An Exploration of the Transferential Issues that can arise in the Work with Traumatised Refugees and Asylum Seekers

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“They must ‘swim’ in the sea of clients’ transference but not ‘drown’ in their own countertransference” (Racker, 1972)

Abstract

The strategic use of transference and countertransference are the cornerstones of psychotherapeutic work for exploring and understanding the symptomatology of the client. By its very nature and due to the intersubjectivity of the therapeutic encounter, these dynamics largely dictate the course of psychotherapy. The interactions of both psychotherapist and client are considered to be co-created meaning that each party is influenced by the other. Therefore, transferential interpretations are fundamental to psychotherapeutic work. Over the last two decades, Ireland has experienced a growing population of traumatised refugees and asylum seekers. These clients present with many difficulties which emerge in the therapeutic space which pose transferential issues for the psychotherapist. This qualitative study illustrates the problematic dynamics that can emerge via the transference and the psychotherapist's countertransference. Six experienced psychotherapists participated in this research which highlighted the prevalence of transferential issues such as identification, maternal transference dynamics and the importance of the psychotherapist's observing ego. This thesis aims to provide therapists who are working with traumatised refugees or asylum seekers with a deeper understanding of the transferential issues that can emerge in the work. This purpose of this study is to inform the contemporary psychotherapist of these challenges due to the lack of research on this topic from an Irish perspective. The author has included some recommendations for this form of psychotherapeutic work.

Chapter 1 - Introduction

1.1 Background and Context

This thesis focuses on the transferential issues that can arise in the work with refugees and asylum seekers. The rational for such a topic arose from the researcher's interest on the subject matter coupled with the widely publicised treatment of refugees and asylum seekers on a global scale. This sparked a curiosity in the researcher as to how these vulnerable client's traumatic experiences could play out in the therapeutic setting.

This thesis primarily aims to inform psychotherapists about the potential problematic transferential dynamics that can emerge with traumatised refugees and asylum seekers. This research is intended to illustrate potential psychotherapeutic reactions that later emerge in the therapeutic setting with an expectation that through identifying these transferential issues, contemporary psychotherapists will be better informed in the work.

This thesis will demonstrate how interventions can be shaped depending on the psychotherapist's awareness and strategic use of transferential dynamics. This research will not focus on the complex traumatic experiences of refugees/asylum seekers who are seeking refuge in Ireland. However, the literature review will document some of the practical challenges that refugees/asylum seekers are faced with. This is intended to illustrate potential difficulties that later emerge in the therapeutic setting.

1.2 Aims and Objectives

The aim of this research is to explore the transferential issues that can arise in psychotherapists who are working with traumatised refugees or asylum seekers. Transference and countertransference dynamics are challenging to psychotherapists within any therapeutic

setting. However, with vulnerable client populations such as traumatised refugees and asylum seekers, the impact on the psychotherapist can emerge insidiously in manifestations such as inexplicable feelings, menacing dreams and counter-somatic responses (Schaeffer, 2015). To further understand these phenomena the objectives of this research are to:

- Explore the struggle of the refugee and asylum seeker in order to make sense of psychopathologies and symptomatology that presents in the therapeutic space;
- Examine empirical studies on these identified symptoms and the meaning of said symptoms to the practice of psychotherapy in Ireland;
- Investigate the complex issues that can arise in the transference due to negative internalised objects and the use of primitive defence mechanisms on the part of the refugee and asylum seeker.

Chapter 2 - Literature Review

2.1 Introduction

This purpose of this literature review is to explore previous studies which have been undertaken on the subject of trauma as experienced by the refugee/asylum seeker and the transferential issues that might arise for the psychotherapist. This is an important topic on considering the intersubjective co-created (Schore, 2014) dynamics of the therapeutic relationship which states that the therapeutic field is co-constructed by both psychotherapist and client and that each has an impact on the other. Bion's term 'reverie' considered not only the client's material but also that of the therapist which Ogden referred to as the 'analytic third' (Ogden, 1994, p. 9).

Therefore, this study is justified on considering the growing global refugee crisis and the increasing number of affected people who are seeking asylum in Ireland which greatly increases the potential for contemporary psychotherapists to be exposed to this client population.

The following literature review begins by providing the reader with a brief understanding of the complex set of circumstances that refugees and asylum seekers have to negotiate on arrival to Ireland. An understanding of these precarious circumstances is important in setting the scene for the implications of the practice of psychotherapy. The literature draws from relevant theories and existing studies to highlight the potential unconscious dynamics that can arise and pose potential transferential challenges for the psychotherapist. Fairbairn's 'endopsychic structure', Klein's theory on 'projective identification' and Winnicott's 'transitional object' are included to demonstrate the likely defensive psychical structures of traumatised refugees or asylum seekers. The use of these primitive defences inevitably emerging in the work and evoking problematic transferential issues. The final stage of this

literature review will focus on the supports, tools and resources that have been identified as fundamentally important for the preservation of the role of the psychotherapist with traumatised refugees and asylum seekers

The researcher used online databases to access published academic journals from the psychotherapeutic and psychotherapeutic sphere. To supplement the material and the most relevant literature, additional web resources such as EBSCO, PEP Archive and PsycArticles were consulted on this thesis's subject matter.

2.2 The Refugee Crisis and Statistics from Ireland

Over the last several decades, it has been widely publicised how various countries in the world are witnessing increasingly turbulent times. This has resulted in the forced displacement of millions of people who have experienced traumatic encounters. Through necessity, these individuals are compelled to seek asylum in other countries (Sweileh, 2017, p. 2).Within the last two decades the island of Ireland has witnessed a huge spike in its number of refugees and asylum seekers. These individuals are originating from countries such as Syria, Afghanistan, Pakistan, Iran and many African countries (Sweileh, 2017, p. 8). At present, Ireland has received some 4,000 Syrian refugees alongside its existing population of refugees and asylum seekers (Pestova, 2017).

These cohorts of people have reported psychological and physical traumas resulting from war, torture, rape, beatings, forced marriages and female cultural norms such as genital mutilation (FGM). Ejorh (2012:585) identified the latter two (FGM and forced marriages) cultural expectations as the primary reasons as to why many African women have migrated to Ireland in an attempt to gain amnesty and with that refugee status. From an Irish perspective, it is important to note that under Article 1 of the Geneva Convention (1951), the Irish

government does not consider these cultural practices as persecutory enough to warrant refugee status in Ireland (Ejorh, 2012, p. 585 - 586).

Other refugee and asylum seeking populations have equally experienced the horrors of war, forced displacement, treacherous journeys, extreme interpersonal violence, imprisonment, torture of self and loved ones, and many other terrible acts (Jackson, 2015). On arrival in Ireland, these people who are already traumatised are placed in Direct Provision centres.

2.3 Direct Provision

There are currently more than 5,000 asylum seekers in Direct Provision (DP) centres across the island of Ireland (Flanagan, 2018). DP has been widely criticised due to the restrictive nature of the process. Asylum seekers are required to stay in these facilities until such a time as they achieve refugee status. The DP environment challenges this already vulnerable cohort of people due to overcrowding, lack of appropriate nutrition, communal bathroom facilities and long durations of stay which add to existing mental illnesses. Morina *et al.* (2017) have identified a lack of funding for necessary services such as therapeutic interventions as an additional difficulty for this traumatised client population.

In addition to the aforementioned difficulties, there is little regard for asylum seekers of different ethnic, religious or cultural backgrounds (Irish Refugee Council, 2018). These issues are compounded by the fact that asylum seekers cannot avail of benefits from the Irish social welfare system and until recently were denied the opportunity to seek employment. Recent measures have been put in place that allow asylum seekers to apply for an employment permit which was previously unheard of since the inception of Direct Provision in the year 2000 (Citizens Information, 2018).

2.4 Obstacles for the Refugee/Asylum Seeker

At present, asylum seekers receive a weekly allowance of €21.60 (Citizens Information, 2018). This is in stark contrast to the refugee who can avail of full social welfare entitlements and legal rights. However, while the refugee has been granted 'status', there remains a plethora of practical issues including housing problems and complex bureaucratic processes. These issues come to life in the therapeutic space in the transference via unconscious wishes and expectations on the psychotherapist. Moreover, talk therapies are an alien concept for the majority of refugees and asylum seekers who typically confuse the role of the therapist with that of an advocate (Guregård & Seikkula, 2014, p. 42). This ensuing unconscious 'demand' potentially creating transferential issues that will be addressed later in this thesis.

2.5 Refugee or Asylum Seeker's Psychopathologies/Symptomatology

Fazel *et al.,* (2005) pointed to post-traumatic stress and major depressive disorders as the prevalent symptoms with refugees/asylum seekers. More recently, Steel *et al.* (2009) undertook a meta-analysis comprising of 181 studies involving some 80,000 refugees and asylum seekers. The findings produced statistics in which 30.6% of the refugee and asylum seeking population were identified as experiencing post-traumatic stress disorder and a further 30.8% suffering from major depressive disorders. These figures are expected to rise in accordance to figures as predicted by the United Nations High Commissioner for Refugees (UNHCR, 2017). The existence of these pathologies coupled with the practical challenges that refugees and asylum seekers are exposed to add complex dynamics to the therapeutic relationship.

Rosenbaum and Varvin (2007) conducted a study on the effects of traumatisation on the body, mind and social capacities of refugees and asylum seekers. They concluded that in order for the psychotherapist to gain an understanding of the workings of this traumatised

psyche, it was necessary to consider three structural characteristics. These were categorised as the *body-other dimension*, the *subject-group dimension*, and the *subject-discourse dimension* (Rosenbaum & Varvin, 2007, p. 1527). Due to word constraints, an explanation of each is out of the scope of this paper however it is worth noting that an understanding of these characteristics aims to inform psychotherapists on the relational difficulties and reservations that refugees and asylum seekers might act out via the transference within the therapeutic space.

2.6 Language Difficulties / Interpreters

In addition to the already strenuous circumstances that refugees and asylums seekers present with, communication and cultural adjustments have been identified as further challenges. Morina *et al.* (2017:2) found that language posed one of the greatest barriers to therapeutic treatment within the refugee or asylum seeking population thus requiring creative ways of working for the psychotherapist. Racker (1972) added that somatic responses such as tiredness in the psychotherapist can be indicative of the therapist feeling abandoned by clients with challenging communicative styles.

Language is widely acknowledged as a barrier to understanding thus attempts at integration. Freud spoke of cultural aphasia and stated that the mother tongue is where the true emotion exists (as cited in Rendon, 1989). Frank (1986) added that discourse was the true medium for exploring the use of words in order to form attitudes or induce actions. Due to this real obstacle the refugee or asylum seeker who use the host country's language are already at a disadvantage.

The use of interpreters in the psychotherapeutic work with refugees equally posed its own difficulties. Guregård and Seikkula (2014:43) identified two stances in which the refugee or asylum seeker can potentially perceive the interpreter. Firstly, they may experience them as a

role model who has successfully adjusted to life in a foreign country or secondly, as a threat in which caution must be exercised.

Codrington *et al*. (2011:131) suggested that in order to overcome the language barrier, it was more beneficial if refugees or asylum seekers consulted with psychotherapists who originated from similar backgrounds. However, an earlier study by Eleftheriadou (1999) explored this subject and found that while the benefits of language and an understanding of culture are obvious, difficulties can potentially arise in the psychotherapist's countertransference due to over-identifying with their client (Eleftheriadou, 1999, p. 219).

2.7 Difficulties in Relating within the Therapeutic Space

The nature of transference and countertransference as evident in the therapeutic dyad posited that both psychotherapist and client are reacting to and being influenced by the thoughts, feelings, projections and defences of the other (Murdin, 2010). The psychotherapeutic concept of empathy encourages the psychotherapist to identify with the other whilst knowing that this is not real. However, if the psychotherapist begins to over-identify or engages in the early unconscious defences of the client, then the therapeutic relationship is brought into disrepute. Ogden (1990:107) stated that awareness in the psychotherapist is crucial in order to avoid becoming enmeshed in the client's experience and risk losing oneself as a result. Racker eloquently reiterated this point by stating that the psychotherapist "must 'swim' in the sea of clients' transference but not 'drown' in their own countertransference" (Racker, 1972).

Winnicott (1971) viewed the mother/child dyad as pivotal in the child's psychological development of being held, weaned and protected. Due to the nature of war and human rights violations, the displaced or forcibly evacuated refugee/asylum seeker have not had the opportunity to engage in a 'weaning process' from their motherlands. An inability to engage in this weaning process leaves the refugee/asylum seeker experiencing a phenomenon known

as *cultural bereavement* (Eisenbruch, 1984). This is marked by an inability to transition from their familiar way of being to that of the new host country (Eleftheriadou, 1999, p. 221). The psychological impact of this traumatic transition later emerges in the therapeutic relationship.

2.8 Mourning the Motherland

The challenge for psychotherapists working with refugees or asylum seekers experiencing symptoms related to loss, resentment and frustration emerges with manifestations consistent of abandonment, fury and bitterness. In *Mourning and Melancholia*, Freud (1924) described the psychical process as one in which the individual has not had an opportunity to experience an object-cathexis which can result in regressive identifications. To compound this point, Freud continued by adding that the loss of the motherland is akin to the loss of a loved one. Both experiences produce melancholia and a process of mourning is required to integrate the affect. The relevance of this phenomenon to the therapeutic relationship with refugees and asylum seekers is that they typically present with a reluctance to embrace the new 'love object' (host country/psychotherapist) which is unconsciously understood to be a substitute for the 'original object' (motherland, family members etc) (Eleftheriadou, 1999).

In other instances, refugees and asylum seekers have a tendency to idealise the new host country imagining a place in which they can recreate aspects of their country of origin. This largely depends on a range of practical and psychological interventions that determine how these people adjust to their new country (Eleftheriadou, 1999, p. 221). The Direct Provision process disillusions these clients in many cases and later becomes evident in the therapeutic process via feelings of anger, frustration, helplessness and many demands placed on the psychotherapist. This adds an additional challenge to the transferential dynamics with an already vulnerable client population.

2.9 Understanding the Refugees and Asylum Seekers' Defensive Structure

2.9.1 Fairbairn's Endopsychic Structure

Fairbairn's (1952) *endopsychic structure* posits that problematic relationships are unconsciously split of psychically and internalised as 'rejecting internal objects' and 'exciting internal objects'. These dynamic psychical structures (rejecting/exciting) act independently and have their own motivations for patterns of relating. For Fairbairn, the emerging styles that presented with impacted clients were twofold. Their internalised bad objects are experienced ambivalently. That being they are understood to be frustrating whilst also alluring (Fairbairn, 1952, p. 111). Fairbairn referred to this as the client's 'closed system of internal objects' in which the psyche splits off and the patient adapts their way of being to fit into their external world (Fairbairn, 1958, p. 380).

The work of psychotherapy is to challenge these internalised bad objects in the client however, in order to do so the client must experience the therapist as a 'good object'. Alexander and French (1946) believed that the therapist should consciously use their understanding of their countertransference so that they could work against (an effort to contradict) negative transference expectations on the part of the client.

Another defensive structure that presents in the work with vulnerable clients is Klein's (1946) concept of *projective identification*. This unconscious infantile phantasy was later identified as a form of communication by Bion (1959) and Ogden (1979). For Klein, the phantasy involved an internalised or part object of the self being projected onto another. The attuned psychotherapist identifies this through the client's projections which indicate their split off feelings (Boulanger, 2018, p. 64). The difficulty for the psychotherapist when language is an issue is experienced on a non-verbal level via the countertransference. Modell (1980) likened this scenario to the child's subliminal affect-laden messages which precede their ability to speak.

The psychotherapist's awareness of their countertransference helps identify the object representation of the client. Fairbairn (1952) pointed to the early stages of therapy as a time when the psychotherapist should deliberately use their countertransference to identify clients who are presenting with closed systems. In doing so, the psychotherapist is able to adapt their therapeutic strategy to suit the client. Dell (1985:9) acknowledged this technique and emphasised the importance of the therapist moulding their structure to fit the structure of the vulnerable client such as refugees and asylum seekers. However, the contemporary view of psychotherapy posits that the client is not a closed system due to the relational intersubjective and co-constructed nature of the therapeutic space (Cavdar & Fisek, 2018). This emphasises an acute awareness of transferential dynamics in the psychotherapist.

2.9.2 Implications for the Psychotherapist

The defensive structure of vulnerable clients such as refugees and asylum seekers creates challenging dynamics for the therapeutic alliance. Within the therapeutic setting, there is the potential for the refugee or asylum seeker to perceive the psychotherapist as an idealising object or the soothing parent who is capable of fulfilling their needs (McHenry, 1994). This dynamic becomes evident as the client unconsciously splits off the 'all bad' aspects of their self and projects the 'all good' onto the therapist which is indicative of Fairbairn's endopsychic structure (Fairbairn, 1952).

Rendon (1989) noted how in some instances refugees or asylum seekers refused assimilation to their new setting and rebelled in an effort to remain loyal to their original cultural values. Zwingmann (1982) referred to this challenge as the *nostalgic paradox* due to the refugee or asylum seeker being stuck in the past to the point where they find it difficult to be in the present. This produced ambivalent feelings in the refugee or asylum seeker due to the traumatic events which led to them being unwillingly uprooted from their motherland. Freud stated that the inability to process the loss from the object of choice resulted in the associated

libido withdrawing to the ego. This ego identification in line with the lost object ultimately transformed to an ego-loss which underpinned the ambivalence. In such cases, the negotiation of the affect rests in the negotiation of the loss of the object, its accompanying ambivalence and the regression of the libido to the ego, with particular emphasis on the latter as critical components of the psychotherapeutic work (Freud, 1924).

The psychotherapeutic task aims to address the affect deriving from the *loss* and *mourning* of the motherland while attempting to facilitate integration into the new environment (Eleftheriadou, 1999, p. 221). This point is supported in the work of Herman (1992:196) who stated that in addition to coming to terms with their traumatic history, the refugee or asylum seeker is now faced with the challenge of developing a new sense of self.

2.9.3 Winnicott's Transitional Object

Adler (1972) warned that these vulnerable clients can perceive therapy as something in which they devour or be devoured, destroy or be destroyed whilst moving between ideas of merging or destroying the object via their anger by rejecting them. The attuned psychotherapist will ultimately be aware of these primitive defensive structures. Cavdar and Fisek (2018) warn that defences in the therapeutic space are considered as co-created.

In the therapeutic space they will emerge as an expectation that the therapist will reject or abandon them. Moreover, the client is likely to unconsciously provoke such actions from the psychotherapist due to their negative introjects and object relations (Adler, 1972). The aware psychotherapist detects these feelings as they emerge via the transference as they become the new object. For Winnicott (1971), the psychotherapist became a *transitional object* that facilitated the client's ability to think, be creative (play) whist developing their capacity to symbolise. In these scenarios, Winnicott (1960) warned of the 'delicate' role of the therapist

as one of being vulnerable and identifying whilst keeping enough space in their empathic understanding so as to minimise the impact of the work.

2.10 Transferential Issues for the Psychotherapist

2.10.1 When Identification becomes problematic?

It is essential that psychotherapists identify transferential issues as they arise in the work. Moreover, lacking the capacity to notice or be aware of these dynamics poses a great limitation to successful therapy. The nature of psychotherapy involves unconscious 'mirroring' of feelings by both parties. Therefore, management of the intersubjective transference and countertransference is of crucial importance (Rosenbaum & Varvin, 2007). It is imperative that psychotherapists acknowledge their own reactions to avoid over-identifying with the client (Eleftheriadou, 1999, p. 229).

2.10.2 Awareness of the Observing Ego

The *observing ego* of the psychotherapist constantly questions their motives and engages in self-scrutiny (McHenry, 1994). The nature of countertransference requires the therapist to have awareness and regain distance if lacking whilst maintaining this observing ego (Adler, 1972). Illiffe & Steed (2000) warned that no matter how well trained or qualified the clinician is that they are not 'immune' to the affects of the stories that are shared with them (Illiffe & Steed, 2000 as cited in Barrington & Shakespeare-Finch, 2013, p. 89). The challenging psychotherapeutic work associated with traumatised refugees and asylum seekers puts the therapist into a place of 'knowing' something that was previously 'unknown' as they become witness to horrifying disclosures and re-enactments (Pearlman & Mac Ian, 1995, p. 564). The repeated exposure to traumatic material can ultimately lead psychotherapists to question their own core beliefs (Barrington & Shakespeare-Finch, 2013, p. 90) or get caught up in over-identification or unconscious re-enactments. The psychotherapist's awareness of their subjective psychological responses coupled with an observing ego is key tools in managing these transferential dynamics (Eleftheriadou, 1999, p. 219).

2.11 The Psychotherapist's Vulnerability

2.11.1 Vicarious Traumatisation

Psychotherapists working with clients who have experienced traumatic events regularly report experiencing symptoms both emotional and somatic similar to those of their clients. This phenomenon is known as *vicarious traumatization* (Neumann & Gamble, 1995, p. 343; Pearlman & Mac Ian, 1995, p. 558) or *traumatic countertransference* (Herman, 1992). This manifests through the psychotherapist experiencing difficulties relating to their sense of self, their belief systems and can compromise their ability to tolerate strong affects (Neumann & Gamble, 1995, p. 344). However, Barrington and Shakespeare-Finch (2013:90) pointed out that vicarious traumatisation is a normal response to the repetitive empathic engagement with traumatic material and should therefore not reflect on the psychotherapist's degree of competency.

2.11.2 Vicarious Post-Traumatic Growth

Herman (2015) found that psychotherapists who had successfully negotiated transferential issues arising from working with traumatised clients later reported a greater capacity and a deeper understanding of themselves in the therapeutic encounter. The work of Barrington and Shakespeare-Finch (2013:96) reported that vicarious traumatisation on the part of the psychotherapist was the forerunner to vicarious post-traumatic growth (VPTG). VPTG has proven to be a positive experience for psychotherapists who have worked with refugees and asylum seekers and other trauma survivors. Many reported an increased sense of confidence in their professional capacity coupled with changes in attitude regarding their life philosophy, self-perception and interpersonal relationships. Professional lives also benefitted due to increased relational skills, a greater appreciation for human resilience and a sense of being an intricate part of the healing process (Barrington & Shakespeare-Finch, 2013, p. 99).

2.11.3 The Importance of Self-care

Pearlman and Mac Ian (1995:558) suggested that certain traits in the psychotherapist such as their interpersonal style, level of professional development, life circumstances and personal history all have an impact on their predisposition to vicarious traumatisation. Moreover, while some of these traits are out of the psychotherapist's control, the practice of self-care is something that psychotherapists can and should be committed to. Self-care is a crucial part of the psychotherapist's own process and minimises potentially maladaptive styles of practicing (Neumann & Gamble, 1995, p. 345).

2.11.4 Supervision and Personal Therapy

The role of supervision particularly supervisors who are experienced in the work with traumatised refugees and asylum seekers has proved to be an invaluable resource to psychotherapists. Moreover, the re-enactments and countertransference dynamics that equally emerge between the supervisor and the psychotherapist can further reveal unconscious material that the psychotherapist may have taken on from their work (Eleftheriadou, 1999, p. 228). Psychotherapists who are supported in engaging with their own transferential reactions are ultimately more available to the refugee and asylum seeker in their quest to understand their emotional world (Eleftheriadou, 1999, p. 229). In addition, McHenry (1994) pointed to the validity of personal therapy as a medium for addressing the intricacies of the intersubjective nature of the therapeutic relationship which provides the psychotherapist with an opportunity to explore their symptoms at a deeper level.

2.12 Conclusion

This literature review introduced the reader to some of the complex issues that traumatised refugees and asylum seekers have to contend with on arrival in Ireland. The purpose of this section was to inform psychotherapists on the practical stressors that are experienced which can contribute to problematic dynamics in the therapeutic space.

The subsequent part of the literature review explored the prevalence of psychological problems that have been reported with this cohort of clients. The author proceeded to identify relevant theories that point to the psychical structures of traumatised refugees and asylum seekers in an effort to better inform psychotherapists in this area. The inclusion of this data illustrates some transferential issues that have been reported from empirical studies. The final section of the literature review focuses briefly on the tools and techniques required in order to preserve the role of the psychotherapist in the work with traumatised refugees and asylum seekers.

The following chapter will focus on the methods employed by the researcher in preparing for the interviewing process and an account of how the extrapolated data was organised will also be provided to the reader.

Chapter 3 - Methodology

3.1 Introduction

This research has used a qualitative approach as the medium for extracting relevant data to corroborate this study. A qualitative methodology permits the researcher to explore the personal experiences of psychotherapists who are currently working within this field (Braun & Clarke, 2006). Qualitative research does not rely on statistical or mathematical information but rather utilises the phenomenological aspect of the interview process as indicative in arriving at an in-depth understanding of the interviewee's experience. Therefore, it is rational to conclude that this style of research is considered the most appropriate in order to accurately capture and identify subjective themes that are expressed by the participants.

This research is deemed important to the practice of psychotherapy in Ireland as it is expected that there will be further increases in the existing number of traumatised refugees and asylum seekers due to the prevalence of global conflicts and projected figures as documented by UNHCR (2017). With that in mind, the overall aim of this research is to explore the impact of the refugee and asylum seeker's experience on psychotherapists who are working in this field. The researcher has consistently been mindful of the potential for biases that could arise while adopting this mode of research.

3.2 Research Design

The researcher has opted for a qualitative analysis due to the intersubjective nature of the therapeutic relationship. This co-created phenomenon permitted the researcher to actively use their self within the interview setting to gain an accurate representation of the dynamics as experienced by each participant. This style of data collection and the subsequent generation of themes aimed to demonstrate to the reader the potential issues that have arisen for psychotherapists who are currently working with traumatised refugees and asylum seekers.

The interpersonal dynamics that emerged from the interviewing process were analysed to determine any underlying phenomenon as it emerged with the psychotherapists who participated in this research. The use of 'face to face' interviews coupled with open-ended questions was intended to highlight the 'spoken' and 'unspoken' words of the participants which is paramount to the field of humanistic and integrative psychotherapy. The research focused on the transferential dynamics that arise within the therapeutic relationship thus the questions utilised were organised in such a way as to extract appropriate data for analysis.

In order to address the primary research question, the secondary questions or interview questions as provided in Appendix A were designed to explicate and contextualise these transferential dynamics. Kvale (1994) stated that it was of little importance as to whether or not the questions utilised during the research were leading adding that it was the direction in which they led the research which was of relevance. For the purpose of this study, the researcher avoided using leading questions being mindful that they could potentially steer the interviewees from the organic conversation that the open-ended question were designed to create.

3.2.1 Sample

The sample of psychotherapists that were recruited for this research comprised of six accredited practitioners who are currently working in organisations that are dealing directly with traumatised refugees and asylum seekers. In an effort to recruit such a sample, the researcher contacted organisations directly, firstly by email and later via arranged phone calls. The recruited sample comprised of six psychotherapists who have been working in this area for varying periods of time. There was an early expectation that the interviewees would have a minimum of three years' experience with the intent that there would be a wealth of

personal experience to support this research. However, one participant was relatively new to the work with refugees and asylum seekers. Their input provided the researcher with a valuable insight from a novice's perspective and this will be discussed in subsequent chapters.

The interviewees' years of clinical experience along with additional relevant information was extracted at the beginning of each interview through the use of a demographic sheet (Appendix B). This facilitated an 'easing in' to the interview process whilst providing the researcher with important professional information on each of the participants. This data is represented in table form (see below) under appropriate headings to illustrate key lines of enquiry which will be later used to situate the findings. To preserve anonymity, each psychotherapist's name has been altered through the use of pseudonyms.

Demographics of Psychotherapists/Participants of this Research

Pseudonyms	**Mary**	**Billy**	**Debbie**	**Suzy**	**Lisa**	**Jane**
Age Group	60+	30+	40+	30+	30+	30+
Psychotherapeutic Orientation	Psycho analytic	Psycho analytic	Psycho analytic	Systemic Psycho therapy	Psycho analytic	Psycho analytic
Years in Clinical Practice	18	8	18	11	8	6
Years Working with Refugees and Asylum Seekers	11	2+	6mths	3+	4.5	5
Years Working with Trauma	11	8	6mths	7	8	6
Additional Trauma Training	Some	Yes	No	Yes	Yes	Yes

3.2.2 Recruitment

The researcher recruited six psychotherapists who are currently working with traumatised refugees and asylum seekers. Each therapist had a humanistic and integrative background. Several organisations associated with refugees and asylum seekers were identified as being in existence in Ireland. The researcher initially contacted organisations relative to this study via email to ascertain if any of their psychotherapists would be interested in participating in this research. This action resulted in scheduled phone conversations with practicing psychotherapists which provided the researcher with a forum in which the research topic could be briefly discussed. This also gave the researcher a sense of the validity of the input of each potential interviewee. The researcher explained the topic of the study and the method of data collection that would be employed which consisted of semi-structured interviews. These phone conversations also provided the interviewer with an early opportunity to request permission to record prospective interviews. It was explained that the recorded data would solely be used for transcription purposes with the guarantee that it would be deleted afterwards.

3.2.3 Method of Data Collection

The researcher conducted six interviews which ranged from 36 to 58 minutes. Each interview took place in a location that was suitable to the participant. The interviews were prepared for in advance with a set of pre-constructed questions that were initially formed from interesting points that arose during the literature review section of this thesis. These questions as detailed in Appendix A were designed in such a way as to provoke a discussion whilst remaining focused on the research topic.

The semi-structured nature of the interviews provided both parties with a relaxed forum. In addition to this, it provided the researcher with a phenomenological opportunity to probe deeper into themes as they emerged and were deemed to be complementary to the study. This inductive approach allowed the researcher to consciously examine ideas or subjective experiences that emerged during the interview process. Each interview demonstrated ideas and themes that were repeatedly presenting to varying degrees with each participant. These revelations better prepared the researcher for subsequent interviews. This style of interviewing also provided the author with an opportunity to further explore the psychotherapists' thoughts, feelings, individual perspectives and any idiosyncratic information as it arose on this thesis's subject matter. The data extracted was then used to undertake the thematic analysis.

3.2.4 Method of Data Analysis

The information retrieved from the interviews was analysed using thematic analysis. Braun and Clarke (2006) recommend this form of analysis as the precursor to any qualitative research stating that the benefits of adopting this method allows the researcher to identify, analyse and report patterns or themes within the data. The data was transcribed verbatim during which time the researcher used parenthesis to highlight any observed reactions, perceived unconscious interactions on the part of each psychotherapist and private thoughts including non-verbal cues that the researcher deemed valid. This action proved important for documenting the post-interview memories and counter-transferential material as experienced by the researcher.

This was an exhaustive task due to the number and length of interviews conducted. Each transcription produced individual thoughts and similarities which will be addressed in the results chapter with supporting vignettes.

3.2.5 Ethical Considerations

From an ethical perspective, the utmost protection of each interviewed therapist's anonymity took precedence during this research. The researcher respected the privacy of each therapist involved and all safeguards were put in place to preserve that this assurance was honoured accordingly. Each participant was informed via an information sheet (Appendix C) and a consent form (Appendix D) in which it was stated that any identifying material would be changed and pseudonyms would be used. The researcher placed a strong emphasis on the security of the storage of data which had been coded and further protected by a password that is only accessible by the researcher. Each interview was recorded with the use of a Dictaphone. The sessions were transcribed soon after the interview stage and each recording was destroyed immediately after the transcription process.

On considering the nature of the subject matter within this thesis, it was impossible to guarantee that the questions that were asked would not cause some distress to the psychotherapists involved in the interview process. This concern was acknowledged and included in the consent form as detailed. The consent form included six statements in which the therapists were asked to tick boxes demonstrating that they had being alerted to and informed about the nature of the interview process, its potential risks and the storage and use of the relevant data.

Of the six participants, two declined to tick the box which related to being aware of the potential risks of this research study. The researcher explained that this statement was included within the consent form to highlight the fact that there was some consideration given to the subjective experience of each therapist while participating in the study. The author's explanation proved futile as both therapists adhered to their original stance. It was

evident that there was an anxiety about this statement and the author wondered about a fear of exposure in the participants.

The examples provided by the therapists in relation to their experience with refugees and asylum seekers were furnished in a professional and ethical manner. The researcher was committed to protecting the anonymity of all parties involved and took all necessary measures to ensure that there are no identifiable cases or individuals within this thesis.

3.3 Thematic Analysis

The author employed a thematic analysis in order to extract the relevant themes as they emerged. Braun and Clarke (2006:52) state that this method of analysing data provides the researcher with the core skills that are necessary for conducting any type of qualitative analysis adding that the technique gives "a method for identifying, analysing and reporting patterns (themes) within data".

The first stage of this process involved reading and rereading the transcripts in order to become familiar with the data. Multiple readings of the transcriptions proved invaluable because each reading of the material provided the researcher with additional views and nuances. The aforementioned action of including parenthesised field notes and other relevant information that was accumulated and documented during the transcription process proved to be a helpful strategy. The existence of these notes complemented the investigative nature of the analysis as they were recorded soon after each interview took place. Moreover, they furnished the researcher with memories and insights from the interview process. Additional themes surfaced on rereading the material which were highlighted and then situated alongside the existing notes.

The second stage of the analysis involved arranging the data into an organised manner and then generating a coding system. The six transcripts contained many pages of information therefore the author employed an additional coding process in an effort to reduce the volume of data with extra care exercised to the retention of important themes as they emerged. The coding system adopted by the researcher was twofold. Firstly, the potential themes or ideas were highlighted using coloured markers. These initial thoughts coupled with the researcher's relevant field notes were recorded in the margins within each transcription. Secondly, the author created a table in an effort to start identifying themes within the transcripts. The purpose of the table was to arrange the data in a visual manner so that recurring themes could be observed and later cross referenced as they presented with each therapist. The table consisted of six columns in which each psychotherapist's anonymity was disguised with the use of pseudonyms. The amount of rows was undetermined due to the potential for additional themes to be added on subsequent readings.

The third stage of the analysis focused on identifying potential themes as they emerged. According to Braun and Clarke (2006:10) "a theme captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set". The reading of the data provided themes which could potentially be grouped under an umbrella theme. This was obvious with the visual aide of the table. (See Table 1 Appendix)

The fourth stage of the analysis involved reviewing the themes so that they accurately reflected the research question. This process was conducted by reverting back to the coded data while simultaneously being aware of the presence of the researcher's accumulated material to support the findings. Stage five of the analysis focused on the refinement of the

themes to accurately capture the essence of each theme that was identified (Braun & Clarke, 2006). During this task, the researcher titled the themes in order to give the reader a sense of the findings that had emerged. The final stage of the analysis was in the writing up of the data in such a way as to demonstrate the prevalence of the themes that were identified including vignettes from each of the research participants to support these findings.

3.4 Potential Difficulties

One of the greatest obstacles in this research was in analysing and identifying the most relevant themes due to the vast amount of data. In order to address the research question, the author put emphasis on identifying recurrent themes focusing on the psychotherapeutic relevance of the emerging material. The challenge that presented itself was the lack of personal knowledge of each participant for arriving at a comprehensive potential understanding of each psychotherapist's symptom. The limited time of each interview also proved problematic for the researcher to fully utilise the intersubjective phenomenological approach for arriving at an interpretation. To support this point, Frank (1986:343) theorised that an understanding of the symptom arose from knowing enough about the client's structural features relating to personality coupled with sufficient details about their life history. Therefore, to combat this deficit regarding each participant, the author drew from the extracted data from each interview and existing theory in an effort to understand the symptoms that emerged with each of the psychotherapists.

The following chapter will describe the themes that emerged from the interview and transcription processes. The themes identified are supported with vignettes from the research participants.

Chapter 4 – Findings

4.1 Introduction

The purpose of this research was to identify the transferential issues that can arise for psychotherapists who are working with traumatised refugees and asylum seekers. The author employed a qualitative method of research including a thematic analysis as the medium for studying the data that was collected from six psychotherapists who are currently working with this client population. The researcher was excited by the three themes that emerged but was more surprised by the admissions of some of the participants. The themes picked out by the researcher are: *identification*, *maternal transference* and *awareness of the therapist*.

4.2 Identification

The first theme that emerged was that of identification. The challenging work with refugees and asylum seekers manifested with many of the participants experiencing this phenomenon. Debbie reported having extensive experience working with other vulnerable clients. During the early stages of the interview, the researcher asked the psychotherapist about the motivation to work with refugees and asylum seekers. The interviewee spoke of past experiences with migrant women who had experienced psychological and physical traumas and human rights violations. Debbie continued by adding that it was a natural progression into the work with refugees and asylum seekers. Debbie stated:

> "I suppose I got a taste of that. I'd say about 11% of the clientele was migrant women and some of them were asylum seekers … so having worked with that I decided ok, why not try here. I had that experience and this would be different. I felt that I have something to give here and I have some experience. It's like bringing it to a different level".

Debbie was the newest addition to one particular organisation and spoke of this experience in a manner that struck the researcher as unconsciously 'mirroring' to some degree the refugee or asylum seeker's experience of a new host country. Debbie reported:

> "You come into a new job, new atmosphere and new organisation. You're landing yourself into a new culture, a new way of working, new people. Everything's new. It's a lot of energy and all that. You're kind of trying to recalibrate and fit in".

This comment was striking to the researcher who understood these remarks to be an unconscious identification. In addition, refugees and asylum seekers report many psychological and somatic symptoms due to their traumatic history. The relevance of this became increasingly pertinent when Debbie continued by disclosing the impact of her new organisation adjustment with accounts that equally matched symptoms that the literature identified as being consistent with those of the refugee or asylum seeker. Debbie stated:

> "I'm feeling it at the level of the body. You know through tiredness. Something is different, but also in my psyche coz in my dreams that certainly is. Now, I'm not saying that I'm traumatised. What I am saying is I can feel how it's infiltrating in a way".

The disclosures made by Debbie and the ironies that they alluded to surprised the researcher on many levels. The majority of the interviewees spoke of the isolation and loneliness that refugees or asylum seekers regularly reported. An additional identification on the part of Debbie emerged in the following statement:

> "It's so easy to get pulled, to spiral down rather than spiralling up. So you need someone there that is naming it for you.Validating it that it's actually normal to feel like that coz sometimes you can feel very lonely and isolated in the work".

The researcher was again struck by how this disclosure mirrored the experience that refugees and asylum seekers consistently report in their adjustment to life in the new country and the Direct Provision system.

During the interview process with Debbie, the researcher noted the prevalence of an empathic countertransference dynamic. In addition, it became clear that while Debbie was very forthcoming with her experience, there was evidence to suggest an unconscious identification that was going unnoticed.

Identification can emerge particularly if the psychotherapist acknowledges similarities with the client. On asking Lisa about challenges in the work, this participant spoke of instances in which their personal life can seep in to the work. Lisa said that:

> "I think usually with those things that are associated to you in your life. Usually if it's a child possibly a boy around my son's age… and afterwards if I'm thinking, Jesus, why did that affect me so much, I would kind of link it to that".

The phenomenon of identification also became obvious during the interview with Billy. This therapist spoke of a client, a young male asylum seeker who had clearly left a mark. The recanting of this young man's current situation had evidently struck a chord with Billy. The researcher noticed how the participant's tone of voice became depressed, the level of eye contract decreased and there were many sighs and exhalations during this participant's disclosures. Billy's detailed description of the client's dishevelled appearance further substantiates this point as he reported:

> "It was a huge challenge because he was my age, maybe slightly younger. But you could tell that this guy was you know, he had a lot and he lost a lot. You know, I think what can be affecting is if you can see a bit of yourself in the person… he'd come in

> very unshaven, the clothes were like donated, no sense of dressing up. He was a nice guy but yeah, you know, that was kind of one challenge where you felt aww".

The researcher observed verbal and non-verbal cues from Billy which depicted a profound identification on the part of this therapist. Further to this, the researcher wondered about which part of the young male asylum seeker's story the therapist was identifying with. On considering intersubjective theory, the researcher was again struck by a countertransference reaction that seemed to fit with the therapist's 'aww' statement. This demonstrated the existence of real affect that was being picked up in the transference by the researcher.

Although identification can be problematic, it can equally be a source of compassion. Jane enthusiastically spoke about the relevance of being able to manage this dynamic as it emerges in the countertransference. On asking about overwhelm in the work, Jane responded with:

> "I think the thing is that we are people and we are affected by it. If someone said that they are not affected, then it is a very bad sign because where's your empathy? Like when we think about empathy, it's a question about identification and I think the two extremes. One can really objectify the person and just be very intellectual, intellectualise or make some sort of an interpretation straight away. And the other extreme is over-identification when you are just, when you can't separate from what's going on in the person and what's going on in you".

This point was interesting as Jane was not of Irish origin and spoke of an anecdotal story about a young male asylum seeker who had experienced a forced evacuation from his home and family but found solace in a song in the new host country. The heartfelt response of the therapist led the researcher to understand this to be identification or an unconscious expression of the therapist's own experience of being away from the motherland. Jane stated that:

> "… he says I sing this song to myself when I think of my mom. Like it was this whole kind of idea of how this completely different culture and language can give you something. Because there is the lack of the mother and the lost mother and how he found in this completely different culture, you know this lullaby that took him back to that kind of stage when he had his mother. And it was this kind of, you know, the mother baby relationship and how he found that. I was very touched by that".

The theme of identification also emerged with the following disclosure by Jane:

> "The way that I can help with the bereavement process… I went through that bereavement process. Culture is so much deeper than something that we learn. It's like part of the superego or something, but it's much more than that. When you grieve your culture, you lose yourself. It's the whole kind of reconstruction of who you are".

The use of the words 'reconstruction of who you are' really struck a chord with the researcher who understood this to be an unconscious communication of the therapist's experience. The most striking part of this comment centred on the idea that the refugee/asylum seeker also has to undergo this process.

Jane's utterances about the lack of the mother/the lost mother/grieving your culture and losing yourself were experienced as very powerful accounts of one's subjective experience. The researcher was struck by the level of emotion that these reports evoked which further suggested that the transferential dynamic of identification was unconsciously presenting itself in the countertransference of Jane.

The theme of identification emerged from the interviews with the psychotherapists demonstrating to the researcher how the refugee or asylum seeker's experience can infiltrate unconsciously in to the therapeutic dyad. This dynamic presents in instances that the therapist

might least expect. An awareness of these unexpected occurrences serves to better inform psychotherapists who are working with refugees or asylum seekers.

The following section will address the second theme that the researcher identified as the prevalence of the *maternal transference*.

4.3 Maternal Transference

The second theme identified in this research was that of a *maternal transference*. Each of the psychotherapists interviewed spoke of their humanitarian interests coupled with a propensity to care for others which drew them into the profession. The work with refugees and asylum seekers tests this transferential dynamic due to the caring nature of the therapist. This research explores this theme as one that can be problematic if the therapist is not aware of its emergence in the therapeutic space.

Psychotherapists are prone to experiencing a maternal transference with clients due to the therapeutic notion of being a 'better mother'. The difficulty with this dynamic resides in the potential for the therapist to be pulled out of their actual role. Mary spoke of her experience with a female asylum seeking mother who was living in a Direct Provision centre. This asylum seeker's predicament was obviously impacting the therapist. The client had a child with a medical condition who was awaiting specialist treatment. It was evident from the therapist's tone of voice and body language that the client's situation was playing out unconsciously. This was apparent with the ambivalence expressed by Mary who reported:

> "You can't help them. You can't do anything for them. I find that difficult because I hate to see anything to do with children suffering anyway. So that kind of thing would get to you a bit. But I have to let it go. We've done all we can. I can do no more. Me sitting thinking about it 7 days a week doesn't change anything".

This disclosure from the therapist was heartfelt. Mary had a very welcoming, caring and motherly air to her. The example mentioned above illustrated what the researcher perceived to be the therapist's unconscious desire to be the 'good enough mother' via the maternal transference whilst negotiating the boundaries of being the 'good enough therapist'. This

conflict was experienced by the researcher in the transference. Lisa also spoke of the challenge that this transferential dynamic poses by adding:

> "It is difficult when someone is sitting there and almost appealing to you, please do something. Because they are not fully sure of the therapeutic boundaries, the process and they sometimes look at you as like you possibly have all of the answers and you can manage all of these things. So, what it feels like is helpless really, completely helpless".

The researcher was struck by each psychotherapist's desire to do more for the refugee and asylum seeker. The maternal transference presenting through this desire to do more, to support the child/client as they negotiate their external world. However, this dynamic proves problematic due to the associated affect as reported by the participants. Each interviewee spoke of feelings of helplessness as evoked by these vulnerable clients. Lisa's account of her experience illustrated to the researcher a potential unconscious desire to intervene:

> "It's very difficult. It's very difficult not being able to do anything. One, in as a human being, and two, in it's not the therapist's role to do anything. But you know, when you hear about cases like this, you have this internal drive to get up and do something, not just to listen. It's about fighting that as a therapist as well and referring on to the right people who can actually get up and do something in their role".

The above example was said with real conviction and the researcher was struck by the words 'get up and do something'. Lisa had earlier spoken about being a human rights activist. Lisa had equally disclosed feelings of helplessness on occasion within the therapeutic space. The researcher detected ambivalent feelings between being the caring mother or playing the part of the vocal activist.

The maternal transference theme was also evident with Mary. The researcher was struck by comments made by this participant particularly whilst working with refugees or asylum seekers who were suffering from night terrors. Mary reported:

> "If they wake up in the night with nightmares which 99.9% of them do… you get them to realise that it's a memory and it's not happening in the here and now. You get them to tell themselves that it was a bad dream. This is in the past, it's not happening now. Tell yourself it is ok and practice taking care of yourself in that way. Part of you is a small child. What would you do to a small child when they are frightened in the night time? You do the same thing".

In line with this maternal theme, the researcher was impacted by a disclosure from Jane which depicted a desire to give something to the refugee or asylum seeker in much the same way as the mother would to a child. Jane explained how she describes the therapeutic process to the refugee or asylum seeker:

> "Being a refugee and being an asylum seeker is about fighting and going on. And I often describe it as running a marathon. I always tell them, I can't run it for you but what we can do and what therapy can do is, I can give you a glass of water or some chocolate, or whatever, to keep going".

The examples provided by the participants were noticeably geared towards protecting or giving something to the clients. The researcher was increasingly struck by the perceived 'mothering' stances that was emerging in the transference. Mary described another experience with an asylum seeker who was due to attend an interview process in order to gain refugee status. Mary reported saying to the asylum seeker:

> "I can't say you'll be asked this, this and this. That's the solicitor's job. But what I can do is advise them how to answer and to take their time. They don't answer straight away, just take time and think about your answer. Bring a bottle of water with you. So take a sip of water and that allows you then to think a little bit. You're slowing the thing down. You hold your pace. This is your future, so you take control. Not in a powerful way, or a domineering way but you know, take your time to answer. If you don't know the question … if you feel that the interpreter has not interpreted what you said, you say look, excuse me, that hasn't been exactly what I said and then try to say it again in English".

The researcher was struck by the lengths that this therapist went to in preparing this asylum seeker for the interview stage of their application. It was becoming evident that the role of the therapist was skewing into that of an advisor. This is typical of acting out the maternal transference. Mary continued by adding that:

> "A lot depends too on the attitude of; I don't know if it's a judge or these interviewers. It depends on their attitude… sometimes they are so cold and clinical whereas if they just gave them (asylum seekers) two seconds just to think a little bit or something. And let them speak you know, and let them have their say. Their English backwards, it doesn't matter how they get it out".

The participants of this research were clearly passionate about the work with refugees and asylum seekers and their frustrations were evident via their disclosures and body language. However, from a psychotherapeutic lens, it was becoming obvious to the researcher that the work with refugees and asylum seekers posed a great challenge due to the many projections and unconscious wishes that are transferred to the therapist which unconsciously evoke maternal transference reactions.

Mary's empathic engagement with this client group provided yet another poignant example of how a maternal transference can be acted out in the therapeutic space. Mary described an experience with an asylum seeking client who received an urgent phone call during a therapeutic session. Mary added that it was obvious that the client was having difficulties understanding the person on the other end of the call. Mary reported:

> "This woman started crying so I said 'give me the phone'. I said who I was and he said… dah, dah, dah. And I said I haven't a clue of one word you are saying (which I hadn't). I said 'how is someone who doesn't speak English'. You have to speak slowly and then I will explain to her whatever it is".

This example shows the difficult challenges that present for the psychotherapist who gets caught up in the unconscious projections of the client. The negotiation of these transferential dynamics such as the maternal transference is of fundamental importance in order to prevent the therapist from being pulled out of their role.

The following section will address the third theme identified by the researcher, *the therapist's awareness*.

4.4 Awareness of the Psychotherapist

The third theme identified by the researcher centred on the concept of the psychotherapist's awareness. This denotes the importance of the psychotherapist's capacity to notice transferential issues as they emerge in the work with refugees/asylum seekers or any other client base. Each of the interviewed psychotherapists reported heightened levels of awareness in this particular field. The research found that while each participant was mindful of somatic symptoms and countertransference responses, there was equally evidence to suggest that unconscious dynamics were infiltrating the work. This section will explore the therapist's awareness with emphasis on transferential phenomena.

The impact of the work on the psychotherapist with traumatised refugees and asylum seekers is something that cannot be questioned. Vicarious trauma and secondary trauma have been extensively documented as the leading causes for burnout amongst psychotherapists employed in this field. Each interviewee, apart from Mary admitted an awareness of the signs and symptoms that are typical of vicarious traumatisation/secondary traumatisation from working with this client population.

In order to get an authentic sense of each therapist's subjective thoughts on this phenomenon, the author asked a question in relation to awareness of personal experiences of vicarious traumatisation/secondary traumatisation or feelings of overwhelm in the work. The researcher had previously watched a movie based on the true story of a young asylum seeking female who had underwent female genital mutilation (FGM). During each interview, this researcher used this personal example of secondary traumatisation in an effort to extract genuine accounts from the participants. The researcher's disclosure led to the participants being very forthcoming and honest with their individual accounts which provided the interviewer with a sense of each psychotherapist's degree of awareness.

Suzy used imagery to describe the experience of working with traumatised refugees and asylum seekers as:

> "You cannot go through water and not get wet even if you have the appropriate clothing. Some of it stays… but the question is what do you do with that afterwards? It's afterwards you need the proper peer supervision or time to reflect".

Suzy's account alluded to an awareness of the challenges of this type of work. However, while Suzy admitted to being mindful of the impact, there were non-verbal indicators that suggested a deeper affect. Suzy spoke in a depressed tone and there was an apparent lack of energy while discussing the topic. This dynamic in turn impacted the interview process. The researcher later identified experiencing somatic responses as mirrored unconsciously by Suzy. This resulted in the interview lasting just over half an hour, which was substantially shorter than the other participants. On reflection, this pointed to the sneaky nature of transferential dynamics and how a lack of awareness can impact the work.

The theme of the therapist's awareness was eloquently stated by Jane with the following statement:

> "It's about awareness, about vicarious traumatisation … that it is so insidious. Vicarious traumatisation is not a question of either I have it or I don't. It's a question of how much. I think we are all affected. It's a question of how aware we become of it".

Jane's account was refreshingly honest and the therapist was experienced by the researcher as one with a great sense of self-awareness. This participant placed great emphasis on her capacity to be disciplined both inside and outside of the therapeutic space as mediating factors in her self-care plan.

The same question about the prevalence of vicarious/secondary traumatisation coupled with the researcher's experience of the aforementioned movie was asked to Billy who replied with:

> "I think sometimes being overwhelmed happens a lot in the sort of field and I try my best to vocalise when I feel it".

Billy spoke of being aware of symptoms as they emerged and acting on them appropriately. The awareness of the potential for vicarious/secondary traumatisation became increasingly important as each interview was conducted. Lisa spoke of being aware of the real propensity for problematic symptoms arising from traumatic responses as:

> "Oh God, yeah! All the time absolutely! Again, you know, we're human, we are not robots and the stuff we are hearing is horrendous. With this work, you could burnout very quickly, very easily. And we are all being vicariously traumatised. It's not that any of us have any special powers to protect ourselves. It's just the heightened awareness about it and making sure that we are doing things actively to keep it in check".

Lisa spoke about the absolute necessity of being attuned to the self and constantly being aware of somatic and psychical responses. The therapist added:

> "There are more signs in the body before you notice them in your mind. So, it's just being very body aware. Like, my stomach feels a bit queasy today and not ignoring it. Do you know why that is? Did I eat something dodgy or did something happen in that session that my body is trying to tell me something?"

Lisa continued by stating:

> "…and listening to your body as well. A lot of the times, trauma affects the body quicker than it affects the mind… so just trying to pay attention to how you're feeling and knowing what part of your body is affected when you are anxious, or upset, or traumatised".

Lisa's accounts were indicative of a heightened sense of awareness however the researcher was struck by the thought provoking disclosures of Debbie. Debbie had extensive experience working in other demanding environments but was relatively new to the work with traumatised refugees and asylum seekers. Debbie reported:

> "The work is very challenging, very emotionally draining. I'm feeling it. I'm feeling different here than I've ever felt anywhere else".

Debbie's above example demonstrated awareness to some degree of the impact of the work at a somatic and psychical level. However, the researcher was becoming intrigued by further disclosures. Debbie continued:

> "…so, the overwhelm - is that psychical? …but, also the horror of the story. And then you're picking it up from others so. Let's say if you're talking to the doctor or your peers, you're picking up their angst as well. You know, so it's happening all over the place if you will".

The author noticed how Debbie's accounts became more poignant and revealing as the therapist appeared to be more comfortable in the researcher's presence. This was evident when the researcher told Debbie that: "I won't take up much more of your time". Debbie responded with: "We still have 12 minutes left". This was interesting as the interview was scheduled for forty minutes, which had elapsed at this stage. Debbie enthusiastically

continued by discussing a conversation that took place with a doctor who worked in a similar field. Debbie's account was as follows:

> "I remember one of the doctors saying to me - informally, I was having a chat with him - do you exercise? Or do you…? I suppose he was asking me to work it out of your body. You know, I think is what he was saying".

This was the second mention in which Debbie spoke of conversing with the doctor. The researcher was picking up on a real sense of 'I want to be heard' by this participant. In addition, Debbie had earlier spoke of her previous work with traumatised clients as the impetus for progressing into the work with refugees and asylum seekers. However, the researcher got a sense that this demanding new environment and the toll of the level of engagement with this client group were not anticipated by the therapist. The following disclosure led the author to wonder if Debbie was uttering something unconsciously:

> "I think that it's knowing your limitations and saying you know what, that's not for me or that is. And I'll give it a go or I'll try it, but knowing when to pull back. You know, and I think that's fine. You see, some people would say that I'd never go into that, into trauma work. They obviously know but then there are others who think I can do it. I'd like to try that".

While awareness was mentioned consistently throughout the interviews, the disclosures by Debbie began pointing to symptoms that are synonymous with vicarious/secondary traumatisation. Debbie spoke of being mindful of:

> "…what you take on with the clients and how it infiltrates into or seeps in. There's also a lot of psychic energy in my own self in trying to protect myself and trying to

> maintain barriers if you like… So you're protecting what's inside but you're also protecting what's coming at you. So it's a lot of, it's heavy work".

Debbie spoke openly about the high attrition rates in this particular field. During these exchanges, the researcher began noticing countertransference feelings of deep empathy coupled with a desire to mind the participant. Debbie continued by talking about the experience of being new to the organisation and the overwhelming nature of the work stating that:

> "And I'll be honest about that. It's very overwhelming in that it's as I say, you know, it's a big trajectory. Straight up there! What's happening to me? Why am I reacting like this? Why am I feeling it in my body like this? This is extraordinary. This is like 'Oh my God'. My body is you know, and this tiredness behind my eyes. I suppose part of that is probably the beginning of the transferential relationship. You know, you're taking on. There are a lot of projections, a lot of internalising, whatever term you use".

Debbie's disclosures became more indicative of the types of transferential issues that can arise in this challenging work. The therapist's awareness being paramount for sustaining them in the work with refugees and asylum seekers. However, the accounts of Debbie were striking the researcher on many levels. There was a real sense that this participant was affected much more unconsciously as opposed to consciously. While Debbie did speak about awareness, the question arose about her degree of awareness. Debbie was the newest to the role whilst Mary was the oldest and most experienced of all the participants. Mary was the only interviewee who reported not feeling overwhelmed or vicariously/secondary traumatisation in the work. The researcher asked Mary about their experience of these symptoms in the same manner as with the other research participants. Mary responded with:

> "No, I don't think I have… but you have to mind yourself. I wouldn't say I've ever been over-whelmed because if you do it's your own fault".

Mary's comment was surprisingly blunt and to the point. What struck the researcher was a comment made by Lisa which was in stark contrast to Mary's opinion. Lisa's response about the impact or the experiencing of vicarious/secondary traumatisation was:

> "Yeah, I would hate if it didn't because then I would feel I was becoming desensitised".

4.5 Chapter Summary

This chapter provided the reader with three salient themes which addressed transferential dynamics that can emerge and prove challenging for the psychotherapist in the work with refugees and asylum seekers. The three themes identified illustrate the complexities that can emerge in the establishment and maintenance of the therapeutic relationship and equally the propensity for enmeshment in the client's story. In addition, Kantrowitz *et al*. (1989) identified the therapist and client's personal history, human characteristics and attitudes/beliefs as predispositions to certain transferential reactions. Luborsky *et al.* (1988) also identified demographic variables including age, sex, religious background and level of education as factors in the therapeutic work. This point is exacerbated in the work with refugees and asylum seekers due to their traumatic past, different cultural beliefs and expectations which manifest in the transference.

The following chapter will discuss the themes as identified in this research with the use of empirical studies and theoretical references to support the findings.

Chapter 5 – Discussion

5.1 Introduction

This thesis set out to identify the transferential issues that can arise for psychotherapists who work with traumatised refugees and asylum seekers. The researcher opted for a qualitative style of research after which a thematic analysis was undertaken. The rich data that was accrued from interviewing six psychotherapists who are currently employed in this field provided the author with three salient themes. These themes were identification, maternal transference and the therapist's awareness. The following section of this thesis will provide the reader with a discussion on each theme.

5.2 Identification

Identification is understood as one of the higher level neurotic defences emerging when one internalises attributes of the other in order to be more like the other (Unoka, 2016). Andrade (2005) stated that the therapeutic relationship promotes an identification which is based on the introjection of a 'good object', namely the psychotherapist. Personality and empathic ability are important variables in the work with refugees/asylum seekers particularly if the psychotherapist has a propensity to easily identify with the client. This became evident with Debbie's accounts of being 'new to the organisation'. In much the same as the refugee/asylum seeker experiences symptoms of malaise in the new host country it became apparent that Debbie was equally experiencing similar symptoms. These ranged from somatic to psychical upset which are in line with past research.

Waugaman (2009) considered vicarious trauma as identification albeit an over-identification between therapist and client. Gampel (1988:352) equally warned of vicarious traumatisation as an over-identification which hindered the client's process through prejudgment. The

implication for this research rests in Gartner's theory of *concordant identification* in which symptoms of vicarious traumatisation and countertransference can become fused (Gartner, 2014). Racker had earlier distinguished between concordant identification as the therapist's 'resonance of the exterior in the interior' (Racker, 1957, p. 312) and vicarious trauma being the identification with the client's narrative. From a therapeutic perspective, Racker was more interested in the therapist's inability to identify with the internal object relationships of the client and suggested that these transferential issues should ideally become an intersubjective endeavour in the therapeutic space. However, Gartner (2014) warned of over-identification as a hindrance to this part of the therapeutic process particularly due to emerging unconscious defences in psychotherapists.

The significance of Debbie's disclosures echoed the transferential dynamic of unconscious mirroring/identification by both parties. Eleftheriadou (1999:229) stated that it was essential for the psychotherapist to notice these dynamics in the countertransference in an effort to protect both therapist and client. Otherwise, the therapist risked getting caught up in re-enactments via identification. In doing so, the therapist's capacity to 'contain' and 'hold' affect becomes diminished which hinders the establishment of a 'secure base' so that the refugee/asylum seeker scan begin their process of mourning, adjustment and a re-creation of the self (Bowlby, 1979).

Herman (1992:196) stated that in addition to coming to terms with their traumatic history, the refugee/asylum seeker is also faced with the challenge of developing a new self. However, unresolved material in the therapist can hamper this process. The comments made by Jane depicted an identification with the refugee and asylum seeker's experience of 'losing yourself'. Within this example, an awareness of identification on the part of the psychotherapist becomes crucial for understanding the real and imaginary transference of the client. Winnicott (1960:267) stated that identifying with the client was a delicate balance

between being vulnerable with the client and remaining professional. The issue with this dynamic rests in the therapist's ability to remain focused on the external reality of the client whilst identifying with them however avoiding the complexities of being enmeshed in the experience.

Due to the similarities of experience as provided by Debbie coupled with academic studies completed on the topic, it became apparent that through identification, there was an enmeshment occurring between Debbie and the refugee/asylum seekers' experience of their new environment. Moreover, the concept of relational psychoanalysis points out how through intersubjectivity the client can notice this in the therapist. Sodowsky *et al.* (1997) warned of the strong emotions that can potentially influence countertransference reactions particularly in instances where the psychotherapist identifies with the client's experience.

Neuman and Gamble (1995:344) found that transferential issues of identification were more likely in the novice psychotherapist noting that the tell-tale signs typically arose through feelings of helplessness and carried a high risk of burnout. Debbie's experience of being new to the organisation reflected the documented reports of the refugee and asylum seeker's experience in the new host country. Pearlman and Mac Ian (1995) also discovered that symptoms of vicarious/secondary traumatisation were more prevalent with psychotherapists depending on their level of experience. The symptoms described by Debbie were consistent with these documented examples of vicarious traumatisation. Debbie spoke of 'feeling it at the level of the body, my psyche and this tiredness behind my eyes'. Herman (1992) named this the therapist's *traumatic countertransference*. On considering identification, Debbie later stated that there was a lot of somatisation with refugee client's or asylum seekers. This was synonymous with Debbie's reported countertransference experiences.

The prevalence of identification hinders the psychotherapist from reaching high levels of empathy in the work. Vulnerable clients such as refugees and asylum seekers commonly present with unconscious primitive defences. These dynamics require strong interpersonal boundaries on the part of the psychotherapist coupled with a capacity to not identify or jointly act out these defensive structures (McHenry, 1994). The transferential issue that potentially can be problematic stems from narcissistic vulnerability in the therapist via feelings of helplessness. These feelings were expressed to some degree by each of the participants. However, despite the many examples of identification that emerged with Debbie, the accompanying statement in which the therapist denied being traumatised by the work alluded to the potential presence of this narcissistic defence.

5.2.1 Object Relations in the Work

Each research participant alluded to their humanitarian interests and a desire to help people which drew them into the profession. From an object relations perspective, Fairbairn spoke of the contrasting drives of the psychotherapist's motivation to work with vulnerable clients as either an innate drive to help or an unconscious desire to be the 'exciting' object (Fairbairn, 1952). In negotiating the transferential issues herein, Eleftheriadou (1999: 221-222) warned of how the refuge or asylum seeker can act out via feelings of anger or rage at the new object (host country/psychotherapist) seeing these as the cause of their current problems. This echoes Fairbairn's (1952) theory in which the new country or indeed the psychotherapist can be perceived by the refugee or asylum seeker as the new exciting object. The issues that can subsequently arise in relation to identification rest in the therapist's ability to negotiate these unconscious defensive dynamics.

Billy gave the example of the client who he experienced as wanting to hit him adding that the sessions were full of tension and likened them to a 'stare down contest'.. Eleftheriadou

(1999) pointed out that traumatic experiences as suffered by refugees or asylum seekers invariably brings common emotions such as frustration, bitterness and resentment to the forefront. Freud (1924) spoke of identification as the preliminary stage of an object-choice adding that it was typically expressed in an ambivalent manner. In addition, Skogstad (2013) found that if the therapist lacked a degree of identification and is experienced by the client as an impenetrable object, the potential for serious therapeutic issues arise due to further projections and the triggering of unconscious defences. Again, this echoes Fairbairn's endopsychic structure theory which suggests that the self unconsciously splits off psychically from the rejecting object (motherland) and redirects the negative affect towards the exciting object (host country/psychotherapist). The difficulty in this scenario with emphasis on Billy's reaction to the perceived violent client is that the therapist can be experienced as persecutory thus unconsciously re-enacting the earlier challenging experiences of the refugee or asylum seeker.

5.3 Maternal Transference

The difficult accounts that refugees and asylum seekers report pose a potential transferential issue due to innate empathic and humanitarian traits of the psychotherapist. This discussion aims to provide the reader with a potential understanding of the maternal transference dynamic by exploring the latent meaning and motivation of the symptoms experienced by the participants of this research and as posited by psychotherapeutic theory.

Winnicott (1960) spoke of the mother/child dyad which the therapist/client relationship mirrors. The client perceives the therapist as an idealising object, the soothing parent, capable of feeling their needs (McHenry, 1994). This is typical of the maternal transference and places the therapist in a role that requires the skills to 'contain' the anxiety and potential assaults on their narcissistic self. The risk of collusion and avoidance in response to the client's demands become very real when this transferential issue arises.

Winnicott's idea of the 'good enough' mother suggests that the maternal figure at times resorts to satisfying the child's needs. With that in mind, and considering the therapist/client dyad, it is fair to say that the psychotherapist equally conforms to the client's demands in an attempt to be experienced as 'good enough'. The difficulty from a therapeutic perspective being that the good enough mother/therapist should not fear the child/client's frustrations (Winnicott, 1960). This mirroring during the developmental stage leads to an unconscious realisation on the part of the child/client that the mother/therapist can be trusted and that strong affect can be tolerated (Adler, 1972). With regard to refugees and asylum seekers, the added vulnerability of their circumstances challenges the psychotherapist's application of 'good enough' theory. This thesis suggests that the transferential dynamic, particularly that of a maternal nature hampers the therapist's ability to maintain appropriate boundaries.

Mary described with a striking degree of empathy the distress experienced by an asylum seeking client who received an urgent phone call during a therapeutic session. The aforementioned client became upset due to an inability to understand what the caller was saying. Mary's action of taking the phone from the client and addressing the caller demonstrates the therapist's acting out. Schauenburg *et al*. (2006) spoke of the importance of maintaining an analytic attitude especially when transferential conflicts became intense. Winnicott (1971) spoke of the necessity of the mother/therapist in being able to tolerate the child/client's frustration. However, this example provided by Mary illustrated how the therapist can be unconsciously pulled out of their role and placed in a protecting role which is typical of the maternal transference.

The difficulty with this dynamic is that the client can unconsciously regress deeper due to the unconscious message that the therapist's response evokes. Heimann referred to this as a *regressive counter-transference* emerging through feelings of rescuing and comforting the client (Heimann, 1950). These transferential dynamics result in the client unconsciously being perceived as helpless and requiring saving. Adler (1972) points out that this form of 'acting out' by the therapist inevitably leads to further demands by the client which are ultimately rejected. The ensuing anger experienced by the client leaves the therapist equally feeling angry and adds to their feelings of helplessness.

To combat this transferential issue, the therapist requires awareness of how the maternal transference can play out and in turn use it to help the client understand what is happening. This forms the basis of a corrective emotional experience by working through difficult emotions (Alexander & French, 1946). Moreover, it prevents the therapist from recreating or re-enacting the client's problematic past.

Ogden (1996) noted that feelings of helplessness and hopelessness arise from the therapist's empathic countertransference and stresses that the therapist's understanding of these projections, particularly that of the helpless mother is an important part of psychotherapy. Moreover, these projections can be problematic on considering the feelings that are evoked in the psychotherapist. Adler (1972) warned of the potential for negative affect in the therapist due to the client's repeated accounts of their helpless state which can result in the therapist experiencing themselves as not 'good enough' and potentially rejecting the client. To compound this point, Adler further stated that despite the therapist's belief that they have high levels of altruism, there is an unconscious desire to get something back from the client. Mary's 'mothering' attempts to prepare the asylum seeking client for the refugee status interview potentially points to that unconscious desire.

Fairbairn's (1952) endopsychic structure states that the therapist aims to become the 'good' object in order to challenge the client's negative internalisations which is typically done through conscious re-enactments. However, these attempts of engagement via the maternal transference must be negotiated carefully. Adler and Ogden warned of the complex psychological issues that can arise in vulnerable clients via the maternal transference if these unconscious re-enactments are not picked up on and explored therapeutically.

The prevalence of the maternal transference with refugees and asylum seekers poses a unique challenge. On considering the transferential dynamics as illustrated with Mary, the researcher posits that the internal drive to 'mind' the client becomes somewhat skewed in the work with this client population. Grinberg (1962) referred to this as *projective counter-identification* in which the therapist suffers the effects of projective identification through counter-identifying with the client.

5.4 Awareness of the Psychotherapist

The literature reviewed in this thesis documents the unconscious responses that are typical of working with vulnerable clients such as refugees and asylum seekers. McHenry lists some countertransference reactions that are unconsciously evoked in the unaware therapist. These are identified as follows: the dependent therapist who requires a sense of self from the client, the seductive therapist who requires the client to be needy, the angry therapist who retaliates against the client, the frightened therapist who uses conversation to ward off feelings of helplessness or the insecure therapist who experiences feelings of overwhelm and impotence (McHenry, 1994. p. 565). Eleftheriadou's (1999:226-227) research also warned of countertransferential feelings of hopelessness, helplessness and a sense of fragmentation among psychotherapists who have been overwhelmed by vulnerable clients' disclosures. These unconscious projective identifications and defences if not acknowledged ultimately lead to disturbances in the therapeutic relationship.

On exploring McHenry's theory, the researcher pondered about countertransference reactions in relation to each of the participants in an effort to determine the psychotherapist's level of awareness. The researcher asserts that Billy could be understood as the angry therapist. The earlier example provided by Billy in which the likened the therapeutic encounter to a 'stare down competition' with a perceived angry asylum seeker could potentially be understood as an unconscious reenactment of this client's history. From an object relations perspective, Billy was containing the projections of self and object representation by remaining silent and present with the client. The silence of the therapist can be understood as an attempt to contain the angry client's feelings. Alternatively, they could well be experienced as persecutory to the client. From a relational perspective, the angry client might be understood to be an aggressive object and the therapist's reaction albeit silent, could be an enactment of the helpless self representation of the client. In being silent, something is being said. Adler (1972) pointed out

that anger can arise in the therapist, and although it is the therapist's anger, it is evoked from projections in the client. Therefore, the therapist's awareness of such reactions and the potential for these transference/countertransference dynamics require an ability to tolerate feelings of anger and hate in the therapeutic space (McHenry, 1994).

Lisa could fit into McHenry's notion of the frightened therapist who uses chit chat in order to avoid feelings of helplessness. Lisa spoke of a strategy employed to relax anxious clients in the therapeutic space by finding a common ground or a way to relate. This took the form of talking and making jokes about the 'weather' and 'tea'. The researcher understood the validity of this approach however was struck by McHenry's point about therapists resorting to 'chit chat' as a way of managing anxious feelings. Unoka (2016) spoke of the use of humour as a mature defence used to diffuse tension and create distance from difficult situations. The difficulty with this dynamic rests in the client's inability to explore their story objectively. On considering refugee and asylum seekers, the holding and containing function of the therapist aims to calmly contain tensions that arise particularly due to the complexities of the transference and countertransference as there is potential for further disturbances to the client's already tentative state (Unoka, 2016).

Further to McHenry's description, Mary might fall into the category of being the seductive client on considering the transferential re-enactments of the 'needy' asylum seeker who became distressed during the phone conversation. Of all the participants interviewed, Mary had the most clinical experience. In addition, Mary was the only therapist who reported not feeling overwhelmed or symptoms of traumatisation by the work. This disclosure was interesting on considering the examples as provided with Mary which are consistent with the therapist unconsciously acting out transferential dynamics of the client via projective identification. This led the researcher to question the awareness of Mary's subjective experience with this client population.

The researcher was more struck by the disclosures of Debbie which suggested the insecure therapist countertransference dynamic. On asking Debbie about the depth of the work, Debbie stated it was at 'the superficial level, keeping it safe rather than getting down to the nitty gritty of the work'. The researcher's countertransference after hearing this statement was one of 'who's protecting who?' Boulanger (2018:63) warned that being unaware of vicarious trauma prevents the therapist from being there fully with the client adding that it acts as an unconscious defence which serves the therapist by protecting them from further negative affect by avoiding traumatic material.

In addition, McHenry (1994) stated that countertransference feelings such as boredom and sleeplessness are indicative of those who have been overwhelmed adding that these defences also demonstrate a defensive withdrawal from the client. Boyer (1997) described somatisation in the therapist as a form of *acting in* stating that countertransferential somatisation manifests in many ways and is highly prevalent in clinicians working with seriously disturbed clients. This was evident with Debbie who described feelings of "tiredness in different parts of the body" and "this tiredness behind my eyes". Neuman and Gamble (1995:344) identified somatic symptoms in the therapist as indicative of vicarious/secondary traumatisation and/or traumatic countertransference which implied a diminished capacity to tolerate strong affect. The descriptions provided by Debbie demonstrate some degree of awareness however the researcher suspected that this awareness was equally at a superficial level.

The absence of awareness coupled with feelings of overwhelm can result in the therapist avoiding issues and feelings as they are projected onto them. The researcher asserts that working at the 'superficial' level as described by Debbie as being potentially indicative of this defence. The difficulty with this form of acting out ultimately results in difficulties in relating to the client as a real person (McHenry, 1994).

Kohut (1959) pointed to empathy as a major factor in the therapeutic relationship but warned of the potential for strong affect in the unaware therapist. This again highlights the important function of the observing ego. Vaughan and Roose (2000) stressed how the psychotherapist must negotiate being a participant and an observer. However, the work with refugees and asylum seekers demonstrates a constant necessity in which the psychotherapist is keenly attuned and aware of transferential dynamics as they emerge.

To further demonstrate the importance of awareness, the researcher was struck by Debbie's theory on the use of medication with refugees and asylum seekers. Debbie described their desire for medication as 'a quick fix', 'a shortcut' 'take my pain away' instead of 'the long route and trying to work it out'. These comments struck the researcher whilst reflecting on Debbie's disclosures in relation to overwhelm and burnout. Debbie used statements such as "you have to do something, bring it somewhere, or you burn out and is that running away?" This remark resonated with Debbie's earlier comment about medication being a "quick fix". The researcher noted how burnout could equally be understood to be a defence or an unconscious 'quick fix' on the part of the psychotherapist.

Moreover, Debbie's comment about working at a superficial level in order to keep it 'safe' seemed to be an unconscious clue as to the motives for Debbie not getting into the 'nitty gritty of the work'. McHenry (1994) had previously warned of the therapist's propensity to collude with the client in order to avoid further projections particularly when the psychotherapist was not aware of overwhelming feelings. Freud (1936) also stated that the symptom serves a purpose. In the case of Debbie, the researcher likened the psychotherapist's potential for burnout to medication being the refugee/asylum seekers 'quick fix' in an effort to take the pain away.

The aware therapist is able to set and maintain appropriate boundaries and address transference and countertransference issues as part of the work. McHenry's theories demonstrate how unaware therapists can unconsciously adopt defences in an effort to ward off anxiety or difficult feelings which could potentially become overwhelming instead of embracing the client's story in an empathic and non-judgemental way. McHenry (1994:563) further illustrates this transferential dynamic with the analogy of passing the difficult feelings back and forth "as if they were hot potatoes" which ultimately leads to a recreation of a negative introjects which jeopardises the therapeutic relationship.

5.5 Chapter Summary

This chapter discussed how transferential issues can arise in the work with traumatised refugees and asylum seekers within an Irish context. The findings of this research points to the complex dynamics of identification, maternal transference and awareness of the psychotherapist also in existence in Irish psychotherapeutic practices. This reflects on previous research that has been conducted globally.

Conclusion

This thesis set out to explore the transferential issues that can arise in the psychotherapist who is working with traumatised refugees and asylum seekers. In order to identify these potential dynamics, this research began by addressing some of the complex circumstances that are reported by refugees and asylum seekers in Ireland. The purpose of this was to set the scene for the reader. This followed on with an exploration of some of the psychopathologies and symptoms that this client group typically presents with. Once these were identified, it became possible to psychotherapeutically investigate the potential meaning of the symptom or the defensive mechanism of both client and psychotherapist. The rational for this was that contemporary psychotherapists would then be better informed about how these complex issues might emerge in the transference.

6.1 Strengths and Limitations

The most notable strength from this research rests in the fact that there is not a lot of literature from an Irish perspective on the potential difficulties of working psychotherapeutically with refugees and asylum seekers. With that in mind, the author believes that this thesis will provide psychotherapists who are working or considering working in this field with an up to date account of the issued as illustrated in this research. A key limitation in this research arose from the fact that most of the psychotherapists that were interviewed came from a psychoanalytic background. Therefore, with such a homogenous sample and a limitation of six participants (of which five were psychoanalytically trained), it became difficult to prove that the findings of this study would be consistent across other psychotherapeutic disciplines.

6.2 Recommendations

The recommendations provided by this research are made with the intention of highlighting to psychotherapists the transferential dynamics that can arise in the work with traumatised refugees or asylum seekers. It is not the intention of the author to assert that psychotherapists who are working with traumatised clients such as refugees or asylum seekers should have reached a complete resolution with their own issues in order to avoid transferential issues. This thesis aims to better inform psychotherapists of the potential impact of working with this client population so that they can avail of appropriate training and supports.

6.3 Clinical and Practical Implications

The findings of this thesis lead the researcher to assert that psychotherapists who are dealing with refugees and asylum seekers should have attained a high degree of supplementary trauma training. The insidious nature of trauma work which has been identified with many of the psychotherapists who participated in this research suggests that an experienced skillset is desirable in the practitioner who chooses to advance their career into the work with traumatised refugees and asylum seekers. In addition, the researcher also believes that organisations that are involved with this vulnerable client group should provide additional training on the nature of transference and countertransference responses to better equip psychotherapists in this challenging work.

6.4 Areas for Future Research

This research posits that further studies are required to understand the nature of these transferential issues in an attempt to better equip contemporary psychotherapists negotiate these challenging dynamics. In addition, the author asserts that future research could explore

the efficacy of more relational forms of psychotherapy when working with traumatised refugees and asylum seekers.

6.5 Reflexivity

The participants of this research explained how traditional psychotherapeutic practices became problematic in the development of the therapeutic relationship. To combat this difficulty, the interviewees reported adjusting their therapeutic style to a more relational form of psychotherapy. Ogden (1994:186) refers to these techniques as 'supportive' therapy. This practice being the fundamental aim of all psychotherapeutic schools so that symptoms can be better understood. The psychoanalytic model relies heavily on the client's ability to play, think and symbolise coupled with the transference and countertransference dynamics of the therapeutic relationship for arriving at interpretations. However, this research has found that the complex work with refugees and asylum seekers limits the use of these strategies and techniques. The nature of psychoanalytic training emphasises the prevalence of transferential patterns and countertransference responses with a fundamental expectation that the practitioner is constantly monitoring their reactions before they manifest in the work. Neumann & Gamble (1995:347) asserted that in order to abide by the ethical and responsible standards of working with traumatised people, it is vital that the psychotherapist is constantly assessing their traumatic countertransference and their level of vicarious traumatization. With that in mind, the researcher was profoundly surprised by the lack of awareness of transferential dynamics that became evident through disclosures and re-enactments with many of the participants of this research.

6.6 Concluding Statement

This thesis has found that transferential issues are very real in the psychotherapeutic work with refugees and asylum seekers. The three themes that were explored; identification,

maternal transference and awareness of the psychotherapist demonstrate how even the most skilled therapist can get caught up in these unconscious enactments. This highlights the necessity of attunement in the psychotherapist so that they can identify these problematic dynamics before they become manifest in the therapeutic space.

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Appendices

Appendix A: Questions

A Psychotherapeutic Exploration of the Work with Traumatised Refugees

What brought you into this type of work?

From your experience, what difficulties in relating have you noticed from your work with refugees?

How do you manage language barriers in the work?

Can you tell me about some of the recurring issues that you have noticed with this type of client?

Can you talk to me about the symptoms that refugees present with?

Could you tell me about some of the obstacles that you have encountered in your work with refugees?

Can you tell me about your views on the use of interpreters in the therapeutic relationship?

Can you tell me your thoughts on psychotherapists working with refugees originating from similar countries/cultures?

Can you tell me about a memorable experience?

Can you talk about any transferential issues that you have noticed in the work with traumatised refugees?

Have you ever felt overwhelmed in the work?

What do you feel sustains you in the work?

How important is self-care to you in this type of work?

Is there anything else that you would like to highlight that may better inform this research?

Appendix B

Demographic Sheet

Female ☐

Male ☐

Age Group < 30 ☐ 30 - 40 ☐ 41 – 50 ☐ 51 – 60 ☐ 60 + ☐

Place of Training _____

Psychotherapeutic Orientation _____

Years in Clinical Practice ☐

Years working with Refugees ☐

Years working with Trauma ☐

Additional Trauma training ☐

Place of Trauma Training (if applicable) _____

Appendix C

INFORMATION SHEET

My name is Elizabeth Lennon and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with refugees and trauma. I will be exploring the views of people like yourself who work as therapists within this field.

What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a therapist working in this area. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an 45 minutes to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION
I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.
I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____
Signature_____
Date / /

Appendix D

CONSENT FORM

A Psychotherapeutic Exploration of the Traumatic Experience of the Refugee and the Impact on the Therapeutic Relationship

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

☐ **Yes** ☐ **No**

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

☐ **Yes** ☐ **No**

I understand that my identity will remain confidential at all times. ☐ **Yes** ☐ **No**

I am aware of the potential risks of this research study. ☐ **Yes** ☐ **No**

I am aware that audio recordings will be made of sessions ☐ **Yes** ☐ **No**

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐ **Yes** ☐ **No**

Participant _____ _____

Signature and dated Name in block capitals

To be completed by the Principal Investigator or her nominee.

I the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved and have invited him/her to ask questions on any aspect of the study that concerned them.

_____ _____ _____

Signature **Name in Block Capitals** **Date**

Emerging Themes (Workings)

Mary	Billy	Debbie	Suzy	Lisa	Jane
Trust #1	Frustration #7	Overwhelm #26	Trust #1	Direct Provision #10	Culture #6
Sleep #2	Direct Provision #10	Vicarious Traumatisation #14	Overwhelm #26	Re-traumatisation #8	Re-traumatisation #8
Choice #3	Dreams #18	Identification #25	Helplessness #9	Culture #6	Direct Provision #10
Isolation #4	Sleep #2	Boundaries #24	Vicarious Traumatisation #14	Frustration #7	Isolation #4
Loneliness #5	Sadness #22	Trust #1	Frustration #7	Vicarious Traumatisation #14	Resilience #28
Culture #6	Hopelessness #23	Sadness #22	Hopelessness #23	Boundaries #24	Awareness #27
Frustration #7	Boundaries #24	Loneliness #5	Re-traumatisation #8	Helplessness #9	Identification #25
Re-traumatisation #8	Identification #25	Isolation #4	Culture #6	Maternal Transference #19	Frustration #7
Helplessness #9	Overwhelm #26	Overwhelm #26	Identification #25	Awareness #27	Overwhelm #26
Direct Provision #10	Anger #20	Maternal Transference #19	Overwhelm #26	Identification #25	
Identification #25				Resilience #28	
Desensitisation #12					

Themes Refined

Mary	Billy	Debbie	Suzy	Lisa	Jane
Frustration	Frustration	Overwhelm	Trust	Culture	Culture
Culture	Hopelessness	Vicarious Traumatisation	Overwhelm	Frustration	Awareness
Helplessness	Boundaries	Identification	Helplessness	Vicarious Traumatisation	Frustration
Overwhelm	Identification	Boundaries	Vicarious Traumatisation	Boundaries	Identification
Vicarious Traumatisation	Awareness	Frustration	Awareness	Maternal Transference	Maternal Transference
Vicarious Traumatisation	Overwhelm	Trust	Frustration	Helplessness	Resilience
Re-traumatisation		Awareness	Hopelessness	Identification	Vicarious Traumatisation
Maternal Transference			Culture	Awareness	
Hopelessness					