negative feelings and attitudes don't only come from Israel, they exist in the U.S. too. As mentioned before, the Jewish community has difficulty dealing with the ever-changing "Israeli dream of Zionism." Israelis who stay in the U.S. are aware of these attitudes, they encounter them every day. They know they are held in contempt by Israelis and by American Jews alike. They also see themselves as deviants and feel guilt, despising themselves and others. Because of these attitudes from the outside and the inside of the country, Israelis, especially of a certain class, tend to cluster in groups and even live close to one another in certain parts of town. What they have in common is the fact that they are all committed to the same deviant act, the act of "Yerida." They speak the same language, share similar values and all feel the same

pain in their hearts. An Israeli activist in Los Angeles who has been in the U.S. for 20 years told this writer in May 1981, "I live here--I live in illusions that I'm there." This pretty much describes it all.

But there are other problems that occur due to emigration of Israelis to the U.S., problems such as: lowered self-esteem and self-worth, economic difficulties, and psychological problems due to adjustment and culture shock.

> Emigration took these people out of traditional accustomed environments and replanted them in strange ground, among strangers, where strange manners prevailed, the customary modes of behavior were no longer adequate, for the problems of life were now different with old ties snapped, men faced the enormous compulsion of working out new relationships, new meanings to their lives . . . . The immigrants lived in crisis because they were uprooted, in transportation, while the old roots were sundered, before new ones were established, the immigrants existed in an extreme situation. The shock and the effects of the shock persisted for many years. (Handlin, 1952)

The next question is, what happens to a person of such national character and conditioning when he or she leaves the State and emigrates to the U.S.? Studies and my own observation have revealed that these immigrant Israelis suffer severe culture shock because they experience so much external rejection and internal guilt. For this population group, the adjustment process can be extremely painful. Most have left friends and relatives; most come not knowing the language very well, have not

initiated new relationships, and as a result, feel great loneliness and isolation.

In keeping with their national character, many Israelis respond to their culture shock emotionally, without reflecting upon or identifying their difficulties. Instead, they act out their distress by being apathetic and/or critical of their new environment. Others cope by a complete identification with their new environment, a reaction formation which merely exacerbates their feelings of guilt for having abandoned the homeland.

On a deeper psychological level, many develop emotional problems that maybe had their origins in Israel but get manifested due to the difficulty in the emigration process. Some get paranoid, excessively aggressive, obsessive, compulsive, tremendously frustrated, and finally feel isolation, helplessness, and a constant longing to go back home.

On a healthier side, if one can go through acculturation in the new country, there is then a greater chance for assimilation. The acculturation process involves an adaptational ability to the new life style patterns in the new culture, while the assimilation is becoming a part of, an absorption, an incorporation in the pulse of life in the new country.

The process of acculturation and assimilation is a long and tedious one. To become accepted and comfortable

in a new country is different from having to identify with its norms and values and give up one's former culture. This process actually never happens to Israelis. They are constantly in limbo emotionally. They are torn between their own culture and the American culture, and do not assimilate. Israelis always consider themselves Israelis even though they might be in the U.S. 20 to 30 years. Therefore, one might say that Israelis are always in a state of flux emotionally, always uprooted and maybe always in some sort of an emotional "culture-identity crisis."

It is important to note that there are a lot of Israelis who have managed to get lost in the American culture. They are uninvolved in Israeli causes, do not donate of their time or their money, but as one Israeli oldtimer said, "If there was a war in Israel now, 100% will be ready to get on the boats or the planes and go to serve." The loyalty to Israel, the upbringing, the guilt, and the negative attitudes of the Jewish community all contribute to the fact that Israelis have difficulty in assimilating in the American culture.

The Current Condition and Typology of the Israeli in Los Angeles and the United States and the Jewish Community's Response to It

As the following official press release attests, there are currently approximately 400,000 Israelis living in the United States:

INDEPENDENCE DAY STATISTICS

JERUSALEM, MAY 10 (JTA) -- ISRAEL'S POPULATION ON HER 30TH ANNIVERSARY WAS 3,676,000 PEOPLE, 3,095,000 OF THEM JEWS. WHEN THE STATE WAS FOUNDED MAY 14, 1948 THE NUMBER OF JEWS IN ISRAEL WAS 650,000 COMPARED TO 150,000 NON-JEWS. OF THE 2,445,000 JEWS THAT WERE ADDED TO THE POPULATION SINCE 1948, SOME 1.3 MILLION CAME ON ALIYA, AND THE REST ARE SABRAS. CLOSE TO 500,000 HAVE EMIGRATED FROM ISRAEL, THE MAJORITY OF THEM TO THE U.S., WHERE IT IS BELIEVED THAT THERE ARE NOW SOME 400,000 ISRAELIS. (JTA Daily News Bulletin), Thursday, May 11, 1978, No. 92.

It is common knowledge and a visible fact in Israeli circles in Los Angeles that more Israelis continue to arrive daily. Seldom is there information on the return to Israel. It is estimated that from 80,000 to 150,000 Israelis (or ex-Israelis) are residing in the greater Los Angeles area alone. These figures are derived from sources such as the Israeli Consulate, some long-time Los Angeles Israeli residents, and certain knowledgeable professionals from the Jewish Federation.

Established statistics on the greater New York-New Jersey area put the Israeli population there at from 250,000 to 300,000, leaving approximately 100,000 to

150,000 for the rest of the U.S. From these data a logical deduction-computation can be made in which it is safe to assume that 80% to 90% of the balance of the Israeli population in the U.S. can be found in Los Angeles and in Southern California (which, by the way, is physically a giant version of Israel's general landscape and climate). This means that between 12% and 25% of Los Angeles Jewry is comprised of Israelis. (The Los Angeles Jewish Community Survey, conducted in 1979 and published in April 1980 by Jewish Federation-Council, reports the number of 503,000 Jews in the greater Los Angeles area.)

Who are they? A typology. Israelis in America represent the complete cross-section and make-up of the Jewish population in Israel, coming from all walks of life and from all possible socio-economic, cultural, educational and ethnic background. Among this population group can be found Israeli-born and foreign-born olim (immigrants to Israel) from all and every national, geographic and cultural-ethnic background--Ashkenazim and Sephardim, etc., holocaust survivors and idealistic immigrants and pioneers, displaced refugees from Arab countries and American Jews who tried it and then decided to return to the U.S., non-skilled emigres, skilled professionals, academicians, artists, musicians, performers, educators, doctors, lawyers, scholars and scientists. Many of these were educated in Israel, others in their former original countries of birth.

They are graduates of every school system and district since World War II, the pre-State undergrounds, the 1948 War of Independence, the 1956, 1967, and 1973 wars and all the special operations in between. They are veterans of every branch of the Israeli Defense Forces, including elite units, commandos, some pilots, etc. Their military ranks range from privates to colonels. They belonged to every political party in Israel. Noticeable, however, to this research, is one significant distinction, the almost complete absence of orthodox Israeli Jews amongst the emigres.

They arrive as students pursuing one degree and often end up getting two or three degrees. Many singles arrive as students or tourists and end up marrying American spouses.

Many come for two or five years "just to study" or "make some money" and stay longer or indefinitely. Many arrive as declared immigrants with anger and pain in their hearts, disenchanted with Israel or tired from its wars and its highest taxation in the world. Some escape problems of commitments, and some are in pursuit of the legendary American dream (Yitchak Dekel-Tafnit, November 1980).

It is important to define and understand the wide range of complex emotional, philosophical, ideological, theological and historical questions surrounding the

phenomenon of Israeli immigrants in America. There are bewildering ironies involved, especially vis-a-vis Israel's desperate need for a continuous flow of Aliyah (immigration). The Israelis in America constitute an irritating abnormality, a very disquieting National-Zionist absurdity.

Israelis in America "rob" the American Jew of the idealized Israeli image and what it stands for. The "Sabra" was its epitomized ideal type. Since 1948, the American Jew looked proudly up to the modern Israeli, who made it in Israel historically, demographically and heroically. A Jew who can fight (and win), who became "the best farmer and soldier in the world." Now many of those strong idealistic Israelis are coming to live in America and thus the legend dulls and is tarnished. By their very presence, Israelis in America are a living reminder to the American Jew of the abnormality of the Jewish condition in the world and in America today. In Jewish historical, theological and Zionist terms, the task of redemption and rebuilding the Jewish nation on its historical and natural land of Israel is incomplete. The dream of the universal ingathering of the dispersed "B'nai Israel" children of Israel in Israel, now open and available to every Jew, and needing every Jew is only partly fulfilled, the challenge and calling that Israel constitutes to every Jew in the Diaspora, is congruent with our most ancient hopes and

aspirations. Our national dreams and yearnings for the revival of our glorious ethos in Eretz Israel (land of Israel) are expressed and reflected in every synagogue service every Shabat and Holy Day throughout America. This intellectual and emotional inconsistency can account for negative attitudes and the reluctance of the host communities to properly respond to the growing numbers of Israelis in our midst.

Attempts to count accurately, pool or identify the Israelis in our midst and their needs have been frustrated by a chronic lack of studies and research with very few recent exceptions. Neither the State of Israel nor the organized Jewish Community in the States or any major university in Israel or here, found it important or urgent enough to invest in thorough studies.

The organized American Jewry traditionally and historically endorsed, echoed and supported almost every Israeli cause and policy. This has changed significantly since the trauma and the aftermath of the 1973 Yom Kippur War. Until recently, Israel's official policy and public opinion, as expressively reflected in the Israel media, fully and categorically condemned Yordim (immigrants) and Yerida (immigration). On grounds of vital interests of national security and classic Zionist ideological arguments, emigration of Jews from Israel is detrimental to its purpose,

fabric, strength and future. Thus, Aliyah is Israel's foremost national interest and Israel will never remain passive, nor will it ever tolerate with ease, emigration from its borders. On the issue of Israeli immigrants, the American Jewish Community's attitude, until recently, reflected Israel's official policy of outright condemnation. This may explain the slow and minimal responses of the various professional agencies in developing the tools of research, outreach and services to the Israelis in America (Tafnit, November 1980--Yitchak Dekel, M.A., a Jewish high official in the Israeli Division of United Jewish Welfare Fund of Los Angeles).

CHAPTER V

THEORETICAL FRAMEWORK

The cases presented in this study were treated by this therapist from a psychodynamic theoretical frame of reference with a focus on object relations theory. They were analyzed from the same theoretical and treatment modality.

Mahler's developmental concepts are described to illustrate separation-individuation issues with these patients and developmental stages in which they entered into treatment. Issues of merging and unity with the therapist will also be looked at from an object relations point of view. Other theorists in psychodynamic theory are interwoven as well, including Freud, Kernberg, Hartmann, Jacobson, and others. From the social work literature, theorists like Perlman, Turner, Hollis, and more are reviewed in relation to the nature of the initial phase of treatment.

It is important to note that cultural issues are also addressed. Specific emphasis is given to the interface between psychodynamics and cultural issues and how it affects the treatment process, specifically the initial phase of treatment.

After reviewing the literature extensively on the initial phase of treatment, it was realized that no one defines the number of sessions comprising this phase (as mentioned before in this study). Therefore, I set the time at six (6) sessions--as an outcome of my experience with these Israeli patients. It seems to me that up to the sixth session, these patients stay in a somewhat "idealized" state of transference.

In order to understand how significant and unusual this "idealized" state of transference is, it would be beneficial to look at what theorists say occurs to the patient in a so-called "normal" initial phase of treatment.

Greenson (1972) claims that the patient comes to treatment (analysis) because he/she is in some kind of intrapsychic pain. This is the motivating factor that brought the patient to treatment. Although the patient is sincere about working on his problems, two very important reactions occur almost immediately in the initial phase of treatment. One is transference, and the other resistance. He says that "transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person, and a repetition or displacement of reactions originating in regard to significant persons of early childhood" (p. 33). This idea came from Freud's 1912 concepts on transference.

Resistance refers to all the forces within the patient which oppose the procedures and processes of psychoanalytic work. To a greater or lesser degree, it is present from the beginning to the end of treatment (Freud, 1912).

Greenson states that in the beginning of treatment, the patient enters into transference immediately and resistance occurs almost from the start. He claims that the treatment situation mobilizes conflicting tendencies within the patient. On one hand, there is a wish to accept, and overvalue the competence of the analyst which may induce the patient to work temporarily, but "that is far more unreliable and prone to turn into its opposite" (p. 99). He says that the overevaluation of the analyst are short term allies which are also basically resistance. Also, the therapist's first task is to recognize that resistance is initially present.

Greenson (1972) mentions in great detail the different types of transference and resistance which occur in treatment. He also makes a strong statement on the "treatment alliance" which occurs much later in treatment.

In 1965 Greenson wrote that the working alliance deserves to be considered a full and equal partner to the transference neurosis in the patient--therapist relationship. This he claimed happens later in treatment, but sprouts in the initial phase of treatment.

Wolberg (1954) talks about the beginning phase of treatment. He centers his discussion on (1) the technical aspects of this phase, and (2) on establishing a working relationship. He claims that due to most patients' high anxiety during this phase, and the therapist's need to explore and elaborate on the patient's problems, a proper kind of working relationship often does not occur. He says that the therapist must help the patient who is in pain to have rapport with him and that the therapist must "win the patient over." "The cultivation of a proper working relationship is the primary objective of the first treatment phase. For without it, the patient will not resolve basic resistance to the meaningful exploration of his problem" (p. 317).

He also claims that the patient is very resistant, nervous and not open to insight. The patient yearns for dependency and acceptance, and has the need to relieve himself of painful feelings and ideas. He also believes that transference occurs right from the start, and that resistance is always present.

Wolberg sees that the patient might force the therapist to fulfill multiple roles, i.e., a helping authority, idealized parent image, actual parental representative or cooperative partner. All these start forming within the transference in the patient's mind but are

worked on in the middle phase of treatment.

Other psychoanalysts and psychotherapists seem to agree, i.e., Kernberg, Freud, Coleman, Fromm-Reichmann, that only in the middle phase or working-through phase is where issues of transference and resistance are worked on systematically.

Helen Perlman (1957) discusses the process in the beginning phase in terms of person, problem and place. She says that in this phase the client must have a demonstration of what he is undertaking. The beginning phase of this experience must involve more than a delineation of problem and an offer of service. The client and case worker should go forward together in their problem-solving effort. She sees it as a "pact" (p. 106) between patient and therapist. She says that the aim of the beginning phase is "to engage client and his will to do something about his problem in a working relationship" (p. 106).

Perlman claims that when a person decides to ask for outside help for his problems, the actual experience does not always feel constructive and hopeful to the person himself. It may, on the contrary, be charged with feelings of desperateness and of relinquishing his own rights and responsibilities into the hands of another. These feelings of sinking dependency or of fighting self-assertion mingle with the emotions that already surge in the potential

client. The business of being helped becomes an additional problem.

The beginning stage is marked with fears, anxieties, mistrust, and perhaps frustration which are experienced by the client simultaneously. She, like Wolberg, also sees that the client gets even more frustrated in the initial phase because of the process of "data gathering." Until there is a "joint understanding" between client and worker, the client may have withheld consciously, unconsciously or unknowingly, certain facts of significance. He may have only a glimmering recognition but a strong trust in what the experience ahead of him is likely to be. On the other hand, he may have considerable clarity about it but some misgivings and only a tentative willingness to involve himself. The worker must use all this information for a tentative diagnosis and course of treatment.

Like others, she sees that transferential issues sprout in the beginning phase, that resistance is always present, but that the working through insight starts only later in the middle phase of treatment. They all agree that a therapeutic relationship, a "working alliance," must take place in order for the therapist to be able to help the patient struggle through the resistance and work through the transference.

The following will be a review of the frame of reference used to analyze the material in the cases used in this study.

One way to understand these patient's problems and difficulties in and out of treatment is to look at their development, and at their developmental arrests.

Mahler's work on the developmental stages of the human infant fits well into the framework of this study. It seems that these patients whose arrest occurred during the separation-individuation process repeat certain aspects of it in their treatment.

Separation-individuation is a very complicated process that begins with the child's birth and entry into the world. "It is at the end of the first year and in the early months of the second year that one can see with particular clarity that the intrapsychic process of separation-individuation has two intertwined, but not always commensurate or proportionately progressing developmental, tracks. One is the track of individuation, the evolution of intrapsychic autonomy, perception, memory, cognition, reality testing; the other is the intrapsychic developmental track of separation that runs along differentiation, distancing, boundary formation, and disengagement from the mother" (Mahler, 1975, p. 63). This is the phenomenon that will be addressed here.

Mahler, Spitz, Jacobson, and Greenacre write extensively on the Mother-Child unit. As mentioned before, this writer sees that in the initial phase, some Israeli patients go through an experience of uniting with the therapist in a very special way. During these six sessions when they create a bond, it is similar to what Mahler (1975) describes in the symbiotic stage when mother is seen as omnipotent, all giving, the "good mother," creating "duality" and "unity." The cathexis is to mother, and is the principal psychological achievement in his phase. The child begins to establish "Memory islands" (Mahler, 1955) of "good" and "bad," pleasurable, and unpleasurable experiences. The mother is feeding the child and holding the child. In the symbiotic months, the child according to Spitz, has familiarized himself with the mothering half of his symbiotic self, as indicated by the unspecific "social" smile. On the other hand, during differentiation, the baby is smiling to her (Mahler, 1957). This specific preferential smile is "a crucial smile that a specific bond between the infant and his mother has been established" (Bowlby, 1958).

During the differentiation, the first subphase of separation-individuation, all normal infants achieve through maturation of apparatuses, their first tentative steps of breaking away, in a bodily sense from their

hitherto completely passive lap--babyhood--the stage of dual unity with the mother. The child is now five to six months old and likes, as much as his motor apparatus permits, to wander just a bit of distance away from the enveloping arms of the mother, but never too far. At this stage, for instance, the child likes to slide down from mother's lap, but also tends then to remain as near as possible and to play at her feet.

Once the child has become sufficiently individuated to recognize the mother, visually and tactilely, not only as part of the symbiotic dyad but as his partner in it, the fact that he is ready to take this step is indicated by his preferential, specific smiling response to and for mother. He also turns to explore other faces, a phenomenon called "stranger reaction." He appears to be checking, comparing, and feeling the texture, and contour of the stranger's face as compared with mother's, as well as with whatever inner image he may have of her. He also keeps checking back all other new experiences with the mother's gestalt. What belongs and doesn't belong to mother (eyeglasses, earrings, etc.), learning about other than mother. Spitz (1946) called this period the "eight-month anxiety" in general and "stranger anxiety" in particular.

It is interesting to note that in children whose symbiotic phase has been optimal, curiosity and wonderment

has been the major thrust of this preoccupation. But where basic trust has been less than optimal, an abrupt change to acute stranger anxiety may occur. Mahler and her colleagues believe that stranger anxiety is the first step towards emotional object-constancy (Mahler & McDevitt, 1968).

In cases where the symbiotic process, the creating of the common shielding membrane of dual unity has been delayed or disturbed, the process of differentiation seems to be delayed or premature. These earliest differentiation patterns are responsible for creating patterns of personality organization which seem to remain consistent in the further development of the separation-individuation process and possibly beyond. The child becomes more of an independent individual in response to the mother's selective attention to his cueing. It is in this process that the child gradually changes his behavior. In 1963, Mahler wrote, "It is the specific unconscious need of the mother that activates out of the infant's infinite potentialities, those in particular that create for each mother 'the child' who reflects her own unique and individual needs. This process takes place, of course, within the range of the child's innate endowments."

During this period of important oneness with the mother, those infants whose mothers have enjoyed the

symbiotic phase without too much conflict, and who have been saturated, but not overly saturated by maternal attention, begin at the average time to show signs of active differentiation by distancing slightly from the mother's body. But in cases of ambivalence or parasitism, intrusiveness or "smothering" on the mother's part, differentiation showed disturbances of various degrees and forms.

But when mothering is adequate during this period, the child is definitely establishing a special relationship with her. He gets a sense of who he is and who is his mother. The differentiation subphase is overlapped by the practicing period.

Mahler (1975) has divided the practicing period into two parts: (1) the early practice phase (seven to 11 months) which is characterized by the infant moving away from the mother by crawling, climbing, etc., while still holding on to her; and (2) the practicing period proper (11-18 months) where there is free upright locomotion.

The most important three developmental steps occur during this time, namely rapid body differentiation from mother, establishment of a specific bond with the mother, and the growth and functioning of the autonomous ego apparatuses in close proximity to the mother. During the early practicing phase, although the infant's world is

expanding dramatically, the mother is still his anchor. He can see, smell, touch, grab, perceive, and recognize objects, and so he can now engage mother from a greater distance. At this stage, the child uses his mother for emotional refueling. Though he is now venturing a bit away from her, there is a need for the sound of her voice and for her physical proximity. Optimally, during this early practicing stage, the child should be allowed to move away from the mother and yet to use her as his "home base." As can be expected, at this stage most children go through separation anxiety, due to the push-pull experience towards and away from the mother. At this sensitive stage, infants need both to hear and see mother, so as to be able to function without fear of her loss.

During the practicing subphase proper, the child is in an upright position which brings him even closer towards individuation. The plane of his vision changes. Greenacre (1957) characterizes this stage as "the child begins a love affair with the world." The child is elated from the escape of fusion and engulfment by mother." Cathexis shifts from libido to the rapidly growing ego. His motor skills are developing and he is experimenting with his environment. The child is intoxicated by his own capabilities, and narcissism is at its peak. His own functions, his body, and the object are the objectives of

his expanding reality--independent of mother. He is immersed in his own grandeur and omnipotence.

This period is marked both by the need and the fear of engulfment by the mother. The importance of walking at this stage cannot be overlooked or overestimated. Walking has symbolic meanings both to mother and to the toddler. Walking means independence. Here the mother's reactions and behaviors are crucial. Her confidence in the child's new skill can trigger his sense of safety, self-esteem and autonomy. Conversely, her fearful, hovering behavior can trigger anxiety and loss of self-esteem. This is a time when the child needs encouragement, not engulfment, from the mother.

During this phase, the beginnings of assertion of self and of individuality are marked. The child feels omnipotent, and everything seems like magic under his control. However, separation from mother, even temporarily, causes a low-keyed effect, like a mini-depression and triggers a fear of object loss.

Paradoxically, then, during this exploring, moving away from the mother phase, there is also a longing for a stage of homeostatis and well-being, and in some children, a wish for unity and closeness with the mother. The ego is developing rapidly, and the child is mastering and practicing his own skills, independent of others or of

mother. But mother is still the center of his world.

The toddler is now about a year and a half. He has acquired free locomotion, upright position, some cognitive development, the beginnings of representational intelligence, and is starting to be a separate and an autonomous person (Mahler, 1958).

Now that the toddler has a separate identity and is more and more aware of it, he is experiencing great strides and great frustrations. The need for mother's presence is great. There is increased separation anxiety and fear of object loss. As awareness of separation grows, there is a complementary need and wish to share with mother every new skill, new experience, and a great need for object love. The mother's acceptance and love of toddler's ambivalence allows the "toddler to cathect his self representation with neutralized energy" (Mahler, 1968). In this period, there is both a search for and avoidance of bodily contact. The interaction with the mother is now on a higher level. There is a symbolic language, vocal or through other ways of communication and play becomes much more prominent and directed towards a toy or any other object.

Separation reactions are now very strong. There is increased "shadowing," the watching and following of the mother. At the same time, there is darting away and

the assertion of autonomy by the use of "no," and increased expression of aggression and the negativism associated with the anal phase. There is great sensitivity to disapproval and criticism.

Here there is more frustration, fear of object loss, and separation anxiety. What looked before as obliviousness to mother's presence is now intensity and a holding onto the mother and a constant concern with mother's whereabouts and presence. The toddler's pattern of shadowing and darting away is increased. His defiant use of "no" and sensitivity to disapproval and negativism reminds us of the anal phase. The toddler is now aware that the world is "not his oyster." That he has to cope with it "on his own." Concomitant with the acquisition of primitive skills and perceptual cognitive faculties, there has been an increasingly clear differentiation, a separation between the intrapsychic representation of the object and the self representation. The quality and measure of the wooing behavior of the toddler towards his mother during this subphase provide important clues to the normality of the individuation process. Fear of losing the love of the object (instead of fear of object loss) becomes increasingly evident (Mahler, 1966).

The toddler's demand for his mother's constant involvement seems contradictory to the mother. While he

is not as dependent and helpless as a half a year ago, he is more eager to be so, and share every aspect of his life with her. During this subphase, some mothers cannot accept the child's demandingness. Others, by contrast, cannot face the child's gradual separation.

There is a definite struggle with the love object--mother through temper tantrums, greater vulnerability, impotent rage, helplessness, and recurrence of stranger anxiety. There are definite danger signs in this stage which could be responsible for later psychopathology. Increased separation anxiety would show that something in the mother-child unit is not soothing to the child and causing him to fear object loss. Less emotionally available mothers would not respond to the shadowing and so the child would exaggerate it to get the closeness or shorten this stage by desperate measures of acting out, such as clinging, crying, spilling or prolonged sleeping. Mothers who are intrusive would shadow the child too much, probably because of their own anxiety of the child's separateness and so the child would be frightened and clinging.

At this stage, there is increasing structuralization of the ego, and the continuing establishment of a cohesive self. Now there is a discovery of separateness and the power to ask and for the wish to be fulfilled, to be praised and admired by mother and others through the performance of

of a skill. At this stage, it is the child who is eager to bring pleasure to mother (for bringing toys, etc.), and the more painful aspects of separateness are only in the shadows.

This brings us to the rapprochement crisis which occurs according to Mahler at 18 to 24 months and beyond. Here there is a need to increase autonomy to the hilt. The toddler has the desire to be separate, grand, omnipotent on one hand, and to have the mother fulfill every wish without a child having to ask for it or having to recognize that the help is coming from the outside.

Some toddlers go through mood changes, dissatisfactions, instability, and increased temper tantrums. This period is characterized by rapidly alternating desire to push mother away and to cling to her. The world "ambitendency" used by Mahler (1975) describes it best, as ambivalence is definitely there. Mother is used as an extension of self--a process by which the toddler somehow denies the painful awareness of separateness. The child experiences sudden anxiety that the mother had left or a "non-recognition" (Mahler, 1975) of mother after a brief absence on her part. This strange phenomenon is probably a forerunner of the projection of one's negative feelings. The desire to function by one's own self may be too threatening to the child, especially because on a feeling level

both mother and child's feelings and wishes are still so poorly differentiated. The wish to be autonomous and separate from mother might also mean emotionally that the mother would wish to leave him (introjection, projection period of Ferenci, 1913). Things are even more complicated by the fact that most mothers react adversely and with annoyance to their separating-individuating toddlers. Another interesting phenomenon is that there is a powerful resurgence of stranger anxiety reaction at this time even to people who were previously considered special friends.

Indecision is another typical behavior. There is a wish by the toddler to enter his world away from mother and a pull to remain with her.

There is also a widening of emotional range and the beginnings of empathy in this stage. The toddler experiences a wide variety of affects which become differentiated. In the period before there was hyperactivity and restlessness as a defense against the sadness and loss of the previous symbiotic unity. Now, the need to deal with the affects of sadness and anger, disappointment in mother, and the realization of one's own limited abilities and relative helplessness could be linked to many different behaviors. Toddlers can often be seen as fighting their tears--attempting to suppress a need to cry.

There are also signs of identification with the attitudes of others, especially mother and father, on a

higher level of ego identification, such as taking over patterns of the mother's caring for them in their own steps toward individuation and separation, i.e., self-comforting behaviors.

There are great separation reactions during the rapprochement crisis (18-21 months). At this stage, toddlers are very sensitive to mother's whereabouts. The idea that mother can be somewhere else (cognitively) and could be found is now established according to Piaget's (1937) object permanence phenomenon. The toddler doesn't like to be passively "left behind." Difficulties with the process of leave-taking itself begin to develop--there is more clinging to the mother accompanied by depressive mood and a brief period of inability to be involved in play. Many times, the toddler would find another adult or even a stuffed animal to sit on their lap or to hug, a symbiotic mother substitute, an extension of the self. Yet, splitting the object world has begun. Mahler (1975) reports that the toddler would get full of impotent rage at the observers in order to protect the "good" mother image from his destructive anger. If the observer during the mother's absence became the "bad mother," then she couldn't do anything right and the mood of general crankiness prevailed. The "good mother" was longed for yet she seemed to exist only in fantasy. When the real mother arrived, she might be greeted with anger, disappointment,

and other negative reactions or with "what did you bring me?" Or the observer might become temporarily a "good symbiotic mother." Then the toddler might passively sit on her lap and eat cookies like a small infant. Yet, when the mother would come, there might be an impulse to get to her as fast as possible or to avoid her as if to ward off further disappointments. The toddler might ignore mother, go towards, and then veer away, rejecting mother's overtures. The observer could have also been "good and bad" mother like mother in real life.

According to Mahler, many of the individual's problems are realized during this period which stay throughout life and many times never get resolved.

By the age of 21 months, a general diminishing of rapprochement--the state of optimal distance--occurs. The clamoring for omnipotent control, the extreme periods of separation anxiety, the alternation of demands for closeness and for autonomy--all these subside for awhile. There is also some optimal distance from mother--a distance which each child could function best in.

Sign of the growing individuation which served to make it possible for the toddler to function at a greater distance and without mother's physical presence are:

1. The Development of Language. Naming objects and desires, and therefore an ability to control his environment.

Use of personal pronoun "I" and the ability to recognize people and self in photographs.

2. The Internalization Process. An identification with the "good" providing mother and father, and the internalization of rules and demands (beginnings of super-ego).

3. Progress in the ability to express wishes and fantasies through symbolic play as well as use of play for mastery.

At this point, 21 months and up, it was observed by Mahler's study that each child was different. It was no longer phase specific. Relationships between mother and child, father and child, were different. Boys' developments were different from girls'. Boys disengaged from mother more than girls did, wanted more closeness, and were more immersed in the ambivalent aspects of the relationship with mother. (The narcissistic hurt of not having a penis experienced by the girl was almost without exception blamed on the mother.) The boys coped with the girls' penislessness in a less overt way, their apperception became confused with anal concerns and later with phallic castration anxiety, expressed symbolically in their play.

By the 23rd month, the ability to cope with separateness and actual physical separation depended on each case history of the mother-child relationship. It was hard to pinpoint just what it was in these individual cases which

produced more anxiety in some and an ability to cope with others.

This has been the "final phase" of rapprochement--a period of intrapsychic development and maturational development in which each child had arrived at his own individual style of coping.

During this subphase, we see the beginning of gender identity. The children have discovered their anatomical sexual difference (16-17 months, more often 20-21 months).

Boys' discovery of their own penis usually occurs earlier. The sensory-tactile component may date back even to the first year of life, but there is an uncertainty as to its emotional impact. Around 12 to 14 months, the ability to be in an upright position facilitates the visual and sensory-motor exploration of the penis. Possibly the maturational advances in zonal libidinization lead to a greater cathexis in this "exquisitely sensuous, pleasure giving organ" (Mahler, 1975).

At the practicing subphase--boys explore their penises--at first an experience of unmitigated pleasure. Later, during the separation-individuation phase (end of second and beginning of third year), boys clutch their penises for reassurance in moments of anxiety.

The girls' discovery of the penis confront them with something that they were lacking. This brought anger,

anxiety and defiance. They wanted to undo the sexual difference. Therefore, masturbation takes a desperate aggressive quality, more than the boys, and at an earlier age. This occurred with the emergence of envy. It could be that early penis envy may have accounted for the persistent dominance of this effect.

The task of becoming a separate individual seemed to be more difficult for girls, according to the psychoanalytic view, because upon discovery of the sexual difference, the girl turns to the mother to blame her, demand of her, be disappointed in her, and still be ambivalently tied to her. At this stage, the girl is hit with the devastating sense of her own imperfection.

Boys seem to be faced with castration anxiety later (second and third year). They seem to find it more expedient to function separately and turn to the outside world quicker or to their own bodies for pleasure and satisfaction. They also turn to father as someone with whom to identify. They seem to cope with their castration anxiety in this phase of quasi-preoedipal triangulation (Abelin, 1971).

According to Mahler (1968, 1975), if the rapprochement crisis persists, it indicates a premature internalization of conflict, developmental disturbances that were precursors of infantile neurosis, but may decisvely stand in the way of development of infantile neurosis, in the classical sense!

The child alternates between coercive behavior with desperate clinging in order to force the mother to function as the child's omnipotent extension of self. In those children with less than optimal development, the ambivalence conflict is realized in the rapprochement subphase in rapidly alternating clinging and negativistic behaviors. In some cases, this phenomenon may be a reflection of the fact that the child has split the object world more permanently than is optimal into "good" and "bad." By means of this splitting the "good" object is defended against the derivatives of the aggressive drive. These two mechanisms of coercion and splitting of the object world if excessive are also characteristic of most cases of adult borderline transference (Mahler, 1971; Masterson, 1975).

According to Mahler (1958, 1975), the clinical outcome of these rapprochement crises will be determined by:

> (1) The development toward libidinal object constancy, (2) the quality and quantity of later disappointments (stress trauma), (3) possible shock trauma, (4) the degree of castration anxiety, (5) the fate of the oedipus complex, and (6) the developmental crisis of adolescence--all of which function within the context of the individual's constitutional endowment (Mahler, 1975, p. 108).

Disturbances during this subphase are likely to reappear in the next subphase, the final one in this process in which a unified self-representation should become demarcated from a blended and integrated object representation.

The fourth and final step in the process of separation-individuation should bring the achievement of a definite individuality and the attainment of a certain degree of object constancy. At this stage, the ego is much more structuralized, and it is clearer that parental demands have been internalized so that the beginnings of a super-ego are formed.

According to Hartmann (1952), the creation of emotional object constancy depends on the infant's gradual internalization of a constant, positively cathected inner image of the mother. This internalization allows the child to function separately--apart from mother despite moderate degrees of tension, anxiety, and discomfort. (Of course, it's important to note here that emotional object constancy will be based also on cognitive achievement.)

This subphase, which begins in the third year of life roughly, is very important developmentally as emotional consolidation and a stable sense of entity (self boundaries) is attained. The child senses where he ends, and the mother begins. A beginning, primitive consolidation of gender identity seems to take place according to Mahler at this time. Both Mahler and Furer (1966) claim that the constancy of the object implies more. It also implies the unifying of the "good" and "bad" object into one whole representation. This is an extremely important part in

intrapsychic development as it fosters the fusion of the aggressive and libidinal drives and tempers the hatred for the object when aggression is intense. Mahler's point of view of libidinal object constancy is identical with Hoffer's who had already addressed this issue in 1955. Hoffer said that object constancy is the last stage towards consolidation of a mature object relationship. It has a great effect on the fate of the aggressive and hostile drives. In the state of object constancy, the love object will not be rejected or exchanged for another if it can no longer provide satisfactions, and in that state, the object is still longed for, and not rejected (or hated) as unsatisfactory simply because it is absent or unavailable. Hoffer's point of view contributed greatly to the understanding of borderline phenomena written about years later by Kernberg, Masterson and others.

The process of the establishment of emotional object constancy is complex, slow, and multidetermined. It involves all the aspects of psychic development. The process is not isolated. Prior developments had to occur for this process to be successful. Trust and confidence that the mother will be there for relief of tension by satisfying the need of the infant in the early symbiotic phase had to have already been established. This need satisfying-relief of tension is gradually attributed to the need-satisfying

whole object (the mother) and is then transferred by means of internalization to the intrapsychic representation of the mother. Another very important prior determinant is the cognitive acquisition of the symbolic inner representation of the permanent object--to the unique love object: the mother. Other factors are also involved like innate drive endowment or maturation, neutralization of drive energy, reality testing, tolerance for frustration and for anxiety, and other ego functions.

Mahler's (1975) belief is that only after object constancy is well under way during the third year can the mother be substituted for during her absence. The presence of a reliable internal image remains relatively stable regardless of the state of instinctual need or inner discomfort, anxiety, or longing. Because of this achievement, temporary separation can be lengthened and better tolerated by the child.

Piaget (1937) and Gouin-Decarie (1965) have written extensively on "object permanence." Mahler, using Piaget's principles, applied it to the fourth subphase. She did not agree with his claim that object permanence occurs at 18-20 months of age. She claimed that the establishment of object permanence and of a "mental image" of the object is a necessary but not a sufficient prerequisite to the creation of libidinal object constancy, and that it occurs

much later in life. She claims that other aspects (as mentioned before) of drive and ego maturation and development take part in this very slow movement from the more primitive ambivalent love relationship which exists only as long as it is need satisfying, to the more mature mutual give-and-take love object relationships of the school child and the adult.

This fourth subphase of the separation-individuation process is not a subphase in the same sense as the first three, since it is open-ended at the other end.

At this stage, there is still some residue from the rapprochement phenomenon in the form of difficulty in leave-taking. There is, however, increased capacity to play separately from mother with an indication that the child can hold onto her image ("the good mother") automatically in her absence. Jacobson (1964) wrote extensively and clearly on the problems of merging of self and object images well into the third year of life.

As the subphase proceeds, separation from mother becomes easier and at times the child actually prefers to be away from her. This is definitely a sign of emotional object constancy. Yet many complex, conflictual and conflict-free processes seem to go on during this third year, making the process of object constancy a rather delicate and even reversible achievement. Its steadiness depends on so many

other developmental factors, since as the prevailing ego states, the environmental affective responses of the moment, and the ongoing conflicts of the ever occurring present.

When summarizing this stage of development, we can see that a few major developments occur during this open-ended phase: (1) Verbal development is rapid. (2) Play becomes more purposeful, and constructive. Fantasy play, role playing, and make believe play is in the beginning stages. Observations of real world are incorporated in play, and there is an increase in interest in playmates, and adults other than mother. (3) A sense of time begins to develop, and with it an increased capability to delay gratification, and tolerate separation. (4) There is an increase of active resistance, a wish, and a great need for autonomy. With this there is a recurrent mild-to-moderate negativism which seems to be essential for the development of a sense of identity. (It is important to note here that the child is still in the anal and early phallic phase of zonal development.) During this period, there is rapid ego differentiation. Individuation develops very greatly and the establishment of mental representations of the self as distinctly separate from representations of the object carves the way to self-identity formation.

Looking at a child's development through object relation theory we see that during the period of normal

symbiosis the narcissistically fused object was felt to be the "good," in harmony and identified with love. The less gradually, the more abrupt, intrapsychic awareness of separateness occurs, or the more intrusive or unpredictable the parents are, the less does the modulating negotiating function of the ego gain ascendancy, and the more the object remains or becomes an unassimilated foreign body--a "bad" introject (Heimann, 1966). As the child tries to eject this "bad introject," derivatives of the aggressive drive come into play, and there seems to develop a tendency to identify the self-representation with the "bad introject" or at least to confuse the two. If the situation arises during the rapprochement subphase, then aggression may be unleashed in such a way as to sweep away the "good object" and with it the good self-representation (Mahler, 1971, 1972). This is indicated by early severe temper tantrums, by increased attempts to coerce the parents to function as quasi-external egos. Great ambivalence will make the development towards object constancy and sound secondary narcissism very difficult.

In Bowlby's view (1958), there are these children who split the object world into "good" and "bad" for whom the "mother in the flesh" or Mahler's (1951) "the mother after separation" is always disappointing, and whose self esteem regulation is more precarious and unpredictable.

According to Mahler (1971), Jacobson (1954), and others, the most primal condition for mental health in terms of preoedipal development depends on the attained and continuing ability of the child to retain or restore his self-esteem in the context of relative libidinal constancy. In the fourth open-ended subphase, both inner structures--libidinal object constancy as well as a unified self-image based on true-ego identification--should have their inception which is only the beginning of this very critical and delicate developmental process. The "internal mother" should be available to the child to supply him with soothing and comfort during her absence or unavailability. The first basis, and most important to the stability and the quality of this inner representation, is the actual mother-child relationship which gets formed by day-to-day interactions.

Each child develops differently as a result of his experience of the optimal or less optimal empathic personality of the mother and her mothering capacity to which he responds. This response branches out to the father and to the entire psychosocial constellation of the child's family. The child's reactions are also greatly influenced by accidents, sometimes fateful happenings such as sicknesses, surgical interventions, separation from mother and father, and other factors. These accidental events constitute each child's fate and the ability to cope with them

varies greatly. These also create different themes in each child's particular and individual life.

Looking at this theoretical conceptualization and applying it to the psycho-cultural issues addressed in this study, the Israeli patients, these "Yordim" have experienced a double loss of the love object. Many have experienced, and have not resolved, the original problems and frustrations during their separation-individuation struggles. Later, upon leaving Israel, these Israelis' unresolved issues creep up again because of the second loss of the love object, namely Israel, the country and all it entails, i.e., motherland.

When they are confronted with a therapeutic situation in which the therapist represents the love object, they regress, and through the transference reenact a great deal of the unresolved problems related to separation-individuation issues.

It would appear that these patients are very ambivalent and guilty about being in this country, the therapeutic situation provides them with a fertile ground to experience and express to their therapist--who by now represents mother, the State of Israel, savior, example of success, caretaker, etc.--all that bottled-up intrapsychic-cultural painful material that has been stored up for many years without an avenue of release.

CHAPTER VI

METHODOLOGY

Description of Study--Procedures

This is an archival descriptive study, designed to examine the impact of cultural similarity between Israeli patients and an Israeli therapist on the therapeutic process in the early phase of treatment.

For the purpose of examing the therapist and patient's cultural similarities and its effects on the initial phase in treatment, the therapist studied six cases from her private practice case notes taken in each session and each case continuously through the patient's initial phase in treatment. These patients entered treatment between 1978-1980. There are three long-term cases and three short-term cases. These short-term cases started as long-term therapy cases but for various reasons were terminated. Only the crisis case was actually time-centered and planned as short-term treatment.

All these cases are presented and analyzed in this study. The analysis consisted of evaluating (through tables and figures) each patient per session, per specific treatments supporting or negating the hypothesis that there are unique

manifestations occurring in the early phase of treatment which enhance treatment.

Positive statements were defined as statements made to the therapist by the patient expressing attitudes that are: hopeful of the treatment; complimentary to the therapist and the office atmosphere; desirous of opening up feelings; and grateful for the opportunity of treatment with an Israeli therapist. Fox example:

Mrs. H. 1) "We have the same past--you'll understand."

Mrs. A. 2) "I thought today how lucky I was to come here."

Mr. Y. 3) "This place is so warm, it's like being in the womb."

Negative/ambivalent statements are defined as statements that are doubtful, that question the benefit of treatment in general, or the benefit of cultural similarity between therapist and patient:

Mrs. Y 1) "Don't know if I should see you, it's a luxury to come twice a week."

Mr. B. 2) "Don't know if I should continue therapy--I'm okay."

Mrs. H. 3) "Maybe you've become too Americanized to to remember and understand it all."

Along with the study issues, pertinent demographic data and dynamic issues are presented. In order to determine

social class of these patients, the Hollingshead scale (1958) was used. It is important to note here that all treatment with these patients was conducted in Hebrew.

The following cases are presented:

Long Term

1. Mrs. H. - Borderline personality disorder with a phobic reaction and narcissistic features (4 year duration, current patient). Started 1979.

2. Ms. Y. - A borderline adult (2 year duration, current patient). Started 1980.

3. Ms. A. - Borderline personality disorder with a psychosomatic component (3-1/2 year duration, terminated). Started 1978.

Short Term

1. Mrs. L. - An inadequate personality with an endogenous depression (8 months, terminated). Started 1979.

2. Mr. B. - Character disorder (6 months, terminated). Started 1979.

3. Mr. Y. - 19 year old (sexual identity) crisis case (10 interviews, 2-1/2 months returned to Israel, terminated). Started 1979.

Tables were devised to look at each hypothesis separately. A demographic data table was devised by grouping the ages of the patients every 10 years from 15-45 per male and female. An average age per male and female was scored by adding their ages and dividing them by the number of males or females. Then an entire average age was scored by adding all the ages and dividing them by the number of subjects (patients) (Table 1).

A marital status and cultural background table was devised by taking this information from the case records. Then a total of how many married and how many single patients per male or female was scored by adding the information up (Table 2). The same was done with the cultural background table. The totals were scored by finding how many Sephardic and Askhenazi patients per male and female participated in this study (Table 3).

The social class table is based on the Hollingshead Scale (1958). Here two separate tables were devised. Table 4-A is concerned with finding out the educational level of each patient, the patient's occupation, and the husband's or mate's occupation for the purpose of determining social class. All this information was taken from the case records.

Table 4-B lists the patients names (by initial only) and gives a score to their educational and occupational levels. This information (scores) and the factor weight score were taken from the Hollingshead Scale. The score and weight then get multiplied. To determine the score height, we add the score weight of the patient's education and occupation. This score determines the social class by Roman numberals and gets interpreted verbally, i.e.:

Class II - Middle Class

Class III - Middle and Upper Class

Class IV - Working Class

Table 5 lists the patients names by initials. Statements which were made by the patients during the first six sessions were recorded per patient, per session, and include positive and negative/ambivalent statements. All these statements were added up per patient, per session, and a grand total of the statements was totaled also per session for all sessions.

The same process was used to total up Table 6 and Table 7. Table 6 includes: (1) statements made by patients discussing early childhood material--per patient, per session; (2) totals per session, and overall totals. Table 7 includes: (1) statements made by patients expecting empathy and instant understanding from the therapist--per patient, per session; (2) totals per session, and overall totals.

Figure 1-3 is a demonstration of changes through time of statements expecting empathy and understanding from the therapist. The figures were drawn per frequency (how many times did the patient make these statements?) and per session 1-6. A curve was drawn with attaching dots which shows through a visual medium how many times these statements were made, and gives an overall impression of the issues discussed. Each patient received an individual figure and curve per session, per frequency of statements.

Description of Sample in the Study

All of the six cases came out of this researcher's private practice case records. All of the data examined came out of this therapist's process notes and records which were taken during each of the six sessions presented. All the six cases were born in Israel in different major cities. They all come from different Israeli cultural heritages. Four of them (Mrs. H., Ms. A., Mr. B, and Mr. Y) were born to parents who immigrated to Israel from Poland or Russia (Ashkenazi Jews), while two (Ms. Y, and Mrs. L) were born to parents who immigrated to Israel from Morocco (Mrs. L) and Afghanistan (Mr. Y) (Sephardi Jews). Four of the patients' ages range from the early to mid-thirties, while Mr. Y was 19 years old, and Ms. A was in her early forties. There are four females and two males.

All the cases except one (Mr. Y) have immigrated to the U.S. in the last ten years. Three are married and have one child and three are single and have never been married.

The long-term cases have been in treatment no less than two and a half years and one over four years. The short-term cases include a crisis case (ten sessions), six months treatment for Mr. B and eight months with Mrs. L.

All treatment was performed by the researcher practitioner from the same theoretical base, i.e., psychodynamic psychotherapy with emphasis on object relations theory.

Description of Patients

Mrs. H. was a 33 year old Ashkenazi Israeli woman who had come to Los Angeles from Israel 10 years previously. She was married to another Israeli and had one adolescent boy from a previous marriage. Although her husband, a Sephardic Israeli, was a blue collar worker and was only sporadically employed, Mrs. H. did not work and was totally dependent on her husband for both financial and emotional support. Because he was Sephardic, Mr. H. had a completely different concept of his role as a husband from her Ashkenazi one. Although on the one hand, Mr. H. seemed to encourage her dependency; on the other hand, he resented it. He tended to avoid his wife by playing cards with his friends or by using drugs while at home.

What little interaction they had was full of friction. Admitting some culpability in the relationship, Mr. H. promised her that he would change. However, when she tried to communicate with him about that change, he was either unwilling or incapable of doing so. Consequently, her dealings with him were marked by anger and frustration.

It is important to note that at one point in the past they had separated because she "didn't love him." Later, however, they reunited after Mrs. H. had her first severe anxiety episode and he took her back to care for her. At that point, they "fell in love," and remained together thereafter.

Her relationships outside the marriage were wide but not meaningful. Because of perceptions of inferiority and worthlessness, she felt beneath most people, and allowed her acquaintainces to "use" her. Conversely, her relationship with her 15 year old son was the "most meaningful" of all her interactions with others and, although she admitted neglecting him at times, the mother-son relationship was basically a good one.

Mrs. H. came to therapy because she had had a "nervous breakdown." Initially, she had been referred to a psychiatrist but couldn't communicate with him in English. At the time of our first meeting, she was under a great deal of intrapsychic pressure, was quite depressed, and fearful of everything, particularly driving, an activity about which she had developed a tremendous phobia. She was unable to be alone, in the home or outside of it. In the feeling realm, she sensed herself to be "out of control"--a person who had constant anxiety attacks. She cried through the first session and summed up her condition as follows: "I'm a complete mess, and feel that I have no personal control over what is happening to me."

As a child, Mrs. H. remembers being very unhappy. Her mother was described as dominant and her father weak and uninvolved ("under mother's thumb"). Throughout her childhood she felt neglected by both her parents and almost

completely abandoned by her father. She felt that her parents did not appreciate her as a person and only valued her if she cleaned or cooked and helped her mother with domestic chores. When Mrs. H. was 18 years old and in the military service, her father died. She felt at that time that they had never known each other.

As a child she lied a lot, stole, and manipulated others whenever possible. She urinated in bed until the age of 15, and had constant nightmares. She had been anxious and depressed, she claimed, all of her life.

Mrs. H. married at a very early age, and divorced after two years, primarily because this first husband was incapable of taking care of her, and because he went out with other women.

Because this patient is very beautiful physically, she has always been popular with men. She had started dating at the age of 12, had had her first sexual experience at 13, and her first abortion at 15. At this point, she was sleeping with both young and old men, and sometimes stealing money from them. Men were also giving her money, and she would "do anything to get it." From adolescence until the present, Mrs. H. has always existed on the fringes of deviant behavior. While in high school, she was caught stealing and was expelled.

After the termination of her first marriage, Mrs. H. worked regularly as a secretary or delivery person, but felt very inadequate. Despite that, she continued to be popular with men and dated many males in the entertainment industry. At one point, she became involved with a married man, and carried on this affair for two years. When she realized the situation would never get resolved, however, she came to Los Angeles with her son. In Los Angeles, she met her current husband.

Ms. Y. was 34 years old when she entered therapy. Born in Haifa of Sephardic background, she has been in the U.S. for 10 years, living on her own as a single woman. Her parents were also born in Israel of parents who came from Morocco and Afghanistan. She was the youngest of five siblings (four brothers and one sister); all of the male siblings were in the United States. Her mother also lived in Los Angeles.

Ms. Y. came to therapy because of chronic depression. She also had had a "nervous breakdown" at age 20, when she decompensated, had a psychotic episode and was hospitalized in Israel.

Here in the U.S., she had severe problems with intimate relationships, great difficulty relating to men, and claimed that she got no satisfaction from life. In general, her attitude toward life was both naive and

unrealistic. She had frequent "anxiety attacks" in which she perspired and shook. She claimed that she was always angry and jealous of people and that she felt like a failure, a big nothing despite her considerable education.

For Ms. Y., who had never been married and whose relationships with men were very difficult, the future and the possibility of not finding a man to marry were her main anxiety in life. Her other ancillary anxiety centered on her ambivalence about whether to live in Los Angeles or to return to Israel.

As a child, Ms. Y. had been dependent and sickly and mothered by an equally dependent mother who did everything in her power to encourage Ms. Y. to cling to her. Consequently, Ms. Y. had problems separating from her mother and great difficulties with her peers. Her relationship with her father, she claimed, consisted of "put downs" and double standards, i.e., the boys (her brothers) were "all good" and she was "good for nothing." Later, in the military service, she also suffered great embarrassments because of her dependent nature.

Despite this, she did well in school up to the junior high level, when her parents decided to transfer her to a French school. She then started showing great emotional difficulty, a fact which neither parents nor teachers seemed to notice. At that point, she failed almost every subject

and finally left school without matriculating. It was the first in a series of failures that culminated in her decompensation and hospitalization after the army service at the age of 20.

After she came out of the hospital, her family arranged for her to emigrate to the U.S. to live with her brother. Here, she somehow managed to get her B.A. Then she went to France on an academic exchange program and got her M.A. in French literature. Upon her return, she earned a teaching credential in the U.S.

Since then, she had lived a very marginal life. For years, she was involved in stealing in the department stores, but somehow was able to stop it herself. Despite the fact that she was a credentialed teacher, she functioned only as a substitute, and had never been able to assume the responsibility of obtaining a bona fide teaching contract. Further, she had had only one semi-longlasting relationship with a man--a relationship which lasted a year, and which did not culminate in marriage.

At the time of our first encounter, she had a pattern of dating only uneducated men who were beneath her. Her relationships with both men and women were marked with dependency, neediness and extreme envy. She seemed to be a person who took a lot from others but who could give only very little. Her jealousy of others was extreme.

She wished no good for anyone, and felt that "everyone has and I don't." Basically, she felt that she hated everyone who was happy. Moreover, her depression and "anxiety attacks" were severe.

At best, her relationships with her mother and siblings were ambivalent.

Mrs. A. was a tall, blonde and very attractive woman of 40 who had a whining, pleading voice. At the time that she entered treatment she was divorced and living with her one child, an adolescent daughter. Although she was not working, she somehow managed to subsist on a miserly income that she had from a small apartment building and some child support. At the onset of therapy, she was completely isolated from the outside world.

Mrs. A. had been referred to me by her dentist who treated her for a dislocated jaw which had occurred 15 years earlier. This had caused her to lose her equilibrium, to stop working, to suffer from great depression, and even to contemplate suicide. Because of this general debilitation, she had stopped driving or going out of her house, had experienced feelings of depersonalization, and was fearful that she might hurt somebody, especially if she drove a car, because she felt that her aggressive, angry feelings were "out of control."

At the first session, she explained that her jaw became dislocated after a dentist in Israel had extracted a tooth, which was, in her words "a fatal condition." Thereafter, she had felt increasingly uncoordinated, and made up of many units, having no dimension and no unity. Mrs. A. described herself as having always been unhappy.

She was raised by a very "strict, meticulous, obsessive-compulsive" mother who was very old-fashioned and who "didn't say a good word to me." Her father was a "cruel, selfish, ugly human being who hated me and who I was embarrased by."

The age of 8 years was a very important period in her history, because it was the time when her mother was pregnant with her sister, and also the time when her mother had caught her in sexual play with her cousin and had slapped her face very hard. She felt as if she had been beaten to death. It was then that she felt that her whole self was shattered, and that her disequilibrium feeling had begun.

Such physical abuse was common to her childhood. Consequently, Mrs. A. felt that part of her brain was probably not functioning from all the abuse she had received at the hands of her parents. Her mother almost "choked me to death," she recalled. Since childhood, she had always had low self-worth and self-esteem.

Mrs. A. had entered into an anorexic state, decompensated, and at the age of 17 had finally been hospitalized. It is interesting to note that her mother had also decompensated when Mrs. A. was 14-1/2 years old.

After she got out of the hospital, Mrs. A.'s mother divorced and both mother and daughter moved into an apartment together. A man from South America was introduced to her. After two weeks Mrs. A., pushed into it by her mother, married the man and the two of them left the country.

Mrs. A. remembered her life with her new husband as "hell on earth"--a time in which she was sick both physically and emotionally. From this union, Mrs. A. had a child, a daughter, who became her "whole life." The couple and child subsequently emigrated to Los Angeles, where she divorced him. In retrospect, her view of him was that he was a "bad object." She attributed qualities of the "devil" to him--a man who resembled her father greatly.

At the onset of therapy, Mrs. A.'s major defense was that of splitting--and it is through this prism of fragmentation that she viewed the world. She was unable to sleep at night and was fearful of everyone and everything she encountered. Further, she was disgusted with herself, viewing herself as ugly, unattractive, and dirty because of her fantasies and primary process thinking. She viewed her bodily functions as disgusting. As a result, she felt

unworthy and guilty about everything that she said, did and thought and was physically and emotionally uncomfortable with herself 24 hours a day.

It is interesting to note that Mrs. A.'s daughter who is her "good object," was viewed by her as an "angel." When it came to dealings with this daughter, Mrs. A. was able to rise out of all this matter and deal with her, educate and teach her, discuss life with her, appreciate her, and admire her.

Mrs. L. came to therapy at the age of 24. At the onset of treatment, she was unhappily married and living with her husband. She had come to Los Angeles nine years previously and had married her husband to get an immigration card. At the time they had agreed to get a divorce once the card was obtained, but had never done so. Although her husband loved her, she "did not love him." All of her family was in Israel.

Mrs. L. got motivated to come to therapy because of her marital problems. They were not communicating with one another and were "fighting all the time." She stated that she had been depressed for many years. Currently, she suffered from great anxiety, frequently "had the shakes," had low self-esteem, was fearful of being alone, did not sleep very well, had some paranoid ideations, and at times contemplated suicide. She described herself to be in a constant state of fear.

Mrs. L. was born in Beer-Sheva to Moroccan (Sephardic) parents. The youngest of 10 children, she remembers being completely and totally neglected as a child. The family was very poor, and she recalled walking around with torn clothes and without shoes a good deal of the time. At the age of three, Mrs. L.'s mother had had surgery and due to an error, her vocal cords were cut. Her mother had never spoken again. Mrs. L. was extremely frightened of the grotesque, gutteral voices that came out of her mother's throat. Despite the fact that she had other siblings, they were older and ignored her, which caused Mrs. L. to experience her childhood as a time of great loneliness. Her father was very old-fashioned and although he cared for her, could not express any feelings toward her. She felt that she lived in an "insane asylum." School was the only place where she felt "sane," had lots of friends, and did well.

During her pre-adolescent years, she had had sexual relations with her brother, but nobody knew. She was too frightened to say anything to anyone, she recalled, and too afraid to resist.

Basically, she had felt lonely, deserted, uncared for, and unloved all of her life. She felt like an "orphan," somebody whom everybody ignored. To this day, she felt constantly anxious and fearful, and was always afraid to

be alone.

She had had only one meaningful relationship with a man in Israel, which never got resolved due to her inability to express herself and give of herself in a relationship. On the one hand, she craved the closeness with him, and on the other, she was afraid of it.

Later, her relationship with her husband was very conflicted because although he could give her a good life economically, he too had trouble with his emotions, and experienced difficulties with intimacy and being close.

Despite her depression, Mrs. L. had been able, prior to the onset of treatment, to open a business with a woman partner, and to operate it for several years. However, the relationship with the woman partner had become complicated because Mrs. L. had such difficulty in giving and sharing openly with another.

At the beginning of treatment, Mrs. L.'s business was falling apart, her marriage was unsatisfactory, and she had no friends to turn to. As a result, she clung to therapy as if it were her only salvation.

Mr. B. came to therapy at the age of 29. He was single at that time and living on his own.

Mr. B.'s presenting problems related to his recurrent occupational instability. He had high aspirations for himself, but things had a way of never working out for him.

When he was employed, he was always trying to make deals with rich investors. He was constantly speculating on some new business venture, trying to become wealthy overnight.

Further, he was always both depressed and lonely, and experienced great difficulty creating an intimate relationship with a woman. He could not make commitments to people, and had great difficulty sharing his feelings. He related that he was always in control, never "got loose," and was never relaxed. He claimed that as a rule he defended himself from pain at all times, and looked only for the logical answers in events. In meetings and dealings with people, he constantly labored under the impression that people were jealous of him. For years, he had smoked marijuana on a daily basis.

Mr. B. was born in Tel-Aviv, an only son, to parents who had survived the Holocaust. Although his parents worked hard to give him all the best in material things and education, and though he was well cared for by maids and by housekeepers, he constantly felt neglect by both parents.

He stated that he did not actually feel unloved, just uncared for. He remembered being a loner in school and having great difficulties with other children. But his most striking memory of childhood was of the period predating nursery school when he felt much pain, loneliness, and alienation.

He recalled having manipulated his parents and teachers from a very early age. He stated that he always knew what his authority figures wanted from him, and early on had learned how to pretend to comply with their wishes, all the while secretly doing exactly as he pleased. He never got along with his parents in a "real way." "I used them," he recalled.

Mr. B. had trouble getting along with persons of all ages and felt that he had never had a meaningful relationship with anybody. Being very wealthy, his parents gave him the means and the freedom to roam around with the jet set of Israel. But he could never settle down, and was always restless, unhappy, and depressed.

After the military service, he went to London to study business, but after two years "got sick of it."

Because his parents were in the habit of giving him a great deal of money, Mr. B. was constantly launching business ventures, which invariably failed. He then started moving from one job to another, was in real estate, stationery, paperhanging, etc. His pattern was that initially the new endeavor would excite him, eventually however it bored him.

Mr. B.'s father died when Mr. B. was 14 years old. Mr. B. claimed that although he had never had a real relationship with his father, his death was very shattering,

as now he felt he could never amount to anything, since he had missed forever the opportunity of knowing his father. As a consequence, he felt that thereafter he had never been able to commit to anything or anybody. Instead, he spent money without thinking of the future and basically set himself up for failures. "I'm out to destroy myself and I don't even know it," he said. Further, he was always smoking marijuana, "so I don't feel nothing," he said.

At the outset of therapy, Mr. B. stated that the major impetuses in his life were money and power. Although he had had many reverses in the six years since he had been in the U.S., he always blamed others, not himself, for these failures.

Mr. B.'s dreams and fantasies centered around power and powerlessness, manipulation and being manipulated, money, wealth, and the lack of it. He was always tense, and unhappy, and living in constant dread of going bankrupt. He had virtually no relationships and only ventured out if he felt extremely needy and lonely "just to be with someone."

In general, he was always trying to figure out ways to "beat the system," but was never quite able to do so.

Mr. Y., 19 years old, came to therapy in crisis due to a homosexual panic. Although he realized that he was homosexual, he was having great difficulty coming to terms with it.

He had come to the U.S. from Israel for a short visit after graduation from high school and before going into the military service. It was here that he came face to face with his homosexuality and his crisis surrounding it. He was so terrified at the prospect of being detected and made fun of in the army that he actually thought of desertion and possible immigration to the U.S. At the onset of therapy, these were the issues with which he was grappling.

Mr. Y. was born in Israel to Ashkenazi parents, the second child in a family of three children. His younger sister, he claimed, also had problems with her sexual identity.

He remembered always having played with girls and being called "a girl" by his classmates very early on because of his feminine features and his preference for being and interacting with girls. He was shy and cried easily; he disliked sports and rough-housing with the boys. He remembered that the onset of sexual fantasies at the age of 12 were only about men.

His greatest fear at the outset of treatment was that his parents would find out about his sexual identity. Both parents had had heart attacks and he felt that this revelation "would kill them."

Also, he feared the military because he felt inadequate socially, emotionally, and physically and was sure

that in the military his life would be made thoroughly miserable.

Most importantly, he feared his homosexuality, and all the social problems attached to it. Because of that fear, he needed to resolve the problem of whether or not to desert the army, and stay in the U.S.

Mr. Y. was in treatment for 10 sessions to resolve the problems presented here.

History in depth was not gathered from this patient, as his treatment was crisis oriented and did not necessitate detailed autobiographical information.

CHAPTER VII

FINDINGS

The purpose of this study was to examine the impact of cultural similarity between Israeli patients and an Israeli therapist on the therapeutic process in the early phase of treatment.

It was hypothesized that in the initial phase of treatment unique transference manifestations occur in that population group which enhance treatment. There is a tendency for the Israeli patients to view the Israeli therapist as an all-good mother, a state of mind which allows the patient to put up little, if any resistance, and to be open and extremely expressive right from the start about early childhood material. The patients also expect great empathic responses from the "good mother" Israeli therapist and express a tremendous wish to be understood immediately by her.

Data analysis shows us (Table 1) that there are more females than males in this study. Although this sample was chosen from the therapist's case records, the literature tells us that this ratio is not unusual. Many studies by Gore (1978) and others point out that

Table 1

Demographic Data - Age/Sex

Ages	Male	Female
15-20	1	
20-25		
25-30		1
30-35	1	2
35-40		
40-45		1
Average	23.5	32.5
Entire Average	29.6	

statistically there are more women than men in therapy.

This finding particularly applies to Israeli men, who tend to be much more reluctant about sharing their feelings with a psychotherapist, especially a woman, and would consider it a weak thing to do. The prevailing view among Israeli men is that a "man should take care of his own problems without washing his dirty laundry outside" (Hazelton, 1978).

The overall age for both men and women in this sample is 29.6. This is a significant number in that it indicates that most of these Yordim have been in Los Angeles for the last 10 years and that most of them arrived in Los Angeles in their very early 20's, the age traditionally when most Israelis have completed military service.

It also indicates that members of this sample did not live in Israel as independent adults, but rather as students and then soldiers, so their view of Israel is arrested at an infantile level and their connection to the motherland is as through a child's, or perhaps an adolescent's view, with some separation-individuation issues still in the forefront of their psychosocial development.

The two tables, Marital Status Table 2, and Cultural Background Table 3, can almost be placed one above the other, in that they are identical. It is not a coincidence, considering that again most of the patients in this group are female.

Table 2

Marital Status

Sex	Married	Single
Male	--	2
Female	2	2
Total	2	4

Table 3

Cultural Background

Sex	Sephardic	Ashkenazi
Male	--	2
Female	2	2
Total	2	4

Three-quarters of the women in the sample (four) were single. Culturally, three-quarters (four) were Ashkenazi.

These two tables reflect the cultural attitudes commonly held by Israelis, that if one is married one does not go outside the family circle to find solutions to personal problems. Instead, one suffers, as this is one's lot in life, or one uses the extended family for help (Hazelton, 1978).

We see that for this reason there are no married men in this sample. Another reason is that Israeli men are not very analytical and mostly will express their anger by shouting or by passive-aggressive means.

It is not unusual to see Sephardic men congregate to talk and play, without a woman in sight. Morever, it is quite possible that these supportive groups provide these men with a forum for discussing their difficulties at home. Apparently the advice given in these settings is very "macho" with respect to women (see Chapter IV).

Conversely, single males or females from this population group would more easily resort to therapy than married ones would if they were experiencing personal problems. Similarly, more Ashkenazim than Sephardim would seek outside help (see Chapter IV).

Table 4-A

Social Class

Patient	Education	Patient's Occupation	Husband or Mate's Occupation
1. Mrs. H.	8th grade	Sales	Boilermaker - unstable
2. Ms. Y.	M.A. French	High school & college teacher	None
3. Ms. A.	High school graduate & secretarial course	Part-time receptionist & bookkeeper	Small business & investments
4. Mrs. L.	High school graduate	Part-time receptionist & bookkeeper - own business	Painter-contractor Own business
5. Mr. B.	2 years college	Different businesses - unstable	None
6. Mr. Y.	High school graduate	Drafted to Israeli Army	None

Table 4-B

Social Class

Patient	Factor	Scale Score	Factor Weight	Score X Weight	Score X Height	Social Class	
Ms. H.	Education	6	7	42	58	Class IV	Working Class
	Occupation	4	4	16			
Ms. Y.	Education	2	7	14	18	Class II	Middle Class
	Occupation	1	4	4			
Ms. A.	Education	4	7	28	44	Class IV	Working Class
	Occupation	4	4	16			
Mrs. L.	Education	4	7	28	36	Class III	Middle & Upper Middle Class
	Occupation	2	4	8			
Mr. B.	Education	3	7	21	33	Class III	Middle & Upper Middle Class
	Occupation	3	4	12			
Mr. Y.	Education	4	7	28	40	Class III	Middle & Upper Middle Class
	Occupation	3	4	12			

The Hollingshead Scale (1958) was used to determine the social class of the patients in this study. Although this scale gives us relatively reliable results, there are two notable exceptions: because Mr. Y. was a student who had returned to Israeli military service, his social class in American standards does not apply exactly. Also, Mrs. A. during the course of treatment married a rather wealthy man, though due to investments, they lacked cash flow. Still, because of this marriage, she would have qualified as an upper middle class or even middle class, rather than a working class member.

Because of changes in the Israeli economy since 1958 when the scale was developed, including changes in the tax situation, and the value and availability of higher education, it is quite possible that the Hollingshead scale must be revised to give us more accurate information about the members of this study's population group. By and large, however, it did produce an accurate scale for social class.

Table 5, which examined the number of positive, negative/ambivalent statements made by each patient per session for six sessions, found that these patients made many positive statements to the therapist, and very few negative/ambivalent ones.

In all, the patients made 136 positive statements, as opposed to a total of 5 negative/ambivalent ones, a

Table 5

Positive, Negative/Ambivalent Statements
Per Patient, Per Session

	Sessions													
	1		2		3		4		5		6		Totals	
Patients	P	N/A	P	N/A	P	N/A	P	N/A	P	N/A	P	N/A	P	N/A
Mrs. H.	2	1	3		3	1	3		3		4		19	2
Ms. Y.	6	1	5	1	3		3		5		5		30	2
Ms. A.	2	4	6		6		6		4		5		28	
Mrs. L.	6	5	4		4		2		2		4		24	1
Mr. B.	1		2		3		2	1	4		3		15	
Mr. Y.	4		2		3		3		4		4		20	
Totals	25	2	21		22	1	24	1	19		25		136	5

statistic which causes us to conclude that something very unusual occurs in the early phase of treatment which allows these Israeli patients to be so positive, non-resistant, complimentary, and accepting of the therapist and of the therapeutic process.

The highest number of positive statements (30) were made by Ms. Y., a severe borderline patient. Her unusually high number of positive statements can be attributed partly to her splitting mechanism, which would lead her to idealize the therapist during this early phase. Despite this, she was able to make two negative/ambivalent statements, perhaps because she had never been in therapy with an Israeli and had some concerns about that fact. Also, her last therapist, she claimed, had "thrown her out" of therapy and pronounced her "incurable." She was extremely worried that this experience would be repeated with the new therapist.

Next in the order of high positive statements about the therapist and the therapeutic experience was Ms. A. with 28 positive statements. Ms. A., also a borderline patient, had psychosomatic difficulties, and some idealization tendencies which seemed chronic. As a general coping mechanism, Ms. A. suppressed negative feelings only to externalize them through her physical condition, pain in the jaw and a loss of equilibrium.

Next to Ms. A. in order of positive statements was Mrs. L., with 24 positive positive responses. At the onset of treatment, Mrs. L. was extremely isolated, desperate, and slightly paranoid. She also felt that she had no home, and viewed therapy immediately as a sort of substitute home. She volunteered only one negative/ambivalent statement which centered around the fact that she had never been in therapy and was apprehensive about it.

Mr. Y. came to therapy because of a homosexual panic, and so his positive responses (20) must be attributed at least in part to his acute neediness at the onset of treatment. Diagnostically, he seemed healthier than most of the other patients, except that because of his crisis, his ego strength was rapidly diminishing.

Mrs. H. made 19 positive responses and two negative/ambivalent ones. Her attitude at the onset of therapy was slightly skeptical of the experience because she had previously seen another therapist who had been unable to help her because of the language barrier. Although she was a borderline patient who functioned on a very marginal level it was felt that her intrapsychic functioning pointed to a higher level borderline diagnosis than the other borderline cases in the sample. In her, the depression, anxiety, and phobias masked her true intrapsychic functioning ability, and hence, her potential.

Mr. B. scored the lowest points for positive statements (15), perhaps because as a character disorder, it is not his habit to give people compliments. Instead, he seemed both cautious and manipulative. In fact, it was surprising that he volunteered as many positive statements as he did. It is possible also that his general ability to communicate was greatly affected by his chronic and prolonged use of marijuana, which would make it difficult to obtain a true reading on his intrapsychic functioning ability.

The early childhood material (Table 6) shows us similar patterns concerning the patients' psycho-diagnoses, disturbances at the onset of treatment, and their perceptions of the etiology of their problems. What is striking about their revelations concerning childhood material is that this therapeutic environment with an Israeli therapist seemed to facilitate quick regression to early childhood, and to the areas of their developmental arrest.

As seen before in the area of positive statements, Ms. Y. again leads in the number of statements (50). She claimed to remember back to the age of two when she was still occasionally diapered and cleaned by her very strict and dependent mother. Ms. Y. felt that her mother had clung to her, feeding her excessive food to soothe her and keep her dependent. Being the youngest of a family of four brothers and one sister, she was constantly held by her

Table 6

Statements Made by Patients Discussing Early Childhood Material Per Patient, Per Session

Patients	Sessions						Totals
	1	2	3	4	5	6	
Mrs. H.	4	3	5	7	5	8	32
Ms. Y.	7	8	8	7	9	11	50
Ms. A.	6	5	8	9	10	10	48
Mr. L.	5	5	5	5	5	12	37
Mr. B.	2	2	3	3	4	7	21
Mr. Y.	3	3	4	3	2	4	19
Totals	27	26	33	34	35	52	207

mother, as if she were still an infant. She was punished, however, if she ever tried to break out of her mother's grasp. Ms. Y. remembered that when she was three her mother told her that since she was the youngest she could not leave, as all the others were already on their way out. She recalled that she had been a very sickly child, and when she would become ill, her mother would invariably keep her home from school much longer than was necessary.

Ms. A. volunteered almost as many statements concerning early childhood (48) as did Ms. Y. Ms. A. remembered and re-experienced in therapy, memories of her mother when Ms. A. was still in the crib. She remembers being diapered in the crib and cleaned by her "meticulous, obsessive-compulsive, cleaning crazy, strict mother," who changed her diapers every half an hour, so that she got a terribly sore body, and the doctor had to tell the mother to stop cleaning the baby so often.

The key memory for Ms. A. was at the age of eight when she played some sexual games with her cousin of the same age, was caught by her mother, and was slapped by her so hard that she dislocated her daughter's jaw. Ms. A. felt that at that time "everything fell to pieces."

Mrs. L., who made 37 statements about her early childhood, recalled that her mother had had surgery and lost her speech due to an accidental cutting of her vocal

cords when Mrs. L. was only three years old. She felt that her entire life changed drastically from that time forward. Her mother made strange and scary gutteral sounds. Her recurring childhood dream was of her mother running after her with a knife, and trying to kill her.

Mrs. H. made 32 statements about early childhood. She stated that she was the youngest child of two other female siblings, and that her parents had had no time for her. She recalled feelings as far back as age four of being worthless and useless--feelings that could be relieved only by cleaning the house and doing domestic chores. Like Ms. A. and Mrs. L., Mrs. H. also had a very dominant mother and a weak, inaccessible father whose affection she craved. But "he let mother do whatever she wanted with the kids, so he could have his freedom from us and from her."

Mr. B. made 21 statements about his early years, all attesting to the fact that his childhood was a very lonely one. He was an only child of a couple who had survived the Holocaust and were now too busy "making money and having fun, everything they didn't have before, and now did not have time for me." He recounted that his parents were very wealthy, and had a large and varied social life in Israel.

One of his earliest memories was of crying in the crib for hours, with nobody coming to him, although, "I did

feel protected there," he stated.

He remembered that his parents gave him many material things, but never gave him personal care. Hence, he learned from an early age, to manipulate them, at times playing one parent against the other.

He recalled being lonely and a loner, even in kindergarten and remembered scenes of great pain, loneliness, and rejection. In the therapeutic session, he quickly developed the habit of lying down on the couch, and stating that in the office, he felt himself to be in the comfort of his childhood crib.

Mr. Y.'s statements about childhood all centered around his ability to remember and detect his homosexual and feminine traits down to a very early age. He recalled boys calling him a girl as early as in nursery school. The central thrust of treatment was an attempt to recall all of these memories, to cathect onto them, and to try to face the truth of what they were revealing to him about his sexual identity.

Table 7 concerns itself with statements by patients expecting empathy and understanding from the therapist.

Ms. Y. scored the highest, with 29 statements asserting that she expected the therapist always to be quick to interpret her thoughts and feelings. She also had had a bad experience in her previous therapy, and so

Table 7[a]

Statements by Patients Expecting Empathy and Instant Understanding from Therapist Per Patient, Per Session

Patients	Sessions						Totals
	1	2	3	4	5	6	
Mrs. H.	1	2	2	3	4	4	16
Ms. Y.	4	4	4	6	5	6	29
Ms. A.	4	4	5	4	5	6	28
Mrs. L.	3	2	4	4	3	5	21
Mr. B.	2	3	4	2	4	4	19
Mr. Y.	2	2	2	2	3	4	15
Totals	16	20	21	21	24	26	128

[a]See Figure 1

expected to be reassured that she was understood instantly, because of a fear of being rejected again by the therapist. Also, because of her history, Ms. Y. had an unusually high need to be understood. "Nobody in my family ever understood me, but you do," she said. This statement was made in the second session.

Ms. A. made 28 statements concerning her expectation of empathy and understanding. She gave a strong impression of being open and trusting, taking for granted that the therapist was totally familiar with her problems. At times she would even skip certain details in her narrative, stating, "You know what I mean."

Mrs. L. made 20 statements concerning expectation of empathy and understanding from the therapist. She said things like, "I feel like I knew you for many years, and now, we re-met. You understand what I feel!" She seemed to cling immediately to therapy and to her therapist, as if she were discovering her actual mother, only this time it was a mother who could empathize, understand, soothe, and respond.

Mrs. H. made 16 statements revealing an expectation of being understood by the therapist. She might have made more had not her phobias and general state of agitation and anxiety not restricted her. But she did often make statements such as: "You do understand me. After all, we

have the same past."

Mr. B. made 19 statements expressing an expectation of empathy and understanding from the therapist. This was quite a large number coming from such a withholding, character disorder type as Mr. B.

The relatively high number of Mr. B.'s responses concerning expectation of empathy from the therapist led me to believe that the therapeutic environment was particularly conducive for him to open up and express such feelings. This was heightened by his constant use of marijuana, which probably rendered him less guarded than he would normally have been in the therapeutic session.

Habitually, during the initial phase of treatment, Mr. B. made such statements as "I know you know what is right for me," or "You'll tell me everything because you know what I went through and you understand my background."

Mr. Y made the least statements (15) concerning expectation of empathy and understanding, probably he was in crisis at the onset of therapy and needed to do a great deal of ventilating. Mostly, he was involved with his own panic and pain. However, under the circumstances, 15 statements is not insignificant.

Table 8, Figure 1 charts graphically the patients' statements expecting empathy, and demonstrates how those statements changed through time in the six initial sessions per patient.

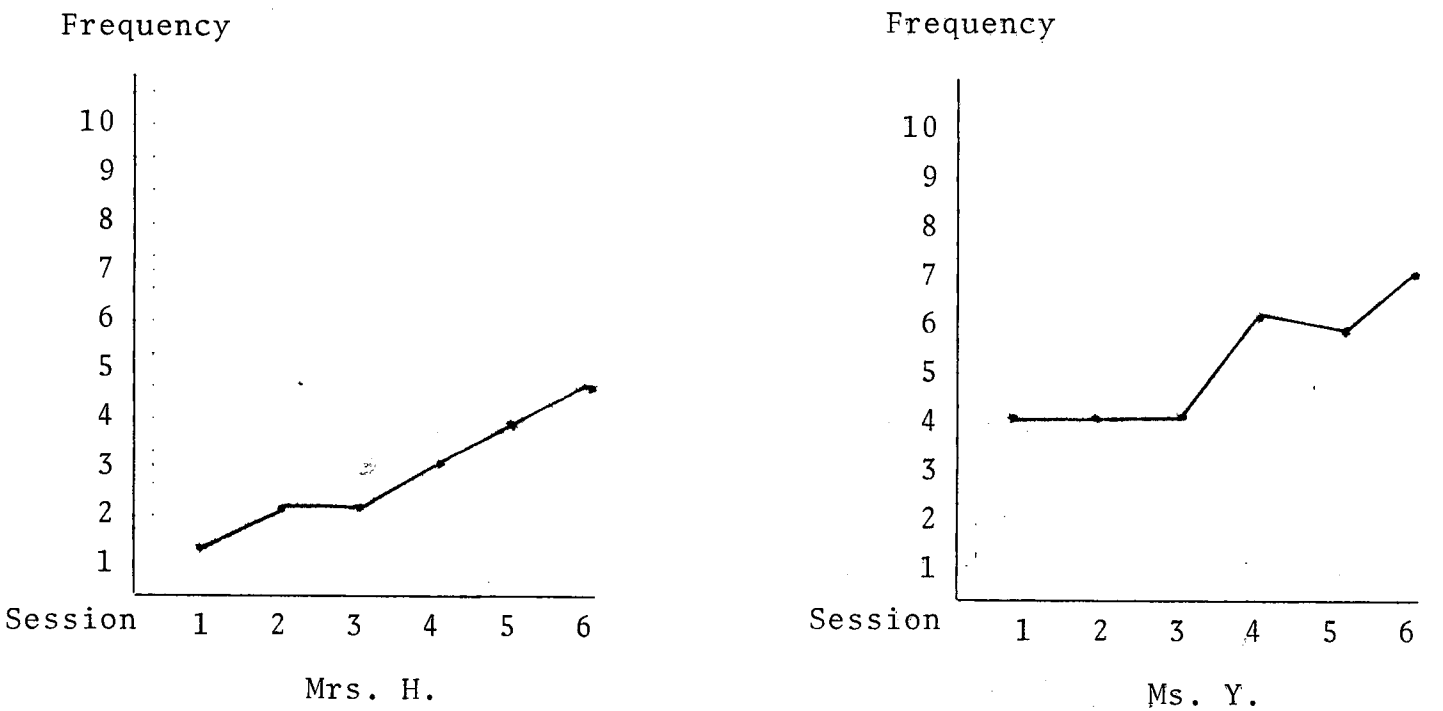

Figure 1. Demonstration of Changes through Time of Statements Expecting Empathy and Understanding from the Therapist

The most noticeable aspect of this illustration is that every person in the sample made at least one statement expecting empathy or understanding as early as the first session.

In general, all of the patients' statements expressing expectation of empathy and understanding increased with time. With no exceptions, all of their curves go upward from the first session.

Mrs. H. had no gradual slope at all. She climbed steadily upward, making expectation statements more and more often as the sessions continued. Ms. Y. make steady statements for the first three sessions; then during session four, while having particular difficulty with her anxiety, and feeling markedly disturbed, increased them, causing the slope to move sharply upward. She felt calmer the next day (session five) but then again went sharply upward at the sixth session, because she had entered into a minor crisis state due to an encounter with her ex-boyfriend.

Ms. A.'s graph looks a bit more curved than the rest, as she begins with four statements, and ends with seven. This reflects Ms. A.'s intrapsychic state related to how disturbed and dependent she felt due to jaw pain, and the loss of her equilibrium.

Mrs. L.'s curve is far more fluctuating than the other patients' because during the initial phase of

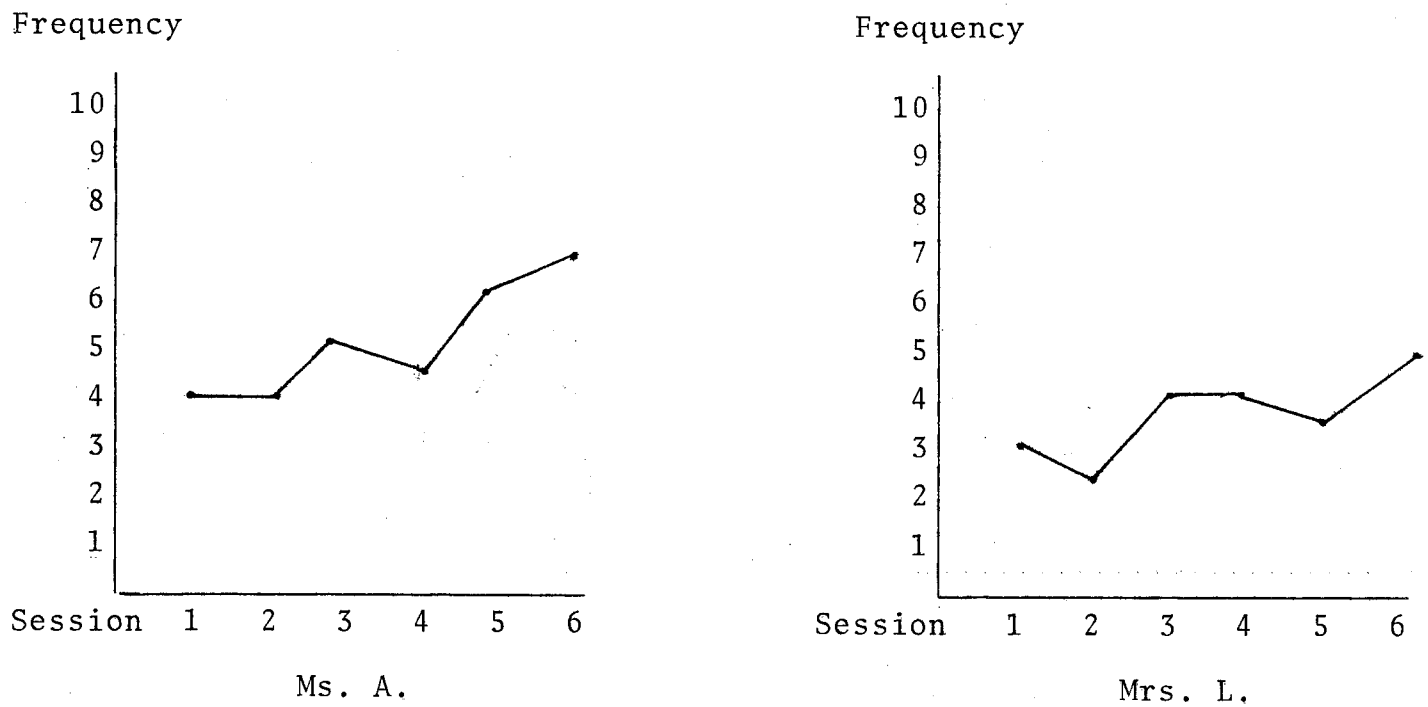

Figure 2. Demonstration of Changes through Time of Statements Expecting Empathy

treatment she was extremely disturbed, cried a lot, and wanted to stay overnight in the office after every session. She was feeling so vulnerable that she expressed the belief that the therapist was her only salvation.

Predictably, Mr. B.'s graph was fairly steady. There is only one dip in the fourth session, because he had concentrated on a dream he had had the night before, and not on the transference.

The graph of Mr. Y.'s statements goes slowly upwards. When he first came to treatment, he was so immersed in his panic that he was only dimly aware of the therapist. However, as he calmed down, he was able to convey to the therapist a range of feelings that were more on the transferencial level.

Looking at this statistical material, we can see that the hypothesis of this study--that in the initial phase of treatment unique transference manifestations occur in this sample group which enhance treatment--was validated through a numerical analysis of statements made by Israeli patients to their Israeli therapist during the early phase of treatment, the first six therapeutic hours.

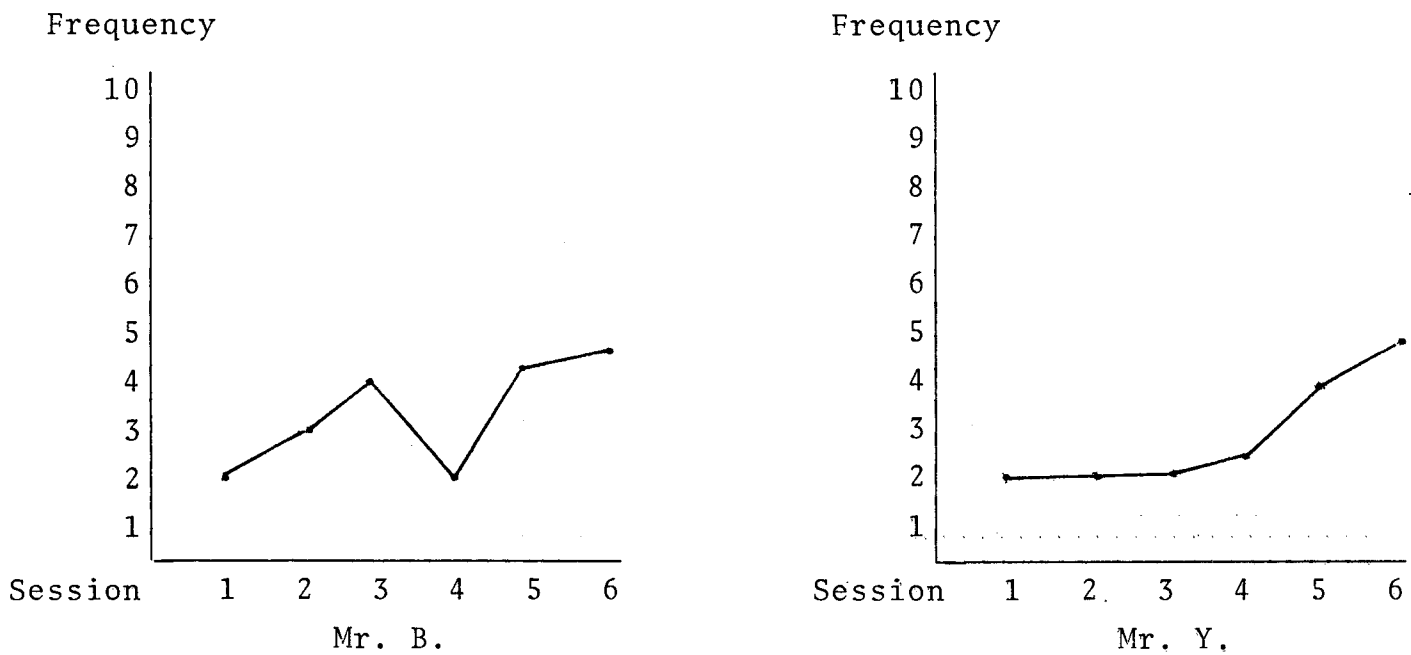

Figure 3. Demonstration of Changes through Time of Statements Expecting Empathy

CHAPTER VIII

DISCUSSION OF FINDINGS

The purpose of this study was to examine the impact of cultural similarity between Israeli patients and an Israeli therapist on the therapeutic process in the early phase of treatment.

The findings indicate that unique transference manifestations occur during this early phase of treatment which enhance the therapeutic process.

Because of the cultural similarity between patients and therapist, these Israeli patients began therapy with a very positive attitude. They had great expectations of being helped, and were very hopeful of personal improvement. Moreover, they invested themselves very quickly in the therapeutic process, and were not resistant to bringing up childhood material which was extremely painful.

It appeared that their overall expectation of the therapeutic process was that it was going to be very soothing, and would provide them with an opportunity to regress and allow themselves to be open and vulnerable to the experience.

Their fantasized familiarity with the therapist, and their idealization of her, allowed these patients to settle into therapy quickly, by-passing most of the normal resistance that occurs in the early stage of treatment. This was made possible, it is hypothesized, by the fact that the Israeli patient perceived that he/she and the therapist had so much in common that it was not necessary to be frighteneed or worried about not being understood. Some sort of natural trust and bonding occurred which enabled them to open themselves to the process with eagerness, transparency, and the motivation to change and get better.

This unique process occurred also due to other reasons discussed throughout this study.

As a whole, these patients (with the exception of Mr. Y.) had all experienced emigration from Israel to the U.S. in terms of tremendous rejection from the Motherland. By deciding to leave Israel and to separate and individuate from it, they experienced their Motherland as having a punitive attitude toward them.

This imagined or real rejection had carved great intrapsychic wounds, and had created pain that they perceived could linger for an eternity. These Yordim who experienced the agony of rejection from the Motherland felt like thoroughly "bad objects," (Mahler) when they entered therapy.

However, because the therapist was "one of them," there was also a feeling of warmth and acceptance, a new sense of unity with their mother and with their Motherland. They saw a therapist who also had left Israel, a Yored who had somehow survived the "going down" from Israel, and who was still able to function and do well in her life.

They immediately regarded the therapist as a role model. By the mere fact that she existed, they felt soothed, hopeful, comforted, and able to imagine that they too could make it in this new land.

The patients who also carried within themselves unresolved separation-individuation problems from their childhoods had experienced a double blow. They had experienced the mother's rejection once before, and were now experiencing it again, symbolically, because they had decided to leave the Motherland. For them the wound of separation from Israel was far deeper, one which Mrs. Y. said "goes to the bottom of my soul."

Thus, when these patients entered therapy with an Israeli, they immediately endowed her with all the qualities, yearnings, hopes, dreams and fantasies that they had lost or had never had. All of this came out early in the therapeutic process, in the actual beginning phase of treatment.

It is important here to look carefully at these patient's diagnoses in order to understand the intensity of

their individual functioning patterns in that early stage of therapy.

The pattern that became obvious in the findings was that the more disturbed the patient, the higher the score of responses. This pattern--that there is a direct correspondence between intrapsychic disturbance and number of responses--arose from the data and was verified in treatment with these patients. It is also substantiated and borne out in many other studies.

The most disturbed patient, Ms. Y., scored higher on the data than did any of the other respondents. Ms. Y. was a low-level borderline patient who was extremely needy, She had suffered great rejection in her life and consequently had never developed an ability to sustain intimate relationships. She expected an unusually high level of empathy from the therapist and idealized her more than any of the other patients in the sample group.

Similarly, she was able to regress to early childhood material more quickly than the others and plunged herself into treatment immediately, moving rapidly past the usual resistant behaviors that are typical of this period in treatment.

For a long time, Ms. Y. had been plagued with pain regarding the immigration issue, and was ambivalent and torn about being in Los Angeles. In her mind, she split

the countries into "good" and "bad" objects (Mahler) and was constantly idealizing Israel and devaluing the United States. Not surprisingly, she was unable to make personal commitments or creat intimate relationships here. When she would go back to Israel for a visit, however, she would then yearn for Los Angeles, which then had become idealized in her mind.

In sum, the pain of Ms. Y.'s early childhood rejection by her mother, coupled with her crucial withdrawal from the Motherland in adulthood, had created a person who was never comfortable with what "is" in her life, but who constantly longed for the absent, good "other."

Ms. A., also a low level borderline personality, who externalized her problems through her injured jaw, scored the next highest points in the responses.

Like Ms. Y., Ms. A.'s major problem centered around the original pain suffered in relationship with her mother. Her difficulties surrounding separation from the other, symbolic mother, Israel, were not as evident as with Ms. Y. It was, however, a real and constant source of pain.

Mrs. L., who had an inadequate personality with an endogenous depression, was struggling both with her old pain of maternal withdrawal (mother's inability to speak) and with her tremendous ambivalence about the Motherland. She too lived in limbo and felt herself to be homeless,

a "nomad." She said of herself: "I'm not here, and I'm not there. I'm nowhere!"

Mrs. H., next highest in the order of responses, was a borderline personality with a phobic reaction, and narcissistic features, who was functioning on a higher level than the other two Israeli women patients. Although her conflict about Israel was not as intense as the other womens', she would make such statements as: "I'd rather be there than here anyday, but I have no money to live there." She stated that she lived in Los Angeles because "it's easier here," but that she felt constant guilt about it.

Mrs. H.'s major conflict lay in the separation/individuation area and encompassed both the separation from her mother and from the Motherland--separations for which she had in her words "paid dearly." Summing up her overall problem, Mrs. H. stated: "Two divorces, one decompensation, and three years of phobias and fears."

Mr. B.'s scores would probably have been higher than they were, or at least as high as Mrs. H.'s, were he not constantly smoking marijuana--a fact which greatly affected his ability to feel, think, and communicate. Also, being a character disorder, and hence both manipulative and cautious, Mr. B.'s constant controlling mechanism greatly affected his score.

In the early stage of therapy, Mr. B. was dealing primarily with his experience of early parental "neglect" as well as his inability to sustain healthy, intimate relationships. Knowing himself to be manipulative, Mr. B. described a constant "internal terror" of being discovered by others as a fraud. That part of him seemed similar to a narcissistic personality disorder. His guilt about leaving Israel was masked by his cynicism and defensiveness. His major defenses were those of reaction formation and denial.

Mr. Y. scored the least points because he was in a crisis and because his major conflict at the onset of therapy was in the area of sexual identity. However, he too was torn between Israel and the United States and predicted that if he decided to remain in Los Angeles and not go back to the military that he would remain separated from Israel forever--a separation that would be virtually unbearable. He said of this: "I'll never be able to live internally in a no-man's land." However, other than this conflict, Mr. Y. did not seem overly intrapsychically disturbed.

Looking at these responses of Ms. Y., Ms. A., Mrs. L., Mrs. H., Mr. B., and Mr. Y., and at the patterns they form, it becomes clear that the more disturbed the patient is, the more he/she would expect empathy, would

idealize the therapist, would expect instant understanding, would be positive, less resistant, and would discuss early childhood material more quickly.

It is important to note that the quality and quantity of the material that these patients present generally comes up much later with other patients. It is this therapist's experience that these issues come up in the working-through stage or middle phase of treatment. Theorists in the area of social work (Hollis, 1964; Pearlman, 1957; Roberts and Nee, 1970) and psychoanalysis (Greenberg, 1967; Kernberg, 1973-1975; Masterson, 1975-1978; Wolberg, 1954) all agree that the transferential material on this scale occurs much later in treatment when the therapeutic relationship has been established for a longer period of time and has been able to go deeply into the patient's psyche.

Greenson (1967) talks about the "working alliance" in therapy which he feels occurs well past the beginning stage of treatment. He claims that it is the formation of this "working alliance" which reflects the patients' capacity to work purposefully in the treatment situation (p. 192). Sterba (1929) claimed that this "working alliance" is possible because of "the patient's partial identification" with the analyst's approach as he/she attempts to understand the patient's behavior. This alliance occurs,

he claims, later in treatment when the patient feels comfortable with the therapist.

In the treatment of these Israeli patients, the working alliance and identification occurred immediately. At times it started when the referral was made before the patient even came to therapy, in his/her fantasies and projections. At times it started over the telephone when he/she made the first call to the therapist.

Whatever the circumstances, this instant working alliance between Israeli patients and therapist seemed for the most part to surpass resistance, and to promote instant rapport with the therapist which allowed the patient to work in the psychotherapeutic situation without the blocks and walls which normal resistance would erect.

In general, the Yordim who have suffered a great rejection from Israel by their act of separation from her, experience tremendous ambivalence towards the mother country. They vacillate between love and anger, hate and rage, and fondness. They feel punished for wanting to separate from the mother. Out of a great sense of guilt, many of them return to Israel laden with gifts for their families, or donate large sums of money to the State of Israel. They are preoccupied with this sense of having been rejected, and carry on at lengths about it, speaking defensively about the reasons why they left the Motherland.

The Yordim examined in this study clung to the therapist during the initial stage of treatment as if she were the mother who would make it all "better," praise and admire them for separating from Israel, (or at least not blame them for doing so), and give them absolution for their real or imagined transgression.

The patients who had experienced difficulty in separation-individuation during their life development and had also experienced the pain of the act of "Yerida" suffered a double blow and clung to therapy and to the therapist almost in desperation. Those were the patients who had to struggle both with intrapsychic problems from childhood and with psychosocial conflicts incurred as a result of separation from the Motherland.

A look at the national conditioning which persons growing up in Israel experience can perhaps shed light on their dilemma.

The State of Israel's psychology has always been to become an "extension of self" for its citizens. So strong is the bond that when it is cut, suffering, anxiety, a sense of loss, and sometimes even psychosis can occur, expecially if past problems were serious and if difficulties in acculturation in the new country persist or if longing for reunion with the rejecting mother (Israel) do not cease.

Culturally speaking, the Yordim in the U.S. feel abandoned by the mothering function of the State of Israel. They address the country as "she." As soon as they decide to apply to come to the U.S. (and especially when they decide to stay in the U.S.) they are cut off psychologically to such an extent that the fantasized and believed oneness once felt (maybe in childhood going to school) with the land of Israel is painfully severed. That special relationship with the Motherland has been disrupted and it is almost irreparable from that time forward.

Such a disruption may cause almost unsurmountable difficulties in adjustment to the new country, which involves many of the functions symbiotically used by the toddler when he is in the practicing stage. As a consequence, Israeli patients cling to the therapist. Their separation reactions as expressed verbally are similar to the behavior described by Mahler of great ambivalence. Under this state of extreme disorientation and discomfort they cannot or will not find in the U.S. a symbolic or symbiotic mother substitute that is soothing enough to ease the pain that they are suffering.

They speak of leaving Israel and their wish to go back there constantly and there is a push and pull towards and away from the homeland. Further, there is the perception on the one hand of Israel being the "bad mother,"

and they of being the "bad object" or on the other hand of Israel being the "good" mother and they being the deserting "bad object" (Mahler). They use splitting as a major defense and are full of destructive rage and fury.

During the first phase of treatment, these Yordim experience the therapist as a "good mother" who is expected to "cure all" and fulfill their wishes and fantasies, sooth and never leave them, and especially protect them and help control their destructive rage, anger, and disappointment with Israel and with life.

As a rule, problems in the area of acculturation with this population group are compounded by the inbred habits of the Yordim.

All the patients in this sample group dated or were married to other Israeli Yordim. As is typical with this group all stayed within the Israeli culture and made no attempt to mingle in their private lives with non-Israelis. Consequently, they contaminated each other with their ambivalences and guilt regarding their immigration, and their pain due to the rejection and guilt experienced by them all.

The private lives of these patients were narrow. They did not allow themselves to have relationships with others outside their tight home groups, and hence, never

experienced the pulse of the city, but remained stagnant, living half a life here, and half a life there.

Those who married (such as Mrs. H. and Mrs. L.) married other Israelis, and hence contracted alliances based on familiarity, not on feelings of compatability, affection, or love.

All of this brings us to conclude that as a group, these Yordim in the U.S. are a lost people. As a result, when they enter a therapeutic relationship which almost magically offers them warmth, acceptance, and an opportunity to share and work in what is perceived to be an empathic, accepting environment, they plunge into it with enthusiasm, immediately creating a bond and a unity with the therapist, and ready to share their deepest feelings and memories without hesitation or reservation.

In summary, this study demonstrated that: (1) the patients experience the therapist as a good, omnipotent, benevolent mother. (2) They present minimal resistance. (3) They are very positive about the therapist and treatment. (4) They are able to discuss early childhood material very early in treatment. (5) They idealize the therapist and expect him/her to be empathic and understand them instantly due to the cultural similarity and all it entails.

These patients appear to benefit greatly from therapy and improve significantly. They work very hard,

and are hopeful, and motivated to change. They use this cultural similarity to their benefit, re-enact their old developmental arrests, re-experience the new psychosocial rejection, and are able to work much of it through in this new, yet comfortingly familiar setting.

CHAPTER IX

SUMMARY AND CONCLUSIONS

The purpose of this study was to examine the impact of cultural similarity between Israeli patients and an Israeli therapist on the therapeutic process in the early phase of treatment.

Corollary issues studied were:

1. Some unique manifestations occur during this phase which enhance treatment.

2. There is a tendency to see the therapist as an omnipotent all-good mother; because of this, the patients exhibit minimal initial resistance.

3. The patients are extremely open and early childhood material emerges right from the start.

4. The patients expect great emapthic responses and instant understanding by the therapist.

Another major purpose of the study was to collect and present a modal Israel personality which also would help to understand the population presented in this study.

The six cases that were examined here seemed to have demonstrated that treatment with a therapist from a similar culture helped them create a bond with their therapist. It helped them to reenact: (1) a unity with their mother

that was probably not worked through during the rapprochement subphase discussed by Mahler, (2) a unity with the Motherland--the State of Israel--whom they address as "she" from which they had been cut off due to the fact that they left, in their minds deserted the State of Israel. The symbiotic bonding that these patients create with the therapist helps them feel comfortable in the therapeutic environment. They idealize the therapist so that the therapeutic setting becomes a very pleasant loving "good" place to go--a place that allows them to open up and deal with painful and disturbing issues very early in treatment.

The findings in this study show that cultural similarity between therapist and patient greatly helps these patients in the early phase of treatment. The bonding which they create with the therapist helps these patients work on very important issues, without worrying about being understood. Hence, despite the fact that they are experiencing great difficulty in adjusting to the new country, they come to treatment very hopeful of resolving their intrapsychic problems and cultural problems because here, at last, there is someone who can understand them and speak in their own language.

Under these special circumstances, therapy is experienced as helpful, soothing, and calming in the initial phase of treatment.

Limitations of the Study

Although this study has implications for broader cultural issues, the findings cannot be generalized across the board. This necessarily small population has been drawn from this writer's own private practice records and the data were taken from each session during each session. This is not a random sample. It has been selected to illustrate the theoretical points which the author wishes to demonstrate.

Inferences, however, can be made from the data presented. The negative projections made towards the "Yordim" from Israel and the Jewish community makes this immigration problem unique and different from other cultures, and therefore it limits the generalization of this study to this and not necessarily other cultures.

The long-term cases examined in this study are all borderline adults. Therefore, one might say that maybe the phenomena discussed in this paper only occurs in borderline adults. But the short-term cases have a variety of diagnoses and therefore it can be assumed that this phenomena occurs across the board (with Israeli patients) with most diagnoses as long as the patient and therapist share cultural similarity.

This study only deals with the initial phase of treatment. Therefore, vast conclusions and inferences

about the whole treatment process cannot be made.

Because only the initial phase of treatment has been discussed, there was no attempt in this paper to deal with long-term countertransference issues in depth or the pitfalls of treating patients from the same culture. It is also important to note that this paper concerns itself mainly with the patients' responses to treatment with a similar therapist. Sex and class differences were being discussed at length, but this author saw a similar response from Israeli patients regardless of sex or class difference. The sex of the therapist, however, might have an influence on the initial phase of treatment. This has not been the main focus here.

Most important to note is that this study is only a beginning effort and points out a significant but limited view of treatment process and treatment issues with this kind of population.

Implications for Practice and Further Study

This study was able to support the premise that when cultural similarity exists between an Israeli therapist and Israeli patients, an unusual therapeutic process occurs in the early phase of treatment which enhances the treatment. Because these patients plunge into therapy with minimal resistance, are open and able to share painful

childhood material, and trust the therapist, they are able to benefit greatly from therapy.

Although transference/countertransference issues in therapy in general are a subject which is well beyond the scope of this paper, I will briefly discuss here those transference/countertransference issues I encountered which could illumine practice with this or other similar population groups.

When I first started working with these Israeli patients, I did not understand this phenomenon of idealization, trust, bonding, and minimal resistance with this population. I had the onmipotent feeling that these patients were doing very well and were very open solely because of something that I was providing. I did not know what it was, but I felt good about it and trusted myself. I felt onmipotent. These patients fed me with positive reinforcement, and I accepted it feeling very good about my professional success with these patients. They idealized me, told me I was a good therapist. I was not aware how to use this material early in treatment, because it seemed so different from other patients whom I was treating.

Although at times it bothered me that all this positive transference was going on so early in treatment, I totally failed to understand it. It took time, thought,

self-probing and some pain finally to get a glimmer of what dynamically was transpiring. It is difficult for a therapist to relinquish an omnipotent role. But for the benefit of both therapist and patient, this is what he/she must do, and it is what I, finally, was faced with.

It is hoped that the experience described in this study will help other practitioners specifically clinical social workers working with culturally similar patients (who perhaps idealize them) to deal with their own countertransference feelings.

The sex of the therapist might also be an important issue to consider in relation to the transference and countertransference.

This study also highlights other special considerations we as practitioners need to give to our culturally similar patients, and to immigrants who have difficulty adjusting to their new environments, and who live intrapsychically between two cultures.

This study points out that there is almost no material written on the effect of cultural similarity on psychotherapy. It is hoped that this study will be a catalyst to others to continue researching this very important area. Also, and most critically important, there are almost no studies available on Israelis in the U.S. As seen in other sections of this study, the

Israeli population in the U.S. is growing rapidly, and therefore we need to know more about these people's personalities, and how we can help them in treatment.

Mostly, it is hoped that this study can illuminate the importance of cultural issues in treatment and how they affect treatment from a theoretical and practical perspective. It is hoped that this study will reawaken therapists' interest and research in the area of culture and its effects, since we all work with patients from all walks of life and from all cultural backgrounds.

Finally, many studies used in this dissertation (see literature review) point to the fact that patients prefer to work with culturally similar therapists. It is hoped that this study will encourage proper evaluation of referrals for other minority groups and women.

Further issues of study necessary in this area could be:

1. Countertransference with culturally similar patients.

2. Ongoing treatment with culturally similar patients.

3. Early termination, and why.

4. Resistance, when is it likely to occur?

5. When resistance finally shows up, when is it, and how does it occur?

6. Envy and negative transference in the latter part of treatment.

7. Termination and disengagement, is it possible?

8. The sex of the therapist, does it make a difference?

Recommendations

As a result of this study, the following recommendations seem appropriate:

1. Agencies or private practitioners who have patients who do not speak English very well, and who seem to have acculturation issues should be referred to therapists who speak their language or who are culturally similar to help them communicate better.

2. Similar consultants or supervisors should be used when cultural issues interfere with treatment or are issues in treatment.

3. More research should be done in the area of cultural similarity, and its effects on treatment.

4. Social workers in particular who treat people from other cultures should put a lot more effort into exploring the area of the effect of culture in psychotherapy.

5. Studies (Walter, 1977; and others) show that patients prefer culturally similar therapists. This

issue needs to be explored in relationship to other minority groups and women.

6. More attention should be given clinically and programmatically to the Israeli population in Los Angeles.

7. Conduct a study comparing two groups of patients, one group of cultural similarity and one group where there is no cultural similarity, to see if these unique manifestations in the initial phase of treatment are significant.

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APPENDIX A

THE INSTRUMENT

Table 1

Demographic Data - Age/Sex

Ages	Male	Female
15-20		
20-25		
25-30		
30-35		
35-40		
40-45		
Average		
Entire Average		

Table 2

Marital Status

Sex	Married	Single
Male		
Female		
Total		

Table 3

Cultural Background

Sex	Sephardic	Ashkenazi
Male		
Female		
Total		

Table 4-A

Social Class[a]

Patient	Education	Patient's Occupation	Husband or Mate's Occupation
1. Mrs. H.			
2. Ms. Y.			
3. Ms. A.			
4. Mrs. L.			
5. Mr. B.			
6. Mr. Y.			

[a]The patients studied come from lower class, lower middle class, and middle class. In order to determine the exact social class of these patients, the Hollingshead (1958) scale was used.

Table 5

Positive, Negative/Ambivalent Statements
Per Patient, Per Session

	Sessions													
	1		2		3		4		5		6		Totals	
Patients	P	N/A	P	N/A	P	N/A	P	N/A	P	N/A	P	N/A	P	N/A
Mrs. H.														
Ms. Y.														
Ms. A.														
Mrs. L.														
Mr. B.														
Mr. Y.														
Totals														

Table 6

Statements Made by Patients Discussing Early Childhood Material Per Patient, Per Session

Patients	Sessions 1	2	3	4	5	6	Totals
Mrs. H.							
Ms. Y.							
Ms. A.							
Mr. L.							
Mr. B.							
Mr. Y.							
Totals							

Table 7[a]

Statements by Patients Expecting Empathy and Instant Understanding from Therapist Per Patient, Per Session

	Sessions						
Patients	1	2	3	4	5	6	Totals
Mrs. H.							
Ms. Y.							
Ms. A.							
Mrs. L.							
Mr. B.							
Mr. Y.							
Totals							

[a]See Figure 1

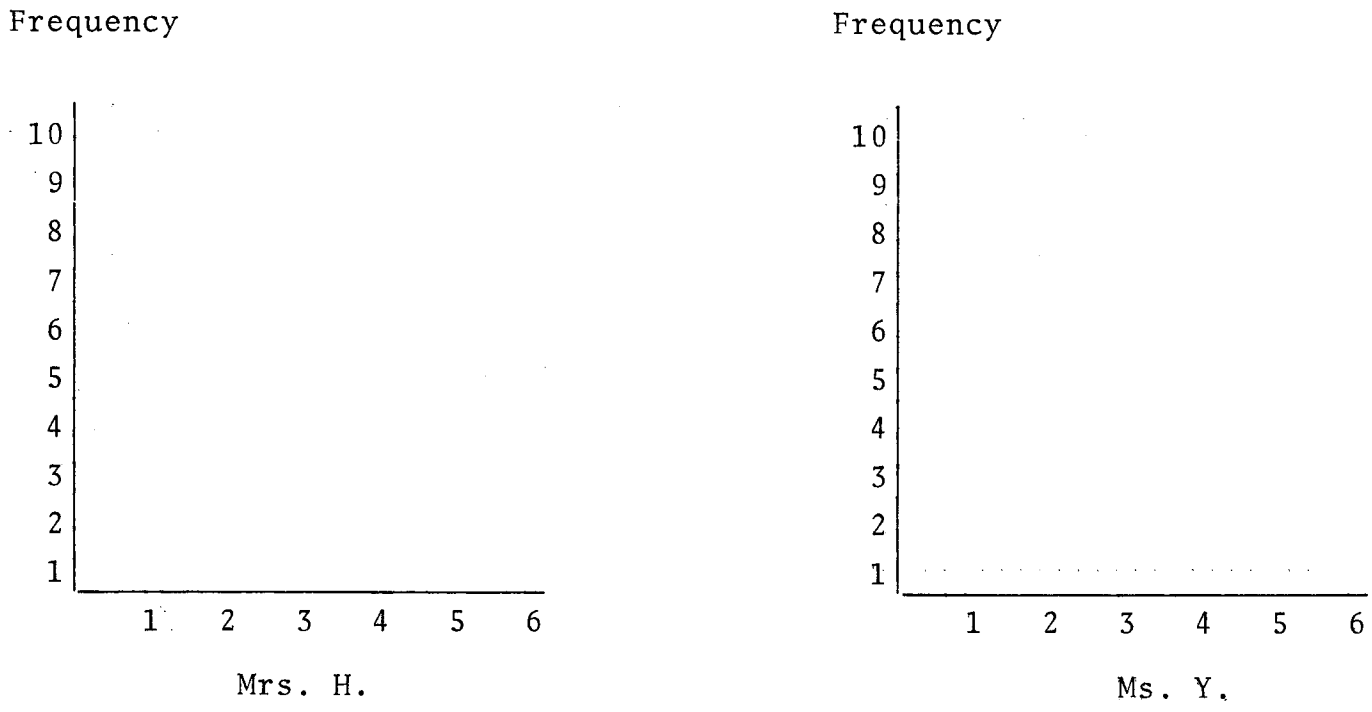

Figure 1. Demonstration of Changes through Time of Statements Expecting Empathy and Understanding from the Therapist

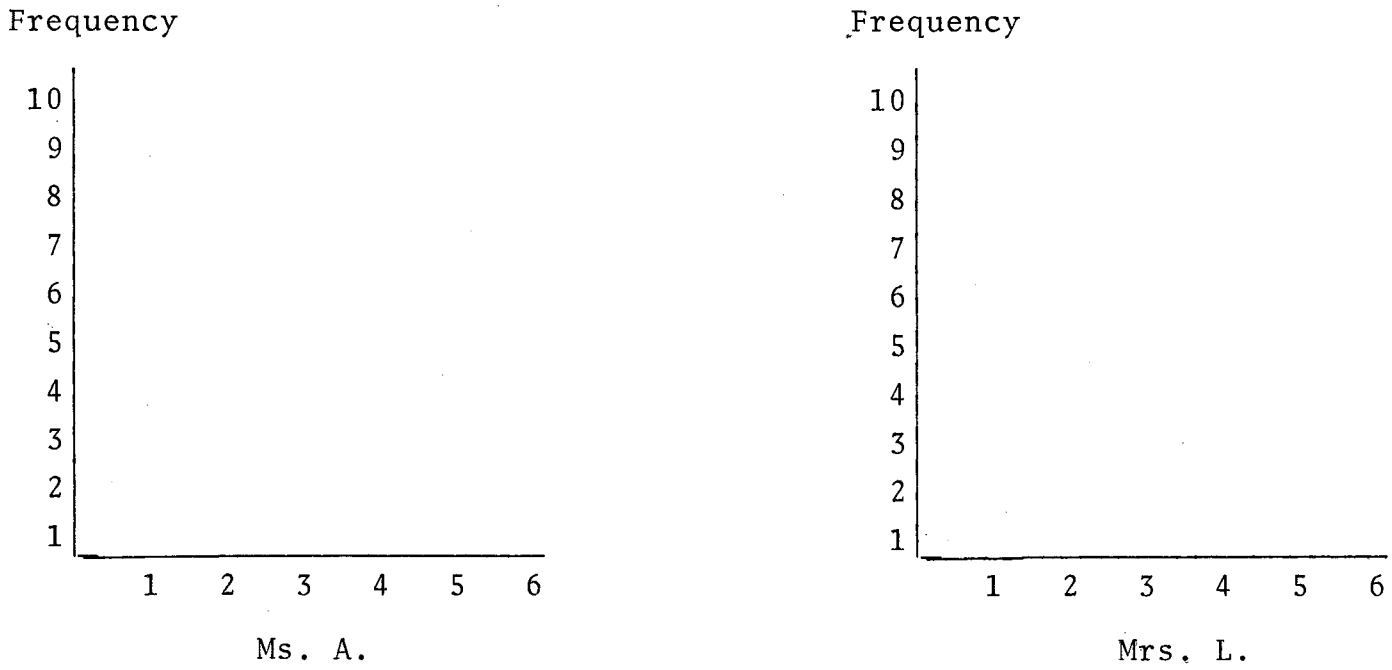

Figure 2. Demonstration of Changes through Time of Statements Expecting Empathy

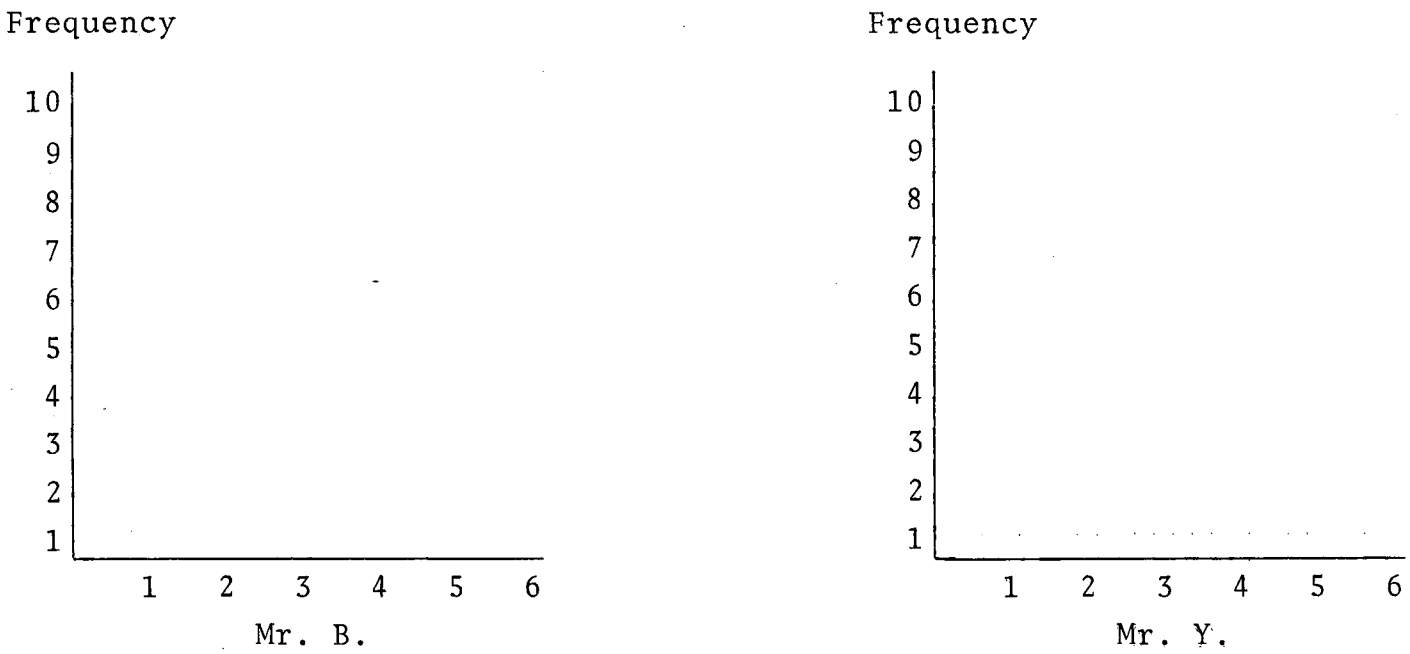

Figure 3. Demonstration of Changes through Time of Statements Expecting Empathy

APPENDIX B

EXAMPLES OF STATEMENTS MADE BY PATIENTS TO THE THERAPIST IN THE FIRST SIX SESSIONS

EXAMPLE OF STATEMENTS MADE BY
EACH PATIENT PER SESSION

Mrs. H.

1st session	1.	Are you Israeli--my luck was lucky.
	2.	You'll be able to help me for sure. You'll understand.
N/A	3.	Maybe you've become too Americanized to remember and understand it all.
2nd session	1.	Dr. G. didn't understand me because of the language, and he didn't do a thing, but you will.
	2.	You won't hurt me because you understand me. We have the same past.
3rd session	1.	You remind me of my mother and aunt both from Poland.
	2.	You're so organized--you've got it all together.
N/A	3.	Don't know if I could be so well like you.
4th session	1.	The big difference between you and Dr. G. is that you are warm and Israeli, and understand Hebrew. He just wanted my case for the money.
	2.	I feel like home here like in my mother's belly.
5th session	1.	Lili, I must tell you but I'm scared that I want to come every day or at least three times a week. Therapy is the most important thing of my life--I'm so lucky.

Mrs. H.
(continued)

6th session	1.	Thank you for everything. I feel like I'm going to start living again.

Ms. Y.

1st session		1. I feel like I need to get therapy without pay.
		2. I want you to be in control for me, and I know you can help me with it.
		3. I'm paying you to make me happy.
		4. I must come back often--must be in therapy, I feel so lost.
		5. You're my hope.
		6. The language is so important to me. I'm Israeli and need that my past be understood, and you do.
	N/A	7. Don't know if I should see you or the other MFCC. Don't know if I deserve this luxury (therapy).
2nd session	N/A	1. Twice a week seems a luxury.
		2. But I want to see you three times a week.
		3. I was very dependent as a child on my mother, and now I'm getting it here.
		4. Now I have you to myself.
		5. My parents loved their kids, a crazy love. You'll teach me the difference.
3rd session		1. You're the only one that I have. You're saving my life.
		2. I'm depending on you.
4th session		1. You make me feel there is hope.
		2. You make me feel that I'm worth something.

Ms. Y.
(continued)

5th session	1. Feel so much better already.
	2. I'll do what you say--go out even when I'm depressed.
	3. I won't be scared of my feelings when you're with me.
	4. When I returned home, the anxiety started but here (office) it feels more safe.
6th session	1. I have a problem in the area of self loving, it's deep, but you're so strong you are the only one who can get it out.
	2. I'm so hurt. You'll help me--with you I feel worth.

Mr. B.

1st session	1.	I know you'll put me back together.
	2.	Being Israeli, you know what is right for me.
2nd session	1.	I'll tell you about everything, and then you'll decide.
	2.	How come I didn't know you were here--I would have come earlier.
	3.	You are so understanding and clever.
3rd session	1.	I can tell you everything, and you'll really understand me as a total person.
	2.	We will go far together.
	3.	You accept me as I am.
	4.	You and I will build a fortress together.
4th session	1.	I dreamt that I had to protect a fortress. The fortress was attacked--I was in it. The person who had the job to protect the fortress couldn't handle it. So I did it--was in charge of it, and got very little money for it. I was angry about it so I told the woman in charge, and she worked it out. I got a star and some extra money.
	N/A 2.	Don't know if I should continue therapy--I'm okay.
5th session	1.	I'll tell you everything about my childhood. You'll know what I mean.
	2.	It feels so good here like in the crib.
	3.	I feel safe and warm here, and outside is like a cold night in London.

Mr. B.
(continued)

4. How lucky you are that you know everything. I'm too--I'm here.

6th session

1. The language makes it easier to really communicate.

2. Being Israeli with Polish background--you know exactly what I mean.

3. You are so warm.

4. I know you won't hurt me. I'm all backed up inside.

5. Crying. It's too close--too familiar here--I'm falling into the trap of being completely open.

Ms. A.

1st session	1.	Nobody could help me except you.
	2.	Only someone with the same background can understand what my mother did to me.
2nd session	1.	I lost equilibrium with other therapists--not here.
	2.	Feel comfortable with you.
	3.	You're so kind.
	4.	You could put such a broken dish together--I trust and believe in you.
3rd session	1.	I thought today how lucky I was to come here.
	2.	Maybe my luck is changing--I met you.
	3.	It's true you'll help me.
	4.	I thought of telling you that you have a wonderful smile. You feel me and everything I tell you--we are from the same blood.
	5.	These Americans--they don't have a heart. I already saw professors from the whole world and nothing helped. With you it's different.
4th session	1.	Wanted to ask forgiveness for not bringing you some cake. I made a cake for the first time in years because of you.
	2.	You are so good to me.
	3.	One of the ways I know how to show my love is to give food.
	4.	Feel like a little baby who is warmed up.
	5.	Must come two or three times per week.

Ms. A.
(continued)

5th session	1.	You're so supportive.
	2.	You dress so well, and you're so pretty and clever.
	3.	I'm feeling better thanks to you.
6th session	1.	Nobody held me or touched me as a child. With you, I feel like you're hugging me.
	2.	I saw a psychologist at 16, what a difference. He was cold.
	3.	You're so warm and understanding.
	4.	You're getting deeper and deeper. You're so good.
	5.	I know you'll make me better.

Mrs. L.

1st session

1. It's a beautiful office.
2. You're so nice.
3. I know you'll understand and tell me what to do.
4. I don't get anything in the relationship with him (husband), but I'm sure I'll get it here.
5. Went to another therapist (American)--he was a jerk. He didn't know what I'm talking about. But with an Israeli--it's different, it's home.
6. It's so comfortable here.

2nd session

1. I wanted to see you right away, and have you near me like family.
2. Felt freer the night I left you here.
3. I knew I have a home to come back to.
4. Can I see you three times a week?
5. I know you'll be able to help me (crying very hard--I held her). She said, "I'm lost, can I stay here for a while."

3rd session

1. Wanted to pack my suitcases and leave, but I heard your voice and didn't do it.
2. He (husband) said, "You're closer to her than to me. Who is she, your mother?"
3. Except here I feel as if I knew you for many years, and we re-met.
4. At home I don't feel anything about me is good, but here you bring out my best.

Mrs. L.
(continued)

4th session	1.	DREAM: I was standing by a pond looking at myself. I saw two figures, me and another girl--woman with reddish hair. Both merged and a big bubble took them away. I woke up happy. It was a good dream.
	2.	I'm telling you things I never told anybody--only you.
	3.	I need a woman to depend on, and I feel good with you.
5th session	1.	I can't depend on anybody except you.
	2.	All my brothers succeeded. The only hope I have is if you help me.
6th session	1.	I feel lost without you on the weekends.
	2.	I've fears and palpitations, but not here with you.
	3.	Feel safe here.
	4.	I'm afraid of closed places, but not here--unbelievable.

Mr. Y.

1st session	1.	I had to see an Israeli. I'm lucky I found you. I'm in a crisis situation.
	2.	I know you work with Israelis and you're good.
	3.	How lucky I am to have found you.
	4.	You understand me completely.
2nd session	1.	You'll help me make a decision.
	2.	This office is so warm like being in the new womb.
3rd session	1.	This place and you gives a warm atmosphere.
4th session	1.	Tell me what to do. You're like my second mother.
	2.	I want to stay here with you forever.
5th session	1.	I know you'll help me.
	2.	I know you'll show me the way.
6th session	1.	Thank you for accepting me as I am and not passing judgment.
	2.	I'd like to lie down and cuddle up on this couch--(cried). I feel like I'm crawling back into the womb. You are so warm, accepting, and may I say loving.