Counter-transference in working with refugees

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Therapists need to be aware of their own feelings and reactions to their patients. We might become affected by strong feelings from the patient's past relationships that had had an influential role in their life, which may now affect the therapeutic relationship. Hearing the stories of patients who have experienced violence and persecution will have some impact on the therapist. It is often the case that therapists feel overwhelmed by the emotions brought by the patient, or by the horror of their story. It is very difficult to remain neutral and to comply with the accepted practice of the blank screen, traditionally adopted in psychoanalytic therapy. For those people who are in the process of reclaiming their lives after fleeing for their safety, blank-screen therapy will be of little help. The therapist needs to be present, and to be emotionally available to themselves and to the patient. In doing so, the therapist is committing to their own personal exploration without guarantees of where it might lead them.

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Providing therapy to recent refugees and asylum seekers presents many challenges to our received knowledge of psychoanalytic therapy as well as to the growing knowledge of psychological trauma. Therapy in the initial stages can be a form of debriefing, listening to the story and accepting with the respect. This aspect of the work can lead to very powerful feeling in therapists, who may find it difficult to be listening and bearing witness to what has happened and is happening to the patient, and seemingly not able to do anything. Often the therapist might be the first person to hear the unrestricted version of the story. Yet cultural taboos may prevent significant aspects of their experiences from being told. In some cases it may take some time before patients build trust and can associate freely in the presence of the therapist.

It would be fair to say that the Western culture of free-ranging psychological discussion may not be the same in many refugees' cultures and may be totally alien to some. The concept of psychological pain may not be recognized as such by patients, so that it can appear only in somatic form as the person could easily relate to the presentation of bodily pain. Therapists also need to be aware that they may not know of cultural taboos which lead their patients to conceal important parts of themselves. In our psychological culture it is good to talk about pain, while in some cultures this may perceived as very bad manners. To propose parallels, in Western culture it is bad manners to talk about digestive process.

As you all know, one of Freud's great discoveries was that these are feelings which the patient transfers to the therapist – but which belong to another relationship entirely. The early psychoanalysts were embarrassed when the patient felt in love with them, until it was realised, this feeling was simply transferred from earlier much-desired experiences of the patient. Decades later psychoanalysts realized that their own feeling towards their patients were also to be a source of useful information.

Because of the unfamiliarity of the client group, when working with refugees, and because of the changed context, therapists can at first feel de-skilled, for want of a better word. Supervision and consultation with a specialist in the field therefore is an important resource for therapists, aiding their professional development and also helping them to use the skills that they already possess more confidently.

From the point of view of the client or patient, we have to remember that, for many people who are not used to have the full attention of listening in such close proximity; therapy can feel uncomfortable or even intimidating. Specifically for some, after the initial telling of their story and expression of the facts, there is a difficulty in experiencing their feelings further. Moreover, at the Refugee Therapy Centre some patients have been able to express their fear that the therapy service is connected to the Home Office or other asylum services, and have been suspicious of their therapist. For those who came from authoritarian states with efficient networks of information-gathering, this caution is not surprising.

Often patients who engage in therapy are very isolated, and the therapist is the only person with whom they may have a meaningful conversation. Consequently, the therapist can become a very significant figure in their life in this way also. People who are going through one of the most frightening experiences in their lives with little support will use the therapist in a variety of ways. It is the therapist's responsibility to stay attuned with their own feelings as well as to the patient's needs- and to remain objective to therapeutic intervention.

I am going to talk about two people that I have worked with at the Refugee Therapy Centre and my feeling:

Grace, fifteen years old, has been coming to therapy for over a year, referred by her support teacher. In her own country her father had been arrested and taken away and shortly after she saw her mother killed in her own home. At thirteen she became the oldest member of the family and the carer for her younger siblings. Grace like other teenage girls was repeatedly subjected to military rape and injured. With the help of neighbours, she was brought to the UK with her thirteen year old sister, and a twelve year old brother. I felt related, and strong empathy with this girl who was responsible for her two siblings. In our second meeting,

she told me that she sees me as her mother - and that I have been sent by God to help her and children like her. In her cultural-religious context her mother was with God and was watching her. Hearing Grace's narrative and her wish for me to be her mother – and having a daughter myself who is older than Grace - I had deep feelings of concern. I felt guilty for my own survival as someone who had escaped political persecution, and also at my daughter's survival. The abuse of children always will provoke a powerful feeling in me, and I get a very strong wish and feeling that I need to take them home to protect them and nurture them along with my own children. I had to learn over and over not to doubt that it was possible for a child to survive such experiences as Grace's, and I had to deal with my helplessness, and my sense of guilt and my wish to help such children, even if I do not take them home. I had to keep hold of the knowledge that Grace had made a skillful link and had good defences to protect and rescue herself and her siblings. I had to understand that although at a comparable age my daughter might well have been unable to cope with such atrocities as Grace had been through, Grace was not my daughter and she did cope, and I do not need to cope with her pain by internalising it. I learned that what my child patient has experienced, she managed very well indeed, and she needed my help as she put it 'to let go of painful memories and to integrate in her new environment'. I had to manage my own feelings, which was not easy. Upon further thought I realised that what I was most identified with in Grace, appeared to be her or my deep anxiety of failing to be a good carer to her younger siblings. I remembered that when I came to the UK, my extreme anxiety was how to be a good mother to my children, having lost all my support and surrounding kinship. Then I could start working with Grace objectively.

We may take it for granted what many of the refugees and asylum seekers who arrive in the United Kingdom have experienced and witnessed debilitating violence, persecution, humiliation, loss, bereavement and displacement. Although some may have experienced these atrocities and traumas without developing serious psychological symptoms, for many the accumulated impact of persecution, flight to a strange country, uncertainty and loss of role, status and a support network in the host country is too much to cope with. Overbearing psychological stress often presents itself in heightened incidences of anxiety, depression, panic attacks, distressing flashbacks, excessive anger or apathy, sleep disturbance, suicidal ideation, problems with memory, concentration and orientation, and psychosomatic symptoms commonly headaches and back pains. The restoration of a normal life as far as possible can be the most effective way of relieving feelings of anxiety and distress, but for many refugees this is not possible and or in some cases their experiences are too overwhelming to brush aside this easily.

It is rewarding to see people coming to the Centre overcome their many problems, and to watch them learn to leave the scars from the past and start to live their today life. Many also arrive with hope and enthusiasm for a new life; like Grace - they only need reaffirmation of their hope and a space which can act as a facilitating and holding environment for them while they settle in the new society.

Amine was referred to the Refugee Therapy Centre by her GP, suffering from anxiety and depression. She is an extremely talented and educated 32 year old woman seeking asylum in Britain. She complains of becoming increasingly withdrawn, anxious and depressed, and feeling extremely angry. Her situation has deteriorated since her arrival in the UK, and she fears that she will lose her personality. She is worried that she can

never return to normality, and that she is going mad. She had been in prison and during her interrogation she was tortured and raped by the numbers of prison officials, by two of the officers repeatedly. After she was released from prison, she found that she was pregnant and it was too late to have an abortion. She also explained that even if she could have an abortion she didn't want to. She explained that she recalled the strange feeling of something special growing inside her and wanting to keep her baby even though she had been raped repeatedly. Every time she was recalling it, she would say that she could not believe that she survived that level of violence. Being pregnant was for her symbolic and representative of being alive and having a life force inside her, close to her heart, she said.

In another very similar case when the patient was released from prison her partner was not able to cope with continuing the sexual side, even though they had had a very respectful and loving relationship. They had been politically together for many years, and he apologised to her and said that he was not able to cope, it was going against his culture and he didn't know how to make sense of it and explain it to other people. In a short while she first found one lover, and then another, to make herself feel better. But she rejected both shortly after her partner finally left her, and became depressed. Twice she attempted suicide, but fortunately was rescued on both occasions and survived. In due course, she gave birth to a son.

To go back to Amine, the process was very painful for her. She was by and large in tears - it was the first time she had the full narrative of how she became a mother even in her own mind she said. She said she had never shared her experience of motherhood with any one, and her feelings about her child. She explained to me that she had a very strong attachment with her daughter. She thought of her daughter as her 'lifetime attachment or friend, something more than a child'. She described being honest with her daughter and very close. She lived her life as a mother, taking care of her daughter, believing that she had to forget her past and keep it inside herself so that no one would ever know what happened to her, and her daughter would never find out.

Now her daughter is in her early adolescence and is starting to ask about her father. Amine feels that her daughter is opening up a very deep, infected wound inside her. She is extremely confused; she feels that she has never lied to her daughter and now she feels guilty that she has to lie. She wanted never to tell her daughter who her father is, and anyway, she can't be sure, because it was a number of officials that raped her. She feels that if she told the facts she would lose the lifestyle she had created for herself and her daughter. She said that the trauma she experienced in prison was very severe, and what she has been through after prison had also been difficult, but she could never imagine that she would get to this stage that her daughter would be demanding to know who her father is and wanting to get in touch with him.

Amine said that she came to the Centre as a sanctuary, to find peace again and to be able to enjoy her life with her daughter. Amine was grateful to have for the first time the opportunity to articulate her experience and to disclose many issues that she has kept to herself, without the fear of being abused or being rejected or blamed or lectured or being told what she has to feel or do, or, that she has to feel guilty or ashamed of herself. She called this process a 'pain relief' process for her.

I have to say something about my feelings for Amine. I felt overwhelmed at being in the presence of so much distress. But also, she was constantly saying and implying that

I could not understand the implications of what she was saying and that I could not possibly understand what she had been through. As it happens, by chance she met someone who knew me, and who gave her an excellent report of me and of my experiences before I came to this country. Now her attitude changed entirely, and she assumed I knew everything as deeply as she experienced it. But also she was angry and reproached me: 'Why did you not tell me about your experiences! For nine months I have been struggling to explain to you, thinking you would not possibly understand!' She felt I had allowed her to struggle hard to explain something which I knew about already, and I had pretended not to know. She felt I had cheated her, and been dishonest.

This is quite a dilemma. If the therapist acts as I did, the feeling of indignation and betrayal is surely legitimate, at least to begin with. But if I had said I know, or I have been in similar circumstances, or I known people close to me who have similar experiences, would that have been better? She might have felt she did not need to talk about herself, or even that I did not want her to talk about herself, or that now we were friends, or fellow-sufferers. So she need not think of me as a therapist. And so on. I wonder and am very interested to know what each of you reading this paper would, think best to do?

Leaving that on one side, let me return to the therapist's experience in the room with a refugee or an asylum seeker who has had bitter experiences.

We all know that therapists at times perceive what patients attribute to them parallels their own unconscious material, and respond to it with interpretation - this adopts a fundamental rule similar to the fundamental rule which governs the patient. It consists in the therapist's listening to what the patient communicates and upon identifying themselves with the patient's thoughts, desires, and feelings, surrendering at the same time to free association; that is to say, the therapist creates an internal situation in which s/he is disposed to admit all possible thoughts and feelings in her/his consciousness. If the therapist is well identified with the patient and if s/he has a lesser amount of mental repressions than the patient, the thoughts and feelings which emerge in her/him will be, specifically, those which did not emerge in the patient: it is the repressed and the unconscious feeling and desire of the therapist and not of the patient. How difficult it is specially if you have been in the same situation to distinguish carefully between what comes to you, because of a patient attributing it, or if patient presentations trigger something of your own experience, which does not belong to the patient, but you were not conscious of it.

Imagine how you would feel if, tomorrow, you had to flee your home and family in fear of your own safety, who would you turn to? Where would you go? How would you cope? This is the tragedy that has befallen people all over the world, and yet refugees often rise above their adversity and make a disproportionately rich contribution to the societies they join.

To end, it will be clear to you that there is a wide gap between refugees' psychological needs and the services provided. Refugees' home countries, cultures and social make-up are widely diversified; and their needs cannot be readily consolidated. People like Grace and Amine who sought help at the Refugee Therapy Centre raise questions of race, ethics, politics, economics and mental health, which haunt the soul and remain an inescapable subject of debate.