Immigrant Psychotherapists and New Zealand Clients

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Abstract

There has been a gradual increase in the number of overseas born and trained mental health professionals practicing in New Zealand. This paper, based on an interactive workshop, looks at those factors which shape the therapeutic relationship between immigrant psychotherapists and New Zealand clients. Variables discussed include: a) the therapist's attachment style and resultant ability to tolerate, process and mourn the multiple losses including friends, family and clients; b) the therapist's phase appropriate use of defences; c) the complementary attitudes and projections of the host country, colleagues and clients; and d) the degree of perceived difference between client and therapist.

Introduction

The migration of people from one country to another is as old as human history. However, it is only in the last few decades that there has been such a significant increase in international migration of highly qualified professionals including mental health practitioners. Akhtar (2006) points out that there has been an "an increase in the number of culturally diverse trainees in psychology, social work, psychiatry and psychoanalysis" (p. 23).

There was a noticeable absence of early psychoanalytic literature on the subject of immigration, despite so many of the early analysts being immigrants or refugees themselves. It is important to differentiate between the emotional aspects of immigrants and refugees: the former have choice – they are 'pulled' by opportunity, adventure and curiosity, whereas refugees are trapped with no choice and are 'pushed' out. Despite two significant migrations during his lifetime, Freud made little reference to them. When he left Vienna for London at age eighty-two, Freud noted that "the feeling of triumph at liberation is mingled too strongly with mourning, for one had still very much loved the prison from which one has been released" (Gay 1998, p. 9). Possibly the early analysts were more concerned with intrapsychic processes rather than the social context and its effects on internal worlds? Or was it simply a denial of loss and mourning with an over-adaptive need to belong to their newly chosen group?

The fact that these European analysts were not actually immigrants, but exiles, might also have contributed to their silence on this issue. Wanting to forget their traumatic departures from their countries of origin, to deny cultural differences between themselves and their patients, and to become rapidly assimilated at a professional level, they had no desire to draw others' (and their own) attention to their ethnic and national origins. Hence, they wrote little about their experiences in practicing analysis as "foreigners" (Akhtar, 2006, p.23). Over the past twenty years more attention has been given to the process of immigration with some significant contributions from Grinberg and Grinberg (1989), Volkan (1999), Mann (2004) and Akhtar (1999).

New Zealand is a relatively young country populated by many immigrants. A significant percentage of the health professionals practicing in New Zealand were born or trained abroad. Compared to other OECD countries, New Zealand had the highest ratio of foreign-born doctors (52% in 2005-2006) and among the highest for nurses (29%) (Zurn & Dumont, 2008). Anecdotally these rates climb significantly amongst psychiatric nurses, particularly those working in crisis teams, and to an even greater extent amongst psychiatrists. Some psychiatric registrar programmes contain more than 90% of foreign candidates.

A significant percentage of psychotherapists working in New Zealand identify as immigrants. For example at the opening of the 2006 NZAP conference in Wellington, when asked with which part of the world they identified, less than 10% of the delegates placed themselves in the Māori or Pākehā group. Even though these were subjective responses in a particular context, the implications are significant. Similarly a large percentage of psychologists working as psychodynamic or depth psychotherapists are trained abroad.

This paper focuses on the process of immigration and the resulting interaction between the immigrant psychotherapist and the New Zealand client.

Immigration

Stress is caused by 'too much change, too quickly, with insufficient preparation'. The process of immigration brings multiple layers of change in its wake. In addition to the loss of parents and family, some of the more predictable stressors are the change in friends, colleagues, social and financial status, housing, culture, educational systems, politics, geography, climate, food, dress, language and identity. Calvo (1977) points out how immigrants need to endure the devastating feelings of loss, while at the same time making intense efforts to adapt to the new environment.

Striking a positive chord, Grinberg and Grinberg (1989) discuss the psychological advantages of immigration. They point to the possibility of true growth and development if the immigrant is able to tolerate the disorganization, pain and frustration and to work through and overcome the losses and conflicts.

Emigrating therapists leave their clients behind in the old country. The process of mourning lost clients is influenced by the different strengths of sadness, anger, guilt and relief as well as duration and depth of the relationship. Therapeutic relationships characterised by conflict and ambivalence, which may escalate after the therapist's declaration about emigrating, are more difficult to mourn. This extremely stressful termination period is characterised by endeavouring to balance respectful due notice to clients and colleagues without jeopardising referrals and income. Frequently all of the therapies are terminated within the space of a few weeks, at a time in which the therapist is chaotically packing, planning and saying farewell to everyone else. Therapeutic endings are confidential and there are no public acknowledgements or rituals to facilitate the process. The consequence is that the way therapists relate to clients in the new country will be determined by how they have worked through and mourned the loss of those in the old.

Some of the complexities specific to psychotherapists immigrating to Aoreatoa/New Zealand include:

1. The infantilizing and narcissistically injuring process of 'jumping through the hoops' of professional re-registration. This is particularly bewildering for therapists arriving from countries with larger and more established analytic traditions.
2. The public confusion between counseling and psychotherapy and the lower status accorded to psychotherapy than in other OECD countries.
3. The different cultural values reflected in the 'doing rather than being', 'number eight wire', and the 'tall poppy' syndromes.
4. The Treaty of Waitangi and the divergent ways Maori and Pakeha view psychotherapy.
5. The domination of the behavioural model and antipathy towards depth therapy found in many universities and District Health Boards. For example psychotherapy was not mentioned in the Ministry of Health funded document on 'Talking Therapies' (Peters 2007).
6. Development of new professional and referral networks.

7. Learning about and adapting to different implicit therapeutic styles and psychotherapy politics, i.e. the splits between psychotherapy and clinical psychology, and the complicated role of the Accident Compensation Corporation (ACC).
8. Recognizing the subtly different ways in which New Zealand clients present, their expectations and their styles of interpersonal relating.

Splitting

Deep sorrow about the multiple losses, coupled with excessive needs for adaptation, leave immigrants vulnerable with weakened ego resources. The most frequently used defence in the 'honeymoon phase' of the first few months is a manic one. The over activity and manic energy fuels the immigrant's idealized aspirations and hopes of the new country. Fantasies of a land with greener grass, milk and honey are amplified by the omnipotently tinged marketing slogans such as "Godzone". The idealization is frequently followed by a sudden crash into devaluation when confronted by a xenophobic reaction as the one described by Kafka (1958):

> Your ignorance of the local situation is so appalling that it makes my head go round to listen to you and compare your ideas and opinions with the real state of things. It's a kind of ignorance that can't be enlightened at one attempt, and perhaps never can be. Never forget that you are the most ignorant person in the village, and be cautious (p.62).

In order to reduce the chaos and pain, and slow down the internal psychic process in order for the ego to be able to marshal its resources, the immigrant starts regressing and makes prudent use of splitting. A similar process is evident in children after families have separated and are adapting to new environments and people. The defence takes the form of retrospectively idealizing and overvaluing the lost country and devaluing the new (Lijtmaer 2001, Akhtar 1999). This is the most evident when immigrants indulge in a "when we" style of nostalgia while at the same time complaining about the new culture.

Authors such as Marlin (1977) and Volkan (1999) conceptualize nostalgia as a fantasy-based return to that which the person never had. However, if used judiciously, nostalgia creatively slows down and assists the process of mourning. As Wernan (1977) states,

> The failure of mourning leads to a continuing search for the idealized lost object, an inability to love new objects, a depreciation of objects

> in one's current life, and an endless pursuit of nostalgic memories for themselves at the expense of an inhibition in many areas of existence (p.396).

In some immigrants the direction of the idealization and devaluation is reversed. The new country is counterphobically idealized while the old is spoiled and devalued. A third style consists of alternating shifts in the direction of splitting. These shifts are triggered when the immigrant moves between reference groups with varying biases towards the immigrant's country of origin. According to Ogden (1985) the shifting from one pole of the dialectic to another is part of the later phases of integration leading to a synthesis and emotional resolution.

In addition to the usual forms of splitting immigrant therapists also split along the lines of therapeutic worldview and style. These 'therapy specific' idealizations and devaluations are emotionally fused with the process of mourning and adaptation. Characteristically therapists devalue the 'new' theoretical orientations, views on confidentiality and the frame, frequency of therapy and supervision, mental health organizational structures and support, the mental health act and ACC, professional organizations and their membership criteria, interpersonal therapeutic style etc. Indigenous therapists feel their hackles rising when they continuously hear statements such as "but it worked much better in Shangri-La".

The 50-minute hour takes place behind closed doors within the therapist's domain. Only the supervisor is privy to a filtered version of this private and confidential process. The immigrant therapist may follow a pattern of professional ethnocentric withdrawal by choosing a like-minded immigrant supervisor and developing a peer group with an aligned therapeutic worldview. The analytic ego then becomes resistant to cultural adaptation and may be the last aspect of the immigrant's personality to change.

Grinberg and Grinberg (1989) coined the term 'postponed depression syndrome' to describe how some seemingly well adapted immigrants paradoxically fall into a state of profound sadness and apathy, often accompanied by psychosomatic symptoms, at the point at which they could enjoy the fruits of their hard won adaptation. They suggest three years is the danger point. Walsh & Shuman (2007) attempted to empirically validate the idea that premature adaptation gives rise to later symptom formation. They interviewed 68 emerging adult immigrants around their sense of self, immigration experience and level of psychological and physical symptoms. Subjects were reassessed one year later. Results indicated that attempts to resolve splits early after immigration led initially to a lower

level of psychological symptoms followed by an increase one year later. Conversely those who took longer to adapt, initially exhibited higher levels of symptomatology but were healthier a year later. Walsh and Shuman (ibid) concluded that splits in the sense of self, following immigration, are an adaptive defence, allowing time to adapt and adjust to a new reality, rather than a pathological reaction to the trauma of migration.

The implications are that those immigrants who initially idealize their country of origin, devalue the host country and experience greater levels of mental and physical illness end up being healthier and more integrated than those who used less splitting and appeared to have adapted in the first few years. Paradoxically the 'when we' immigrants who irritate the natives with their devaluing whingeing turn out to be better citizens in the long run than those who initially 'shut up and blend'.

Attachment

Klein (1937) was one of the first psychoanalysts to link the immigrant's sense of mourning to the loss of the original maternal object:

> Thus we speak of our own country as the 'motherland' because in the unconscious mind our country may come to stand for our mother ... In psycho-analytic work it has been found that phantasies of exploring the mother's body, which arise out of the child's aggressive sexual desires, greed, curiosity and love, contribute to the man's interest in exploring new countries ... In the explorer's unconscious mind, a new territory stands for the new mother, one that will replace the loss of the real mother. He is seeking the 'promised land' – the 'land flowing with milk and honey'. We have already seen that fear of death of the most loved person leads to the child's turning away from her to some extent; but at the same time it also drives him to re-create her and to find her again in whatever he undertakes. Here both the escape from her and the original attachment to her find full expression (1937, p. 333).

Recent neuroscientific evidence (Schore, 2001) built upon the work of Bowlby, Winnicott, Main and others, has confirmed that the quality of childhood attachment is intimately linked with patterns of interpersonal relatedness throughout life. Immigration is all about attachment, separation, loss, and re-attachment. The authors propose that this even influences the choice of country for immigration.

Based on Ainsworth's Strange Situation Test and the resultant Adult Attachment Interview we can see adult styles of relating to primary

attachment figures parallel the attachment styles identified in the early maternal relationships. Hazan and Shaver's (1987) research showed childhood attachment styles are evident in adult romantic relationships:

> ...attachment styles of couples can be viewed in terms of the answer to the question "Can I count on this person to be there for me if I need them?" If the answer is "Yes" in a positive and secure way, the partners feel confident that they may rely on each other, have open communication and experience flexible co-operative relationship. If the answer is "Maybe" partners tend to have an insecure-ambivalent style with vigilance about loss, and alternating clinging and angry demands for reassurance. If the answer is "No"... in the resulting insecure-avoidant attachment style, the partner avoids closeness or dependency, denies the need for attachment, and views others with mistrust (Goldstein and Thau, p. 268).

The way in which the immigrant responds to the host country may be similar in style to how he or she relates to the other in a partner relationship. The authors postulate that immigrants' attachment styles influence their process of leaving and arriving in the new environment. Being separating from the 'motherland' re-activates early attachment issues and affects the immigrant's ability to settle in the host country. These re-activated early patterns will be mirrored in relationships with partners and clients. The way in which the mourning and integrating into the new country is managed may be dependent on the original attachment process in early life. How was the first rapprochement phase handled, as well as the adolescent process? Akhtar (1995) refers to immigration as the third separation-individuation phase.

Just as relationship with the self often becomes adversely affected by immigration, so do other significant relationships i.e. with partners, family members, colleagues and clients. The stressed immigrants are forced to turn to those closest, frequently with detrimental effects imploding within these relationships within the first few years after arrival. Often splitting, melancholia, resentment, somatising and mourning symptoms are experienced within partner and family relationships. Relationships that were under strain before immigration, often crack, break down and fall apart with the extra pressure. The resulting loss of the significant intimate relationship adds to the difficulties of settling into the new country and maintaining a cohesive sense of self.

It is suggested that the original attachment style affects the immigrant therapist's decision to emigrate, the ability to process the difficulties, and

may affect the ability to work productively in the new country. In addition, how effective is the new country at providing a secure base for this newly arrived therapist? As Winnicott said "there is no baby without a mother"; so there is also no partner without the other, no immigrant without a host environment and no therapist without a client. Can immigrants count on the new environment to be there for their needs so that they in turn can provide sufficient holding for their clients? How does an environment of ignorance, neglect or even xenophobic rejection affect the newly arrived therapist? The way in which each attachment style may play itself out in the immigrant therapist is discussed below.

Secure attachment

Securely attached infants in the Strange Situation sought their mothers when distressed, seemed confident of her availability, were upset when she left, eagerly greeted her upon her return and were readily comforted by her embrace. Mothers of secure infants responded more promptly to their babies, offering affectionate joyful holding. The babies returned to excited or contented play.

It is proposed that securely attached immigrant therapists seem confident of their nationality, are upset and mournful on emigrating, eagerly greet the new motherland upon arrival, are comforted in their mourning by her warm responsive holding, and are able to continue with creative playful practice.

Insecure-Avoidant

Avoidantly attached children depended less on their mother as a secure base, sometimes attacked her aggressively, were far more clingy and demanding than the secure children in the home environment and despite often being just as openly upset by the mother's departure, showed no interest upon her return. Mothers tended to interact less with their babies and in a more functional way. These children remained watchful of mother and inhibited in their play.

Insecure-avoidantly attached immigrant therapists depend less on the motherland as a secure base, sometimes attack her aggressively, and are more clingy and demanding in the home country. Despite being just as openly upset and distressed on emigrating, these immigrants show no interest in transitional phenomena, or in returning for visits. The new country feels unresponsive and they remain watchful and inhibited in their therapeutic practice.

Insecure-Ambivalent

Insecure-Ambivalently attached children tended to be the most overtly anxious, and the most clingy and demanding at home. Upset when abandoned, they sought contact when reunited, but resisted by arching away, or remaining limp, in the mother's embrace. Unsoothed, they continued to alternate between anger and clingness. Mothers of these children tended to ignore their babies' signals for attention and be unpredictable in their responsiveness. Exploratory play was inhibited.

Insecure-ambivalently attached immigrant therapists are the most overtly anxious and demanding in the home country. Distressed at the time of emigration, and although seeming to seek contact when arriving in the new country, they resist by turning away from a dismissive environment and remain apathetic and uninterested. These immigrant therapists cannot be soothed, and continue to be angry and complaining. Creative and exploratory therapy practice is unsettled and inhibited.

Insecure-disorganised

Insecure-disorganised children showed a diverse range of confused behaviours when reunited. The children appeared to be both drawn to and fearful of their mothers, who had unpredictable and detached responses to their babies. Instability of attachment or oscillations between dependency and detachment were typical in both mother and baby. Play was confused, inhibited and erratic.

Insecure-disorganized immigrant therapists show a range of confused and unpredictable responses to the home country prior to leaving, are distressed at emigrating as well as on arrival in the new environment that is viewed with suspicion and hope. They display ambivalence about returning for visits to the homeland. There is a possibility of disintegration, psychic collapse or even psychotic breakdown. Therapy practice may have to be adjourned to facilitate recovery.

Language

As part of attachment, language is the most important of the cultural transitional phenomena that keeps the new settler linked to the original motherland. Food, folklore, religious rites, music etc are all linked to language. In addressing the process of splitting in immigrants and bilingual persons, Marcos, Eisma and Guimon (1977) emphasized how they experience a dual sense of self, depending on the language that they speak.

On the positive side bilingualism provides an ability to stand in another's shoes, to experience another's culture from the inside, and early in life possibly helps in the process of mentalisation.

Akhtar (2006) suggests that words with the same denotive meanings in two languages are often capable of stirring up different associations and affects. One of the authors observed a client who tended to alternate between her mother tongue and her second language. The issues brought to therapy and the affect displayed was markedly different depending in which language the client was immersed. Similarly, Javier and Munoz (1993) point out that memories recalled in the actual language of an experience are more affectively charged and vivid than if they are recalled in a different language.

Language is strongly linked to our sense of identity, and when an immigrant's sense of self is already under threat, the additional difficulty of having to manage living and working with a second language adds to potential destabilization. As Mirsky (1991) points out:

> The loss of the mother tongue in immigration is accompanied by a deep sense of loss of self-identity and of internal objects. Learning a new language involves an internalization of new objects and self-representations and reactivates the internal process of separation (p.620).

How does this affect an immigrant therapist in transition, already struggling with a transforming and possibly fragmenting sense of self, to have to translate into a second language? Akhtar (2006) puts it like this:

> The bilingual analyst's own language-related inner experience has remained unexplored in the literature. This is surprising, since an immigrant analyst often conducts treatment in a language other than his mother tongue, and this must, from time to time, impact his analytic capacities…(he) might occasionally miss puns, double-entendres, metaphors, or allusions (p. 31).

This is problematic when patients arrive in our rooms wanting to be understood, and wanting to understand without the added effort of trying to decipher the therapist's pronunciation or cultural peculiarities. If the immigrant is a 'hidden' immigrant there may be little to indicate this to the patient – the therapist may speak the native tongue of the country, and look ethnically similar, but hide a vast difference of experience and culture.

Degree of perceived difference between client and immigrant therapist

The degree of difference between the therapist and client influences the therapeutic relationship. In order to provide an estimate of the perceived degrees of difference between the immigrant therapist and client, the authors constructed the following rudimentary scale. It has proved to be a useful tool in stimulating discussion in workshops and discussion groups. The items chosen appeared most frequently in the therapy conducted by the authors as well as in conversations they had with colleagues and the public.

Client and Immigrant Therapist Degrees of Difference Scale

Skin colour

0 1 2 3 4 5 6 7 8 9 10

Language (accent)

0 1 2 3 4 5 6 7 8 9 10

Worldview/culture

0 1 2 3 4 5 6 7 8 9 10

Distance from "home"

0 1 2 3 4 5 6 7 8 9 10

Time self and/or family has lived in Aotearoa/New Zealand

0 1 2 3 4 5 6 7 8 9 10

Total degrees of difference (average)

0 1 2 3 4 5 6 7 8 9 10

This raises the perennial question of optimal therapeutic difference, distance and flexibility. For argument's sake the scale could be divided into three levels of difference. At lowest level of perceived difference, the therapist can easily identify and empathize with the client. Their shared scotoma keeps the work at the level of simple counseling and precludes interpretive work on the unconscious. At the middle level the optimal difference provided by the immigrant therapist facilitates the client's ability to break free of their invisible social and cultural defences. The client can alternate between identifying with the therapist and using them as a different object. At highest level, the differences outweigh the empathic common ground. The gap is too wide and the therapy may falter at the initial interaction. In New Zealand many

immigrant psychologists and psychiatrists, who would fall into level three, work for government organizations providing free or subsidized therapy. The disjunction is at its height with these therapists consulting clients often on the lower socioeconomic end of the spectrum who are less well traveled and au fait with foreign values and cultures.

Gedo and Gehrie (1993) describe difficulties faced by therapists at the extreme end of the scale:

> The deck is stacked against an analyst's treating someone from an entirely different cultural background with no knowledge of that background. An analyst relies heavily on shared cultural meanings in any analysis, as in any sort of intimate communication. Possibilities for misunderstanding are so broad as to be endless and not correctable solely on empathy (p. 5).

Work as a psychotherapist

In a recent paper Akhtar (2006) evocatively describes some of the technical challenges faced by the immigrant therapists. These are: a) maintaining cultural neutrality by remaining equidistant from their own and the client's cultural patterns of thought and moral dictates; b) curiosity and 'gentle scepticism' regarding the client's unconscious choice of an immigrant therapist with its accompanying projections; c) inter-ethnic clues to deeper transferences; d) conducting therapy in a different language to their mother tongue; and e) avoiding shared projections, acculturation gaps and nostalgic collusions when working with clients from similar ethnic backgrounds.

A career provides the worker and their family with money, status, security, and a sense of belonging. The more time, money and energy invested, and the fewer outside satisfactions and interests, the greater sense of identify is fused with the career. Similarly, practicing as a competent and useful psychotherapist in the new country provides the immigrant with a sense of identity, purpose, and 'going-on-being'. When an individual loses his or her capacity or opportunity to work, he or she also loses an important experience vital to the maintenance of a "cohesive, energetic, and balanced self" (Wolf, 1997, pp.77-73).

It may be argued that doing therapy with clients plays an important role in stabilizing immigrant therapists and helping them adapt. To what extent do clients function as a 'therapist to their analyst' Searles (1960), a transitional object (Winnicott 1953), or the container for unmetabolized trauma (Bion 1962)? This is a subtle process because therapists tend to deny their own

emotional neediness and project it onto willing recipients, i.e. the helping profession syndrome (Malan, 2004). Immigrant therapists may specifically use their clients to repair the anguish and guilt felt at deserting their friends, parents and patients. These tendencies may be eased if the immigrant initially works in an agency that can provide firm containing and a supportive collegial network, as opposed to the loneliness of private practice.

Workshop responses

Following a 50-minute presentation by both authors, they moved the audience into a circle. They then facilitated a 40-minute group discussion. It was hoped to elicit ideas and experiences about how immigrant therapists worked with local clients.

We were intrigued by the group's general responses to the presentation. Many acknowledged they felt 'triggered' and had strong personal responses to the issues. The themes of loss, mourning, and guilt predominated. Some of the content was personally conveyed to us only days and weeks later. Despite our facilitation attempts, it seemed premature and forced for the participants to talk about the therapeutic relationship, when the fundamental issue of identity, language, family and personal fragmentation was foreground. The issue of intergenerational grief due to the trauma of immigration, displacement and asylum was a recurrent theme amongst the group members. That the group seemed not to be able to get past grief, is in the authors' opinion indicative and representative of the very issue that keeps many immigrants stuck in melancholia versus the process of mourning.

The group agreed with the suggestion that, despite often being in a difficult financial position, additional supervision and personal psychotherapy is recommended for any new immigrant therapist to facilitate this potentially traumatic process. The group also suggested a longer workshop as well as ongoing support groups for immigrant therapists.

Conclusion

The quality of the therapeutic relationship developed between the immigrant psychotherapist and the New Zealand client is influenced by a variety of factors. Some of these discussed in this paper include: a) the therapist's specific attachment style which is amplified by the stress of migration; b) the success with which the therapist is able to tolerate, process and mourn the multiple losses, particularly those of friends, family and clients; c) the judicious and phase appropriate use of splitting i.e. idealization and devaluation; d) the complementary attitudes and projections of the host

country, professional associations and clients; and e) the degree of perceived difference between therapist and client. Due to the increasing numbers of immigrant psychiatrists, psychologists and psychotherapists this critical issue merits further discussion and research.

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