

*Section: Transcultural reflections***Dialogue of Cultures in Psychotherapy: Transcultural Model of Transference and Countertransference Relations in the Method of Positive Transcultural Psychotherapy****Ekaterina Dokunova**

Psychologist, European certified psychotherapist (EAP),  
Master Trainer and Supervisor of Positive Psychotherapy  
(Tbilisi, Georgia)

Email: [edokunova@gmail.com](mailto:edokunova@gmail.com)

ORCID: [0009-0003-5088-8060](https://orcid.org/0009-0003-5088-8060)

Received 25.10.2025

Accepted for publication 23.12.2025

Published 23.01.2026

DOI: [10.52982/lkj305](https://doi.org/10.52982/lkj305)

**Abstract**

The article examines transference and countertransference in psychotherapy from a transcultural perspective. Attention is given to the influence of cultural values, norms, and traditions on the dynamics of therapeutic interaction and the forms of mutual understanding.

The paper presents a literature review that explores changes in the understanding of transference and countertransference and reexamines the importance of cultural factors in psychotherapeutic interaction more broadly. The article analyzes clinical examples that illustrate how cultural values shape distinct manifestations of transference and countertransference. It also examines the limitations of applying Western psychotherapeutic models to clients from other cultures without proper adaptation and critical reflection, which may result in diagnostic errors, distorted interpretations, and, consequently, reduced therapeutic effectiveness.

The potential of the Positive Transcultural Psychotherapy method is described, whereby culture is viewed as an active and formative element of the therapeutic process, influencing interpretations, expectations, emotional reactions, and the structure of the therapeutic relationship. The concepts of actual capacities and the theory of conflicts, proposed by Nossrat Peseschkian, explain how cultural norms and emotional patterns determine ways of contact, trust, and self-expression in the therapeutic process. Through the concept of “actual capacities,” the mechanism underlying the formation of interpersonal and intrapsychic conflicts is revealed, with the cultural factor taken into account.

This approach deepens the understanding of which cultural scripts are activated in therapy, how transference and countertransference are formed in intercultural dyads, and how awareness of these processes contributes to the development of mutual understanding. Positive Psychotherapy, through its focus on resources and cultural reflexivity, provides a unique tool for working with and understanding human experience as a multidimensional, culturally conditioned phenomenon.

**Keywords:** Positive Psychotherapy, transcultural psychotherapy, transference, countertransference, cultural sensitivity

**Introduction**

*“Since 1968, I have been working on a new method of psychotherapy that arose from extensive psychosomatic practice. Although the*

*fruits ripened in the European West, the roots of this tree run deep into the Persian East, the country where I was born and where my youth passed. Thus, my psychotherapeutic practice represents an attempt to integrate the*

*knowledge and wisdom accumulated in the East with the scientific achievements of the West. I am aware that such an approach, from the outset, presents many problems. Nevertheless, I consider it useful and even necessary precisely at a time when geographical distance is losing its significance.”*  
(Peseschkian, 1987)

Modern society is characterized by accelerated globalization, the transformation of social structures, and increasing mobility. Migration processes lead to the formation of multicultural communities.

Increasingly close contact between cultures creates the need – including in psychotherapy – to rely not only on one’s own cultural foundations but also to take into account other models of thinking.

This tendency manifests itself not only as a sociological fact but also as a clinical reality. It has posed new challenges for psychotherapy: the development and implementation of culturally sensitive approaches that consider how attitudes, traditions, and values influence health, its maintenance, mechanisms of disorder formation, and the therapist-client relationship.

Psychoanalytic psychotherapy is also a culture – one formed in the context of 20th-century Western European and North American society. Only in recent decades have anthropologists, sociologists, and psychotherapists begun to discuss the extent to which psychoanalytic concepts and techniques can be applied to ethnic groups, cultures, and social strata that are significantly different from those in which these ideas originated.

Among the central concepts of the psychoanalytic tradition, which are increasingly requiring rethinking in a transcultural context, is the interaction between the deep experiences of the client and the therapist in the processes of transference and countertransference. Most research remains focused on intrapsychic and interpersonal dynamics, while the cultural dimension still receives insufficient attention.

In the transcultural dyad, transference and countertransference are shaped not only by individual biography and interpersonal dynamics but also by complex cultural influences. For the therapist, this creates new challenges – the risk of cultural distortions and unconscious biases – as well as additional resources that expand the

possibilities for interpreting and understanding the client (Stampley & Slaght, 2004).

In this regard, it is necessary to seek therapeutic approaches that integrate the cultural dimension into the analysis of transference and countertransference.

Positive Transcultural Psychotherapy (initially called Differential Analysis) (Peseschkian, 1987) is based on cultural research conducted by a group of scientists led by N. Peseschkian in more than 20 cultures, which led to the method’s development in a transcultural direction.

The method can be described as a humanistic and transcultural psychodynamic approach grounded in a positive view of human nature and salutogenic principles (Peseschkian, H., n.d.; World Association for Positive and Transcultural Psychotherapy, n.d.). This conceptualization is grounded in the original theoretical framework developed by Peseschkian (1987), whose emphasis on cultural factors has been identified as a specific contribution to psychodynamic psychotherapy (Henrichs, 2012).

This approach considers the interaction between therapist and client, the therapeutic process, and the dynamics of transference and countertransference as a space for exploring cultural values behind the facade of symptoms, disorders, and conflicts. Thus, it allows a meaningful integration of culture into the therapeutic relationship.

The goal of this article is to carry out a theoretical analysis of the phenomenon of transculturality in relation to transference and countertransference processes, and to consider the potential of Positive Transcultural Psychotherapy as a means of working with this dimension.

## Methodology

Empirical studies in recent years confirm that a therapist’s cultural (transcultural) competence and clinically oriented, culturally sensitive methods influence therapy quality, related risks, and treatment outcomes (Sue et al., 1992; Ridley, C.R. et al., 1996, 2005; Juster Kangai et al., 2025; Jairo N. Fuertes et al., 2002; Siying Li et al., 2023).

Previous attempts to apply psychoanalytic theories to cultures outside Western Europe and America have followed one of three paths:

(a) asserting that Western psychoanalytic theory describes the norm of human development, and deviations are abnormal;

(b) focusing only on universals found across cultures while ignoring culturally specific elements; or

(c) emphasizing what makes each culture unique at the expense of shared features.

Each approach privileges different aspects of psychoanalysis and culture, but none unites them (Shweder & Bourne, 1984).

Applying Western models to clients from other cultures without proper adaptation and reflection may lead to diagnostic errors, distorted interpretations, and reduced therapeutic effectiveness. Cultural meanings may be misinterpreted as pathology. (Kozuki, Y., et al., 2004; Xu, H., et al., 2016; Ren, Z., 2022; Dwairy, M., 2002; Read, G. F. H., 2007).

Psychoanalytic psychotherapy evolved within the Western paradigm, emphasizing values such as individualism, rationalism, belief in progress, autonomy, and verbalization of internal experience. However, these are not universal. In cultures that prioritize harmony, hierarchy, or collective identity, psychoanalytic therapy may be perceived as alien or even threatening (Draguns, 2008).

For example, strong family involvement in an adult's life in Mexican or Arab cultures may be misinterpreted as dependency or as a failure of individuation (Díaz & Díaz-Loving, 1999; Al-Krenawi & Graham, 2000). Silence during sessions may be interpreted as resistance, whereas in another culture it may symbolize respect or reflection (Roland, 1996).

#### **Japan**

In the Japanese cultural context, norms of emotional restraint and social harmony may conflict with psychodynamic expectations of emotional expressiveness and individual self-disclosure. Empirical case analyses have shown that Western therapists frequently misinterpret culturally normative behaviors as psychopathology when working with Japanese clients, leading to misunderstanding and ineffective treatment (Kozuki & Kennedy, 2004). Japanese cultural norms also shape therapeutic relationships in ways that differ from Western individualistic assumptions, further underscoring the need for cultural adaptation in psychotherapeutic practice (Nippoda, 2012).

#### **Latin America**

The region's cultural values – familismo (the centrality of family), personalismo (the importance of personal relationships), and religiosity – shape particular expectations for

therapy (La Roche, M. J., 1999; Díaz & Díaz-Loving, 1999). In transference, clients may perceive the therapist as a “family member” or a mentor, which complicates maintaining classical neutrality. Countertransference may include excessive involvement or, conversely, distancing when faced with intense familial expectations.

#### **Asia**

Asian cultures are commonly characterized by a predominance of collectivism, an emphasis on relational harmony, and hierarchical social organization (Hofstede, 2001; Triandis, 1995). These cultural orientations shape interpersonal behavior and are reflected in therapeutic relationships, in which clients may prioritize maintaining social balance, role obligations, and contextual appropriateness over the open expression of individual desires or intrapsychic conflict. Empirical and theoretical work on cultural models of the self indicates that in many East Asian societies, the self is construed as fundamentally interdependent and relational, embedded within social roles and obligations rather than defined by autonomy and individual self-expression (Markus & Kitayama, 1991; Varnum et al., 2010). Such orientations may influence psychotherapeutic processes, including transference dynamics, which may manifest as idealization of the therapist as an authority figure or senior rather than as an egalitarian relational partner. Correspondingly, countertransference reactions may involve heightened responsibility, rescuing tendencies, or frustration regarding the client's perceived lack of autonomy, reflecting a potential cultural mismatch between Western psychodynamic assumptions and relational norms prevalent in many Asian contexts (Hofstede, 2001; Walker et al., 2005).

The Western «self» is defined by what makes a person unique and individual, whereas the Eastern self is a collective entity that builds bridges with family and community (Draguns, 2008).

Furthermore, the Asian concept of the spiritual dimension may include astrology, psychics, palmistry, shamans, and communication with ancestors (Roland, 1996).

#### **China**

In China, psychodynamic therapy faces philosophical and cultural constraints. Jie Zhong (2011) showed that conflicts between psychoanalysis and Chinese culture are linked to hierarchical structures and strong family

obligations. In transference, clients may perceive the therapist as an authoritative figure, which hinders open expression. The countertransference of Western therapists often led them to interpret restraint as resistance, resulting in misunderstanding.

#### **Arab Countries**

In many Arab cultural contexts, family ties, honor, and religious values play a significant role in shaping individual identity and interpersonal expectations (Al-Krenawi & Graham, 2000). These cultural orientations may be reflected in psychotherapeutic processes, including transference, where some clients may expect the therapist to engage with family dynamics or affirm religious frameworks. In cases where psychological distress is primarily expressed through somatic complaints, traditional psychodynamic interpretations may be experienced as less immediately relevant (Okasha, 2012).

From the therapist's perspective, countertransference reactions may include feelings of helplessness or irritation that reflect a cultural and theoretical mismatch between Western psychodynamic assumptions and clients' culturally grounded expectations. More broadly, Okasha (2012) notes that core emphases of classical psychoanalysis – such as sexuality and unconscious fantasy – may require careful cultural contextualization when applied in Islamic cultural settings, where religious norms and taboos shape acceptable forms of self-expression.

Thus, in transcultural psychotherapeutic contexts, transference and countertransference acquire culturally specific forms that reflect the values, norms, and sociocultural traditions of both clients and therapists. The implicit universalism underlying many Western psychotherapeutic models – developed primarily within Euro-American cultural frameworks – has been critically challenged for obscuring culturally embedded assumptions and limiting clinical relevance outside Western settings (Kleinman, 1988). Effective psychodynamic practice in such contexts, therefore, requires cultural adaptation, flexible and culturally informed engagement with transference and countertransference processes, and a reconceptualization of the therapeutic alliance from a transcultural perspective rather than an exclusively Western universalist framework (Sue et al., 2009; Hall et al., 2016).

#### **The Experience of Collective Trauma in Transference and Countertransference**

Contemporary research emphasizes that trauma may have not only an individual but also a culturally conditioned nature, and the experience of such traumas actively resurfaces in therapeutic relationships. (Nickerson, A., & Bryant, R. A., 2014). The therapist's cultural competence becomes a key condition for a productive therapeutic alliance: recognizing the client's cultural narrative and the historical dimension of trauma allows therapy to become a space of healing.

Bodnar (2004) argues that a therapist working with clients from different cultures encounters histories of trauma and a wide spectrum of dissociative processes. Many children of immigrants carry the inherited experiences of their parents: poverty, fear, war, and, perhaps, genocide, loss and grief, discrimination, and disorientation in a new country. In therapeutic dyads, "diverse identities mutually penetrate each other," aspects of ourselves are reflected in the other and vice versa.

Thus, the acknowledgment of collective trauma – both one's own and the patient's – becomes an essential aspect of therapeutic work with transference and countertransference, especially in intercultural dyads.

#### **2.1. Evolution of the Concepts of Transference and Countertransference**

##### **Classical Model**

Sigmund Freud (1912, 1915) conceptualized transference as the projection of infantile object relations onto the analyst. In his view, transference represented not an obstacle but the royal road to the unconscious, allowing the analyst to reconstruct early conflicts through the repetition of past relationships in the therapeutic setting. Countertransference, by contrast, was initially considered a disturbance arising from the analyst's unresolved personal conflicts (Freud, 1910).

Melanie Klein (1932) later deepened Freud's notion, arguing that transference reproduces the patient's internalized object world. For her, it provided access to primitive anxieties and early relational experiences, opening possibilities for reparation and transformation.

Carl Gustav Jung (1954) expanded the concept beyond the personal domain, introducing its archetypal dimension. He

understood transference as a symbolic process expressing universal themes rooted in the collective unconscious.

#### **Re-evaluation of Countertransference**

In the mid-twentieth century, the understanding of countertransference shifted significantly. Paula Heimann (1950) proposed that countertransference should not be seen solely as an obstacle but as a vital diagnostic instrument. The therapist's emotional responses, she argued, reflect unconscious communications from the patient. Heinrich Racker (1957) further refined this idea by distinguishing between reactive countertransference (arising from the therapist's own personality) and projective countertransference (induced by the patient's projections).

Object relations theory – developed by Melanie Klein (1946), Donald Winnicott (1960), and others – views both transference and countertransference as revivals of the patient's internal object world within the analytic dyad. Through this framework, transference was understood as the patient's attempt to reenact early relationships with caregivers, whereas countertransference was understood as the therapist's participation in these dynamics.

#### **Intersubjective Approach**

During the 1980s and 1990s, intersubjective and relational perspectives transformed the understanding of transference and countertransference. These approaches emphasized that the therapeutic situation is not a one-sided projection of the patient's inner world but a mutually created field of experience. Transference and countertransference were reconceptualized as co-constructed phenomena arising from the interaction of two subjectivities (Stolorow, Atwood & Brandchaft, 1987; Mitchell, 2002; Ogden, 1994).

#### **Transcultural Perspectives**

Contemporary research highlights the profound cultural conditioning of transference and countertransference and demonstrates that these phenomena extend beyond the personal and familial domains to encompass collective representations and ethnic identities. (Ticho, 1971; Akhtar, 1999; Dalal, 2002).

Stampley and Slaght (2004) noted that therapists' cultural biases can lead to misinterpretations and therapeutic impasses. Pérez-Foster (1998) introduced the notion of cultural countertransference, emphasizing that the therapist's reactions are influenced by their

own cultural background and social positioning. Incorporating culture into psychotherapy requires therapeutic capacities to tolerate ambiguity and work with differences (Bennett, 1993)

A particularly significant contribution to transcultural psychodynamics was made by Nossrat Peseschkian, who developed Positive Psychotherapy as a culturally sensitive method. (Peseschkian, 1987; 1991). Peseschkian viewed the therapeutic process through a transcultural lens, integrating individual psychodynamics with sociocultural dimensions. He proposed a model in which psychogenesis (individual development) and sociogenesis (social and cultural development) interact dynamically (Peseschkian, 1991).

The evolution of psychodynamic theory has thus moved from classical notions of transference as the reconstruction of infantile relationships and countertransference as the analyst's personal obstacle, toward recognizing their mutual and cultural nature. Today, both processes are understood as arenas in which personal, collective, and historical experiences intersect – mediated by culture, language, and social context.

### **2.2. Historical Context of the Concepts**

Discussions of transcultural or culturally oriented psychotherapy are meaningful only when the term culture is clarified.

According to Wolfgang Pfeiffer (1971), "Culture is a complex that includes traditional experience, ideas, and values, as well as social orders and rules of behavior transmitted through generations. It encompasses the categories and codes by which people interpret their world and coordinate their actions."

The development of culturally sensitive approaches in both the humanities and the clinical sciences has been accompanied by the emergence of a set of concepts that reflect different stages in understanding the relationship between psyche and culture.

The term "comparative psychiatry" was introduced by Emil Kraepelin in the early twentieth century, based on his research in Java (1904–1906). Kraepelin sought to compare forms of psychopathology across cultures, laying the foundation for cross-cultural approaches (Kraepelin, 1904, 1906).

Anthropological studies – particularly those of Margaret Mead (1928, 1935) – greatly

influenced the development of cross-cultural psychiatry and psychology by emphasizing the relativity of norms and the cultural determination of personality development.

In the 1940s and 1950s, Erik Wittkower expanded Kraepelin's ideas and effectively established the field of transcultural psychiatry, which later gained international recognition and institutional support within the World Psychiatric Association (Wittkower, 1965).

During the same period, new terms emerged, including "ethnopsychiatry," "ethnopsychanalysis," "cultural psychiatry," and "anthropological psychiatry."

From the late 1950s onward, the term "cross-cultural" became established in psychology and psychiatry, denoting the systematic comparison of psychological processes across societies.

In the 1960s and 1970s, the growth of cross-cultural psychology was linked to the work of Harry Triandis (1964, 1995), who explored cultural variations in individualism and collectivism, and David Matsumoto (1989, 1990), who studied cultural patterns of emotion and nonverbal behavior.

In the United States during the 1970s and 1980s, the concept of "multicultural counseling" emerged to describe psychotherapy and counseling conducted between individuals from different cultural backgrounds (Pedersen, 1991; Sue et al., 1992).

Nossrat Peseschkian further developed Positive Psychotherapy (PPT). Later, other authors, including Hamid Peseschkian (1988, 1999, 2002), examined the transcultural background and introduced the term «transcultural» into the name "Positive Psychotherapy". This method of cultural sensitivity toward the client's worldview emphasizes careful attention to values, symbols, and traditions within the therapeutic process. His approach bridged psychodynamic theory with practical methods of culturally oriented therapy.

The evolution of the concepts multi-, cross-, inter-, and transculturality illustrates a movement from the idea of simple coexistence and comparison of cultures toward intercultural dialogue and, finally, to transcultural interaction – understood as mutual enrichment and transformation.

Within the psychodynamic context, this progression allows a new understanding of the therapist–client relationship and of the

processes of transference and countertransference: not merely as repetitions of the client's past relationships, but as a mutual transformation in which new meanings and forms of experience emerge.

## Discussion

### 3.1. *Psychotherapy as a Culture*

Psychotherapy does not merely explore the client's culture; it constitutes a distinct culture in its own right, carrying with it particular norms, values, and historically shaped worldviews. According to Wohl (1989), psychotherapy contains particular sets of assumptions, rules, myths, and rituals. These can be viewed as the «psychology and psychotherapy cultural baggage» that «we tote around as creatures of our professional culture». Based on Triandis' (1996) definition of culture, psychotherapy culture comprises shared elements that establish standards for perceiving, believing, evaluating, and communicating.

Each therapeutic school embodies implicit assumptions about what it means to be human, how the psyche operates, and what constitutes normality or pathology. Psychotherapy, therefore, represents not only a set of healing methods but also a system of beliefs – a symbolic and ritualized practice embedded in a sociocultural framework.

From this perspective, every psychotherapeutic approach can be understood as a microculture, with its own language, rules, rituals, and ethical boundaries. This cultural matrix operates as an additional dimension of meaning in the therapeutic relationship, influencing the interaction between client and therapist alongside their individual cultural identities.

In transcultural therapy, one can distinguish between three interacting cultural systems:

1. The culture of the client,
2. The culture of the therapist
3. The culture of psychotherapy itself.

These three systems intertwine to form a unique therapeutic space. When therapists are aware of this triangular structure, they can potentially use differences productively – as material for understanding transference and countertransference, as resources for interpretation, and as opportunities for genuine cultural dialogue.

The following descriptions are intended as heuristic representations of dominant tendencies within therapeutic traditions rather than exhaustive or uniform characterizations of each approach.

#### **The Psychoanalytic and Psychodynamic Culture**

The psychoanalytic and psychodynamic traditions have historically emphasized introspection, the pursuit of self-knowledge, and the value of the “speaking subject.” This therapeutic culture has often prioritized the verbal articulation of inner conflict, free association, and reflective exploration of unconscious processes. For some clients from cultural contexts in which the open verbalization of internal experience is less customary or may be socially constrained, entering this “culture” of analysis may evoke misunderstanding, ambivalence, or resistance (Akhtar, 1995).

#### **The Cognitive-Behavioral Culture**

Cognitive-Behavioral Therapy (CBT) has frequently been described as emphasizing rationality, structure, and pragmatic problem-solving. For clients who expect a more relational, exploratory, or process-oriented therapeutic engagement, CBT may at times be experienced as reductive or as insufficiently addressing the complexity of emotional life. Conversely, clients socialized in task-oriented or achievement-focused cultural contexts may find resonance in CBT’s clarity, structure, and predictability.

#### **The Humanistic and Existential Culture**

Humanistic and existential approaches promote values of authenticity, acceptance, and non-judgment, cultivating a phenomenological stance that privileges the client’s subjective experience. These traditions emphasize personal growth, self-actualization, and meaning-making (Rogers, 1957; May, 1983). The existential dimension further introduces philosophical concerns related to freedom, responsibility, and mortality. In cultural contexts where obedience, modesty, and interdependence are strongly emphasized, the humanistic focus on autonomy and personal self-expression may be experienced as unfamiliar or potentially challenging (Triandis, 1995).

#### **The Body-Oriented Therapeutic Culture**

Body-oriented therapeutic approaches are grounded in the understanding of the body as a site of memory, emotional experience, and psychological transformation. This therapeutic culture values spontaneity, sensory awareness,

and the integration of embodied and reflective experience (Lowen, 1975). Therapeutic practices may include breathing techniques, movement, and guided attention to bodily sensations. In cultural contexts where bodily expression is restricted, or physical proximity is culturally regulated outside intimate or medical settings, engagement with this therapeutic culture may elicit discomfort, hesitation, or resistance (Roland, 1996).

The effectiveness of psychotherapy and the dynamics of the therapeutic relationship depend not only on interpersonal differences between therapist and client, but also on the client’s capacity and readiness to engage with the cultural assumptions and practices embedded within a given therapeutic modality (Ayazi, 2006). In this sense, psychotherapy does not merely interpret the client’s cultural background but also actively creates a cultural space of its own – a distinctive symbolic environment within which the therapeutic process unfolds.

### *3.2. Possibilities of the Positive Psychotherapy Method in the Study of Transcultural Phenomena in the Psychotherapeutic Process (Part 1)*

#### **The Transcultural Aspect in the Positive Psychotherapeutic Process**

Nossrat Peseschkian, through his lived experience in a transcultural context, was among the first to develop a culturally sensitive approach to psychotherapy. His contribution to contemporary psychodynamic and humanistic psychotherapy addresses the growing needs of the globalized world (Henrichs, 2025).

The method of Positive Transcultural Psychotherapy (PPT) provides tools for achieving a holistic diagnosis that encompasses not only symptoms but also their causes – rooted in the client’s life situation, family, subculture, and wider cultural environment. Peseschkian’s approach integrates the psychodynamic, social, and cultural dimensions of human functioning into a single coherent framework.

Positive Transcultural Psychotherapy conceptualizes personality development through four interconnected levels:

1. Psychodynamics (in the narrow sense) – the intrapsychic organization of conflict processes.

2. Sociodynamics – the mutual processes in which individuals are engaged.

3. Sociogenesis – the evolution of group traditions influenced by the impulses and interactions of group members.

4. Psychogenesis – the individual developmental conditions that determine the content of conflicts and the structure of personality. (Peseschkian, 1991).

Within a transcultural process, the therapist works with culture-specific concepts, norms, worldviews, and behavioral styles. Such an approach encompasses the essential characteristics of a given population, including collective values, body-related norms, illness perceptions, and socially accepted forms of conflict resolution.

By analyzing these factors, therapists gain a deeper understanding of how culture shapes individual modes of emotional expression, coping, and the dynamics of transference and countertransference within therapy. The instruments of Positive Transcultural Psychotherapy thus provide a structured framework for analyzing how cultural values manifest within the therapeutic relationship, allowing for the integration of sociocultural meaning into psychodynamic work.

### 3.3. Observation and Structuring of Transference and Countertransference Reactions

The therapist's awareness of countertransference increases with emotional involvement in the therapeutic relationship. Before these reactions – such as anger, anxiety, helplessness, guilt, admiration, or tenderness – reach conscious awareness, they often require a certain emotional intensity.

Peseschkian's concept of the four modes of perceiving reality provides a highly practical framework for observing and structuring transference–countertransference reactions in a transcultural context.

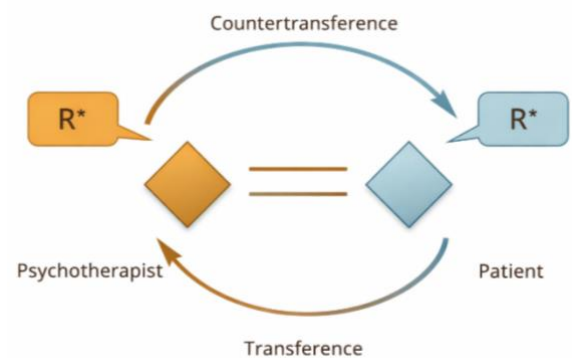


Figure 1. Psychodynamic diagram of the transference-countertransference cycle.

According to this concept, human beings experience and interpret the world through four primary channels:

- Through sensations (emotions, feelings, and bodily experiences);
- Through logic and reason (thoughts, evaluations, impulses);
- Through tradition and personal experience (associations, memories, learned behavior);
- Through intuition and imagination (fantasies, fears, expectations). (Goncharov M. 2020)

At the stage of observation, it is essential to notice and record these reactions without the immediate need for interpretation or causal explanation.

### 3.4. Cultural Practices and Forms of Conflict Processing

#### The Four-Mode Model

Culturally embedded traditions of upbringing and socialization establish norms for the expression or suppression of emotions, the preservation of social harmony, or the value of autonomy. These, in turn, determine typical patterns of responding to conflict.

Positive Psychotherapy identifies four modes of conflict processing, corresponding to the four dimensions of human functioning:

- Body/Sensation,
- Activity/Reason,
- Contacts/Relationships,
- Fantasies/Imagination and Meaning.

Exploring which of these domains is most emphasized – or most repressed – helps the therapist account for how cultural values shape both unconscious defense mechanisms and conscious coping strategies.

Cross-cultural studies have confirmed that cultural norms and value systems largely shape coping strategies. In individualistic societies, individuals may more frequently employ active, externalized strategies – such as cognitive reappraisal or direct emotional expression – linked to defenses such as rationalization or sublimation. In collectivistic cultures, however, coping tends to favor social harmony through suppression, somatization, and avoidance-based strategies (Triandis, 1995; Markus & Kitayama, 1991).

Within any given culture, significant individual variations also exist, influenced by age, gender, education, and degree of acculturation. Women tend to use emotion-focused coping strategies – such as emotional expression or seeking social support – while men often prefer problem-focused or behavioral strategies.

For the therapist, understanding these cultural variations is crucial: what might appear as “maladaptive” in one culture could be a normative and adaptive form of regulation in another. In therapy, these differences often surface within transference. For example, a client from a collectivist society may expect the therapist not to push for overt emotional expression, and may even interpret excessive empathy as intrusive. Conversely, the therapist may experience discomfort or frustration when the client does not conform to Western models of openness – reactions that become valuable material for countertransference analysis.

### 3.5. The Four Life Spheres Model

Positive Transcultural Psychotherapy describes human existence as a dynamic balance among four interrelated life spheres:

Body / Health,  
Achievement / Work,  
Contact / Relationships, and  
Meaning / Future.

In societies with a medically oriented worldview (for example, where physical health is understood as the main value), the emphasis is on the body: maintaining physical well-being, appearance, and control over health become central guidelines. In a number of Eastern cultures, the spiritual and meaningful sphere is pronounced: the search for purpose, values, and images of the future is perceived as the basis of harmony, and fantasies about the future are often associated with collective hopes or religious beliefs. In some traditionally collectivist

societies in Asia, the social sphere comes to the fore: interpersonal contacts, maintaining harmonious relationships, and belonging to a group are valued above individual needs. Thus, the balance between the four spheres in a transcultural perspective is understood as a dynamic system, where each culture forms its own emphases, determining not only a person's life orientation, but also their ideas about harmony and well-being.

The four-sphere model not only allows us to structure the client's life experience but also serves as a guide for fine-tuning therapeutic interaction in an intercultural dimension.

### 3.6. Model of Identification and Family (Basic) Concepts

Personality development depends decisively on early attachment relationships. According to Peseschkian, these can be described through a four-dimensional model of role identification, reflecting how significant figures relate to the child and to one another:

I – the relationship of parents and siblings toward the child;

You – the relationship between the parents themselves;

We – the relationship of the parents to the social world and community;

Primary-We – their relationship to religion, philosophy, and worldview.

This model expands on psychodynamic theories of object relations with parents. The experience of significant adults' relationships with each other, interaction with the social environment, cultural values, and philosophy of life form three more functions of the role model of sociodynamics and psychodynamics. In addition to intrapersonal conditions of development, social, cultural, and transcendental relationships are considered first and foremost. These four dimensions form a child's internal orientation system: attitude toward oneself, capacity for partnership and intimacy, interaction with society, and understanding of life and the future.

This tool makes visible the deep social scenarios that influence therapeutic relationships. It allows us to identify which images of relationships are considered normative in the client's culture and how these images influence expectations of the therapist. Thus, understanding the cultural specificity of

family concepts helps the therapist to construct more accurate and respectful interventions.

### 3.7. Conflict Theory in Positive Psychotherapy

The model of conflicts (actual, key, basic, and inner) proposed by Positive Psychotherapy allows us to view mental dynamics as a system in which individual experiences are constantly correlated with a broader social and cultural context.

Internal expectations and concepts come into conflict with external demands (actual conflict). Emotions, affects, and bodily reactions in this context act as signals indicating an internal conflict of values and an imbalance of actual abilities.

In the therapeutic process, basic conflicts manifest themselves in therapeutic relationships through the processes of transference and countertransference. The client may expect the therapist to confirm the correctness of their habitual, culturally acquired norms of behavior.

The therapist's countertransference, in turn, often reflects the clash between their own cultural ideas about "normality" and the client's norms. Awareness and analysis of these reactions allows for a deeper understanding of the client's value system and avoids projections based on one's own cultural matrix.

Conflict theory in Positive transcultural psychotherapy combines individual psychodynamics and transcultural sociodynamics. It allows us to see conflict as an opportunity to become aware of the contradictions between cultural values.

Thus, in therapy, it is important not only to explore the source of internal tension but also to consider the cultural meanings underlying it. This approach allows the therapeutic process to be more differentiated, careful, and culturally sensitive.

### 3.8. Theory of Actual Capabilities

N. Peseschkian drew attention to the importance of psychosocial norms in socialization and in the emergence of interpersonal and intrapsychic conflicts. He found that among both Eastern and Western (European and American) patients, these conflicts could be reduced to a number of recurring behavioral patterns. He then compiled a list of these phenomena, which made it

possible to describe the substantive component of conflicts.

Actual capacities are formed in the process of socialization and correspond in content to the sociocultural system of relationships, manifesting themselves under the unique conditions of individual development. As conceptual structures, they are transferred into self-perception and determine how a person perceives the surrounding world and resolves emerging problems.

Primary actual capacities are a person's emotional capacities – instruments and preconditions for the establishment and development of interpersonal relationships (trust, contact, sexuality, faith, patience, time, etc.).

Secondary actual capacities are rational capacities – cultural norms and rules that function as regulators in relationships with other people and the world (obedience, reliability, loyalty, politeness, accuracy).

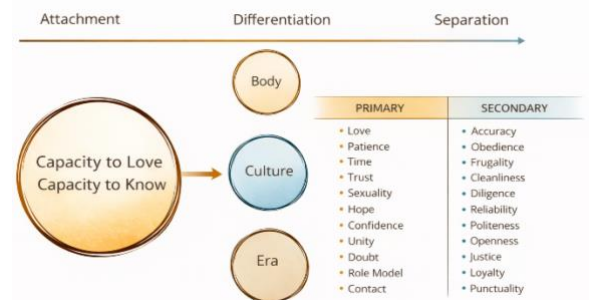


Figure 2. Development of Primary and Secondary Capacities.

Through the concept of actual capacities, N. Peseschkian offers a unique tool for analyzing cultural differences, demonstrating that the prominence and social significance of these capacities vary from culture to culture. From a transcultural perspective, we can observe that in some Eastern cultures, primary capacities (love, trust, faith, contact) are more pronounced, whereas secondary capacities (orderliness, punctuality, diligence, cleanliness, responsibility) are characteristic of some Western cultures. From early childhood, parents and society emphasize different aspects of emotional and social development.

From a transcultural perspective, a client may expect a therapist to display the very qualities that their culture considers "normal." Thus, clients whose cultural backgrounds emphasize collectivist values may, in some cases, anticipate

greater relational involvement, emotional warmth, and expressions of care within the therapeutic relationship, whereas clients socialized in more individualistic cultural contexts may place greater value on personal autonomy, interpersonal distance, and clearly defined boundaries.

When working with clients from cultural contexts that encourage emotional restraint or interpersonal reserve, therapists may notice internal reactions such as discomfort with silence, a wish to reduce perceived distance, or an impulse to foster greater closeness. When approached reflexively, these responses can serve as valuable material for understanding countertransference processes and for exploring culturally embedded expectations within the therapeutic relationship.

Kirillov (2021) proposed examining the development of primary capacities in ontogenesis through three levels of integration corresponding to stages of interaction:

- Low – attachment
- Medium – differentiation
- High – separation.

The formation of primary capacities occurs through the satisfaction of a child's primary needs (for contact, trust, pleasure, time, hope). The extent to which adults are able to respond adequately and in a timely manner – using their own primary capacities – determines the development of corresponding emotional qualities.

Each need generates three types of impulses:

Dependent – aimed at compensating for a deficit

Adequate – reflecting harmonious satisfaction of the need;

Avoidant – arising from over-saturation of the need, when a person seeks to distance themselves from it.

For example, the capacity for contact may manifest as intrusive overinvolvement (dependent impulse) or, conversely, as avoidance, isolation, and distancing (avoidant impulse). The capacity for idealization may appear as the need to idealize the therapist or, on the contrary, to devalue them.

This framework enables reflection on clients' early developmental experiences and provides a more nuanced understanding of levels of personal functioning and personality disorder types – without pathologizing, while connecting individual development to its cultural context.

### 3.9. A Content-Oriented Approach to Transference and Countertransference

In Positive Transcultural Psychotherapy (PPT), social and cultural reality is seen as a natural and significant part of the therapeutic reality. Each meeting between a patient and a therapist is an interaction not only of two personalities, but also of two value systems, two cultural worlds that determine the forms of perception, expression of feelings, and ways of mutual understanding.

In an intense encounter between patient and therapist, mutual expectations, desires, thoughts, fantasies, and emotions arise. The client has certain needs and expectations that correspond to his strong individual attitudes. In turn, the therapist also has individually determined expectations regarding the client, determined by his role. In terms of content, both bilateral role expectations and "personal" attitudes are oriented towards already established psychosocial norms (actual capabilities), the substantive elements of psychodynamic processes that determine both intrapersonal and interpersonal conflicts.

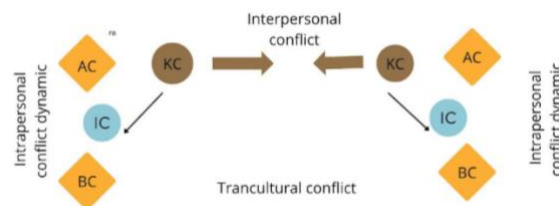


Figure 3. Intrapersonal, Interpersonal, and Transcultural Conflict Dynamics in Positive Transcultural Psychotherapy.

It is through actual capabilities that socio-psychological and cultural factors are included in therapy, which makes it possible to analyze not only the structure of the conflict, but also its specific content.

For example, the client may be very reserved (politeness) or have little initiative, expecting more guidance and instructions from the therapist (obedience). Or strive to control the course of therapy and demand submission from the therapist (obedience), be late for sessions (punctuality), refuse to follow agreements (reliability), and show a lot of effort (diligence).

The client's stories about conflicts outside the therapeutic relationship will also include the central themes of these conflicts (loyalty, obedience, accuracy). All these manifestations cause responses from the therapist. These

reactions can be partially unconscious and manifest themselves at emotional, cognitive, and physiological levels - in the form of fatigue, anxiety, irritation or tension, or sympathy, admiration, tenderness.

The therapist's responses to the relationship offered by the client often reflect deep-seated, culturally conditioned expectations and interaction scripts. Their awareness becomes an important part of the analysis of the dynamics of transference and countertransference.

The next step in the psychotherapeutic process is to explore the experiences and circumstances under which these capabilities became meaningful to the client and therapist. What relationship (primary capabilities- love, trust, time) in their experience is associated with the expected or proposed behavior (secondary capabilities - obedience, politeness, reliability)?

The client and therapist explore their behavior as having its own "tradition" – a chain of learned reactions and meanings. The personal history of the formation of abilities, their cultural design, and the socio-historical context in which they developed comes to the fore.

Discovering the faculties involved in interpersonal conflicts is the tip of the thread that we then follow to discover intrapsychic conflicts and their dynamics. This conceptualization allows us to explore the dynamics of conflicts at the intrapsychic, interpersonal, group, and system levels.

This opens up the opportunity not only to become aware of, but also to rework unconscious expectations, transforming them

into new forms of interaction that are appropriate to personal and cultural conditions.

## Conclusion

The theoretical analysis presented in this article demonstrates that transference and countertransference in psychotherapy are shaped not only by the individual experiences of the client and the therapist but also by cultural norms, values, and collective expectations. These factors significantly affect the dynamics of the therapeutic relationship.

The results further indicate that psychotherapy itself functions as a distinct cultural system interacting with the cultures of both client and therapist. Awareness of this triadic structure allows transference and countertransference to be understood as co-constructed processes and reduces the risk of ethnocentric interpretations.

Within this framework, Positive Transcultural Psychotherapy offers a structured and clinically applicable model for analyzing transference and countertransference. The concepts of actual capacities and conflict theory make it possible to identify the culturally conditioned content of expectations and emotional reactions within the therapeutic dyad.

Overall, Positive Transcultural Psychotherapy demonstrates substantial potential for understanding and working with transference and countertransference in culturally diverse therapeutic contexts, thereby enriching psychodynamic practice and deepening insight into the therapeutic relationship.

## References

1. Akhtar, S. (1995). A third individuation: Immigration, identity, and the psychoanalytic process. *Journal of the American Psychoanalytic Association*, 43(4), 1051–1084.
2. Akhtar, S. (1999). *Immigration and identity: Turmoil, treatment, and transformation*. Northvale, NJ: Jason Aronson.
3. Al-Krenawi, A., & Graham, J. R. (2000). Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings. *Health & Social Work*, 25, 9-22. <http://dx.doi.org/10.1093/hsw/25.1.9>
4. Ayazi, T. (2006). Psychotherapy in Gaza: Application of psychotherapy in a non-western society. *Tidsskrift for Norsk Psykologforening*, 43(2), 120–129.
5. Bennett, M. J. (1993). Toward ethnorelativism: A developmental model of intercultural sensitivity. In R. M. Paige (Ed.), *Education for the intercultural experience* (pp. 21–71). Yarmouth, ME: Intercultural Press.
6. Dalal, F. (2002). *Race, colour and the processes of racialization*. London: Brunner-Routledge.
7. Díaz, R., & Díaz-Loving, R. (1999). *Cultura y personalidad en América Latina* [Culture and personality in Latin America]. México: Trillas. [in Spanish]
8. Draguns, J. G. (2008). Culture and personality: Cross-cultural perspectives. In G. Misra (Ed.), *Psychology in India* (Vol. 2). New Delhi: Pearson.
9. Dwairy, M. (2002). Psychotherapy in competition with culture: A case study of an Arab woman. *Clinical Case Studies*, 1(3), 254–267. <https://doi.org/10.1177/15350102001003005>

10. Freud, S. (1910). The prospects of psychoanalytic therapy. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 11). London: Hogarth Press.
11. Freud, S. (1912). The dynamics of transference. In: *The Standard Edition* (Vol. 12). London: Hogarth Press.
12. Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Clinical Psychology Review*, 43, 44–57. <https://doi.org/10.1016/j.beth.2016.09.005>
13. Heimann, P. (1950). On counter-transference. *International Journal of Psychoanalysis*, 31, 81–84.
14. Henrichs, C., Hum, G. (2025). The Development of Positive Psychotherapy in Dialogue with Other Psychotherapeutic Methods. In: Messias, E., Peseschkian, H. (eds) *Positive Psychiatry, Psychotherapy and Psychology*. Springer, Cham. [https://doi.org/10.1007/978-3-031-94645-5\\_40](https://doi.org/10.1007/978-3-031-94645-5_40)
15. Hofstede, G. (2001). *Culture's consequences (2nd ed.)*. Thousand Oaks, CA: Sage.
16. Ilina, T. S. (2021). The Balance Model in Russian and Chinese Culture: Preliminary Study and Comparative Analysis. *The Global Psychotherapist*, 1(1), 15–21. <https://doi.org/10.52982/lkj136>
17. Jung, C. G. (1954). *The psychology of the transference*. Princeton, NJ: Princeton University Press.
18. Kirillov, I. O. (2021). *Positive Psychotherapy: Basic course*. Moscow: Academy of Transcultural Psychotherapy.
19. Klein, M. (1932). *The psycho-analysis of children*. London: Hogarth Press.
20. Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York, NY: Free Press.
21. Kozuki, Y., & Kennedy, M. G. (2004). Cultural incommensurability in psychodynamic psychotherapy in Western and Japanese traditions. *Journal of Nursing Scholarship*, 36(1), 30–38. <https://doi.org/10.1111/j.1547-5069.2004.04008.x>
22. Li, S., Xi, Z., Barnett, P., Saunders, R., Shafran, R., & Pilling, S. (2023). Efficacy of culturally adapted interventions for common mental disorders in people of Chinese descent: A systematic review and meta-analysis. *The Lancet Psychiatry*, 10(6), 426–440. [https://doi.org/10.1016/s2215-0366\(23\)00118-9](https://doi.org/10.1016/s2215-0366(23)00118-9)
23. Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, 98(2), 224–253. <https://doi.org/10.1037/0033-295X.98.2.224>
24. Marseille, A. R. (2025). The intellectualization of multiculturalism: Implications for Positive Psychotherapy. *The Global Psychotherapist*, 5(1), 38–48. <http://doi.org/10.52982/lkj257>
25. Matsumoto, D. (1990). Cultural similarities and differences in display rules. *Motivation and Emotion*, 14, 195–214. <https://psycnet.apa.org/doi/10.1007/BF00995569>
26. Mead, M. (1928). *Coming of age in Samoa*. New York, NY: William Morrow.
27. Mead, M. (1935). *Sex and temperament in three primitive societies*. London: Routledge.
28. Mitchell, S. (2002). *American Generations: Who They Are, How They Live, What They Think*. New Strategist Pubns Inc.
29. Nippoda, Y. (2012). Japanese culture and the therapeutic relationship. *Online Readings in Psychology and Culture*, 10(3). <https://doi.org/10.9707/2307-0919.1094>
30. Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. *The International Journal of Psychoanalysis*, 75(1), 3–19.
31. Okasha A, Karam E, Okasha T. (2012) Mental health services in the Arab world. *World Psychiatry*, 11(1), 52–4. <https://doi.org/10.1016/j.wpsyc.2012.01.008>
32. Peseschkian, H. (1988). *Positive Psychotherapy as a transcultural psychotherapeutic approach* (Unpublished doctoral dissertation). Johannes Gutenberg University Mainz.
33. Peseschkian, N. (1987). *Positive Psychotherapy: Theory and practice of a new method*. Springer-Verlag (Germany, USA).
34. Peseschkian, N. (2016). *Positive Psychosomatics: Clinical Manual of Positive Psychotherapy*. Bloomington, USA: AuthorHouse.
35. Pfeiffer, W. (1971). *Transkulturelle Psychiatrie; Ergebnisse und Probleme* [Transcultural psychiatry; results and problems]. Stuttgart: Thieme. [in German]
36. Racker, H. (1957). The meanings and uses of countertransference. *The Psychoanalytic Quarterly*, 26, 303–357.
37. Read, G. F. H. (2007). *Psychoanalytic psychotherapy and the analytic attitude: A cross-cultural case study approach* (Doctoral dissertation, University of Pretoria, Department of Psychology). <https://repository.up.ac.za/server/api/core/bitstreams/b879debc-1177-49fd-982a-5aa08d79bcb7/content>
38. Remmers, A. (2023). Transference and Countertransference. *The Global Psychotherapist*, 3(1), 75–79. <https://doi.org/10.52982/lkj183>
39. Roland, A. (1996). *Cultural pluralism and psychoanalysis: The Asian and North American Experience*. New York, NY: Routledge.

40. Shweder, R. A., & Bourne, E. J. (1984). Does the concept of the person vary cross-culturally? In: R. A. Shweder & R. A. LeVine (Eds.), *Culture theory* (pp. 158–199). Cambridge: Cambridge University Press.
41. Stampley, C., & Slaght, E. (2004). Cultural countertransference as a clinical obstacle. *Smith College Studies in Social Work*, 74(2), 333-349.
42. Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach*. Analytic Press, Inc.
43. Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20(2), 64–88. <https://doi.org/10.1002/j.2161-1912.1992.tb00563.x>
44. Sue, S., Zane, N., Hall, G.C.N., Berger, L.K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annu Rev Psychol*. <https://doi.org/10.1146/annurev.psych.60.110707.163651>
45. Ticho, G. R. (1971). Cultural aspects of transference and countertransference. *Bulletin of the Menninger Clinic*, 5(5), 313-34.
46. Triandis, H. C. (1995). *Individualism and collectivism*. Boulder, CO: Westview Press.
47. Varnum, M. E. W., Grossmann, I., Kitayama, S., & Nisbett, R. E. (2010). The origin of cultural differences in cognition. *Current Directions in Psychological Science*, 19(1), 9–13. <https://doi.org/10.1177/09637214093593>
48. Walker, G. J., Deng, J., & Dieser, R. B. (2005). Culture, self-construal, and leisure theory. *Journal of Leisure Research*, 37(1), 77–99.
49. Wohl, J. (1989). Integration of cultural awareness into psychotherapy. *American Journal of Psychotherapy*, 43, 343–355.
50. Xu, H., & Tracey, T. J. G. (2016). Cultural congruence with psychotherapy efficacy. *Journal of Counseling Psychology*, 63(3), 359–365. <https://psycnet.apa.org/doi/10.1037/cou0000145>
51. Zhong, J. (2011). Working with Chinese Patients: Are there Conflicts Between Chinese Culture and Psychoanalysis? *Int. J. Appl. Psychoanal. Studies* 8(3), 218–226. <https://doi.org/10.1002/aps.304>