“...a world where broken spirits abound and surround us with their silent cries and unspoken loneliness”


The psychotherapeutic process of a Kosovar adolescent asylum-seeker mother exposed to violent traumatizing experiences is described and discussed in this chapter. The effects of these experiences, especially in the vulnerable period while she was pregnant with her first child, resulted in severe consequences in the mother/child interaction and brought extra complexity to the case. The description of this psychotherapeutic process was enriched in the text by theoretical elements relating clinic to theory.

In the therapeutic process of the client here described, conducted in a center for child and adolescent mental health care in the Netherlands, we made two different modalities of psychotherapeutic interventions with Sara, the adolescent mother: the first intervention, after the beginning phase (in which her partner was also present), was an individual psychodynamic psychotherapy, while the second intervention was a mother/child psychotherapy, with Sara and Denis, her one-and-a-half-year-old child. During both psychotherapies, the Sandplay method was eventually used to help the client to project and elaborate her inner world and conflicts.

Considering the fact that asylum-seekers, refugees and immigrants are high risk populations for psychiatric disorders, the Reinier van Arkel Groep, in ‘s-Hertogenbosch, in the Netherlands, developed the Transcultural Problems Program – BTP, a specialized service for these infants, children, adolescents and their families. Since January 2007 this service was integrated with the service for adults in the new Psychotraumacentrum Zuid Nederland – PTZN, International Centre for Victims of War, Trauma and Political Violence. The PTZN consists of a multidisciplinary team which includes psychiatrists, psychotherapists, health psychologists, system therapists, physicians, social-psychiatry nurses, creative therapists and others. In addition to the outpatient treatment, the PTZN provides, if necessary, in-patient treatment (in a short-term closed setting) and a day-hospital treatment. The children and adolescents whose mental conditions do not allow them to attend a regular school, may attend a special school affiliated with the clinic, while participating in the clinical or day-hospital treatment.
The diagnosis and treatment process for infants, children and adolescents in the Transcultural Problems Program – BTP (Wiese & Burhost, 2004, 2006) and recently in the PTZN starts with an initial interview with the child and his/her parents, and results in an individual treatment plan, established by the multidisciplinary team. The treatment plan may include medical and/or psychiatric assessment, psychological assessment, system assessment, anamnesis, play therapy, individual group or family psychotherapy (including ethopsychotherapy), art therapy, parent counseling etc. After three months the assessment and treatment evaluations take place, followed by further three-monthly follow-up evaluations.

I work as a psycho-dynamically oriented psychotherapist and treatment coordinator at the PTZN, with children and adolescents, as well as with babies and infants (in parents/child psychotherapy). Love brought me to the Netherlands and my life changed suddenly when I married a Dutchman. Prior to this, I was a psychologist, born in Rio de Janeiro, with extensive professional clinical experience, who was for many years a lecturer in the Clinical Psychology Department of the Institute of Psychology of the University of Sao Paulo, in Brazil. My knowledge of languages and my experiences of living abroad in different countries during various periods of my life also help me with the challenges of my clinical work in the Netherlands.

The fact that I am not Dutch myself, but from South America, makes it easier for many clients to identify themselves with me (also a foreigner) and this identification seems to help them to develop a positive transference and a therapeutic bond. For the asylum-seeking clients in particular, the fact that I am a foreigner helps them to regard me as someone who is disconnected from the very strict asylum policy of the Dutch government.

It was in this context that I saw Sara for the first time. She was referred to me by a BTP colleague, because of my experience in parents/child psychotherapy (Batista Pinto, 2000, 2004; Wiese, 2004).

The Encounter with Sara

Sara came to the outpatient clinic, brought by her partner Andre. When they entered the consultation room he had Denis, their seven-months-old baby, sleeping in his arms, to whom Sara did not even look during the first interview. Sara was eighteen years old and Andre was twenty-six years old at that time. The couple was from Kosovo, from an Albanese ethnic group, and Sara’s family had a Muslim background.

Andre requested treatment for Sara because he was worried about her psychological condition, her depression, isolation and inability to take care of herself and of their child. He attributed Sara’s condition to traumatic experiences, including rape, she had suffered in Kosovo, shortly before they left the country.

Considering the importance of the attachment to the mother for the baby’s development, Sara’s treatment coordinator in BTP asked my intervention as a psychotherapist, aiming to improve the mother/child interaction.

Kosovo is a small province in Eastern Europe, located in southern Serbia, with a majority population of Albanians. Kosovo has had a long-running political and
territorial dispute with the Serbian authorities. During the twentieth century, the Kosovo population had six different government systems, ranging from a dynastic monarchy (until 1918), a constitutional monarchy (1918/1941), fascist occupation (1941/1945), a communist one-party government (led by General Tito from 1945/1990), a nationalist dictatorship (1990/1999) to a United Nations administration (1999 to present). During the period of nationalist dictatorship, an unequal gender and ethnic policy was imposed, resulting in a bloody ethnic-cleansing campaign against non-Serbian ethnic groups (United Nations Development Fund for Women War Peace, 2006).

In Kosovo, in 1996, an armed conflict started between the Serbian and Yugoslav army, security forces and the Kosovo Liberation Army, an Albanian group seeking independence for the province. Following this conflict, in 1999, a war started between Yugoslavia and the North Atlantic Treaty Organization – NATO. From 1996 to 1999, thousands of Kosovars were killed and approximately 1 million people were forced to migrate (United Nations Interim Administration Mission in Kosovo, 2004).

This period was experienced by the Kosovar-Albanian women in various ways: a few of them took up arms, but the majority lived through this conflict as civilians, and experienced traumatic situations. During this period, the Kosovar-Albanian people were internally displaced, with work and school interrupted. Many of them had their properties destroyed and their belongings robbed; they were threatened and they witnessed or underwent sexual violence and other human rights violations on a large scale. These experiences caused extreme traumas, with posttraumatic stress symptoms in many persons (International Helsinki Federation for Human Rights, 2000).

The United Nations Population Fund – UNFPA (2006) report of May 1999 (Fitamant, 1999), described accounts of rape, abduction, detention and torture of women refugees in Kosovo. According to the same report, young women, including pregnant ones, were abducted in groups, were threatened and raped by scores of men.

During our first consultation, in the presence of an Albanese/English interpreter, Andre told me that, in 2004, he and Sara had fled from Kosovo to Sweden when she was seven months pregnant. Sara was very disturbed at that time because of the recent traumatic experiences she had in their country.

Denis was born in Sweden, where the family stayed for a few months. Although very important in her culture, Sara refused to breastfeed her baby.

After the birth of Denis, Andre decided to come to the Netherlands to ask for asylum, because their asylum procedure in Sweden was not going well (after the killing of the Swedish foreign minister Anna Lindh by the son of Serb immigrants) and because he did not like the medical treatment Sara was receiving there.

In 2004, the worst ethnic violence (since 1999) happened in Kosovo, when houses and cultural sites were destroyed, people were killed, injured and displaced. In this displacement, women and children were the first group to be evacuated from their communities, and relocated in refugee camps, without knowing whether they would ever be able to return to their homes (United Nations Development Fund for Women War Peace, 2006).
The effects of these traumatic experiences were enormous, long-lasting and shattering to these women’s inner and outer worlds. This was worsened still by religious and cultural attitudes. In the Muslim culture, the honor of a woman for example, reflects upon her entire family. Therefore, a rape victim of Muslim faith may believe that the rape was a punishment for some sin she had committed. Even if she does not blame herself, she may feel such a strong cultural responsibility to protect her family that she remains silent about the rape (National Center for Posttraumatic Stress Disorder, 2006).

The family had been living in the Netherlands for the past four months, in a reception center for asylum seekers, and Sara’s mental health problems prevented her from taking even fundamental care of herself and her child.

From our first contact, Sara made a strong impression on me: she avoided eye contact and seemed to me frightened, weak and hopeless. Even though she was a beautiful young woman she did not look well: her facial expression was sad, closed, and she had wrinkles in her forehead. She was disoriented about time, space and about her actual life context. She was afraid of and she was very confused towards new places, new people, the present and the past. She almost could not talk, not even with the help of an interpreter, and when she tried to answer a question or to say a few words, her voice was so low that it was very difficult to hear and to understand her. Sara’s self-esteem seemed very low and she did not seem capable of any basic independence.

Sara was suffering from the basic symptoms of Posttraumatic Stress Disorder (PTSD) combined with depressive symptoms and psychotic hallucinations which repeated the traumatic events in flash-back. She also had a remarkable lack of attachment to her child. She would talk to Andre, her partner, when she did not understand one of my questions, but she avoided any physical contact with him. During the first session, it seemed to me that the presence of Andre was important for Sara to feel safe and to build the foundation of her relationship with me.

Sara already was been treated by a psychiatrist and taking psychiatric medication (for anxiety, depression and psychotic symptoms), and she and her husband were being supported by a colleague, a system therapist.

After the exposure to traumatic events a victim may have heterogeneous and complex manifestations and symptoms (APA, 1995). Yet, in the etiology of trauma, it is also necessary to consider the person’s mental state at the moment of the traumatic experience, when several affective impressions were agglutinated.

Freud (1917,1992) postulated that in trauma there is an indirect relationship between two factors: one being the predisposition of the person and the second being the fantasy about the event and the gravity of the event itself. Therefore, in the trauma, the terrifying feelings (as experienced by the victim) are frequently more important than the fact or situation itself.

In the first consultations, Andre did most of the talking, describing the day-a-day difficulties with Sara in the dealing with her frightened and dependent behavior. I gave them support and understanding in order to develop their adjustment to this new period in their lives.

After a few consultations, Sara slowly started to talk about her fear. It seemed to me that she wanted to tell more about her past experiences, but that it was difficult for her to do so in the presence of her partner and of the interpreter. I understood that her need to talk to me was also related to her need for female support and for a more flexible and benevolent “mother figure” with whom she possibly identified me.
Although Sara would still deny the presence of her child in the sessions (and in her life), she slowly started to take care of some of the child's possessions, for example, bringing his bag to the consultation room, or arranging his toys when I gave them to her at the end of the sessions. These were the first signs of her acceptance of her child's presence in her world. However, Sara's psychological condition was very vulnerable and unstable and the mother/child relationship was at high risk.

To bring a child into the world, especially the first child, is, for the immigrant woman, a very important step in her own immigration history, because it is through this child that, in general, she will have more contact with the host society, its culture and demands. Besides pregnancy and birth being very vulnerable periods for a woman, for immigrants these periods can be affected by several influences, for instance by the migration project itself (reasons, conditions, experiences, feelings, hopes, etc.), the number of years spent in the new country, the cultural differences between the country of origin and the new one, the social and economical conditions, and the support from partner, family and community.

When the birth of a child occurs during the migration process, it exposes the parents to the paradox of being parents between the others and for the others (Sayad, 1999). The immigrants are torn from their original group, what can be very disturbing, especially when they were used to belong to a rural collectivist society, in which the community bonds were very strong. They must also assimilate into their host society which requires them to be like the people in their new country. This injunction, in the case of occidental western societies, includes the consideration of a more individualistic culture.

Mestre (2003) pointed out the importance for a new mother of the presence of her own mother and of close female relatives at the moment of the child's birth and in the first period hereafter. On top of this, we know that loneliness is not an exclusive experience of the immigrant woman. The loneliness of the mother in occidental societies is a cultural constant, but it can constitute a real trauma for immigrant mothers, especially for the ones who came from a more traditional environment, where the culture supports the circulation of the child between relatives in the family (Rabain-Jamin & Wornha, 1990). As a consequence, loneliness in the absence of partnerships with other women of the same family can be a real threat.

Therefore, a woman who gives birth to a child in isolation frequently forgets the rituals of her own cultural group, and this makes the child more vulnerable to and dependent on the mother's personality and competences. The presence of elements of the mother's cultural group can, as a result, be important to support cultural transmissions to the child. Besides, the immigrant mother can be burdened by the responsibilities in raising a child that must achieve more individual goals and values, as expected from a good mother in the occidental culture.

To better understand this process, Mestre (2003) conducted a survey among immigrant women in France, and observed that all of them spoke about the absence of their own mother with sadness, fear, pain and stress. However, these feelings depended on the quality of attachment the woman had to her own mother and on her competences to take care of a child, as she developed in her
own childhood. This survey showed that good attachment to the own mother can provide a basis to be more competent in the care for her child and to build a harmonious relationship with her child.

The resources of the mother’s own culture are also very important, to give to her a sense of her role as a mother and, in case of psychological or psychiatric disorders, the culture can provide an envelope to support mother and child in their interaction, especially in critical periods.

Considering culture as a transgenerationally transmitted system of shared beliefs, values, customs, behaviors and artifacts that members of a society use to cope with their world and with one another (Schwimmer, 2006), the cultural envelope brings to the person magical components of his/her group. These components can assure the maintenance, the countenance, the inscription and the transmission of the basic elements in the mother/child dyadic and mother/child/father triadic interaction.

Therefore, the parents’ migration brings a vulnerability factor for the child, because being in between different cultures, with conflictive values and beliefs may result in considerable risks for the child’s psychological development. This vulnerability can be apparent in the child’s less resistance to traumas in comparison with children who are raised within their own parents’ culture. About this matter, Lebovici (1989) stated that the same circumstances and situations can have many different effects in infants.

Denis was a pretty, blond, healthy and active baby. He received ample attention from his father, with whom he had a secure attachment, but he avoided any contact with his mother. Denis had just started to go to crèche once a week. During the first sessions with the family, I observed that Denis had good cognitive and motor development but emotional difficulties in the attachment with his mother.

The mother/child emotional communication, since the early period of the child’s life, is based in the rhythmic and dynamic frames of their affective interaction (Golse, 2004). Therefore, at a very young age, the child is, in general, competent to decode the modality and interactive style of the mother (or her substitute), and to adjust to it.

The babies of traumatized mothers perceive, directly or indirectly, their mother’s traumas, as they leave strong traces in their relationship. These traces are written in a developmental line, in the present of the child, but also in his/her future as an adolescent and an adult. We can hypothesize that these traumas modify the child’s perceptions of his/her past and history (Moro, 2005).

When the parents are traumatized, it can result in direct consequences to the child’s life and development, because traumatized adults are often unable to deal with the child’s needs.

**The Video of the Mother/Child Interaction**

After a short period to establish good rapport with Sara, her treatment continued with the regular procedure for mother/child psychotherapy and a video recording of Sara and Dennis in a free play session was made.
This video recording technique aims to have a detailed assess to the mother/child
and father/child interaction (Batista Pinto, 2001; Piccinini et al., 2001).

In the mother/child video-interaction, when Denis was 12 months old, Sara did not give
him any spontaneous attention. The child did not want his father to leave the room during
the session and he seemed to be afraid of staying alone with his mother and me. While
Denis cried, Sara did not look at him, she did not touch or approach him. My intervention
in the situation was necessary, so I took the child and helped him to sit in his mother’s lap
and, very slowly, she could accept to hold her child by herself.

The qualitative analysis of this video-interaction concluded that Sara did not show
sensitivity to her child, even when he was reacting in a disorganized way. She did not give
him any structure in the play. Sara was not intrusive in her behavior, on the contrary, she
avoided interaction most of the time, and showed a covert hostility towards the child. Dennis
showed moderate responsivity to Sara (for example looking at her and taking a toy from her
hands), but very little involvement in the spontaneous interaction with her (he neither looked
for physical contact, nor did he give signs of pleasure in the interaction).

Several factors can affect the parent/child interaction, and it is very important
to assess them in an early stage of the child’s life. This helps to plan interventions
that can prevent and/or treat functional disorders and psychopathology. It is
important to consider the patterns of attachment and the dynamic of the interaction
in the parent/child interaction.

In this phase of the treatment it was difficult for Sara to start to talk. It seemed to me that
her thoughts were empty, far away from reality and from the therapeutic encounter. She
could not recollect memories about her past or even talk about the present. She said that it
was very difficult for her to talk about her family and even more difficult to talk about what
happened to her and to talk about her child. I made an interpretation, establishing a
connection between these three subjects, telling her that because of the difficulties in
the relationship with her family and because of what happened to her in Kosovo, she had
difficulties in the relationship with her child at present. She listened to my interpretation
but did not have any direct reaction to it.

At that stage in the psychotherapeutic process, as an attempt to give Sara a mean to
express herself in a non-verbal way, I proposed to Andre and Sara to do a Sandplay.

The Sandplay

Sandplay is a non-verbal psychotherapeutic method created by Dora Kalff (1980),
a Swiss Jungian analyst. The method (Batista Pinto & Franco, 2003) consists of
inviting the client to create a scenario, in a standardized box filled with sand, using
miniatures at his/her disposition, which broadly represent elements of the world
(persons, animals, trees, houses, cars, food, sacred objects, instruments of war, etc.).

The sand-box constitutes a field in which the client can use his/her creativity
to project elements and conflicts of his/her internal world. Therefore the client
can be taken by images or sensations that the sand and the miniatures elicit in
him/her, turning fantasy into an actual scene, which he/she leaves in the sand-box
with the psychotherapist (Mitchell & Friedman, 1994).
At the end of the Sandplay activity, the psychotherapist asks the client to give a
title to his/her scene, and if the client wants, he/she can also explain the scene he/she
has created or comment about his/her feelings while doing it. The psychotherapist
subsequently takes a photograph of the scene and asks the client to close the box.

The basic function of the Sandplay method is to challenge the client to express,
in a non-verbal way, the conscious and unconscious contents of his/her internal
world and, by doing so, to develop the psychological function of self-regulation

In the Sandplay method the contents and interpretations of the scene are not
discussed with the client in the same session, but eventually this can be done
after a continued period of psychotherapy, when the psychotherapist can bring the
photographs of the scene and discuss the material with the client (Batista Pinto &
Franco, 2003). This way, the client’s non-verbal projection in the Sandplay is
preserved, but at another stage of the therapeutic process it is possible to talk
about it enhancing the understanding of the client’s conflicts and psychological
mechanisms.

Andre started the first Sandplay scenario by putting the figure of a (Dutch) country man
and, next to it, the figures of a (Dutch) country woman and child. Although Sara was very
depressed and inactive in that period, she started working persistently on the scene. She
was very focused on the activity. Immediately, surprised by her motivation and initiative,
Andre withdrew and let her do the scenario alone. Sara created a very detailed scene in her
first Sandplay scenario which she named “War and rape”.

![Image of Sandplay scene with labels: Saint with a baby in his arms, Country man, woman and child, Woman being raped](Clients's view)

**Figure 13.1.** The first sandplay scene: *War and rape.*
The first figure that Sara chose was the saint which holds a baby in his arms. She put it next to the family that Andre had placed in the sand, projecting the wish for protection for her small family. Then she made a disturbed scene of an armed conflict, with several dead people, especially children and women, and also with some dead animals. There were soldiers with guns everywhere.

The scene is divided in two parts: one representing the war and violence with all its elements – soldiers, guns, people immobilized watching, dead people, women being raped and threatened; in the other part some other elements emerged: the police car, airplanes and helicopters. This part of the scene possibly illustrates that the only way out of the chaos, the suffering and the fear of death, is to run away. But we also see in the scene a small separation between the elements of chaos and the possibility to escape, to move and run away, showing that Sara realized some possible solutions for the situation in her mind.

Sara projected herself directly in the scene, pointing out to me that she was the young woman being held by two men and being raped. She was alone, powerless, facing strong armed men and unable to defend herself, paralyzed by the trauma.

Through the Sandplay, Sara was able to express her recent traumatic experience during her pregnancy. The presence of her partner in the room, his knowledge of the facts and his unconditional support to her, seemed to comfort Sara.

Sara projected a weak and vulnerable image of herself in the scene and of women in general, as victims who cannot protect themselves nor their children. The men in the scene were mainly aggressors.

In this scene there were only few elements, such as the “Dutch” country family, which could be related to her present life. The trauma seemed to take up all the psychological space in her mind. Nevertheless, the making of the scene showed Sara’s possibilities to recover traumatic memories and to express them, with fear, grief and sorrow.

Andrè, by way of the only figures he chose – a Dutch country man and a Dutch country mother holding the hand of a child – projected the strong maternal figure he had preserved in his internal world, making it easier for him to be identified with her and to also be a maternal figure to his own son. He also showed confidence in me and in Sara’s treatment, as well as his hope for their future as an integrated “Dutch” family.

In this first Sandplay scenario, Sara was able to express her trauma in a non-verbal way. The method helped her to open a door to her past.

The analysis of the Sandplay scenarios shall consider, besides the photos of the scenes, also the notations made by the psychotherapist, including the free-association, comments, attitudes and behaviors of the client during the activity. It must also take into account counter-transference elements from the therapist. For a better categorization of the scene a Sandplay Categorial Checklist (SCC) as the one proposed by Grubbs (1995) can be very helpful. For a qualitative interpretation of the scenario, Mitchell & Friedman (1998) created some criteria of analysis of elements related to psychological wound (aspects in the scenario related to: chaos, emptiness, division, threat, wound, hiding, tension and block out) or indicative of cure (aspects in the scenario related to: journey, union, energy, birth, profoundness, reconstruction, centralization and integration)

From the moment Sara made her first Sandplay scenario onwards she started to share some of her memories.
As a child and adolescent she lived in a very big house with her family and her uncle (her father’s brother) and aunt, in a remote rural area close to a small village in Kosovo. She could not remember whether her uncle and aunt had children who would live with them in the same house. Sara remembered that she and her parents, her brother and sisters slept together in a very big bedroom. She did not remember her bed . . .

These memories were from the period during the war, when the family was afraid all the time, because Serbians lived behind their house. They could not have electricity in their house, so at night they stayed in the dark, and Sara could see the neighbors in their lit houses. The family received anonymous written messages stating that Albanese children would be kidnapped. So Sara, her brother and sisters could not play outside the house, and they could only leave the house in the company of an adult man. They could not go to school anymore either, because the schools were closed for Albanians when Sara was about twelve years old, and in seventh grade.

The descriptions above gave us the thread to follow fragments of her memory and recall experiences from her childhood. I could interpret Sara’s current passiveness and her dependence, in relation to her war experiences, when she was dependent on others and had to stay at home. It seems that in Sara’s mind the streets and paths were still closed and she needed Andre to be her protector and guide. This interpretation provided an explanation for Sara’s fear towards unknown people and her neighbors in the asylum-seeker center, whom she perceived as dangerous enemies.

At that stage, I thought that Sara needed individual attention and space to talk about herself, before being able to include others in the sessions, especially her child. I proposed to her to continue the treatment in individual psychotherapy.

At that point, I knew more about Sara’s psychological functioning, her Posttraumatic Stress Disorder – PTSD, with depressive and psychotic symptoms – and her behavior difficulties. I hypothesized that her psychiatric problems were a result of several related factors: an attachment disorder from childhood; a war trauma, which included displacement and the witnessing of violence in her community, a trauma of the rape she experienced during pregnancy, a trauma of forced immigration and the lack of safety in her current asylum situation.

In the individual psychotherapy, Sara was able to talk about herself, to answer questions, and her attention span was longer. She seemed to have a good understanding of the interpretations that were made in the sessions, but she also said that she very easily forgot about them. She was still weak, and she left all initiatives to others. I realized that Sara had a positive, but very dependent, relationship with me and with her partner. Sara’s behavior was very passive and she was depressed.

It was during this period in her individual psychotherapeutic process that Sara created her second Sandplay scenario.

She had difficulties starting the activity, but after a few minutes she was able to do it independently. She also worked continuously and was very focused. She named the scene “Big graves”.

The second scenario expressed again a very traumatizing event for Sara. It is a disturbing scene of an armed conflict, with several dead persons – including many children – and animals. There are armed soldiers all over the scene. It expresses the power of the army towards people, who were impotent and immobilized in the situation. It also showed Sara’s suffering and fear. In this session Sara shared with me yet another of her many traumatic memories.
Sara projected herself directly in the second Sandplay scene, as the small (Dutch) country girl with her mother (placed close to the house), relating it to a traumatic scene she witnessed during the war, when she was about twelve years old and when her uncle was killed by Serbs. The mother figure, who could have represented an element of protection, was not effective, and both she and the child figure (representing Sara herself) were only able to observe the terrible event. It is possible that Sara, identifying herself with her mother’s attitude, was also immobilized and unable to give protection to her own child.

In the scene there are no elements related to her present life, as the past and the traumas probably still took most of the psychological space in her mind. The direct projection shows the strong physical and psychological violence to which Sara was submitted.

Nevertheless, the making of this scene showed Sara’s possibilities to express her memories and feelings in a coherent way. While in the first Sandplay scenario Sara expressed a recent trauma, in this scene she expressed traumatic experiences from her childhood.

In the following sessions, Sara continued to talk about her memories of the war in Kosovo, when she was around twelve to thirteen years old. This was the framework that Sara provided to start to talk about the trauma which she expressed in the second Sandplay: her uncle had his head chopped off by the enemies in front of her and her mother. It was a terrifying experience which paralyzed Sara’s emotional development: she even today still behaves as that young twelve year-old girl.

In the following period Sara again suffered great emotional instability. She re-started having hallucinations (visual and acoustic), re-experiencing the traumatic events, which frightened her very much. In this period she was able to talk to me and to answer questions about her present and day-to-day functioning, being extremely focused only on herself and
her own needs, and unable to pay any attention to her surroundings and the needs of others. In addition, the difficulties in the family’s asylum procedure caused her great fear for their present and future.

Sara’s passive and very dependent behavior started to affect me, especially because she seemed to perceive it as normal. For me, a Brazilian who had immigrated to the Netherlands less than one year before and who was also facing many cultural differences and changes in life to adjust to the Dutch system, Sara, with her extreme passivity, mirrored the opposite behavior of mine and challenged me to understand and accept her slow adjustment rhythm.

During the subsequent period, Sara recovered some psychological stability and she did not have hallucinations, although she was still very frightened. When asked about the beginning of her relationship with Andre, Sara did not at first remember how she met him. After a while, she could remember that his sister was married to a man who lived in her village. Andre sometimes came to visit his sister’s family and that was how they met. They started a secret relationship because of the background of Andre’s family, especially because of his father (who had already died) who had worked for the Yugoslav police, something which was condemned by her family.

A short time after the beginning of their relationship, Sara and Andre decided to live together and she left her family and moved with him to his mother’s house in the city. Sara’s family did not accept their relationship and broke off contact with her. Sara and Andre were very afraid of her family’s reaction, especially of her father’s and uncles’ possible revenge. Sara was pregnant and she and Andre made plans and dreamt about having the child.

One day, when Sara was seven months pregnant, she was alone at home and the house was invaded by two men who sexually abused her, using violence. These men had guns and they spoke another language, which Sara could not understand. From this moment, Sara was shocked, terrified and immobilized. During the short period they continued to live in Kosovo, she and Andre received anonymous threats by telephone to kill her, Andre and their future baby.

After these traumatic experiences, Sara’s psychological development and the emotional interaction with the child who was growing inside her belly were frozen. She was extremely afraid and panicky when she saw or heard other men, especially if they communicated in other languages.

It seemed to me that Sara established a perverse link between her rape and her pregnancy, with the notion that the unborn child was contaminated by elements of the men who had raped her during her pregnancy.

Pregnant women who were raped can have feelings that, in addition to themselves, their child was also abused. To touch an unborn child with violence has a very strong symbolic meaning which includes elements of today and tomorrow, present and future, leaving important consequences in the transmission of the trauma and the risk of a secondary trauma for the child. As Moro (2005) reminded us, the family can have a Biblical curse with a heritage of suffering for seven generations.

To talk about traumatic experiences was still difficult for Sara but at the same time, slowly, it enabled her to start moving away psychologically from the “frozen state” she was in. To share these experiences with me was very important, also because of her parents’ refusal to have any contact with her. Sara also had fantasies that the rape could
have been ordered by her own father as revenge for the fact that she was pregnant and
she went to live with Andre.

For Sara the fact that I, as well as being her psychotherapist, was an older woman,
who could accept her story and support her in her grief, anger and sorrows, helped her in
starting to let go of the weight with which these traumatic experiences and thoughts had
burdened her.

When facing concrete problems, Sara was still very passive and incapable of finding
ways to solve them. Her fear of a man physical proximity brought her great difficulties in
medical and other treatments, but also in her relationship with Andre. She systematically
refused any physical or sexual contact with her partner, who accepted her behavior with
resignation.

During the psychotherapy, Sara was able to communicate better than before (we had
been assisted by a female interpreter via the telephone). Sometimes she was able to bring
up some special subject by herself, but she was very passive in her actions. Nevertheless,
a change started to occur because she began to bring up themes related to her difficulties
in the relationship with her child.

Through the way Sara spoke about Denis, describing his behavior when they were
together, I understood that her interaction with him was developing, but more so in her
mind, in her fantasies, than in her behavior or in practical aspects. She was still not able
to interpret his actions and intentions, nor was she able to give him the attention and
care he needed. She did not feel responsible for him, not even for his basic needs or his
safety.

At one point in treatment, during my vacation, Sara had a relapse and was admitted to
a closed ward for a few weeks. It was an attempt to provide her with more intensive treat-
ment in a closed and protected setting, where she might have felt safer. She was having
acoustic hallucinations again with male voices demanding she kill herself. She also replied
to these voices, saying: “I will not kill myself because I am not guilty”, referring to the
rape. Upon discharge from the closed clinic, she said that the men’s voices were still in her
mind during our consultation, and they talked about the rape and sometimes she felt that
these “men”, who “talked” to her, would also touch her shoulder.

We worked in the sessions on the possible sources of Sara’s guilty and ambivalent feel-
ings, but she did not have memories of her parent’s moral values in her education nor did
she know what they would think about subjects such as pregnancy out of wedlock, rape
and immigration. I gave Sara an interpretation in which I related her guilty feelings to the
fact that she had left her family and was being punished by them. As a consequence of
the conflicts and dilemmas related to her relationship with the parents, she seemed to be
also punishing herself with isolation from those who were close to her – Andre, her part-
tner, and Denis, her child. I also pointed out that a possible meaning of her hallucination
could have been roused from ambivalent feelings about being “touched”: in one way a
desire for a loving sexual touch, and in another the fear for it, which perhaps made her
produce the specific hallucination of being “touched” in a threatening way.

It was, in general, difficult for Sara to develop her thoughts and insights when the interpre-
tations were given, but she listened to them, and slowly she started changing her behavior,
showing that she had integrated them.

During the following period Sara started to feel calmer. She was able to tell me about her
daily life: she liked to do embroidery and to help Andre in the kitchen. They sometimes pre-
pared dinner or sandwiches together, but she could not help cut vegetables, out of fear of
cutting herself with the knife. We worked on her fantasies about knives, which were
related to aggression. We also brought to light some memories related to food: her mother
used to cook for the family and Sara did not usually help her; her mother made a good
goulash and Andre also made a very good one.

In these sessions we helped Sara to recover some balance in her day-to-day activities. She also spoke about the birthdays: in her family they were not used to celebrating birthdays. She talked of a date in July when she would be twenty years old. She remembered that they had celebrated Denis’s birthday, but she did not know when it was. She did not know the year in which she was born, Andre’s birthday nor month or year in which Denis was born. She also did not know which date or month it was; she only knew the year correctly. This lack of memory can be understood as Sara’s effort to keep herself distanced from reality.

At this point in her treatment, Sara made a third Sandplay scenario, which she gave the name “Problems of my dead”.

Sara did not want to comment on or explain the scene. I understood her refusal as being related to the sexual elements present in the scene, in which several figures, representing men and women, old and young, mostly at home, were engaged in sexual intercourse. Considering the title of the scene, we can also suppose that for Sara these figures represented dead persons. Therefore the scene establishes a relationship between sexual intercourse and death, and is a direct reference to Sara’s traumatic sexual experiences and her psychological “death”.

At the same time, the fact that she had created this scene and left it closed in the sandbox in my care, could represent her liberation from this psychological “death”.

As Sara started to be more aware of her day-to-day life, it was arranged for her to have a female home help coach three times a week, aiming at structuring her life and helping her to raise the child. Frequently the coach went out with Sara and Denis for a short walk and some play with the child, but in her absence Sara did not know how she could play with him. Sara also thought that it was difficult to play with him because he was agitated and she liked to be quiet. She told me that Denis did not have “good behavior”, because
he did not “play nicely alone” as she would like him to do. She only wanted him to stay quiet and when Denis screamed it would make her afraid.

Sara seemed to me like a little girl when she said about Denis’s behavior: “I do not know what to do.” I interpreted to her that on the one hand she loved him and worried about him, while on the other hand, she did not want to talk to him, play with him or educate his behavior. At that point Sara expressed the following wish: “When I am alone I think he is still inside my belly”, relating this thought to the rape during her pregnancy.

With this affirmative Sara expressed her wish to stay physically attached to Denis but to avoid bringing him into the world, with all the responsibilities of raising the child and promoting his development. Sara also showed that she wanted to postpone her role as his mother.

At that time, Sara told me that Denis was starting to talk: he would call “Mamie” and “Papie”. It seemed to me that Sara’s fear for Denis could be related to the fact that he only spoke baby language, a mixture of Albanian, Dutch and German (which he heard in TV cartoons). Sara said that she could not understand what he wanted to communicate nor the words he said. I spoke about his command of language, which was adequate considering his age and the bi-lingual development. I also spoke about his need to listen to their language, Albanian, and how important it would be if she could speak to him, stimulate his communication and have verbal interactions, teaching him simple words. After some time, I understood that Sara was afraid for Denis to learn Albanian, afraid of him relating to her country and culture. This was an important point to understand in Sara’s conflict in her role as Denis’s mother and in helping her to overcome it.

After several months of individual treatment Sara was feeling better. She told me that she was having problems with Denis, and that she was worried about their relationship. It was the first time in the psychotherapy that she spontaneously considered her child from the point of view of a mother, bringing up her worries about their interaction. She said that he would beat her, throw his toys at her and cry when he was left alone with her. Through these talks Sara opened another door in her mind for her child.

Sara’s increasing interest in the child gave me the opportunity to propose to re-introduce the child in the psychotherapeutic setting. So, six months after the beginning of the individual psychotherapy, I proposed to Sara to re-start the mother/child psychotherapy with her and Denis together.

Dennis came to the first mother/child psychotherapeutic session, holding his mother’s hand. He started playing with the baby doll and putting it in the stroller. In this play he was reproducing the previous situation when he came to the consultations and was put in a stroller. He tried to include his mother in the game but she did not join him.

Sara could not understand the meaning of his behavior. She had some attention for concrete aspects of it, but she did not get the symbolic meanings and this made it very difficult for her to play with him.

After a short period of mother/child psychotherapy, Denis, who was about twenty months old at that time, showed me that he enjoyed the sessions very much. He included both his mother and me in his play. He was very serious, but also curious. He explored his surroundings and played constructive simple games. He was also able to imitate me, which he enjoyed. Sara stayed seated close to him, but frequently she seemed to be bored.

When the session was over, Sara would help me to re-arrange the room. Denis, often, did not want to leave the room but he would accept it when I would take him by the hand and hand him to his mother. They would walk away together. My feelings were that these were very good sessions where mother and child were starting a positive interaction. I also felt that it was necessary to continue the treatment at a very slow pace.
As their psychological treatment progressed, Sara and Dennis developed a routine in the sessions. Denis would say good-bye to his father and take Sara’s hand to enter the play room. He would go straight to the toys and start to play. Sara was starting very slowly to get used to his play and to follow him in some of it, when he asked her to.

In the mother/child psychotherapeutic sessions, Denis was usually calm and he played well for his age. He sometimes needed guidance which Sara was not able to give to him. We divided the sessions in periods during which we would talk and periods that we would play with Denis. Trucks and cars in a noisy garage were his favorite toys at that time.

Denis was frequently kind and friendly to his mother: he would take her by the hand and smile up at me, as if showing his understanding that I was there to help him and his mother. At that time, any negative behavior by Denis during the sessions had disappeared.

Sara called the forth Sandplay scenario “Difficulties”.

In this fourth Sandplay scenario, the elements of war and rape are still present (especially in the right-hand side section of the scene), but there are also several elements in the left part, where we can see a country house and animals. So, we can see elements representing Sara’s former life in her own country as well as other figures, such as the windmill and the winter house, which possibly represent her current life in the Netherlands.

At this same time a new situation arose: the family was granted asylum in the Netherlands on medical ground (due to Sara’s mental problems and necessity of the treatment). At first, after receiving this information, Sara had difficulties understanding what it was all about. It fueled fear of changes in her life: the family was to move from the asylum-seeker center to a house. She was also afraid of going to live far from the clinic, and perhaps having to stop the mother/child psychotherapy, which was so very important to her. This was a difficult period for Sara and her condition worsened for a few weeks, with more somatic complaints and an exacerbation of depressive symptoms. However, this time she did not suffer from psychotic symptoms at all.

At night Sara could not sleep well because: “during the night I fear that somebody will knock at my door and take our furniture away.” I asked more about this: Was it a dream?
Could she see someone? Did she know of other people who had left the Center? I also associated her fear with other situations in the past, when she had to move. “During the time of the war we did not know that we would have to move, so we were not stressed about it before but it was all very sudden”, she told me.

At that time Sara had a dream about going to another clinic for treatment, but she could not talk there. She wanted to talk to me, but she could not because she was in another place.

We spoke about her fear of discontinuing the treatment with me now that she would be moving to another city, and I was able to explain that even if she had other treatment for herself, she could continue our treatment with Denis for a while. We also spoke about the changes earlier in her life, such as when she left her house and moved to live with Andre.

She said that her parents did not know that she was going to leave. After she moved, Andre’s sister, who lived in the same village, went to talk to Sara’s parents but her father said that he did not want anyone from Andre’s family to have any contact with them. Sara’s father was very angry and threatened Andre’s sister. Sara explained me that this behavior of her father is common in their culture, and Sara and Andre were very afraid that her family would find and harm them.

When Sara was talking about this difficult subject Denis hit his head in a shelf and started to cry. He asked for his father as it was difficult for him at that moment to accept that his mother would console him with my help. It was also impossible for Sara to do it by herself. I picked Denis up, spoke to him, put him on Sara’s lap, and helped Sara to hold him close and to caress his head. After a few minutes, when Denis was fine and started to play again, Sara continued to talk about her family but Denis got upset again. I could understand and interpret that he could feel his mother’s sadness and tension about this subject and that reacted to it. I explained to Sara this fine example of “psychological mutuality”. Dennis came close to me and I told him that we would continue this talk another time.

The changes in the family’s life were very positive for Dennis. He showed his happiness during the session. He played simple symbolic games, frequently including small dolls representing a “father”, a “mother” and a little boy. The “father” was the coordinator who took care of both mother and child, as it was in real life.

Slowly Sara started to talk to me about Denis’s good behavior. They liked to watch television together and he also played in the living room while she was there. Sara liked to watch cartoons. She was less depressed and she also smiled more often. She was able to talk to me about her fear that Denis would be taken away from her, when he was at the crèche. These fears revealed Sara’s ambivalent feelings towards Denis, but also showed her increasing attachment to him and her fear of them being separated.

In another session Sara was looking at Dennis playing and she was able to describe it very well, showing her cognitive capabilities, but at the same time showing that she was not interested in the meaning of his play. She also said that Denis had been sick during the night and he vomited. She had not known how to handle the situation. She remained paralyzed. She was afraid of losing him; she was afraid that he could die. She also started to talk about having had the same feeling before, when she was pregnant and she was also afraid that her baby would die.

While we were talking, Denis came to his mother with a book. This time he could stay sitting on his mother’s lap for longer while I played with a figure from the book and he enjoyed and imitated me. Both, mother and child were smiling. It was very good to see this very active and smart boy with his mother, very close to each other, enjoying it.

Sara started to speak again about her family. She told me that she had nobody from her or Andre’s family in the Netherlands. She has an uncle, (her mother’s brother) who lives...
in London, and once Andre spoke with him by telephone, asking if he could act as an
intermediary between Sara and her family, but it was in vain. The uncle was afraid of
revenge, because her father and other uncles in Kosovo, were very strict and refused to
talk about her.

While speaking about this subject Sara cried, saying that she missed her parents. She
would like to have contact with them, especially with her mother, but she explained to me
that in her culture, women had to accept and to do what the men said. We talked about
cultural differences: how it was for Andre (who came from a city) and how it was for her,
to live in the Netherlands.

Sara explained to me how she wanted to talk to her father, because in her childhood
she used to be very attached to him. He was a good father who loved her and was never
aggressive to her. We spoke about her blocked feelings, her wishes to contact her par-
ents and the importance of her attempts to build a bridge between them. Sara was able
to show more about her grief and her fear to be rejected again by her parents. I under-
stood this and talked to her about this conflict which contributed to her passive and
blocked behavior.

The Interaction Assessment Procedure

When Denis was two and a half and Sara was twenty years old, we again proposed to record
their interaction on video, this time following the Interaction Assessment Procedure – IAP
(Batista Pinto, 2004)

The Interaction Assessment Procedure – IAP, which can be used in a clinical
setting and in research, was developed by the Infant Psychiatry of our clinic
(Wiese, 2006; Batista Pinto, 2006), in order to assess the parent/infant interaction.
The IAP is an assessment method based on the attachment theory, which proposes
holistic clinical judgment, in which the observer uses contextual aspects to infer
the appropriate behavior of the interaction partners. The IAP uses a script inspired
by the KIA-Profile (Stern et al., 1989), for the sequence of the interactive activi-
ties to be registered on video. It proposes a global qualitative analysis of the inter-
action exchanges, based on clinical aspects and on the criteria presented in the
Emotional Availability Scales (Biringer, Robinson, & Emde, 2000).

In the Interaction Assessment Procedure (which takes about twenty minutes),
the parent/infant interaction is recorded in video, in the following sequence: to
play without toy, to play with toys, to teach, to ignore, to separate, to meet. The
analysis must consider the behavior and the affective interaction of the dyads, with
special emphasis on the qualitative analysis of the mother/child and father/child
interaction. The parents’ sensitivity, structure of the play, non-intrusive and non-
hostile behavior, as well as the infant’s responsivity and involvement are taken into
account.

Although Sara understood what she was meant to do during the IAP video recording of her
interaction with Denis, she was not able to play with him without toys. Denis waited
patiently for his mother, sometimes looking at the toys which were behind him.
In the activity with toys he took the initiative and showed them to his mother, who held them, but was unable to actively play. She interacted with the child in a passive way. Denis explored the toys structuring his play.

In the video-interaction we clearly see that there was still a gap between the expectations of the child and the behavior of the mother. The child seems to know his mother’s behavior and her reactions to intrusiveness quite well and he keeps himself physically close, but not directly touching her. When the mother withdrew her attention, Denis noticed it, but he continued to play, accepting the situation. He also searched for support in his surroundings and accepted it.

There were only a few verbal exchanges in Albanian between the two of them during the video recording, but they communicated mostly in a non-verbal way, being able to establish a certain rhythm in the interaction.

Analyzing the IAP video interaction, after a period of one year of mother/child psychotherapy, I saw that Sara showed weak sensitivity, inconsistent structure in the play, partial intrusiveness and covert hostility towards her child. Dennis showed moderate responsivity and moderate involvement in the interaction with his mother.

Nevertheless, this second IAP video interaction, when compared with the first one (about one year earlier), showed great qualitative improvement in the mother/child interaction, with both partners in the dyad showing better adjustment to each other’s patterns of functioning.

The Last Sandplay

A few weeks after Sara and her family moved to a new house, she made her fifth Sandplay scenario, which she called “Begging them”.

In this scenario we can distinguish several scenes which seem to be connected in a time line to the past, present and future. The first scene closed in a fence that has no entrance, represents the past: Sara’s parents’ farm, with a house, animals, trucks, trees. Here she placed a couple, symbolizing her parents, facing each other in conversation. She added...
three human figures which represent her uncles talking to her father (a soldier figure with a gun). A windmill, which is the most famous symbol of the Netherlands, stands next to the house. Although a part of the scene is bucolic, the addition of the soldier figure, representing her father, placed in a group of male relatives, projects Sara’s fear of the aggressive behavior of her father, supported by the other men in the family. The fact that she is living in the Netherlands now is also clearly represented by the windmill.

In the scene, the big dolls of a man and a pregnant woman represent Andre and Sara, and one of the reasons she was rejected by her family: the pregnancy. Between these two figures she placed a saint with a child in his arms, showing the need for protection for the couple, but also for the unborn child. Close to the girl (big female pregnant doll) there is an ambulance, representing the treatment she needs to deal with the situation, and the telephone to communicate from a distance with her parents.

The four figures in front of the couple represent Sara and Andre begging her parents’ forgiveness. In this scene, Sara’s mother is represented by a saint and her father by a superman. Sara added three Dutch human figures in the corner of the scene, close to the telephone, representing her Andre, herself and Denis. The last figure Sara added, again showing her need for protection and her wish to protect her family in Kosovo, was an angel.

In this scenario Sara could express her inner psychological conflict: her grief caused by having left her parents and not having any contact with them since then, her fear for the aggressive reaction of her father and uncles, and her wish to communicate with them and to have their acceptance of her choices in life.

After two years of psychotherapy, in this Sandplay scenario, Sara expressed, in an organized way, a major conflict which was not directly related to the war and the trauma, but which referred to her individual history as a woman in her culture and her family. This projection also shows that Sara was able to move forward in her psychological development. Nevertheless, the mother/child psychotherapy with Sara and Denis is still in progress.

When I was finishing writing this chapter the family received a permanent resident permit to stay in the Netherlands.

Final Remarks

The case of Sara and Denis clearly illustrates the implications of a woman’s traumatic experiences since childhood in establishing a severe Posttraumatic Stress Disorder, with depressive and psychotic symptoms. It also exposes the consequences of the mother’s mental disorder for her interaction with her baby, and later her infant, putting the emotional development of the child at risk.

The case shows how the individual psychotherapy treatment was important to access the mother, and to help her to express and to elaborate on elements of her traumatic experiences related to the child and how the mother/child psychotherapy succeeded in helping them to develop both individually and in their interaction.

The mother/child psychological mutuality (Cramer, 1974) during pregnancy and in early childhood, determines the real and the imaginary mental representations that the mother has of the child and this affects the psychological organization of the child.
Parentalization is a complex process in which the experience modifies the symbolic and vice-versa. This process includes the recognition of the child as the bearer of a psychic heritage, which holds the parent’s culture, conscious dilemmas and unconscious conflicts that can exist in the family line: the transgenerational mandate (Lebovici, 1998).

It has as metaphorical paradigm – *The Tree of Life* – a transgenerational transmission which tends to be a family myth that defines the axe of the life mandate imposed on the descendent. This heritage is transmitted to the child through the care and the real and phantasmal parent/child exchanges and complex and reciprocal identifications, constituting the inter-subjectivity (Lebovici, 1996, 1998).

The fact that Denis was a healthy child and had a positive interaction with his father was a good basis for the mother/child psychotherapy, during which we could focus on the mother’s representation of the child, helping her to diminish her massive projections that were related to the very traumatic experiences she had during his pregnancy on to him.

Moro (2002) and Moro, De la Noë, & Mouchenik (2004) pointed out that the migrant child has to develop in a transcultural situation and, as a consequence, must build a cultural structure in the separation between the two worlds with different natures – one related to the family’s culture, the world of affection, and another, to the outside world, the world of rationality and pragmatism – frequently resulting in many conflicts in his/her interaction.

Even though we still see important sequels of the traumas in Sara’s personality and behavior, the individual psychotherapy, followed by the mother/child psychotherapy, helped to instill in her the motherhood process as Denis’ mother, as well the process of becoming a son of his own mother in the child.

Thus, the mother/child psychotherapy, combined with the Sandplay method, opened an important psychological space for the detection and treatment of the client’s maternal conflicts, favoring the development of a better attachment in the dyad, contributing to the emotional development of both mother and child, as well as preventing the development of psychopathology in the child.

As we saw in Sara’s case, the transcultural clinical work with clients with PTSD, is very complex and demands sensitivity, strength and emotional stability from the psychotherapist. Several authors have written guidelines (Nader, 1994; National Center for PTSD, 2006) with suggestions for the therapist’s attitude to the client. Inspired by these authors, as well as based on my clinical experience with clients such as Sara and Denis, I suggest the following basic guidelines for the psychotherapists who work with traumatized children, adolescents and young adults:

1. be able to talk about the traumatic events;
2. provide means to express the experiences and feelings related to the trauma;
3. support the client in positive strategies to cope with anxiety, anger and other stress reactions/symptoms;
4. be consistent and predictable in your relationship with the client in view of his/her vulnerability;
5. be affectionate and take into account the context and the culture of the client;
6. discuss what is expected in the client’s behavior in different situations and contexts;
7. answer the questions and explain what is needed;
8. look for signs of re-enactment, dissociation, avoidance, and reactivity;
9. empower the client to avoid re-traumatization;
10. talk to the client about choices giving him/her some sense of control of his/her own life;
11. ask for help and supervision if necessary.

Most of all, as psychotherapists, we must be aware that traumatized clients need to re-establish their connection with the world and with other persons, and that we are an important element in helping them in their healing process.

References


