What are you expecting from a short editorial called ‘Culture and Countertransference’? The ‘cross-cultural’ debate has been around for decades so we are all likely to think we have a position on this. However, this editorial will not contribute much to that debate—it does not situate culture as a point of difference between clients and therapists, but rather focuses on the interplay of culture and countertransference to the extent that it inhibits us from being attuned accurately to the client at an emotional, as well as cognitive, level.

In every stage of my work as a clinical psychologist, I have been challenged by these disruptions: feelings that are aroused—from the more obvious and acceptable to the forbidden—can interrupt the connection and make me less able to hold the whole client in mind, and can damage rapport when I focus on my own feelings. One of the determinants of this dynamic is the culture/countertransference dialectic.

Definitions of culture limit and prescribe our capacity to reflect on its impact. Every person involved in the therapy has a ‘culture’. More traditionally, it is the set of beliefs, worldview, traditions prescribed by ethnicity, nationality and religion that are transmitted and expressed by individuals in their communities. More broadly, it includes communication styles, ways of using language and the body, and relational definitions. This is where we include the culture of the family—the part that, as a clinical psychologist, I have spent years with.

A point about language—how to refer to ‘other’ cultures and communities? My concern about this is serious and I have no solutions. I would like to avoid the hopelessly inaccurate ‘Culturally and Linguistically Diverse’—White English speaking Australians are also culturally and linguistically diverse. I would never be put into the CALD category, although I belong there, as do all of you.

What defines your own personal culture? This awareness is fundamental to a conscious therapeutic relationship in a way similar to insight into our own emotional styles and the history we carry that can drive the countertransference. I will be using a more contemporary perspective than the traditional: ‘The spontaneous or evoked responses of the therapist in regard to information provided, behaviours exhibited, emotions displayed by the...client.’ Daniell (1996:196)

Verbal interaction is central to our work; language and the culture of ethnicity and nationality are linked intricately. We use interpreters to bridge or facilitate the communication and this adds to the complexity of countertransference in ways we can’t anticipate easily or describe, including that the primary therapeutic relationship becomes mediated by a third person.

Let’s not pretend that part of our empathy is not guided by our (even unconscious) identification with our clients. Empathy is our stock in trade, our currency, our way in. When we convey empathy, we say ‘I hear you’ implying that we get it. But, do we? When we engage in therapy with people who have some fundamental similarities to us (particularly racial, cultural, language), we assume similarities in our experiences and our experience of the world. This will lead to errors in over- and under-identification that impact directly on the way we react to and attempt to work with a client’s needs. These minefields are due largely to our unquestioned racial and cultural assumptions (which is why it is a good idea to work through these somewhere in training).

The client becomes someone who: is too different from me; evokes my prejudice; is psychologically simple; only has practical needs; is unable to talk about emotions; needs me to be the authority and so on.

Culture impacts on expression of emotions—what is permitted or prohibited and how it is expressed. The most common confusion occurs in the presentation of somatic symptoms. Isn’t it ironic that we say to ‘western’ clients—‘Tell me where you feel the sadness in your body’?, and we aim to psychologise emotion with clients who ‘somatise’.

Given the personal and confronting nature of countertransference, there is a natural temptation to distance ourselves from it. Racism, mistrust and assumptions about normality are all unpleasant to admit.

The final issue I would like to reflect on is our choice of therapeutic modality. Communities have ways to resolve conflict and deal with distress in their members. For most of us reading this, that would include seeking counselling. How do we respond to the client who really struggles to tell us, a stranger, about their distress?

Religion and ritual are used to celebrate, purify and atone. In individual, traditional therapy, some of these rituals are broken down, seen as defences against anxieties that need to be verbalized, confronted. Is it possible that we become envious of this, calling the ritual defensive?

It is difficult for me to end on a point that fundamentally challenges so much of what I believe about psychological healing. The above ideas are not particularly radical but they apply essentially to individual psychotherapy! What about other therapeutic modalities—group work, life skills and rehabilitation, community development, non-verbal work (dance, drama, art, and spiritual ritual)? These may be the most effective modalities for any client, but I have not addressed my countertransference to the idea that I might not be offering the best healing environment for our clients.


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