

Culture, Trauma, Transference and Counter-Transference: A Working Model for the Complex Interaction Between Refugee Client and Therapist

Introduction

The recent literature on transference and counter-transference in therapy with refugees puts strong emphasis on the traumatic experience, giving less attention to the difference in the cultural backgrounds of therapist and client. The authors present a working model which they hope will do justice to both aspects. It is a practical instrument composed of seven points in the form of questions that a therapist can ask himself to clarify certain aspects of his interaction with a refugee client. The aspects relate to culture, trauma and transference within the therapeutic relationship. It is a model that we can apply ourselves, while it also furnishes a framework for discussion in intervision or supervision.

Refugees in mental health care

Refugees are distinguished from migrants on the basis of the structural violence they have experienced and the coerced nature of their departure. What they have in common with migrants is that they have been deprived of their familiar surroundings, and must make themselves a place in a new society. This process of acculturation must also take place in the contacts between therapist and client. Acculturation is a lengthy process; the outcome is determined by many aspects, including a person's history and background, but also by the obstacles a person encounters along his way, such as his chances of being granted legal title for residence, of finding meaningful work and a meaningful existence and the possibility of being reunited with his family.

Differences with indigenous clients may be present in the following fields:

- views on sickness and health (what health problems do I perceive, how do I express this, how do I deal with it and how I can be rid of it)
- unfamiliarity with the function of the professional health care worker
- the “cultural gap” (things that I find to be perfectly ordinary, that are (to me) a familiar part of this society, are not yet ordinary for the client, *and* what is ordinary to the client's mind, in his society, is not yet that for me as a therapist)
- values and norms in respect of family relationships and family ties, in respect of the role of husband and wife, in respect of faith and its significance, and possibly differences in political standpoints
- what one may and may not mention to a professional health care worker, to an outsider: what is public and what is private, what causes shame, what is taboo?
- how much is understood of the spoken language; in what language should one speak; who is at the greatest disadvantage in that language; how is culture implicit in language; how often can an explanation be asked and how often can it be given; how much non-verbal communication is visible and meaningful?

Terms

First we will explain a few terms which will be used in this article.

Culture may be taken to mean a pattern of shared experiences, behaviours and meanings attached to them by people in a society or a group.

Trauma. From the Greek word for wound, this term is used to refer to emotionally shocking experiences that give rise to a great sense of powerlessness and that disrupt a person's very existence. Refugees have often been through traumatic experiences that have left them uprooted and marginalized. Many refugees suffer from symptoms of traumatic stress, with aspects such as repetition, avoidance and overstimulation.

Transference. The phenomenon that experiences, wishes, fears, fantasies and forms of resistance in relation to an important person in a person's life are now experienced in relation to another person, often named in connection with the therapist. There is also transference from the therapist onto the client. Previously, transference was primarily seen as a projection from the past; nowadays, it is increasingly coming to be recognized as a universal psychological occurrence, a way of organizing experiences and constructing meanings. It is interwoven in a person's current perception of relationships, and in an anticipatory sense as well.

Counter-transference. In a broad sense, the total of the therapist's conscious and subconscious emotional and cognitive reactions to, and fantasies about, the client; in a more limited sense, the emotional reactions of the therapist to, and in relation with, the transference on the part of the client. The prefix "counter-" is increasingly coming to be regarded as superfluous; there are several transferences, intertwined in a subtle interplay, and the crux of the matter is to become aware of and utilize the phenomenon. But because the term is so widely used, we have chosen to add the prefix "counter-".

It is fascinating to see how, in cultures with a familial self, people exhibit more multiple and pluriform transferences (in the past, therapists were wrongly tempted to define this in terms of suboptimal individuation). In therapies with migrants, we see strong transferences involving many close and distant relatives in the associative material. In the literature, we often encounter descriptive terms, such as floating transferences, that originate with parents, parent surrogates, other relatives (often grandparents), friends, priests or healers (Neki, in Dahl, 1989) and teacher transference (Taketomo, 1986).

Counter-transferences can also reflect this broader context. In the therapy, it is often wise to adopt, in a general sense, the same forms of pattern recognition, resistance, defence, coping and giving meaning, and to focus these primarily on others in the client's environment rather than specifically on the therapist. In a therapy with a migrant, the therapist occupies a relatively larger space as a new object, a new person in the client's life. In therapies with people from a different culture, cultural differences can encourage stereotype transferences, resistance and counter-transference, but they can also facilitate individual-specific transference and counter-transference developments (Van Waning, 1999).

We feel that phenomena such as transference and counter-transference play a role in all contacts, and so in a therapeutic contact as well. From this point of view, it makes no

difference whether the interaction involves psychotherapy on a Western basis with a refugee or an interaction that leans more towards psychosocial counselling and aid.

A working model

All seven aspects in the working model concern the intersubjective interaction; emphasis in the first two lies on the client; in the third and fourth on the therapist and the interaction; the fifth and sixth points primarily concern cultural and context aspects; and the seventh point refers to the universal cultural aspect of the therapy. Of course, cultural aspects play a role in all seven.

We will first state the seven questions we can ask ourselves, and then explain them further.

1. What ideas, which emotional and cognitive constructs in relation to the world, to his fellow human beings and to himself have primarily been affected and disturbed in the client?
2. Which transference role does the client assign to me as a therapist?
3. Which transference and counter-transference themes do these constructs and roles (mentioned in points 1 and 2) touch in me?
4. To what forms of coping and defence, in the sense of transference or counter-transference reactions, does this lead in me?
5. What cultural aspects play a role and what cultural dangers lurk in the interaction between the client and me?
6. From the point of view of the client's history and background, how can the problems of the client be understood, within the person, within the interpersonal relationship and within the social and historical context?
7. To what extent are there clear differences in this therapy in comparison with a therapy with an indigenous client; which differences; how are they expressed?

Explanation

- 1. What ideas, which emotional and cognitive constructs in relation to the world, to his fellow human beings and to himself have primarily been affected and disturbed in the client?**

People develop emotional-cognitive constructs, self-formed personal realities: these are complex schemes that comprise opinions, assumptions, expectations and ascribing meaning about oneself and the world (McCann and Pearlman, 1990). In survivors of violence, these constructs can become extremely distorted. Here we name the constructs in relation to the client; we also indicate how their distortion can have repercussions on the therapist (this aspect is further discussed in question 3).

The constructs distinguished by McCann and Pearlman (see also the description of Haans & Van Tienhoven, 1998) are:

1. *Trust*

Survivors of violence, whose trust in their fellow human beings has often been disappointed, lose this trust and may tend to continually discover “proof” of the disloyalty between people. This can cause them to become suspicious and cynical. The therapist may adopt this same attitude.

2. *Safety*

Because innocent people have been threatened and hurt, a person’s sense of social and personal safety may have been affected. This may lead to excessive watchfulness and a preoccupation with unexpected threats; the therapist may possibly do the same.

3. *Power*

Powerlessness in the face of repression, genuine powerlessness within the Dutch social context, and a feeling of paralysis, can play a big role for the client. The therapist may also feel extremely powerless.

4. *Autonomy*

When clients have been in prison and been restricted in their freedom of movement, it may have greatly undermined their sense of autonomy; this can have a detrimental effect on the feelings of independence and autonomy in the therapist as well.

5. *Respect and esteem*

Fellow human beings are no longer viewed as sympathetic and respectful. A person’s self-respect may have been damaged. The therapist may also become cynical and pessimistic about human nature.

6. *Intimacy*

Survivors can become alienated from the people around them. This may apply to therapists as well because they identify with their clients; within the treating institution, this can lead to professional isolation and alienation.

7. *Frame of reference, cohesion*

Due to experiences of violence, the existing constructs on causality--the “why” of events--may have been strongly distorted; this is about imparting meaning and making sense of things. Therapists may well become confused in this respect as well.

2. Which transference role does the client assign to me as a therapist?

Here questions will arise such as: do I feel I have been given the role of saviour, must I be able to resolve everything, make everything right again? Do I feel I have been placed in the position of passive onlooker, one who may only watch--and who is therefore also guilty? Do I feel I have been turned into an offender, in that which I subject the client to, in that which I am unable to give, in that in which I am now inadequate; as a resident of a country that leaves him or her in the cold?

3. Which transference and counter-transference themes do these constructs and roles (mentioned in points 1 and 2) touch in me?

A number of themes are mentioned in the classification of McCann and Pearlman which was cited in question 1: they involve changing visions in the client with which the therapist can also identify. Therapists will differ in what affects them the most; one person may react strongly to the theme of danger and unsafeness, another to power and powerlessness. In working with refugees, the therapist may experience these reactions in a general sense, but also specifically in the relationship with a certain client. When their clients are traumatized, the meaning and the interpretation suggested by therapists may change, may sometimes become disjointed, but they will primarily be put to a very severe test.

Danieli (1984) named a number of emotional counter-transference themes that she found in psychotherapists who worked with seriously traumatized clients. Her list shows some overlap with previously mentioned themes, and reactions are named that will come up in greater detail under point 4. Danieli's main points are given below (cf. Haans & Van Tienhoven, 1998).

1. Guilt

Usually guilt is experienced as "observers' guilt". Such feelings get in the way of therapists when asking questions; this is then rationalized away by thinking that the client is too vulnerable. On the other hand, the therapist may also be too lenient and set no limits.

2 Anger

On the one hand, anger is projected onto the aggressor; on the other hand, it can be rationalized away when the therapist himself becomes angry with the survivor. In family therapy, the anger of the children, in a collusion between children and therapist, may sometimes be shifted to the parents, who are then identified with the "persecutors".

3. Horror and dismay

Therapists may have violent nightmares, or during the sessions they may react with horror at the relived cruelties, just as do their clients.

4. Shame

The humiliation that survivors have had to undergo, and the degrading acts that they have sometimes performed in order to survive, can fundamentally undermine their belief in the value of human life and human dignity, resulting in shame.

5. Sorrow and mourning

The confrontation with massive cruelties sometimes makes it very difficult for therapists to give an event a place where it can be worked through in the therapy, and in their own perception of sorrow and mourning. This can undermine the capacity of the therapist for holding and containing as well as the shared mourning in the therapy.

6. Victim/liberator

When survivors are seen as victims, this evokes emotional reactions that are linked with observers' guilt, anger and shame. The therapist can then easily find himself in a situation of saviour counter-transference. If survivors are seen as heroes, the relationship can become bogged down in admiration that forms an obstacle to the therapeutic investigation of pain and suffering. In addition to an emotional counter-transference theme, this final point mentioned

by Danieli also shows an interaction constellation. For a more extensive discussion of this, see point 5.

4. To what forms of coping and defence, in the sense of transference or counter-transference reactions, does this lead in me?

Here we are looking at reactions, at what people do and what they do not do--however subtle it may be--on the basis of the vehement and less vehement transference and counter-transference emotions. Coping refers to cognitive, emotional and behavioural strategies that people use to deal with stress and its consequences. Defence refers to the subconscious strategies that people develop to deal with emotional tensions and fear. There is an overlap, but in general it can be said that coping is used more consciously, with some freedom of choice, and that defence, more so than coping, is a response to internal sources of tension.

All vehement emotional reactions can turn into therapeutic defences: they make it more difficult to observe the client and the therapy process adequately, to be “fully with the client” while keeping an open point of view. Some forms of defence in this context are silence, denial, avoidance, taking distance, clinging to professional role and protocols, reducing the contact to methods and theory. In fact, all types of defences may be enlisted, including, for example, repression, denial, shifting, projection and regression, reversal, turning passivity into action, and splitting, idealization and devaluation.

An example on the subject of “power”: when a client feels very powerless, the therapist may feel pulled along with this and have the feeling he has nothing to offer, that he is empty-handed, and fall silent; he may also try to make a defensive escape from the feelings of powerlessness through reversal, with fantasies about great personal power, promises and inadequate actions.

These reactions can be represented in a diagram with the dimensions of high and low (hierarchy) and distance and nearness. Some of the defences mentioned above in fact express increasing distance and are probably accompanied by the acceptance of a remote superior position, a retreat into the professional role. A subordinate role of the therapist on the basis of powerlessness and feelings of guilt is also conceivable.

In respect of the dimension of distance and nearness, the classification by Wilson and Lindy (1994) into two basic types is illuminating. They distinguish:

Type I reactions, which involve keeping distance, in which they distinguish the following patterns (see also Van Tienhoven, 1999): denial of parts of the client’s story; minimizing the client’s experiences and feelings; distortion of the story’s content; avoidance of overly painful portions of the story; indifference or reserve towards the client; keeping oneself at a distance or withdrawing as therapist.

Type II reactions are characterized by too much nearness: becoming dependent on the client; becoming overly involved with or identifying with the client; a tendency to act as a liberator or to exhibit hyperactivity; a very strong emphasis on the role played by the trauma in the client’s life.

Lindy (1996) wrote very poignantly about staging repetitions of traumatic events in the therapeutic setting. These are enactments in which the therapist may be invited to participate, as it were, and in which he encounters his own forms of coping and defence which, once consciously recognized, can shed light on the client’s traumatic experiences.

5. What cultural aspects play a role and what cultural dangers lurk in the interaction between the client and me?

When we speak of cultural aspects of therapy involving traumatized refugees, it is necessary to recognize both cultural differences and similarities. Problems arise if basic presumptions lead a life of their own and are not tested. Jessurun (1997) described four pitfalls that can play a role in the therapy when therapist and client come from different cultural and ethnic backgrounds. They might be viewed as two pairs of attitudes, two manners in which the therapist views things: 1 and 2 are one-sided contrasts, 3 and 4 show complementary projection and delusion.

1. The illusion of colour-blindness

The illusion of colour-blindness: a client who is a migrant-refugee of colour is the same as a white (indigenous) client; after all, we are all people; no special interest or approach is needed. In this case, the starting point is often taken to be that the dominant white way of thought is universal; forms of expression used by the migrant or refugee are seen as deviating.

2. The “they-are-so-different” attitude

This is the reverse of 1: even highly experienced white therapists can become rigid in their contacts with a migrant-refugee client based on the idea that different is the same as inaccessible; rather than adopting an attitude of openness and delving deeper into the context, the culture and their own reactions, they see themselves as “inexpert”.

3. The irreversible mark of repression

The irreversible mark of oppression implies that all problems of people of colour can be traced back to the fact that they were black or coloured in an oppressive society; the colonial past or the capitalist hegemony rears its ugly head. As a result, a) the therapist may pathologize a person: oppression and deprivation are thought to lead to permanent damage; and b) he may not see the individuality, the dignity and the personal problems of the client. The therapist may then over-identify himself, overcompensate, or allow special privileges on the basis of a “collective sense of guilt”.

4. The great white father or mother syndrome

The white therapist persuades the client (and himself) that he, the all-knowing, only wants the very best for the client. This mechanism can be reinforced by a need for authority in the client, but it means that the client has decided against reality-testing.

A number of pitfalls in this context have also been catalogued by Gorkin (1996). They are pitfalls in a transcultural sense, in which the therapist can play an active initiating role. The following are examples of possible constellations (keeping to the numbering):

5. Excessive, ambivalent curiosity in respect of the client’s culture

This can contain a great deal of anxiety and defence; it is a curiosity that surpasses that for which the client comes.

6. Making an island of the treatment situation

Avoiding discussion about cultural and political differences: a resistance to counter-transference that is based on anxiety, this can mean a narcissistic self-elevation in respect of “the others” in the therapist’s own group, by which he makes an exception of himself. The

therapist can enter into a collusion, over-identifying with the other, who is also a “victim”: together against the rest.

7. *Manifestations of guilt and aggression*

It is important to distinguish between collective historic guilt and individual feelings of guilt that are conducive to conflict. Out of a sense of guilt, a therapist may make an attempt at compensation in the form of a corrective emotional experience for the client. If his own guilt--called up, as it were, by the presence of the client--evokes aggression, this can lead to more guilt, thus further strengthening the aggression in a vicious circle.

Aspects in relation to the majority or minority group such as social dominance, feelings of superiority and prejudices can lead, on the one hand, to a passive-aggressive subordination and, on the other hand, to an overly assertive attitude.

6. **From the point of view of the client’s history and background, how can the problems of the client be understood, within the person, within the interpersonal relationship and within the social and historical context?**

It will be clear that many meanings play a role, at many levels. It is wise to look at this from several perspectives.

In relation to the person: to what extent do individual inner problems play a role; with which inner conflicts may the client have been struggling even before fleeing?

Which relationship problems were and are present (which we may recognize in the relationship between client and therapist)?

In relation to the third aspect, the context: in a broader sense, we might think of the institution where the therapy takes place, but this also refers to the social, political and historical aspects. Which meanings do black and white, and class, have for the two, and how is this expressed in their expectations of one another? Which stereotypes play a role, what does it mean for the client to be constantly discriminated against and marginalized, is a role played by a collective colonial past?

Of course it is wise to investigate--just as in every therapeutic process--whether there are parallel processes (Caligor, 1984). The term parallel process refers to a similarity of the behaviour and feelings in the relationship between client and therapist to the behaviour and feelings in the relationship of the therapist to, for example, his supervisor, team leader, colleagues, or the organization where he works.

7. **To what extent are there clear differences in this therapy in comparison with a therapy with an indigenous client; which differences; how are they expressed?**

A person brings his history, appearance, clothing, his problems, his questions, his experiences with the indigenous people, his experiences with the new society and its institutions, along with him into our consulting room. There, culture cannot be defined and delineated, but it reverberates and is visible, palpable in a great many ways that are noticed by the therapist.

We may find behaviour to be strange to a greater or lesser extent; it may arouse sympathy in us, and it may not. In this sense, there is probably no essential difference with the encounters with clients with the same ethnic background that we as therapists enter into. Perhaps the differences are only somewhat more striking, the feelings perhaps somewhat more intense.

When a person's history, a person's past lies in a far-away country, we must use our empathic capacities, our imagination and our fantasy to form ourselves a picture of it. It may mean that we must start out with a high degree of unfamiliarity and ignorance: everything is strange and therefore we are uncertain. Frequently, there are no joint terms of reference. The shared context must be discovered and built up. By being open and sympathetic and showing curiosity, we attempt to pave the way over which the interaction will take place: that of mutual trust.

Many of the aforementioned questions (particularly 1-6) touch on the special aspects of the therapeutic relationship with refugees. An unpublished study among transcultural psychotherapists (Van Dijk, 2001) speaks of differences in emphasis in the treatment of clients from other cultures. The final question is intended to investigate whether differences with indigenous clients are only relative, or whether the differences perceived are fundamental, and thus determine the therapeutic relationship in more than the usual sense.

Conclusion

We have illuminated seven points in the form of questions that a therapist can use to gain more insight into certain aspects of the interaction in therapies involving traumatized refugee clients. We primarily drew on the work of McCann and Pearlman (cognitive constructs), Danieli (transference and counter-transference emotions), and Wilson and Lindy (counter-transference reactions in respect of trauma survivors); in citing the work of Jessurun and Gorkin, we focused on the pitfalls in our work with clients with a different cultural background.

How does it help you, what can you do with it? It has been our experience that the working model with these seven questions can be helpful in the following sense:

- 1) Designating and taking apart complex phenomena helps to clarify them; it can bring to light a core theme (in the client, in yourself, in a parallel process), can lead to a search strategy and hypotheses.
- 2) Recognizing your own reactions can create space and lead to dis-identification; when you are "stuck", it offers you a way to move on, an intermediate space, room to manoeuvre.
- 3) Your own reactions can clarify and reflect aspects of inner processes in the client, and provide insight into them.
- 4) In a more general sense, the working model can help you to develop yourself and your skills as an instrument; if you use it on yourself frequently, in intervision or supervision, you may start to see enlightening patterns.

Not only the impact of their traumatic stories, but also the fact that our refugee clients have a different view of the world, can turn our own world upside down. Our certainties, our values and norms, our own cultural background that we take for granted--all these take some hard knocks.

The foregoing will have made it clear that we attach importance to investigating and getting to know aspects of other cultures. But it has been our experience as well that our attempts should not so much focus on learning more about another culture, but rather that we should search ourselves, ask ourselves what we think and what we are. Our own "culture" also needs to be scrutinized and discussed.

It is very instructive to study the culture we live in, and the subcultures (such as the therapeutic one)--getting to know them, placing them in perspective and seeing them within a larger context. And it is important that we get to know ourselves better in our transference and counter-transference patterns, our stereotypes and blind spots--that we learn to live more easily with uncertainty and ambivalence, with that which is “strange” in ourselves--so that we will learn to better understand our clients and the therapeutic process, and the therapy can be more effective.

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