Complexity of Therapist’s Feelings in the Work with War-Traumatized Patients

Ljiljana Milivojevic

Cabinet for Psychotherapy, Institute for Mental Health, Belgrade, Yugoslavia

Aim. To present the complexity of therapist's feelings and emotions in the work with war-traumatized persons and the importance of psychological mechanisms taking place in such circumstances.

Methods. The method of psychoanalytical psychotherapy was used, adapted to the work with war-traumatized persons. The therapy sessions were held once a week and lasted for 50 minutes. The patients were given transference interpretations differing from customary transference interpretations. They were modified to provide support, aiming at overcoming of the feelings overwhelming each patient.

Results. The diversity of the therapist's feelings amalgamated into countertransference was one of the most important psychological mechanisms in the therapy procedures, and served as an indicator of the patient's feelings in the procedure. It was related to the processes of projective identification as a framework of the complex patient-therapist relationship.

Conclusion. In the work with a war-traumatized patient, it is inevitable that the patient's feelings are partly shared by the therapist through projective identification. This can lead to the "burnout" syndrome and threaten the boundaries of the therapist's psychological system. The role of the therapist includes not only knowledge but also the personal experience of work on himself. Through the process of therapy and by using interpretations as the powerful tool, the therapist is capable to accept such traumatic feelings and help the patient overcome them, but also to remain within the framework of his role.

Key words: Croatia; defense mechanisms; ethnic groups; psychoanalytic therapy; psychotrauma; war; Yugoslavia

War, being a dynamic process in itself, possesses powerful forces, which are used for destructive purposes. Those forces are brought about by human nature, which has been neither tamed nor restrained through culture and civilization. The inner being of man creates the possessing principle which is the source of destructive power— all that with the purpose of achieving domination, whose intensity, forms, and mechanisms change while violence remains as a constant (1). Violence contains the vast scope of negative aspects, and each individual possessing these aspects has a need to be freed of them because they are threatening. In such situations an individual resorts to regressive and archaic defenses in order for the outside world to receive all his or her unbearable contents. Projection and projective identification, as the most frequent aspects of primitive defense mechanisms, are used because through them an individual is freed from unbearable and threatening tensions (2).

The aim of this report is to show the complexity of therapist's feelings in the work with war-traumatized persons, and to underline the importance of psychological mechanisms taking place in such situations.

The concept of projective identification (2), has found its application in the therapeutic work and has therefore facilitated the understanding and implementation of countertransference reactions that are to be the subject of this paper. M. Klein (2) considered this mechanism to be a regular part of normal development, used with the purpose of the defense against anxiety. This mechanism serves as the omnipotent fantasy of a child where the bad and the good parts of the self are separated and projected into an object in the outside world.

In further psychodynamic research this concept was used not only as a possibility for a better understanding of the object relationships, but also as the possibility for the development of psychoanalytic technique. It became one of the most important terms used for understanding transference and countertransference.

Freud (3) considered countertransference to be unconscious, unresolved conflicts of the analyst creating hindrances in his analytical work. After Freud, psychoanalysts began to consider countertransference to be an important tool in understanding the patient. This concept
was first introduced by Heiman (4) and Racker (5). Heiman believed that the unconscious of the analyst communicates with the unconscious of the patient, and that this rapport surfaces as the analyst’s emotional response to the work with the patient, and can be used as a tool in understanding the patient. Racker held that countertransference is the key to understanding the patient's unconscious processes.

Bion (6) considered projective identification to be not only one of the first defense mechanisms, but also the first form of communication between the mother and the child. With this he explained the situation when a child, when overwhelmed by unbearable emotions, has the fantasy of evacuating them into the mother. Should the mother prove capable of understanding and tolerating these emotions, she can respond to them and accept them so to be able to deal with them.

These concepts allow us to understand how the therapist’s emotions during the communication with the patient become the foundation for understanding the patient. This enables the earliest capacity of empathy, i.e., the capacity to identify other person’s feelings. The basis of this process is entering the part of self having the capacity of self-perception into other person in order to understand his or her emotional experience (7). The therapist’s capacity to contain the emotions aroused by the patient, and to transfer to the patient his or her understanding in the form of interpretation, stands equal to the function of the mother in the early development of the child. Adequate interpretations allow the patient to introject his or her feelings in a modified form, as well as the understanding therapist. In this way the patient obtains a sense of inner stability. Bearing in mind such emotions, the therapist can make use of the countertransference as the source of information on the patient’s emotions, but should also be aware of the possibility of error and, of confusing own emotions for the emotions of the patient.

The question for the therapist is how to differentiate his own emotions in the communication with the patient, how to decide whether they are created by his own psychopathology, or through the patient's projections, or both. This is an important technical problem, the solution of which depends on the therapist’s knowledge, experience, self-awareness, and adequate assessment of the patient. However, if the therapist learns how to use and interpret his countertransference, if he or she is capable of distancing from it and of taking it into consideration, then countertransference can become an important source of information on his or her interaction with the patient, and, at times, even the only key to understanding the events of the session. For this reason it is vital that the therapist follow both verbal and non-verbal communication of the patient, and also their effects concerning himself or herself, in order to use his countertransference as the only available means of registering certain aspects of the patient’s emotions that cannot be discerned otherwise. Therefore, it is highly desirable for the therapist to be open towards his patient's emotions, to allow them to make their impact on him, but also never to neglect observing and evaluating them.

Countertransference to War-Traumatized Patients

The first months of disintegration of former Yugoslavia were in many ways marked by feelings of despair and helplessness, by fear of losses, or by actual losses. The whirlwind of war spread everywhere, using different routes. The former capital of the former Yugoslavia, which was the heart of very many events, was the place where people were confused and perplexed by the events. The war that was gradually spreading to various parts of what used to be our country was an absolute shock to all of us. Many people tried to negate the reality, to refuse accepting it. Gradually we were all immersed into what reality brought to us. I will use several examples of my work with the patients to illustrate the feelings of the people, and also to make clearer the way in which my feelings reflected through the work with these patients.

Case 1

A female patient of Croatian nationality, who was born and grew up in Belgrade, was referred to me, and she came, overwhelmed by fear for her family in Croatia. She was married, lived in Belgrade, and had two children. She gave up her job, remained in her room all the time, and completely ceased any communication. After the introductory conversation, I felt powerless: she communicated to me all her feelings of helplessness and anger and criticized and attacked me verbally, expressing her doubts that I could understand and help her. My attempt at interpretation made her even more furious, which left me desperate, depressive, and with the impression of complete blankness. In the following sessions, which were regularly held, these feelings continued. During one of the sessions, I told her that she wished me to become desperate because that was her own emotion – she had a need to communicate it to me but could not. She began to cry and told me she hadn’t been able to cry or to be desperate since the war started, that she felt paralyzed and helpless, overwhelmed by the feeling of guilt due to her inability to think about her family and her fear for them.

This illustrates that a patient can project into the therapist his or her emotions, which he or she cannot tolerate but unconsciously wants to express. With my patient I realized that those were the same emotions I felt and that the patient actually provoked in me the already existing emotions of despair and the need to cry because there was nothing else for me to do. I felt overwhelmed and paralyzed by the same fear for the people close to me living in Croatia.

The work with this patient continued for three years. During this time she constantly brought to me material related to her fear of death, separation, and loss. She talked about her close relatives who were wounded or killed in the war, about the separation from her parents when she got married, and the feeling of guilt concerning all of them. At times she was completely overwhelmed by fear and doubts about her family’s ever accepting her again.

Although matters were essentially related to transference and expressed her fear that she could lose me as her therapist as well, I felt her to be a difficult and exhausting
person. It was not easy for me to maintain contact with her. I noticed that I took rather an active role in the sessions, so I wondered whether that was the way of defending myself against her projections. There were long breaks during her talks, and I eventually noticed that that was unusually disturbing for me. Suddenly I had powerful feelings of emptiness, of not existing, and I passionately fought these thoughts. After each of the sessions I tried to think the matters over. I realized that my countertransference reflected the way my patient experienced separation—as terrifying emptiness and absolute non-existence. At the very same time, my fears of separation from persons close to me living in other territories grew stronger. I felt empty, devastated, discouraged, which led to depression and a need to escape. During the next sessions I tried to check whether I could keep my own feelings apart from those of my patient’s. I carefully watched for her reactions to my words, for signs of changes in her moods and emotions or of her ability to make the connection between the past and present experiences, events, and thoughts. I tried to discern whether she could achieve the necessary insight and the feeling of relief.

Analyzing my work with this patient I realized how overwhelmed I was by painful feelings related to the fear of being separated from persons close to me in other parts of former Yugoslavia, and also how I reacted by withdrawal and emptiness in my thoughts whenever she flooded me with her fears of separation. It was obviously the pressure of my feelings and emotions, which were in upheaval and threatened me. However, every time I faced them I was able to acquire new knowledge about myself. In that way, as the therapy went on, my insight and self-knowledge, which had the role of keeping me in the reality, gradually expanded and served to keep apart my own emotions from those of the patient. It was a process which lasted for several years and marked my work in that period until the war came to an end and new possibilities for survival arose.

Case 2

The patient came to me for help because of the fears that she would die and that someone would attack her in the street. At first she did not mention her origins. However, judging from her speech, I guessed that she probably came from Zagreb, which made me feel highly tense. She talked a lot about her family, the unsatisfactory relationships with her mother and, later on, in her marriage. She talked very quietly and rather monotonously, as if feeling sleepy, putting in her words neither energy nor vitality. She was often confused and absent-minded. I would start thinking of other matters and could not understand what she was telling me. Even when I thought I understood something, it would suddenly become lost to me.

My work with this patient provoked many questions. One of them was whether the patient’s communication in such a manner was meant to transfer her emotions concerning her primary object. It was her mother, who was aloof and depressive, and towards whom the patient at that time felt a strong emotion of guilt, thinking that she had abandoned her in such an awkward situation. It seemed to me that my barriers were reflections of her barriers and of her inability to think about the feelings which she experienced as painful and unacceptable. Her confusion affected me, controlled and distorted my capacity to think clearly. I felt her restraint and lack of confidence in me. My words had no effect. Everything seemed hopeless until the moment I decided to talk the way she talked. Suddenly she seemed wide awake, she stared at me and asked if I was a Croatian. I did not answer her question. Full of enthusiasm, she went on to talk about her mother and the difficulties they had faced. I told her I thought that until that moment she had felt that I could not tolerate her emotions, that my only response would be aloofness, which in turn had made her suspicious and reserved. She revealed that she resisted telling me about her feelings, particularly because she remembered her mother speaking a different language. She thought that they had actually never had a common language. At that moment, when she heard me speak, she suddenly felt I was able to understand her and she brightened up.

In the following therapy sessions it became obvious that the patient was frightened of her own desperate need for other people. The situation of inevitable separation that she found herself in caused the fear of loss and punishment, which was also meant for me, because I was the one to be flooded by her unbearable emotions. As the therapy went on, the patient became afraid of becoming dependent on me and the therapy. She told me once—“What if you too were to leave?” That was, in fact, her way of influencing the countertransference, through attacking my cognitive capacity and my capacity to “feed” her during therapy. Her aim was to avoid possible feelings of dependence, inferiority, and loss. As the therapy went on, she grew more and more willing to tolerate her feelings, and I felt much better and more capable of thinking about our sessions. I was therefore able to turn this uneven therapy into a smooth therapeutic process.

Case 3

The patient was a Serbian refugee from Croatia. She was a student and came to Belgrade with her family. It was troublesome for her to adjust to her new surroundings, and she also experienced difficulties in studying. She came to me because one of her relatives had asked her to. During the introductory sessions, she was silent and reserved, and I was not able to get from her anything to use in interpreting her feelings. Then she told me about the possibility to go and live with an elderly lady, who was a Croatian. She would have to take care of her, and in return would have the peace she needed for studying. I expressed my support for that idea.

During the next session I found her quite cheerful. She told me that finally there was someone who spoke her language, someone with whom she could maintain the relationship of mutual understanding. I told her that my impression was that she was satisfied by my support for her moving in to live with the old lady. She was obviously happy at my words and said that my support had been invaluable, because she felt it to be a kind of relief for her feelings of insecurity concerning the move. She also told me of her being peaceful, and finding new pleasures in communicating with people, since she had been lonely and helpless for a long period of time. She also expressed her belief that the therapy had brought her back to life.
My thoughts were concerned with the patient's use of the positive aspects of transference (8), which also meant imposing a certain role upon me, the role I also felt and experienced. I felt I had a lot of understanding and compassion for my patient, which was actually the reflection of the patient's and my feelings becoming confused. My patient made use of that through her unconscious mechanisms, which served to bring the process of therapy to a standstill. Inevitably, my further understanding of her unconscious mechanisms was slowed down. In this particular situation, my feelings were much too close to my patient's, which made adequate interpretation almost impossible.

All this served to make me aware once again of the fact that the relationship between the patient and the therapist is quite special, and that the therapist should at all times beware of being drawn into the countertransference traps set by the patient.

Thinking about my confusion about the borderlines of the therapy situation, which has its strict rules, made me feel incompetent and helpless. However, my thoughts also dwell on the particular difficulties of the therapy in such circumstances, and on the inevitability of the therapist's being engulfed in the same reality as his patient's, which made it extremely difficult to strictly adhere to the rules of the therapy procedures.

Discussion

When I think about my work during the war in the former Yugoslavia, I am overwhelmed by feelings of helplessness and insecurity. I cannot but wonder whether I succeeded in helping my patients, bearing in mind my own diverse and alternating feelings, which often rendered me helpless.

These feelings and emotions on my part can be related to the aspects of countertransference where the therapist's abilities of understanding may be impaired. However, I attempted to use them in order to acquire new knowledge about the interactions with the patient. In such a situation, according to R. Money-Ryrl (9), the therapist has a complex task of becoming aware of his or her own feelings of conflicts and fantasies that have made it difficult to understand the patient, i.e., which feelings and/or fantasies of the patient caused such responses. However, the same author points out that those are the very stages in therapy when the therapist is able to expand his or her insight, solve some of the problems, and learn more about the patient, through analyzing his or her own responses.

The most difficult part of my work was doubtless destructive criticism deprecating my work, and the need to belittle the value of my work. Under such influences I felt helpless, worthless, and professionally incompetent. I put a lot of effort into trying to overcome such feelings and to bear the patient's projections. I found it most difficult to do so when I was involuntarily given the role of a helpless, confused, depressed, and cruel person, since my feelings in such situations were that my patient sees me as a hostile figure about to penetrate into his or her being in a hostile manner.

I used the countertransference feelings in order to find about the patient's feelings. When I succeeded in my attempts, I was able to recognize my patient's painful awareness of her own inferiority, and of being dependent on the therapist, as well as her attempt to deny, in an omnipotent way, these feelings through projective identification of the therapist with the feeling of inferiority and misery. At times when I did not succeed in that and could not bring myself to tolerate such projections owing to my own feelings of fear that everything I had spent years putting together would fall apart, my reactions during therapy were withdrawal, indifference, or anger. At those times I was not certain to what extent I identified with the patient's projections, which made me feel inadequate and incompetent.

Such experiences in the work with patients can on no account be termed pleasant. Quite often they were invasive and upsetting. I knew that my task was not only to experience them, but also to take them and bear them. These pressures were sometimes subdues, but also from time to time so powerful that I could hardly restrain from acting out. I put a great amount of effort into overcoming them and into discerning the feelings related to countertransference. I used them as a tool in the therapy, as a means of facilitating the process of therapy. In that way I met with the theoretical concepts of Bion (6) concerned with the therapist's ability to contain the patient's projections, to assimilate, analyze and interpret them, thus offering understanding to the patient, modifying his experience, and creating a new psychological environment.

I believe that the work with war traumatized patients demands special efforts on the part of the therapist, since there exists a possibility that the therapist may experience the feelings and emotions of the patients as his or her own, i.e., overwhelmed by projective identification (10).

The modifications I used in the therapy of the described cases were mostly related to the non-application of the usual transference interpretations, caused by the events in the reality, which overwhelmed both my patients and me as their therapist. My feelings were quite independent of the modified procedure and at times it seemed as if I suffered from complete inertia of thought and from overpowering despair. This shows that projective identification is indeed a powerful mechanism and that it can be overwhelming for the therapist, who at times finds herself forced to bridge a gap between strictly adhering to the procedure and the actual reality that demands casting it away.

Despite all the complexity such therapy work requires, I found that patients succeeded in fulfilling their unconscious aspirations, i.e., in projecting either the good or the bad parts of the self, in order to be freed from them. Their aim was to destroy or evade separation, and therefore improve the outer object through a certain form of primitive reparation (11).

References

Received: April 26, 1999
Accepted: October 4, 1999

Correspondence to:
ljiljana@bozic.co.yu