Chapter 8

Countertransference in Trauma Clinic: A Transitional Breach in the Therapists' Identity

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Abstract

In line with the theoretical elaboration of countertransference in the trauma clinic, this article addresses the therapist's relationship to the strangeness of the trauma, as well as his/her interaction with the cultural difference of the other, who is in this case, the traumatized patient. Thirty-one therapists were interviewed about their subjective experiences, using the methodology of interpretative phenomenological analysis. This article shows interesting subtleties in countertransference reactions to trauma narratives and sheds light on processes indicative of trauma transmission. Therapists interviewed could express experiencing moments of strangeness and inner disquiet; resonance in the defense mechanisms deployed by therapists and by patients at certain moments of the therapy; resorting to disregarding cultural interpretations/generalizations to make sense of an utterly painful situation and put a protective distance with the patients' culture of origin.

Keywords: countertransference, trauma, humanitarian context, transmission, trans-cultural psychology

1. Introduction

In line with the theoretical elaboration of countertransference in the trauma clinic, this article addresses the therapist's relationship to the strangeness of the trauma, as well as

his/her interaction with the cultural difference of the other, who is in this case, the traumatized patient. Our objectives are to explore the mechanisms implicated in trauma transmission through countertransference reactions in therapists working with traumatized patients and to depict and analyze the processes that could potentially lead to vicarious traumatization.

1.1. Countertransference and trauma clinic

Countertransference is a concept originally coined by Freud [1], referring to the unconscious reactions of therapists to their patients' transference. The classical definition postulates that the implications of a therapist's unresolved childhood conflicts on their reactions require examination in order to be controlled [2].

A broader perspective on countertransference suggests a more totalistic definition [3] and includes the total emotional reactions of the therapist to the patient [4]. Such emotional reactions relate to a variety of factors, such as the therapist's life experiences, inherited internal unknown objects [5], personal psychoanalysis experiences, and theoretical affiliations [2] in interaction with the patient's transference. Therefore, countertransference reactions are bidirectional and refer to the inter-subjectivity of the psychotherapeutic dyad of patient and therapist [6].

In the totalistic perspective of the psychoanalytical theory regarding countertransference, the latter is an essential tool in helping the analyst better understand the patient. The analyst is expected to position himself/herself as a subject of observation and analysis, in order to acquire the required objectivity [4].

Additionally, Balint examines countertransference reactions in non-psychoanalytical situations, focusing on the presence of subjectivity in all therapists and its countertransference mobilization in all types of therapeutic relations [7]. From the same perspective, Devereux [8] broadens the concept of countertransference to include the social sciences and their impact on the findings of research conducted in this domain. Devereux [8] introduces the concept of cultural countertransference, which is related to the position the therapist adopts towards the otherness of the patient and to the latter's cultural codes and perceptions of illness. According to this perspective, cultural transference and countertransference are also influenced by history, politics and geography. Thus, any non-examination of cultural countertransference will compromise the therapeutic alliance and will enhance the risks of aggressive, affective, and racist acting-outs [8].

This aspect of countertransference seems to be of particular interest in the therapy of traumatized patients, although it has sparsely been investigated. Over the past two decades, many studies have investigated the impact of trauma work on therapists who work with trauma patients through the identification of emotional, cognitive, and physical countertransference reactions [9–14] and trauma transmission elements [15]. This accumulation of research has led to innovative concepts such as secondary traumatic stress and compassion fatigue [10], vicarious traumatization [11], and empathic strain [16].

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2. Methods

The clinical material in our research was collected through interviews with ten therapists working with traumatized patients, in a humanitarian intervention context, within which the therapeutic encounter is mostly short and intense. The encounter can occur between an expatriate therapist and a patient, or between a foreign therapist and the patient's community of affiliation. The therapists were recruited through humanitarian institutions that provide psychological care programs in critical contexts (natural disasters, war zones) or within their development missions (malnutrition programs in precarious contexts). We have contacted the heads of psychological programs departments in the humanitarian institutions to explain the research. We have then sent an email explaining the research objectives, the interview procedure, and the possibility to withdraw their participation at any stage of the research. Therapists who were interested in participating to the research contacted us by email. All those contacted met the selection criteria as we had targeted NGO's providing programs in trauma clinic. We set an appointment for the interview that would take place at the researcher's office or the participant's office, at his/her convenience. In a later stage, the interview analyses were sent back to the participants to have their validation of the results.

Sex	Age	Nationality	Years of experience	Field of interventions	Countries of missions	Approach	Access to supervision
Five Men and five Women	Mean= 41.9 Standard deviation = 12,4 Range: 30–63 years old	Belgium; French; Iranian; Lebanese	Mean = 10.9 Standard deviation = 8 Range: 5–30 years	Six on Natural disaster (three earthquakes, three tsunami); seven on War zones (five civil war; one invasion; one war in a context of colonization)	Haiti; Indonesia; Lebanon; Occupied Territories of Palestine	Psychodynamic Psychoanalysis Integrative Relaxation Cognitive Behavioral	Eight referred to supervision experience but none had access to supervision on the time of the mission

Table 1. Participants' characteristics.

Our interviews lasted one and a half hours each, were recorded and transcribed, and then analyzed using the interpretative phenomenological analysis (IPA) methodology [17]. IPA provides a dynamic approach of the material and privileges a close access to the participants' experience of the studied phenomenon. The researchers' conceptions of the phenomenon are used to make sense of the participants' personal world through an interpretative activity. Participants' characteristics are described in **Table 1**.

The narratives of humanitarian workers are informative on two levels: (a) the countertransference reaction is one that occurs on-the-spot, in an unusual environment and within an unfamiliar framework for the therapist, and usually in a context wherein certain traumatic events have happened); (b) it allows the observation of a "disquieting strangeness" in the making, throughout the course of the therapeutic relationship, leading to creativity at some times, or to a deadlock in the therapeutic elaboration at other times, and consequently, resulting in a disrupt, or even in the loss of empathy [16, 18]. Finally, it is specifically interesting to see the evolvement of the therapist's narrative and changes in their positions throughout the whole interview.

The objective of our research was to approach the subjective experiences of therapists as closely as possible, through their own narratives. Each interview encompassed the therapist's theoretical background and training, the story of his/her personal traumatic experiences, the context of his/her work, and finally, the description of a specific situation he/she had with a patient. In the last part, the therapist reported the situation, his/her emotional, physical and cognitive reactions, in addition to his/her dreams, and the emergent scenarios towards the trauma narrative.

3. Results

Using the IPA, three themes emerged from the therapists' narratives about their countertransference: (a) personal therapy as a condition and theoretical views on neutrality; (b) attack of the therapists' thinking capacity triggering shame, guilt, and change in worldview; and (c) therapist's issues concerning patients' cultural difference. We will document in the following these three themes reporting when necessary excerpts from certain therapists verbatim. Each therapist is identified by the letter T. followed by a number.

3.1. Personal therapy as a condition and theoretical views on neutrality

The interviewed therapists highlighted the importance of personal analysis as a condition that promotes countenance capacity and elaboration of the countertransference reactions. For instance, T.10 considers that "*the essential part in therapeutic work in general, but especially with persons who have underwent traumatic experiences, is the personal analysis of the therapist. It is about being constantly vigilant and conscious about everything that is happening, of what we are experiencing with the patient, because the narratives are usually very heavy. A narrative loaded with death drive, aggressive drive, a lot of violence, a lot of themes about death and loss. I consider it to be a very dense narrative that the patient can throw in our face, and if we are not protected enough, it is not an obvious task to really treat the verbal expression, the patient's narrative and help him/her elaborate on his/her experience by himself/herself*".

Therapists head into the journey of trauma clinic with theoretical a priori deployed to anticipate more or less such encounters, mobilizing defense mechanisms that are eventually constructive and useful for their thinking and elaboration capacities. "Theoretically," or as some interview-

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ees would say "ideally," the therapist should be in a neutral and welcoming listening position as T.10 explains: "*I believe that in my practice the following was essential: how to be able to dissociate my inner experience of the patient's narrative from his/her experience, in order to be neutral in my work, to have a benevolent listening as they say, to be interiorly available for the patient's account.*" In response to the question about being affected by a certain situation reported by the patient, some painted a caricature of the affects that could overwhelm the therapist, such as T.9 who says: "*to be affected and say: oh my god, and start crying with the patient? No, no. I don't believe this is what the patient came to look for, or that it could be of any help. So if it is a demonstration, then no. To let yourself get affected by all cases isn't of any help*"; others imagine a pragmatic schema to protect themselves, such as T.1 "*well, I believe that if you are already well protected, it won't affect you. You come, you already have your barriers and so you have your stuff with you that are solid enough. You are able to separate things, have empathy with the patient, help her, and then clean yourself up afterwards, and you are fine.*"

In the same interview for instance, we can notice the gap between the theoretical stance and the lived experience. On that note, T.10 says: "*well yes, during that moment, the limit wasn't clear anymore. For a while, maybe for a minute, I was myself absorbed by what she was saying. It was as if I was in the scene, I was looking at the scene from an outside perspective. And really, there was a feeling of revolt, a feeling of rage. She was sad and I was revolted.*" We can also observe this feeling of being within the scene of the traumatic event in T.1's narrative, who, while recounting his experience of the patient's traumatic event narrative, says: "*I saw all the scene happening, I saw all of that, I was there.*"

3.2. Attack of the therapists' thinking capacity triggering shame, guilt, and change in worldview

T.1 describes his experience while listening to the trauma narrative of his patient *"in this situation, feelings were all confused. There were my feelings, actually the feelings the patient would give me, and then the feelings that a therapist is not supposed to have: injustice, the need to stop the therapy, disgust, the need to vomit, things like that, well, a therapist is not supposed to feel this, but at that moment, I had them*." He repeats twice that a therapist is not supposed to experience such feelings, thus, leading us to the issues of shame within the community of peers and guilt regarding what the professional superego imposes. He continues "*my stomach was knotted with the need to vomit, I felt disgusted, I was horrified and all. I believe that this is all the countertransference of the other, and the need for injustice.*" Herein, we witness an obvious disorganization of the narrative that exposes two Freudian slips: the "countertransference of the other" and the "need for injustice."

The theme of shame recurs in another sequence—in the frame of a post-trauma therapy group interview: a young therapist had of her patient, the image of a Minotaur, a devouring monster. She contemplates the emergence of this image as follows: *"I had a feeling of shame, of disgust by myself, to have had such a feeling that I am not supposed to have. I was a trainee in a learning position, confronted by something that was very disturbing; I know somehow, from what I have learned during my studies, that what I feel towards the patient is good, in the sense of a countertransference reaction that is generally useful working with the patient. But the intensity to that extent was disrupting. In a*

supervision group, I would express this experience in a more intellectualized way, in terms of dehumanization. I wouldn't have been able to express it as is. I am dealing with an image of an aggressor, to whom I am supposed to be welcoming. I see the patient as an aggressor, like the Minotaur who is aggressive, it devours." The therapist here is deeply disturbed by her discovery of certain cruel sensations in herself towards this patient and by being prompted into an archaic fantasy of devouring. T.1 had also referred to "something archaic" that was awaken in him in the situation he reported.

In this sense, T.9 says: "*On the long term, it is inscribed in us (…). Thus, it is repetitive, and indeed, we are much more sensitive to what happens in the world around us."* This heightened sensitivity is also reported by T.8 who describes a sense of a widening gap with others once she is back from her mission, she says: "*for example, I go to a movie that takes place in a shantytown. The movie contains lots of scenes happening in the shanty town where I had worked, of which I was an indirect witness with the children. And in the movie, it is so distant from the reality of the spectators, and I had this feeling that people around me were not in the reality. They could almost laugh or… well I had cried as if … I was crying out of shock. (…) It was terrible because the shanty town, at some point, is put on fire, and the shanty town where I was, had been put on fire by the authorities in order to empty the terrain (…) and there were children and families who died there (…). For me, it was serious; it is something that happens in real life. So, not only was there a whole gap between me and the people in the audience, but really I felt almost traumatized."* As shown in these illustrations, therapists report a change in their worldview once they return to their home country in the aftermath of a humanitarian mission.

3.3. Therapist issues concerning patients' cultural difference

In contexts of expatriation and inter-community differences, therapists tend to highlight the cultural differences as a difficulty or sometimes as an impediment to the therapy with the patient. In this sense, T.8 explains " *I am always afraid that they (the target population) see me as a traditional therapist or a priest or something. In my dream, I had that role in the ceremony*." This account clearly reveals a fear of self-loss, of depersonalization.

T.9 recounts a situation wherein she was confronted by a mother who—as T.9 puts it—"*preferred to let her child die"* of malnutrition. T.9 found herself incapable of helping the mother, or of providing her with therapy: "*when it is about a mother who is really 'closed,' I don't understand the culture she lives in, I don't know enough to understand this mother, what motivates this mother to do so. I don't know how to help her get out of this circle. Therefore, I passed it over."*T.9 refers to culture without grounding her account in any etiological theory or cultural genealogy. Moreover, she says: *"well, I mean, I can understand that for some mothers who have five or six children, and who live in economic situations, in some countries where they cannot find ways to nurture their children, the only way would be indeed to have one child who suffers malnutrition, as a way to benefit from food program's help for this child, and then share the food with the others, while letting this one die, because in all cases he is already malnourished, and thus 'uninteresting.' So, in a way, in such situations, mothers can be violent with these children. Well, I understand her functioning modality. I understand why she is like this. Nevertheless, what I can't always do is to find a way to make her understand that this is a child, this is a life. Wouldn't there be other means? Can't we together find other means to help feed the*

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others without letting this child die?" So for T.9, this mother had been forced to pick and choose between her children, as she was unable to feed them all. This functioning would be grounded in "cultural thing." To another question in the interview, the same therapist responds: *"well… actually, in general, whether it is within a humanitarian action or not, we arrive with a mandate and a specific project. Therefore we cannot accept all of the patients who had been traumatized, not when they do not fit our program. Therefore yes, there are persons that we do not accept in the program. And there are persons whom we accept, because, well, we know it entails other implications."* This statement highlights another cultural specificity that regards the non-governmental organization's culture of implementing programs.

4. Discussion

Our research's results draw attention to some of the established theoretical concepts that therapists acquire through their trainings and hold in their background while working in trauma clinic. Representation of neutrality in psychotherapeutic work refers to the first Freudian conceptualization of countertransference (1910) whereby he urges the analyst to have an attitude analogous to that of a surgeon [1]. Neutrality is to be understood here in the sense of the imperturbable, as Donnet highlighted in his article "Neutrality and the gap subject-function" [19]. Nevertheless, while exploring the therapists' elaborations on specific clinical situations, theoretical stances seem to fade in favor of the clinical experiences as experienced hands on. Therefore, we can note particularly intense countertransference reactions that seem to disrupt the therapist in his/her theoretical assets, consequently unsettling his/her professional identity.

The dread produced by the trauma entails a threat of self-annihilation, hence, mobilizing defense mechanisms that are immediately operated by the person. These defenses—actualized in narratives of traumatic experiences—induce a major part of countertransference reactions. In this sense, actualized defense mechanisms deployed by the patient during the session underpin the countertransference reactions of the therapist, a sort of countertransference that is specific to the encounter with trauma.

The fascinating encounter with the unthinkable of the trauma conveys traumatic substance through infra-verbal channels. This substance is deposited into the therapist's psychological system. Yet, as Bion [20] elaborated, this psyche is the means to transform the beta elements (raw, unthinkable, unlinked sensations) into alpha elements (representable, metabolizable elements). What happens then, within the therapist's psyche, when these unidentified sensations are deposited into him/her through projective identification mechanism, making him/her share the unedited transgressive experience? We witness then an attack of the thinking capacity of the therapist. For instance, the slips highlighted in the results seem to underline a strong resonance with two mechanisms deployed by the patient: one, dissociation, through the therapist's concordant identification with the patient's self; and two, an identification with the aggressor, in an attempt to escape the helpless state of the patient, through mobilizing

complementary identification, in the sense that the therapist identified with the object-aggressor incorporated by the patient.

On one hand, trauma seems to revive the "unshaped substance" of an era associated with cruelty, which itself could be the origin of the feelings of shame, and the threat of unsubscribing from the peers community. On the other hand, archaic resurrections of cruelty are hardly bearable by the therapists, at least in the first phase. Such archaic resurrections seem to obstruct the thinking and elaboration capacities of the therapists, even within the framework of supervision, which is supposed to act as a holding and transforming space for these feelings.

As Heimann stated in [21], such elaboration spaces are supposed to render the analyst capable of containing feelings within him/her, instead of simply expelling them as the patient would do, in order to subordinate these feelings to analysis, whereby the therapist functions as a mirror reflection for the patient.

Nevertheless, it would be misleading to believe that the countertransference analysis grants the analyst the possibility to control his/her inner reactions, as Freud urges [1]. Margaret Little [22, 23] formulates the concept of countertransference analysis as an insufficient remedy with inevitable remains unconscious infantile countertransference.

Some of the interviewed therapists, described timidly and with a surprised tone, the resurrection of what they qualified as "archaic," despite the long personal analysis and regular supervision that they have engaged in. It is significant to note here that the supervision space is not always experienced as a room for free and spontaneous expression, but rather, as a space wherein the therapist is required to intellectualize his/her countertransference experiences. This brings to mind what Heimann [21] highlighted regarding the difficulties that analysts face to admit their errors and discuss the issue "we all have our private cemetery, but not all graves have tombstones."

Another aspect of countertransference which emerges in the interviews, is that related to cultural issues. In line with Devereux [8] and Nathan's theories [24], Moro [25] specifies that the cultural countertransference emanates from the inner stance of the therapist and influences this very stance regarding the patient's otherness. The stance is underpinned with the therapist's personal history, as well as the collective, political, geographic, and socioeconomic history. In contexts of expatriation, therapists sometimes describe a phase of loss of cultural references and know-how, and find themselves confronted by a double-layered otherness: the first being the trauma, and the other being cultural otherness. The difficulty facing trauma sometimes resorts in disregarding cultural interpretations and making generalizations to make sense of an utterly painful situation and put a protective distance with the patients' culture of origin. At first level interpretation, the cultural dimension seems to have obstructed the possibility of engaging in therapy: The therapist was confronted by a dead-end that of cultural difference. However, what we observe here is a displacement of the products of traumatic reality lived by the therapist, for instance the unbearable guilt and violence, and relocating them to the "stagnant" and "unchangeable" host culture itself, in a defensive move that consequently maintains security for the therapist, by masking social injustices and deferring the dread for reality until a further notice. The violent socioeconomic reality—which is

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probably a source of guilt for non-governmental organization staff (who live in relatively comfortable conditions in comparison to the context's reality)—is conflated with the violence of cultural otherness, and probably with the violence of the trauma problematic. Clearly, in humanitarian contexts, expats often find themselves obliged to "pick and choose" the patients they accept in their programs. They too, engage in prioritizing needs/demands, and thus, operate on basis of selectivity. What we observe here is a displacement mechanism: the therapist, deployed in a foreign culture, is confronted by a traumatic encounter with traumatized patients, from a target population that is enduring severe socioeconomic precariousness. Defensively, the therapist assigns to the host culture, the unbearable guilt of having to select and to prioritize. Thus, the culture becomes the platform within which this violence is contained and made sense of. The transgressive aspects of the trauma narratives are the most implicated in the disqualification of the patients' culture of origin. The transitory disruptions in the therapists' beliefs highlight the particularly intense mobilization of countertransference reactions to trauma. Exploring the disorganization in each therapist's narrative structure reflects the style of that therapist's defense mechanisms implicated in countertransference.

This double-layered otherness, trauma and cultural difference, questions the therapist's identity, both, the professional and the human, hence, disrupting their working capacity at certain times.

5. Conclusion

To conclude, we would like to refer to Françoise Davoine [26]: "the trauma asks the analyst: who are you?" Trauma calls into question the very identity of the therapist, disturbing his/her narcissistic assets by evoking questions that concern his/her affiliation to the human community.

This study reflects subtleties in countertransference reactions to trauma narratives and sheds light on processes indicative of trauma transmission. It also provides corroborative evidence to previous study findings in the field of countertransference to trauma work. The findings underline the presence of trauma transmission and depict some of the channels through which it is conveyed within countertransference reactions. However, this transmission is not static and does not necessarily obstruct the therapeutic alliance, insofar as the examination of countertransference reactions helps transform trauma transmission elements into means to better understand the therapeutic process.

Moreover, as seen in some therapists' narratives, the angst triggered by the cultural difference complicates the transforming function of the countertransference. What would be the impending future of the trauma residues deposited in the therapist's psyche? Our results have shown different paths for investigation. Themes of shame and guilt have emerged in therapists' narratives seemingly arising from the transgressive encounter with the not-to-be-seen aspects of the trauma, and hence, entailing counterattitudes and reactions that can be hardly shared with peers. Furthermore, the inscription of un-representable elements of trauma on the

therapist's body that can be observed through somatic symptoms experienced by our participants–therapists while working with their patients on the trauma narrative

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References

[1] FREUD S. (1910). Perspectives d'avenir de la thérapie psychanalytique. In: La technique psychanalytique. trad. fr. A. Berman ed. Paris: PUF; 1953. p. OCF.P, X, 1993; GW, VIII.

[2] MARTIN CABREL J. (2000). La contribution de Ferenczi à la notion du contre transfert. Filigrane; printemps: pp. 7–18.

[3] KERNBERG O. (1965). Notes on countertransference. Journal of the American Psychoanalytic Association. 13. 38–56.

[4] RACKER H. (1957). A contribution to the problem of countertransference. Psychoanalytic Quarterly. 34. 313–324.

[5] DE URTUBEY L. (2006). *Des origines du contre-transfert*. Revue Française de Psychanalyse. LXX. 2. pp. 371–384.

[6] SHUBS C.H. (2008). Countertransference issues in the assessment and treatment of trauma recovery with victims of violent crime. Psychoanalytic Psychology. 25. 156–180.

[7] BALINT A., BALINT M. (1939). On transference and countertransference. International Journal of Psychoanalysis. 20. 223–230.

[8] DEVEREUX G. (1967). From Anxiety to Method in the Behavioral Sciences.Paris: Flammarion. 1980.

[9] DANIELI Y. (1980). Countertransference in the treatment and study of Nazi Holocaust survivors and their children. Victimology: An International Journal. 5. 355–367.

[10] FIGLEY C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: an overview. In C.R. FIGLEY (Ed.).*Compassion Fatigue: Coping with Secondary Stress Disorder in Those who Treat the Traumatized*. New York, NY: Brunner/Mazel. pp. 1–20.

[11] MCCANN I.L. & PEARLMAN L.A. (1990).Vicarious traumatization: a framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress. 3. 131–149.

[12] PEARLMAN L.A. & MACIAN P.S. (1995). Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*. 26. 558–563.

[13] DALENBERG C.J. (2000). Countertransference and the Treatment of Trauma. Washington: American Psychological Association.

[14] SABIN-FARELL R.& TURPIN G. (2003). Vicarious traumatization: implications for the mental health of health workers. *Clinical Psychology Review*. 23. 449–480.

[15] OUSS-RYNGAERT L. (2006). *Transmissions des traumatismes psychiques de la mère au bébé*. In BAUBET T., LACHAL C., OUSS-RYNGAERT L. & MORO M.R. *Bébés et Traumas*. pp. 99–134. Collection Trauma/La Pensée Sauvage éd.

[16] WILSON J.P. LINDY J.D. RAPHAEL B. Empathic strain and therapist defense: type I and II CTRs. In: Countertransference in the Treatment of PTSD. New York, NY: The Guilford Press; 1994. pp. 31–61.

[17] SMITH J.A. FLOWERS P. LARKIN M. Interpretative Phenomenological Analysis, Theory, Method and Research. SAGE ed. London: SAGE; 2009.

[18] WILSON J.P. LINDY J.D. Empathic strain and countertransference. In: Countertransference in the Treatment of PTSD. New York, NY: The Guilford Press ed. 1994. pp. 5–30.

[19] DONNET J.L.(2007) "la neutralité et l'écart sujet-fonction" in Revue Française de psychanalyse, Paris, PUF 2007/3

[20] BION WR. (1962). *Aux sources de l'expérience* — 2nde édition. Paris: PUF. 1991.

[21] HEIMANN P. (1950). A propos du contre-transfert. Le contre-transfert. Paris. Navarin. 1987.

[22] LITTLE M (1951) Countertransference and the patient's response to it. IJP 32, 1951, 32–40.

[23] LITTLE M (1981) Transference Neurosis and Transference Psychosis. Toward Basic Unity. New York u.a. traduit en 1991 Des états-limites: l'alliance thérapeutique.

[24] NATHAN T (1977). Sexualité idéologique et névroses. Essai de clinique ethnopsychanalytique. Grenoble. La Pensée sauvage.

[25] MORO M.R. (1991). Essai d'analyse des propositions thérapeutiques spécifiques en entretien ethnopsychiatrique mère-enfant, Psychologie Française, 36–4, 307–322.

[26] DAVOINE F (2014) Intervention à la journée de l'URFT de Saint-Denis; Quels traitements pour l'effraction traumatique? Le traumatisme dans tous ses éclats.