Psychoanalytic Psychotherapy and the Analytic Attitude: A Cross-Cultural Case Study Approach

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By

Gary Frank Hoyland Read

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ABSTRACT

The relevance of individual psychoanalytic psychotherapy in the context of post-apartheid South Africa is a contentious issue. The western-centric universalist bias of this treatment approach has been criticised for not being applicable to Black South African individuals. With these criticisms in mind the appropriacy and efficacy of psychoanalytic psychotherapy was examined by focusing on three Black English-speaking South African women between the ages of 25 and 35 from the urban Western Cape. A collective case study design situated within a postmodern framework of enquiry was chosen for its capacity to incorporate both the therapist's and the participant's experience of the therapeutic process over time. This study focused on the analytic attitude, which comprises the basic template through which psychoanalytic psychotherapy is practised. The model used was that described by Ivey (1999) which includes five elements: generative uncertainty, abstinence, neutrality, countertransference receptivity, resoluteness and three related concepts: the task process and setting. The therapeutic dyad comprised the principal unit of analysis; by examining the interactive responses within this dyad in terms of the eight sub-units of the analytic attitude it was possible to evaluate the effectiveness of this modality. The findings showed that this model was successful with an emerging group of individuals who simultaneously hold traditional collective values and western values of individuation and self-determination. Some adjustments to abstinence and neutrality were necessary and a high degree of vigilance and self-reflection on the part of the therapist was required. It was revealed that western ideals of individualism, subject/object dualities, and taken-for-granted assumptions tend to obscure the practice of psychoanalytic psychotherapy across culture. The relational two-person model was able to accommodate cultural difference to good effect, opening the way for universalistic assumptions to be challenged and re-thought. This attitude was effective both as a treatment model and as a research tool. The participants in this study represent an emerging class of Black South Africans who are seeking different pathways for psychological concerns. The findings of this study can be generalised to a body of knowledge concerning the use of the analytic attitude in specific cross-cultural contexts in South Africa.

KEY WORDS

Case Study	Psychoanalysis	Psychotherapy	Analytic Attitude
Cross-cultural	Relational	Individualism	Dualism
Universalism	Postmodern		

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CHAPTER ONE: INTRODUCTION

This study arises out of general trends in thought pertaining to the evolution of psychoanalysis in the context of post-apartheid South Africa. The applicability of psychoanalysis in this context is a contentious issue, highlighted at the psychoanalytic Trust Conference held in Cape Town, March 1998. At this meeting several questions were raised about the relevancy of psychoanalytic theory in the context of South Africa's traumatised communities. This conference was a watershed: it signified a turning point in the evolution of thought on the development of psychoanalysis in a new South Africa. Not only did it provide a foundation for debate on the professional training of psychologists but it also encouraged practicing clinicians to be critical of the value systems and theoretical assumptions they were using when interpreting and understanding issues of a cross-cultural nature (Swartz, S., 1998)[1]. This conference concluded by raising the concern that whilst standard psychoanalytic theory may be relevant to a western-based White minority, its applicability to the broader community of a new South Africa is questionable and remains largely unresearched.

In September 2002 the Psychological Association of South Africa (PSYSSA) held its 8th annual meeting at the University of the Western Cape. Similar themes emerged from this meeting with discussion focusing largely on ways of making psychological services more available to poor and rural communities. It was strongly felt that the general perception of psychology needed to be broadened beyond "the couch": the couch - and by implication, psychoanalysis - was an inappropriate tool for helping the previously disadvantaged deal with their problems (*Cape Times* article 26/09/02). However, it was concluded that psychology has a role to play in the healing of all people in the developing world and should not be confined exclusively to the "middle class".

Psychoanalytic psychotherapy is a form of therapy that is based on understandings drawn from classical psychoanalysis. This form of psychotherapy relies on making conscious those processes that are unconscious. It adheres to certain principles of practice that must necessarily be followed in order for unconscious processes to be made manifest. These principles are enacted within a specific therapeutic frame of working and are embodied in the concept of the **analytic attitude**, which is central to the practice of psychoanalytic psychotherapy.

The analytic attitude refers to a professional mindset involving five principles: *generative uncertainty*, *abstinence*, *neutrality*, *countertransference receptivity, resoluteness*; and three inter-

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[1] The format of this dissertation follows the guidelines laid down in the publication manual of the *American Psychological Association*

related concepts: *the analytic task, the analytic process* and *the analytic setting* (Ivey, 1999, p. 6). These principles underlie the practice of all therapeutic approaches that adhere to the concept of the human unconscious. Various depth psychology philosophies may disagree on the level of theoretical and technical issues but all these divisions practise the analytic attitude (ibid). More specifically this attitude refers to a "deeply rooted, coherent, professional mind-set that incorporates philosophical, ideological, psychological and ethical concerns" (Ivey, 1999, p. 3). It defines the psychoanalytic practitioner in terms of what he[2] knows, what he believes and how he should conduct himself in the therapeutic setting (ibid).

Within a western framework of practice psychoanalysis is widely accepted as an effective form of treatment for individuals with psychological difficulty, especially those who are neurotic and are encumbered in daily living by the intensity of childhood desires that cause them repeatedly to recreate in their current relationships the distressing scenarios experienced in early childhood. However, whilst it is well recognised that this model of understanding represents a sophisticated treatment approach, it must also be acknowledged that the basic conceptual framework of psychoanalytic psychotherapy is born out of western notions of subject-object duality and is therefore not directly transportable to those cultures that are based on collective notions of subject-object unity. Psychoanalytic psychotherapy and its corollary the analytic attitude has evolved out of and is strongly attached to western values and beliefs about self-determination and individualism. Furthermore, psychoanalytic psychotherapy has been devised and implemented in accordance with western assumptions about psychological health and development.

To expect that specific theoretical assumptions can be transported in their current form and be effective to Black South Africans is optimistic because the cultural patternings are different. For instance the Oedipus complex, which is central to the psychoanalytic thought established by Freud, arose at a time when the cultural patternings of authority in the family and in society were strongly paternalistic. Whilst it is well established that the oedipal struggle is a universal phenomenon (Abel, 1987), it is also recognised that variations on this framework occur depending on the cultural patterns of approved behaviour inculcated by parents and society at any given historical period. The "Parent" in many African families may be a parent surrogate or a series of parent displacements, thus giving rise to unpredictable manifestations of castration anxiety and the oedipal struggle.

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[2] To assist the flow of text throughout this thesis "he", "him" and "his" etc will be understood as referring to "she", "her" and "hers" etc and vice versa.

Similarly it is reasonable to expect that certain elements of the analytic attitude and the way in which it is implemented will need to be re-thought. Individuals from traditional collective communities who seek treatment for psychological concerns are more orientated to accepting a directive and authoritarian model of treatment. Such an expectation does not fit well into the analytic attitude, which deliberately withholds suggestion and direction. The analytic attitude, which is based on the values of the western individualistic self, is more likely to call upon individuals to introspect, self-reflect and to locate the source of their psychological concerns in themselves. This way of thinking about psychological difficulties as being located primarily within rather than without may be unfamiliar to individuals who still adhere to a collective cosmology that sees symptoms as being caused by external agents such as curses, bewitchment and ancestors.

This study does not support the perception that practice of psychoanalytic theory is irrelevant to a new and developing South Africa. On the contrary it supports the view that psychoanalytic theory provides a sophisticated system of understanding for those unconscious processes that form a part of all human personality - regardless of race and culture (Schlebusch, 1998). It recognizes that psychoanalysis is a valid model for treating and alleviating distressing symptoms in people's lives deriving from unconscious motivations. However, this study also acknowledges that practice of psychoanalytic psychotherapy in South Africa has been largely confined to a western minority group.

Historically the concept of the individualised self and its derived treatment modalities has been elevated to represent an ideal standard against which all cultures are judged and treatment provided. This universal approach has given rise to many misunderstandings and it is now generally accepted that whilst certain elements of psychoanalytic theory may hold true across culture, the differences need to be acknowledged by adopting a relativist approach that allows for such concepts to be de-contextualised from their western framework and then re-contextualised in terms of the unique nature of the culture to which it is being applied.

In order for psychoanalytic psychotherapy to move beyond its current field of practice certain elements of theory and practice need to be modified. If this framework of "thinking about" and "treating" individuals is to be effective then it needs to adjust to the specific cross-cultural patterns of a non-western population. Current understandings concerning the implementation of individual psychoanalytic psychotherapy on the level of both practice and theory are not necessarily irrelevant but will need to be revised if this model of working with and thinking about people cross-culturally is to carry credibility and be further developed in South Africa.

A person's sense of self is inextricably linked to his definition of himself through cultural values and ideals that are inseparable from his psychological processes. Culture informs the configuration of the self. All approaches for treatment and healing flow out of and reflect culturally determined conceptualisations of self. Just as the traditional healing practices of Black South African culture reflect the collective self so does psychoanalytic theory and practice in its present form reflect the concept of the western individualised self. The ability to be consciously aware of and describe subjective experience, thoughts, feelings and opinions serves little purpose and carries little value in traditional communities. Individuals are not encouraged to self-reflect, that is not to say that they are unable to do so but rather that traditional structures of expression have not required them to develop these resources (Ulmer, 2003). If effective treatment approaches can be seen as logical extensions of cultural configurations of self then it follows that psychoanalytic theory in its western dualistic form cannot be readily applicable to those traditional cultures in which dualisms are absent and little or no emphasis is placed on the individual.

The socio-economic and past political conditions in South Africa have caused much fragmentation of social and familial structures. This has given rise to much violence, poverty, unemployment and dehumanisation. The vast majority of individuals in South Africa are in a process of transition and new identity formation. Many South Africans straddle two worlds: a rural to urban shift, a traditional to western viewpoint, and a collective identity to an individual identity (Donald, Dawes & Louw, 2000). There is an emerging group of Black South Africans educated through a western system who represent a conglomerate or hybridisation of the collective self and the individualised self. This sense of self is at once different from and similar to its polar opposites of the individual and collective and in this study is referred to as the "expanding self" (Roland, 1988, p. 6). Members of this group aspire to the ideals of individualism but also maintain strong elements of the collective self into which they were born. The effect of this transition on the individual is profound and often causes much distress. With the breakdown of traditional structures of support individuals require new support structures, which are presently lacking.

As South Africa society continues to develop in accordance with the western ideals of individualism, as encapsulated in the constitution and the bill of rights, so more and more people are adopting the values of western culture. Economic policy, health care, legal and judicial and educational systems all promote the rights of the individual (Donald et al., 2000). It seems clear that as these values become more entrenched so the need for appropriate models of psychological treatment will increase. These models will have to be tailored to the specific needs of an

emerging class of individuals who embody both collective values and western values simultaneously. Traditional healing approaches do not adequately meet the needs of this emerging group as most of its members are aspiring towards western ideals. Similarly western psychoanalysis in its present form is also inadequate in so far as it is unable to accommodate the inherent collective element of this group. An adapted form of treatment needs to be devised for this group that is able to incorporate both collective and individual elements.

By examining the evolution of psychoanalytic thought from its historical foundations towards more contemporary developments it is clear that both theory and practice of psychoanalytic treatment are flexible and able to accommodate the changing needs of society. Psychoanalytic theory and practice is not a fixed entity but rather is in a state of flux and continues to be revised in the light of new developments in analytic experience and changing social conditions. Cross-cultural psychotherapy is now a part of everyday practice in many western countries and the practice of psychoanalysis is beginning to reflect this transformation (Kadyrov, 2002). Whilst such historical changes have been significant, they have been largely confined to the changing needs of different western cultural groups. Adaptations to non-western cultural groups have moved more slowly (Kadyrov, 2002). This study contends that if psychoanalytic theory and practice has always been in a state of change then it is reasonable to suggest that this treatment modality can be amended to meet the specific needs of an emerging class of Black South Africans who are showing an increasing interest in this form of treatment.

Arising out of the concerns raised above, the main objective of this research study is to explore the applicability of individual psychoanalytic psychotherapy to Black second-language English-speaking individuals in the Urban Cape peninsula, and if necessary to make recommendations for theoretical and technical adaptations to the analytic attitude. It must be noted that while psychoanalysis has been a frequent subject of research literature in South Africa, little research has been done specifically on the conceptual and practical aspects of the analytic attitude and on the reformulation of basic psychoanalytic principles to meet the needs of Black South Africans in individual psychotherapy.

In order to establish the applicability of the analytic attitude it was useful to explore it in practice. By critically examining the analytic attitude in practice, it should be possible to judge its relevance to, and its ability to achieve therapeutic results in, a particular group of Black South Africans.

The principle research question under investigation in this study is: *How does the therapist and each participant under study respond to the conceptual and practical framework of psychoanalytic psychotherapy comprising the analytic attitude and its counterparts the analytic task, process and setting.* In order to answer this question it was necessary to provide a theoretical context. Chapter two outlines a definition of psychoanalytic psychotherapy and describes the model of the analytic attitude, deriving from Gavin Ivey (1999) that is used in this study. It discusses the evolution of psychoanalysis, and shows how theory and practice have been changed in accordance with shifting epistemologies. This chapter emphasises the adaptability of psychoanalytic theory and makes the point that psychoanalysis as a body of knowledge has a history of assimilating and reflecting societal change and should therefore be capable of adapting to societies that are becoming increasingly multicultural such as in South Africa.

Chapter three situates this study within the field of cross-cultural psychotherapy. The discussion in this chapter is organised around the central concept of the self and maintains that an individual's sense of self is configured in accordance with the needs and demands of his culture. Furthermore it shows how different psychological treatment modalities reflect different configurations of self. The concept of the emerging self, which is applicable to the vast majority of Black South Africans, is introduced in this chapter. It is this emerging self that forms the basis to this study which is ultimately testing whether current models of treatment that are western-centric and dualistic in essence are in fact appropriate tools for treating individuals who are configured in terms of this emerging self.

Chapter four sets out the research methodology and explores the various qualitative options that are available to the researcher for answering the research question. This chapter proceeds to outline in detail the exact procedures that were chosen. A collective case study design represented the most suitable research strategy for the material under investigation. The data collection focus was on the therapeutic dyad which included both the participant and the therapist as the unit of analysis. Three female participants who had committed to long-term psychoanalytic psychotherapy were selected for this case study research. The first 40 sessions of this process for each participant were examined in terms of the central tenets of the analytic attitude. The therapist took detailed notes of each session focusing particularly on the way in which each participant responded to the analytic stance. This note taking related not only to the participant, but also to the stance of the therapist and the maintenance (or otherwise) of the analytic attitude.

In chapter five the data was organised under the five sub-units of the analytic attitude and the analytic task, process and setting. This part of the data collection therefore comprised an

individual case report for each participant. Each session of therapy was detailed under the element of the analytic attitude that was considered to be most prominent for that particular session, such as abstinence. If two or more elements were considered important in one session then this information was apportioned to the respective heading. All eight elements were documented for each participant. The data analysis therefore took the form of three individual case reports, which were condensed into a cross-case report in chapter six. This report was used to test already-established theoretical assumptions and provided a basis for the discussion in chapter seven.

The main focus of this study is on the response to individual psychoanalytic psychotherapy of three Black English-speaking women in transition, and the main benefit of this study lies in making a contribution towards the establishment of this therapeutic model as a relevant and applicable form of treatment to this emerging group. All individuals, regardless of race or culture, suffer distressing symptoms that are unconsciously driven. By utilising the resources and the body of knowledge that derives from mainstream psychoanalysis and by adapting the principles and practice of this model to different cultural groups, it is hoped that a form of treatment can be made available to a group that was previously denied access to relevant psychoanalytic treatment.

CHAPTER TWO: THEORETICAL ORIENTATION

Psychoanalytic Psychotherapy

2.1: Definition of Psychoanalytic Psychotherapy

Psychoanalytic psychotherapy is a form of therapy that is based on understandings drawn from classical psychoanalysis (Bauer, 1990). Psychoanalytic psychotherapy adheres to the fundamental principles of classical psychoanalysis. Essentially, this treatment procedure aims to elucidate into consciousness those neurotic motivations that are unconscious and often cause immense difficulty in daily living (Sandler et al., 1992). Similarly psychoanalytic psychotherapy adheres to certain principles of traditional psychoanalytic practice that must be closely followed in order to allow for unconscious processes to manifest themselves. These principles of practice are enacted within a specific therapeutic frame of working and are embodied in the concept of the **analytic attitude** (Ivey, 1999).

When Freud considered the issue of what should and should not be referred to as psychoanalysis he made the point that resistance and transference were pivotal requirements of the work. He stated "Any line of investigation, no matter what its direction, which recognises these two facts and takes them as the starting point of its work may call itself psychoanalysis, though it arrives at results other than my own" (Freud, 1914). Using this definition Hollender (1965) states that what he refers to as psychoanalytic psychotherapy would qualify therefore as a form of psychoanalysis. The question of how psychoanalytic psychotherapy differs from psychoanalysis was raised as early as 1947 when a committee on the evaluation of psychoanalytic psychotherapy was set up within the American Psychoanalytic Association. In its report in 1952 the committee failed to reach a consensus of agreement on the difference between psychoanalysis and psychoanalytic psychotherapy and was forced to conclude, "that a strong resistance to any investigation of this problem existed among the members of the American Psychoanalytic Association" (Hollender, 1965, p. 6). Whilst a consensus on the differences and similarities of these two ways of working has not been conclusively established, Kernberg (1999) offers a comprehensive and plausible framework of distinction.

In his examination of the relationship between psychoanalysis and psychoanalytic psychotherapy Kernberg (1984, 1989, 1999) points out that this relationship raises concerns of a conceptual, clinical, educational and political nature. He acknowledges that psychoanalysis today consists of a profusion of divergent systems that lay claim to different theoretical understandings and clinical

procedures. However, he maintains the boundary between the two disciplines can be drawn in accordance with the techniques that arise out of the different objectives of each approach. He states that the translation of each discipline's objectives into a technical approach is what characterises and differentiates these modalities of treatment.

In attempting to establish the parameters of psychoanalysis Kernberg refers to Gill's (1954) definition of psychoanalysis as follows: "The facilitation of the development of a regressive transference neurosis, and its resolution by interpretation alone, carried out by a psychoanalyst from a position of technical neutrality" (1999, p.4). Using this definition, Kernberg states "Although Gill himself questioned that definition in later years, I strongly believe… that this is the simplest and, both clinically and theoretically, most useful definition of psychoanalytic method… . I would define interpretation, transference analysis and technical neutrality as three essential features of the psychoanalytic method" (ibid). Kernberg believes that this definition in terms of technique should satisfy the conceptual requirements of the psychoanalytic mainstream. However, he recognises that whilst this definition may be accepted by most Anglophone and French psychoanalysts, as well as the broad spectrum of object relations theoreticians, it may not sit well with the American Intersubjectivist, Interpersonal and Self-psychology approaches. Robert Wallerstein (2005) supports the view that in the face of diversity and theoretical pluralism in psychoanalysis today there is a growing trend towards a convergence or inherent common ground that will define the psychoanalytic discipline. He recognises that on a theoretical level there exist many divergent explanatory systems; however, on a clinical level there exist empirically tested and discernable concepts that are shared by these different theoretical perspectives. Wallerstein proposes that there is a growing impetus in psychoanalysis towards an overarching theoretical and clinical structure that will eventually transcend the theoretical pluralism that currently exists in the discipline. Other authors such as Glen Gabbard (1995) and Robert White (2001) also point to the "common ground" that Wallerstein suggests may ultimately develop into a coherent unified structure of theory, practice and technique in psychoanalysis (Wallerstein, 2005).

Kernberg (1999) states "Psychoanalytic psychotherapy… does not dilute the 'gold' of psycho-analysis with the 'copper' of support, but maintains an essentially psychoanalytic technique geared to analyse unconscious conflicts activated in the transference within a modified framework…". He argues that whilst psychoanalytic psychotherapy uses the same basic techniques as psychoanalysis there are certain quantitative modifications that give rise to qualitative shifts in the nature of the treatment. Whilst the techniques of both approaches are essentially identical the goals of psychoanalytic psychotherapy differ from psychoanalysis in that

the former is often used with patients who suffer severe pathology. For this reason technical neutrality may have to be abandoned in favour of setting limits for life-threatening or treatment-threatening acting out. In contrast technical neutrality in psychoanalysis is ideally maintained throughout the treatment. Whilst transference analysis remains central to psychoanalytic psychotherapy patients with primitive defence structures are likely to exercise splitting operations which may give rise to severe dissociation and acting out, in or out of the therapy context. In such instances it is necessary to modify the transference analysis by establishing linkages between transference developments in the therapy process and events in the patient's external reality. Whilst psychoanalysis relies strongly on interpretation of unconscious meanings, psychoanalytic psychotherapy relies more on clarification, confrontation and interpretation. Interpretation is confined to the 'here' and 'now', rather than to the 'there' and 'then'. These modifications to technical neutrality, interpretation and transference analysis usually arise as the therapy process unfolds. As Kernberg (1999) states, "Any given session of psychoanalytic psychotherapy may be indistinguishable from a psychoanalytic session, but over time the differences emerge quite clearly" (p.1080). It is not the use of the couch or the number of sessions that is conceptually significant when defining the difference between psychoanalysis and psychoanalytic psychotherapy, rather, it is the respective goals of these treatment modalities and the techniques that are adjusted to meet these goals.

Kernberg (1999) acknowledges that recent developments within the Self-psychology, Intersubjectivity and Interpersonal schools, specifically shifts in transference analysis, countertransference utilisation and flexibility regarding technical neutrality may blur the distinctions that he proposes above. However, he maintains that his model of psychoanalysis fits the mainstream, which includes ego-psychology, Kleinian analysis, French psychoanalysis and the British Independents. Kernberg recognises that contemporary psychoanalysis is characterised by a pluralism, unknown in any previous era, which makes it difficult to definitively circumscribe psychoanalysis per se, let alone the differences between psychoanalysis and psychoanalytic psychotherapy. In spite of this Kernberg believes that whilst these approaches are similar the differences between psychoanalysis and psychoanalytic psychotherapy emerge clearly over time and are distinct enough to justify a boundary, albeit common, between these two modalities.

2.2: The Psychoanalytic Procedure

Sandler et al. (1992) briefly outline the basic elements of the psychoanalytic procedure as follows: The therapist establishes a treatment alliance with the patient and the patient is encouraged to talk as freely as possible about the thoughts that come to mind (free association). The therapist maintains a sense of anonymity, with the patient being in possession of relatively

few facts about the therapist (abstinence). The therapist's interventions involve interpretations, confrontations and reconstructions. In the course of free association the patient will inevitably avoid certain material and evade certain topics (resistance). It is expected that material produced by the patient will contain overt or covert references to the way the patient feels about the therapist (transference). Through appreciation of his own emotional responses to the patient the therapist is able to obtain further insight into the patient (countertransference). It is expected that the patient will gain some understanding of the links between his conscious and unconscious tendencies and with the present and the past (insight). A period of time is required for the patient to explore, extend and relive emotionally those insights gained through interpretation (working through). Regressive trends appear as the transference develops; these are generally evident as the re-emergence of childhood wishes and fantasies, feelings and modes of relating that are expressed in behaviour towards the analyst (Sandler et al., 1992, p. 17).

In order for this psychoanalytic procedure to unfold specific requirements need to be met. Psychoanalytic work is a structured endeavour that occurs within certain parameters referred to as the "analytic event". Freud outlined the central requirements and recommendations in his paper on psychoanalytic technique (Freud, 1912). The role of the analyst is to create the conditions for analysis of unconscious processes occurring in the patient and to convey this understanding to the patient. These unconscious processes manifest in the transference phenomena. The essence of analytic work is contained in the transference. Sandler et al. (1992) state that the analysis of transference phenomena is regarded by psychoanalysts as being at the very centre of their therapeutic technique. In order to allow for the emergence of feelings, fantasies and defences towards the therapist in the present that represent displacements of reactions originating from childhood, the therapist is required to adopt a certain disposition and technique.

With changing theoretical perspectives on the analytic situation and process Freud's initial recommendations have been revised. However, it is generally accepted by all therapeutic approaches that hold a strong appreciation of the unconscious that there is a way of working analytically which provides optimal conditions for these unconscious communications to emerge (Ivey, 1999). Those therapeutic approaches that resist the need for anything but minimal structure in the therapeutic encounter generally do not give authority to the workings of the unconscious. However, all depth psychology approaches are keenly aware of the intensely delicate nature of the unconscious and its ubiquitous manifestation in interpersonal relationships. Hanna Segal (1986) states that the role of the psychoanalyst is confined to interpreting the patient's material, and all criticism, advice, encouragement, reassurance, and the like, should be rigorously avoided. The interpretations are centred on the transference situation, impartially taking up manifestations

of the positive and negative transference as they appear. This interpretive activity occurs within the context of what has been called the "psychoanalytic setting" or "frame". Langs (1982) has written extensively on the importance of maintaining this therapeutic frame. He provides good clinical evidence to show that the frame provides conditions best suited to the patient's therapeutic needs. A secure frame creates an atmosphere of trust and security, which is necessary for effective symbolic communication to take place.

Langs (1982) refers to the frame as the ground rules of psychotherapy and states that any rupture to this frame will be experienced negatively by the patient. Even though the patient may express conscious gratification to changes in rules, unconsciously he will comment negatively on such changes. Langs (1982) outlines two important dimensions to the therapeutic frame. Firstly, rules relating to the relationship between the patient and the therapist and secondly, rules concerning the nature of the therapist's interventions. He provides a succinct description of the ground rules of therapeutic work as follows:

1) The spatial, temporal and financial constraints of the setting:

- A single, private, relatively neutral space, free from outside intrusions
- Fixed session duration and appointment times
- A single fixed fee which the patient is expected to pay personally without mediation by any third party.

2) Rules concerning the relationship between the patient and the therapist:

- The absence of any prior, concomitant or post-treatment external relationship between the patient and the therapist and the essential absence of any physical contact
- A one to one relationship with total privacy and confidentiality
- The therapist's maintenance of relative anonymity.

3) Rules concerning the nature of the therapist's interventions:

- Adoption of the fundamental rule of free association
- The therapist's maintenance of free-floating attention
- The therapist's use of appropriate silence, framework management, neutral interpretation, and playback of selected themes having latent significance (Langs, 1982).

Quinodoz (1992) introduces four more important components to the frame as follows:

1) Spatial aspects refer to the conditions of the room including stability and privacy.
2) Temporal aspects refer to the length and frequency of the sessions.
3) Financial aspects include parameters regarding payment for sessions.

4) Refraining from "doing" includes no extra-analytic contact, no retaliation in the analysis and no contact with third parties.

Ivey (1999) pulls together the central threads of the concept of working analytically in his article *Thoughts on the "analytic attitude"*. He draws a distinction between technique and attitude stating that whereas technique refers to a circumscribed set of intentional *behaviours*, attitude refers to a s*tate of mind*. He points out that historically the analytic attitude has not been well defined; this is because attitude has generally been discussed under the rubric of the analytic technique. Schafer's book *The Analytic Attitude* (1983) appears to be one of the very few publications overtly discussing the topic (ibid), but it is implicitly recognised by most depth psychology practitioners that the analytic attitude is the basis of all psychoanalytic treatment. This stance is thus the unifying principle across the different disciplines. "Freudians, Jungians, Kleinians and other theoretical divides may disagree on [the level of theoretical and technical issues] but all would … claim allegiance to the analytic attitude" (Ivey, 1999, p. 2). The analytic attitude refers to a "deeply-rooted, coherent professional mindset that incorporates philosophical, ideological, psychological and ethical concerns". It defines the psychoanalytic practitioner in terms of what he knows, what he believes and how he should conduct himself in the therapeutic setting (Ivey, 1999, p.3). Technique, which most theories have discussed as superordinate to attitude, is seen by Ivey as following on from attitude rather than defining it. Technique is subordinate to and can be defined as the methodological expression and actualisation of this attitude (Ivey, 1999).

2.3: The Analytic Event

Analytic attitude and analytic technique do not exist in isolation but are intimately associated with the analytic task, the analytic setting and the analytic process. These together constitute the *analytic event*. Although in theory the elements of the analytic event can be considered separately, in practice they are indivisible. The analytic attitude exists as a conscious mental disposition on the part of the practitioner that provides a neutral potential space for the emergence of the therapeutic material. The analytic task refers to the rationale for therapy, that of providing the patient with greater insight and psychological freedom. The analytic process refers to the unfolding of the analytic task over time. The analytic setting refers to a literal and metaphorical place which contains the analytic process and is necessary for the unfolding of the analytic task. The technique used refers to interpretations and other interventions which may differ in accordance with different theoretical divisions (Ivey, 1999). The analytic attitude and its corollaries have been poorly defined and inadequately formalised under "technique". While Freud himself in his 1912 paper "Recommendations to Physicians practising Psychoanalysis"

was overtly addressing issues of "technique", he was in fact commenting on "attitude" although he did not describe it as such. Similarly, when Jung introduced his "general method of analysis" he was implicitly referring to some of the fundamental tenets of the analytic attitude. Jung's well-known method included, above all, respect for what is encountered; respect for what is unknown, respect for what is unexpected, for what is unheard of. (Young-Eisendrath & Dawson, 1997). His attitude of generative uncertainty was strongly evident through the mental disposition he adopted when working with the dreams of his patient's. Before attempting to understand a dream he reminded himself, "I have no idea what this dream is all about" (p. 37). In doing so he consciously attempted to free his mind of presuppositions and assumptions that could have undermined the intrinsic meaning of the material (ibid). The following excerpt from Jung's writing shows clearly how he understood the relationship between doctor and patient.

> The uniqueness of the individual and of his situation stares the doctor in the face and demands an answer. His duty as a physician forces him to cope with a situation swarming with uncertainty factors. At first he will apply principles based on general experience, but he will soon realise that principles of this kind do not adequately express the facts and fail to meet the nature of the case. The deeper his understanding penetrates, the more the general principles lose their meaning… [and] the situation becomes increasingly subjectivised (in technical terms transference and countertransference). [The doctor's] profession compels him to have as few preconceptions as possible. Similarly while respecting metaphysical (i.e. non-verifiable) convictions and assertions, he will take care not to credit them with universal validity. This caution is called for because individual traits of personality ought not to be twisted out of shape by arbitrary interventions from the outside. The doctor must leave this to environmental influences, to the person's own inner development, and - in the widest sense - to fate with its wise or unwise decrees. … The responsible doctor will refrain from adding unnecessarily to the collective factors to which his patient has already succumbed. Moreover, he knows very well that the preaching of even the worthiest precepts only provokes the patient into open hostility or a secret resistance and thus needlessly endangers the aim of treatment. The psychic situation of the individual is so menaced nowadays by advertisement, propaganda and other more or less well-meant advice and suggestions that for once in his life the patient must be offered a relationship that does not repeat the nauseating "you should," "you must" and similar confessions of impotence. … As the dialectical discussion proceeds, a point is reached where an evaluation of… individual impulses becomes necessary. By that time the patient should have acquired enough certainty of judgement to enable him to act on his own insight and decision and not from the mere wish to copy convention – even if he happens to agree with collective opinion. Unless he stands firmly on his own feet, the so-called objective values profit him nothing, since they only serve as a substitute for character and so help to suppress his individuality (Jung, 1958, pp. 36-39).

2.4: The Analytic Attitude

As stated above psychoanalytic psychotherapy adheres to certain principles of traditional psychoanalytic practice that are enacted within a specific therapeutic frame of working. Both Freud and Jung recognised that in order for analysis to proceed the analyst was required to adopt a particular stance towards the patient. This stance was later formulated into and described as the "analytic attitude". The descriptive terms used throughout this study to discuss the analytic attitude are those outlined by Ivey (1999) in his article *Thoughts on the "analytic attitude"*. Ivey codified the concept of the analytic attitude into five principles: *Generative uncertainty, Abstinence, Neutrality, Countertransference receptivity and Resoluteness.*

Generative Uncertainty.

The principle of generative uncertainty refers to an attitude of enquiry that Freud outlined as "evenly suspended attention" (1912, p. 111) and what Bion (1970) was conveying in his advice to therapists to approach each session without memory, desire or understanding in order to be open and receptive to what is new and different. It involves a disciplined but unfocussed listening, free from any presuppositions or pre-judgements of the meaning or importance of any part of the patient's communications.

Ivey (1999) introduces the term *generative uncertainty* as an attitude of productive enquiry which stands in opposition to the attitude of unproductive neurotic certainty often held by the patient. Neurotic certainty refers to a particular belief system about the nature of reality that lies behind every symptom. For instance the dependant patient knows with certainty that he is unable to cope on his own. Certainty, whether on the part of the therapist or the patient, implies that meaning has been foreclosed and that one is not receptive to other interpretive possibilities. The therapist who claims to know the patient's problem from the outset is closing off the possibility of further understanding. Freud stated that if the analyst "follows his expectations he is in danger of never finding anything but what he already knows; and if he follows his inclinations he will certainly falsify what he may perceive" (1912, p. 112). Generative uncertainty therefore refers to the therapist's capacity to sit with the tension, ambiguity and ambivalence of "not knowing" and to allow simultaneously for an openness of understanding as to how the patient experiences himself and how he experiences the therapist.

Bion's notion of "without memory and desire" is often misinterpreted. The rationale behind this statement is that by remembering previous sessions new shifts in the transference are not noted and the patient is often given a fixed and outdated identity. Desire refers to the therapist's inclination to selectively listen for information that confirms beliefs and theories which have

already been established. According to Bion (1970) the only issue of importance in each session is the "unknown". He proposes that the therapist should work as far as possible towards a state of mind whereby each successive session should be experienced as if the patient is being met for the first time. As therapists, it is not possible to rely on our own experience, our previous experience of the patient, or on psychoanalytic theory to tell us the meaning of any particular communication. All too often therapists adopt specific roles concerning their perceived function in relation to the patient. Once again this serves to foreclose the possibility that the patient may require the therapist to adopt different functions in accordance with their shifting transference needs (Ivey, 1999).

<u>Abstinence.</u>

The concept of abstinence is frequently criticised from a post-postivistic position as being sterile and anti-therapeutic. Freud's statement promoting "emotional coldness" as a technique of abstinence has set the tone for much debate (1912, p. 118). Furthermore the "Mirror" and "Surgeon" analogies for abstinence proposed by Freud have contributed to this discussion. He stated "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him"; further "I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible" (1912, p. 115). Whilst Freud's more scientific views of abstinence are less acceptable to modern psychoanalytic psychotherapy the concept of abstinence remains central to the analytic attitude. Freud's suggestion to use a technique of emotional coldness was unfortunate: not only did it fail to reflect his own work but it also has no place within the concept of analytic abstinence generally. On the contrary, analytic abstinence refers more to abstaining from action rather than feeling, nor does it promote the stereotype of a "cold detached therapist". Abstinence creates a reflective space in which emotional receptivity may give rise to empathic understanding. In Ivey's words (1999) "Abstinence… implies feeling spontaneously but acting reflectively" (p. 10).

The principle of abstinence places emphasis on the therapist's disciplined avoidance of those behaviours that may (inappropriately) compromise the evolving transference. Bauer (1993) states that transference requires a gap between what the patient wants and what the therapist provides. This gap is frustrating and creates a necessary sense of ego dystonia. If it is closed by the therapist's conscious or unconscious attempts to gratify the patient's wishes then no analysable transference is possible. The therapist is required to abstain from interventions that obstruct the flow of free association and from frame-breaks that may distort the analytic process. The

therapist's responding differently to what the patient is asking for is an issue which has been raised in a number of theoretical approaches. Bion's "maternal reverie" and Winnicott's "holding environment" both support the notion of a maternal attitude, whilst Lacan emphasises the concept of father and a paternal attitude. Kohut and the school of psychoanalytic self-psychology places strong emphasis on an attitude of "sustained empathic enquiry" (Stolorow et al., 1987, p. 10). In response to the therapist's adopting a particular role Patrick Casement (1985) has the following to say: "If a therapist insists on being experienced as different from the original objects there can be no analysable transference … At best there can only be charismatic cure, which evokes change by seduction" (p. 88). Ivey (1999) further emphasises the need for a therapist to abstain from taking on roles and using analytic metaphors as this obstructs the analytic process by presenting an image which could be contrary to what the patient may unconsciously need of the therapist.

Neutrality.

In recent years increasing attention has been given to the interpersonal aspects of the therapeutic relationship. The concept of the therapist's analytic neutrality has been highlighted and is often taken to mean a restriction of emotionality on the part of the therapist. Unlike abstinence, which refers to a withholding of active behaviours which may affect the unfolding transference, neutrality is the withholding of emotional judgement, bias or partiality on the part of the therapist in response to the patient's experience.

Modell (1989) points out that defence and resistance are not only intrapsychic phenomena but also occur extrapsychically between patient and therapist. An attitude of neutrality on the part of the therapist may therefore evoke defences and resistances that are more to do with the therapist than to intrapsychic unconscious factors. Far from attempting to evoke obstructive responses in the patient the principle of neutrality refers rather to an internal self-reflective and self-questioning process on the part of the therapist. It is characterised by a state of "emotional poise or balance", a "self-reflective suspension" of the therapist's moral and ideological beliefs about the experiences, fantasies and behaviours of the patient (Ivey, 1999). Schafer (1983) points out that one of the rules of analysing is that one should not take sides in the analysand's conflicts. This point is further elaborated by Anna Freud (1936) who states that neutrality is about maintaining a position equidistant from the patient's id, ego and superego. That is, the therapist remains neutral by siding with neither the patient's desires, defences nor critical judgements. Ivey (1999) describes the therapist's neutrality as serving three purposes. The first is to assist patients towards an understanding of their transferential needs by creating "optimal frustration". Secondly, neutrality safeguards the therapist from neurotically identifying with his patients'

needs. Lastly, neutrality protects the patients in allowing them to maintain autonomy and thus a sense of security within the treatment framework.

Countertransference Receptivity.

The interpersonal process of countertransference has been revised considerably since Freud originally referred to this concept as the therapist's unresolved transference to the patient. In spite of this statement Freud himself implicitly recognised the importance of countertransference as a therapeutic tool (Ivey, 1999). The appreciation of how a therapist's emotional response may facilitate rather than hinder the therapeutic process has assumed increasing attention in recent years. With the rise of intersubjectivity, the concept of countertransference has evolved to the point where it is now considered as important as the patient's transference.

Bollas captures the essence of countertransference receptivity in his statement that "in order to find the patient we must look for him within ourselves" (1987, p. 202). Countertransference receptivity therefore refers to the therapist's willingness to allow the patient to manipulate him through transference usage into object identity (ibid). It requires that a part of the therapist - sometimes referred to as the "observing ego" - witness and contain a frequently turbulent and unformed emotional response to the patient (Ivey, 1999). A high degree of responsiveness towards subtle emotional changes in the patients as well as towards their unconscious fantasies is what facilitates countertransference receptivity. In Sandler's words "Parallel to the free-floating attention of the analyst…is what I should like to call his free-floating responsiveness" (1976, p. 45). It is only by the therapist's allowing himself a degree of spontaneous feeling and action, which Sandler refers to as "role responsiveness", that the patient is able to communicate his unconscious experience and make therapeutic use of the therapist. By being open and responsive to the transference manipulations of the patient the therapist allows himself to introject and enact the regressive internal world of the patient. This frequently gives rise to anger or other strong emotional reactions on the part of the therapist, which represent identifications with the patient's childhood family dramas (Ivey, 1999). In such cases the therapist may not be aware of the significance of his behaviour until neutrality has been lost: the importance of recovering an analytic equilibrium and reflecting on the meaning of such enactments is thus crucial to the process (ibid). Personal countertransference feelings that impede the receptivity of the therapist are inevitable and may complicate the process. An awareness of the possible contribution of countertransference to the patient's unconscious experience of the therapist can be safeguarded to some extent through the therapist's own awareness of his internal complexes (ibid).

Resoluteness.

Gavin Ivey states succinctly that "the analytic attitude describes a mode of self-relating as well as a style of relating to one's patients" (1999, p. 15). The maintenance of the tension of the analytic attitude requires resoluteness. Therapists are repeatedly drawn into the unconscious world of the patient and pressured to re-enact primal dramas. Such enactments give rise to strong resistances in both the patient and the therapist which can only be counter-balanced by an attitude of resoluteness. The principle of resoluteness refers to both "courage in the face of the communicative unknown and faith that the process will take its course if we can restrain ourselves from trying to direct it" (Ivey, 1999, p. 15). Resoluteness can thus be described as the therapist's willingness to concede control and tolerate the tension this may create. Ivey states that failure to maintain resoluteness may give rise to deviations in the analytic attitude, usually occurring as a result of countertransference anxiety; this is the anxiety that certain feelings may arise in both the patient or the therapist if the therapist simply listens and refrains from filling the space with questions, advice, or reassurances. It is important to note that in the highly charged atmosphere of the therapeutic event it is inevitable that the therapist will at times lose equilibrium. In this regard, as Ivey (1999) points out, Winnicott claimed that patients sometimes require the therapist to fail them as this often replicates the failures of their own childhood and thereby assists them in getting in touch with such failures (1963).

2.5: The Analytic Technique

Ivey (1999) defines "technique" as the goal-oriented application of theoretical knowledge and states that it is not to be confused with "attitude" which refers to a mental disposition or psychological orientation to the world. Analytic technique is a behaviour predominantly enacted in the form of verbal interventions. Greenson (1967) outlined the verbal components of analytic intervention. He considered the term "analysing" to be a shorthand expression for certain insight-furthering techniques including confrontation, clarification, interpretation and working through. Other authors include certain instructions, questions and constructions as part of analytic technique.

Since the very beginning of psychoanalysis interpretation has been an essential element in effecting therapeutic change and has been considered the most characteristic and most significant feature of an analyst's technique. However, the precise way in which interpretations are formulated varies according to the frame of reference of the therapist. As with other principles in psychoanalysis the concept of interpretation has been modified with changing theoretical developments. The most striking of these changes is the way interpretation is used by the self-psychologists. Psychoanalytic self-psychology deliberately moves away from single

interpretation statements towards reconstructive interpretations. Similarly it moves away from an inferential model towards a more empathic mode of relating. Self-psychology interpretations arise out of a theoretical orientation that places an emphasis on the importance of deficits in early experience. Interpretations that arise out of a "conflict" model as opposed to a "deficit" model are therefore likely to differ in structure and content. An increased interest on transference and countertransference in the therapeutic relationship is reflected in interpretations which now tend to be directed to interpersonal processes rather than focussing predominantly on resistances (Sandler et al., 1992).

Glen Gabbard and Drew Westen (2003) challenge the view of interpretation as the principle method in eliciting therapeutic change. They state that interpretation that aims at reconstruction through "digging for buried relics from the patient's past" (p.824), whilst still useful, is less important than focusing on the here-and-now interaction between the patient and the analyst. They emphasise the point that, "We no longer practice in an era where interpretation is viewed as the exclusive therapeutic arrow in the analyst's quiver" (p.823). These authors propose that there is no single path to therapeutic change but rather change occurs through multiple mechanisms. The idea that there is one basic principle which accounts for all change is strongly challenged as the analyst can no longer lay claim to know everything. In fact 'knowing' is dependent on a collaborative effort of both the analyst and the patient. Whilst these authors do not negate interpretation, they de-emphasise its importance and suggest broadening its use beyond the boundaries of simply interpreting the transference. Mitchell (2002) states that it is not possible to separate insight and relationship as two separate modes of therapeutic action. He points out that over the past two decades this traditional dichotomy has been proved wrong; it is now well understood that interpretations always take place in the context of specific transference-countertransference situations. The analyst is thus seen as a participant observer who constructs the analytic process with the patient. This process includes the personal history and fantasy life of both participants. Interpretations in this context of intersubjectivity speak not only to the patient, but also convey the values, goals and world-view of the analyst (Friedman & Natterson, 1999).

2.5.1: The Analytic Task

The analytic task is the rationale for analytic work. It is the attempt on the part of the therapist to facilitate a degree of psychological freedom in the patient through the insightful resolution of unconscious conflicts (Ivey, 1999). The task of the therapist is to provide a relationship that will facilitate freedom of thought and speech. It does not aim to alleviate symptoms or change behaviour but instead aims at elucidating the unconscious emotional meaning behind the

necessary upkeep of such symptoms. Through the dialogue of "feelings" the possibility is created for these unconscious meanings to be "languaged" into consciousness. As stated by Freud (1937):

> Our object will not be to rub off all the corners of the human psyche so as to produce "normality" according to schedule, nor yet to demand that the person who has been "thoroughly analysed" shall never again feel the stirrings of passions in himself or become involved in any mental conflict. The business of analysis is to secure the best possible psychological conditions for the functioning of the ego; when this has been done analysis has accomplished its task (p.403).

The fundamental task outlined above remains steadfast despite new developments in psychoanalysis from a one-person model to a two-person model. Post positivistic perspectives and intersubjective insights may differ on their understandings of the most effective means to access the unconscious, but would agree that the fundamental task over time remains making conscious those elements that were previously unconscious (Maroda, 2002).

2.5.2: The Analytic Setting

The analytic setting is both a physical and a metaphorical location. It is the place that contains the analytic process and simultaneously provides the "conditions of safety" for this process to unfold (Schafer, 1983). Furthermore the analytic setting provides the necessary boundaries that differentiate and demarcate the world of symbolic communication from the taken-for-granted world of ordinary social intercourse (Ivey, 1999). Whilst the analytic attitude provides an invitation for patients to explore the unfamiliar it is the analytic setting which makes this exploration possible (ibid). The analytic attitude is thus meaningless without the structure of the analytic frame just as the frame is empty without the analytic attitude. However, as Ivey (1999) states, "together…they create the space and atmosphere for the incubation, birth and nurturance of the analytic process" (p. 6).

2.5.3: The Analytic Process

The analytic process is the evolution of the analytic task over time (Ivey, 1999) This process involves the "gradual emergence of ego-dystonic and hence anxiety-provoking unconscious fantasies in the interpersonal context of the therapeutic relationship, and the defensive strategies that patients resort to in order to avoid acknowledging and owning these fantasies" (Ivey, 1999, p. 4). The analytic process therefore refers to a measured increase in conscious awareness that is fostered through the secure maintenance of the analytic attitude.

It is the progressive psychic change in response to the therapist's presence and interventions that comprises the healing aspects of the process (Ivey, 1999). This teleological unfolding of the analytic process in the context of patient and therapist usually occurs along the lines of the patient's internal object world. However, the outcome - which is largely unpredictable - is also strongly influenced by the presence of the therapist, his interventions and the unique inter-subjective quality of the therapeutic relationship (ibid). As stated by Ivey (1999) "it is humbling and comforting to realise and remind ourselves that therapist and patient are part of a process that transcends both of the participants" (p. 5).

2.5.4: Critique of 'The Analytic Attitude' as described by Ivey (1999)

This study relies strongly on the framework of the "analytic attitude" as outlined by Ivey (1999). As shown above, this framework emerges out of the insights and experiences of Freud and Jung and is extended through the work of Segal, Langs and other prominent authors who have contributed towards formalising the psychoanalytic procedure. However, it must be accepted that whilst the framework offered by Ivey (1999) provides a useful and systematic frame for research in this study, it is not representative of all the approaches. Ivey's claim that all psychoanalytically oriented psychotherapies adhere to his interpretation of the analytic attitude should be considered controversial. For instance the American interpersonalist, intersubjectivist and self-psychology schools are strongly critical of the techniques of abstinence, anonymity and neutrality. In fact many critics would state that psychoanalysis today comprises a diversity of approaches that cannot be contained under one rubric. To this end it could be stated that there is no single "attitude" but rather a variety of different "attitudes" that belong to different psychoanalytic approaches. Having said this, Ivey's attitude holds true to the three concepts that Kernberg (1999) feels are central to mainstream psychoanalysis and psychoanalytic psychotherapy, namely technical neutrality, transference analysis and the interpretation of unconscious meanings.

New developments in psychoanalysis have given rise to concomitant developments in the analytic technique. These conceptual developments and their related techniques present a significant challenge to mainstream psychoanalysis and for that matter a challenge to the analytic attitude proposed by Ivey (1999). These new currents are predominantly organised around the intersubjective and interpersonal approaches that include both self-psychology and the cultural psychoanalytic tradition expressed through contemporary interpersonal psychoanalysis. Stolorow, Brandshaft and Atwood (1987) introduced the idea of objectivity and pointed out that the concept of intersubjectivity was a response to the belief in classical psychoanalysis that there is an 'objective reality' known to the therapist. They proposed that the only reality in therapy is a 'subjective reality'. The essence of this shift is captured in the words of Jessica Benjamin (1990)

who states, "An enquiry into the intersubjective dimension of the analytic encounter would aim to change our theory and practice so that where objects were, subjects must be" (p.34).

Self-psychology focuses on self-object transferences as the principal matrix of treatment. In doing so it moves away from technical neutrality, emphasising rather, emotional attunement and immersion in the subjective world of the patient. This approach also promotes an anti-authoritarian stance on the part of the analyst and questions the privileged nature of the analyst's subjectivity (Kernberg, 1999). This position is upheld by the intersubjective and interpersonal approaches who support the notion that personality develops continuously in a relationship matrix, rather than in the context of drive expression, conflict and defence. The analyst's role is to compensate for past overstimulation or understimulation of the patient's archaic self. This requires the therapist to focus intently on the intersubjective nature of the relationship. Emotional growth on the part of the patient is dependent on new affective interpersonal experiences that arise in this intersubjective encounter. Clearly, the intersubjective position attempts to overcome the boundary between subject/object, therapist/patient. It emphasises mutual exchanges, conscious and unconscious that point to a fundamental inter-relational dynamic in the therapeutic encounter. This inter-relational aspect was previously not acknowledged by classical psychoanalytic approaches that focused on intrapsychic determinism.

These conceptual shifts have implications for analytic technique. Most importantly, these shifts question the traditional positivist view of the analyst's objectivity in interpreting the patient's transference. Abstinence, neutrality and anonymity have very little place in the intersubjective model that proposes a constructivist imperative. Interpretation in this model relates to exploring developments in the affective exchange between patient and therapist and the extent to which the patient assimilates this new affective experience (Kernberg, 1999).

Merton Gill (1994) emphasised the interactive nature of the analytic process and argued for an expansion of the traditional understanding of the analytic situation in one-person terms to an understanding that includes two-person considerations. He was critical of the rigidities of strict Freudian analytic etiquette that excluded any consideration for the influence of the analyst on the patient. In this model the analyst could be assured that the patient's feelings towards the analyst (transference) were merely distortions or displacements from significant figures in the patient's early oedipal life. Gill argued that this classical analytic frame did not remove the analyst's influence on the process, it merely denied it, attributing everything that happened to the patient's fantasies and projections. Patients are much more engaged with the 'here-and-now' analyst than

analysts are inclined to accept, and therefore the analyst's participation is a key feature of everything that happens in the analytic situation (Mitchell, 1995).

Mitchell (2000) extends Gill's position of contemporary psychoanalysis and presents his understanding of relationality by describing that the basic motivation in human experience is the engagement with other minds, not biological pushes from within. He emphasises that minds interpenetrate one another and are shaped in relation to each other; that the patterned processes in minds reflect the patterned processes between minds; that ways of being with oneself are inseparable from ways of being with others; and that subjectivity develops always in the context of intersubjectivity. This understanding is supported by Zeddies (2001) who states "The analyst does not only see the patient's world, he or she inhabits it" (p.2). Mitchell emphasises that traditional psychoanalytic theory presumes an individualistic, monadic view of human experience that minimizes, if not completely avoids, a full acknowledgement of the extent to which human beings are interconnected and interdependent from the beginning of life. For Mitchell, psychoanalysis is therefore perspectival and constructed, not universal and absolute (Zeddies, 2001). He further suggests that the relationship between the analyst and the patient is at the centre of the analytic solar system, the hub around which everything else in the analytic process orbits, and the reference point against which all interventions and communications are defined (Mitchell, 1997).

For Mitchell the most important challenge to analysis is to find a way out of the paradoxical impasse in which the potential for transformation is translated into the familiar and static. He feels that most psychoanalytic theories do not attend sufficiently to the issue of 'relational influence'. Instead these theories attempt to cross the gap between the analyst's understandings and the patient's problems by advocating clinical concepts such as interpretation, empathy and unconditional positive regard (Zeddies, 2001). Mitchell therefore endorses the idea that psychoanalysis is about exploring and transforming deeply rooted conflictual experiences, but he challenges the idea that non-directiveness is the best route to uncovering these dynamics (ibid).

Safran and Muran (2001) suggest that the interpersonal and relational perspectives allow for greater technical flexibility. By being freed from classical notions of therapist abstinence and neutrality such perspectives are able to focus on a constructive relational experience that is a critical component of change. They emphasise the point that rather than relying on some inflexible and idealised criterion such as therapeutic neutrality the analyst should be guided by what a particular therapeutic task means to a particular patient in a given moment. They also suggest that ruptures in the therapeutic alliance are the royal road to understanding the patient's

core organising principles (ibid). Owen Renik (2004) explores the notion that as most psychoanalysts today would in principle agree that intersubjectivity is a part of the psychoanalytic event, how does this affect theory and practice? He points out that whilst the importance of countertransference has been well recognised in psychoanalysis, the concept itself and the way in which it is generally used reflects a compromised understanding of the intersubjective nature of the analytic event. Furthermore he argues that by acknowledging the intersubjectivity of the therapeutic encounter we are obliged to re-define the nature of the analyst's expertise and authority. If insights are co-created by analyst and patient and are not simply the product of the analyst's objective expertise per se, then it is not possible to give prominence to the analyst's voice as this would prohibit circularity in the clinical investigation. This circularity is further obstructed through the longstanding principles of analytic neutrality and abstinence. He states that if it is accepted that analytic truths are co-created, then the rationale for minimising personal self-disclosure on the part of the analyst becomes obsolete.

Theodore Jacobs (2002) provides a balanced perspective on these techniques under debate in the literature. He recognises that the shift to an interpersonal position has added significantly to psychoanalysis; however, he points out that these gains have been at the expense of abandoning some of the older techniques of accessing the unconscious. He suggests that the most effective pathway to understanding the unconscious is one that utilises techniques which focus on both the intrapsychic (one-person) and the interpersonal (two-person) dimensions of the analytic experience. He states that the interactional style with its focus on the here-and-now, specifically concentrating on interpreting the transference, can obscure the importance of evenly suspended attention and for that matter, the importance of listening. He also points out that an over-enthusiastic understanding of the positive use of countertransference can overshadow its negative impact (Jacobs, 2002).

Jacobs believes that some of the older generation techniques provided a sufficiently quiet and reflective space which was useful in accessing primary process thinking and other primitive aspects of the patient's imaginary world. Whilst he agrees that progress in psychoanalysis should adopt new interactive and communicative ways of understanding the mind, he also believes that an integration of some of the older techniques will amount to the most creative use of the analytic instrument (Jacobs, 2002). This is a view proposed by Bollas (1999) who states that in any given session a patient can oscillate between a one-person mode of relating and a two-person mode. At times the patient will speak to the therapist as an internal object with which he is communing and at other times the patient may address the therapist in such a way that the therapist feels his otherness is being called into interpersonal engagement. Bollas likens this to everyday life where

a person may at times find himself lost in thought in the presence of another person and at other times intently engaged in dialogue with another person.

It can be argued that whilst these theorists are emphasising the point that a relational intersubjective position is more conducive to understanding the patient's problems, they are not suggesting that the analytic process becomes loosely interactional. Some form of distinction between the analyst and the patient must be contained. Hoffman (1994) suggests that the therapist must at times 'throw away the book' in order to demonstrate a genuine willingness to place the patient before the rules of therapy. He believes that spontaneous deviation from the conventions of practice opens up the possibility of a more authentic engagement. On the other hand, throwing away the book has in some circles 'become the book'. Slavin and Kriegman (1998) describe how the new order of spontaneity and self-disclosure has become idealised to the point where it now represents a new codified system of practice that reflects the collective agenda of new factions and schools of thought. They suggest that what is required is not a new set of rules and technical guidelines, but rather a new sensibility that recognises that any attempt to codify the analytic encounter will inevitably become biased towards the needs and views of those who advocate it (ibid). Owen Renik (2003) points out that the challenge for contemporary analysis is not in doing away with psychoanalytic standards of practice but lies rather in formulating a set of standards that takes into account the heterogeneity of the psychoanalytic community. He points out that responsible standardisation represents an effort to get away from a kind of self-glamorising vagueness that excuses psychoanalysts from accountability (Renik, 2003). Ivey's model of the analytic attitude provides one attempt in this direction.

By sufficiently negotiating many of the controversies discussed above, Ivey (1999) offers an interpretation of the analytic attitude that is well informed and provides a usable account of the ground rules for psychoanalytic psychotherapeutic practice. This 'attitude' is not inconsistent with contemporary relational understandings of the analytic encounter. The current intersubjective climate has ostensibly abandoned the notions of 'neutrality'. However, the way in which Ivey presents this concept is more in line with Jacob's (2002) vision of creating a 'reflective space' rather than with the traditional positivistic notion of 'non-interference' and 'restriction of emotionality'. 'Neutrality' in Ivey's model does not imply lacking in care and empathy, rather it refers to a self-reflective suspension of the therapist's moral and ideological beliefs. Similarly, Ivey's concept of 'abstinence' refers to abstaining from action, not from feeling. This attitude creates the necessary conditions for 'emotional receptivity' on the part of the therapist and fosters a climate for what Ogden (1996) refers to as 'reverie'.

Abstinence in Ivey's model goes far beyond the traditional one-person model of a withholding, authoritarian stance. His use of abstinence refers to the therapist being consciously aware of not taking on roles that are contrary to the unconscious expectations of what the patient requires the therapist to be. As pointed out above, one of the criticisms of the intersubjective model is that increased emphasis on interaction in the here-and-now reduces the possibility for 'quiet reflection' that is necessary in order to access primary process thinking. Ivey's particular use of abstinence and neutrality allows for the meditative space that gives rise to the intersubjective 'analytic third' that Ogden (1997) refers to. Ivey's model places a strong emphasis on the transference-countertransference dimension of the analysis. In this sense he raises the importance of the analyst's subjectivity to a level that is consistent with relational two-person models of analysis that emphasise a need for greater mutuality. Ivey's 'attitude' acknowledges the impact of conscious and unconscious communication and in doing so it incorporates an understanding of intra-psychic and interpersonal exploration in the analysis. His concept of 'generative uncertainty' reflects a non-directive openness to interpretive possibilities and is aligned with Bion's (1970) concept of 'not knowing'. Such a stance goes far beyond the traditional notions of the therapist being imbued with all knowledge and certainty. In fact Ivey's suggestion of sitting with the tension and ambiguity of "not knowing" is highly consistent with postmodern logic.

Clearly the model proposed by Ivey (1999) is open to controversy. However, for the purpose of this research study Ivey's description of the analytic attitude was considered to provide a useful blend of new generation (two-person) and older generation (one-person) techniques that have been sufficiently re-worked into a relational paradigm. His emphasis on the subjective, interpersonal, imperatives of contemporary psychoanalysis places the 'analytic attitude' in a framework that is free of the one-person, objective, structural and deterministic imperatives of classical psychoanalysis.

Psychoanalytic Developments

2.6: The Evolution of Psychoanalysis

Psychoanalysis "is often regarded as being a completely integrated and consistent system of thought, but this is far from being the case" (Sandler et al., 1992, p. 1). In fact psychoanalysis has undergone many adjustments through the course of time. Freud himself was responsible for modifying and in some instances completely revising his original concepts. As he successfully developed new insights he subsequently added new dimensions to technical procedures. This process of mutability in psychoanalysis has been a trend that persists to this day. Many of the

concepts are not all well defined, and changes in their meanings have occurred as psychoanalysis has developed and aspects of its theory have changed (ibid). For this reason, when discussing one or another concept in psychoanalysis, it is important to take an historical approach and to locate the meaning of the concept in its historical time and the context in which it was used. The situation is complicated further by the fact that different schools of psychodynamic thought have inherited and then modified certain concepts for their own use: for instance the Freudian terms such as *ego*, *self* and *libido* have different meanings in Jungian psychology (Sandler et al., 1992).

The widening scope of psychoanalysis, which began in the 1950's, has given rise to a significant extension of meaning to many of the core concepts. In recent years much attention has focussed on expanding the classical metaphor of the analyst-as-a-mirror to the more contemporary understanding of the analyst-as-a-partner in the analytic situation. This has resulted in a more comprehensive understanding of the dimensions of transference and countertransference.

Two important developments have occurred in the evolution of psychoanalytic theory and practice in recent years. Mitchell (1993) and Hoffman (1991) both state that these two paradigm shifts can be broadly described as a shift from drive reduction to the relational paradigm, and from positivism to what Hoffman refers to as a "constructivist or perspectivist epistemological position" (1991, p. 77). He suggests that our experience of reality in this position is constructed by culture and society, and how we experience therapy is influenced by our therapist. Both perspectives reflect a postmodernist stance which moves away from the classical position that emphasises the universality of psychoanalytic concepts. Rubin states:

> It has been known for some time that psychoanalytic theories about human nature are not universal but specific to time and place. Freud's psychoanalysis seemed to work for sexually repressed middle-class Viennese in the late 19th and early 20th century, but has less relevance to the social and psychological problems of contemporary western culture (1997, p. 1).

Postmodern epistemology poses a significant challenge to the traditional views of human nature and the concepts of self and object inherent to classical thought. As a result it has had a strong influence on re-shaping contemporary psychoanalytic theory and practice. A postmodern approach believes firstly that truth is situational and relates to social consensus as much as reality, and secondly that different groups of human beings create widely diverse pictures of human nature, each supporting the indigenous power structure of the group creating it (ibid). The postmodern position deconstructs the objective-subjective dichotomy of the therapeutic relationship: the therapist is no longer a neutral objective observer but rather a participant. It has

been suggested that, "postmodern psychoanalytic theories may have value in overcoming some of the problems of cross-cultural therapy encountered in traditional practice, because these theories affirm the validity of different experiences and perspectives" (Rubin, 1997, p. 6).

2.7: Historical Developments

The historical developments in psychoanalysis are best discussed in terms of phases outlined by Sandler et al., (1992) and Wollheim (1987). The first phase was essentially pre-psychoanalytic and lasted until 1897. This phase involved the mutual work of Freud and Breuer and was characterised by the application of hypnotic methods to hysterical patients. Real traumatic events were thought to lie behind the symptoms of the neurotic patient. Based on this traumatogenic theory of neurosis treatment involved attempts to force the forgotten memories into consciousness, simultaneously bringing about a discharge of affect in the form of "catharsis" or "abreaction" (Altman, 1995).

Freud's rejection of the trauma theory of neurosis heralded the second phase in psychoanalytic development. In this phase attention shifted from external to internal factors and the emphasis was placed on the role of unconscious wishes and the way these impulses manifested themselves on the surface. It was at this phase of development that many of the core concepts of psychoanalysis were laid down (Wollheim, 1987). Freud's *Interpretation of Dreams*, published in 1900 outlined the process whereby unconscious wishes seeking direct expression conflicted with the individual's assessment of reality and with his ideals. This conflict between instinctual forces and repressive or defensive forces gave rise to the construction of a compromise formation (Sandler et al., 1992). The compromise formation represented an attempt to allow fulfilment of unconscious wishes in disguised form. Manifest dream content and free associations were seen as disguised or censored derivatives of unconscious wishes. Thus Freud established three important dimensions to the "mental apparatus": the conscious system, the preconscious system and the unconscious system. This became known as the "topographical model". The unconscious system was seen as containing instinctual drives and wishes that constantly sought expression into the conscious system but simultaneously posed a threat to the conscious ego. If this content were allowed into consciousness it would give rise to unpleasant and disturbing feelings and was therefore defended against. Expression of such wishes was therefore only allowed into consciousness in distorted or disguised form. Preconscious material contained knowledge and thoughts outside of consciousness but more accessible and not as strongly contained by the forces of repression (Altman, 1995).

The third phase was signified by a decisive shift in Freud's conceptualisation of mental functioning. In the *Ego and the Id* (1923b) Freud introduced the "structural model", later referred to as the "second topography". In this paper he put forward a revised formulation of the mental apparatus which accounted for the increasing complexities and inconsistencies that could not be explained through the initial topographical model. The concepts of id, ego and superego were introduced and the central role of the ego as mediator between the demands of the id, the superego and the external world was emphasised. The compromises created by the ego amidst these conflicting demands were seen as the basis for personality (Sandler et al., 1992). Furthermore under certain conditions these compromises gave rise to symptomatology that represented the best possible adaptation of the ego to specific circumstances.

The fourth phase in the development of psychoanalysis included contributions from analysts beyond Freud (Sandler et al., 1992). Anna Freud's *The Ego and the Mechanisms of Defence* (1936) extended the notion of defence and Hartman's 1939 publication of *Ego psychology and the Problem of Adaptation* introduced the popular notion of "ego psychology". In the 1960s "ego psychology" gradually gave way to significant new developments, such as Heinz Kohut's "self psychology" and the "Object relations" perspectives of Edith Jacobson, Hans Loewald and Otto Kernberg. Kernberg's views were drawn from the well-established theories of Melanie Klein and from Ego Psychology. British contributions to psychoanalytic theory were extensive and were drawn mainly from the Kleinian school and object relations theorists such as Ronald Fairbairn, Michael Balint and Donald Winnicott. The theories of Wilfrid Bion provided new extensions to theory, as did the work of Jacques Lacan. Developmental theorists such as Margaret Mahler, Daniel Stern and Robert Emde provided invaluable insights into the psychoanalytic understandings of human development (Sandler et al., 1992).

Psychoanalytic theory has thus undergone considerable elaboration since Freud. There has subsequently been much criticism of Freud's original concepts. Nonetheless, it is important to point out that much of what constitutes current psychoanalytic thinking is based in essence on insights from the second and third phase of development - for instance, clinicians continue to make use of the topographical model and the structural model when describing problems encountered by their patients (Sandler et al., 1992).

2.8: The Movement Towards a Constructivist/Relational Perspective

The drive reduction model outlined by Freud is based essentially on the understanding that human beings are internally pressured to discharge and gratify biological instincts (usually sexual), which are often at odds with culture and environment. Normal development is measured

in terms of the individual's success in negotiating culturally acceptable expressions for these drives. In this model "Objects" or significant others are seen as a means to gratification or release and are linked to instinct (Greenberg & Mitchell, 1983).

The British object relations theorists introduced a major shift in psychoanalytic theory by moving the emphasis from drive reduction to the satisfaction of drives within the context of early care-taking experiences. Human potential was seen as being realized within the context of relationships, with the basic unit of personality being a relational one. Objects were no longer construed in terms of Freud's instinctual drive theory but were seen rather as fantasised images of significant others with which the subject interacts (Ivey, 1990). Melanie Klein felt strongly that human infants sought love and understanding in addition to nourishment and Fairbairn (1952) reinforced this view by stating that libido is object seeking rather than pleasure seeking. Winnicott further emphasised the importance of the family environment in development, by suggesting that, "we cannot describe the baby without describing the environment" (Winnicott, 1965/1969).

This relational model heralded a move from the more mechanistic metaphor of Newtonian logic toward a post-Einsteinian model of relativity in which there is no such thing as a context-free event: every thing occurs in relation to another thing (Alvarez, 1992). The understandings embedded in this relational model introduced a way of working with patients that was previously not amenable to classical psychoanalytic work (Ivey, 1990). It was also able to focus on a level of psychopathology and associated symptomatology, etiology and psychodynamics that classical psychoanalysis was theoretically and practically not equipped to work with. Psychopathology was seen as arising from the internalisation of disturbed interpersonal relations in early childhood and not from instinctual frustration (Ivey, 1990). Relational theory introduced a stronger emphasis on the here-and-now of therapy and on the interpersonal relationship between the therapist and patient. Rather than simply attempting to uncover repressed material the therapist was more acutely aware of the interpersonal relationship. The concepts of projective identification and introjection of split off parts alerted therapists to a level of interaction - even in apparently well functioning patients - that required a different technique. These new developments to theory required a more textured way of working that took into account the changing transference of the patient, the changing countertransference of the therapist in the here-and-now and consequent changes to techniques in intervention.

The second important shift in psychoanalysis is the move from positivism to constructivism. The classical position of the therapist as the arbiter of reality and an objective observer has given way

to an appreciation of the therapist as a participant in the construction of reality. Hoffman (1991) points out that in order to move from a positivistic position to a constructivist position the therapist needs to recognise that his personal participation in the process of therapy has a continuous effect on what he understands both about himself and about the patient, and that this relationship involves a world of mutual influence and constructed meaning. Altman (1995) refers to this development as a shift from the one-person model of psychoanalysis to a two-person model. He claims that such a model is more amenable to cross-cultural work as it locates the mechanism for change in the relationship between the therapist and the patient rather than relying purely on the patient to develop insight. He also states that a relational model can overcome some of the problems that may be encountered when working with individuals from a non-western culture. A more directive approach, which is action oriented rather than verbally oriented may be necessary. For instance the therapist may be required to offer material assistance or advice. Altman (1995) states that central concerns such as the patient's pre-occupation with material deprivation become problematic within a one-person model but are more easily dealt with in a two-person model. He states that adjustments to abstinence and neutrality can be accommodated in the two-person model "without necessarily compromising the analytic stance, mitigating against the development of the transference, or rendering the transference unanalysable" (1995, p. 63).

2.9: Contemporary Developments in Psychoanalysis: Conceptual, Clinical and Technical

H.S Sullivan in the 1930's and W.R.D Fairbairn in the 1940's introduced the beginnings of a broad shift in understanding human experience which has evolved into various psychoanalytic relational perspectives: interpersonal, two-person psychology, intersubjectivity, relational, interactional, mutuality and field or systems theory (Mitchell, 2002). This shift to a two-person model has taken a firm foothold in American Psychoanalysis and is often contrasted with the traditional paradigm of the one-person model reflected in classical, drive theory and ego psychology (Spezzano, 1996).

Mitchell (2000) describes the essential feature of these new perspectives as the understanding that humans are principally defined by their relationships. To understand truly the individual's experience is to understand the interpersonal contexts in which the person lives. The basic unit of study, therefore, is not the individual as a separate entity whose desires clash with external reality, but rather the interactional field within which the individual is situated. From this perspective the unconscious could no longer be viewed in the same light as in the classical model. Mitchell (2001) states that in postclassical analysis the unconscious refers less to specific content to be uncovered than to a kind of experience to be opened up. The classical understanding of the

unconscious and how to access its meanings gave rise to a great body of technical procedures to govern consulting room behaviour for analysis. These parameters included a non-directive approach that did not interfere with the freedom of the patient's free associations. Non-interference was therefore a means to allowing for the patient's unconscious derivatives to emerge. Exposure of these infantile sexual and aggressive conflicts at their points of fixation was followed by interpretation and ultimate transformation (ibid). A position of objectivity, neutrality, abstinence and listening for unconscious derivatives meant that the conscious here-and-now dimension of the analytic dyad was under-emphasised.

Mitchell (2001) suggests instead cultivating an experience in the immediate analytic relationship, which is free of goals and less driven by secondary process concerns (such as effectiveness, productivity and performance), a relationship that is more open to affective currents, fantasy and imagination. He proposes a mode of relating that is in essence meditative and similar to Jung's concept of 'active imagination', Ogden's notion of 'reverie' and Winnicott's idea of 'going on being'. Simultaneously, however, Mitchell rejects the classical notion that analysts should not concern themselves with symptoms because symptom change will automatically occur when underlying conflicts have been resolved. He maintains that a more pragmatic involvement with the patient, searching for alternatives and stretching the patient's imagination through "thought experiments" can be useful in transforming highly obstructive symptoms and behaviours (2001, p. 3).

Contemporary psychoanalysis has broadened itself far beyond the task of simply making the unconscious conscious (in the language of the topographic model) or of transforming id into ego (in the language of the structural model). It is more concerned with fostering the capacity of the analyst and the patient to create a space that lies between reality and fantasy (Ogden, 1996). Ogden refers to this space as "the intersubjective analytic third" which is an unconscious intersubjective construction produced by the individual subjectivities of both the analyst and the patient. In this model the analyst gains access to a greater understanding of the patient's unconscious internal world through using his own unconscious in the service of being receptive to the 'drift' of the patient's unconscious (ibid). Ogden emphasises that the analyst's reverie experience provides an indispensable avenue to understanding the intersubjective analytic third and thus to understanding and interpreting the transference-countertransference (1997). Spezzano (2001) reinforces the notion that access to unconscious activity can be gained through techniques that reach beyond the classical understanding of merely listening for free associations. He proposes three sites of access: free association, the analyst's reverie and the intersubjective drama jointly created by the analyst and the patient.

If the conceptual model of relationality proposed above is to be the new grounding for analytic treatment then it follows that new systems of technical procedure will emerge. In the one-person model of analysis it was understood that by 'free associating' and receiving accurate interpretations transformation would occur. The idea that 'information' leads to transformation has been revised in a two-person approach. Emmanuel Ghent (1995) points out that most relational theorists recognise that what the patient requires is an 'interactive' experience. There is a need in the patient for a 'quality of experience', a need to be deeply recognised in the here-and-now, without which therapeutic effect will be minimal. Natterson (1993) states that a relationship that relies solely on interpretation and objectivity is not therapeutic. He proposes a movement beyond neutrality and suggests creating a mutual experience of intersubjectivity where the affective experiences of both the therapist and the patient are relevant. He points out that such a relationship of warmth and concern is necessary for interpretation to be effective. Interpretation in the absence of this intimacy may prove little more than an intellectual exercise. Ogden (1994) broadens traditional techniques of interpretation by emphasising the concept of interpretive action, which involves communicating aspects of the transference-countertransference to the patient through activity (e.g., facial expression) rather than verbal communication. He also challenges the Freudian concept of 'the fundamental rule' which entails encouraging the patient to say whatever passes through his mind. In an interpersonal matrix Ogden argues that such a 'rule' is antithetical to the analytic experience of creating a capacity for reverie. He states that it is important for the patient to know that he is free to be both silent and free to talk.

Karen Maroda introduces the controversial technique of "deliberate self-disclosure" on the part of the therapist (1999, p.1). This technique has never been considered an acceptable part of traditional analytic practice and is currently treated cautiously by most interpersonal, intersubjective and relational approaches. She claims that self-disclosure is an essential component of any analytic practice that aims to make repressed affect conscious and is necessary in providing affective attunement between the therapist and the patient. Maroda (1997, 1999) is critical of contemporary relational theorists stating that she recognises a general reluctance on their part to alter psychoanalytic technique to accommodate new two-person theories, "preferring the safety of trying to fit one-person pegs into two-person holes" (1997, p.323).

Chodorow (1996) reminds us that structural thinking and determinism in psychoanalysis is on the wane. Contemporary psychoanalysis is no longer bound to clinical understandings and interpretations that flow out of developmentally created objective structures that rely on theories of childhood development and its determinative effects on the psyche throughout life. She states

that psychoanalysis has throughout its history relied on causal explanatory models describing the analytic encounter in terms of libidinal fixation, or ego, or self structures that are being enacted. The contemporary focus on the here-and-now shifts away from universalist claims about the panhuman content of unconscious fantasies, the temporal continuity of the self, the belief that life unfolds in a coherent stages from past to present to future and that transference is construed in terms of past psychic realities enacted in the present. Chodorow claims that "what is expressed in the analytic encounter is fed by infantile sources, but it is also fed by many sources in daily life – by the moment-to-moment animating of and investing the world with subjective meaning, and by the new meanings that emerge in the interchange between two (or more) people" (1996, p.32).

In this poststructural theoretical climate analytic knowledge is required to release itself from developmental, universal understandings of the human mind and focus rather on emergent meaning in the transference-countertransference that is mutually constructed rather than intrapsychically caused by one person. In the words of Steven Stern (2002) "In today's postmodern climate, the concept of self as a coherent and enduring psychological structure is under siege. The self is not unitary but multiple, not static but in flux, not a separate centre of initiative, but intersubjectively constituted" (p. 694). Conceptual shifts of this nature have implications for the development of an analytic technique that must take into account subjectivity rather than objectivity, ambiguity rather than certainty and fluidity rather than fixation.

As is evident above, the plurality of contemporary psychoanalytic perspectives presents a significant challenge to the foundations of mainstream notions on technique. Psychoanalysis in a constructivist postmodern age with its revised theoretical understandings of core concepts such as the self, the unconscious, transference, countertransference, dissociation and projective identification has created further tension in the search for a universal system of standards. Aron (1999) states that traditional psychoanalytic theories do not highlight the individuality of the analyst or the uniqueness of the interactive matrix. Whilst contemporary psychoanalysis puts the interactive matrix at the center of its theoretical and methodological agenda, this should not be at the expense of surrendering ethical standards, professional responsibility, or clinical judgement. On the contrary he maintains that the postmodern sensibility of contemporary relational and intersubjective psychoanalysis requires that the analyst accept full responsibility for the fact that it is his own personality and subjectivity underlying his values and beliefs which upholds and infuses his theoretical convictions. From this perspective there can be no technical choice or clinical decision that is not imbued with the analyst's subjectivity (ibid). Aron points out that analytic technique has always been, and currently remains under, revision. However, the search for a standard technical procedure becomes obsolete when it is accepted that "the individuality of

the analyst as well as the particularity of the analysand makes every analysis a unique and unrepeatable event" (1999, p.12). In the words of Stern (2002):

> Postmodern psychoanalytic theorists view themselves as abandoning the linear, hierarchical and essentialist models of the mind, represented by Freud's structural theory and Kohut's self psychology, in favour of a decentered, open, and 'horizontal' model wherein subjective experience is understood to be in a constant state of flux between discontinuous self-states that are grounded in the history of a person's relational experience (p.694).

In summary it can be seen that psychoanalysis has moved from the classical model of one-person psychology with its intrapsychic, structural and deterministic model of the mind towards a two-person model that takes on intersubjective postmodern sensibilities. In spite of these developments, intersubjectivity is in itself not a unitary system. The term intersubjectivity often has different meanings for different approaches. While most approaches support the concept of mutual reciprocal influence defined by Stolorow and Atwood (1994), two-person theorists such as Mitchell (1997) have been criticised for not sufficiently recognising the ongoing influence of the analyst. Karen Maroda (1999) in turn criticises Stolorow and Atwood stating that whilst they recognise mutual influence they fail to verbalise this mutual influence to the patient, rather they use such insights to inform their interpretations alone. Jessica Benjamin (1992) introduces a shift to standard intersubjective theory by showing that therapists' and patients' attempts to influence one another can be both positive and negative with periodic impulses from both sides to destroy connection and meaning.

Many critics feel, however, that the intersubjective two-person pendulum has swung too far. They state that there is too much emphasis on the here-and-now and the analyst's experience. As a result the regard for the unconscious has notably declined (Grotstein, 1999). Jeanne Wolf Bernstein (1999) points out that whilst the new relational perspectives have released us from the antiquated Freudian notion of the neutral analyst it now "allows for psychoanalysts to be preoccupied by and enamored with their own musings by listening more to their internal echoes at the expense of their patient's intrapsychic conflicts" (p. 281).

New understandings of basic concepts of the mind have radically influenced technique and clinical practice. These developments continue to shape an ever- evolving discipline. However, it is important to note that several voices are beginning to emerge that are critical of the subjective nature of the analytic relationship. They claim that this position relies heavily on a philosophical perspective rather than on a pragmatic one. Maroda (2002) states that "once we admitted to our countertransference and the mutuality of the analytic encounter, we did not have a clear idea of how it should be handled in the consulting room" (p.102). Maroda is suggesting that technical

shifts have not kept up with philosophical shifts, and that more emphasis needs to be placed on how these new intersubjective understandings can be translated into technical procedure.

2.10: Adaptability of Psychoanalysis to Non-Western Cultural Groups

Throughout most of the twentieth century into which psychoanalysis was born there has been significant social upheaval, war and changes in economic conditions that have caused mass migration. Analysts and patients have changed countries of residence, culture and language. As a result psychoanalysis has been obliged to change its predominant language and adopt new customs and standards of "another world" (Kadyrov, 2002). It can be said that since its birth psychoanalysis has been developing in the context of a rapidly changing multicultural and multilingual world. With increased international mobility of different cultural groups psychoanalysis is being constantly challenged to pay attention to cultural and linguistic differences on the level of theory, practice and procedures for training (ibid).

With these tensions in mind the issue of psychoanalysis across cultural and linguistic divide formed part of the 42nd Congress of the International Psychoanalytical Association, Nice, France, 26th July 2001. Psychoanalytic propositions continue to be modified, added to and amended in the light of new developments and changing analytic experience. This study claims that psychoanalysis is constantly adapting to the social needs of the societies that it serves. Whilst the drive theory of Freud's nineteenth century Vienna seemed well equipped to deal with the repressions of the time it has proved largely inadequate to deal with other levels of pathology that appear in a modern and postmodern society. Relational theory arose in response to a need for treatment of patients that could not be conceptualised in the classical model. The revolution of intersubjectivity and postmodern approaches of relativism and constructivism reflect the complexity of industrialised society today. However, whilst psychoanalysis has adapted swiftly to the changing needs of western cultural groups it has moved at a slower pace with regard to adapting to non-western cultural groups further a field. In spite of this, cross-cultural therapy is becoming more a part of everyday practice in western countries and psychoanalysis is beginning to reflect this change. With the introduction of psychoanalysis into Russia, Eastern Europe, the Middle East, the Far East, South America and South Africa amongst others it is fast becoming a cross-cultural discipline of international practice and discourse.

2.11: Summary

When discussing the difference between psychoanalysis and psychoanalytic psychotherapy it must be recognised that although the objectives of each approach are different, both approaches use similar techniques. However, these techniques are adjusted to suit the differing treatment

goals of each approach. As contemporary psychoanalysis becomes increasingly characterised by a pluralism of divergent systems it becomes more difficult to distinguish between modalities. Ivey (1999) attempts to codify the analytic process by proposing the "analytic attitude". Whilst his position is open to criticism, he offers a model of practice that is highly self-reflective on the part of the therapist, a model that re-works many of the older order understandings of abstinence, neutrality and anonymity. This model is consistent with the two-person model of intersubjectivity that characterises recent developments in psychoanalytic thought. The intersubjective position has emerged in response to the classical belief that there is an 'objective' reality known to the therapist. They propose that the only reality in the therapeutic encounter is a 'subjective' reality. This movement in thought has given rise to similar changes to technique. Interpretation is no longer emphasised to the extent that it was in the modernistic framework. Relationality presents a strong challenge to the concepts of abstinence and neutrality and it places more emphasis on the interpersonal dimensions of the encounter. This movement from the intrapsychic one-person model to the interpersonal two-person model provides a more flexible framework that is able to incorporate the challenges that increasingly present themselves today in terms of cultural and linguistic difference. The more postmodern intersubjective model inherent in the analytic attitude proposed by Ivey (1999) is more amenable to cross-cultural work than the classical one-person model of the modernist era.

CHAPTER THREE: CROSS-CULTURAL PSYCHOTHERAPY

Culture and Psychological Treatment

3.1: Psychological Treatment Approaches and Culture

When discussing the applicability of psychoanalysis across culture it is necessary to understand that culture itself is inextricably linked to the psychological processes of the individual. These processes are embodied in the concept of "self". Just as language is an innate human capacity, which is configured differently in accordance with the particular social context of the developing individual, so can the self be considered as an innate capacity, which is manifested and organised differently depending on the individual's social milieu. As recognised by William James in 1890, organisation of the self is strongly shaped through socio-cultural factors (cited in Owusu-Bempah & Howitt, 2000). Jungian analyst Vera Buhrmann (1984) in her work with the Nguni people of South Africa makes reference to the impact of culture on shaping the self. From a Jungian perspective she outlines an alternative dimension to the mind, which she believes is of great importance for a better understanding of other cultures. She refers to this dimension as the "cultural layer". She situates this cultural layer in the Jungian topography of universal unconscious, personal unconscious and ego-consciousness and states that it is shaped and determined by the norms and value systems of the culture that one grows up in and like the ego, is partly conscious and partly unconscious (ibid).

It is important to recognise, when considering psychological treatment approaches, that all approaches for psychological healing and treatment are based on culturally defined conceptualisations of self. The following section therefore places culture and self as central to the discussion of cross-cultural psychotherapy and emphasises the often neglected point that the concept of self differs according to culture, and theoretical approaches adapted from one cultural expression of self may not be readily transferable to a different culture.

This section gives a detailed account of how the principles of psychological practice and psychoanalytic theory have been applied across cultural boundaries both historically and contemporaneously. Western notions of self have been very strongly informed by the Cartesian concept of dualism, which has strongly informed the Western individualised self. There has been an historical trend whereby the concept of the individualised self was held as an ideal standard, which could be imposed as a universal rule holding true for understanding the formation of self in all cultures; more recently post-positivistic stances have understood the need to examine the self

from within its specific cultural context and allow for differences in self-formation to emerge from this context (a relativist as opposed to a universalist approach).

If psychoanalysis is constantly evolving to reflect the changes of the society it represents, then it is feasible that such theories can be reformulated to accommodate the nuances of different cultural groups in South Africa. Whilst it is not the aim of this study to revise the core concepts of psychoanalysis, it should highlight the fact that such concepts need to be de-contextualised from their western position and then re-contextualised in a different cultural milieu. All Black South Africans have been exposed to Western influences and ideologies. It would be just as short sighted to speak of a traditional African self as it would be to speak of an ideal Western self. No society is static and this is especially visible in South Africa. This study takes into account the fact that whilst Black English-speaking South Africans may have taken on many of the values and beliefs of the Western system through their education, they also rely strongly on their traditional belief systems. These beliefs show themselves most clearly in times of emotional distress (Pretorius, 1995). Such beliefs are highly personal, comprising symbolic understandings that are often culture specific (ibid). In the words of Buhrmann many South Africans are:

> Living in two worlds… the Western world, which is primarily scientific, rational and ego-oriented, and the world of the Black healer and his people, which is primarily intuitive, non-rational [and] oriented towards the inner world of symbols and images of the collective unconscious (1984, p. 15).

It is a part of a colonialist mind-set that believes one system is superior to another and can be transposed and will be suitable. All too often clinicians are faced with great confusion when working cross-culturally. In some cases clinicians and hospital staff may label a patient as 'cultural' rather than 'psychiatric' implying that a more effective treatment solution lies outside the boundaries of biomedicine. This re-labelling may have positive and negative impacts for individuals with serious mental illness (Swartz, L., 1998). In other cases clinicians may compensate by referring the patient for pharmacological intervention or for the use of suggestive, short term or cognitive forms of therapy. Pelzer (1996) points out that medical and psychiatric services in Africa are prescribing psychotropic medication for an increasing number of patients with psychological illness. In short, treatment interventions often reflect western views and in South Africa such views have been further complicated by colonialist and Apartheid ideologies. This research study aims to explore ways of thinking about such patients that are psychoanalytically based. It does not pre-suppose a specific outcome but rather hopes to contribute by allowing these changes and adaptations to emerge out of the therapeutic encounters that comprise the three case studies of this research.

It can be reasonably assumed that the primary tools of psychoanalysis, classical and contemporary, are imbued with the dualistic stance of western culture. Whilst contemporary psychoanalysis attempts to overcome the subject/object dichotomy the essence of dualism is still present to a greater or lesser degree depending on the approach used. In accordance with the classical model the patient engages in free association saying whatever comes to mind whilst the quiet and listening therapist attempts to maintain a neutral stance. This neutrality requires the therapist to reveal little about himself. The expected aim of withholding such information is to inspire transferential reactions from the patient that reflect inner conflicts. This relationship is artificial by nature and often evokes anxiety responses. The tension that may arise in these interactions is expected to bring to the fore fantasy material to be interpreted, thereby transforming the unconscious wishes and desires into the conscious life of the person. A patient in this relationship is required to be active and willing to co-operate in a stylised interaction. Patients vary in their willingness and in their capacity to engage in such a relationship. With regard to working in the transference they may experience difficulty in putting aside their immediate feelings, such as anger, and reconsidering how such feelings towards the therapist may illuminate conflicts with others in the patient's current and past life. Individuals who are well acquainted with the discourse of psychotherapy and the nuances of western style communication do best in this relationship. Individuals from non-western cultural groups may not respond as favourably and often experience the relationship as unnatural and anxiety provoking (Levenson, H., Butler, S. & Beitman, B., 1997). They are already confronted with the challenges of communication and trust. They may often experience difficulty verbalising emotions and may be unused to the notion of introspection and articulation of the individual self. This is especially pertinent for individuals who come from a cultural background that places a strong emphasis on a community rather than an individual sense of self. To expect such individuals to conform to a model of psychoanalysis that relies on the classical use of abstinence, non-interference and objectivity is presumptuous and needs to be re-thought. It is likely that contemporary models of psychoanalysis that adopt an interactive here-and-now approach will be more suitable to cross-cultural work.

The developmental and intrapsychic models that are fundamental to psychoanalytic treatment are based on the belief that the individual can be empowered to overcome his own internal conflicts. Such a belief cannot be assumed for non-western cultures where the source of conflict is often understood to be located outside the individual, who considers himself far less empowered to bring about personal change. As Buhrmann states, "treatment, [in traditional African cultures] especially for any mental dysfunction, is not individual but requires the co-operation of the

family and at times the active treatment of others in the family" (1984, p. 25). She goes on to point out that "certain healing ceremonies cannot be done without some relatives of the patient being available to fulfil certain obligations. In addition to the living, no ceremony can hope to succeed without the guidance and co-operation of the 'living dead' kin – the ancestors".

3.2: Defining Culture

In order to understand how we can use psychoanalytic psychotherapy in a different cultural milieu, we need to have a better understanding of what culture is and how it informs the concept of self. Most elements of a culture are intangible and include: beliefs, values and ideas which its members incorporate into their selfhood and which become important motivating factors in moulding and shaping (conscious) dreams, aspirations and conduct. An individual's cultural background therefore becomes inseparable from his psychological processes (Owusu-Bempah & Howitt, 2000). Gonzalez, Griffiths and Ruiz (2001) describe culture as a set of meanings, behavioural norms, values, practices and beliefs used by members of a given group in society as a way of conceptualising their views of the world and their interactions with the environment. In this respect, language, religion and social relationships are manifestations of one's own culture. This definition implies that culture is a composite structure of the corporeal, the symbolic and the mythical: objects, institutions, artefacts, beliefs, ideas, mythology, religion and rituals transmitted and internalised in varying degrees by members of that culture. The culture of a given group is the sum of the shared ways of thought, reactions, rituals, customs and habits or behaviour acquired directly or vicariously by its members. It includes child rearing practices, kinship patterns, marriage rites, diet, dress, music and art; it also includes interpersonal relationships (Owusu-Bempah & Howitt, 2000).

3.3: Western Culture and the Foundations of the Western Self

3.3.1: Dualism

The social structures of any culture are based on "myths" which interpret the perceived realities of a society; in the case of western culture dualism is a central "myth" around which social structures and social interactions are built. The foundations are derived from Cartesian dualistic understandings of the world as delineated in terms such as self/other; subject/object. Western culture is constructed around an understanding of the world based on these dualistic principles; each individual is orientated into this understanding from birth. Given that the self emerges out of interactions with others and cultural symbols, the western self clearly incorporates dualistic notions of functioning.

The majority of western concepts of mind and its consequences for the self are encapsulated in Descartes' writing (Stanley Messer & Seth Warren, in Muran, 2001). The Cartesian approach to self includes the following features. The mind is a separate individual self, which can be known in isolation, independent of other human beings. Knowledge of the essential self (which is regarded as a separate thinking entity) comes from observation and analysis. The mind – the thinking thing (*res cognitant*) – can be more aware of the reality of itself than the reality of anything else. Consequently knowledge of one's self as a separate, distinct being is the starting point of Descartes' philosophy. The mind's existence or knowledge of the mind is not dependent on or related to the existence of the body. There is thus a separation of the mind from the body in his philosophy.

Descartes' philosophy splits the experienced world into the subjective (inner) and objective (outer) worlds. The mind is pictured as an objective entity that exists amongst other objects in the world, it is a "thinking thing" that looks out on an external world from which it is essentially estranged. In this way the mind is seen as separate from all experience and separate from all other minds. The mind is the subject separate from the external world of objects. The culture of individualism - and in psychological terms the individual self – emerges out of the Cartesian dualistic perspective.

Postmodern developments in philosophy have had a strong impact on psychoanalysis and psychotherapy (Gabbard & Westen, 2003). The shift away from the subject/object dichotomy towards a more constructivist understanding of the nature of reality is at the centre of these developments. This study acknowledges that postmodern epistemology represents a powerful revisionary force in the social sciences however, it also accepts that this revision is still in transition. In spite of the developments that have occurred, western philosophy still reflects a dualistic explanation of human nature and development. Theories of psychology that emerge out of a particular culture will reflect that culture's understandings of self; dualism is therefore an integral part of western psychologies, including psychoanalysis. The very fact that psychoanalytic theory often refers to internal objects and external objects is reflective of dualistic thinking patterns.

The ideological and methodological tools which psychoanalysis has created to bring about the desired therapeutic outcome in its subjects are therefore based strongly on the dualistic myth. Theories of psychological development and intra-psychic theories are the product of the values, norms and beliefs of the culture of individualism in which they were developed (Muran, 2001). Individuals are seen as separate from the world and as mechanics of their own destiny. Implicit in

psychoanalysis is the notion that all individuals have the capacity to do exactly this: manufacture their own destiny as autonomous entities. Therapists trained within this system will enter the therapeutic encounter with a set of assumptions about the nature of the individual and human development. These assumptions are supported and reinforced by psychoanalytic theory.

3.3.2: The Influence of Dualism on Western Psychology

George Kunz (1998) states that modern psychology is founded upon the philosophical and cultural tradition of individualism. He states that psychology has moved the ego to the heart of its philosophical assumptions about the nature of the human. Modern psychology has shifted in its capacity to study the human psyche's ability to transcend its needs to find a deeper desire, rather it has become a science of the ego, an *egology* or an egocentric psychology. The *psyche* of modern psychology is the *ego* establishing itself in the centre of the individual personality, constructing its own identity through self-development, manipulating its environment to meet its needs, and enjoying the pleasure of satisfying those needs. The meaning of the word *psyche* in psychology has therefore been altered to justify the dominant ideology of individualism and self-reliance. In making such a shift psychology has defied the self, paradoxically by reifying it as a natural force. As a result self-interest acts as a core principle upon which much of the social sciences are founded.

Individuals in western society hold a view of themselves as separate from the community and the environment. Success is generally viewed in terms of individual rather than collective achievement. Competency in western society is seen as obtaining, exercising and utilising control over resources. Individuals are encouraged towards self-development and urged to develop skills that empower them to be self-sufficient (Kunz, 1998). Self-identity has as a result taken on supreme importance for the individual. Operating from the position of the ego as the centre, the western individual takes up a particular position in relation to the world. This position is exemplified in the following description:

> As an ego-centred self I define myself as the *subject*, the one who acts upon all that is not me as subject, that is, *objects*. I, the *subject*, know manipulate, and enjoy those things that are other than me. I define all others (things and persons) as *objects* available to my understanding, effort and satisfaction. Claiming my power to myself, I totalise (objectify) others. I claim others to be *nothing-more-than* what I make them to be. As an ego-centred self I try to *comprehend* (totally grasp in understanding), I try to *control* (totally dominate by my own effort), and I try to *consume* (satisfy my needs…) (Kunz, 1998, p. 108).

Messer and Warren cited in Muran (2001) reinforce the point that western psychology is structured around dualisms that are absent from non-western thought. These include dualisms of

the self and other, mind and body, the theoretical and the applied, the subjective and the objective and most importantly religion and science. In western thought psychology and religion are independent. Western psychology evolved out of science and medicine and is fundamentally isolated from religion. In the East as well as in Africa psychology, religion and philosophy are united. Thorpe (1991) established that in Zulu thought the material (or the organic) and the spiritual are almost indistinguishable. "No fundamental distinction is made between a person's visible, physical being and his invisible spirit being" (Thorpe, 1991, p. 36). In many African cultures there is no separation between issues of magic, religion, health and disease. Western philosophy tends to dichotomise and polarise aspects of human experience. This is particularly evident in the way that western biomedicine emphasises a division between the psychological and the physical. In this framework mental and physical states are thus seen as separate.

The attempt to divide illness into areas of speciality is not only losing some of its impact within western biomedical thought itself, but is largely untenable in other systems of thought. In many non-western societies it does not make sense to separate the physical from the mental and many forms of healing do not make this distinction (Swartz L., 1998). This point is further emphasised by Buhrmann who states "Western medicine divides illness into the different categories of somatic, psychological and psychosomatic; the Black people do not: they say that 'when part of me is ill, the whole of me is ill', irrespective of what the illness is" (1984, p. 26).

Cultural Foundations of the Self

3.4: Understanding the Concept of Self

The self is understood as emerging out of a process through which "social relationships and cultural symbols are filtered through and internalised into the psyche in affect-laden inner images of self and other(s) in complex inter-relationships" (Roland, 1988, p. 5)[3]. Roland draws on anthropological and sociological perspectives and categorises the self as encompassing three aspects. He states "[there are] three overarching or supra-ordinate organisations of the self: the *familial self*, the *individualised self* and the *spiritual self*, as well as an *expanding self* [my italics]". He makes the important point that different cultures emphasise different aspects of the self and integrate them differently (Roland, 1988, p. 6). The "expanding self" represents a

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[3]

Roland's terms for discussing "self" are derived from object-relations theory and owe much to the works of Grinaker (1957), Jakobson (1964), Kahn (1974), Kernberg (1975), Segal (1964) and Winnicott (1965). The work of Klein (1976) and Gedo (Gedo & Goldberg 1973; Gedo 1979, 1981) describes the self as having its own organisational schema or sub-organisations.

growing individuation of the self, arising out of cross-cultural influences on the existing construct of the primary self.

3.4.1: The Familial Self

The familial self refers to a basic inner psychological organisation that allows the individual to function with the hierarchical relationships of extended family and community kinship structures. This familial self is generally characteristic of strongly relationship–centred cultures, such as is the case in India and Africa. Central to the functioning of the familial self is an emphasis on certain sub-organisations. These involve *symbiosis-reciprocity*, which refers to intensely intimate relationships which are strongly inter-connected and inter-dependent and in which there is a constant affective exchange through permeable outer-ego boundaries. High levels of empathy and receptivity to others are an essential part of this sub-organisation, where sense of self is experienced as highly relational in different social contexts. The term "we-self" has been used to describe this experience of self (contrasting with the "I-self" implicit in the Western framework of self (Collins & Desai, cited by Roland, 1988). *Self-regard* is based on a self-esteem derived from strong identification with familial rather than individual reputation and honour, and culturally encouraged idealisation of elders.

For the familial self the *ego ideal* is very much a socially contextualised entity in which social responsibilities, obligations and hierarchical relationships are scrupulously observed and form the structural basis for ego aspirations. The *superego* is largely constructed through the requirements of the hierarchical extended family. Modes of cognition and ego function and communication adhere strongly to context, and place overt emphasis on a shared understanding of symbols, signs and influences (whereas in the individualised self symbols and signs are far more covert and individually interpreted) (Roland, 1988).

Buhrmann (1984) shows that the Xhosa and Nguni people of South Africa place particular importance on the role and place of the individual in the community. The importance of the individual rests largely in his usefulness to the group; for the most part personal achievements are secondary. This results considerable interdependence within the family group.

3.4.2: The Individualised Self

Development in a western society emphasises a conceptualisation of self in terms of individual autonomy and self-responsibility which is well adapted to functioning in a highly dynamic society. The individual is compelled to choose from a variety of social options in contractual, egalitarian relationships governed by the dominant cultural principle of individualism. The

individualised self is characterised by inner representational sub-organisations that emphasise an individualistic "I"-ness with relatively self-contained ego-boundaries, sharp differentiation between inner images of self and other, and considerable social individuation.

In the individualised self the *ego ideal* is orientated to functioning as an autonomous unit in a great number of extra-familial groups. Aspirations are organised around competitive individualism and self-actualisation. *Self-regard* is self-contained and self-derived and is relatively independent of mirroring. The *superego* is orientated around abstract principles of behaviour that are separated from contextuality and familial organisation and are appropriate in a large variety of situations. *Modes of ego functioning and cognition* are adjusted to self-reflection and rationalisation, and also have considerable mobility and adaptability to the different situations confronting the individual (Roland, 1988). The sub-organisations of the individualised self are structured in accordance with "the ongoing self-creation of one's own self-identity through the realisation of one's inner potentials" (ibid, p. 9).

Owusu-Bempah and Howitt (2000) suggest that the attainment of a "fulfilled self" in western society is synonymous with individual autonomy. Psychoanalytic theories of human development that have gained prominence in western thought reflect these values in that they present human development as a pathway to the idealised state of autonomy from others. Foster (1998) describes how children are construed as being in a struggle for liberation from their mothers. Adolescence is a period of independent identity formation, through which the individual achieves separation from a family that would otherwise impede growth towards independent adulthood. The healthy outcome is perceived to be individuals able to function as independent adults who have a mind of their own and are prepared to speak their mind. Whilst this may be considered normal development in western society it becomes problematic when transferred universally to non-western cultures.

3.4.3: The Spiritual Self

The spiritual self is the inner spiritual reality that transcends the ego and ego aspirations. As with the other two notions of self, it is an inherent capacity in all individuals and is experienced and expressed to a varying degree; however, unlike the familial self or the individualised self, it rarely becomes the dominant organising self. It is manifested differently by the familial self and by the individualised self. In the latter it is more often an individual spiritual endeavour; in the former it tends to be manifest through overt symbol and ritualised religious practices.

3.4.4: The Expanding Self

The expanding self is the term devised by Roland to describe the process whereby the basic sub-organisations of self developed through a primary context, while remaining intact, are able to assimilate new sub-organisations when confronted by a different culture with its attendant standards and expectations (1988). This is particularly relevant to many urbanised Black South Africans who often experience conflict between their traditional social structures and the expectations of a westernised society.

3.4.5: Changing Conceptions of Self in Western Society

The modernist view of self is encapsulated in the notion of self as self-contained individualism with a rich conscious and unconscious life, "as an autonomous entity, not subject to continuous change and reformation, but a stable and rational being: *res cogitans*, in Cartesian terms" (White & Hellerich, 1998, p.3). In this study the African notion of self is sharply contrasted with the classical concept of self as unified, firmly bounded and highly individuated. However, there is no single definition for the so called western self, in fact it is true to say that on the level of theory, the modern search for self has failed to yield a universal truth. There is no one discourse that can unify all theories of self in psychotherapy but rather there are multiple discourses that are not mutually reducible to one another (Muran, 2001).

In the process of re-defining clinical conceptions of the self it was the prominent theorists Harry Stack Sullivan, Ronald Fairbairn and John Bowlby who rejected the ego psychology focus of the self as subordinate and representational. They elevated the self, claiming that it was primary and functional. Sullivan (1953, 1964) outlined the self in the context of interpersonal processes, claiming that self should not be considered in isolation but in relation to others. This notion was developed further by the object relations theorists who extended the idea of self as a process. Fairbairn (1952) initiated this turn of thought when he provided a dramatic revision to the Freudian model, in claiming that the libido was object seeking. This fundamental need to seek others was placed into a biological frame by Bowlby (1988) who considered 'attachment' as part of survival. These changing trends in the understanding of self were recognised by Greenberg and Mitchell (1983) who identified a movement away from the *drive model* particularly evident in the ego psychology, towards the *relational model*. In their own words this represented a movement in psychoanalysis from solitary reflection to relational struggle (ibid). In the relational model the analytic situation is seen as inherently dyadic. This train of thought was supported most strongly by the interpersonal, object relational, and self-psychology orientations (Muran, 2001). In the relational model we see a postmodern trend away from understanding the self as 'autonomous'

towards seeing it as 'expressive'. This perspective on self does not contrast as sharply with African theories of self as does the modernist perspective.

In recent years there has been numerous postmodern challenges to the way that self is understood. In the clinical setting there are several overlapping trends in the consideration of self. These include (a) *contextualism*: the recognition that we are intrinsically embedded in context; (b) *multiplicity*: the idea that we are composed of multiple selves; (c) *intersubjectivity*: the appreciation of subjective relations in our interpersonal encounters; (d) *social constructionism*: the understanding of our selves as social and historical constructions; and (e) *deconstruction:* the process of decentering from such identities as gender and race in our self constructions (Muran, 2001).

Theoretical conceptions of self are constantly being revised; however, there still exists a plurality of perspectives on a concept that is central to understanding the human condition and its possibilities for change. These new developments in theories of self have strong implications for the practice of psychoanalysis across culture. The movement away from a modernist position means that issues such as abstinence and neutrality are not important in the analytic situation. This allows for greater technical flexibility as well as a constructive relational experience, which is more able to accommodate difference, diversity, symbol and metaphor.

3.5: Structure of Self in Traditional African Society

The concept of self in traditional African society is predominantly organised around the familial self as described by Roland (1988). Mason, Rubenstein and Shuda (1989) state that a deep sense of kinship is one of the strongest forces in traditional African life. Kinship controls social relationships between people in a given community, it binds together the entire life of the tribe, and is even extended to cover animals, plants and non-living objects through a totemic system. The concept of family is not limited to father, mother and children but includes an entire network of members bound by blood and betrothal ties. In this system the individual does not exist alone but rather corporately, whereby he is defined in terms of both contemporary members and past generations or ancestors. The individual is part of the whole. It is through other people - that is, through relational responsibilities, duties and privileges - that the individual consciously defines his being. Individual aspirations are subsumed to familial and community aspirations.

In this framework the individual perceives all natural occurrences in terms of the entire group. Whatever happens to the individual happens to the group and whatever happens to the group happens to the individual. The individual therefore implicitly views his relationship to others in

terms of "since we are, therefore I am": the Cartesian dictum "I think therefore I am" becomes "I am because we are" (Owusu-Bempah & Howitt, 2000). Similarly disease, illness and treatment in this context are generally understood in terms of the relational context and not as being located in the individual alone (Mason et al, 1989). Jagers and Mock (1993, p. 394) emphasise that in African traditions one's "identity is tied to group membership rather than to individual status and possessions". Sharing as opposed to self-centeredness is promoted because it confirms the importance of social interconnectedness. "The centrality of human connectedness in the African conception of self gives rise to the moral obligations of communalism, mutual support, collectivism and co-operativeness, with one of the highest values being positive interpersonal relationships" (Myers, 1993, p. 13).

Buhrmann in her seminal work *Living in two worlds* (1984) documents her experiences in South Africa with the Nguni and Xhosa people. Through this work she clearly illustrates that any understanding of the self in such communities that does not incorporate the "living dead" or the ancestors would be incomplete. Ancestor communication and obligation are an integral part of communal and individual life. In fact ancestors are often conceived of as "living in one's body", communicating through dreams, somatic symptoms, and other signs. She shows how the traditional structure of self in such communities engages with unconscious dynamics through relating to ancestors as literal beings in the objective world. The western notion of the "individualised self" sees the unconscious rather as a subjective internal phenomenon. However, the relationship between the ego and unconscious in the western mind is not dissimilar to the relationship between the family and the ancestors in traditional communities. Just as the personality of the western individual needs to negotiate, engage and respect the manifestations of the unconscious through dreams, visions and fantasies in order to remain healthy, so the traditional community needs to engage with the wishes and demands of the ancestors in order to maintain an equilibrium.

Buhrmann states "I perceive the fantasies about and images of the ancestors and *abathakathi* (witches and sorcerers) as expressed in Xhosa cosmology as projections from their unconscious, especially the cultural and collective layers. The ancestor and witch concepts are therefore archetypal" (1984, p. 21). She suggests these groups are in touch with the archaic levels of the psyche in ways generally not available to the western mind. During healing ceremonies symbols from the unconscious are brought to the fore, these symbols are worked with ritually and carry powerful transformative properties. In western society the ego has developed at the expense of the unconscious matrix from which it was born. An over-emphasis on the rational, logical and intellectual properties of the ego has served to distance the western individual from the deeper

resources of the psyche. Buhrmann believes that what the "modern" individual thinks and talks about is in traditional cultures acted out through dancing, singing, ritual and ceremony.

In illness and healing the ancestors play a pivotal role. The purpose of such ritual and ceremony is often to decipher the wishes of the ancestors (generally transmitted through dreams), to be guided by their wisdom and to have communion with them. Clan Ancestors are omniscient and play an ever-present role in the day-to-day lives of the family and clan. They represent protection and guidance and are consulted in times of difficulty and illness. If customs are not kept or not regularly performed the ancestors can withdraw their protection and expose the individual or clan to evil powers and bewitchment. Many healing ceremonies aim therefore to restore the broken connection with withdrawn ancestors, thus restoring physical and psychological health.

The sharp divisions in terms of subject-object duality, which are characteristic of the western concept of the individualised self, are virtually absent in traditional African culture, which is based rather on subject-object unity. Jung himself found during his travels that "in Africa the 'without' and 'within' were so interdependent that he spoke of it and remembered it all to the end of his days with astonishing detail" (Van Der Post, 1975, p. 89).

Interpretation of Psychological Meanings across Culture

3.6: Theoretical Approaches

When considering psychoanalysis as a form of treatment across cultures, it must be constantly borne in mind that psychoanalytic schemata have been developed in a western cultural setting and are therefore strongly bound to western values and notions of self. Concepts which western psychoanalysis takes for granted as universals holding true in all analytic circumstances may need to be reformulated in different cultural settings. As pointed out by Kim and Berry (1993), a relativist approach affords a partial means of overcoming the likelihood of misinterpretations and misunderstanding arising from the top-down universalist approach.

The relativist standpoint attempts to understand "self" from the patient's own perspective, including cultural, social or psychological factors. By adopting a relativist approach it becomes easier to understand the patient in his own context. The relativist approach allows for the emergence of *derived etics*. Kim and Berry use the terms "etic" and "emic" as substitutions for "universalism" and "relativism" respectively. "Derived etic" is their phrase for describing the process of identifying the universal components across cultural groups that are not imposed from

the outside but arise as emics from within. These derived etics can form the basis for a more indigenous psychoanalysis. This is not suggesting that psychoanalytic universals must be dismissed, but rather that derived etics in the process of recontextualisation should be integrated into modified universals of psychoanalytic belief.

Psychoanalysis is known as the "Talking Cure". With increased migration in the western world it is becoming more frequent for practitioners to be confronted with issues relating to language in psychotherapy. It follows therefore that language plays an important role when interpreting psychological meanings across culture. In any discussion of cross-cultural psychotherapy these issues relating to language must be addressed.

3.6.1: Theoretical Approaches to Language

An area in which psychoanalytic practice comes into apparent conflict in cross-cultural settings is with language. An important concept to consider when practicing psychotherapy across language divides is the fact that language reflects a world-view. The hermeneutic/constructionist approach maintains that language creates its own reality and reality is negotiated through language (Swartz, S., 1998). This is an extension of the well-established Sapir-Whorf hypothesis (Crystal, 1998) which maintains: "language creates world" and vice versa. That is to say a language will develop to express the world-view of its users; a changing worldview will lead to a change in the language. Language thus reflects the symbolic structure inherent in a group culture. For instance in Xhosa culture in South Africa the question "How are you?" often elicits a response of "We are fine". The plural form in this case reflects the subject/object unity inherent in the collective self (Ulmer, 2003).

Language is thus a reflection of cultural world-view; however, just as culture is not a static entity, nor is language: it adapts to express changes in world-view. An individual from one culture attending psychoanalytic psychotherapy with an individual from another culture and language is expressing an already present and existing change in his world-view. It can be postulated that although his mother-tongue language may not have the means to express this changing world-view there exist a series of "vacuums" awaiting new terms. These new terms for expressing new concepts may be supplied by the analyst or may be provided by the patient himself: this word or term will not have the same meaning when used by the patient as it would when used by the analyst, but it reflects a changing world-view which the analyst will have access to through paying close attention to the context in which the word is being used. Individuals adopting western value structures are simultaneously searching for new words to express and define their changing world-view.

The only means that the analyst has of understanding his patients' psyche is by listening to what they say, what they do not say and how they say it. The empiricist view of language regards words as labels, with each word having a set meaning readily available to speaker and listener and by extension readily amenable to translation. More recent theories of language understand that this is an over-simplification of an extremely complex framework of interactions between world, language and the individual (Crystal, 1998). Postmodern/deconstructionist philosophers such as Derrida (1989) have postulated the concept of the word as not only a denoting device but also a connoting device. The word chosen generates a series of meanings and excludes other word choices and thus other meanings. There is no one-to-one relationship between word and entity, but rather an endless deferment of meanings, which are strictly speaking only available to the speaker and not necessarily to the listener. This has implications for psychoanalytic psychotherapy in that the analyst is constantly required to focus on the patient's potential meanings rather than his own suppositions, and further, on how the patient uses the word, this includes tone, body language and combinations with other words.

Given this understanding of language as a dynamic, rather than a static process it follows that meaning in the therapeutic dyad can be generated through negotiation and attention to context. From this perspective different language bases do not represent an insurmountable obstacle in psychoanalytic psychotherapy. To this end Amati-Mehler (1990) makes the point that psychoanalysis was born out of linguistic and cultural multiplicity. Referring to the cosmopolitan atmosphere of Freud's Vienna she emphasises that hardly any analysis was conducted in the mother tongue of either analysand or analyst.

3.6.2: Universalism

The fundamental assumption of *Universalism* is that there are natural laws that govern all humanity. It is further assumed that human psychological development and mental illness can be understood by universal natural laws and "our job in looking cross-culturally is to find evidence for these universals" (Swartz, L., 1998, p. 12). Owusu-Bempah and Howitt (2000) state that cross-cultural psychology as it is generally understood involves testing theories and concepts that have been developed in the west on cultures outside of western perspectives in order to form a picture of the generalisability of these theories. The search is for cross-cultural universals, which are presumed to be much the same in all populations. Universalism as practiced in western psychiatry tends to use diagnostic systems that claim to identify core syndromes universally applicable, albeit with different manifestations in different parts of the world.

The universalist tradition has given rise to major studies, such as the International Pilot study on Schizophrenia conducted by the World Health Organisation (WHO, 1973, 1979). The assumption of this study was that the disorder was the same across all cultures (Swartz, L., 1998). A main criticism of this approach is that it does not give attention to the fact that "our ways of seeing the world, and our assumptions, help shape how we see the world" (p. 13). Furthermore it is argued that universalist psychiatry, far from being truly universalist, simply imposes western psychiatric models on the world and does not take sufficient account of the actual experience of the sufferer (Eagle, 2005). These models tend to reify psychological illness as static and fixed, thereby failing to take account of illness within the context of social relationships.

The dominant theories which constitute psychoanalytic thinking generally include Drive Theory and Structural Theory (often referred to as Classical psychoanalysis), Ego Psychology, Object Relations theories, Self Psychology and various forms of developmental psychology. Major proponents of these theories include psychosocial theorists such as Erik Erikson (1950) and Margaret Mahler (Mahler, M. S., Pine, F., & Bergman, A., 1975); Object Relations theorist Melanie Klein (1957); Otto Kernberg (1976) whose views included a development from both ego psychology and Melanie Klein and developmental theorists such as Winnicott (1969), and Kohut (1971) who was a proponent of Self Psychology. It can be argued that all these theorists adhere to the philosophical stance of the individualised self. As the very names of these theories suggest, the movement of the individual from dependence towards autonomy is fundamental to most psychoanalytic approaches. Central to psychoanalytic theory are developmental schema that trace psychological growth from infancy through childhood, adolescence and adulthood in accordance with certain stages of development. These theories began with Freud's psychosexual stages and were expanded by Melanie Klein's concepts of object-relations development in early childhood and Winnicott's theory of transitional objects. This was followed in turn by Erikson's and later Mahler's stages of psychosocial development. More recently Kohut's Self Psychology proposes notions of developmental needs and deficits involving narcissism.

The schemata inherent in these theories form the basis of psychoanalytic interpretation when considering how a patient's current symptoms derive from past conflicts and deficits in the developmental process. Psychoanalysis has generally operated on the explicit assumption that these schemata hold true universally, regardless of culture or background, and that they may be used in any context to judge normality and mental health.

However, western perspectives embodied in psychoanalytic theory are not directly applicable to other cultures. For instance, child-rearing practices clearly vary from culture to culture. Any

attempt to apply the theoretical perspectives of "normal child-rearing practice" grounded in a western value system will inevitably fail when attempting to interpret such practices in non-western cultures. Roland (1988) describes childrearing practices in India that are significantly different from the accepted western norm. Unlike the norm in western society, weaning does not take place until the second or third year. Similarly, a young child may remain in the maternal bed until being displaced by the next sibling or until several years old, in some cases well into adolescence or until ready for marriage. Often the child will exchange the maternal bed for that of a sibling, aunt or uncle, but rarely sleeps alone. Using schemata from Western developmental theories, such a relationship between mother and child would be construed as a pathological narcissistic involvement. For a child being prepared for an individualised self with strong interpersonal boundaries and values of independence, such a scenario would be untenable. However, for a child being prepared for a collective and familial self with values of connectedness and more fluid interpersonal boundaries, such a scenario is fitting. The central schema of separation-individuation therefore cannot be taken for granted across all groups and needs to be revised.

The process of enculturation is not confined solely to the interactions of the parents. The seminal work of Abel, Metraux and Roll (1987) point out that the very architecture of the home environment gives the child cues about the ordering of life, not only in the home but also within the self and in the community. The whole setting of the home environment, what it incorporates of the wider world and what it excludes, enters into the child's experience from an early age and sets up complex expectations of the larger world. The use of space and time, the assignment of certain activities to certain parts of the house, the parts of the house to which only certain individuals are allowed full access - these clear limits of time and privacy all contribute to the enculturation of the child into the acceptable cultural norms and values of larger society.

Roland gives a vivid example of the western psychoanalyst recognising the limitations of his pre-conceived universals in his book *In search of self in India and Japan* (1988). He describes his experience:

> What I had originally thought would be an interesting journey in clinical psychoanalytic research in India and Japan turned out to be a much longer odyssey with a far greater re-thinking of psychoanalysis and myself than I had anticipated. … As I wrestled with psychoanalytic formulations that would capture the make-up of the Indian self as I was observing it, I began an increasingly searching re-examination of the theoretical models of psychoanalysis I carried with me. From my reflections on the current psychoanalytic theories. … I realized that the whole elaboration of the psychoanalytic theory of

personality in its many variations is Western-centric. Much of it is clearly related to the clinical data of Western personality in societies emphasising individualism. Although psychoanalysis repeatedly claims to deal with the universals of psychological make-up and ideal norms of mature human functioning, yet these universals, ideals and norms were frequently contradicted in India and Japan (1988, pp. xiv-xv).

Buhrmann in her work with the Xhosa people of South Africa states that whilst there are universal psychic similarities these universals are expressed in unique ways by different cultural groups: "The basic content is similar, but the forms in which this is experienced are different, much like different musical variations on one theme" (1984, p. 31).

3.6.3: Relativism

Fundamental to the *Relativist* approach is to be as true to the context as possible. In order to understand illness in different contexts the relativist approach attempts to gain as comprehensive a picture as is possible of the meaning of the illness to the sufferer in the context of the family, community and spiritual background. In so doing the relativist endeavours to enter into the *explanatory models* (emotional worlds) of those people being studied or treated. "Explanatory models" refers to the ways in which all individuals understand their own illness. Many of the beliefs that individuals hold with regard to illness often appear strange to western mental health workers; however, these beliefs have a valid internal logic. In this approach it is the responsibility of the clinician to attempt to understand the individual's explanatory model and to negotiate these understandings with understandings drawn from a professional explanatory model so that there is some common ground for treatment acceptable to both parties (Gilbert, 1999). Negotiating between the individual's and the professional's explanatory models increases compliance; in other words a patient is more likely to participate in a treatment plan if there is some common understanding of the illness. Even in the physical biomedical framework practitioners are often faced with situations where a patient complains of illness without any obvious sign of disease. In such cases adopting a universalist approach may give rise to much frustration; however, from a relativist standpoint it becomes possible to understand that for cultural, social or psychological reasons the patient is in fact experiencing illness. By adopting a relativist approach it becomes easier to understand the patient and therefore easier to consider other possibilities for treatment beyond western biomedicine (Swartz, L., 1998).

3.7: Psychoanalysis: Universalism versus Relativism

Both the Universalist and Relativist approaches have their limitations with regard to understanding psychological development and illness across culture. The universalist perspective

often gives rise to distortions in understanding internal processes; whereas the relativist runs the risk of missing the larger picture. Kim and Berry (1993) suggest that relativism may be used to consider universals in a different way. The terms etic and emic are substituted for universalism and relativism respectively. They believe that it is possible to conduct a series of emic studies in different cultures and then to explore the commonalities that exist between these cultures. In this way it should be possible to establish universalist trends across these cultures referred to as a *derived etic*. With a derived etic the universals emerge from a series of local observations and not from a set of a priori assumptions held by the practitioner - an *imposed etic* (ibid). This latter term refers to the imposition of one set of cultural and philosophical norms on an alternate culture.

The theoretical structure of psychoanalysis is based on Western-centric thought. Postmodernism has taken a critical stance towards deconstructing the positivist tendency to maintain clear boundaries between subject and object. However, the fundamental split between self and object and between self-representation and object-representation based on Cartesian dualistic assumptions is deeply embedded in western understanding of human nature. Moreover there is a tendency to universalise these understandings and to assume that that everyone has essentially the same nature (Rubin, 1997). Alan Roland states:

> I found that psychoanalytic theory was indeed helpful to my Indian patients, that the various dimensions of human nature that psychoanalytic theory addresses were all relevant… [however,] the content of these dimensions as spelled out in psychoanalytic theory is western-centric (1988).

Roland offers a more postmodern position towards the use of psychoanalytic theory across culture. He believes it is possible to develop a theoretical strategy to integrate both western universalising and Indian contextualising modes of thinking whereby broad psychoanalytic categories from the major models of Freudian psychoanalysis are used as universals, but are elaborated upon contextually from the actual observations of clinical psychoanalytic work with Indians and Japanese rather than from their present content in psychoanalysis. He shows how it is necessary to de-contextualise various psychoanalytic categories of their Western content before re-contextualising them with clinical data from Indian and Japanese patients. Roland's theoretical strategy of integrating psychoanalytic universals with actual contextual phenomena parallels Kim and Berry's proposals of developing derived etics from emic data – in other words recontextualising the data to create (new) universals. In a similar vein Gilbert, (1999) points to the necessity to develop a working synthesis between western and traditional approaches to understanding mental illness in Africa. She emphasises the importance of overcoming the cultural

imperialism of psychiatry in Africa that ignores cultural understandings of illness and health. In her effort to establish a culturally appropriate ideology for teaching psychiatry in Africa, one that draws on both western and traditional belief systems, she emphasises the need for: "listening, recognising, and valuing difference and diversity, seeking parallels and similarities across different methods of healing, and actively working to establish cooperative, culturally appropriate, mutually respectful ways of collaborative working " (p. 293-294). In essence Gilbert proposes a similar framework to the 'derived etic' of Kim and Berry and the notion of re-contextualising proposed by Roland. Berg, (2003) captures the spirit of this exercise by pointing out that psychiatry and psychology in South Africa must work towards building bridges between cultures and world-views. Its aim should not be to colonise African concepts , nor to clothe them in Western psychological language, but rather to see, understand and describe what lies on the other side of the bridge.

3.8: Psychoanalytic Universals to Reconsider in Cross-Cultural Settings

A predominant universal in psychoanalysis is the oedipal complex. The oedipus complex forms the central core of psychoanalytic theory. Freud defined the oedipal struggle as a universal phenomenon. Much research at the interface of psychoanalysis and anthropology has been conducted in this regard. It is generally accepted that the Freudian understanding of this complex arose at a time when patterns of authority where strongly delineated. However, contemporary patterns of authority within western culture have changed. For instance in American and Southern Italian families it is largely the mother who sets the tone of the home and establishes the ethical standards and rules of conduct. She defines the circumstances in which her son should stand up for himself and fight as well as the situations in which he should refrain from sex, alcohol and other unacceptable behaviours. She expects him to succeed and often defines his success in terms of excelling his father. Fathers themselves also expect their children to surpass them financially, educationally, socially and occupationally. These expectations are very different to the expectations of society at the time of Freud's writing. At Freud's time the authority of the Emperor, the father, the Priest and other authority figures was absolute; the position of the mother was subordinate and submissive (Abel et al., 1987).

It is therefore clear that the oedipal struggle differs not only across culture but also within western culture itself. These differences depend on the cultural patterns of approved behaviour inculcated by parents as well as by other significant persons in a society at a given historical period. Devereaux (1985) has reiterated that oedipal impulses are not universally identical and are highly responsive to familial and cultural patterns. However, the different patterns can all be considered to be variations of the oedipal struggle through which a male or female child learns to give up the

pre-genital sex object (the mother) and the genital sex object (the parent of the opposite sex) and to identify more rather than less with the parent of the same sex. In many cases the parent may be a parent surrogate or a series of parent displacements, as among the Chinese (Abel et al., 1987).

Psychoanalytic theory has undergone many revisions, the most notable of which is the shift from the "topographical position" as outlined by Freud in *The interpretation of dreams* (1900) to the "structural theory" he presented in 1923 in *The Ego and the Id*. In the topographical model the mind or mental apparatus is divided into unconscious, preconscious and conscious; in structural theory the mind is divided into the Id, Ego and Superego. It is this latter which has been expanded and become strongly incorporated into general theory relating to the ego, its defences and the concept of instinctual drives. Structural theory has been used in those formulations of infant development that emphasise the formation of the ego and the superego and the relations of these structures to the id and to each other as the child gradually enters into object relations and begins to relate differentially to significant persons in his life. The superego, an introject from parental pressures based on concepts of right and wrong, is strongly affected by the cultural values upheld by parents. Similarly ego functions - integrated beliefs, values, modes of thought and behaviour - reflect cultural patterning.

Roland (1988) states that different superego manifestations are generated by different cultural codes and family structures. In close-knit hierarchically oriented families there is a strong necessity for the containment of unacceptable aggressive and sexual feelings and impulses, which often results in specific symptomatology. Such was the case in the Vienna that Freud grew up in and is the case in contemporary India and Japan. In traditional societies where inter-relational and dependency needs are intensified a high degree of anger and ambivalence can be generated through disappointed expectations and a perceived lack of reciprocity, a strong superego response to contain or often repress such reactions may give rise to compulsive symptoms, amnesias, somatisation or physical ailments. The superego exercises control and containment over these angry feelings for the purpose of maintaining familial hierarchical relationships and the harmony of emotional connectedness that exists between family members. This contrasts with the contemporary western superego where internalised cultural values allow for a much freer expression of anger and sexuality in the more mobile nuclear family (Roland, 1988, p. 255).

Identity formation.
Another universal in psychoanalysis relates to identity formation. Erickson (1950, cited in Roland, 1988) introduced his seminal concept of identity formation which involved both **self-identity** and **ego identity**. Self-identity refers to the contents and self-experience of identity and

ego identity refers to the process of identity formation. Erickson essentially viewed identity as the major organizer of the psyche (Roland, 1988, p. 4). It has been argued that whilst Erickson's concept of self-identity focuses on self-experience and successfully links the intra-psychic with the social, cultural and historical, it is nonetheless rooted in western individualism and does not provide an accurate representation of identity formation in many non-western cultures. Erickson's theory places a strong emphasis on the notion of self-creation that is central to western personality (Roland, 1988, p. 20). Western culture grants the individual an enormous degree of autonomy in adolescence and young adulthood. Individuals are free to choose love and marriage partners, their educational and vocational direction, their social affiliations, their work, where to live and what kind of ideology or value system to develop and to become affiliated to. This process of self-creating requires integrating adult role commitments with the intrapsychic identifications and self-images developed within the family. Successful negotiations of earlier psychosocial stages - such as autonomy and initiative - impact strongly on the adolescent's struggle for a self-created identity.

Whilst Erikson's (1950) understanding of identity formation may provide a highly accurate description of psychological development in western society, it does not reflect well on the experience of childhood, youth and young adulthood in non-western society. Buhrmann (1984) points out that western culture encourages the individual to strive towards personal achievement and face the loss and relinquishment of primary dependency. However, in African tradition individual fulfilment largely coincides with being integrated into the community (ibid). Traditional and even urbanised non-western cultures that are family and community centred do therefore not allow the same degree of autonomy to the individual nor do they offer such a vast range of social and cultural options to the person. Marriages are often arranged, educational and occupational choices are made in collaboration with parents and elders, social affiliations and friends are often absorbed into the extended family and spiritual and religious choices are often taken for granted rather than chosen. It follows therefore that in these communal cultures the pressures and conflicts of identity formation are not present in the same form as they are in the western society. That is not to say that identity formation is conflict free in non-western culture but rather that the schemata proposed by Erickson need to be reformulated to incorporate the nuances of each cultural group.

Formation of conscience: superego versus ego ideal.

The conscience as understood universally in psychoanalysis comprises two inner organisations: the superego and the ego ideal. The superego is frequently unconscious and is orientated towards regulating drives and affects, whereas the ego ideal is oriented around the conscious inner effort

to live up to certain ideals and also idealised images of oneself (Roland, 1988, p. 250). Muensterberger's 1969 paper on psychoanalytic anthropology supports the view that "conscience" in Asian and African societies lacks the internalised psychological structures of the western superego, and is essentially dependent on external controls and guides such as family elders. This point of view is typical of the universalist stance that has prevailed in writings on this topic. In fact the conscience in such societies is profoundly internalised into psychic structures that develop and function significantly differently from those of individuals with a different value orientation (ibid). In family and community based culture the ego ideal is a social-contextual ideal. Reciprocities and ways of relating in varied hierarchical relationships influences conduct. What is correct conduct in one situation or relationship is not necessarily correct in another. Thus what is said on a particular topic to one person in a given situation and time may be quite different from what is given to another person in another situation, with both statements being quite appropriate to their contexts. It is this socially contextual way of functioning which often appears unprincipled or hypocritical to a western individual. Western ethical decrees, which are incorporated into the ego ideal, tend to be universal such as "thou shalt not kill". In non-western culture the ethic is not a universalist ethic but is rather a context-oriented ethic (ibid). For instance in India each class or "jati" has his own laws and ethic. Roland (1988) suggests that in the western conscience it is generally the unconscious superego that regulates behaviour whereas in non-western culture it is often the ego ideal that determines correct conduct in specific contexts.

3.9: Indigenous Theories of Illness: Causation and Cure

The way in which any society understands illness is completely embedded in that society's way of making sense of the world. While some types of illness appear to have similar symptoms across cultures others are culture bound. However, even if symptoms appear similar, how they are understood is totally dependent on the context in which they emerge. For people in developing countries illness and healing most commonly involve beliefs concerning supernatural powers, ancestors, or being bewitched (Gilbert, 1999). Psychiatry and psychology in Southern Africa has in the past concerned itself with trying to develop taxonomies of indigenous illnesses similar to the DSM-IV. Swartz, L., (1998) suggests that diagnosis in African indigenous healing may be better understood through theories of causation. Diagnosis of illness is inextricably related to causation, including natural, social, personal, spiritual and political issues. By using this system it is possible for two individuals to receive the same diagnosis, such as bewitchment, but to exhibit different symptom patterns. Illness may be related to ecological imbalance, pollution, impaired social relationships, bewitchment, sorcery or disturbed relations with the

spiritual world (such as not complying with the wishes of the ancestors) (ibid). In such systems a strong emphasis is placed on contextual information to make sense of the illness.

In African medicine a distinction is often made between illness and disease. In her book on healing amongst the Zulu people Ngubane (1977) draws a distinction between *umkhuhlane* and *ukufa kwabantu*. The latter refers to 'African illnesses', which are generally treated in a ritualised way. The former refers to illnesses that are universal, such as influenza that can be treated biomedically. Two well researched 'African illnesses' or Culture Bound Syndromes in South Africa are *amafufunyana* and *ukuthwasa*. The former is generally viewed as a negative spirit possession state and is commonly associated with mental disorder, the latter is seen as a positive state of emotional turmoil experienced by a person on the path to becoming an indigenous healer. However, Swartz, L., (1998) notes that these illnesses do not have one single meaning. The meaning shifts according to different contexts and different accounts from healers. Similarly whilst depression in Africa is on the increase, the way in which it is understood presents some difficulty for professional health services that rely on a high degree of differentiation of emotional states for diagnosis and treatment. For instance the word *khatazekile* in Xhosa can be translated as either 'sad' or as 'worried'. These terms are confusing for biomedical forms of diagnosis and treatment as one term suggests anxiety and the other depression. Swartz, L., (1998) suggests that the first step towards developing a culturally informed view of depression is to recognise the diversity of emotional experience in different contexts.

Diagnosis and treatment in a western system relies on the careful differentiation and grouping of symptoms. In indigenous systems the approach is different. Most African conceptualisations of health and illness arise out of two fundamental philosophical concepts, Ubuntu (humanity and compassion) and Ancestor reverence (Berg, 2003). From this perspective, illness is better understood through a hermeneutic rather than an empiricist view of science. It is important therefore to note that indigenous systems of healing differ not only in terms of actual labels and diagnoses but also in terms of how diagnostic systems are constructed (ibid). The process of healing itself - which may for example involve dancing and drumming - will provide more information about the problem as the treatment proceeds (Buhrmann, 1984). This position is not unlike certain branches of psychotherapy, which emphasise the healing relationship above the diagnostic abilities of the therapist (Swartz, L., 1998). Similarly, the capacity to put aside overt symptoms and to focus rather on aetiology is reflective of the psychoanalytic position in western society.

In African indigenous healing there exists wide variety of healers. These healers are highly trained therapists who undergo extensive training, sometimes lasting several years (Berg, 2003). These include an *inyanga* (doctor) and an *isangoma* (diviner). The *inyanga* is generally a man who learns through apprentice to dispense herbal treatments. The *isangoma* is often a woman who has been chosen by the ancestors to be a healer (Ngubane, 1977). Pelzer (1996) states that most healing methods focus on psychosocial problems and disorders. This view is supported by Hewson (1998) who states that traditional healers work most successfully with psychological and psychosomatic illnesses. Ritual and herbal remedies, dance, dream interpretation and co-habiting with the healer may form part of a treatment process. Healing takes place either on an inpatient basis with the inclusion of family members or on an outpatient basis with the inclusion of the community (Pelzer, 1996). During treatment the healer may makes direct statements to the patient and others present. By monitoring the reaction of the group, new interpretations and understandings of the patient's problem emerge. Healing is therefore not only about the individual but also about maintaining the norms of the particular community. The emphasis on non-rational procedures in indigenous healing can give the mistaken impression that there are no rules or rational codes of practice. In fact rationality does play an important part in these healing processes (Reynolds, 1996). This is exemplified by Sinzingre and Zempleni (1992) who show that in African medicine there are four key questions that are generally asked. These are: Which sickness is it? How has it happened? Who or what produced it? Why did it occur at this moment in this individual? Rather than following pre-determined rules, the healing procedure flows on from the meaningful logic that emerges out of these questions.

In most African cosmologies disconnectedness can cause profound suffering (Hewson, 1998). Traditional healing rituals are generally aimed at restoring connectedness and therefore restoring psychological health to the individual or community. The efficacy of this process lies in the fact that it addresses the fundamental human need of establishing links. Through ritual, connectedness is re-established and concrete links are made between the individual, the family, the community and the ancestors. Such links simultaneously serve to re-connect body and mind, the conscious and the unconscious. This process occurs in a ritualised space, presided over by a trained healer who acts on behalf of the ancestors (Berg, 2003).

In spite of enormous cultural differences, there are certain characteristics of healing that are common to all societies. Frank and Frank (1991) outline some of these features:

1) An emotionally charged, confiding relationship with a helping person (often with the participation of a group).
2) A healing setting.

3) A rationale, conceptual scheme or myth that provides an explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them.

4) A ritual or procedure that requires the active participation of both patient and therapist, and that is believed by both parties to be a means of restoring the patient's health.

Western individualised forms of therapy and indigenous collective approaches to healing are therefore in essence not entirely different. The challenge for biomedicine and African medicine is similar to the challenge for psychoanalytic psychotherapy and traditional healing practices. It is not a case of romanticising indigenous practices and seeing them as better, neither is it acceptable to elevate western-based systems of healing. As stated by Swartz, L., (1998.), "Much more work needs to be done which critically examines the interface between indigenous healing and professional mental health care, so that the best can be gained from both approaches, in the interests of the users of these services" (p. 254).

Cross-Cultural Psychotherapy in Africa and South Africa

3.10: Cross-Cultural Psychotherapy in Africa

The most dominant form of psychotherapeutic care in most African countries is provided through traditional forms of practice. Traditional healing rituals are culturally organised, symbolically meaningful events which provide standardised therapeutic experiences aimed at reducing anxiety and emotional distress in individuals suffering from a variety of mental illnesses (Kiev, 1989). Research shows that traditional and religious faith healers attend to approximately 80% of mental cases in Africa (Madu, S., Baguma, P. & Pritz, A., 1999). Whilst these traditional healing methods are highly appropriate to the vast majority of individuals, such methods are becoming increasingly unable to deal with the newly structured psychopathologies that appear with modernisation, urbanisation, economic and political instability. As a result the demand for psychotherapy is increasing, particularly in urban areas (Peltzer, 1995), and psychological disorders now account for approximately one fifth of all contact with health services in Africa, with the majority of mental health problems being psycho-social rather than psychiatric (Madu et al., 1999). The need for increased psychotherapeutic intervention in Africa having been established, the question has been raised as to how to proceed. It was in the spirit of these questions that a forum for cross-cultural dialogue was established by the World Council for Psychotherapy. At the First World Congress for Psychotherapy (Vienna, 1996) specific questions relating to "psychotherapy in Africa" were raised. This was followed by the First African Conference on Psychotherapy in Kampala (Uganda, 1997) and the second African Conference on

Psychotherapy in Sovenga (South Africa, 1998). This debate has been continued at further conferences and meetings. In South Africa the following statement encapsulated the spirit of the Sovenga conference:

> Psychotherapy as it should apply to (Black) Africa is yet to be well defined. The right attitude towards the western forms of psychotherapy, the appropriate ways for adapting them for use in Africa, the right attitude towards African traditional and religious ways of healing, how to relate them to modern methods of treatment of emotional problems of Africans, and what psychotherapy-related areas should draw the attention of researchers: these are some of the questions that have generated dialogue among psychotherapists (Madu et al., 1999, p. 270).

Discussion arising from this conference established that the interest in and the need for psychotherapy in Africa are indisputable (ibid). The World Council for Psycho-therapy initiative requires ongoing dialogue and research to ascertain how different forms of therapy, both indigenous and western-based, can be developed into meaningful structures for general use. The question of how psychoanalytic psychotherapy, which is a particular form of therapy, can be adapted to a South African context is one of the goals of this thesis. It is important therefore to consider how this form of therapy has been adapted in other countries.

3.11: Adaptations of Psychoanalytic Concepts for Treatment and Research in South Africa and other Non-Western Cultures

Psychoanalysis in Africa has been largely confined to ethnopsychoanalytic studies, which utilise psychoanalytic research methods to understand different cultural dynamics. Whilst psychoanalytic thinking has been used in various African countries for a number of decades there are no references in the literature that discuss in detail the use of psychoanalysis as a treatment strategy with Black Africans. In some instances, particularly South Africa, various forms of psychoanalytic treatment have been used, however the use of this treatment has been confined to patients of western culture: mostly White South Africans. On the whole psychoanalytic psychotherapy has not established itself firmly as a treatment approach in Africa.

Peltzer (1995) states that as a treatment method in the third world psychoanalysis needs to undergo certain modifications and adaptations to technique. However, in certain non-western cultures psychoanalysis has been adapted to the needs of the cultural milieu. This is particularly evident in Latin America where Rabanal (1990) practised psychoanalytic work with patients living in a slum in Lima, Peru. He adapted his treatment strategy to the context by conducting sessions with patients in their home environment. Similarly, Devereaux in his work with an American Plains Indian adapted his technique to "expressive-supportive therapy" (1985, p. 207),

which did not attempt to change the cultural values of the patient but rather adapted the goal of treatment to the external cultural conditions. These successful uses of psychoanalysis in a cross-cultural environment suggest that psychoanalytic psychotherapy should also be capable of adaptation to an African context.

In South Africa psychoanalytically informed thinking has been integrated into various programmes to good effect. The Kathorus Parent and Child Counselling Centre was established in 1995 and grew out of what was previously the Johannesburg Child Guidance Clinic, which was founded in 1946 during the time of Wulf Sachs. A strong psychoanalytic orientation has been maintained at this centre since its inception, throughout Apartheid and into its current transformation as an appropriate resource, which is strongly based in the community. Other programmes, mostly coordinated through universities, have shown how psychoanalytic thinking can be used in different cultural settings. For example, Dr Astrid Berg started the Infant Mental Health service in the community of Khayelitsha in 1995. This is a clinical service that has a psychiatric and psychotherapeutic focus. It is a culturally sensitive programme that takes account of traditional healing practices (Berg, 2003). Van Breda (1997) explored the possibility of using Jungian dream analysis as a psychotherapeutic framework for White therapists working with Black patients. In this essay Van Breda concludes that the Jungian understanding of the psyche, particularly the universal unconscious, offers a promising framework for working across culture in South Africa. The concepts of the universal unconscious, the archetypes and images are well suited to the cosmology of indigenous healing practices, particularly with regard to understanding the role of ancestors in such communities (ibid). Other examples are the psychodynamic outreach work of Valerie Sinason (1998) in Cape Town with traumatised communities and the work of Anne Mckay in Durban with deprived and delinquent youth (Mckay, 1996), which are further testimony to the effectiveness of psychoanalytic thinking across culture.

3.12: Psychoanalytic Psychotherapy in the South African Context

When discussing the evolution of psychoanalytic thought in South Africa it is important to contextualise these developments in the historical and socio-political past. Prior to the institutionalisation of Apartheid in 1948 attitudes towards mental health were directed by the Mental disorders Act No. 38 of 1916. This act declared the superiority of Whites and popularised a Eurocentric view of mental health. This mindset flowed out of European imperial notions of the presumed superiority of Western culture, and the universal application of western norms (Sadowsky, 2003). Cultural stereotypes equating primitive society with degeneration, disruption and pathogenesis were readily adopted and woven into Apartheid ideology. As a result in the early years of Apartheid, psychology and psychiatry acted largely in the political interest of the

white minority (Vontress & Naiker, 1995). In later years these disciplines moved towards a more neutral position, largely dissociating themselves from political systems and in some cases leaning more towards the provision of appropriate social services. There is no doubt that the Apartheid system and its predecessor the colonial system caused untold harm to the people of South Africa. The systematic disruption of Black families and communities created social and psychological problems that are likely to linger for many generations. Furthermore this system was responsible for skewing and retarding the development of a mental health service that takes account of cultural difference and the needs of the general population at large. It is no wonder that white psychologists and other mental health professionals who work in African contexts stand accused of oppression, irrelevance, elitism, Eurocentricism, and neo-colonialism (Bakker & Snyders, 1999). The practice of psychology and psychiatry in South Africa has undergone significant change in recent years (Swartz, 1999) these efforts have focused on overcoming the racial and cultural barriers that were defined and upheld by the Apartheid system. As Berg (2003) states: "In South Africa western-trained health professionals can no longer ignore the needs of the majority culture. As professionals we have to move out into communities of need" (p. 276).

Despite the academic isolation of the Apartheid years there has been a long tradition of psychoanalytic thinking in South Africa. This started most definitively with Wulf Sachs, a psychoanalyst who liased closely with Ernest Jones in attempting to establish a South African branch of the International Psychoanalytic Association (IPA). This did not materialise as Sachs died in 1949 before it could be firmly established. As a pioneer of psychoanalysis in South Africa, Sach's work is well documented in his book *Black Hamlet* (1947). This work was the first attempt at cross-cultural psychoanalysis in South Africa. The subject of this book was a biography of his client, the Black traditional healer John Chavafambira (Madu et al., 1999). After Sachs' death the further institutionalisation of psychoanalysis was prevented largely through the installation of Apartheid. In 1972 the South African Institute for Psychotherapy (SAIP) was established by Dreyer Kruger in collaboration with senior psychiatrists and psychologists. This institute carried a strong psychoanalytic emphasis. In 1979 a psychoanalytic study group was founded in Johannesburg and in 1984 a similar group was established in Cape Town (Gillespie, 1992; Hamburger, 1992). In January 1987 the Centre for Jungian Studies was inaugurated by Sir Laurens Van Der Post, Vera Buhrmann and others. This centre continues to offer postgraduate training in advanced psychotherapeutic techniques and is affiliated to the International Association of Analytical Psychology. Strong connections are maintained with the international psychoanalytic community and psychoanalytic theory continues to play an important part in the training and practice of therapy in this country.

There have been no co-ordinated programmes but there have been a number of individual and local initiatives looking at the practice of psychoanalytic psychotherapy in the South African context. Becker and Isaacs (1993) found from interviews with 29 clinicians working in Cape Town that 48% practised brief dynamic psychotherapy and 72% had a psychodynamic orientation. However, questions about the relevancy of psychoanalysis in post apartheid South Africa are continuously raised. This was particularly evident at the International psychoanalytic Conference in 1998, held in Cape Town. This conference attracted a large number of South African delegates, many of whom took the opportunity to question the appropriateness of psychoanalytic understanding to communities beyond the western ethnic minority. Despite this controversy it is clear that, as Sally Swartz (1998) points out, "In a sense we do not have a choice about whether or not psychoanalytic theory is a feature of the landscape: it is a part of the landscape" (p. 1). She further notes that psychoanalytic thinking has been a strong feature of the psychological training in most South African universities as far back as the 1920s and 1930s.

Two threads of argument emerge from the controversial position of psychoanalysis in South Africa today. The first relates to the appropriacy of imposing a western conceptual framework on a non-western setting. The second relates to the fact that there is, strictly speaking, no choice as to whether psychoanalytic thinking should be used or discarded as it is indelibly an ongoing part of South Africa's psychological evolution. It follows therefore that research is required to determine ways of bridging the gap between the present use of psychoanalysis and the appropriate use of psychoanalysis in South Africa. Sheila Miller, an English psychoanalyst working in Johannesburg, gives an interesting cross-cultural example of culturally different analyses of the same symbol. When a child's drawing of an elephant was presented to her she offered an interpretation which derived from her own cultural association of "elephant" with "memory"; her non-western colleagues pointed out that many of the indigenous South African cultures would associate an elephant with power (1999). This simple point raises the important issue of allowing the individual to express his own associations and interpretations of a particular symbol rather than the clinician imposing culturally derived assumptions. This requires a relativist stance such as is expressed through Kim and Berry's notion of the derived etic (1993). This is precisely the challenge that the whole of psychoanalysis needs to meet in South Africa.

3.13. Interracial and Cross-Cultural Concerns in the Practice of Psychotherapy in South Africa.

During the decade from 1970-1980 Black students in South Africa received only 2% of the degrees in psychology (Vontress et al, 1995). These numbers have been steadily increasing with most universities placing a strong emphasis on restoring this imbalance. In spite of this most psychologists in South Africa are White. Such individuals are well aware of the legacy of

Apartheid and the associations that still exist when attempting to work across culture. White therapists working with Black patients need to contend with issues of power emanating from a legacy of segregation and racial discrimination. Other factors that may impact on the process include patient mistrust, lack of awareness and education about the effectiveness of psychotherapeutic interventions and limited financial resources. Therapist bias and gender issues are also concerns that need to be taken account of. Therapists are required to be aware of their own cultural values and biases and simultaneously need to develop culturally sensitive attitudes and skills towards their patients' cultural difference (Wilson & Stith, 1991).

Apart from these factors the fundamental issue highlighted in this study is to what extent are psychodynamic and other psychological models of treatment are appropriate across racial and cultural divides. Jackson and Greene (2000) consider psychodynamic theory in a cross-cultural context to be ethnocentric, perpetuating sex role stereotypes, pathologising difference, and failing to provide an in-depth understanding of the experience of the other. They state that the real task for psychodynamic work across culture is to train clinicians towards expanding theoretical paradigms and therapeutic methods of enquiry that take into account the historical, political and real life experiences of Black people. In doing so a better understanding of the psychodynamic underpinnings of these individuals' psychological experience can be gained.

White therapists working with Black patients in a South African context are confronted not only with the recent socio-historical factors but also with more general issues pertaining to cross-cultural work. Most studies agree on several critical points that culturally-sensitive therapists need to consider when working across culture. Berg (2003) highlights the fact that the archetypal presence of ancestors in African culture is a reality that cannot be ignored in the consulting room. Dupont-Joshua (2003) extends this argument and points out that when the African individual walks into the therapy room he may often bring with him his entire family, both alive and dead. Therapists are therefore compelled to look beyond the therapeutic dyad in order to understand their patients.

This view is supported by Peavey and Li (2003) who argue that successful intercultural counselling depends on the extent to which the therapist understands the socially contextual factors surrounding the interaction. Secondly they argue that intercultural counselling is a collaborative process, the success of which depends on how well the therapist and the client co-ordinate their communication on process and content issues. Therapists that have an understanding of their client's social and cultural contextual variables are more likely to establish a working alliance. Ruiz, Bland, Pi and Zulueta (2005) support the notion that no successful

intervention can occur without the engagement and establishment of a therapeutic alliance. A strong alliance requires that therapists openly acknowledge potential impediments to the process in order to gain credibility with the client. They need to acknowledge that their racial difference may create an experience of social distance for both patient and therapist. Also, that this distance may mobilise anxiety and mistrust thereby decreasing self-disclosure on the part of the patient. These open acknowledgements can only serve to increase the empathic bonding that is necessary for a successful treatment outcome. Most studies agree that the therapist needs to know the cultural rules of conversation, other than language, that may hinder communication. An attitude of reciprocity, negotiation, humility and respect, together with a reverent attitude towards difference is necessary to facilitate successful outcomes in cross-cultural therapy.

White therapists working with Black patients in South Africa cannot divorce the consulting room from the larger socio-cultural and political context. Race relations, the exercise of power, stereotyping, discrimination and issues of gender inequality that exist in the broader context will be reflected in the therapeutic encounter (Palmer, 2002). Given that the relationship between Black and White individuals has always been typified by conquest, oppression, exploitation and discrimination, it is paramount to develop models of practice that can overcome these issues of dominance, rather than perpetuating old themes of White authority and superiority that may cause further damage. One aspect of conditioning established through colonialism and Apartheid is the perception that White people are knowledgeable, powerful, wealthy and intelligent. For this reason Black patients may have more confidence in a White therapist than a Black therapist. Conversely they may also harbour deep feeling of resentment (Palmer, 2002).

Furthermore, therapists need to understand similarities and dissimilarities between their own cultural values and the values of their Black patients (Wilson et al, 1991). Sharing, obedience to authority, respect for elders, and values associated with patriarchal dominance may differ markedly to the value system of the therapist. The position of women in most African value systems is largely subordinate. For a White male therapist working with Black female patients an understanding of the impact of, not only his Whiteness but also his maleness, must be acknowledged from the position of the patient's own cultural patterns. Similarly, the therapist needs to be aware of his own cultural stereotypes concerning gender inequality.

A postmodern constructivist orientation as opposed to a rationalist style of intervention has been recommended for cross-cultural and interracial work (Eagle, 2005). This approach is a form of discourse located in a particular cultural context. It embodies a style of working that encourages sensibility in the culturally mediated communication of the participants (Peavey et al, 2003).

Peavey et al state that constructivist counselling is premised on multiple realities and is receptive to myth, symbol and metaphor. It focuses more on the dictates of cultural knowledge than on the claims of universal scientific knowledge and "it eschews the 'authoritative' voices and vocabularies of professional and academic psychology, as well as the pathologising vocabularies of psychiatry and psychotherapy" (2003, p.189). Eagle (2005) emphasises that it would be impossible to fully engage with African clients holding to traditional world-views by using a model of understanding that does not encompass subjectivity, alternative logics and content that the therapist might consider to be non-rational or irrational.

Peavey et al outline the main features of a constructivist approach for cross-cultural counselling. These include:

1) Respect for difference and diversity.
2) Openness to a range of possible ways of interpreting reality.
3) Encouragement of creativity, inventiveness and cultural resonance.
4) A sense of real-life engagement.
5) Resistance to the negative effects of classification or categorisation.
6) Helping based more on cultural rather than psychological hypotheses.
7) Direct use of language tools and social artefacts.
8) Cooperation and consensus rather than authority and imposition.
9) Help construed as emancipatory and capacity-building in intention (2003, p.189).

The constructivist approach to counselling across culture and race is in keeping with the relativist position outlined in 3.6.3 above which aims to remain as true to context as possible. From this position meanings are constructed collaboratively and are viewed as interactional achievements in the therapeutic encounter. In this process the therapist gives prominence to the patient's explanatory system of cultural meanings. By listening, responding and re-contextualising these meanings, rather than imposing universals, the constructivist approach allows for the emergence of a therapeutic framework that is, in principle, similar to the concept of a derived etic suggested by Kim and Berry (1993).

3.14: Summary

There is no universal model of self. The western individualised self, arranged around the core concept of dualism, is deeply entrenched in the theory and practice of psychotherapy. This theoretical mindset is inappropriate for understanding the life experience of those individuals whose sense of personhood is socially constructed. Treatment approaches that base themselves on western-centric ideas of health, illness and cure are therefore counter-therapeutic in cross-cultural

work. For psychotherapy to be practicable in South Africa it is necessary to acknowledge the fundamental differences in the arrangement of self that exist across culture. It is important to note that the construction of self reflects the cultural system from which it emerges. Family structures, child-rearing practices, education, obligations to the community, social hierarchy, morality and spiritual beliefs are some of the constructs that inform the development of self in all cultures. When considering how to work across culture it is clear that a model of practice is needed that can assimilate these different perspectives of self and can integrate different cultural patterns. Such a model needs to free itself from dominant western assumptions and values such as self-reliance, self-control and autonomy. Furthermore, such a model needs to acknowledge the damaging effect that universalist assumptions - entrenched through colonialism and Apartheid – have had on Black South Africans.

Psychoanalytic thinking has a long tradition in South Africa. If this discipline is to continue to meet the challenges of its context and to develop into an appropriate tool it must incorporate models of practice that are based on the concept of an *expanding self* rather than an *individualised self*. Such a model needs to be critical of past inadequacies and develop new ways of interpreting psychological meanings that replace the positivist and modernist epistemologies. It needs to adopt a relativist position that is culturally sensitive and allows for meaning to be constructed rather than imposed. White therapists working with Black patients need to be culturally sensitive to indigenous cosmologies and need to be acutely aware of their own personal beliefs and prejudices as well as the associations and negative transferences attached to them by their patients. In order to make sense of the life experience and life difficulties of Black South Africans it is necessary for therapists to understand their patients not only from an emotional perspective but also from within their cultural and social context. Prejudice, racism, poverty and social disadvantage form part of the total life experience of most people in South Africa. White therapists also need to consider their own negative countertransferences, recognising that they belong to a society that has always projected negative images of Black people (Dupont-Joshua, 2003). Those therapists who remain unconscious of their own understanding of race are more likely to experience negative reactions and outcomes, often indicated through early termination (Palmer, 2002).

Contemporary psychoanalytic models of practice that have moved beyond the constraints of the classical determinist model are more able to accommodate the therapeutic needs of Black South Africans in transition. The intersubjective relational quality that is inherent to these approaches allows for an easier assimilation of diverse cultural configurations of self that include both collective/traditional and individualised/ western values.

CHAPTER FOUR: RESEARCH METHODOLOGY

Research Methods in Psychology

4.1: Quantitative and Qualitative Research Methods

Psychological research has two super-ordinate methodologies of enquiry: the Quantitative and the Qualitative. The former is about determining relationships between pre-selected and tightly controlled variables according to an hypothesis; the latter aims to describe and understand processes that are not directly observable or measurable (Denzin & Lincoln, 1998). As stated by Breakwell, Hammond and Fife-Schaw:

> Research methods can be differentiated according to whether the data are submitted to qualitative or quantitative treatment. A qualitative treatment describes what processes are occurring and details differences in the character of these processes over time. A quantitative treatment states what the processes are, how often they occur, and what differences in their magnitude can be measured over time (1995, p. 13).

4.1.1: Quantitative Traditions

Quantitative methods of research are derived from the positivist tradition of the natural sciences and are aimed at supporting a predetermined research hypothesis (Dyer, 1995). These methods are statistical and amenable to mathematical interpretation and explanation. Experimental methods and other objective strategies are the most frequently used techniques for this type of research. Typically experimental research examines a limited number of isolated variables under rigorously controlled conditions.

4.1.2: Qualitative Traditions

Qualitative methods of research are not orientated to a specific outcome and do not attempt to answer a research hypothesis. Rather they are able to examine a process of naturally occurring real-life events which is generally uncontrolled and not pre-determined by the researcher. They are therefore able to encompass a large number of variables.

> Whereas experiments are, almost exclusively, geared to the generation of "hard data" in the form of quantitative measures of a variable, the alternative methods are able to provide the researcher with "soft" qualitative information consisting of verbal descriptions of psychological events and processes… such as dreams, which… do not easily lend themselves to meaningful quantification (Dyer, 1995, p. 20).

Denzin et al. (1998) make the point that qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter and an ongoing critique of the politics and methods of positivism. Qualitative researchers incorporate the use of a variety of empirical materials such as case studies, personal experience, life stories, interviews, observational, historical and interactional texts. They attempt to make sense of or interpret phenomena in the natural setting in terms of the meanings people bring to this setting.

<u>Critique of qualitative research.</u>

Qualitative research has undergone many historical changes since the age of classic ethnographers, such as Malinowski's 1914-1917 account of traditional communities in the Trobriand Islands. Denzin et al. (1998) point out that five important historical changes, reflecting different theoretical epistemologies, can be identified in the evolution of qualitative research: The **traditional period** (1900-1950) was associated with a positivistic paradigm that reflected colonising accounts of field experience. Post-positivistic epistemology gave rise to the **modernist age** (1950-1970) where the social realism, naturalism and "slice-of-life" ethnographies of the previous era were extended but retained an emphasis on developing rigorous methodological procedures that emulated quantitative research practice.

Gradually, the previously established positivistic behavioural models of human understanding gave way to more interpretive, open-ended perspectives such as structuralism, phenomenology and hermeneutics. This was referred to as the **Blurred Genres** phase (1970-1986), where "the essay as an art form was replacing the scientific article" (Denzin et al., 1998, p. 19). The **crisis of representation** period (1986-1990) reflected the difficulties that researchers were experiencing with regard to representing themselves and their subjects in reflexive texts. The essential conflict that arose in this phase related to the researcher/author's presence in the interpretive text and questions concerning how the researcher/author could directly capture the lived experience of his subjects. It was argued that such experience is created in the social text written by the researcher. Issues of gender, class and race and the way in which they shape enquiry were also called into question. Grounded theory gave way to interpretive theory and older models of truth and meaning were radically revised. In the 1990s the **postmodernistic** era developed.

<u>The postmodern movement in qualitative research.</u>

The postmodern/poststructuralist movement (1990 to the present) is characterised by a new dispensation of doubt that no longer has a commitment to objectivism, believes no discourse has a privileged place and no theory or method can hold a universal claim to authoritative knowledge. This phase is characterised by what Denzin et al. (1998) call the "double crisis" in the social

sciences. This involves the crisis of representation discussed above and the crisis of legitimation. Legitimation refers to the need for a serious re-consideration of the criteria for evaluating and interpreting qualitative research. If the experience of "the other" is to be represented textually in accordance with postmodern sensibilities, then terms such as validity, generalisability and reliability need to be rethought and a new set of legitimising criteria developed that allows both the author and the reader to make the connections between the text and the world that is being written about. Common forms of evaluation that have arisen include personal responsibility, an ethic of caring, political praxis, multi-voiced texts and dialogues with subjects (ibid).

Currently qualitative research is in a period of discovery, the epistemologies of the past having been radically revised and giving way to new critical epistemologies. New ways of seeing, interpreting, arguing and writing are being constantly debated and discussed; however, the tension between remaining true to the positivistic, post-positivistic and naturalist forms of enquiry and simultaneously acknowledging the legitimacy of the postmodern sensibility is strongly present. The postmodernist claim that no specific method or practice can be privileged above another and that none can be eliminated means that earlier strategies of enquiry, evaluation and methods of analysis belonging to different historical periods are still valid. As a result researchers are faced with a multitude of paradigms from which to choose. It is now well accepted that "there is no [one] clear window into the inner life of the individual. Any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity" (Denzin et al., 1998, p. 24). Similarly "there are no objective observations, only observations socially situated in the worlds of the observer and the observed" (ibid, p. 24). Postmodernist perspectives have therefore contributed to the understanding that no particular method can fully grasp the subtleties of ongoing human experience (ibid, 1998).

4.2: The Research Study

This research study aims to explore the appropriateness of long-term psychoanalytic psychotherapy for a group of Black English second-language speaking women from an urban South African context.

4.2.1: Field of Research

In order to define the parameters of the research it was decided that the study should concentrate on the analytic attitude and its counterparts, the task, process and setting, as they are applied to a group of Black English second-language speaking women from an urban South African context. These parameters were chosen because the analytic attitude and its counterparts represent the basic underlying structure of all forms of psychoanalytic practice. Regardless of the theoretical

stance used, the analytic attitude defines and distinguishes psychoanalytic practice from other forms of practice. It follows therefore that by noting how participants respond to the analytic attitude and how the therapist is able - or unable - to maintain this attitude it will be possible to comment on the applicability and appropriateness of psychoanalytic psychotherapy to this group of individuals. In order to judge the effectiveness of this form of psychotherapy for this group it is necessary for these participants to be in a process of long-term psychoanalytic psychotherapy.

4.2.2: Focus of Research

The focus of this study will be on the therapeutic dyad itself. This will include both the therapist and the participants in a process of long-term psychoanalytic psychotherapy. The central *research question* arising out of the field of study outlined above is as follows:

> *How does the therapist and each participant under study make use of the conceptual and practical framework of psychoanalytic psychotherapy comprising the analytic attitude and its counterparts the analytic task, process and setting.*

4.2.3: Research Propositions

Study propositions are focused statements that provide rationale and direction for the study. These initial assumptions may later be proved wrong; however, it is important for propositions to be formulated from the outset as they delineate the purpose of the study. In any research process it is not possible to analyse all the information collected. Propositions therefore help to focus the data collection. The term 'proposition', borrowed from a quantitative discourse, was deemed suitable for this study as it allowed for large quantities of data to be organised into manageable units. This method of triangulating qualitative and quantitative methods of enquiry, is supported by Denzin and Lincoln (1998) who emphasise how qualitative research crosscuts disciplines, fields and subject matter, representing a complex interconnected family of terms, concepts and assumptions. These include the traditions associated with positivism, poststructuralism and many other perspectives. In this study the main propositions are as follows:

1. *The conceptual and practical framework of psychoanalytic psychotherapy in its current form is inappropriate to non-western urban-dwelling participants.*

2. *The conceptual and practical framework of psychoanalytic psychotherapy requires modification in order to meet the cross-cultural needs of non-western urban-dwelling participants.*

These propositions are drawn from the research question and have as their basis the exploration of the analytic attitude in practice. By examining the analytic attitude as it is enacted in the therapeutic dyad its efficacy in the context of non-western urban-dwelling individuals can be elucidated.

4.2.4: Units of Analysis

The field of study provides the context for the research. The research question and its propositions establish a focus for the study within this context. However, as the research question and its related propositions still encompass a very wide framework of enquiry, it is necessary to further reduce this scope by demarcating the basic units on which the study intends to focus. Yin (1989) states that *units of analysis* need to be generated; this refers to the process of narrowing the field of enquiry into manageable constituents that outline the boundaries of the body of data.

The focus of the study is the therapeutic dyad but given the vast amount of material that is likely to emerge from the therapeutic dyad with three different individuals, individual dyads must be further broken down so as to facilitate analysis and discussion. This will be done using the eight elements of the analytic attitude as outlined by Gavin Ivey (1999). These elements include: *Analytic task, Analytic setting, Analytic process, Generative uncertainty, Neutrality, Abstinence, Countertransference receptivity* and *Resoluteness*. The way in which the three participants respond to these eight elements of the analytic attitude and the therapist's degree of success in maintaining these elements comprises the principal material for data collection.

4.3: Choosing a Research Method

After having identified the specific research question and having established precisely the units that will be focused on, it follows that a qualitative research method needs to be selected that can adequately address this question. An important consideration when differentiating between various social science research strategies is to identify the type of research question being asked (Nelson et al., 1992, p. 2). When deciding which strategy to adopt it is important to focus on the research question itself. Research questions have both *substance* (what is the study about?) and *form* (is the focus of the study a "who", "what", "where", "why" or "how" question?). The form of the question provides an important guide regarding the appropriate research strategy to be used.

Different qualitative strategies have different advantages and disadvantages depending on three conditions: 1) the type of research question, 2) the control the investigator has over actual behavioural events, and 3) the focus on contemporary as opposed to historical phenomena. The method used depends on these three conditions (Denzin & Lincoln, 1998).

De Vos Strydom, Fouche and Delport (2002, pp. 273-275) discuss five types of qualitative research strategy:

1) *Biography*: this approach usually relies heavily on documental and archival material and is an individual's account of his life experiences and history. There is not necessarily a theoretical bias to such a report.

2) *Phenomenology* examines a series of individuals and aims to understand and interpret the meanings that these individuals give to a particular phenomenon or experience. Phenomenological research is aimed at distilling the essence of this experience.

3) *Grounded theory* is concerned not with the testing of established theories but with the development of new theories deriving out of close study of multiple individuals participating in a process concerning a central concept or phenomenon.

4) *Ethnography*: this refers to the study of an intact defined entity (social, cultural or individual). Observations are typically undertaken in the field, over considerable periods of time. This implies that the focus is on *observable* behaviour, traditions, customs and rituals which allows for a deep understanding of a particular way of life.

5) *Case study*: an exploratory or in-depth analysis of clearly circumscribed phenomena over a period of time. This can involve a single case or multiple cases.

Other strategies for research are discussed by Dyer (1995). These include *histories* which are the preferred strategy when there is no access or control and where there are no persons alive to report, even retrospectively, the events. *Surveys* focus on a limited number of variables around which specific questions can be asked. For this reason surveys are best suited to outcome-based studies or studies that focus on prevalence.

Dyer contrasts these latter two strategies to the case study approach. Case studies are more suitable to the examination of contemporary events where the relevant behaviours cannot be manipulated. The case study relies on many of the same techniques as a history but it adds two sources of evidence not usually included in the history technique: direct observation, and systemic interviewing. The case study's unique strength is its ability to deal with a variety of data types such as documents, artefacts, interviews and a variety of different methods of observation as the object of study evolves over time.

4.4: The Case Study Method

A case study method of enquiry is most suitable when "how" and "why" questions are being investigated, when the investigator has little control over events, and when the focus of the study is on contemporary phenomena within a real-life context. The case study allows investigations to retain the holistic and meaningful aspects of an event. Yin defines the case study as "an empirical enquiry that investigates a contemporary phenomenon within its real-life context; when the

boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (1989, p. 13).

The particular research method chosen for this study must incorporate a methodology that is best able to capture - in as much as any method could capture - the subjective and inter-subjective mental processes of the therapeutic event under study. This methodology should allow for meanings and understandings to emerge that reflect on both how and why the therapist and the participants think, respond, feel and act within this framework. Furthermore this methodology will have to accommodate all departures, deviations and difficulties that are experienced by the therapist and the participants in attempting to maintain the analytic attitude. This will include resistances, frame breaks, responses to interpretations and other interpersonal dynamics. As this information will derive from individual experience it is likely to be multifaceted and highly nuanced. A qualitative research approach that moves away from seeing the "other" as an object to be studied at a distance, and focuses rather on the interactive processes and subjective experiences that constitute the analytic event, is therefore required.

4.4.1: The Case Study Method in Clinical Psychoanalysis
In the earlier part of the twentieth century the case study method played a significant role in the contribution of psychoanalysis to psychological knowledge. However, with the rise of psychometrics, questionnaire methods, survey design and statistical analysis, there was a significant decline in the use of the case study in general psychology and sociology. By the 1950s this method of enquiry in sociology had virtually disappeared (Bromley, 1986). This decline was due to an increased emphasis on the positivistic research methods of the pure sciences. Psychological research and more importantly psychotherapeutic research began to imitate these positivistic methods and as a result began to lose sight of the phenomenon that it set out to study. Edwards (1990) points out that psychotherapy research tends to involve persistent and excruciating attempts to objectify and quantify experiential and behavioural data in an effort to isolate those variables that supposedly make up what psychoanalysis is.

In recent decades there has been an increased recognition of the shortcomings of the positivistic methods of enquiry for psychotherapeutic processes and other psychological phenomena. Edwards (1998) explains that when experimental research methods are used for psychotherapy research they tend to obscure the phenomenon under investigation. As a result of these shortcomings there has been a recovery of the case study method in general psychology and psychotherapy. "Over the past three decades… there have been many independent moves to correct [this] balance and to legitimise case-based research models" (Edwards, 1998, p. 39).

Case-based research strategies are not confined to case studies alone. In fact the case-based approach is used across a large number of different qualitative methodologies including grounded theory development, phenomenological research method, discovery-oriented psychotherapy research and psychotherapy process research (Edwards, 1998). A case study method allows for access to the participants' experience and is able to incorporate the experience of more than one psychotherapeutic event in the form of a multiple study. The principles of case-based research are not dissimilar to the principles that are generally incorporated into the practice of clinical psychotherapy. In fact many of the methods of clinical practice can be seen to constitute an informal, systemic process of enquiry that emulates the principles of case-based research (Edwards, 1998). The frame of psychotherapy demarcates a clear boundary around the case being focused on. Denzin and Lincoln (2000) point out that the case study method is most useful when "the object of study is a specific, unique and bounded system" (p. 436): the rigour required in maintaining the analytic attitude in these psychotherapeutic cases provides a clear example of such a system.

4.4.2: Advantages and Disadvantages of using a Case Study Method

Case study research has often been viewed as inferior to other forms of enquiry such as experiments or surveys, mostly because of concerns about the rigor of case study research. Often the findings and conclusions of such studies have been open to bias and external influence because of weak designs and procedures. It is important to note, however, that similar problems are encountered in all research strategies such as in designing questionnaires for surveys (Denzin et al., 1998).

A further concern is that case studies provide very little basis for scientific generalisation. The question of how it is possible to generalise from a single case is often raised. The answer to this is that case studies are only generalisable to theoretical propositions and not to populations or universes. The investigator's goal is therefore to expand and generalise to theories and not to enumerate frequencies (statistical generalisation). Having said this, Dyer points out that case studies can provide descriptions of individuals who are representative of people in general. "The power of the case study approach… is that it allows features of behaviour or experience which are shared by many people to be studied in detail and in depth" (1995, p. 48).

In case based research one or more cases of the phenomenon of interest are studied with a view to attaining an understanding and developing or extending existing theoretical knowledge on a particular topic (Edwards, 1998). One of the benefits of using the case study format in this

research study is that from the data generated it should be possible to make a qualitative generalisation about the applicability of the analytic attitude to a certain category of Black South African women.

A good case study can be a difficult venture, requiring specific abilities from the researcher. One of the criticisms of this form of research is that there is no clear set of criteria outlining the skills that are required of a researcher to perform qualitative case study research. Denzin and Lincoln (1998) point out that qualitative research as a site of discussion or discourse is difficult to define because it has no theory or paradigm that is distinctly its own. Other criticisms of case studies focus on the fact that they are time consuming and result in large amounts of unreadable material. This criticism has some truth in that many studies in the past have traditionally involved lengthy narratives. However, more structured ways of writing case studies have evolved which do not rely so heavily on detailed observational or ethnographic evidence. Many of the shortcomings outlined above can be overcome through developing a research design that provides clear guidelines for the collection, analysis and interpretation of data.

4.4.3: Applicability of the Case-Based Approach to Psychotherapy Research

This study has as its data the psychotherapeutic event in process. Stolorow et al. (1994) outline the fundamental aim of psychoanalytic therapy as "the unfolding, illumination and transformation of the patient's subjective world" (p. 9). This transformation is a process that occurs over time within the specific parameters of a therapeutic frame. Such a transformation is inter-subjective in that it always occurs in relation to, and in the presence of, the therapist. Furthermore this transformation is enacted through the maintenance of a specific attitude, referred to as the analytic attitude. This attitude represents a mindset with associated intentional behaviours that are not amenable to quantitative measurement.

Case studies are suitable to psychotherapy research as they are process-oriented and are able to explore the character of changing processes over time (Breakwell et al., 1995). The case study approach was chosen for this study as it allows for a descriptive method of investigation that offers the means to achieving an in-depth understanding of the experience and behaviour of a single individual within a context (Dyer, 1995). As case studies are always conducted in a context they can reveal important contextual considerations and internal complexities that are not revealed by more closely controlled experimental investigations (ibid). Typically a case study is able to offer a highly detailed description of an individual's subjective feelings, beliefs and impressions as well as of objective aspects of his behaviour. This approach allows for both

objective and subjective information to be regarded as valid data from which inferences can be drawn (Dyer, 1995).

The use of a case study approach in this type of research has numerous successful precedents. Kazdin (1990) suggests that the case method is a valuable tool for assisting clinicians in generating ideas around new therapeutic techniques that may emerge during the course of their work, thus enabling them to extend given techniques to new problems or client populations. In fact the case study has generally been seen by psychoanalytically oriented clinical work to be the principal and chosen method of research (Stolorow et al., 1994), largely because this method succeeds in generating insights that other methods fail to achieve.

This study maintains that psychoanalysis has moved in a postmodern direction. The modernist view, with its emphasis on splitting the subject and the object, believed that by distancing the observer one could obtain an unbiased view of the subject. This way of thinking was strongly prevalent in 19th century psychoanalysis where the patient was seen as a separate bounded individual distinct from the analyst (Altman, 1995). Furthermore, the analyst was viewed as being unaffected and unchanged by the analytic process. Current understandings of the analytic attitude as defined by Ivey (1999) demonstrate how new conceptualisations of the therapeutic encounter have moved far beyond the understanding of the analyst as an objective blank screen. The analytic attitude as used in this study is relational and thus is in keeping with a post-modernistic sensibility. As stated by Altman (1995) "In relational psychoanalysis, in dialectical fashion, the patient and the analyst are thought to be constituted by the dyad insofar as each discovers a version of self within the dyad that, in many respects, has not existed before" (p. 68). In the relational model the therapist is a participant rather than an objective observer whose subjective feelings and responses to his patient are as valid as his patient's responses to him.

Given that the principle method of investigation used in this study, the analytic attitude, is relational and therefore amenable to a postmodern perspective, it follows that a postmodernist paradigm of investigation would provide a suitable philosophical framework for this study. A postmodern mindset is more appropriate to cross-cultural studies in that it affords a way of overcoming the universal assumptions of culture, class and race that are easily upheld through an epistemology of positivism. A postmodernist mindset enables the researcher to be aware that a research study is an interactive process, which is strongly informed by the researcher's and his participants' personal history, biography, gender, social class, race and ethnicity. This self-reflective stance is particularly relevant to researchers in a South African setting where issues such as politics, power, race, and income have become entrenched along racial lines and still

remain a part of the experience of all South Africans. By adopting a postmodern position the researcher is encouraged to be critically aware of his interpretation of the events studied. The researcher in this paradigm is more conscious of the way in which events are reported and how such an account is likely to reflect a specific storytelling tradition or interpretive community that is never value free and always carries political connotations (Denzin et al., 1998).

Current understandings of qualitative research emphasise that no single method of enquiry is more important than another. Qualitative research draws on several different methodological approaches depending on the subject under study and the questions asked. A case-based approach was chosen as the most appropriate method of investigation for this study. A system of multiple methods (triangulation) was used to add depth and rigour to the study (Denzin et al., 1998). Triangulation is defined as the researchers effort to seek out several different types of sources that can provide insights about the same events or relationships (De Vos et al., 2002). Triangulation can be employed in the planning stages of a study as well as in the interpretation phase. Typically this may involve the creative synthesis of multiple theoretical perspectives or the triangulation of different methods that are drawn from both qualitative and quantitative traditions (ibid). In this study the researcher used positivist and poststructuralist orientations in the research design. For instance the terms 'propositions' and 'units of analysis' were borrowed from the quantitative tradition and were used to refine the scope of the study. Other methods of triangulation included collecting data from the experience of both the therapist as well as the participants. This technique was chosen for the purpose of achieving greater insight into the relational dimension of the therapeutic encounter.

In the spirit of a postmodern ethos the researcher drew on currently established qualitative methods of evaluation that related to validity and reliability. The research analysis and interpretation, rather than being "loosely narrative" as is typical of a classic postmodern style, incorporated tighter controls that echoed a more positivist ethos. The focus of the study remained faithful to the research question and its propositions throughout. Similarly the data analysis was structured in terms of categories that the researcher deemed useful for answering the research question and its propositions.

Research Design

4.5: The Case Study Design

Having established that a qualitative case based approach was most suitable for this study, it follows that an adequate research design had to be formulated. When designing a research study, five components to the design should be considered. These include:

a) Components relating to the data collection: 1) The study questions, 2) its propositions and 3) its units of analysis; and

b) Components relating to the data analysis: which include 4) the logic linking the data to the propositions and 5) the criteria for interpreting the findings (Yin, 1989).

Breakwell et al. (1995, p. 241) state that the "research question should act as a prism through which you view the data to be collected". A research design therefore represents the logic that links the data to be collected and the conclusions to be drawn with the initial questions of a study. Nachmias and Nachmias (1976) provide a classic definition of a research design:

> A research design is a plan that guides the investigator in the process of collecting, analysing and interpreting observations. It is a logical model of proof that allows the researcher to draw inferences concerning causal relations among the variables under investigation. The research design also defines the domain of generalisability, that is, whether the obtained interpretations can be generalised to a larger population or to different situations (Nachmias & Nachmias, 1976, p. 77-78).

The success of a case study is dependent on following a set of carefully thought-through pre-specified procedures: this constitutes the design. It is thus important to choose a design frame incorporating specific strategies and techniques for optimising data collection, analysis and interpretation.

4.5.1: Three Types of Design for Case Studies

When designing case studies a primary distinction needs to be made between a single case and a multiple case. This design choice must take into account the nature of the research question and should precede any data collection. In order to maximise meeting the standards of quality for research, there are three different considerations for design that can be used. These are 1) an intrinsic case study, 2) an instrumental case study and 3) a collective case study (Denzin et al., 1998).

Intrinsic studies are focused on gaining an in-depth understanding of an individual case. It is thus most useful for studying individuals or events which deviate greatly from the norm. In such studies the purpose is to describe the case itself, rather than to gain insight into broader social or theoretical issues (De Vos et al., 2002).

Instrumental case studies are used to gain deeper understandings of a social issue rather than an individual. The emphasis is on elaborating a theory; the actual case is secondary to the researcher's gaining a deeper knowledge about a theoretical issue (Denzin et al., 1998).

Both intrinsic and instrumental case studies are single case designs. Single case designs are suited to certain conditions such as when the case represents a critical test of existing theory, where the case is an unusual or rare event, or where the case serves a revelatory or descriptive purpose. A series of two or more cases can be done in a multiple case design. These designs have in the past been considered to comprise different methodological strategies to that of single case designs. However, there is no clear distinction between the so-called classic single case study and multiple case studies. A multiple case design offers a more encompassing perspective of the phenomena under study and is therefore more likely to render a more robust body of data (Babbie, 2004).

Multiple case designs are called *collective case studies*. The strength of a collective case study is that it allows for an extension beyond the findings of one individual: comparisons can be made to other cases and concepts. This in turn allows for the revision or extension of theories (De Vos et al., 2002). The logic behind collective case studies is that each case should be carefully selected in such a way that similar results should be obtainable with the other cases, or, if contrary results are obtained, the reasons for this should be predictable (ibid). It must be emphasised therefore that in order to achieve comparability the subject cases must be chosen within rigorous criteria that will ensure that the conclusions drawn should be comparable from the outset.

Case selection and the definition of specific units of analysis are important steps in the design and data selection process. In a collective study each individual case consists of a whole study in which convergent evidence is sought regarding the facts and conclusions for the case. The final discussion of results should draw each individual case into a multiple case report that indicates how and why for each case a particular proposition was or was not demonstrated. The conclusions of each case study are thus related back to the propositions and inferences are made from this as to the merit of the research question (De Vos et al., 2002).

4.5.2: Criteria for Evaluating the Quality of Research Design

A sound research design should represent a logical set of statements. It should be possible therefore to gauge the quality of any research design by using a logical set of criteria. Marshall and Rossman (1995, cited in De Vos et al., 2002, p. 351) state that "All research must respond to canons that stand as criteria against which the *trustworthiness* of the project can be evaluated [my emphasis]". In order to claim that the findings of this study were "trustworthy" certain criteria for evaluation needed to be established. Furthermore in order to generalise these findings to theory the research itself needed to reflect an element of credibility. In this study it was felt that a postmodern perspective was the best way to bring the material to light. However, in order to communicate and generalise these findings to a body of psychoanalytic theory it was necessary to draw on a more structured approach that increased the credibility of the study.

Criteria for evaluating qualitative research reflect an attempt to discover and record the truth of the subject, process or phenomenon under study. Traditional criteria used to evaluate case-based research studies include construct validity, internal validity, external validity and reliability. These criteria have been strongly criticised from a postmodern perspective. Such standards are understood to emulate a positivist epistemology that has no place in a poststructuralist/postmodern paradigm of investigation. Denzin et al., (2000) state that "If there is no means of correctly matching word to world, the warrant for scientific validity is lost, and researchers are left to question the role of methodology and criteria of evaluation" (p. 1027). If language cannot adequately reflect human experience then the entire basis for arguing that a particular study is scientifically valid is undermined. Contemporary qualitative theory proposes an alternative set of legitimising criteria for the evaluation of qualitative research. The criteria used in this study are those proposed by Lincoln and Guba (1985, cited in De Vos et al., 2002). These include credibility, transferability (or generalisability), dependability and confirmability.

Credibility.

Credibility as an alternative to internal validity aims to demonstrate that the study has in fact described the processes, the subjects or phenomena that were initially identified in the research question. Credibility is well evidenced in most qualitative work through constant reference to and quotation of the data itself and can be further increased through providing embedded in-depth descriptions of variables and interactions that reveal the complexity of the data. In order for this data to be credible the setting, population and theoretical framework surrounding such descriptions must be clearly demarcated by the researcher.

Transferability.

This involves establishing the domain to which the study findings can be generalised beyond the immediate case. In this sense transferability is an alternative to external validity. The attempted generalisation of qualitative findings to other contexts has traditionally been seen as a weakness of this approach. Criticisms have been levelled in particular at single case studies through the argument that a single case offers a poor basis for generalisation. This argument derives from the logic of survey research where "samples" are selected for their generalisability to "universes". Survey research typically relies on statistical generalisation, whereas case study research relies on analytical generalisation. In analytical generalisation the researcher aims to generalise from a particular set of results to some broader theory (De Vos et al, 2002). Transferability can therefore be enhanced in a qualitative study by demonstrating how data collection and analysis reflect the theoretical, framework, concepts and models that were initially outlined. The technique most useful for enhancing generalisability in qualitative studies is triangulation (ibid). By triangulating multiple sources of data the research question under study can be corroborated and illuminated in such a way that different perspectives allow for greater applicability to other contexts (De Vos et al., 2002).

Dependability.

Dependability in qualitative research offers an alternative to the concept of reliability as described through positivist traditions. Positivist understanding of reliability involves demonstrating that the operations of a study - such as the data collection procedures - can be repeated with the same results. However, this positivist understanding of reliability "assumes an unchanging universe where enquiry could quite logically be replicated" (De Vos et al., 2002, p. 352). Qualitative researchers generally disagree with this assumption and state that such an understanding is inappropriate because the social world is not static, but rather is always being reconstructed. The notion of replicating an entire study is therefore not considered relevant. Current qualitative research requires that the findings themselves within the study be replicable. In order to repeat the process of a study it is important to document systematically the procedures that have been covered: a clearly established research design is the primary means of ensuring dependability. The concept of dependability focuses on ensuring that the researcher accounts for the changing conditions that may arise in the phenomena under investigation and the way in which such changes are incorporated into the design as the researcher gains an "increasingly refined understanding of the setting" (De Vos et al., 2002, p. 352).

Confirmability.

Confirmability is of great importance in case study research in that it describes the need for unbiased reporting of the data. In this it replaces objectivity, which refers to the stratagem whereby the findings of any one study can be confirmed by a similar study. Current research methodology recognises that it is impossible for a researcher to be thoroughly objective: part of the focus of much qualitative research (and in this study) is on the researcher as an active participant rather than an objective viewer. Lincoln et al. (1985) suggest that a focus on the data, rather than the researcher's objectivity, will provide confirmability: any reader or further researcher will be able to use the data itself to ascertain inferences and conclusions. (cited in De Vos et al., 2002).

4.6: Case Study Procedure

When designing a research study it is necessary to outline the exact procedures of the study in the form of a case study protocol. The rationale for providing a case study protocol is two-fold: firstly, it assists the researcher in defining the precise procedures that are required to implement the research study successfully; secondly, it serves to increase dependability in that it provides a template against which the required standards of such a study can be measured.

4.6.1: Protocol for this Study

This section outlines the procedures adopted to select, collect and interpret the research data. The research design comprises a collective case study involving three participants and a therapist.

Research participants.

Referrals for this research study came from various sources. The therapist informed colleagues that he was doing a cross-cultural research study and was seeking referrals of Black South African women between the ages of 25–35 years. Individuals participating in this research study were drawn from a group of six referrals to the therapist's private practice in the space of four months. All referral sources indicated that the participants had enquired about seeing a professional psychologist for psychotherapy. These patients had been made aware by the referral source that the therapist was a White English-speaking male. All six patients referred for long-term psychoanalytic psychotherapy were given the option of participating in the study. In the initial session they were provided with information as to the procedure and purpose of the study. Participants were under no pressure to conform, rather they were told to spend some time thinking about whether they wanted to form part of this study. Either way, it was strongly emphasised that treatment would proceed unabated from the initial session. Furthermore participants were told that if they initially agreed and then chose to discontinue as a research

participant, treatment would still continue. In other words the treatment focus would always be given priority over the research study. Those participants who chose to enter the study were informed that all efforts would be made to ensure that identifying data be excluded from printed material. Furthermore it was indicated that they had the right to peruse draft transcripts of collected data and to subsequently exclude any unwanted material. These, and other details were contained in a letter of introduction and in the consent form (see appendix 1 and 2).

The researcher was aware that for those individuals who chose to enter the study the double role of patient and participant would have some impact on the process, both consciously and unconsciously. For this reason patients were explicitly encouraged to openly discuss any feelings they held in this regard. For the purpose of the study it was fully acknowledged from the outset that any reference to this issue would need to be discussed and subsequently documented as part of the research process.

Participants in this research study are drawn from a population of young Black South African women who were all prepared to see a White male psychotherapist in the knowledge that treatment would involve talking about their emotional concerns. Participants in this study therefore represent a population of urban-based Black women who were actively seeking this form of treatment. This group of women represent an emerging class of urban Black women educated through a western system, adopting western ideals and seeking out western forms of treatment for their emotional difficulties. Any inferences made from the results of this study can be made only to this group; no inferences could be made for instance to rural women.

Of the six participants referred who fitted into the age parameter three were eventually excluded. One participant was unsure whether she wanted to be in therapy and remained ambivalent about committing herself to the process. She decided to terminate after only six sessions. Another participant committed herself fully to the process; however, after approximately thirty-five sessions she terminated because her mother was averse to the idea of psychotherapy and eventually ceased paying for her transport to get to sessions. The third participant had come to therapy for assistance during a crisis. She felt that she was unable to commit to a long-term process as she was thinking of leaving the country. The other three participants consented to participate and all three have remained in long-term psychotherapy for well over the research requirement of 40 sessions. In fact all three participants remained in therapy for a period of over two years.

<u>Therapist.</u>

It was extremely important for the therapist consciously to adhere as closely as possible to the fundamental tenets of the analytic attitude. The effectiveness of this attitude for these participants could only be measured if the therapist maintained the basic practical and conceptual rules of the analytic attitude as it is used generally in psychoanalytic psychotherapy. For this reason the therapist had to be well acquainted with both the conceptual and practical aspects of psychoanalytic psychotherapy. The therapist in this study is a qualified clinical psychologist with ten years' clinical experience who has obtained a certificate in psychoanalytic psychotherapy through the South African Institute for Psychotherapy.

From a postmodern position of critical self-awareness the researcher was well aware that his own training and interest in psychoanalytic psychotherapy would influence his judgement and interpretation of the data collected. This inevitable bias could only be addressed through maintaining a set of legitimising criteria that would add soundness to the study. In this regard the concept of confirmability (outlined above) allowed for measures to be included that ensured the findings of the study were reflective of the process under investigation, with minimal impact from the researcher's own prejudice and bias.

<u>Setting.</u>

Participants were seen in a private practice psychotherapeutic setting and were required to adhere to set times of attendance and an appropriate fee structure.

<u>Participant Criteria.</u>

This research study used a western framework of treatment with an English-speaking therapist. From the outset it was understood that treatment would be conducted through an English language medium. For all participants English represented a second language. In order to ease the flow of communication between the therapist and the participant a minimum level of competency in English usage on the part of participants was therefore required. Furthermore, for the purpose of generalisabilty it was necessary to maintain clear parameters. As the focus of this study was confined to Black English-speaking adult females from the Western Cape Peninsula, the following criteria were required for participants in this study:

- A Matric education pass in English
- Black adult female individuals of South African birth and upbringing
- Age range from 25 to 35
- Urban-dwellers within the Western Cape Peninsula

The focus of this study was on long-term psychoanalytic psychotherapy, which is characterised by indefinitely extended sessions. This approach differs from the intentional time-limited focus of Brief Psychodynamic Psychotherapy, which is typically characterised by 20 sessions or less (Book, 1998). In order to qualify for participation in long-term psychoanalytic psychotherapy all participants were required to remain in the therapeutic process for a period of at least 40 sessions.

Duration.

In accordance with general practice the duration of long-term psychoanalytic psychotherapy is decided by the patient, with no fixed time period being imposed from the outset. Regardless of the number of sessions achieved, material was drawn from the first 40 sessions only, covering an average of 12 months.

Data collection procedure.

At the end of each fifty-minute session the therapist completed a data collection record, which involved comment and reflection on the preceding session. This data collection record involved two components:

Step 1. The therapist's observations of his own ability to maintain (or not maintain) the analytic attitude in each session.

Step 2. The therapist's observations and documentation of all content information emerging from each session, with specific focus on the way the participants responded to the elements of the analytic attitude. Verbatim notes that were recorded in the session were used.

In accordance with step one, at the end of each session the therapist reflected on the process just undergone and critically assessed his use of the analytic attitude and its applicability in this process. Patterns of responses to the exigencies of the analytic attitude were monitored through careful note taking. The therapist documented the tensions of trying to maintain this attitude as well as instances where it was broken. These written documentations related specifically to the therapist's observations on the elements of the analytic attitude, showing how he was able (or unable) to maintain each element.

In accordance with step two the therapist collected detailed information on the content of the session as it unfolded during the therapeutic hour. Information relating to the way in which the

participants were able or unable to relate to the elements of the analytic attitude comprised the main focus of data collection in this step.

4.6.2: Procedure For Organising and Analysing the Data Collected

The data collection was organised into two phases: A) the case history phase for participants One, Two, and Three and B) the individual case report phase for participants One, Two and Three. The data analysis phase comprised a combined cross-case report for all three participants.

Phase one of data collection: case history phase.

This phase provided a concise patient profile, incorporating demographic details, personal history, relational history, academic and employment history and the presenting problem. These records were referred to as "Case History One / Case History Two / Case History Three". This stage of the data collection was purely *descriptive*, without any interpretation. The main purpose of this section was to provide the reader with a preparatory context of understanding for each participant's communications contained in the individual case reports to follow.

Phase two of the data collection: individual case report phase.

This section comprised the *interpretive phase* of the case study process. Each individual case report explored the maintenance or otherwise of all eight elements of the analytic attitude for each participant. These records were referred to as "Individual Case Report One / Individual Case Report Two / Individual Case Report Three".

In this phase an individual case report of 40 sessions of psychotherapy was compiled for each participant. This report was structured in accordance with the eight headings of the analytic attitude that comprised the central focus of this study. An example of the procedure used for organising the data is as follows:

For participant one (session one)

- Material gathered for session one in terms of step one and step two outlined above was closely scrutinised by the researcher.

- The researcher noted which aspect or aspects of the analytic attitude were most significantly demonstrated in this session.

- The task of organising the data under relevant headings was assisted by the fact that the data had already been prepared for this task. Significant themes relating to the analytic attitude that emerged from session one had already been identified through step one and step two outlined above.

- If neutrality appeared as a central concern in this session then this information was discussed under the heading "Neutrality". If a concern was also raised in this session that related to the therapeutic frame, then this information was apportioned to its respective heading "The Analytic Setting"

The process of organising the date in terms of step one and step two and in compiling the individual case reports relied strongly on the researcher himself. The researcher was aware that the decision to include or exclude information was dependent on his judgement, experience, knowledge and proficiency with regard to understanding the processes of the analytic attitude in each session.

The data analysis phase: combined cross-case report.

This phase comprised a combined cross-case report for all three participants in which the findings of each individual case report were compared and contrasted. This section, comprising the *analytic phase* of the case study process, used a specified set of criteria to judge the overall effectiveness of each element of the analytic attitude separately. These criteria related back to the initial research question and its propositions.

In terms of the study question and propositions, all difficulties encountered by both the therapist and the participants in maintaining each element were discussed, together with the adaptations used by the therapist while attempting to maintain the analytic stance. In this section each element of the analytic attitude was considered independently in terms of its overall effectiveness and success. Possible reasons for the breakdown of the analytic balance and necessary modifications to the analytic attitude in order to accommodate such breakdowns were generated.

The data analysis in the cross case report was discussed under the following headings for each element of the analytic attitude. The following provides an example for the first element, generative uncertainty:

- Discussion of the use of generative uncertainty for three participants
- Criteria used to judge the effectiveness of generative uncertainty
- Difficulties encountered in using the stance of generative uncertainty
- Adaptations used by the therapist in maintaining the stance of generative uncertainty
- An evaluation of the overall effectiveness of generative uncertainty

Once the analysis was completed the findings of this section were discussed in the broader context of the entire study. Suggestions were made concerning the applicability of the analytic attitude to a certain category of Black English second-speaking urban women and possible modifications that were necessary for this framework of practice to be relevant were discussed. Data emerging from the combined cross case report of the analysis phase was considered in terms of the central argument of the thesis and in terms of the larger context of other research. This section comprised a general discussion and conclusion to this research thesis.

4.7: Efforts to ensure Accountability and Legitimacy in this Study

The researcher's attempts to establish applicability, consistency and neutrality were considered within the crisis of representation and legitimation outlined above. Because of difficulties concerning how to represent "the other" and how to legitimise the study it was necessary to establish a set of reasonable criteria that could judge the study's credibility. It was also necessary not only to maximise the applicability and transferability of the findings, but also to be reasonably sure that such findings could be approximated under similar conditions. Furthermore, the researcher needed to establish controls to ensure that the findings reflected the phenomena under study and were not skewed by his selection bias. Measures to maximise legitimacy were established through defining clear parameters and objectives for research from the outset. The researcher was aware that the study's *credibility* relied strongly on outlining the procedural steps of the work and recognised that the value of each step depended on the validity of the preceding steps (Edwards, 1998).

Prior to entering the field and conducting the research, knowledge of relevant literature was gained by the researcher (Babbie, 2004). The theoretical framework of psychoanalytic psychotherapy and the analytic attitude was outlined at the beginning of the study. The researcher ensured that the questions and propositions that evolved out of the designated area of research were carried through into the design of the study. It was stated at the outset that the data collection, analysis and discussion would adhere only to material that was relevant to the eight components of the analytic attitude. This method of reduction represented an attempt not only to minimise the inclusion of material irrelevant to the research question but also ensured that the data collection and analysis flowed out of and were consistent with the theoretical framework, concepts and models initially outlined. By systematically linking procedures with theory the *transferability* of the study was enhanced (De Vos et al., 2002).

After establishing the research domain with its focus, propositions and units of analysis, a design was chosen that was best suited to the study. A collective case study design incorporating three

independent cases was chosen because it reflected the purpose of the study, which was not on the individual *per se*, but rather on how a group of individuals responded to a particular framework of treatment. The scope of enquiry, the therapeutic dyad, was demarcated into eight sub-units of analysis comprising the elements of the analytic attitude. Each element of this attitude was clearly explained to provide the researcher and the reader with clear insight into the concepts that would form the basis for data collection. The credentials of the researcher/therapist were established by outlining his qualifications and experience in the use of psychoanalytic psychotherapy and the analytic attitude. It was also emphasised that the therapist's use of the analytic attitude would comply as closely as possible with the model outlined by Gavin Ivey (1999).

A method of triangulation, which involved step one: recording verbatim responses of each participant's experience and step two: the therapist's own response and experience to each session was used. Triangulation was also enhanced by the researcher's discussing his therapeutic processes and interpretations with his own therapy supervisor[4]. This double-focused approach was in keeping with postmodern developments in qualitative research and in psychoanalysis. Triangulation afforded a way of capturing the relational aspect of the analytic attitude, thereby achieving a more in-depth and embedded perspective of the dynamics of the therapeutic event. These different perspectives served to illuminate the research question under study in such a way that its *generalisabilty* and usefulness in other contexts was increased.

Measures for *dependability* in the study were incorporated through the way that the data was collected and analysed. The researcher recognised that that the experience of each individual's psychotherapy process was unique and could not be replicated. Dependability therefore relied not on replicating individual experience but rather on demonstrating that by adhering closely to the principles of the analytic attitude similar responses, difficulties, deviations and consistencies could be expected across similar studies that used the analytic attitude in the same way and focused on a similar group of participants. The importance of each participant's and the therapist's individual experience was relevant in so far as it interacted with the principles of the analytic attitude.

In this study a postmodern method of enquiry was used to elucidate the experience of therapist and participant in the therapeutic dyad. This position was most suited to this study in that it mirrored the relational nature of the analytic attitude. The concept of objectivity was seen as unnecessary from this postmodern position of enquiry; however, it was still necessary to ensure

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[4] In accordance with common practice, the researcher regularly attended supervision for all his therapy cases. This was enacted within the standard requirements of confidentiality and anonymity.

that the findings were reflective of the participants and the enquiry itself, rather than the bias of the researcher. To ensure that the findings of this study could be confirmed by other studies, the researcher was aware that the data itself, and not the objectivity of the researcher, had to *confirm* the significance of the findings. For this reason the researcher chose to analyse the data through a set of criteria that most closely resembled the theoretical stance and concepts initially outlined. These criteria for codifying, analysing and discussing were informed by the data itself in the cross case analysis and included findings relating to the difficulties encountered in maintaining each element of the analytic attitude, adaptations that had been necessary, reasons for deviations and departures from this stance and a measure of the overall success or failure of the treatment model. By categorising and discussing the findings in such a way it was possible to determine whether psychoanalytic psychotherapy was in fact an appropriate treatment strategy for the participants under study.

CHAPTER FIVE: DATA COLLECTION

Case History One, Two and Three

5.1: Case History One

Participant One is a thirty-five year old Xhosa woman employed as a social worker at a local hospital. She lives in a local community township with her 13-year-old son (her only child). She was referred for therapy by her place of employment after consulting with a fellow health care professional. During the course of psychotherapy she has been receiving pharmacological treatment under the supervision of a psychiatrist.

Presenting problem.

The participant first presented on the 16th of November 2001. She stated that she had been depressed for a number of years but things had got worse in 2000 after the break up of her relationship at that time. She was currently experiencing difficulty in her relationships with her family, her boyfriends and her son. She described an ongoing conflictual relationship with her mother in particular. She said that she suffered from mood-swings, got frustrated easily and frequently felt rejected by people. She described how the previous weekend she had turned off her cell-phone and slept for most of the weekend: "I went for a walk and watched a film, but felt bored and just wanted to sleep… I wanted to be on my own and was hiding from my friends".

The participant had attempted suicide on seven occasions since July 2000. She had been admitted to a psychiatric clinic five times for depression and suicide attempts by overdose. She once intended to attempt suicide on a railway line but withdrew. She had been on antidepressant medication for a number of years. She had consulted many different doctors and had received numerous forms of medication, which she supplemented with over-the-counter remedies. She had come to the conclusion that none of these treatment approaches were helping her and had subsequently decided to "try psychotherapy".

Home environment/childhood.

The participant identified from the outset that her "major problem" was "trust". She explained that her issues had started when she was very young. At the time of her birth the participant's parents were not married to each other - in fact at the time of her birth the participant's father was married to a woman who lived in the Transkei. Her parents separated shortly after she was born. At the age of two months the participant was sent to live with a caregiver until the age of six years, when she was sent to another caregiver together with her brother. She lived (temporarily) with her mother for the first time at the age of 16. As a child she did not see much of her mother. She remembers that her mother may have visited her once a week when she was at primary school. However, she recalls that her father visited her every day.

Family history.

After the participant was born her mother got married. Her first husband died after she had had two further children, a daughter and a son. She subsequently re-married and had one son from her second marriage. Her son from the first marriage was sent to Johannesburg and the family has not heard from him since. The participant feels that her mother always preferred her younger brother to her and her sister. She believes that her mother never wanted her and abandoned her and her sister at an early age. The participant's sister subsequently has a very poor relationship with her mother and tries to avoid her. The participant states that her mother has never once told her that she loves her and recalls that one of her boyfriends told her that she acts like her mother never loved her and she is "still seeking love – like a baby".

In 1977 when the participant was eight years old her father died. She was very close to her father, and remembers looking forward to his visits. She described how one Wednesday she had waited as usual but her father did not arrive. She was told the following Sunday by the caregiver that he had died on the previous Wednesday. None of the family attended the funeral; she believes her mother deliberately stopped her from attending. She feels that her father was the only person who

ever loved her. The participant states that this is when her problems started: when she felt that "she no longer had a parent".

Academic/employment history.

The participant attended primary and high school in a local township. She left school at the end of Std 8 to seek employment because there was insufficient finance at home for school fees. She subsequently worked as a general assistant in a local hospital. She supported herself and went to night school for a period of five years to repeat Std 8. She then completed Std 9 and Std 10. She attained her Matric in 1994 and in 1995 she went to university to study for a BA degree. After the first year she changed her course to social work and studied for a further four years. Throughout her studies she continued to work night shifts at a local hospital.

Relationship history.

When the participant was completing her schooling she lived with her boyfriend and fell pregnant. She described this boyfriend as very jealous and violent. He used to abuse her physically. He wanted her to give up her work and studies and stay at home. She consulted a doctor and was advised to leave him. Initially he maintained contact with his son for some time but has not been heard from since 1996. At this time the participant was unable to work and care for her son so he was looked after by her cousin. He came to live with his mother when he was nine years old. The participant has never been married, which she states is unusual in her culture. She states that her culture "places pressure on a woman to be with someone". It is difficult for an unmarried women to be friends with married women", furthermore a woman who is successful and independent is generally seen as different. The participant stated that this perspective is stronger in the rural areas, whereas in the township people are more tolerant and a person "is generally allowed to mind their own business". The participant's family are not as concerned about her unmarried status as "the women in my family are not the marrying type". Her mother has always discouraged her daughters from marriage because of her own poor experiences. The participant's sister is 42 years old and has never been married. All the women in her family are either divorced or unmarried.

5.2: Case History Two

Participant Two is a twenty-five year old Swazi woman working in a local branch of a national company. She completed her Matric education and passed with exemption. She lives in the southern suburbs with her fiancé. She was referred for psychotherapy through a family member and started sessions on 25 March 2003.

Presenting problem.

The participant initially stated that she periodically felt depressed and moody. At times she had panic attacks and she was unsure whether she was in the right job. In the past she had taken off time from work for depression. She found the work environment difficult and often thought her colleagues were talking about her behind her back. She stated that she could not handle conflict or confrontation at work and was insecure about her intellectual ability. Socially she felt that when people first met her they thought that she was "stunning" but this it got harder as she had to try to live up to their expectations. She recognises that when interacting with people she tends to elevate them and "tell them how great they are"; at the same time she puts herself down. The more she is not complimented the more she tends to compliment the other person. She states she generally feels that other people are better than her and she tries hard to get people to like her. In doing so she does not tell people the complete truth about herself. Her fiancée becomes irritated by this behaviour. She also states that when she has been socialising with friends she often feels depressed the next day. She feels embarrassed about exposing herself the day before, especially if she has had something to drink. She sometimes feels guilty about having fun and drinking and feels that she talks "meaningless nonsense". Her mother sees drinking as evil.

She pointed out that she has difficulty in making decisions and relies strongly on her fiancé to help her. She states that she cannot do anything without him, "not even exercise, unless he is with me". She recognises that she is dependent on him but states that her negative attitude to dependence is influenced by her western beliefs. From a traditional perspective "it is accepted to run everything by your husband and dependency is not seen as bad". She explains that she is dependent by nature and has always wanted to be in a relationship. When she was younger she was very dependent on her brother. She explained "I feel my personal identity hasn't quite developed, at times I feel like a normal human being in shoes that are too big for me". The participant thinks she is scared of being her real self because she might be "serious, heavy and depressed like a friend I know". She is sometimes scared to show the serious part of herself because she feels people may think she is "weird".

The participant felt that she does not cope well generally and hoped that therapy would help her to feel less insecure and to understand herself better. Initially she felt that she would like to see a Black female therapist.

Home environment/childhood.

The participant states that she does not remember very much of her childhood. Her family informs her that she suffered from "fits" up to the age of 13 years. The participant states that she

does not remember having these fits. Apparently her sister used to carry her on her back to the clinic whenever she had a seizure. The participant recalls that there was always tension in the home because her mother and grandmother did not get on and her father would sometimes drink. This would result in arguments and physical fights between her mother and father. There was a lot of financial stress at home. The participant's father was paid on a Friday but would often return home drunk without any money. In spite of these problems at home the participant states that she always knew that her mother loved her and she always had a "soft spot" for her father even though he did not play much of a role in her upbringing. The socio-political climate at the time strongly affected her family; however, the participant states that she was too young to be affected directly. She recalls a strong police presence in the area in which she lived. They sometimes came to her house but this was because her cousin used to hijack and steal cars and they would come to the house to look for him. The only direct experience of racism that she recalls was on a visit to the zoo when she was looking at the monkeys and some White children called her a "monkey".

Family history.

Participant Two was born and raised up in a large township in Gauteng. Her father had been married before and his wife had died. When he married the participant's mother there was some bad feeling in the family. The participant's mother felt that her mother-in-law did not accept her. When the participant was born she was very sickly and it was believed that she was "possessed". Her mother felt that because her mother-in-law did not approve of the marriage she had bewitched her child as a form of punishment. On another occasion the family ate food that made them all very ill. It was believed that the mother-in-law had played a role in this. Prior to getting married the participant's father was alcoholic; also he was supporting several cousins and was often in debt. The participant's mother made a lot of changes and set about improving her husband's life. These changes were not appreciated by the extended family. Her father's drinking problem improved but he would still be very aggressive and at times abusive and violent. The participant states that she grew up in a home environment where it was "ok to hit children". In spite of her father's aggressive behaviour he also has a very kind and gentle side to his personality. The participant explained that her mother is the one who makes most of the decisions at home. At times her mother asks her father for permission, "to make him feel like a man", but usually she tells him what to do. She states that her father is not pro-active. This is probably because when he tries to take any initiative he is criticised by his wife.

Her father supports traditional cultural values and customs. He worked as a driver and is currently on a state pension. The participant's mother follows a less traditional lifestyle and belongs to a

specific denomination within the Zionist church. When her mother discovered that the participant was in a cross-racial relationship she was told to return home from Cape Town. The priest of her mother's branch of the Zionist church (he is albino and a friend of her mother's) undertook to purge the participant of this person that she was seeing. This process involved a ritual cleansing for one week, which was repeated at sunrise and sunset. On the last day she had to drink "holy water" and then make herself vomit into a bowl and throw the contents into a stream. In the morning and afternoon she had to steam her body covered in blankets under a plastic sheet and primus stove. She was bathed by the priest and told that a "horse does not mate with a cow". After the cleansing she was told that "she looked better and had some light". The participant's mother told her a story of someone who had a relationship with a White man and had then died of an unknown illness.

The participant at times feels judged by Black men. She feels they think that she "puts on airs", especially if she speaks in English, even though she knows that she is admired because she drives a car and has a good job. The participant states that inter-racial relationships are generally not seen as positive in her culture. The perception is that "a nice looking Black girl is wasted on a White man". The participant claims that she is not particularly worried about this perception as the people she mixes with do not hold these beliefs; however, she feels the pressure of these stereotypes and finds that in her own home in Cape Town she still plays the traditional role of being in charge of the domestic environment. She feels very uncomfortable with employing a domestic worker and finds it hard to tell an older woman what to do, especially as her mother was a domestic worker.

She is aware of class differences and feels uncomfortable when people see her as belonging to a higher class. The participant states that class differences are becoming more obvious in South Africa. She states that Black people who have lived overseas see themselves as better than someone educated in South Africa. Accent and material possessions often indicates class. The participant states she has a "Model C school" accent which is different, and other people notice this. She states that she feels there are some White people who are a class below her. However, she sees herself essentially as *ekasi* - a township girl. Like many Black people who moved into the suburbs after the Group Areas Act was abolished, she still visits the township on weekends as the suburbs are "very quiet and boring".

In spite of the fact that the participant's older brother and sister have a different surname it was only recently that she understood that they are not her father's children but were born from a previous relationship of her mother's. The participant is unsure whether her mother was married

to this man: these issues are never spoken about. The participant's father was also married previously and he has a daughter from this marriage. This daughter is now married and lives some distance away. The participant has also a younger brother; some people say that her younger brother is not her father's child but is in fact the child of her mother's priest. Her mother denies this. The participant is sure that she is her father's child as she has a mild deformity similar to that of her father's brother. The participant maintains strong ties with her family and she supports her mother and father, her sister and sister's children by depositing money into her mother's account each month.

The participant states that a previous girlfriend of her older brother reported that she thought he was unsure about his sexuality. The participant thinks that there may be some truth in this. Homosexuality is not accepted by her family or her community and if this were the case then there would be "a big scandal". She states "it would cause a lot of internal turmoil in the family".

<u>Academic/employment history.</u>

Participant Two moved to Cape Town when she was 12 years old to attend a prestigious girls' boarding school on a scholarship. On arriving at school in Cape Town she initially boarded with a young White couple. She found it difficult to adjust and subsequently moved in with a family who had children. She stayed with this family for three months. They supported her and often paid for clothes and other expenses. This family was Catholic and the participant subsequently converted to Catholicism. She then moved into a boarding hostel at school and remained there until completing her matric. At her previous school she was at the top of her class. At her new school she was at the bottom. She went through a period of time where she was very depressed, she was one of four Black girls at this school and felt left out and different. The Black girls did not befriend her and called her a "coconut" and a "traitor" because she had been living with White people. The White girls spoke of things that were unfamiliar to her. The participant states that in her home she had been brought up to be quiet and obedient and never thought of asking "why". She learnt that in a western environment you are always asked your opinion and encouraged to ask "why". Most of the children at school came from wealthy families and their parents were "doctors and lawyers" where as her mother was a domestic worker. The participant found the school environment extremely difficult: she never had "enough money or enough of anything". To this day she feels that she is always "wanting" and never feels fully satisfied with what she has.

She befriended a "Christian group of girls" as they were the only group that she felt accepted by. The participant did not like the hostel and felt very excluded by the Black girls and the White

girls. During free time she did not know where to go. She did not have the same skills for sport as the other girls and "In gym I could not do the exercises, I could not even catch a ball" The participant felt a strong sense of "difference" and compensated for this by trying hard "to be accepted and be cool"; she smoked cigarettes and bunked classes. She tried to lose weight by using laxatives, exercising and dieting. For a period of time she suffered from bulimia. She states that when she was growing up weight and food had never been an issue.

After leaving school the participant studied for a National Diploma in Public Relations. She is currently studying economics through the University of South Africa (UNISA).

Relationship history.

The participant had previously been in a relationship that affected her deeply. She felt she had been naïve and was used and deceived. This was terminated when her partner went overseas on a trip. When he returned he did not bother to contact her. At the same time he was selling cannabis and she was ignorant of this. This person later became married to a friend of hers. She no longer has any contact with this friend. She sometimes thinks that there may be some truth in what her mother said to her in the cleansing process about how White men use women because this was her experience in this relationship.

The participant is due to be married. She explained that the marriage would consist of a traditional wedding and a western ceremony. The traditional wedding will involve the slaughtering of a beast by the men with a blessing from God, the ancestors and the family. It is important that the beast's blood falls on the ground of her parents' home. The western ceremony will involve the exchanging of vows with a priest. Her mother is very nervous about her fiancé's relatives who are coming "all the way from England". She insists that the participant wears a white dress because she states that "you can't expect people coming from England to see you in a traditional dress". The participant feels that she would like to wear a formal dress with aspects of her culture. Her parents are re-doing their house and having a professional to sort out the garden in preparation for the wedding. The participant is angry that they are spending so much money on all these appearances. She states that her mother looks up to White people. When she entertains the White people at the wedding "she will not be cooking 'Pap and Vleis', she will be doing grilled vegetables and taking out the best china". Her mother feels that the neighbours will now respect her because her daughter is getting married to a White person.

5.3: Case History Three

Participant Three is a twenty-eight year old unmarried Xhosa woman who was born in the Transkei. She moved to Cape Town when she was 20 years old. After consulting a General Practitioner at a day hospital she was referred to a tertiary hospital for psychiatric evaluation. She was subsequently referred by a psychiatrist for psychotherapy treatment. Prior to attending psychotherapy sessions the participant had contemplated suicide on a number of occasions. She started psychotherapy on 11 April 2002 and has attended regular weekly sessions.

Presenting problem.

At the time of her first visit the participant was being treated for severe facial shingles. She stated that when she gets upset her shingles re-appears. She said that from the age of eight years old she has experienced emotional difficulties. At this time she was living with her Aunt in the Transkei and her brother arrived from Cape Town to live with them. Until this time the participant was unaware that she even had a brother. He was 16 years old and they shared a room. The participant was subsequently raped by her brother on three occasions. She was eight years old at the time. He threatened to kill her with a knife if she told anyone. She carries a lot of anger towards her brother and states that "just seeing his face makes me angry…I wish I had a gun, I would shoot him. I can't face what he has done to me…he took something from me that I can never replace, he ruined everything". She disclosed this incident to her Aunt who thought that she was making it up. She blames her brother for the fact that this incident affected her relationship with her Aunt, whom she felt was the only person who really cared for her. At the age of 15 years the participant was staying with a neighbour in Umtata when her family had gone away and she was raped by the owner of the house. She became pregnant and was given traditional medicine to induce a miscarriage. The participant feels that she will not be able to have children again as she often experiences gynaecological problems. After being admitted to hospital in 1999 for abdominal pains she was told that she has "a problem in her womb which will obstruct pregnancy and she may not be able to fall pregnant again". She still experiences a lot of feeling about the child that she lost and carries a lot of anger towards her family for insisting that she had an abortion. The participant states that she has not been able to have a relationship with a man since these rape incidents as she is still afraid of any man touching her: "it still hurts a lot".

The participant's main presenting concern was that she has always felt rejected and abandoned by her family. She questions whether the surname on her identity card is in fact correct. Her birth was not registered and she only managed to get an identity document through an affidavit from her grandparents. She states that the only loving relationship she has ever experienced was with the aunt who raised her. When she moved to Cape Town she was so concerned with trying to

integrate with her real family that she lost contact with her aunt. The aunt died in March 1995; the participant was only told by her mother in August 1995. She feels a lot of guilt about losing contact. She acknowledges that she has found it difficult to get on with her life as she feels held back by the fact that she needs to know what actually happened in her childhood and why her mother sent her away to the Transkei. She has subsequently been consumed by her feelings of rejection, abandonment and a lack of identity. The participant states that she feels trapped. "I have no father to run to, I can't go forward and I can't go back. The only thing I can do is drop dead…maybe it is my fault, maybe I tore up my family". The participant attempted suicide by overdose in September 2000 and was admitted to hospital.

Home environment/childhood.

The participant was born in a small town in rural Transkei. She comes from a family of eight children (three sisters and four brothers) of which she is the third last. When she was a few months old she was sent to another village to live with her aunt (a distant cousin of her father). In spite of the fact that she was living only 20-30 km away from her parents she did not meet her mother until she was fifteen years old. The participant grew up thinking that her aunt was in fact her mother. It was only when her brother arrived from Cape Town that she was told about her mother and father. She was eight years old when she learnt that her mother had moved to Cape Town and was working as a domestic worker. She yearned to be re-united with her family and made plans to move to Cape Town. On arrival in Cape Town her excitement at finally discovering her real family was short-lived. The participant felt that her mother treated her differently to her other children and she felt her siblings did not accept her and saw her as an "outsider or intruder".

Family history.

The participant has always questioned whether her mother is actually her mother. In spite of this doubt her need to be part of a family and to have a sense of belonging has always been very strong. However, for many years she has wondered why she was sent away to live with her Aunt and imagined that she must have been born of either her mother's or her father's infidelity. Her parents' marriage started to deteriorate shortly after she was born. She feels that it might have been because of her that her parents eventually separated. This would explain why her mother appears to resent her and why her father appears uninterested in her. The participant has met her father only once, in 1994. At this meeting he did not know who she was. The participant describes this experience as "strange and painful". He has never made any attempt to see her again and the participant feels that he would rather not acknowledge that she exists. The participant recalls that at school the other children spoke about their parents. She always felt very

sad as she could not relate to their experience. She feels that her problems with her parents stay with her and follow her everywhere. She states "it complicates everything for me".

With regard to traditional healing practices the participant stated that she believes "curses" can happen. She was once very ill and was seeing things that other people cannot see. At this time she was a member of the Apostolic church. The church told her that someone was trying to "witchcraft her". The church was able to protect her from this curse. "The uniform that the church gives you to wear protects you from witchcraft and demons". The participant stated that if she were to get sick she would go to a western doctor as she believes that "Sangomas are not always safe and you can't trust all of them". She states further that she has always felt that she must get to know herself and do things her way, "I want to know who I am". She would like to do something on her own, like open up her own business. She feels that she is different to some other people and has a problem with some of the values of rural people as "they live in the old days. When a person in the rural area makes a cup of coffee or cooks a meal then it is important to go around and offer everyone. It is not possible to just do something for yourself". She states that in the traditional areas people spend all day sitting on a bench outside the house talking about other people. She is not interested in this sort of thing and sees herself as different.

Academic/employment history.

The participant completed most of her school education in the Transkei. She repeated Std 5 four times and Std 7 three times. When she arrived in Cape Town she was still in Std 7. She persisted with her schooling and eventually completed her Matric in 1998. In 1999 she started an introduction course in computer programming but did not complete this as she was unable to pay her fees. She worked as a domestic worker in a guesthouse for two years to pay for her studies. In 2002 she started work as a waitress and during this time completed a three-month Hospitality course which she passed. She currently works as a waitress and lives in an informal settlement.

Relationship history.

The participant has had three relationships. Her last relationship was five years ago. She has never had a sexual experience and explains that this is generally why her relationships do not last longer than six months. Her rape experiences have left her feeling very anxious about any form of sexual contact. For many years she would not wear any clothes that were revealing of her body and drew attention to herself. She now pays more attention to her appearance and is able to wear shorter skirts. The participant states that she has read a lot of books about rape survivors and is determined to overcome her insecurities. She states that she always knew that she wanted to find a positive way through what happened to her. She states that she did not want this incident to take

her to drugs, prostitution or alcohol and that is why she chose to go to therapy and start talking about it. Now that she has started to talk about her experience she realises that it is good for her. For many years she was unable to speak. She states that in her community and in her family it was a closed topic. When she initially spoke about her rape experiences it caused a lot of tension. She learnt therefore to remain quiet. She states "I want to speak out because there are too many people who keep quiet… I want to help other people by telling my story".

Individual Case Reports One, Two and Three

5.4: Individual Case Report for Participant One

Procedure.

1. Analytic task
2. Analytic setting
3. Analytic process
4. Generative uncertainty
5. Neutrality
6. Abstinence
7. Countertransference receptivity
8. Resoluteness

1) Analytic task.

In the first session the participant outlined her main issues. She explained what she felt to be her goals in therapy by identifying the issues that she wanted to explore: "I can't maintain relationships with my family or with my boyfriends, or my son - [we are] not on good terms". She also pointed out that she suffers from mood swings, is depressed a lot of the time and finds it difficult to tolerate frustration. "I feel quite down, last weekend I turned off my cell phone, I was sleeping all weekend…I just wanted to be on my own…I was hiding from my friends". The participant related three incidents whereby she had been let down in her relationships with men: her son's father had abused her; she was once involved with a man for three months before she discovered that he was due to be married; and in her current relationship she felt that she was unable to trust her boyfriend. Another theme that emerged related to the difficulties she experienced in her relationship with her mother. "My mother [has] never liked me or my sister…she preferred my younger brother". The participant clearly felt that whilst she does a lot for her mother and assists her financially, she receives little in return. "[When I was in hospital] she did not even come to visit me". From the outset the participant had identified the main themes that caused her distress. She appeared to have a clear idea of why she had come to see a therapist.

These descriptions provided a framework for the analytic task in that it alerted the therapist to those concerns and symptoms that would require exploration. These included: feeling depressed; difficulties with trust following repeated interpersonal rejections and disappointments; feeling uncared for and used.

In session sixteen the participant arrived at the session with some notes that she had written prior to her appointment. These insights were considered to be an important development in terms of the analytic task. She showed insight on some of the issues that had brought her to therapy in the first place. "I am terrified about my son's behaviour, especially now that I think I am the primary source who contributed to his behavioural problems". The participant was beginning to see that "I sometimes take my anger out on my son". A significant shift was reflected in her capacity to move away from seeing the source of all her difficulties as being located outside of herself. She was beginning to move away from a "blaming style" and starting to acknowledge that many of her problems in life were due to her own choices and decisions. "But now it seems this dark cloud won't move away from me, I feel fully responsible for everything that is happening…I am feeling guilty for everything that is happening to me, I've got no one to blame, I am afraid it is going to effect my work performance". The participant moved to speaking about her relationships with her boyfriends. "I don't know why but I'm always looking for a fault to fight with [my boyfriend]…why do I let everyone down who is close to me?" furthermore "I really don't know how to handle my life, how can I be able to help or handle other people if I am going on like this…everyone around me is ending up miserable including myself…my life is quite a mess". These insights represented a significant achievement in terms of the therapist's analytic task in that the participant was beginning to take ownership of her projections.

In session seventeen, the participant extended some of the thoughts that she had raised in session sixteen. "I am always blaming people, I am always blaming my boyfriends, I want the perfect partner". She was able to recognise that this need to find the perfect partner originated from within herself. "I work too [hard] because I want to be perfect and I want others to be perfect too…I have high expectations of my son and high expectations in all my relationships". The therapist made the interpretation to the participant that perhaps her quest for perfection was her way of overcoming feelings deep within herself that she was not worthwhile, and that perhaps these feelings were instilled in her as a child through the experience of feeling abandoned by both her mother and father. She did not pick up on this interpretation but rather moved to the position of victim (thus asking for compassion) and showed some anger "I am finished with men, I can never make people happy, I am not good company…people try to isolate themselves from me". The therapist was aware that this interpretation went against the transference needs of the

participant. She often experienced such interpretations as alienating. She was seeking support and became frustrated when she felt that the therapist was moving out of this position and asking her to look within herself for meaning. She ended the session by stating "I told [this boyfriend] a pig will always be a pig, you can wash it but it will go back to the wallow".

In session twenty-eight the participant stated "I feel like I need a holiday from my house". Whilst this statement was on one level meant literally it was understood that the participant was saying she was tired of all the emotions that she experienced and wanted to escape from herself. Following the recent ending of a relationship she was feeling depressed. In this session she moved to a position of victim again and stated that she was always let down and people always took things from her. One boyfriend had stolen her watch; another had borrowed one thousand rands that he had not returned; the third had threatened to take her life. The participant concluded that she does not have good relationships with people because "I am shouting, angry and blowing things out of proportion". This session was seen as a return to the goals that the participant had initially outlined. The analytic task of fostering an ongoing exploration of these goals appeared to be effective in that the participant was clearly attempting to negotiate her issues. In this session her negotiation took the form of shifts between the polarities of blaming herself entirely or blaming others. She ended the session by adopting an extreme position with her son and stated that she had decided to send him to live with her family in the Transkei as she was unable to deal with him anymore.

In session twenty-nine the participant stated that she had been thinking about the fact that "most of my problems are caused by myself". In terms of the analytic task, the therapist was aware that such an acknowledgement was previously incompatible with the participant's perception of herself. This acknowledgement therefore represented a significant shift. The participant stated that she thought she might be repeating her own history with her son in that she was treating him in the same way her mother treated her. "I don't make my son feel loved even though I do love him…I am beginning to see that [he] feels that I will never be satisfied with anything [he does]". She stated that she wanted to change her behaviour with her son, she also recognised that he worries about her, "He is also concerned about my health and sometimes enquires". She showed a lot of emotion in this session and acknowledged that "Most of the time I am hard on my son, I make him feel uncomfortable in the house". The participant moved on to her relationships and stated "There are still things I need to forgive in myself before I can include other people in my life…I become very angry if other people make mistakes". She stated further that she was able to see that she expected very high standards from herself and from other people including her son "My supervisor at work told me that I am always trying to prove myself by going the extra mile".

In this session the participant expressed some clear insights on the issues that she had chosen to work with in therapy.

In session thirty-seven the participant received a report from her son's school indicating that he was trying to improve his behaviour and academic work. She felt pleased and said that she had been more open with him. "I explained to him that when I get angry about small things it was not about him but rather about issues from my work". The participant then tried to explain to her son why she often gets depressed and angry. "I started to tell him how I grew up…he was sympathising with me…I spoke a lot and told him about my life". She was clearly communicating better and developing more of an understanding with her son. She stated "I realise he worries when I am down and I have a headache or am depressed, I think it may affect him". The therapist was aware that the participant was beginning to show an increasing capacity to entertain conversations that she previously avoided. The therapist's role of facilitating insight into those issues of most significance to the participant appeared to be working in that she was beginning to entertain different perspectives on and explanations for her feelings and behaviour.

2) Analytic setting.

In session nine the participant stated that she had considered taking an overdose during the past week, but had decided against this as she was on a contract. She had then decided not to keep her appointment with her psychiatrist and to stop taking her antidepressant medication. The therapist was aware that these decisions were counter-productive to her current clinical condition. The therapist was also aware that the participant had agreed at the outset of therapy to continue seeing her psychiatrist regularly to monitor her medication: she had in fact broken this agreement. The therapist pointed this out to the participant and asked her if she thought she had made the best decision for herself. The participant then agreed to discuss the matter with her psychiatrist. Whilst her adherence to her written contract for safety was seen in part as a positive development for the analytic process, her non-adherence to her verbal contract to keep her psychiatric appointments was seen as an attempt to alter the therapeutic frame. This behaviour was understood in terms of the transference. By creating a scenario of non-compliance she was unconsciously attempting to get the therapist to respond in the way she required. If the therapist had rebuked the participant for her non-compliance it is likely that she would have adopted her characteristic position of extremity, felt angry and therefore justified in leaving the relationship. This style of relating was generally evident in all her relationships outside of therapy.

The maintenance of a secure therapeutic frame is necessary for the analytic process to unfold. However, for this participant the need for firm parameters to the analytic setting was vital. It was

clear that her defences curtailed the expression of her dependant needs; these needs were only likely to be revealed if she were certain that the setting was a safe place in which to do so. It emerged that frame breaks and negotiations were particularly prominent at times when the participant felt most vulnerable. Points of vulnerability were generally marked by break-ups in relationships. At these times she would become very depressed and often suicidal. In session eighteen the participant was complaining of chest pains, lack of sleep, mood swings, tiredness and headaches. She was taking several forms of medication to control her condition. These include various different antidepressants, benzodiazepines and painkillers. The therapist reminded the participant that the agreement at the outset of therapy was for her to have her medication controlled by her psychiatrist. It was explained that she may well be exacerbating her depressed condition by self-medicating. It was agreed that the participant would bring all her medication to the next session and an appointment would be arranged with her psychiatrist. She appeared satisfied with this arrangement.

In session twenty the participant brought in her medication and revealed that she was recently taking up to 16 different tablets a day. The therapist saw this dependence on medication as both an expression of the distress that she felt and an expression of her dependency on external controls to make her feel better. By asking the participant to bring in her medication to the session the opportunity arose for this discussion to take place. The therapist ventured to speak of the participant's reluctance to look internally for solutions and her tendency to look outwards to various doctors, psychiatrists, therapists and medications to assist her.

In session twenty-one the participant stated that she had revealed to her psychiatrist the different medications that she had been using and was told that if she continued to take these quantities she might have renal failure. The participant then asked her psychiatrist for morphine. This was refused but it was understood as a measure of how much distress she was feeling.

In session twenty-two the participant stated that she did not want to keep her next appointment with her psychiatrist and she was thinking of stopping therapy "because nothing helps me". The participant was clearly not happy with the way that the therapist had tightened the frame by exercising some supervision on her use of medication. The therapist explained that this measure of control was out of concern and was for her own benefit. In spite of this explanation the participant clearly saw these efforts to tighten the frame as acts of punishment for her behaviour and she felt let down by the therapist. After this interpretation, the participant did not comment but it was noticed that she became less angry. The session ended with the therapist saying that he would see her at the same time next week. The participant agreed. The therapist remained

consistent with these ground rules throughout the course of therapy and the participant continued to meet her sessions, though at times reluctantly.

In session twenty-three the participant said that she had decided to see the psychiatrist. He had changed her medication and she was no longer taking "the other stuff" and was now less irritable and feeling a bit better. In this session the participant asked the therapist to intervene with the headmaster of her son's school as he was not assisting her in placing her son in a senior school. She explained that her tolerance was low since the recent break-up in her relationship, she was not able to manage this crisis and she needed the therapist's assistance. She had given the headmaster the therapist's phone number and asked him to contact the therapist. The headmaster then phoned the therapist who explained to him and to the participant that issues of this nature fell outside of the therapeutic frame and therefore outside of the role of the therapist. In spite of this the phone call seemed to precipitate some action on the part of the headmaster who then set about assisting the participant. On matters concerning the frame the participant did have some difficulty in accepting that the therapist was unable to intervene beyond the boundaries of the therapeutic setting. At times of extreme difficulty she often asked the participant to speak to various people on her behalf such as her boyfriends, her son, her work colleagues, her doctors. These requests were considered to be an extremely important element in the therapeutic process which could not be ignored and which required careful management.

3) Analytic process.

In session two the participant started the session by stating that she had not felt well over the past week and that the antidepressant that she was using did not seem to work. "I have taken a number of antidepressants, still none have worked". The therapist was aware that the participant was unconsciously questioning the usefulness of psychotherapy treatment and was wondering if this process would make her feel better. No interpretation was actively made and the participant proceeded to discuss why she had been feeling so down. After giving an account of her recent argument with her boyfriend she stated that "I am worried about my behaviour with my boyfriend, I feel I may chase him away as I am always suspicious of him…this might destroy the relationship". After this statement she immediately proceeded to talk about her father, expressing how much he had loved her, and how shocked she had been when she heard of his death. "My problems started then…I felt very alone with no parent…I still think about him a lot". The therapist noted the connection between the participant's father and her boyfriend and stated that "perhaps the reason you are so suspicious of your boyfriend is because you believe that he may leave you in the same way that your father left you". To this the participant replied that one of her past boyfriends had said to her "You are acting like your mother never loved you, you are seeking

love like a baby". In this session the recognition of a strong need to be loved, a fear of abandonment and an acknowledgement of the link between past disturbances and current relational difficulties was established. These insights provided a basis for a way of working that was considered useful for the unfolding of the analytic process. The therapist was also aware that the statement made by the participant's boyfriend was astute in so far as he recognised that it was the lack of love from the participant's mother, which was a central issue for her. Her idealisation of her father acted as a compensation for the neglect she had experienced in her relationship with her mother. In session three the participant consolidated her insights by stating "My father left me and I am scared that my partners will leave also…this is why I don't give everything of myself [in my relationships]".

In session nine the participant spoke of arranging a family gathering with traditional beer and the slaughtering of a sheep. She said that this was her effort to make peace with her family in spite of the fact that she had many feelings "boiling inside". More importantly it was an attempt to re-establish a connection with her mother, "She kicked me out eighteen years ago…I want to make peace with her". The participant pointed out that prior to commencing therapy she had not spoken to her mother for one year. In the session she spoke extensively about the lack of support that she had received from her mother and her mother's family during her life. She stated that she had received more support from her father and his family. At this traditional gathering she would invite both her mother's family and her father's family. In terms of the analytic process two concerns were raised. Firstly, the tremendous need to secure some form of acceptance from her mother, secondly, an attempt to bring together and consolidate elements of her internal object world which was split between the concept of bad mother and good father.

In session ten the participant provided a description of what had happened at the family gathering. At this gathering she took the opportunity to express the feelings that she held towards her mother. "It was time now to confront my mother, or never. I told her 'you were never there for me, that you preferred my brother…and chased me out of the house when I was eighteen'.". The participant felt proud of herself for having finally spoken out what she was feeling. "I feel stronger for having spoken to my mother like this". At the end of the discussion her mother stated "You are special even though I have three children and I love all of them". The participant concluded the session by stating "But I don't mind doing things for my mother". She clearly felt she had reached a turning point in her relationship with her mother.

In session eleven the participant stated "My mother does not want me to get married, she chased away my son's father and [many of my previous boyfriends]". She described how her mother

tries to control her life. "I once told her that I was going to work overseas and she became very ill…it is all about the fact that she does not want me to abandon her because she wants me to provide for her". In terms of the therapeutic process it was clear that the growing sense of assertiveness in the participant's attitude towards her mother represented an internal negotiation towards a position of independence and individuation. She found it liberating to adopt this new position and stated "Initially when I came to therapy I did not want to come back because there was no direction, but now since I have confronted my mother things are much better…I have not told my mother I am in therapy as she would not approve of this". Marriage, independence and commitment to therapy were all seen as acts of separation, a movement away from the control of her mother.

In session thirty the participant was referring to her mother in the context of why she expects high standards from other people. She stated "My mother [always] wanted us to be perfectionists; when we went to visit we could not even go to the toilet or ask for some water". She then pointed out that she had recently received a phone call message from her mother asking her for money. The participant did not reply for three days. When they eventually spoke her mother said that she does not need it anymore. In the next sentence the participant pointed out the reason for her delay in responding to her mother: "When I was in hospital no-one cared, they always want from me".

In session thirty-two the participant explained that she had contacted her mother and spoken about the difficulties that she was experiencing with her son. She told her mother that she is unable to look after him and wants to send him away. Her mother then told her that she thought the participant was running away from her responsibilities. The participant was clearly looking for support from her mother and did not receive it. She subsequently became angry and stated "My mother is judging me, I regretted phoning her…I was looking at trying to forgive my mother for the past, now I do not care". She felt let down and unsupported and responded typically by withdrawing and becoming angry.

In session forty the participant described her feelings as "Everything is going well, there is nothing I can't handle at the moment". In this session she was reflecting on some of her main issues. She had reached the conclusion that her mother was not going to change and she would just have to accept this. "I don't know what to do to satisfy her, if I phone her she gets suspicious [wondering what I want from her], if I don't phone she gets upset [with me]…I will never be able to please my mother". She then pointed out that she was beginning to accept that "I don't know what the meaning of love is - it was never given to me and that is why I can't show it to my son". She was able to see that as a young child her needs were not seen as important and this is why as

an adult she becomes very angry when people do not consider her needs. "As a little girl I remember going Christmas shopping with my mother, I wanted to go to the toilet and she would say no". In this session the participant was looking at her behaviour closely and stated "Most people pick up my behaviour is strange, one minute I am friendly then I change and they can't understand why I have changed…It is because I am very sensitive". The therapist suggested to her that perhaps these changes occurred when she became closer to people and therefore more vulnerable, and that whilst there was some distance between herself and others it was easier to be friendly. She replied "Yes, as I said I am too sensitive, some guy at work said that he noticed I can't have people in my office for too long".

4) Generative uncertainty.

In session four the participant discussed the fact that she had told her current boyfriend that she no longer wanted to continue the relationship. The therapist was aware that the failure of the relationship was largely due to the participant's mistrust and suspicion, which had driven her partner to behave in ways that confirmed her expectations. She was able to recognise her part in the process but only to a limited extent. "He is avoiding me…I know it is because of my behaviour…but I have decided that I am better off without this [relationship] because I feel he doesn't want to be there". The therapist realised that her choice to end the relationship was consistent with the patterns of ending that she had described in previous relationships. The therapist was also aware that by deciding to withdraw from the relationship the participant was avoiding the very issues that needed to be addressed in order for her to achieve a measure of success in her relationships. Whilst these assumptions appeared to be objectively valid, the therapist was very careful not to verbalise these preconceived views as he was keenly aware that by holding such inferences he was in fact going against the fundamental principle of generative uncertainty, namely "without memory or desire". Instead he asked her how she was feeling to which she responded "I have no energy, I want to be on my own". This statement revealed the extreme emotional difficulty that such situations caused the participant when she found herself in the very position she feared most – abandonment. At this early stage in the process the therapist was aware that the participant's comments about starting and ending romantic relationships could also be understood in terms of her unconscious fears around establishing a therapeutic relationship with the therapist.

In session eight the participant outlined that the solution to her emotional difficulties lay in "stopping medication, praying hard and not getting into any more relationships". The therapist recognised that the participant has a tendency to seek solutions to her difficulties by withdrawing from the source of her frustration and adopting an extreme position, "What's the use of trying".

She held on to this style of seeking solutions with a rigid certainty. By not supporting this view or undermining it the session moved to a more neutral position whereby the participant stated that it had been her birthday the previous day but that "No one wants to be with me" When the therapist asked why she thought people might be avoiding her, she stated that "I must stop complaining…it might drive people away…people might see me as self-centred".

In session eighteen the participant again found herself in a place of abandonment after ending her relationship. "He does not tell the truth. I am intolerant of people who lie to me". She was feeling very depressed and was attempting to find reasons for her decision "to be on her own". She stated, "With these boyfriends I find fault in them because I do not actually love them".

In session nineteen she continued on this theme, stating that she thinks people only get involved with her because they want something from her. "People come to me to use me, they come for this reason, friends and family too, I cut people out of my life who bring these negative things to me". She ended the session by stating, "do people love me for who I am, or for what I have got?"

In session twenty-seven the participant started making contact with a boyfriend that she had seen some years before. It was becoming clear that the participant needed to have someone in her life at all times. She had ended her last relationship only two weeks previously. Whilst she acknowledged that this boyfriend had hurt her in the past she still felt "he is the only one who has ever really loved me, the first one I ever loved". It was clear to the therapist that she was trying to overcome her recent disappointment by contacting this previous boyfriend who was now married. The participant saw this person several times but was scared of getting involved because she felt that his wife will "find medicine to harm me; she has done it before to someone and can do it again…she will give it to a man who will give to me when he touches me and I will become sick…these things do happen". The therapist was aware of the strong belief that the participant held concerning witchcraft and refrained from commenting. This was an area of cultural belief and certainty on which the therapist felt ill-equipped to comment. The participant was able to reach a point in this session where she could see that her feelings for this man were ambivalent. "One part wants him and another part wants my freedom and independence". She ended the session by stating that "I won't get involved again because of the hurt he caused me in the past…Maybe I should go overseas for some time...I think it is time I came to a closure on my love life".

In session thirty the participant learnt that this one-time boyfriend had been showing her SMS messages to other people and that he was telling people that she was running after him. "I locked

myself up the whole weekend, now I feel hatred towards him". This experience raised feelings again for the participant of being let down by her boyfriends.

In session thirty-one the participant stated that she had not been to work for a week. She was feeling depressed and had flu. She was not feeling good about herself and felt that her new medication was making her put on weight. She also acknowledged that she might be comfort eating. The participant found herself in a place where she was on her own without any relationship and stated that she felt lonely. She was reflective and stated "I am becoming more aware of my emotions now…I realise that my explosions have a negative outcome…it drives people away". She was making a conscious effort to control her anger and other emotions. "I feel that I am trying to learn how to communicate all over again…I am really trying to change". The therapist was aware that these reflections contained an implicit understanding on the part of the participant that her inability to contain her feelings was destructive to her relationships. The therapist did not intervene but allowed her to continue. The participant then moved to a position where she described how people use her because she is always trying to satisfy their needs. She thought it was time that she started to look after her own needs. Towards the end of the session she acknowledged that "All [my failed relationships] where my fault that they did not work…it is because I do not love myself…I have chased men away because I don't believe that they could love me". The therapist felt that the participant had moved to an acknowledgement about herself that was extremely hard for her to hold in consciousness. The feelings raised by these thoughts caused the participant to feel a great deal of distress and she was very tearful.

In session thirty-five it was clear to the therapist that the participant maintained the certainty that she would ultimately be let down and rejected by those people that she became close to. This neurotic certainty was pervasive in all her relationships and was evident in the transference. In this session she arrived one hour early for her appointment. She had to wait and was clearly angry as she felt that this misunderstanding was an error on the part of the therapist. The participant had in fact made the error by previously changing her time because of a work commitment that she could not get out of. This session was considered an example of how she unconsciously creates situations where she feels let down by people and fails to recognise the part that she has played in creating such situations. She had been carrying some anger towards the therapist for some time because she felt that he was behaving neutrally and not siding with her in her opinion towards her son. This was likely to account for why she had shifted her appointment and then not arrived at the rescheduled time. She expressed her anger through statements such as "therapy is not making any difference…you don't understand me". In an attempt to maintain the analytic attitude the therapist refrained from interpreting this communication in terms of the main theme and tried to

remain open to subsidiary themes to understand this behaviour. Had an interpretation been made it was felt that the participant would become more angry and the session would have been consumed by this affect. By refraining from any form of direct intervention the therapeutic space was left open for the emergence of other feelings. After a period of quietness the participant was able to talk about the frustration and disappointment that she was feeling about herself and her issues with her son. She stated that she had decided to give up on her search for a school for the following year, as she had no energy left to deal with this issue. She felt that the headmaster of the current school was to blame for the predicament that she found herself in. Characteristically the participant had felt that he had not been supportive; she had become angry and subsequently chose to dismiss the issue. This sequence of feelings reflected precisely what she was currently feeling towards the therapist in this session. At the end of the session it was possible to discuss how anger was often used as a screen to avoid speaking about other feelings, such as the need for support and care.

5) Abstinence.

In session seven the participant explained that over the Christmas holiday she had felt very depressed, suffered from headaches and was subsequently admitted to a clinic by a GP who works close to where she lives. This admission was precipitated by the ending of her relationship. The participant was very tearful in this session. The therapist was aware of the extreme emotional difficulty that the participant had undergone during this time. The impulse on the part of the therapist to offer reassurance and comfort to the participant was strong but needed to be curtailed. The therapist did state, however, "I can see you have been feeling a lot of pain during this time". She acknowledged this statement and replied, "I need to put my love life aside, it causes too much problems [for me]". She then talked about her depression and her suicide ideation. The therapist realised that if he had entered into direct emotional comfort the session may have remained at that level. By restraining himself from a direct expression of pity it left the space open for the participant to disclose her thoughts of suicide. The therapist was able to act on this disclosure and contract with her for her safety.

By the therapist's not acting on the transferential role it was possible for this role to shift and progress. The pressure in the therapeutic relationship for the therapist to play out certain roles was very strong. The participant made constant reference to the fact that therapy, medication and hospitalisation did not really make much difference and did not really work. In session thirty-five the participant implied that "therapy was not really useful for her". Such comments were in keeping with her predominant belief that no one could help her and no one could really care for her in the way that she required. So long as she saw people this way she could maintain the

understanding of herself as being abandoned and having to fend for herself. It was clear that the participant often evoked angry responses in her relationships. Her demeanour and often off-hand and angry attitude was an attempt to get the therapist to push her away thus confirming her belief that she was in fact unlovable. Abstaining from being pulled into certain roles by the participant made it possible for the therapeutic relationship to continue in a way that was not possible outside of therapy, where most of her relationships failed because her partners acted out these roles.

6) Neutrality.

In session fifteen the difficulty in maintaining neutrality was strongly present. In this session the participant found herself distraught about her son's misbehaviour at school. She was very angry and stated that she wanted to give up on her son. She had been unable to sleep the previous night as he had left the house and not returned. It transpired that she "had given him a hiding" following a report from the school that he was not working and had been misbehaving. During this session the participant also revealed that she had been having an extremely difficult time with her lover, was feeling very depressed and had thought of taking her life again. She stated that in her culture a "hiding" was an acceptable way of disciplining a naughty child. The therapist was aware that her son's behaviour was strongly associated with his mother's condition. He generally performed well and was well behaved except during times when the home environment was very unsettled. In this session the therapist felt the participant was asking for recognition that she had been let down by her son, that he was another problem that she had to attend to on top of all her other problems. By the therapist's not colluding with her opinion it was possible for the participant to move towards a place where she was able to consider that "My son is my only family; if he is feeling uneasy around me then there must be something wrong with me". However, often when she moved to recognising her deficiencies she would do so to extremes, seeing the only solution being to kill herself, "I think the best thing for me is death". In an effort to maintain neutrality the therapist was required to hold back on imposing any moral judgement concerning the situation with her son and did not side with her view of herself as a victim or as a failure but rather to pointed out that her opinion of herself shifted between the polar extremes of being a victim of her circumstances or of being the creator of her circumstances.

In session twenty-three the participant described an argument between herself and her boyfriend. Since she told this boyfriend that she no longer wanted the relationship he had become angry. "He hit me and I hit him back, I hit him in his face and he punched me". She explained that her boyfriend had a gun and had threatened to shoot her because he believed that she was seeing someone else. This argument occurred in front of the participant's son who had developed a good relationship with this particular boyfriend. The psychological impact of this behaviour on the participant's son evoked feelings in the therapist, which provoked much internal dialogue. He had

to make an effort not to judge these events. The incident did, however, give an indication of the level of feeling the participant experienced when she felt her trust had been broken and she felt disappointed. "I told him [the boyfriend] 'I don't want you in my house', I physically pushed him out".

In session twenty-five the participant described the difficulties she was having with her ex-boyfriend who was unable to accept that the relationship had ended. The participant stated that she was concerned that he may commit suicide or may use his gun on her. "In the township people are shooting themselves and their partners; every Saturday people are being buried". The participant explained that she had now started going to Bible study classes as she felt that "something is missing in my life". One evening whilst walking to her class she noticed that her ex-boyfriend had followed her. "He is stalking me…I feel he might be unstable because when I tell him 'I no longer love you' he cries". The participant was visibly upset and asked the therapist what she should do. The therapist replied that he thought the participant should do whatever necessary to keep herself safe and should try not to walk alone at night. Whilst this intervention represented a frame break it was felt to be necessary for the purpose of the therapeutic alliance. It was felt that not to intervene at this moment would have been more damaging. The participant seemed satisfied with this comment and became less upset.

In session twenty-six the participant explained that she had encountered her ex-boyfriend who had arrived drunk at her cousin's house whilst she was visiting for supper. He slapped the participant who retaliated, "I took a stone and hit him on the eye". He then told the participant "I am going to follow you and shoot you in the dark". Later in the session the participant stated that the boyfriend was angry about a certain sum of money that he felt she owed him. When the participant refused to pay this money he had tried to take off her shoes so that he could take them to a Sangoma who would put a curse on her and make her "sick, paralysed and unable to walk". It transpired that another reason her ex-boyfriend was so angry was because the participant had started making contact with a previous boyfriend and he had found out about this. The therapist had many mixed feelings about the events that the participant described but refrained from judging or giving advice and allowed the session to flow. It was interesting to note that the participant then moved to a position where she was able to acknowledge that she still held feelings for her ex-boyfriend. She also stated that she was trying to work on herself and was reading a book on life strategies.

In session thirty-two the participant was depressed following the break up with her boyfriend. She was trying to place her son in a school but was having difficulty finding a school that would

accept him because of his poor performance record and disruptive behaviour. A lot of conflict had ensued between her son and herself. It had become clear to the therapist that the participant generally felt unwell when she was not emotionally connected to a romantic partner. When she was feeling unwell she often experienced difficulties in her relationship with her son. In this session the participant stated "I do not trust him [my son], I lock my door at night because I think maybe he will stab me". It was evident that those ambivalent issues of trust, suspicion, disappointment and explosive anger together with feelings of an underlying need for love and care that arose in her romantic relationships were also present in her relationship with her son. It was also clear that in spite of these angry feelings she currently felt towards her son, she still loved him and at the end of the session was able to state "I don't really want him to leave".

In session thirty-four the participant described that there was another man that was interested in her and had been phoning her. The therapist was aware that the participant does not remain on her own for long as she finds it very difficult to sit with the feelings that arise when she is on her own. It is the intolerance of such feelings that drive her towards being connected emotionally with another person. The space between the ending of one relationship and beginning another was generally very short with the time between relationships being fraught with feelings of depression, physical ailments and a lot of anger which was often expressed towards her family members. Once again the therapist was careful not to verbalise this understanding as it would foreclose other possibilities. However, the therapist did ask the participant if her liaison with this man was perhaps an attempt to escape the intensity of negative feelings that she had been sitting with recently. To this the participant replied, "This time I am not going to follow my heart - I am going to follow my mind".

In session thirty-nine the participant was trying to distance herself from her current boyfriend; she found herself re-thinking her ex-relationship and decided to contact him. She felt rejected when he did not recognise her voice on the phone. She concluded what she wanted was intimacy without emotional difficulties, "I wouldn't mind a sexual partner but not the commitment". The therapist was aware that this represented another instance of how the participant unconsciously creates scenarios that are likely to lead to disappointment. He was also aware of the necessity to reserve this judgement.

7) Countertransference receptivity.

In session three the therapist's own feelings of ambivalence alerted him to the strong ambivalences of the participant's own internal world. The participant was able consciously to reason that her suspicious behaviour was destructive to her relationship but she was

simultaneously unable to control this behaviour, which was driven by overwhelming emotions of a primary nature. "I am trying to stop myself from being suspicious…I would like the relationship to continue". The participant's way of dealing with the intensity of these ambivalent feelings was to withdraw from the relationship, "On Sunday night I told him I am not sure about continuing this relationship". This sequence of suspicion, argument and subsequent withdrawal was recognised by the participant as a pattern that frequently emerged in her relationships with men. "This is not the first time I have said 'Let's take a break in the relationship' ".

In session four the therapist became aware of repeated reference to romantic relationships and the difficulties therein. He was aware that these manifest communications were reflections of the participant's unconscious negotiations and conflicts concerning the therapeutic relationship. The therapist realised, however, that any interpretation at this early stage in the process would be counter-productive.

In session eleven the participant spoke of her new relationship. She stated "He is trying everything he can to keep me in this relationship…he is trying to find out why I broke up with the other guys so that he does not make the same mistake…he is trying to be perfect in every way." These statements were understood as unconscious communications about the therapeutic relationship and the therapist. The participant proceeded to state "I am blocking my feelings but because he is working so hard I find it difficult not to respond…but I have a history of hurting people that I am in a relationship with". The resistances and fears towards her own dependent needs were being expressed in the transference towards the therapist. She then stated that she "often loses interest in men who try too hard". She felt that "he is acting like a baby and wants me to be his mother…he has a drinking problem". It became clear to the therapist that in her relationships the participant needed a strong person to take care of her and not someone that she perceived to be weak or she needed to take care of. Although she was frightened of allowing her dependent needs to the surface this was in fact what she required in a relationship. In terms of the transference the participant needed a strong containing relationship before she could allow this part of herself to the front. The therapist felt that the participant was unconsciously communicating to the therapist that like her current boyfriend she felt that he was "trying too hard" and was not strong enough and therefore not safe enough to contain this part of herself. It was noted that the participant was at some point likely to test the strength of therapist. If the therapist did not maintain a firm and contained frame then she would perceive him as weak and would terminate as she did with those boyfriends whom she perceived in a similar way.

In session twelve the participant strengthened the therapist's understanding of the transference role that she expected of the therapist. She stated, "Why can't I be happy with what I have got [I am always wanting] the exceptional person". She had been discussing her disillusionment with her current boyfriend who was beginning to show his weaknesses and failings. "He said he will kill himself if I dump him…He says he really does want to stop drinking". Whilst these statements were essentially about the state of her current relationship, it was felt that she was also commenting on the role she expected of the therapist. By pointing out her intolerance of weakness and fault in others she was revealing her intolerance for her own capacity for dependence, which she saw as a weakness. Her unconscious need to be dependent was evident, but it was clear that the participant would not allow this to emerge in the therapeutic relationship until she was sure that the therapist was free of weakness and fault himself. She expected high standards of self-discipline in her relationships and constantly tested her boyfriends to see if they could maintain these standards.

In session thirteen the participant reported that she was feeling very depressed "I am very upset at present…I feel like screaming". These feelings were preceded by a decision on the part of the participant to end her relationship with her boyfriend. "I wrote a letter and told him I think we must end this…I never want to be in another relationship…he is treating me like his mother…[it] is a lot of responsibility…he promised me he would not drink and he did…I am very angry with him". The participant was pointing out that she could not see her way forward in this relationship because this boyfriend lacked the strength to support her, rather she felt he required her to support him, "I don't see myself as his future wife". In terms of role responsiveness the therapist was strongly aware that the participant was unsure about her therapeutic relationship in as much as she was unsure about her romantic relationship. At the end of the session the participant was very distressed and stated that she was concerned about "who will be there for me when I stop therapy". The therapist replied, "I will be there". Whilst this remark represented a frame break it was felt that it was a necessary reassurance in order to maintain the therapeutic alliance. The participant had been indicating for some time that she was unsure of the relationship and was indirectly threatening to leave. She did not reply to this comment but seemed satisfied and confirmed her session for the following week.

In session fourteen the participant explained why she had not attended her session the previous week. (She had previously left a message to say that she was unable to attend due to work commitments). In this session she explained that she had been on her way to therapy but had then changed her mind. She stated that she had been too "embarrassed" to arrive because she had broken her contract and had taken an overdose. This occurred after an argument with her

boyfriend when she had taken "various pills" and had "landed up sleeping for nearly two days". She had seen the staff doctor at the hospital where she works who had subsequently booked her off work for three weeks. The therapist made an appointment with the participant for the following day. The pattern of suspicion, argument and subsequent withdrawal once again played itself out in the ending of her recent relationship. This pattern was generally followed by feelings of depression and was often marked by a suicide attempt. The therapist could recognise that in the transference the participant had already indicated her suspicion of the therapist. By breaking her contract it was felt that she was trying to evoke feelings of anger in the therapist. He was very aware that if he played out this expectation the participant would withdraw from the therapeutic relationship. Although the therapist did feel frustrated by the participant's behaviour he realised the importance of containing these countertransference feelings.

A working understanding of the participant's transferential needs was only possible through the therapist being acutely aware of the feelings that were evoked in the therapeutic relationship. In session seventeen the full extent of the participant's transference needs became clear to the therapist.

The participant required the therapist to be caring and supportive: to play a parental role that had been absent in her earlier life. She required this in her relationships with men generally. A strong need for love, dependent needs and a fear of abandonment were at the core of the participant's interior world. These feelings were repressed and compensated for by a persona of independence and autonomy: "I am a liberated woman, not a traditional one". This sense of independence was particularly evident in her career. Being intolerant of her own dependency, the participant was intolerant of it in others. She sought relationships with people who were strong and independent, people who could care for her. She was terrified of allowing herself to release this vulnerability with someone who was not able to meet these needs. To make herself vulnerably dependent on someone who would then abandon her was her greatest fear as this would open up the feelings of extreme loss, rejection and abandonment that occurred in childhood with her parents. For this reason any suggestion of weakness in her partners was met with extreme suspicion and derision. She unconsciously tested them to see how strong they were. Partners who were dependent on her, dependent on substances, or unable to maintain high moral standards were seen as "weak". This search for the perfect partner played itself out through suspicions, arguments and subsequent withdrawals. In the transference the participant repeatedly tested the strength of the therapist by breaking her contracts and not complying with the agreed-upon rules of working. She deliberately evoked feelings of frustration and anger by actions such as answering her cell phone in the session and talking to a friend. These events were aimed at precipitating scenarios whereby she

could feel justified in withdrawing from the relationship. She feared allowing herself to be dependent on therapy but unconsciously she was asking for this. This ambivalence was felt strongly in the therapeutic interaction.

In session seventeen the therapist was caught between the desire to make insight-furthering interpretations and knowing that any interpretation that challenged the participant to consider that the source of many of her difficulties lay in herself would be experienced negatively. The participant wanted the therapist to meet her dependent needs and not make interpretations that pointed to self-responsibility. The therapist found that early interpretations were generally not received well but resilience in terms of holding back on interpretation often lead to insights. In this session the participant aroused pity and frustration in the therapist moving him to feelings of compassion and anger. Compassion was what she was asking for anger was what she expected. Both responses were her attempt to coerce the therapist into playing out the roles she required. He was aware that too much compassion would leave her feeling he was "weak" and any display of anger would complete the repetitious cycle of abandonment that she expected.

In session thirty-three the participant began the session by stating that "I did not want to be here today". She was experiencing a lot of difficulty with her son and was feeling unsupported by the therapist. The therapist was aware that the participant wanted him to concur that her son was the problem. He realised that by siding with her it would relieve her of the tension she felt concerning her own part in these difficulties. She generally got angry when she felt unsupported. She then told the therapist that she thought that her psychiatrist understood her better. This comment was clearly designed to arouse feelings in the therapist. Once again the therapist held back on his feelings. The participant proceeded to state "from next month I am not paying my son's transport to school, he must walk". Towards the end of the session the participant said that she thought she would write a letter to her son because when she spoke to him she just became angry.

In session thirty-eight the participant said that she "wanted to take time-out from therapy". This session was considered to be very important because the full extent of the transference was brought to the fore and verbalised to the participant. The therapist considered this session to be a turning point in the analytic process. In this session the participant pointed out that she was thoroughly disillusioned with people. "I don't like people around me. I would prefer to be with my book and with myself…I get irritated with people". She pointed out that she finds it difficult to get along with her work colleagues, her family and her friends. "My family they use me…I can't get along with anyone at work, I don't associate with them…[my friend -] I was always available for her but she gives nothing back". The participant proceeded to describe that she once

made an arrangement with her friend to meet at three 'o'clock. Her friend arrived after this time. "I told her it was too late, and I have never seen her again". The therapist told the participant that he was aware she carried a very strong set of criteria on how other people should interact with her. Her expectations were very high and she was often disappointed because most people could not perform at this expected level. As a result she generally set herself up for disappointment. The therapist pointed out that he felt this in the therapeutic relationship. She expected a level of care and support from the therapist that was not possible and this is why she had decided to leave therapy. To this the participant replied "Yes, I seem to have this problem with everyone…I withdraw so that I will not be disappointed…I understand that if you had problems in your childhood then it will be difficult to form relationships in the future".

In session thirty-six the participant was discussing a new boyfriend. She stated "I don't want to try and establish a relationship, I am still dealing with myself… I feel I am not ready for him". She then gave reasons why she thought this relationship would not work. "He lied to me and told me he was 35 but I saw his ID book and he is 45…he is not my type, he has no formal education…he does not like TV, books, magazines, watching Oprah or sport…we live in different worlds…he was brought up in the Transkei and sees the world differently to me…we are of a different class…but he is trying very hard and he says that he loves me". The therapist was aware that in recent sessions the participant had stated that she thought therapy was not useful to her and that the therapist did not understand her. It was felt that the above description of why she felt she should not get into a relationship with boyfriend four was also a comment about her therapist whom she also saw as different to herself and "from a different world".

Fortunately the therapist was able to recognise the transferential needs of the participant early in the process. For this reason he could sufficiently contain his own countertransferential enactments in the face of transference pressure. What was more difficult to contain was his personal countertransference.

As mentioned earlier the participant needed to confirm her unconscious belief that she was unlovable and would be let down and rejected by people, thus re-creating in the present the painful scenario of abandonment experienced in earlier life. A complex need system with unrealistic interpersonal standards for relationships and friendship ensured that most individuals with whom the participant came into contact would fail to provide her with what she needed. These individuals would unwittingly perpetuate the participant's experience that "people did not care". An unconscious strategy that she used to confirm this belief was to evoke feelings of anger in 'the other'. When 'the other' expressed anger towards her, confirming the belief that "people

do not understand me", she felt justified in ending the relationship. These dynamics were anticipated in the therapeutic relationship and the therapist was aware that if he acted on this transference pressure then the therapy process would follow the same fate as her relationships outside of therapy. Efforts to give prominence to her own rules and standards above the ground rules of the therapeutic relationship were evident through the way in which she related to the therapeutic frame. This took the form of cancelling sessions, shifting the times, not arriving for scheduled appointments and asking the therapist to intervene with personal matters outside the therapy room. Her attempts to evoke feelings of anger in the therapist were evident through undermining statements such as in session twenty-one, "nothing helps me. I want to stop therapy, I am wasting my time" and in session thirty-five, "you don't understand me". Other attempts to manipulate the therapist into feeling frustrated were evident through actions such as breaking her verbal contract to continue seeing her psychiatrist, threatening to take an overdose, and visiting other general practitioners for different medications without disclosing her ongoing treatment relationship with a psychiatrist. These efforts were aimed at eliciting the familiar response of rejection that the participant required. This placed the therapist in a position whereby he had to exercise extreme vigilance and caution in all of his responses.

The therapist also carried feelings that were best accounted for by personal countertransference rather than transference pressure. On one occasion in session thirty-five the participant phoned and asked to change her appointment, she then arrived at the wrong time, was obliged to wait an hour, became angry and blamed the therapist. The therapist in turn felt extremely angry but was able to contain his response. He was aware that a large portion of his reaction related more to his own need for professionalism, principle and structure than it did to the actual situation. There were other instances when the therapist felt unenthusiastic about the arrival of the participant for a scheduled appointment. This was especially at times when she had recently broken up with her boyfriend. He was aware that at such times she was vulnerable, volatile, and 'moody'. She often found fault in her son and was passively aggressive in her sessions - remaining mute. Such sessions required a lot of preparation on the part of the therapist and he was generally aware of having to contain his strong negative feelings. Such feelings existed as a cue to the therapist to be self-reflective about his own countertransference.

Being made to feel inadequate generally raises feelings in most people. To some extent the therapist already felt inadequate within the framework of cross-cultural practice. When the participant made statements such as "It is a cultural issue, you will not understand", this raised mixed feelings. On one occasion the therapist reflected to himself and to the patient that "most of my patients - western and non-western - will at some point hold beliefs in the therapeutic process

that may be considered irrational by others". Preparation in dealing with such issues involved exercising all aspects of the analytic attitude and moving to a position of understanding why the participant behaved in such a way, rather than simply acting on emotion.

Strong feelings were raised in the therapist particularly with issues relating to violence, the acceptance of the ubiquitous presence of firearms, physical abuse, parental discipline and the ritual slaughter of animals. The values, culture and beliefs of the therapist differed from those of the participant and he needed to be aware of his own biases in this regard. This took a lot of personal effort especially as the therapist had once been victim to an armed robbery himself. Feelings from this encounter were brought to the surface by the participant's discussion of firearms such as in session twenty-five, "Every Saturday people are buried in the township, people are shooting themselves and their partners". His own prejudices about township life and crime were provoked by the participant and he had to be careful not to fall into the stereotypes that had been inculcated through his experience of growing up as a White South African in Apartheid South Africa.

Statements such as in session twenty-three "I hit him in the face and he punched me, he then threatened to shoot me in front of my son" and in session twenty-six "I took a stone and hit him in the eye" jarred strongly with the therapist's own feelings towards aggression and violence. In these instances he felt judgemental and thought to himself that "such behaviour is unacceptable". These feelings were particularly strong in session thirty when the participant stated, "I grabbed him [my son], got hysterical and hit him". In all these instances the therapist was aware that he was internally judging the participant. The internal negotiations around these issues were at times extremely difficult for the therapist who on several occasions felt inclined to express his viewpoint. On one occasion the participant justified her physical punishment of her son by stating, "in our culture it is allowed for us to discipline our children in this way".

Different cultural norms and practices also raised countertransference feelings. In session nine the subject discussed inviting her mother and family to her house and slaughtering a sheep. Whilst this also raised strong feelings in the therapist he was better prepared for such cultural practices than he was for violence. He was able to understand that the meaning of such an event was to re-establish the broken connections that the participant felt with her family. Other beliefs were more difficult to work with such as in session twenty-six when the participant stated that her partner tried to take off her shoes to give to a Sangoma who would then make her paralysed. The necessity for the therapist to have some knowledge of the participant's cultural beliefs and

practices was made evident through such statements. A basic understanding of her cultural worldview helped the therapist to modify his own countertransference reactions.

8) Resoluteness.

In session twenty-eight the therapist listened to the participant describe that she had headaches and was tired. He was able to recognise that this was largely due to the disappointment she felt at the ending of another relationship possibility. The participant stated "I am not at peace with myself; this is why I am not at peace with other people". She was reflecting on herself in terms of the themes that often arose after the ending of a relationship. Without pointing this out or offering re-assurance and interpretation the therapist allowed her to proceed hoping that she would gather her own insights. The appearance of physical symptoms at times of emotional distress was a common occurrence. In this session the participant remained on the level of her symptoms without venturing to the feelings and meanings underlying these symptoms. Her resistance to move beyond this level of understanding presented a major challenge to the therapist's sense of resoluteness. It was necessary for the therapist to maintain the belief that in time she would make the link between her somatisation and her emotional life. Towards the end of this session the therapist suggested that perhaps she was feeling this way because of the suffering that she had undergone recently. The participant agreed but then stated, "I think I need to change my medication".

In session thirty the participant described how she had lost her temper with her son. "I grabbed him, got hysterical and hit him, he has a scratch on his eye…I felt angry with myself, I am not supposed to do this, I am scared he will run away". She had experienced headaches ever since this altercation and stated that she had bought some painkillers but had not used them. She then pointed out "my headaches are emotionally based". The therapist felt that the participant had reached her own conclusion on the link between physical concerns and emotional concerns.

5.5: Individual Case Report for Participant Two.

Procedure.

1. Analytic task
2. Analytic setting
3. Analytic process
4. Generative uncertainty
5. Abstinence

6. Neutrality
7. Countertransference receptivity
8. Resoluteness

<u>1) Analytic task.</u>

In the first session the participant identified a set of issues that she wanted to explore. In doing so she outlined those concerns that would form a basis for exploration in the analytic task: "I hope that therapy will help me to understand myself better. I have insecurities about people speaking about me behind my back… when people first meet me they think I'm stunning, then it gets harder". She was subconsciously aware that when interacting with people she presented a confident social front which was not a true reflection of how she actually felt. She felt unable to handle conflict. She also identified issues with alcohol and spirituality. Another concern of hers was her perceived intellectual incompatibility with her fiancé, "He once said that we don't have intellectual communion".

The therapeutic goals for her were to be an exploration of these issues, rather than to provide a definition of or an "answer" to her problems. She made it clear that she saw therapy as a process of assisting her in understanding herself better and subsequently coping better in her life. Her sense of the therapist's role appeared insightful from the outset. She did not grade these issues in terms of their importance to her, nor did the therapist attempt to rank them or probe further.

In session thirty the participant discussed her therapeutic goal of attempting to be true to herself and not interact through a stylised persona. She indicated she was able to relax and felt more grounded with her fiancé's family. She realised that "I will attract the wrong friends if I live in the persona… but I find it difficult not to be 'the exciting [person] who has so much on'". The therapist was aware that part of his task was to sustain an environment of trust whereby the participant could continue to exercise her true feelings and feel safe enough to show her real self.

The therapeutic task of fostering a place of safety for the expression of thoughts and feelings that lay behind the participant's social front appeared to be showing some success. In session thirty-one she continued to focus on many of the themes outlined by her initially. She gave a cohesive narrative moving logically from issue to issue and showing at least a partial resolution of many of the issues she had been working with over the past thirty sessions. She discussed her relationship with her elder brother at some length and was able to accept his emotional distance from her and his lack of emotional support, "It is great if we are friends, but if we are not life goes on". With her brother and with others the participant showed a greater capacity to be independent of

approval. "I feel all round the need to be loved and needed has changed". She no longer felt intellectually incompatible to her fiancé and was less dependent on him. "Every time I hit a crisis I would call him: this is not happening as much".

The therapist felt that his task of assisting the participant towards thinking and conversing more freely was evidenced through her increasing ability to tolerate her own utterances on topics that she previously avoided. The participant had had worries surrounding her use of alcohol. She now indicated that she no longer needed to drink. "The drinking thing was playing a role in my depression… I had a drinking binge in January [and lost control]. My fiancé had to help me; we spoke about this and I haven't touched a drop since then". The participant also spoke about her relationship to her mother, recognising that much of her interaction with and interpretations of her mother's behaviour was based on her own strong need to feel wanted and accepted. "I still try to get [my mother's] approval or praise, if I speak to her and she is not happy, I feel 'what have I done', [instead of recognising her unhappiness is not caused by me]". The participant discussed her relationships at work. "I am not intimidated by the people as much, I don't care as much as I did about the impression I create".

Later in the session the participant again discussed an argument she had had with family members at the time of her father's funeral. During this argument she had openly defied family members, particularly her brother, and had pointed out a number of discordant truths that she felt the family were choosing to ignore. Previously she had avoided conflict with her family at all cost. This argument was a turning point in her family relations and served to empower the participant and give her a greater sense of her own strength and autonomy. It was the first time she had challenged rather than acquiesced to the needs of her family members. The therapist found with particular interest that in this session she was far readier to show her emotional involvement with the events and topics she was describing. This was recognised as a significant shift towards emotional integration and maturity. The therapist's task of facilitating the expression of feelings from the true self rather than from the persona was effective. The participant provided several examples where she had found the courage to speak out her true feelings. The therapist was also beginning to experience a more real sense of the patient in his relationship with her.

2) Analytic setting.
The participant stated from the outset that she had initially contemplated choosing a Black woman as her therapist. However, she felt comfortable with a White male and seemed prepared to follow through with this decision.

In session fifteen the participant got off her chair and seated herself on the floor. The therapist felt immediately disconcerted by this act, but initially refrained from commenting. For the therapist this was felt as a transgression of his conception of the analytic setting. He saw this as an act of elevating himself and sub-ordinating the participant thereby potentially disrupting the nature of the analytic relationship. It was noted that once he made the participant conscious of her action she returned to the chair. She showed some awareness that she had over-stepped the boundaries of what was generally expected in the analytic setting. The therapist realised on reflection that his own discomfort had encouraged the client to return to her chair. What he had not taken into account was that this was also an act of increased rapport. The participant was indicating that she felt comfortable and relaxed enough to shift her position. By not acknowledging this, the therapist had in fact obstructed further exploration of transferential issues that may have arisen from this new position.

3) Analytic process.

The participant introduced her family relationships in the first session by stating that she got on well with her family but that her relationship with her brother was not as good as it had been in the past. "I used to think he was perfect but he didn't stand up for me [when I needed him]".

In session six the participant spoke of the recent revelation that her older brother and sister were not the biological offspring of her father but were from her mother's previous marriage. Although her older siblings had a different surname to her, she had always assumed that it was her mother's maiden name. At the same time, her younger brother discussed with her the possibility that he also was not the son of her father. These revelations distressed her greatly and she did not want to accept these facts. She resented being "forced to come to terms with the reality of the family surname". In this session the participant appeared to be working through her sense of identity, which was closely related to her sense of belonging to a family unit with interfamilial loyalties and mutual support. "I am upset with my older brother for pursuing a relationship with these people [with the same surname as him]. He calls them 'brother, brother'. They are not really our relatives. I think he is distancing himself from my Dad and Dad's family – i.e. me". In this session the therapist noted that below the manifest level of discussion about family loyalties and blood relationships the participant was being forced to redefine her own identity. This subtext of identity-consolidation was a process that developed throughout the course of therapy with the family acting as a metaphor.

In session eight the participant, for the first time, spent most of the session talking about herself as an individual [not as a family member] and revealing a number of personal emotions. These emotions related mostly to the conflict between her expanding individuality and her contrasting cultural roles. She described an incident in which she had asked two Zulu men to meet with her regarding a tailoring job, "These guys were looking at me, I felt this, they wanted me to speak in Zulu, I was talking in English but conscious that they thought I was putting on airs". In this session the participant was able to be self-reflecting, "I think I do put on airs, I was trying to meet them at their level". She had disclosed to these men that she drove her own car, had a good job and was engaged to a White man. She discussed in therapy that these attributes were not the norm and would be viewed ambiguously by most members of her culture. "Being involved with a White guy is not generally seen as positive. … A beautiful girl is wasted on a White man". She explored these feelings of ambiguity further through speaking of her experiences at school and at home: An elite White government school and a relatively poor township background. She showed good insight into the pressure she felt in trying to bridge these two worlds. "[At home] you don't argue and debate with your parents, you don't ask why. In a western environment [at school] you are encouraged to ask why". It became clear in her discussion of school and later experiences that she had developed two disparate roles. In her work environment she had adopted western values of independence, self-reliance and personal ambition, in her home environment she had adopted the more traditional values of obedience, domesticity and other aspects of a woman's "duties". "I am trying to get [my fiancé] to gain weight and look good, if he looks good then people will consider I am looking after him well". In the initial session the participant had defined the analytic task as needing to get to know herself better, in this session she showed an increasingly acute awareness of her difficulties with self-identity, "I feel my personal identity hasn't quite developed".

In session nine the participant continued to discuss the difficulty she experienced in attempting to combine two sets of cultural expectations, "I asked someone to clean the house – domestic worker – I found myself bowing to her [opinions]… she is an elder person. She is like my mother [also previously a domestic worker], how can I tell her what to do".

In session ten the process of self-exploration was evident through the way in which the participant's focus had shifted over time. Initially she had placed a strong emphasis on family issues, then moved to cultural issues, in this session she focused on issues of a more personal nature. She was able to confront aspects of her behaviour which previously she had not been conscious of. She described her persona at work, "I speak big and make no sense even to myself… when I am with my colleagues I talk about how I am going to take the client to new

heights". The participant was implying her awareness that she carries a social front at work and is often hiding what she really feels. "When someone can see that I am not who I think I am, I become aggressive or I charm". This comment represented a major shift from her previous statement in session three where she had indicated, "I feel I have been true to myself [in my dealings with other people]".

In session thirteen the participant was clearly in touch with her feelings of anger, which had not been shown to such an extent before. This session had been preceded by a period of depression. As the participant appeared to be moving out of her depression so she became more in touch with these feelings. Whereas before she had discussed her family in either positive or neutral terms, she now expressed a great deal of anger towards her father and was able to show compassion and admiration for her mother. Her family were not discussed as extensions of her own needs as they had been previously. Instead they began to emerge as individuals in their own right with their own emotions and needs.

In session fourteen the participant again raised the issue of the development of her self-identity. She described the difficulties that she had undergone at school. During this time she had felt unaccepted and alone. She had compensated for this by trying to fit in. "I did naughty things to be cool and gain acceptance from others… Christian girls, I hung out with them but did not say much". There were three other Black girls in the school but they called her a "coconut" and saw her as a traitor because she lived with White people. The participant's need to belong drove her to seek out attachments with highly divergent groups: Black/White, Christian/rebel, "I think that is why my personality hasn't fully developed, I was trying to fit in with different groups". The participant showed a growing awareness of her tendency to use roles as a defence against rejection, loneliness and difference.

In session seventeen the participant was very forthcoming about the eating disorder she suffered when at school. She also for the first time articulated very clearly her tendency to shift and change her persona as a way of achieving acceptance from different peer groups. This level of disclosure within the therapeutic context was seen as a positive development in the analytic process as such disclosure suggested a strengthening alliance between the participant and the therapist.

In session twenty–two the participant described feelings of great relief following her disclosure the previous week about a relationship in which she had suffered abuse and been betrayed. In the transference the therapist had represented the potentially betraying object. By disclosing very

sensitive material of a sexual nature in the previous session the participant had taken a risk and trusted the therapist. She did not feel let down after taking this step and had come to the important realisation that she would not necessarily be invariably let down. This realisation seemed to free her to discussing extremely sensitive matters in her present relationship. The analytic setting provided the necessary safe space and continuity for her to have the courage to risk disclosure and vulnerability and thus further the analytic process.

In session twenty-five the participant returned to "her need to be liked" and how this impacted on her behaviour in relation to others. "I don't tell people the complete truth because I want them to like me… I am scared that if I disagree with a person's opinion they will not like me anymore". Although the participant did not explore the possible reasons for her need to be liked, she did not attempt to rationalise or justify her behaviour either, whereas in previous sessions she had.

In session twenty-eight the participant spoke extensively of thoughts pertaining to her position in South African society as a Black woman. She spoke of class, race and changing socio-political trends, "In Mocambique people are class conscious not race conscious, in South Africa people are race conscious". She continued, "I feel that there are White people who are a class below me". In this session the participant sounded far more at ease in her role in-two-worlds than she had done in previous sessions. "When group areas was abolished then people moved into the suburbs, but some of these people go home to the community on weekends because they are bored in the suburbs".

In session thirty-two and following sessions the participant showed an increasing awareness of her use of persona roles. She started the session by saying, "I have moved towards being myself, I feel horrible after I have used the persona". She explained this statement by describing an incident where she had met up with some old housemates. "I previously liked them, then I realised that they were not my true friends… I saw them on Saturday and entertained them with a big smile on my face… I wasn't being myself".

In session thirty-seven the participant described a recent business trip to Johannesburg. She showed a strong awareness of her ability to be vivacious and affected in certain contexts and stated, "I am not sure if it was the real me or my persona, but I was happy, quite loud and had a lot of fun… [my colleagues in Johannesburg] loved me". In session thirty-eight the participant focussed on her inability to express her feelings, particularly her anger, towards her mother and her brother. She described how she had woken up in the middle of the night feeling very angry at the events of the previous day. "When they piss me off, I am always sweet and coy, I feel I can't

be truly myself around them… when my mother cannot make up her mind I feel like saying to her 'get a grip'". The therapist was aware that she was expressing her feelings towards her mother and brother in ways that she had not done previously. She continued by stating, "for me since I have been coming to therapy I am expressing myself so much more, it is now part of my day to talk [about my feelings]". She proceeded to point out that "generally in my family we don't talk too much about emotional stuff". The participant was explicitly stating that she could recognise the benefit of discussing emotions. "I would like to express my feelings more to them [the family], it would be better for the relationship, for instance we don't talk much about my mother's illness… we should speak more about these things… our family does not know how to talk, we are a television family". The therapist recognised a significant shift in the participant towards recognising the value of articulating her feelings and the positive impact this could have on her relationships.

In session thirty-nine the participant began the session by stating, "I am generally feeling very well and I don't think it is just my persona, I feel it is really me". She attributed this good feeling to the fact that she now understood clearly that her problems with her brother stemmed from her jealousy. "It may seem absurd to say this but I feel it has to do with letting go and accepting the reality of my jealousy [towards my brother]". The therapist recognised that the participant was also feeling more positive about her work. She was able to move to a new level in her therapy. She was no longer caught up with feelings of resentment towards her brother and was able to discuss other issues in her life. For the first time the participant was able to acknowledge that the reason she had not begun to look for another job was fear. "I have not told you before but the reason I stay where I am is because I am actually scared… at least in my current job people support me, elsewhere I am afraid there will be no support… and I don't have the confidence to be a leader". In this session the therapist felt that the direction of the participant's therapy had shifted away from family issues towards more personal issues concerning her career. The participant ended the session by stating, "Last Saturday I went to supper, I felt I was real that evening, I didn't even drink".

4) Generative uncertainty.

In session three the participant discussed in some detail her dependence on significant others. She attempted to rationalise her clearly ambivalent feelings about this dependence on others by stating that she had been encouraged by her exposure to Western culture to hold a negative attitude to dependence whereas in her own culture it was entirely acceptable for a woman to be dependent on her husband and family members. The therapist did not challenge this notion

although he was fully aware that given the degree of distress that her dependence caused her, she herself did not completely accept the above rationalisation.

In session seven the participant spoke of a dream in which her older brother had died, "He was dead but in the dream his body was there and he was standing with us and making arrangements for his own funeral". The therapist noted that in the previous session the participant had recently learnt that her brother was not her father's child. Her need to belong to a family unit was extremely important and her sense of being distanced from them caused her to feel upset. Most of the previous session was spent trying to negotiate these feelings and the impact they had on her sense of identity. The therapist understood this dream to symbolise the death of her childhood understanding of her brother and his role in her life. The therapist felt certain that there was an obvious link between the dream and the previous session. However, instead of confronting the participant with this interpretation he asked her what she thought this dream meant to her, thereby generating her own possibilities for understanding rather than imposing his own certainties. She responded, "He [my brother] is burying the old bits of himself and is going to start afresh". This statement introduced a different dimension to the one the therapist held. It was clear that the participant did not see the symbolism of the dream in terms of her own process, but rather saw it in terms of her brother's process. She went on to discuss her brother in some detail, his relationship to the family and other non-family members. She proceeded to describe a series of transgressions in which her brother appeared to be distancing himself from the family: not her father's son; rarely contacting her; failing to intervene on her behalf during her purging process; adopting a new young friend and spending more time with this friend than with the family; possibly being gay, and not bothering to send money home to his family. Despite these transgressions she re-iterated her willingness to accept her brother and to hold the family together. "It is my mission to keep things going; I believe in family". The therapist realised that her interpretation of her dream as being about her brother's need to lose an old life and move to a new life might be an implicit or projected reference to her own life. It is unlikely that these insights would have emerged if the therapist had not abstained from imposing his initial interpretation of the dream which opened this session.

In session nine and ten the participant began the sessions by stating that she had no pressing issues or anxieties in her home or work environment. This lack of worry she cited as being a worry "I feel that I should be worrying – when I am not worrying I feel I should be". The participant had shown previously that she suffered from free-floating anxiety. On one level this was true as she did have a tendency to "worry about not worrying", however on another level it was also clear that the participant used this "worrying technique" as a way of consciously

deflecting thoughts and feelings that would arise if she was not "worrying". In session nine and ten the participant had claimed to have no external distractions to worry about. Interestingly these sessions were characterised by a considerable degree of inward focus. Most of the participant's concerns centred on her family. It started to emerge that many of these concerns and worries about family were a useful way of avoiding a deeper level of introspection which often put her in touch with extremely uncomfortable emotions. "I don't want to confront the real me, and expose it… my real self I am scared is going to be serious, heavy and depressed".

In session eleven the participant re-iterated her concern about feeling dissatisfied with her work. She said that she felt "inadequate at work" and had been going out a lot at night with her friends "drinking and smoking" whilst her fiancé remained at home studying. This was causing some tension in the relationship. The therapist was confronted with several different lines of enquiry. He chose to opt for the possibility that this behaviour represented acting out or avoidant behaviour, which was consequent on her unhappiness at work. He proceeded to ask the participant why she still remained in her job if she was so unhappy. This was an attempt to get her to think of her behaviour as following on from her work dissatisfaction. This intervention represented a breakdown in generative uncertainty in that it foreclosed any discussion of the possibility that this behaviour may be related to issues deriving from the home environment or simply that it arose out of a tendency towards "extravagant behaviour" that she had previously mentioned to be a source of guilt to her. The attempt to promote insight along the lines of this intervention failed as for the remainder of the session the participant spoke vaguely about possible work plans and made no attempt to pursue the issue on hand.

In session eighteen the participant described in some detail the proposed plans for her wedding in three months. It became increasingly evident that she was discussing a series of demands and desires being made by her family and her fiancé's family. She felt her needs concerning the wedding plans were not being acknowledged. She was carrying a lot of frustration and resentment, which she could not express because of her predominant need to please and adapt to other people's wants. The therapist allowed the participant to stay with her feelings and made no intervention. In doing so the participant moved towards discussing the central conflict - that of her inability to communicate her own needs and desires. This inability left her feeling depressed, uninterested and wanting to withdraw from her responsibilities. "I want someone to sort everything out for me [concerning the wedding arrangements]". This session provided good insight into the extreme difficulties she faced in trying to reconcile different cultural expectations. "My mother [is] insisting I wear a white dress, she says 'you can't expect people coming from

England to see you in a traditional dress'… I want to wear a formal dress with aspects of my tradition".

In session twenty the participant spoke extensively but vaguely about her childhood, citing a list of superficially unrelated reflections. After some time the therapist intervened with a direct question stating "Do you feel you had a happy childhood?". In this breakdown of resoluteness he was attempting to elicit the underlying direction of these reminiscences. This interpretation arose out of an understanding on the part of the therapist that the participant was using the therapy session to explore the relationship between her current difficulties and her past experience. This causal frame of understanding was imposed on the participant's discussion without there being any direct evidence that this was in fact what the participant was doing. In this session the therapist brought his own analytic desires and preconceptions to the flow of the session. After this intervention the participant appeared to set about pleasing the therapist by trying to provide him with what she felt he wanted to hear. He realised that his own impatience had obstructed the necessary flow of free association in this session.

In session twenty-one the participant brought up the topic of dreams she had been having recently. "I often dream that I am dying". She offered her own interpretation of these dreams. "Dying dreams – maybe these are ways of trying to escape whatever I am feeling". The therapist was tempted to interpret these "death" dreams as a positive development symbolising the death of outgrown personas. However, he did not suggest this or even query the participant's interpretation, but rather allowed her to continue talking. She then described a dream that she had mentioned some seventeen weeks earlier at the beginning of her therapy process. In session four she had said "I dreamt last night [I was] stuck between two concrete slabs" In the current session she elaborated on this dream. "I was at the train station running for a train, but there was a concrete door slowly closing the subways, I got stuck between concrete blocks and I couldn't breathe. It was scary and dark, it was a small space" The therapist realised that the participant was obliquely discussing her fear of the therapeutic space and the changes the therapy process was evoking. This secondary interpretation had only become possible by not intervening with the initial interpretation. Having implicitly expressed her fears of the therapist, the client then moved to discussing a previous relationship that she had had with a "White man". She became very emotional when describing how he had abused her trust and not given her what she felt she deserved. It was understood that on one level the participant was speaking of her fears of being vulnerable in therapy. "I feel he took advantage of me, I was tricked, let him trick me… I didn't want [a relationship] from the start but didn't stop myself". In this disclosure she was moving

towards a recognition of her own responsibilities in a relationship process, and simultaneously acknowledging her need to take responsibility for the direction of her therapy process.

Shortly before session twenty-nine the participant's father had unexpectedly died. The participant spent the session describing the time that she had spent at home over the funeral period. In the first part of the session the participant focused solely on a series of arguments that she had had with her family, particularly her elder brother whom she felt had been domineering and had excluded her from any decision making. She described a physical fight between her brother and herself over sleeping arrangements. The therapist refrained from asking her outright how she actually felt about the loss of her father as he realised that her anger towards her brother was in fact displaced anger towards the unexpected loss of her father. It had been noted before that the participant did see her brother as a father surrogate. Eventually the participant was able to state that she had no real feelings about the loss of her father. It then became clear to the therapist that some of the frustration felt by the therapist in the initial part of the session at the participant's refusal to bring any emotional content to her narrative was a reflection of the participant's own frustration with herself for not being able to feel. She expressed her dismay a number of times at the lack of communication over the funeral period, "No-one asked what I was feeling, communication was minimal… [After the fight] there was no communication about the funeral". This lack of communication as discussed in terms of the family reflected the participant's projection of her inability to communicate with herself and access her own feelings about her loss. "I can't access my feelings about the loss of my father, I don't know if I feel anything about it".

By being open to a multiplicity of interpretations the therapist was able to understand the client's anger towards her brother in two equally valid ways. Firstly her brother represented her father who she was angry at for dying, secondly, her brother represented the hierarchy of a traditional community which gives power to men and relegates women to passive roles in times of crisis and important events. The participant found herself becoming increasingly frustrated with many of these traditional roles that required her to suppress her feelings and opinions.

In session thirty-two the participant was showing a lot of anger towards her brother. In this session she clearly felt that everyone, particularly her mother, sees her brother as benevolent. She feels that he is un-deserving of this title because he is selfish and oriented towards his own interests. The participant outlined a number of examples of her brother's selfishness. "I send one thousand five hundred rand to my mother each month, he sends four hundred… At the wedding he did the renovations to the house because he could not bear his friends seeing what sort of

house my mother lived in… I have a legacy that [my brother] educated me, actually it was only for one year that he [paid for my fees]". The participant concluded "I need [him] to stop being the mighty [brother] because it is not true. The therapist was aware that beneath these statements the participant carried strong feelings of being unacknowledged for the things that she does for her mother. In spite of what she does her brother is still seen in a more favourable light. "I feel resentment that my mother seems happy that [my brother] is only sending four hundred rand". The therapist was also aware that much of the anger the participant carried towards her brother was born out of the fact that whilst she constantly worked hard to gain the approval of her mother, her brother invoked this approval without even trying. The therapist made this interpretation and it was received well. The participant proceeded to state "He broke down the wall [at my parent's home] that I built with my money… he gave away the gate that I paid for, he built a smarter wall and bought a new gate".

In session thirty-four the participant spoke of a dream that she had experienced. "My cousin and a friend were driving [a car] and were hit by a train. They both died. The funeral was scheduled for eleven that morning. My mother arrived with two bags of apples and one bag of bananas. She was still in her mourning clothes. I went into the main house and found my [dead] cousin with my mother telling her how the accident had happened – he looked his usual self but had a swollen left foot at the big toe. He said they had been driving and when they saw the police they had sped off and then hit a train. He [was trying to escape the police] because he feared going back to prison. I then went to my mother's bedroom and saw my father lying on my mother's bed. He asked me if my mother was still wearing a shawl [which is a sign of respect and mourning for someone who has died]. I then went inside and tried to convince my cousin that he should report himself to the police because this would save him from death". The therapist asked the participant what the dream meant to her. Instead of understanding the dream symbolically she took it literally and stated that it was "the first time I have seen my dad since he has died, he looks like he is fine". The participant also wondered if she should speak to her cousin and warn him that "he is in danger" because she had had a dream about his death. The therapist held the view that perhaps that this dream about death may have something to do with the participant recently learning that her mother was not well. He cautiously held back on this opinion, but was interested to note that the participant then proceeded to discuss her mother's illness and stated that her mother would be coming to Cape Town to see a traditional herbalist that could heal her cancer. At this point the therapist ventured to ask the participant if the dream was in any way related to her mother's illness. The participant replied, "No it is about death but I don't relate it to my mother". She then continued, "I believe in dreams, I take it literally and I will tell my mother that my cousin's life is in danger, I won't tell my cousin because he may think that I am wishing him ill". The therapist

was strongly alerted to the fact that a standard symbolic approach to dream work was not necessarily appropriate to the participant. The possibility that the participant was defending against feelings around her mother's illness was raised at the end of the session when she said "There is a possibility that I am transferring… I might be pushing all my thoughts and feelings into work… re-directing away from other stuff".

In session thirty-five the participant began by saying that she was exhausted and tired. This was strongly related to the fact that she knew her mother was in pain as a result of her illness. "I could hear her crying when she went [to the toilet to urinate], she was in pain… When I got home I cracked, she is going through a lot of stuff alone". The participant then proceeded to discuss the herbalist that her brother had arranged for her mother to see. "I am concerned with the way he conducts her treatment, he is not qualified… he has not done initiation". The therapist was aware that underneath the participant's criticism of herbalist there was some anger towards her brother. She implicitly felt that her mother had taken her brother's side once again. "She says she should have gone to a herbalist sooner, rather than see a medical doctor". "[My brother] has a medical background, I would have thought he wouldn't believe in herbalists…what's new… he is always right". The participant felt that once again her brother was being viewed in a positive light when in fact she was doing all the work. "I don't want to sound like I am complaining but I am spending more time [with my mother] than he is". The participant ended the session by stating that she was also feeling down because her house had been burgled the other night and she had had some stuff taken which was important to her.

In session thirty-six the participant acknowledged that on a conscious level she was trying not to think about her mother's illness, but that on an unconscious level there was some activity. "I haven't had time to think of stuff, I just keep going...[though] I am probably unconsciously thinking about it because of my dreams". The participant then proceeded to relate a dream she had experienced.

"My mother was in the shower, I helped her get in, then I got in with her. I felt something coming out of my vagina, like worms. My mum took them and squashed them into a paste and then wanted to smear them into my vagina, but I had my panties on". The therapist encouraged the participant to describe her understanding of this dream. The participant stated that she thought the worms were a positive sign of her mother's healing. "The worms coming out could be seen as her healing - the infection coming out – it is like healing yourself with the venom". The participant then proceeded to relate another dream. "I was at my sister's church, a neighbour who lives up the street was also at this church. She asked me a question and I answered roughly. She said the

reason you are aggressive is because there is something growing in your womb, when it is out you will be fine". The participant interpreted this dream. "I took this to be the cancer, although she was talking to me, I translated this as a message directed to my mother going through me".

In both dreams the therapist was interested to note that the illness her mother carried was located in the participant. Unresolved anger and her apparent difficulty in dealing with feelings around her father's death, her mother's illness and her anger towards her brother were other possible explanations for the "dream object" growing in her womb. However, it was felt that any interpretation which placed the relevance of these dreams on the participant and her own body would have been unacceptable to her.

The participant spent the remainder of the session talking about her brother. "We all put [my brother] on a pedestal… he actually has faults which we refuse to acknowledge… I have great characteristics that no one acknowledges, particularly my family and my mother. I need them to acknowledge the good things about me and the bad things about my [brother], and treat us fairly". The therapist felt that this insight had been latent for some time and had now come to the surface. She felt that there was a tendency in her family to overlook her good qualities and ignore her brother's bad qualities.

In session thirty-seven the participant said she had been discussing the death of her father with her fiancé. In this session the therapist noted that the participant spoke openly and showed genuine feelings of loss towards her father. She explained that she was sorry that he died before he could come on the holiday to Cape Town with her mother. She was also sad that he had died before her wedding. She explained that she had intended moving to Johannesburg next year so that she could stay with her parents and get to know them better. "I definitely do think about him and regret he died before his holiday, my year there and the wedding". In this session the participant indicated that she was missing her father, "I have been wondering what it was like for him in hospital [before he died], I have been wishing I could turn back the clock". The therapist was aware that this was the first time that the participant had accessed her feelings concerning the death of her father.

In this session she also indicated that she had come to understand that she is jealous of her brother and jealous of the attention that he receives from the family. "I realised the other night that I am jealous of his life, what he has, I resent how he always looks good… he always receives praise, I never get it… he gets the attention of my mother and I have to work hard at it". The therapist realised that this insight represented a breakthrough in the participant's understanding of

the difficulties she experiences in her relationship with her brother. The participant was able to move to a position in this session where she could understand that her need for her mother's attention was a pivotal factor in her jealousy. She stated, "When I was at boarding school my mother never initiated a phone call, she only ever wrote letters, I wasn't at home to get what I needed from my mother, [this is why I still look for her attention]".

In session thirty-eight the participant stated, "I have been feeling light-headed since admitting to myself that I am jealous of my brother, since then I have felt a huge weight lift off my shoulders". In this session the participant was able to adopt a more balanced perspective of her brother and was able to recognise both his strengths and his weaknesses. She was also able to recognise that many of the attributes she complains of in her brother are in fact attributes that she recognises in herself. "He wants high standards… I have this quality as well, just that my standards are not [quite] as high, for instance whereas I would like the house to look clean, he would want his house to have Italian tiles". The participant concluded this session by saying, "it feels good to come out into the open about this".

5) Abstinence.

In session two the participant's detailed description of her purging experience aroused strong feelings in the therapist, who felt that she had been exposed to an abusive process without any regard of her individual needs. The therapist was surprised at her lack of emotional response to this experience. He had to acknowledge the necessity to abstain from comment or interjection. In this session the discrepancy between the culture of the participant and that of the therapist was clearly manifest. The therapist was forced to be aware of the need to question and control his emotional responses.

In session twelve the participant gave a strong account of her feelings of inadequacy and helplessness, particularly in relation to her job. She strongly desired affirmation and support. The therapist abstained from any overt affirmation, though he was keenly aware of her depressed state. The participant ended the session by stating, "people never tell me I have done a great job". The therapist understood this as an unconscious comment against his abstinence.

In session fifteen the participant was discussing her difficulties at work and was implicitly asking her therapist for affirmation in her various work decisions and in her ability. Her need for external validation was manifest in a variety of different ways in this session. "[My fiancé] helped me to see that [my work] can't be as bad as I think… he says that I am not a horrible person to be around". Throughout this session she was attempting to gain overt support and

praise from the therapist. She declared that she felt the therapy process was helping her. "Because of therapy [I am] doing much better". This was seen as an attempt to get reciprocal praise from the therapist. During this session the participant got up and sat on the floor. The therapist asked the participant if she felt more comfortable on the floor. She replied "I feel more grounded and safe". Although she denied that this act was in any way consistent with her cultural background, she did state that in her culture this behaviour was "a sign of respect when greeting an older man, or speaking to adults". The therapist understood this act as a concrete version of the participant's transference need for the therapist to act as a compassionate father figure. He resisted the call to act out the transference role of an idealised supportive father. In doing so he was deliberately preventing premature closure in the transference and was thereby encouraging the participant to engage further with her feelings for her father.

In session twenty-six the participant described feelings of inadequacy, self-doubt and anger regarding a work event she had organised. It became clear that although she was overtly blaming her clients she was also angry with herself and was reluctantly acknowledging her own inability to succeed with this event. "I am sick of convincing people that [my client's project] is a great story. [The client] is hard to sell… I don't think I did a good job at the conference". The therapist realised that the client was looking for reassurance, pity and support from him but he abstained from any emotional feedback. A half hour into the session the participant made a direct appeal for more emotional involvement by saying, "I feel I am not communicating [to you] how horrible it was". The therapist responded that he could understand how difficult this experience had been. The participant then expressed her sense of relief by crying. The therapist recognised that this lapse on his part in abstinence was in fact beneficial rather than unproductive.

In session thirty-three the participant revealed that her mother had been diagnosed with cancer of the uterus. She stated that she had known for over a year but had not thought much about it as her mother had looked very well until recently. The therapist immediately felt compassion towards the participant but refrained from expressing his feelings openly. He said to the participant "This news must be very hard for you especially as you have recently lost your father". The participant replied "The prospect of losing her, I hadn't thought of that, just as with my dad I don't have times when I bawl my eyes out, but I do think of him". The therapist suspected that she was protecting herself from her feelings and mentioned this to her. "This must be a big thing for you, the prospect of losing your parent". She replied, "No not really… I don't feel it is such a big thing the idea of losing my mother, part of me believes my father is somewhere around and if my mother were to die she would be somewhere around". She continued, "I think my approach is quite healthy, in the past I heard my mum say that being in the world is a daily struggle, heaven is

a resting place". The therapist realised that his choice to abstain from showing compassion had been correct. She was clearly not ready to engage with her emotions concerning the imminent loss of her mother. It also occurred to the therapist that his expectations of how she would feel were not necessarily correct. He realised that his own feelings about death and the structures through which he understood death were likely to be different to the participant's. He was therefore faced with two options of enquiry: either the participant was defending herself against painful feelings of imminent loss, or the therapist was imposing his own culturally derived response to death, which differed to the participant's framework of understanding, and was therefore inappropriate. The participant continued to speak of her understanding of death. "When my grandmother died I felt relieved… with my father, I don't feel devastated, I just wonder how he is doing… I guess I am not in touch with death… maybe I don't have the usual ways of dealing with death that society would think is normal".

6) Neutrality.

In session four the participant's discussion of her father's tendencies to aggressive behaviour towards the family after he had been drinking - "he would beat us up, and once ran after my mother with an axe" - was cited as an example of what she feared might be her own tendencies to violence after she drinks. She implicitly stated that her superego needs are opposed to any display of feelings such as anger, conflict or violence. It was clear to the therapist at this stage that her tenuous sense of identity correlated with an underdeveloped ego-strength leaving her vulnerable to unmoderated shifts between superego and id needs. He felt it to be inappropriate to affirm or alleviate her fears by condoning either her superego or her id needs.

In session five the participant again spoke about her strong superego needs in relation to her sense of family obligation. She showed concern on two levels: the first was letting herself down (id impulses over-running her superego needs); with regard to this she described feeling guilty whenever she had a night out, "When I've had fun out with my friends, the next day I feel embarrassed at having exposed myself - it might be the alcohol". Her second concern was letting her family down in terms of her obligations to them, "My mother hates drinking… I used to worry about spending money on alcohol. … If I have a good life, I feel guilty about my family. …My nephew, I worry about him, [about my] not taking care of his future. When things go wrong he will say 'My aunt doesn't care'". The therapist's interpretation of these needs was understood in the cultural context of the participant. He was aware that for an individual in a western-based culture such a strong sense of obligation as described above would not be the norm.

In session thirty the participant provided a factual description of her wedding day. The wedding itself comprised a mixture of traditional and western rites of passage. The participant described how her husband-to-be had been required to bring the last instalment of the "lobola" to her family's house. He then had to cut the throat of a goat and smear its bile on his wife's-to-be ankles and head. This completed the traditional ceremony, which was followed by a western ceremony the next day. The therapist was aware of his own feelings about the ritual slaughtering of a beast but recognised the inappropriacy of these emotions in the cultural context.

In session forty the participant spoke extensively of her "superstitious" beliefs and her feelings towards holding such beliefs. She revealed that she thought the death of her father might have been linked to her marriage. She explained that some people in her community viewed her marriage in a negative light and were jealous of her successes. This information had been given to the participant by the "Witchdoctor" that her family had consulted shortly after her father's death. "I don't understand why he died; the wedding could have been the cause of his death… the Witchdoctor said some people are not happy and are trying to stop the wedding". In this session the participant was able to move to a position of recognising that she held two opinions about such beliefs that were not reconcilable: a western view and her own cultural perspective. "It is difficult for me to believe these superstitions because they are not scientific: I have [this] western view - but another part [of me] believes [in superstition] because my mother believes and always has... people ridicule me when I talk of my African beliefs; [my fiancé] thinks I am ridiculous". She further revealed that a part of her thought that her mother's illness and the recent illnesses of other members of her extended family may also be linked to curses concerning her marriage. Furthermore, she was very hesitant to employ a domestic worker in her home because she was afraid that such a person could "do things to me in my marriage, using witchcraft". Whilst the participant recognised that she could not reach a conclusion on these conflicting sets of beliefs, she was able to say that it felt good to speak about these things to someone as it helped to clarify her thoughts. The therapist was conscious of his own ideological position during this session, but was respectful of her worldview and did not intervene. By maintaining neutrality he allowed the participant to explore the difficulties she experiences when discussing such beliefs in a western setting.

7) Countertranference receptivity.

In session two the participant described the process she had undergone in order to be "purged" of her emotional involvement with a White male. This disclosure was factual with very little emotional content revealed. She described in some detail the various cultural actions and rituals she experienced in the process of being cleansed of what her family regarded as an undesirable

attachment to this young White man. She appeared to make no judgements of the justice or injustice, rights or wrongs of these events but seemed happy to accept them as part of the family norm. Her emotional experience of this process was related most importantly to which of her family members had supported her and which had not. Although fully receptive to emotional input and indeed expectant of emotional content in the participant's description of her purging experience, the therapist was interested that there was very little emotion generated in her reminiscence.

In session thirteen there was a marked shift from previous sessions where the participant had been feeling depressed for some time. In this session she displayed anger at a level that had not been witnessed before. She had been talking about her work frustrations for the last few sessions. In this session she described an incident whereby she had had an argument with a client and her boss had taken the client's side. She was extremely angry and described a dream in which she and her boss had sworn at each other and she had then left her job. "I had a fight with the CEO – he said 'fuck you' and I said 'fuck you too' and I left". The participant then proceeded to talk about her father and her anger towards him. The therapist realised that in discussing the dream she was also speaking about her father. She talked about her father and her mother with the constant theme being that they were unwilling to change from their "old ways", particularly her father. In previous sessions she had spoken of her father in neutral terms but she now showed considerable anger and bitterness, "He was never there [for me and my mother] emotionally and financially, he still isn't". The therapist was also aware that the participant was expressing her frustration at the lack of change in therapy. Her angry feelings towards her father and her boss and their inability to support her were also understood as feelings she held towards the therapy process and the therapist's abstinence.

In session sixteen the therapist got a strong impression of the level of sadness that the participant still carried with regard to her feelings of isolation during her school years. She described the degree of isolation on a variety of levels. She was removed from her family and community support. She initially boarded out with a White family "[It was difficult] staying with people in the suburbs, [I] saw no other kids". She was removed from the familiarities of her own culture and felt very unprepared for many aspects of western culture. "In gym I couldn't do the exercises, I couldn't catch a ball or do gymnastics… I was definitely different". She reflected on the choices she had made including becoming a Catholic and realised that many of her actions had been inspired by a desire to conform rather than being an expression of her innate self. The participant's rendition of her school experience evoked feelings of sadness and regret in the therapist. These feelings were understood as a reflection of how the participant was actually

feeling. It was also clear that these feelings of sadness and regret were in fact what the participant was feeling in her current life, with a perceived lack of support from work, and an emotional distancing from her brother.

The transference needs of the participant were set up through earlier life experiences relating to a strong need for parental approval. As stated in session thirty-one, "I still try to get my mother's approval or praise; if I speak to her and she is not happy, I feel 'what have I done?' ". This dynamic of seeking approval was present in all the participant's relationships and was strongly evident in the therapeutic relationship. The therapist could recognise early in the process the participant's need to be liked and influence him positively in the way in which she adapted to his perceived wants. He felt at times strong pressure to respond with support, advice and affirmation. However, he recognised that if he responded to this transferential pressure, then he would be perpetuating the participant's need for an idealised, supportive parental figure. By abstaining from offering affirmation and direct support, the therapist guided the participant beyond her persona towards her own inner locus of control rather than an external locus.

The participant's transferential needs were on occasion overtly manifested by a series of statements and actions such as her saying in session eight, "at home you don't argue with your parents, you don't ask 'why?' ", and in session nine, "I always bow to the opinion of older people". In session fifteen the participant physically 'elevated' the therapist by sitting on the floor, reflecting a strong need to subordinate herself into a position of dependency. In this instance the therapist was caught between the transferential needs of the participant and his own countertransferential anxiety relating to the breaking of an established ground rule. The therapist reflected later that had he allowed the subject to remain on the floor he would be condoning her dependency behaviour. He also acknowledged that asking her to return to her chair was meeting his own countertransferential fears to not be seen as superior, thus perpetuating Apartheid White-Black stereotypes.

The participant's need to be approved of showed itself through a close adherence to the therapeutic frame in almost all circumstances. Furthermore her own avoidance of conflict and suppression of any anger or other strong 'negative' feelings ensured that the therapy process remained unprovocational and undemanding. The constant need for external validation left the therapist feeling that the therapy lacked the necessary tension required for transformation. By recognising his countertransference in this regard he was able to reflect to the participant her need to neutralise social situations as a way of avoiding challenges to her true self.

At times issues were raised by the participant which evoked personal counterransferential reactions in the therapist. This was particularly evident in relation to dream analysis. In most dreams presented by the participant the therapist recognised that his own interpretation, had it been offered, would have been incorrect. The therapist's framework of dream analysis was for the most part inappropriate. This 'inappropriacy' emphasised cultural differences and forced the therapist to re-evaluate those constructs which he was used to relying on.

Other personal countertransferential factors arose around issues such as social hierarchies, the subordination of women, expectations of providing for family, traditional healing methods, understandings of illness and death, and ritual cultural practices. The therapist's knowledge of cultural practices assisted him in identifying the emotions engendered by these factors and enabled him to contain these emotions.

A strongly-recognised countertransferential response related to the therapist's frustration with the participant's need to maintain persistently a false self rather than show her true self. He used these feelings as a cue to reach an understanding of how necessary this persona was as a defence-mechanism for the participant, "I don't want to confront the real me because I am afraid it is going to be heavy, serious and depressed" (session nine).

8) Resoluteness.

In session three the participant spoke of feelings of anxiety: "[There are] times when I feel like just hiding… I feel I get panic attacks". The therapist explored these symptoms with her and established that she suffers from a free-floating anxiety relating mostly to when her persona was strongly displayed (she did not have clinical panic attacks). The therapist suggested to the participant that the anxiety was in part the result of a discrepancy between her projected persona and her denied inner self. Even after extensive discussion of what was meant by "persona" the participant rejected this interpretation, claiming that, "I don't have a persona. I feel that I have been me. I have been true to myself and true to you". In the therapist's understanding, these statements were so at variance with the participant's previous concerns – for example "when people first meet me they think I'm stunning, then it gets harder" - that he broke out of the analytic attitude and tried to prompt a recognition with the problems associated with the persona by discussing with the participant emotions she might have felt, such as anger, which conflicted with the ideals of her persona. This breakdown in the analytic attitude did not in fact lead to any further insight on the participant's part during this session. Picking up on the suggestion of anger, she responded, "People who drive on the wrong side of road make me angry".

The participant proceeded to talk about dependence and made a series of contradictory statements. "[I am angered that] my partner thinks that I can't do things by myself. … I can't do anything without him, not even exercise unless he is with me. … My mother is dependent on my father… my mother is the strong person in the house". The therapist did not confront the participant with these contradictions as he realised nothing further could be gained. However, in session four she picked up on the theme of anger and although she did not overtly reflect on it she proceeded to discuss her capacity for anger and violence. She was afraid of this trait in herself and claimed that she usually suppressed it, "I don't show my anger at work but when I drink alcohol I worry that I might say what I think". She was not able to relate this loss of inhibition under the influence of alcohol to a loss of the persona, but was able to discuss her emotions, specifically anger, more usefully than in the preceding session. This suggested to the therapist that his breaking of resoluteness, if it had not achieved any furthering of insight, had done no harm. On reflection, the therapist recognised that in the spirit of resoluteness, which encourages the therapist to refrain from directing the therapy process, he had in fact moved out of this stance by prompting the notion of a 'persona'. When the participant challenged this concept the therapist, rather than conceding control, attempted to defend his position by pointing out to the participant that he was giving a name to a pattern of behaviour that the participant had previously made reference to on a number of occasions. The therapist was later able to acknowledge that his own need for an accumulation of insights in the therapy process that paralleled his own theoretical views caused him to prematurely push for an understanding that the participant was resistant to. In doing so he had deviated from an attitude of resolutely accepting that despite contradictions and resistances the participant would ultimately develop her own system of meanings that may or may not follow the trajectory of understanding held by the therapist.

In session nineteen the participant discussed her feelings of insecurity at work, particularly in relation to a new employee. The therapist was aware from the outset that the participant felt threatened by this employee who she feared may see through her persona. She spent a large part of the session rationalising her difficulties with this employee. "She gets on with everyone, but not with me, maybe I am the problem but I have been very open with her". The therapist did not ask her to expand on the possibility that she may be viewing the situation in terms of her own insecurities, rather he allowed her to reach a greater understanding of this issue herself. At the end of the session she was able to recognise that her feelings towards this colleague were in part due to the fact that she felt intellectually inferior and felt that this colleague may see through her, "I won't enter into debate with her because she may win and then expose me and I hate that".

In session twenty-four the participant, without presenting anything new, was recounting material that had been spoken of a number of times previously. The therapist chose to intervene by stating that perhaps her constant return to the matter of her ex-boyfriend suggested that she still carried feelings in this area that she needed to work with. She denied this emphatically. This breaking of resoluteness arose out of the therapist's frustration at the participant's disinclination to engage emotionally with herself during this session. The therapist was aware that these feelings may well have been countertransferential reflecting the participant's own disengagement with herself.

5.6: Individual Case Report for Participant Three

Procedure.

1. Analytic task
2. Analytic setting
3. Analytic process
4. Generative uncertainty
5. Abstinence
6. Neutrality
7. Countertransference receptivity
8. Resoluteness

1) Analytic task.

In session one the participant described a series of significant life events which formed the basis of her reason to come to therapy. She did not overtly outline her hopes for a therapeutic outcome. In this first session she was extremely emotional and used the session as a cathartic space in which she discussed certain traumatic childhood events that she felt had a significant impact on her current psychological functioning. One of the tasks for the therapist implicitly outlined in this session related to the participant's need to establish a sense of belonging and acceptance with her family group. Another task, which was defined in the outset, involved her desire to come to terms with two rape events and a subsequent abortion. This abortion was a family decision that went against the will of the participant. She had not disclosed any of these events before and saw the therapy process as a place where she could safely explore her emotions regarding these events.

In session nine the participant outlined two goals for herself. One was establishing her independence through studying and working; the other gaol was searching for concrete proof of where she had come from and the events and circumstances surrounding her birth and upbringing. This latter task was of exceptional importance to her. "It is terrible to not know who I

am and where I come from, the only person who can end it is me, and I will end it". Part of the concrete steps the participant outlined was to visit the hospital where she was born in an attempt to find out "my real name and date of birth… I don't really know when I was born". She was implicitly indicating a need to find out where she came from before she could comfortably move forward with her life.

The therapist's task was to provide a contained environment for the participant to further elucidate her therapeutic goals. The participant's apparent inability to move beyond the concerns she initially outlined raised questions for the therapist as to whether he was maintaining the correct disposition for the further exploration of such issues. In spite of this, the level of expressed feeling on the part of the participant was very high. The task of providing a safe context for the expression of affect appeared successful. It was interesting to note that in terms of the therapeutic process the participant did in fact eventually move towards adopting different perspectives on these goals.

2) Analytic setting.

From the first session the participant appeared to take for granted the safety of the therapeutic setting. She revealed information to the therapist that she had not disclosed to anyone before. It was interesting to the therapist that in spite of his being an older White male, the participant felt at ease to be open about very personal details from the outset.

In session five the participant surprised the therapist by breaking out of the setting and asking him to intervene directly in her affairs by finding out whether she would be eligible to adopt a child. He replied that it would probably be best if she found out this information herself. This incident caused no disruption and the therapist chose not to discuss overtly this breaking of the treatment frame. In session eight the participant posed a direct question to the therapist concerning her family. "Do you think I am expecting too much out of them?" This question was unexpected and did not arise in relation to a particular issue. He did not answer the question directly, but instead suggested to the participant that she reflect on her communication style with her family.

In session twenty-six the topic of the participant's suicide ideation arose for the second time. Although she denied active suicide ideation, her mentioning the topic was recognised by the therapist as an indication of her current level of despair. He proceeded to reinforce the conditions for safety, thereby containing her.

In session thirty-two the participant arrived late, explaining that she had been mugged on the way by three men. These men had not managed to take any of her 'stuff' as someone in a motor car intervened and they had run off. This represented an instance of the participant's life circumstances intruding into the therapeutic setting, which could not be interpreted within an analytic frame.

In session thirty-five the participant discussed her relationships with men. After her experience of being raped she naturally found it difficult to trust men and stated that she got "edgy quite quickly [around men]". She then went on to discuss her differing feelings towards Black men and White men. "I feel more threatened by Black guys… with White guys I don't feel tension… I feel more relaxed". Regarding the therapeutic relationship the therapist was aware that the participant was indirectly informing him that despite the fact that he was male, she found it easier to trust him because he was White. This was taken up with her and confirmed.

3) Analytic process.

In session three the participant outlined a number of significant themes that she felt very strongly about. An important theme related to her ambivalent feelings concerning her family, particularly her mother. These feelings involved the need to be accepted, loved and supported by the family on the one hand, and resentment at not having these feelings met on the other. She struggled with her sense of identity as a family member and saw the family's dismissal of her as fundamentally undermining her sense of self. Another theme raised was a strong sense of loss and missed opportunity. This was most obvious when she spoke of the baby she had had aborted. "If the baby were here I feel he would comfort me". Other lost opportunities included a sense that she had not been able to get on with her life academically and vocationally because of her lack of a support structure. "Because I have lacked the support in the past, I have not done what I wanted to do". Yet another theme involved feelings of self-blame, worthlessness and depression centring on her belief that her family did not accept her. "I have nowhere to run, I feel trapped, I have no father to run to, I can't go forward and I can't turn back, the only thing I can do is drop dead". These feelings of worthlessness had gone as far as suicide ideation and on one occasion a suicide attempt. Central to and connected to all other themes was her concern with identity; this showed itself on a practical level with concern over discrepancies about her birth date and her family name. It also showed on a more symbolic level where she saw the family's treatment of her as excluding her, seeing her as an outsider. "I tried to ask my mother once… where was I born, what is my real name, I don't even know if this [her surname] is my real name, everything about me is different".

In session four the participant stated clearly that her concerns around identity, feeling unwanted and not belonging were pervasive and obstructive in her life. These feelings were preventing her from moving on both emotionally and physically. "I feel this stays with me and goes everywhere with me, it complicates everything for me".

In session seven the participant was able to acknowledge the possibility that she herself may be contributing to some of the difficulties that she was experiencing with her family. "Maybe I have been too sensitive and this blocks the others from talking to me". She was able to see that she was carrying a set of negative emotions such as anger, aggression and hatred and that "maybe this was keeping others out". She used the metaphor of being locked in a small room to describe her ego defences, "I feel that I am holed up in my own world".

In session eight the participant was exploring the option of moving into her own house. In doing so she felt her family would no longer take her for granted and when they visited she would know that they had come because they wanted to see her. "I think if I get a place of my own, maybe things will be better, I might feel needed because they will miss me when I am not around". The therapist realised that on a symbolic level the participant was exploring the idea of re-defining herself and constructing a sense of identity that was independent of her need to belong to a family.

In session eleven the participant stated clearly that her experience of rape made her distrustful and suspicious of men in circumstances that may be inappropriate.

In session thirteen the participant was feeling overwhelmed and despondent at not being able to find a job. She extrapolated from this claiming that although she tried hard, she always seemed to meet with no success. "My prayers have not been answered". She felt rejected by everyone and tired of fighting her own battles. "I have to be my own role model". She went on to discuss what was in effect several attempts to create a sense of her own identity. She revealed to the therapist that the name he knew her by was a name that she had chosen for herself. "When I chose this name I wanted it to be a new beginning of my life, this would boost my self-confidence". She ended the session by wishing that she had parents who could help her to consolidate her identity and stated "What did I do wrong that made my parents hate me so much?". In session fourteen the participant showed that she was becoming increasingly frustrated with her situation at home. Whilst she still felt disappointed and angry at being let down by her family she was beginning to search for solutions to her predicament. These included looking at ways of improving her self-confidence, thinking positively, showing determination, looking for a job, being independent and

putting her needs first. "I don't want my family's help anymore, I am always worried about the family and [I put] their needs above my own… I believe I can do it - be successful - because I have done it before… I am now reading *The power of positive thinking*… I want to take the 'buts' out of my sentences and I am not going to take 'no' for an answer… somewhere I lost my self-confidence and I want to get all of this back". In this session the participant followed two conflicting themes, one was her ability and desire to be independent, the other was her strong wish for her family's help and support. In the latter she constantly felt disappointed. The therapist realised that statements about independence represented wish statements, and statements about disappointment represented reality statements.

In session fifteen the participant declared that she had found a job. She had chosen not to tell her family. "[I] didn't tell them at home [that] I have a job. Now I must look for a place of my own… if I tell them they will want me to buy groceries". She then proceeded to speak of her relationship, which she had recently ended. "He has been putting pressure on me to sleep with him… I told him not to rush me". The participant was angry and disappointed because she had discovered her boyfriend sleeping with another woman. She extrapolated from this incident by stating that she "is tired of compromising for people" and "she wants to be accepted for who she is". She feels strongly about the fact that sex is not the most important part of a relationship, "most Black men expect you to sleep with them to make a relationship work". In this session the participant was implicitly indicating that she intended to stand up for what she believed in and was no longer going to give in to the needs of others. She appeared to feel empowered by her decision. "I don't need this - I am not going to satisfy his needs". However, she also indicated that she was sad about what had taken place, "It is very painful when you trust someone and they drop you like this". In this session the therapist was aware that her decision to leave home and leave her boyfriend was strongly related to her newfound sense of empowerment at finding a job.

In session twenty-five the participant discussed her relationship with her mother on the level of trans-actions concerning money and material possessions. The therapist was aware that such transactions represented a metaphor for emotional transactions. The participant stated, "She takes but gives nothing back, even something that costs nothing - love… I have to buy her love". In this session she indicated that she was determined to confront her mother once and for all. "I am going to tell her I am sick and tired of her attitude and behaviour to me, I have let her get away with things so often, this time I will not let her get away with it… she will be angry but I do not care about her feelings, she has hurt me so much… I think I must worry about *my* feelings now". In these statements she showed a high level of self-determination, moving away from a position of passivity towards a more active stance regarding her relationship with her mother. She

indicated that the direction of this relationship was to be more in line with her own choices, rather than her mother's choices. The participant ended this session by resolving to go home immediately to speak to her mother.

In session twenty-seven the participant spoke of friends she had recently made and how much support she had received from these friendships. She indicated that she was more open to communicating her feelings and seeking out support from friends. "[My new friend] understands me, there's nothing I wouldn't tell her". She discussed plans for Christmas and instead of putting herself into a position of potential disappointment with her family she was planning to keep herself active at work. This was noted as a proactive choice. However, despite these positive steps towards helping herself it was clear that her sense of loneliness and need for support was becoming increasingly strong as was evidenced by her effort to make friends and through her reiteration of suicide themes.

In session thirty-five the participant spoke of her efforts to meet her need for support by extending her friendship circle and actively participating in a church. She discussed in particular her relations with men. "I am trying to face my fear of being around men". She described how she had recently been able to tell a particular male that she was not interested in a relationship with him. The therapist noted that confrontation of this sort was something that the participant had struggled with previously.

In session thirty-eight the participant stated that she was feeling well and in good spirits. "I am feeling strong, I am beginning to regain my self-confidence that I lost". The participant indicated that she was coming to terms with her issues concerning her mother. "I have finally accepted the fact that I don't have a parent… I really feel that I have learnt to accept this… it makes me feel that everyone around me is my friend, I am beginning to see that there is more to life than where I was, isolated and locking myself away with nowhere to go and no-one to talk to, now there are other things to live for". The participant proceeded to explain that she had previously been reticent and un-disclosing about her feelings. "In the past I didn't have many friends, I thought they would laugh at me if I told them my problems, my story". The therapist was aware of a marked change that had occurred without any obvious precipitant. She was looking more towards the future than her past and appeared positive in spite of the fact that she had recently been told the restaurant she worked at might be closing down, "If the place closes I am afraid to lose the position, I have a lot to learn". The therapist recognised that there had been a definite shift in the patient. She stated, "I never enjoyed my childhood, I had to be an adult before I was even a teenager. I need to enjoy my life now, because I was not able to then. I need to go out on dates,

see my friends, laugh and enjoy seeing the sunshine on the mountain, go away for a long weekend… I want to feel free, I want to be a woman who is free".

In session thirty-nine the participant indicated that the restaurant she worked at would not be closing, this news made her feel "more secure". The shift evidenced in session thirty-eight was strongly apparent in this session. The participant spoke of how she had made friends and was going out and "having fun". She also described that she felt more confident with people. "I can speak out, not as shy anymore… I can start a topic on my own, not just answer questions like I did in the past, now I can open up a topic and talk about it, I have more confidence". The participant explained that she felt a lot more positive about life and was no longer feeling depressed. "I have had to go through so much, I now feel I am a totally different person to a year ago where I didn't want to exist anymore, I am thankful that I did not end my life [then], I am pleased that someone showed me there was more to life than sitting on your hands and feeling sorry for yourself". The therapist felt that the participant held a balanced view towards some of the issues that had previously caused her intense distress. This was particularly evident in her statement "[When I go to the place of my birth] I hope that I will find out who I really am, if I don't find out then I will have to let it go". A balanced perspective was also evident in her view of herself. "I am a nice down-to earth person but I am also a bad person because if someone does something to me that is hurtful then I get angry. There is a lot in me that I never knew, I have a lot of skills and capabilities I never knew I had… this makes me feel stronger every day". The participant ended the session by stating that "Life is beginning to make sense to me, it is more in my control. I still feel guilty about aborting my baby, but maybe I would not be the person I am now if this had not happened".

4) Generative uncertainty.

In session four the participant's neurotic certainty was amply displayed through the fixed belief that her family members disliked and rejected her. "My sister does not like me at all. I proved it this weekend, everyone was concerned about me - she was looking at me like I am a stranger to her". She described meeting her father for the first time in 1994 and how she immediately came to the conclusion that he disliked her, "When he was told who I was he said 'Oh ok' with a low voice like he was fed up about the whole thing". She rationalised her family's perceived dislike of her by assuming that she was the result of an adulterous relationship and was to blame for the break-up of her parents' marriage. The participant tended to blame herself for all the familial emotional disturbances; she idealised the relationships between other family members and saw herself as the cause of all discord. "My father didn't even come to his son's *amakwetha*, I think it was an excuse for him not to see me". The therapist did not challenge this neurotic certainty but

allowed the participant to hold these feelings. She eventually moved towards a recognition that she did in some ways hold herself aloof from the family because "I don't feel I belong, I am not quite open to them".

In session five the participant's certainty that she lived in a world where things were constantly taken from her was well demonstrated. She revealed that she felt she had lost her teenage years as a result of her childhood rape experience. "Every time I see [my brother], I see him as a stranger who interrupted my whole life, I never enjoyed my teenage hood - I do blame him for all of this". She also felt that her attempt to study had been thwarted by her circumstances. "I couldn't afford to pay [the] fees". Her abortion and subsequent inability to have a child was another example of how she felt something had been taken from her. In this session the participant explained how she had constantly given up things and sacrificed herself for the benefit of others, such as paying for her brother's circumcision and bringing up her sister's children. For all of this she felt she had received only ingratitude in return. "They take me for granted… I gave up so much for them but have only been disappointed".

In session twelve the participant spoke of her family in very negative terms. She described how they take her money, her food, deliberately wish her ill and spoil everything for her. In response to this perceived malice from her family she had chosen to keep many of her thoughts and activities secret. The therapist's general impression from her description of her family was that there was an element of extreme thinking and magical thinking. "I believe there is a spell that comes from [the family house]… whilst I am living there everything I want does not work out". Her pre-occupation with not communicating clearly with her family was reflected in the discourse of the session itself, which was unclear and at times hard to follow.

In session fourteen the participant described how her sister had made her a financial offer and then withdrawn it. She was very disappointed and angry. This offer involved looking after her sister's child on a full-time basis. After agreeing to this her sister then told her that she had decided to put her child in a crèche. "I feel totally disappointed, I don't want my sister's sympathy… It is that fact that destroys me most, they use me for what they want". The participant extrapolated from this event to other disappointments that she had experienced from her family. She stated that her mother is not brave enough to stand up for her and say, "She is my flesh and blood". She then moved on to talk of how she felt she had been a disappointment to her aunt who had raised her. She explained that she had not contacted this aunt after she moved to Cape Town because she was trying hard to fit in with her new family, "I had never written to her or visited her or attended her funeral… I feel I disappointed her a great deal, maybe she got sick

because she was so disappointed in me". This theme of disappointment that was so prevalent in the participant's life was strongly expressed in this session. The therapist raised this point by stating that he could see that she felt a great deal of disappointment towards her family and towards herself. The participant responded by demonstrating her certainty that her family repeatedly lets her down and does not care about her: "I always thought families stood up for each other, I am disappointed".

In session sixteen the participant stated that she now had a job and had left home. She was staying with her cousin close to her workplace. She had explained this move to her family by stating "I am moving to [another part of the city] because this is where I want my life to be… I did not tell them I have a job". This issue of non-communication about choices and feelings arose several times in the session: the participant stated that her family was not communicating with her; she was unable to communicate well with the cousin she was staying with; and her ex-boyfriend had told her that he had become frustrated with her because she does not communicate her feelings with him. The therapist did not intervene although he was strongly aware that the events she outlined and the consequent difficulties that ensued were in part due to her poor communication and expression of her needs to those involved. She then moved towards a position where she was able to say, "maybe [my relationship did not work] because of not talking, not communicating, this may have also have been part of the problem… he wanted to know more about me and I found it hard to talk, [I] feared rejection as I was too ashamed, I didn't tell him about the rape and abuse… he may have felt I was too closed". In this session the participant was able to recognise that her relationships are obstructed by the fact that she carries a lot of painful feelings inside herself, which she finds difficult to communicate. "Getting involved means telling him about the rape, but then he might leave me… this whole thing is blocking my way to happiness… I don't know when and how I am going to tell people about this".

In session eighteen the participant described with conviction that since moving away from home she no longer "existed" for her family. "None of them have bothered to phone me". In her new home she felt isolated and in strong need of guidance and maternal support. The therapist noted that the participant's use of the term "mother" comprised a collection of ideals and virtues, which she felt a mother should embody. She discussed her own mother in terms of this ideal and indicated that she failed to meet these standards. However, her deceased aunt was described in far more positive terms. "I don't miss my mother at all… I do think about my aunt a lot… when I had an argument with my manager [at work], my aunt would have told me what to do". She reinforced the sense of failure she felt in her own mother by stating "My so-called mother said she wanted me to live with her because she missed me and wanted to bond with me… if I had

known that this is what she meant by bonding, I would never have agreed and would have stayed with my aunt".

In session nineteen the participant described the circumstances surrounding her resignation from one of her jobs as a waitress. She discussed a series of conflicts with her manager and quoted him as saying "It doesn't look like you want this position". It was clear to the therapist that in fact the participant did not want this job but was unable to recognise this. Instead she used a series of strategies - such as arriving late - to provoke the management into behaving in negative ways and therefore justifying her decision to leave. She was thus confidently able to externalise the blame for resigning from her job and affirm the certainty that she was a victim.

In session twenty-four the participant described that her mother had contacted her and was showing a lot of concern for her. The therapist noted that this was the first report of the participant's mother making a positive and compassionate step towards the participant. However, she rejected this impulse from her mother and instead of feeling pleased at this gesture she felt suspicious. "She said 'I miss you', but I think she misses using me, she misses taking over my life… All of a sudden she misses me, why? - because I think she definitely needs something from me". The therapist recognised in this session that the participant's lack of faith in her mother and the underlying belief that "she really did not care" was profound. When the therapist intervened and asked her if she felt there was anything genuine in her mother's statements, she explained that her mother had then proceeded to ask "When are you getting a new cell phone so that I can have your old one". Clearly the participant could not accept any truth in her mother's stated concern for her.

In session twenty-eight the participant focused on the belief that if she were to find out the truth of her origins, then everything will be different. Instead of pursuing her mother for an answer she shifted her quest towards her father and the issues she would like to discuss with him. Although she retained the certainty that her mother had rejected her because she had been the cause of the family break-up, she was able to explore new means to ascertain the truth rather than remaining focused on her mother. "I want to meet the man that is supposed to be my father. I think he might know something that can help me move on with my life".

In session thirty-three the participant spoke of how she felt let down by her male manager at work and a male friend. She felt disappointed by her manager because after applying for an advertised managerial job at her workplace the position had been given to someone else. She felt of her male friend that "I don't trust him, I think he just wants to sleep with me". The participant conceded, "I

am developing a problem of being edgy and irritated around males". With regard to her job the participant felt that after showing so much loyalty to the company she should have been considered for the position. Whilst the therapist understood the legitimacy of her complaints he was also aware that the participant's fundamental belief that "men are untrustworthy" was likely to impinge on all her relations with men because she felt she had never had the experience of a positive male role model. The therapist was aware of her belief that all the men in her life had abused her in one way or another.

In session thirty-seven the participant spoke of "letting go and moving on" from her family. The therapist noted that she understood "moving on" as closing off the past, "I don't want to go back there again [to my mother's house]… I feel I have moved on". In spite of this statement the therapist was aware that she experienced extreme difficulty with letting go of the feelings from her past. However, he did note in this session that she was not emotional when she discussed the topic and mentioned this observation to her. She replied, "I am coming to terms with it [the perceived abandonment], hence I am not so upset anymore". Whilst the therapist was aware that re-visiting these emotions in therapy was a necessary part of her healing process he was also respected the fact that she carried a strong certainty that concrete proof of her identity was necessary before she could move on. The participant explained that she had made arrangement with her work to give her time off to visit the place where she was born. "My aunt's sister-in-law still lives there, I think she will know something".

In session forty the participant returned to the fixed belief that her family have never cared about her and she therefore felt justified in cutting ties with them. She substantiated this decision by providing an example of how they had treated her after she was admitted to hospital in September 2001 for an overdose. "I remember when I was in hospital my sister phoned me and was angry… she blamed me saying that I was trying to kill my mother by [giving her] a heart attack… she should not have harassed me and shouted at me when I was still in the hospital bed… they showed me they don't care". It was clear to the therapist that the participant had always had tremendous difficulty in expressing her feelings to her family. Through attempting suicide she was trying to communicate the extent of her unhappiness. Similarly by moving away from home she was also trying to express her unhappiness. The therapist observed that she was attempting to explore new and more effective ways of communicating her feelings. "I think I should write a letter to my mother and tell her what I feel about all of this, about the way they have treated me".

5) Abstinence.

In session one the therapist realised immediately that the participant required a lot of emotional support. The therapist needed to show appropriate sympathy in the face of extreme emotional disclosures, but simultaneously recognised the importance of not playing into the participant's desire for unconditional emotional support.

In session thirty-four the participant described receiving a visit from her sister and her mother and the negative feelings she carried about this visit. In fact she described in some detail her efforts to avoid meeting her family such as not answering her phone, being away from home, and asking her cousin to lie to her family of her whereabouts. The therapist felt surprised that after frequently mentioning how much she wished her mother would visit her, she should be so evasive and negative. The therapist was aware of his own feelings of sadness at the fact that each time the participant's family did meet her needs she was dissatisfied and felt it was not enough. He found himself wondering if it would ever be possible for the participant to feel satisfied and made happy by her family. He in some ways felt tempted to confront her on her inability to acknowledge her family's efforts and her tendency to constantly "move the goal posts". However, he chose not to express these feelings as he knew that she would perceive this intervention as a judgement rather than an expression of concern. He realised that such a confrontation would damage the therapeutic relationship greatly.

In session thirty-six the participant raised three themes that she often referred to. The first was how she feels people take advantage of her, the second was her desire to be more independent and the third was her belief that life would have been considerably easier for her if she had had a supportive mother. The therapist was inclined to point out to the participant that these three themes often arose in her sessions. He chose to abstain from intervening as he realised that each time she returned to such themes she tended to explore them from a slightly different angle. By his abstaining from interrupting the flow of the session each theme was discussed a different way to how the participant had previously discussed them. On the theme of being taken advantage of she spoke of how she had previously given advice to her brother's girlfriend. At the time this girlfriend had not taken her advice. The participant felt that she was not obliged to help her now because she had not listened to her advice. "She never took my advice so I refuse to help her… she is now asking for money". On the theme of independence the participant spoke of moving out of the "shack" in which she was staying and building her own house in a better area. "I want to find my own place and have my own space… I have applied for a number and a site". On the theme of feeling unsupported by her mother she related a story she had seen on television of a young girl who became a prostitute because her mother had "kicked her out" of the home. The

participant identified with this story and stated, "I also had chances to be a prostitute but this would have ruined my life and my dignity".

6) Neutrality.

In session five the participant was speaking of her rape experiences, with particular reference to the sexual abuse by her brother. She discussed this issue in terms of her cultural milieu, suggesting that incest was not explicitly condemned in her culture because people tended to ignore it rather than punish it. She cited a young woman she knew who appeared to be proud to be carrying her father's child, whereas the participant stated she personally would feel ashamed. The therapist found it difficult to accept this view knowing that incest exists as one of the strongest taboos across all cultures. He doubted therefore that her culture was as accepting as she indicated. These views remained a part of his internal dialogue and were not expressed. However, he attempted to understand why the participant needed to hold this rather negative view of her culture. It represented for him another example of her alienation and subsequent resentment against her family, community and culture.

In session six the therapist noted to himself that most of the participant's descriptions of her life came to the same outcome: that is, she was an innocent victim, the scapegoat for her family, yet the only one who really cared for her mother. Whilst the therapist acknowledged that the participant had substantial grounds for seeing herself as a victim in many of her life circumstances, he was also aware that there was an unconscious need to see herself in this way. This awareness had to be held against his initial feelings of pity and sympathy for her which he knew it would be inappropriate to express.

The therapist felt in session twenty-two that the steps the participant had taken towards achieving her goals of being independent from her family such as having a secure job, increased feelings of self-worth, and successfully completing a computer course were insignificant compared to her ongoing feelings of rejection and disappointment regarding her family. In fact it appeared that as she made practical gains towards independence so her feelings towards her family became more extreme and less rational. "I want to scratch them out of my life… I want to change my surname… they try to ruin everything for me… [my mother] deserted me: this is one thing, but burying me alive is another thing". In this session the therapist found himself engaging internally with the prospect that perhaps the participant's incapacity to let go of these feelings was driven by her fear of what lay beyond. By letting go of this painful yet familiar perception of herself as a victim she would have to re-define herself in ways that may appear even more daunting than the suffering she currently experienced in this "victim" position.

In session twenty-three the participant explained that she was becoming increasingly dissatisfied with her place of employment, "I trusted the company but their promises have come to nothing… I want to move out of there". The therapist was aware that this statement echoed previous sentiments about her family. The therapist monitored his own internal understanding that the participant unconsciously and repeatedly places herself in situations that confirm her view of herself as being unfairly treated, "When I put my hopes up for something it always goes wrong".

In session twenty-six the participant discussed her disappointment at her family's request for financial support. She resented these requests and judged a number of the family's acts of concern as being motivated by a desire for financial assistance from her. "I will only help [my family members] when I choose to, not when my mother wants me to". In this session the therapist registered a strong emphasis on the concepts of "giving" and "taking" in relation to material possessions and resources. The therapist was aware of the complex nature of this metaphor but chose not to encourage the participant into explaining it more deeply in this session.

In session twenty-nine the participant raised the issue of her unsettled emotions regarding her aunt and her need to expiate these feelings. She proposed visiting her aunt's grave, slaughtering a goat to ask for her aunt's forgiveness and having a tombstone erected. She then indicated that after doing these things "my money will be short so I won't be able to do my management course just yet". She had previously seen this course as a very important goal. The therapist was initially surprised at her readiness to postpone her studies. After questioning these priorities internally the therapist came to the conclusion that there were two possible explanations. One explanation was that the participant needed to enact certain rituals and sacrifices before she could move on. The other explanation was that the participant was using self-imposed family obligations as a rationalisation to avoid her own success and subsequent transformation. The therapist also realised that part of the difficulty he experienced in this session was due to the complexity of cultural factors involved.

7) Countertransference receptivity.

In session one the participant began immediately on a very intense emotional level. The therapist was aware that feelings of distress, pity and fear in himself were a reflection of the participant's own inner feelings. He found it difficult to contain these feelings and stop himself from making over-involved gestures of compassion. By abstaining from any overt expression of emotion, he allowed the session to unfold without obstructing the participant's obvious need for catharsis.

In session six the participant described her relationship with her family members, particularly with her mother, her brother and her Aunt. In this session the therapist had the sense of a series of sub-texts which were disordered and confusing. He felt compelled to ask questions to clarify the participant's recitation of events and emotions but on those occasions when he did ask questions they did not prove to be helpful. He was left feeling confused and aware that many questions were left unanswered or were not answered clearly. It became clear that the therapist's own feelings of confusion were a direct reflection of the participant's state of mind. She constantly referred to secrets, believing that her family was deliberately withholding information from her. The unanswered questions, unclear answers and feelings of confusion felt by the therapist were precisely what the participant was feeling in relation to her family.

In session ten the therapist was aware of his own feelings of sadness whilst listening to the participant's account of her missed opportunities in life and her unfulfilled dreams. "I once thought of going overseas to study then come back to South Africa, now it is too late, I wanted to expose myself to other people, other religions, but now it is all too late and not one of these dreams has come true". The therapist was aware from his perspective that twenty-seven was by no means too old to achieve her goals. However, the participant made it clear that from the perspective of her culture she should "be looking after [and providing financially] for parents and her family". She was also expected to have established herself as a wife and a worker. At the end of the session the therapist felt strongly in touch with her disappointment at her life and the depth of her sadness.

In session twelve the participant spoke for the first time of her relationship with a young man. The participant described this relationship as "caring", "supportive" and uncritical". However, she also described feelings of disquiet and a general suspicion of this man's motives for spending time with her. The therapist was alerted to the possibility that these statements may reflect an unconscious description of her feelings surrounding the therapy process. The transference element of this communication was particularly evident in the participant's statement "I am afraid to fall in love, in case he rejects me".

In session twenty the therapist listened to the participant describe her feelings towards her family in ways similar to many previous accounts. The therapist had a sense of tiredness and frustration as the participant was speaking. Many of her statements were re-workings of previous discussions, reflecting her difficulty in letting go and moving on from the issues that disturbed her when she first came to therapy such as, "What made [my mother] give me away? Previously I had wanted to know [but] I don't really want to know because it hurts too much". In this session,

however, she showed a strong awareness of how these concerns were blocking her from moving forward. The therapist recognised that his feelings of tiredness and frustration were introjections of the participant's own sense of exasperation at being caught in the same emotional difficulties that she had been experiencing before. The therapist also became aware that her repeated attempts to find answers to questions that would confirm a sense of belonging to her family, her family name and her birth date, were also attempts to establish a sense of her own identity.

In session thirty-two the participant reported that she had been mugged on her way to her session. The participant was shaken and the therapist encouraged her to speak of what had happened. Instead of referring to the mugging incident the participant began to discuss how her family constantly excluded her and used her. She was allowed to have nothing of her own, not even a child. "I have always been excluded… [my mother] has been trying for so long to drive me away". She proceeded to speak of the abortion that her mother had insisted on after she had been raped. "She made me raise other children but made me get an abortion". In this session the therapist felt strongly that the concept of "mugging" that the participant referred to went far beyond the events of the day. He felt that the participant was in fact referring to how she felt generally in her life. The concept of "being mugged" therefore represented a metaphor for how she felt she had been taken "advantage of", "used", and "victimised" by her family, particularly her mother. The therapist made this interpretation and she responded "I feel they [my family] have taken serious advantage of me… this mugging today it is the same feeling as me being against the world and battling: this idea was reinforced today".

The participant's overriding transferential need arose out her perception of herself as a victim. She constantly dwelt on the image of herself as alienated, disconnected, discarded and abused by family members, employers and others. Her account of her profoundly traumatic past provoked a feeling of sustained pity in the therapist. By taking note of the intensity of his own feelings, the therapist was able to gauge the intensity of the participant's need for support and belonging. This dynamic was central to the participant's account of her life, which was principally organised around unrelenting efforts to establish a sense of connectedness and love with her family of origin. This strong need for connectedness showed itself in the transferential relationship, and presented a challenge to the therapist's maintenance of abstinence. Modifying his position of abstinence raised countertransference anxieties in the therapist around maintaining the principles of the analytic attitude on the one hand and a need to be sympathetic on the other hand. The therapist understood that supporting the participant's victim position would be counter-therapeutic in that it would perpetuate her focus on the past, deflecting her from an awareness of opportunities and responsibilities in the present and future. However, he was also aware that not

responding to the call for sympathy would impact negatively on the therapeutic alliance. The therapist needed to strike a balance between these conflicting countertransference needs.

The pressure to adapt the attitude of abstinence by offering sympathy and support beyond the established frame of therapy had shown itself with all three participants but was most obvious with participant three. In effect this participant was demanding a therapy process more appropriate to crisis management, asking the therapist to intervene at this level in most sessions. In fact the therapist found in his own countertransference the question or suspicion that this high degree of emotional intensity was deliberately used by the participant to elicit help and that culturally she was imbued with the belief that emotional pain should be actively demonstrated.

The therapist developed strong feelings towards the participant's inability to let go of her past and the neurotic certainty that "people do not care". She repeatedly returned to the same theme in her sessions and would often begin a session by saying that "my family does not care about me". The therapist was able to recognise that his feeling of frustration was in part related to transference pressure and in part related to his own personal value attached to a desire for progress. At times it felt to him that in each progressive session the subject had lost the insights gained in previous sessions and was starting from the beginning again. By utilising the principles of generative uncertainty and resoluteness the therapist was able to negotiate his countertransference feelings raised by this transference pressure. Furthermore, by identifying his own personal countertransference need for progress he was in a better position to understand and contain his feelings of frustration.

Personal countertransference feelings related to incest, rape, abuse, abortion, neglect, family disintegration, material expectations from family members and other issues. As the participant discussed in session sixteen, she was raped at the age of eight by her brother and again at 16 years by a neighbour. In both instances the family and community response was to ignore the issue. The participant became pregnant after the second incident; the family forced her to have this child aborted. She is subsequently physically incapable of having children. She also has extreme difficulty in dealing with trust and intimacy in her relationships with men. The therapist felt strongly about the injustice which the participant had suffered. A myriad of personal feelings arose in the therapist relating to his recognition of the participant having had her individual rights grossly violated. The therapist felt that these series of incidences highlighted the oppression to which the participant as a woman was subject in a patriarchal society and conflicted with his own desire to accept cultural differences.

Other cultural beliefs such as superstition the therapist was better prepared for and he did not feel that these conflicted with his beliefs about individual rights. In session twenty-nine the participant suggested slaughtering a goat and erecting a tombstone as a means of seeking forgiveness from her dead aunt. Whilst the practice of slaughtering a goat was disquieting to the therapist, the ritual process described by the participant was one with which he could identify in terms of closure.

8) Resoluteness.

In session eight the participant returned to the sub-text of "feeling unwanted and not belonging to a family". She mentioned her brother, her mother and her sisters in rapid succession. She said she was happy because her brother had left the house. She stated that she had realised she would never get on with her mother. She was getting on better with her sisters, but still felt marginalized. All these were statements that tempted the therapist to explore the logic further. However, he began to realise that what the participant was essentially trying to relate was her profound sense of alienation and incompleteness. "I [will] always feel there is a big part of me missing with [my] family and a part of them that is missing from me" and "At times I just feel that I am nobody, I don't belong anywhere". By not attempting to search for logical connections in her descriptions, the therapist was able to access more strongly than before her profound sense of "incompleteness" than in previous sessions.

In session nineteen the participant regressed to themes discussed in the first few sessions. "This is something that I will have to live with - that [my family] does not care". The therapist's resoluteness allowed for the understanding to emerge, on the part of the participant, that her new-found sense of independence gained through moving away from her family had in fact not brought her the relief she expected and had not solved her problems. This regression to earlier themes was understood in terms of the participant's current feelings of loneliness and isolation.

In session twenty-one the participant displayed a great deal of anger and hurt at her mother's perceived indifference to her since she left home. "It is about one month now that I have not seen her, she has not phoned at all". The therapist was aware that the participant's anger towards her mother arose out of the fact that her manoeuvre to evoke a feeling response from her mother [moving out of home] had been unsuccessful. However, the therapist saw this escalation in emotionality as a positive catalyst aiding movement towards a resolution on her issues concerning her mother. The therapist realised that the participant needed to endure a return to these perennial themes and associated feelings in order to negotiate a resolution.

In session thirty-one the participant was able for the first time to articulate the fact that while her decision to move away from home was in part an act of independence, it was in fact more to do with the hope that the move would generate a response from her mother. She was hoping that she would miss her and ask her to return. This response from her mother would be for the participant more of an achievement than any achievement she gained towards independence. "During this time of absence I was secretly hoping that she would hunt me down to see how I am doing… I prayed that one day she would come around". The participant then returned to the theme of how her mother abandoned her as a child. "She dumped me, I never received any letter from her that is why I thought my aunt was my mother". She then proceeded to focus on other themes such as "I wish she would just say that she didn't want me, at least I would be able to live with this… maybe I need to come to terms with the fact that she doesn't care for me". In this session the therapist was acutely aware that the participant was emotionally stuck and found it exceptionally difficult to move beyond the certainty that her mother "did not care". Whilst the therapist found himself feeling frustrated at her repeated return to these themes he also recognised that this experience of "being stuck" in this session was a direct reflection of her general emotional immobility in her relationship with her mother. The therapist exercised an attitude of resoluteness in his understanding that repeated returns to these themes was the only possible way that she could ultimately come to terms with her feelings in this regard.

CHAPTER SIX: CROSS CASE ANALYSIS

Combined Cross Case Report for Three Participants

In this section material drawn from the individual case reports is condensed into a combined cross case report. This material is organised under the eight elements of the analytic attitude. To assist the reader each element is introduced with a brief preamble that outlines the main features of the element under study. In order to ensure that the cross case report adhered closely to these central features the researcher found it useful to generate a set of criteria. The researcher used these criteria to guide the data collection; they also acted as a reading guide to assist the researcher when organising the data under a set of more appropriate headings for the cross case report that were able to capture the process.

6.1: Analytic Task

The analytic task refers to the therapist's capacity to establish a therapeutic relationship and environment in which the participant is able to feel sufficiently safe and at ease in order to venture into thoughts and feelings that would generally be avoided outside the therapeutic frame. It is the therapist's task to facilitate a context of symbolic relating that encourages insight into actions, thoughts, behaviours and feelings. The aim is to assist the participant towards gradually developing into ego consciousness those understandings that were previously unacceptable to the ego and therefore repressed, denied, rationalised or projected. This process is facilitated through the therapist's recognition of the participant's transference needs and his gradually making the participant aware that her experience of the therapist represents a re-creation of earlier life experiences. By re-working conscious rationalisations and recovering projections the participant is gradually able to acknowledge and take ownership of material that was previously disowned. Such understandings are generally ego-dystonic and their emergence into consciousness is often painful and slow, moving only at a pace that the participant is able to bear. Greater conscious awareness does not necessarily imply the alleviation of symptoms; however, it creates choices that were not present before acknowledgement. As the participant re-authors her conscious understanding of herself and endures the associated emotionality of holding material that was previously unacknowledged, so change occurs.

Criteria used to judge the effectiveness of the analytic task.

1. To what extent was the therapist able to establish a relationship and an environment conducive to analytic exploration within the technical and ideological parameters of the analytic attitude.

2. To what extent were participants able to use the analytic space created by the therapist and to what extent were they able to appreciate the symbolic nature of this space as being a transferential re-creation of formative styles and responses set up in earlier life.

3. To what extent were participants able to reach an understanding of the unconscious motivations for their symptoms.

4. To what extent were the therapist and the participants able to maintain a commitment to the therapeutic task of thinking and speaking of feelings.

Participants' responsiveness to the use of the analytic task.

The analytic task involves creating a specific type of relationship and way of communicating that is different to everyday relating. All three participants entered into this relationship with some understanding of the issues that they wanted to focus on. By outlining issues and expectations, each participant was implicitly indicating that she was aware of some difference between a therapeutic relationship and an everyday relationship. Participant One identified relationship issues, feelings of depression and feelings of being let down by her family and by her boyfriends as her central concerns. Participant Two identified the need to understand herself better. Her central concerns involved interpersonal difficulties and a strong need to be accepted. Participant Three was able to recognise the impact of earlier traumatic events on her current level of emotional functioning, as well as a strong need to establish her identity and to gain a sense of belonging. All three participants accepted that the therapeutic process would involve speaking of painful feelings and memories as well as difficulties with daily life. They indicated that they were aware that the therapeutic relationship constituted a place where they could disclose thoughts and feelings about personal concerns that were previously undisclosed. They all saw the process of psychotherapy as a place to explore their issues and were not asking for specific outcomes or answers to their problems. Throughout the course of therapy all three returned to their central concerns monitoring the feelings and changes that they felt had taken place. In this sense it was felt that there was no strong adverse reaction or any sense of discomfort concerning the therapeutic task. In fact all three participants seemed to fit into the therapeutic space created by the therapist with relative ease.

Difficulties encountered in the use of the analytic task.

Self-reflection, symbolic relating and the process of recognising that many of the dramas in the objective world were in fact reflections of internal unconscious conflicts was slow. Insight into such conflicts was often thwarted by the participants' need to remain with objective events. In this sense the therapeutic task of facilitating insight into unconscious processes was hampered by the need to remain with the literal and external rather than the internal. However, progression in this regard was noted for all three participants. Each participant showed an initial tendency to externalise, blame and remain on the level of the concrete. Participant One often described her emotional distress in terms of headaches and other ailments and saw the source of her difficulties as being located in her colleagues, friends, family and boyfriends. Participant Two's attempts to organise and consolidate her identity were described in terms of the interpersonal difficulties that she experienced, particularly with her family. Participant Three blamed her family entirely for her unhappiness. However, all three gradually moved towards a more internal understanding of the part they themselves played in contributing to the difficulties that they experienced. This was largely facilitated through the transference dimension of the therapeutic relationship. By encouraging the participants to focus on the here-and-now the therapist was able to assist them in recognising that current dynamics and feelings arising in the therapeutic relationship were in fact reflections of formative relationships.

Increased conscious insight into behaviour and feelings was often painful and difficult to bear for long. Participant One vacillated between seeing herself as "the problem" to seeing others as the problem. Participant Two felt angry at herself when recognising that she relied strongly on her persona to cope with day-to-day situations. Participant Three found it difficult to acknowledge that behind her anger towards her family there was an intense need to be accepted and loved by them. However, as the participants gained a greater insight into themselves through the transferential process in the here-and-now, they were able to re-evaluate dysfunctional beliefs which were previously entrenched. Participant One learnt that her issues of trust and rejection played out in the therapeutic relationship derived from her childhood experience. She was able to acknowledge that "I feel fully responsible for everything that is happening". Participant Two learnt that her need to be liked by the therapist derived from her need for love and connectedness with her family of origin. She later realised that her anger towards her brother arose out of a jealousy that he had achieved the acceptance from her family that she strongly desired. Participant Three moved more slowly in this regard. However, she was gradually able to recognise in the here-and-now that her expectations from the therapist of sympathy and care were in fact needs she desired to be fulfilled by her family. She was ultimately able to recognise that

her inability to express her needs to her family was the basis for much misinterpretation and subsequent distress on her part.

Adaptations used by the therapist in maintaining the analytic task.

The therapist found himself deliberately drawing participants away from the literal world towards their subjective worlds. By locating the source of difficulty within rather than without it was hoped that participants would move towards a more internal rather than external solution. Whilst it was recognised that these manoeuvres represented a standard part of the analytic task it was also noted for all three participants that the tendency to remain with the literal world was particularly strong. Similarly, it was noted they had a tendency to put the therapist into a position of authority and often asked for advice. Such a position impacted on the therapeutic task in that it created a top-down relationship counter-productive to the therapeutic goals. The therapist was repeatedly compelled to shift the perceived locus of control and responsibility back on the participants by asking them "what do you think".

Was the analytic task successful overall.

All three participants discussed their concerns within the therapeutic space with a high degree of affect and openness. They indicated that they felt the therapeutic environment to be safe enough for them to speak about concerns that was often highly personal and emotionally difficult. The analytic task of creating an environment that facilitates freedom of thought and speech was therefore considered to be successful. Participants showed not only their distress in sessions but were also able to express other emotions such as anger towards certain significant others. Culturally the expression of such anger, especially to parents, was unacceptable. Participants indicated that they felt able to show anger in the therapy room that would not be acceptable outside. This was particularly the case with Participants Two and Three. The discussion of certain topics such as sex was very difficult for all three participants, especially with a male therapist. However in the therapy room the therapist was given the impression that participants felt they were able to discuss these difficult topics largely because he was not a part of their culture: this appeared to give them the freedom to speak more easily.

The licence to display emotion as well as to speak freely on issues that are generally considered unacceptable served to facilitate insights that may not have arisen otherwise. All three participants moved towards an understanding of their central issues that was quite different to the understanding that they had held when starting the therapy process. These understandings were more reflective of unconscious motivations rather than conscious rationalisations.

6.2: Analytic Setting

The analytic setting or frame of psychotherapy is best described through the metaphor of the alchemical vessel. The essence of the work of medieval alchemy involved the transformation of substances within a hermetic vessel. This process is likened to the transformation within the therapeutic frame where disparate parts of the psyche are brought into conscious awareness. This process involves holding the incongruent and often opposing elements of the psyche in consciousness and allowing the "heat" of this union to give rise to symbolic transformation. However, transformation does not occur unless the container is sealed. Similarly, transformation within the enclosed space of the therapeutic container will not happen unless the therapeutic frame is intact. It is the ground rules of psychotherapy that circumscribe, hold and contain the process, which is simultaneously a holding of the subject's unfolding psychic process (Young-Eisendrath et al, 1997).

Criteria used to judge the effectiveness of the analytic setting.

1. Was the therapist able to maintain the parameters of the analytic setting?
2. How did the participants respond to the ground rules, including spatial, temporal and financial aspects of the therapeutic frame?
3. How did the participants and the therapist respond to the ground rules that define the relationship between the therapist and participant? These rules relate to confidentiality, no extra-therapeutic relationship, no physical contact and the maintenance of anonymity on the part of the therapist (Langs, 1982).
4. How did the therapist maintain the rules relating to therapeutic intervention? These include maintenance of free association and free-floating attention, the use of appropriate silence, neutral interpretation, framework management, and playback of selected themes holding latent significance (Langs, 1982).

Participants' responsiveness to the use of the analytic setting.

The maintenance of a secure therapeutic frame was an essential part of the therapeutic process. Participants related to this frame differently according to their transference needs, their levels of resistance and defence. The therapist was required to contract for safety with Participant One and Three after they expressed active suicide ideation. In both cases the participants responded well.

Participant One's negotiations with the frame were particularly evident as she held strong feelings of mistrust and suspicion towards any form of containment. In terms of the transference relationship, Participant One strongly desired to be cared for but was extremely cautious in allowing herself to live out her dependent needs for fear of being rejected and abandoned. Any

pretence towards "closeness" or "care" in the therapeutic relationship, or in her relationships outside of the therapy room, was treated with caution and suspicion. The level of containment offered by the therapeutic frame was thus seen as threatening and represented an ongoing negotiation as the participant attempted to protect herself from her own vulnerability. These negotiations included non-compliance with contractual agreements such as having her medication monitored regularly by a psychiatrist, suicide threats, and threats to end therapy.

Participant Two showed less negotiation than Participant One with the therapeutic frame. This was partly due to the fact that her resistances and defences were less prominent. However, on one occasion Participant Two sat on the floor during the therapy session. The therapist felt immediately uncomfortable with this behaviour. The participant noticed that the therapist was uncomfortable and responded by returning to her seat. Whilst the therapist understood this shift in position to be potentially disruptive to the analytic relationship he neglected to acknowledge that that this behaviour represented a concrete example of how the participant often viewed the therapist. Such a position is not uncommon for a woman of the participant's cultural background and represents an act of respect when in the presence of an elder. This apparent break in the frame could have been used to good therapeutic advantage in understanding the participant further. A deeper exploration of the participant's transferential issues could have arisen from this new position. What was also not acknowledged at the time was that such an act could be understood as a measure of the level of rapport that had been gained over 15 sessions. The participant felt sufficiently comfortable and relaxed in the relationship to display behaviour that arose out of her collective values.

From the outset Participant Three indicated that she felt relieved to find someone with whom she could speak about her problems. She appeared to take for granted the safety and confidentiality of the therapeutic setting and spoke with ease about the trauma and loss that she had experienced in her life. In general, Participant Three fitted well into the parameters of the analytic setting. She indicated from the beginning that she felt secure and comfortable enough to discuss her troubles without reserve. She showed little negotiation with the therapeutic frame. This was understood in terms of her transference needs. While Participant One felt threatened by the containment of the frame, but actually required containment, Participant Three responded very well to containment, although the therapist was aware that this was in part an avoidance of taking responsibility for herself. She required the therapist to be the positive maternal listener that was so seriously lacking from her life. For this reason she experienced the frame as a "holding environment". Attempts on the part of the therapist to go against this transference need and encourage the participant towards independence were contrary to her predominant transference need. However,

the therapist was also aware that the participant needed the experience of containment and acceptance before she could move towards a position of self-reliance.

Difficulties encountered in the use of the analytic setting.

All three participants asked the therapist to break the frame by negotiating with persons outside of the therapy room on their behalf. Requests to speak with boyfriends, teachers, employees, family members and children were often made. In such cases the therapist explained that this was not possible as it lay outside the parameters of his role. All three participants appeared to accept this explanation and there was no marked change in the therapeutic alliance. With Participant Three the therapist had to exercise tight control over the use of over-the-counter-medication and visits to her psychiatrist. The therapist was aware that any attempt to tighten the frame would raise strong feelings in the participant and would be interpreted in accordance with her belief that the therapist, like other people in her life, did not really care. The therapist chose to take this risk hoping that the participant would see that such an act was in fact a measure of care. In this instance the outcome was favourable and the participant responded by complying.

Adaptations used by the therapist in maintaining the analytic setting.

All three participants appeared comfortable with an analytic setting constructed along the lines of a western individualistic treatment frame requiring participants to sit for a certain period of time facing the therapist and to speak of their emotional difficulties. Whilst it was apparent that the participants had no real difficulty with the logistical and physical boundaries of this frame, it appeared that there were some negotiations with the frame on the level of expectations about the role of the therapist. Participants understood the therapist's role to involve active negotiation, not just facilitation. They required the therapist to interact in all aspects of their lives, not only with their immediate emotional concerns. The therapist became aware that there was a set of mutual obligations present in the interaction between him and the participants. From the participants this involved disclosure, respect, and providing information about their life difficulties; in turn they expected the therapist to intervene in the social aspect of their lives and negotiate on their behalf with significant others. Part of the adaptation required by the therapist was to be aware of these reciprocal expectations and transactions that were placed on him. The underlying text was organised around the sense that participants saw the therapist as not only working with their emotional problems but also with their social, occupational and familial problems.

The therapist was very cautious in the way he handled requests for interventions with people outside the therapeutic frame. He was aware that requesting assistance in this regard was not uncommon in the collective value system of all three participants. Elders were often asked to

intervene in disputes and treatment for spiritual and emotional difficulties was understood to include family members and significant others. The expectation, especially in times of crisis, that the therapist should intervene in all areas of the participants' lives was particularly apparent with Participants One and Three.

Was the analytic setting successful over all.

All three participants paid their accounts directly to the therapist without any difficulty and attended weekly sessions with consistency. Non-attendance and lateness was rare and if it did occur was generally due to legitimate factors such as transport failures. It was possible for the therapist to understand frame breaks, when they did occur, in terms of transferential factors. Strict adherence to the therapeutic frame on the part of the therapist therefore gave rise to a deeper understanding of each participant's conflicts. All three participants appeared to fit in with the basic ground rules of therapy with relative ease. The therapist's maintenance of anonymity was not difficult to maintain. Participants rarely, if ever, made any attempt to ask the therapist about his personal life; there was no attempt to negotiate a relationship with the therapist outside the therapeutic setting and no attempt at physical contact.

6.3: Analytic Process

The analytic process refers to the evolution of the analytic task over time. As the participant gradually takes ownership of the totality of her personality, so her full potential comes to the fore. The analytic process is based on the understanding that the psyche seeks wholeness with the unconscious working constantly to seek admission and assimilation into conscious life. Interpretation of defences and understanding the purpose of symptoms opens the way for an acknowledgement of underlying feelings. By allowing such feelings and thoughts into consciousness the participant simultaneously opens herself to a recognition of the opposing elements of her personality. The unfolding of the analytic process takes place in the shared intersubjective context of therapist and participant. It is through the intersubjective processes of transference and countertransference that unconscious conflicts are revealed and new meanings constructed. The therapist's presence, his interventions and the tension that exists between both participants drives this process forward.

Criteria used to judge the effectiveness of the analytic process.
1. To what extent did the therapist's interpretation of resistances and transference needs contribute or hinder the unfolding of the analytic process?
2. To what extent did the participants show expected or unexpected psychic developments over 40 sessions of psychotherapy?

3. To what extent were participants able to let go of symptoms and defences and to hold insights in consciousness that were previously unacceptable?

4. To what extent where participants able to engage emotionally with their latent insights?

<u>Participants' responsiveness to the use of the analytic process.</u>

In terms of the analytic process all three participants were able to integrate certain understandings into consciousness that were previously unacknowledged. Whilst resistance to integrating material was strong, all three participants showed some capacity to let go of their defences and move towards a position of resolution.

Participant One was able to recognise that her current relational difficulties also reflected in the transferential relationship, were in part due to the expectation that her partners - and the therapist - would abandon her in the same way that she had felt abandoned earlier in life by her mother who sent her to live with a care-giver and her father who died. She was able to state "My problems started then, I felt alone with no parent… my father left me and I am scared that my partners will leave again, this is why I don't give everything of myself [in my relationships]".

In terms of the analytic process Participant Two indicated from the outset that she experienced difficulty with "fitting in" and being accepted. This was reflected very strongly in the therapy process as she tried to manipulate the therapist into liking her. She indicated that she was having a lot of difficulty in just being herself as she was unsure who she was. She had therefore come to therapy "to get to know herself better". Her fundamental difficulty arose out of her attempts to consolidate her identity. She stated, "I feel my personal identity hasn't fully developed".

At the outset of the therapy process Participant Three explained her situation in terms of abandonment, past traumatic experiences, loss and rejection. She had experienced extreme abandonment at an early age and was left with a fundamental sense of identity confusion. Her attempts to search for specific answers and concrete evidence represented an attempt to consolidate her sense of self. This condition was further exacerbated by a series of profoundly traumatic events, which included being raped by her brother, falling pregnant as a result of being raped by an older man and subsequently having to undergo an abortion on the insistence of her family. The participant manifested through the transference a strong need for support and care from the therapist to counteract her feelings of abandonment and rejection arising out of these experiences.

As the therapeutic process unfolded and transference needs became clearer, so the central dynamics of all three participants began to emerge. Participant One learnt through the here-and-now of the therapy process that her anger and prevocational style towards the therapist were reflective of the central dynamics in her past and present life with others outside the therapy room. A fundamental sense of not being cared for was a theme that was developed and negotiated throughout the course of therapy. Feelings of disappointment and anger at not having her needs met in this regard were present in the therapeutic relationship, in her actual relationship with her mother and in her relationships with her boyfriends. She felt that "my mother was never there for me", that her boyfriends repeatedly let her down and that her doctors had failed her because after repeated consultations she still felt the same. These statements acted as rationalisations against acknowledging a strong need for care and support. In spite of her belief that no-one cared for her she still attended her sessions regularly, visited her doctors regularly, tried to make peace with her mother and continued to seek new romantic partners.

During the course of therapy Participant Two was able to acknowledge that her need for success (embodied in her brother's achievements) was a manoeuvre against deeper feelings of "not being good enough" instilled through being cut off from her family at a young age and being placed in a school environment where she felt different, lonely and rejected. She came to recognise that her projection of herself in the therapy room as a successful and likable person was a microcosm of the Oedipal dynamics set up in early life and currently enacted with family members. On the one hand the participant was still trying to recover a sense of belonging to her family and on the other she was moving in the direction of independence, self-reliance and ambition. Both pursuits involved different sets of values that often conflicted with one another thereby frustrating the formation of her identity.

Participant Three's over-riding concern throughout the therapeutic process was her need to establish a sense of belonging to her family. Initially, she expressed a lot of anger towards her family "for not caring enough". She felt excluded, marginalized and treated like a servant at home. As a result she carried feelings of self-blame, worthlessness and depression. Much of the therapy revolved around her unanswered questions of why she was sent to live with her aunt, why her father was not interested in her and why her family excluded her, as well as discrepancies concerning her birth date and her family name. As the participant was unable to secure from her family concrete answers to these questions, it was left to her imagination to provide answers. She became convinced that she was the result of her mother's infidelity and thus the reason her parents separated. She felt that her mother hated her because she had broken up the marriage. Through a gradual recognition of the here-and-now dimension of the therapeutic relationship, the

participant was able to understand that her need for affirmation and concern from the therapist was a compensation for feelings of abandonment in early life. By recognising the extent of this need, she was able to come to terms with what she wanted from her mother, rather than harbouring feelings of anger and resentment.

As the therapeutic process evolved so new insights began to emerge and the central dynamics for each participant began to take on a different narrative. Participant One moved towards accepting that her strong need for care and her inability to acknowledge this was born out of past rejections and the fear that this would be repeated again. This new insight served to dissolve the intensity of these feelings and the participant moved towards a new position whereby she appeared stronger and more able to take the risk of raising topics with her mother that she would previously have avoided for fear of losing her mother again.

With Participant Two the process of identity consolidation was a theme that gradually unfolded in the therapeutic process through the metaphors of culture, family, work and relationships. The adoption of western ideals of individualism such as being assertive and independent were often off-set against perceived duties to her family such as being subservient, accepting and un-questioning. This negotiation of values was strongly apparent in the participant's wedding ceremony, which included both a traditional and a western ceremony. At the time her mother insisted that she wear a white dress at the western ceremony; the participant objected to this, preferring to wear a dress that contained elements of her "African heritage". Similarly after the death of her father there was a lot of conflict between the participant and her family on the level of personal values, family values and cultural values. This conflict between western and traditional ideals was also apparent in the purging process that the participant had to undergo as a consequence of her cross-cultural relationship.

During the course of therapy Participant Three tried desperately to fight her feelings of dependence on her family and attempted to move slowly towards a position of independence. However, it became clear that she was unable to move forward until she had secured a sense of familial acceptance. She felt unequipped to cope in the world without a secure foundation of support, acceptance and belonging. On a number of occasions she had left home and then returned. As the analytic process unfolded it became clear through the transference that the participant's need for support from her therapist was very high. In fact it was evident that much of her distress related to the fact that she required such support from her family but felt it was not forthcoming. It began to emerge that a major reason for her needs not being met in the family was not because she was not able to express what she required from them. At home she was quiet,

unobtrusive and shy. She conceded that "maybe I have been too sensitive and this blocks the others from talking to me". She also began to recognise that her anger "may be keeping others out". Simultaneously she had to recognise that the over-riding emotion, which was often hidden by negative emotions, was in fact the need for love. She grew to recognise that her almost obsessive need for concrete evidence of her past was also a search for a confirmation of love and acceptance from her family.

All three participants were able to develop a more textured understanding of their central dynamics and move towards a position of increased self-acceptance. Participant One came to recognise that the suspicious and questioning behaviour that emerged when she became emotionally involved had more to do with herself and her background than it had to do with the situation at hand. She was able to accept that this behaviour was strongly related to a lack of trust that arose out of the fundamental belief that all people would repeat the scenario of her childhood and would let her down or abandon her. She was also able to recognise that her need for success and independence represented a compensation against her fears of failure and dependence.

Participant Two was able to understand that her way of hiding her fragile sense of identity was to develop a persona of self-confidence and likeability, which belied deeper feelings of insecurity. In terms of the analytic process she was initially defensive about this persona and stated "I feel I have been true to myself" but later conceded "when someone can see that I am not who I think I am, I become aggressive or I charm". The process of recognising the extent to which she relied on this persona in a western context, especially at work, was marked by a period of depression. It was also noted that after the participant was able to reflect on the extent to which she was persona-identified she began to make a conscious effort to be "more herself". As a result her need to please the therapist receded and the participant began to talk more about the insecurities and unspoken experiences that lay behind her social front. For instance she was able to discuss sensitive material concerning past relationships and was able to speak about her belief in witchcraft and magic which she had generally kept to herself because she felt most people in western culture dismissed such thoughts as irrational.

Participant Three moved more slowly in the process and in most sessions returned to the principle theme that her family "did not care", "What did I do wrong that made my parents hate me so much". Her inability to have her needs met left her feeling exasperated, victimised and taken advantage of. However, it became clear that whilst the participant had experienced many situations in her life where she had in fact been a victim, she had also created situations where she was taken advantage of. This was evident at home, at work, with boyfriends, and with

friends. So long as she upheld the perception of herself as "…me being against the world and battling" she could justify why she had remained at home and had not continued with her life. She blamed her mother for obstructing her development and keeping her at home. In fact the real reason for not venturing out into the world was because she lacked self-confidence and was afraid.

During the course of therapy the participant attended a computer course and passed, she secured a job as a waiter, left home and found her own place to stay, and she made a small circle of friends and supported herself financially. Even more importantly she was able to acknowledge many of the insights outlined above. After becoming more comfortable with her strong dependent needs she was able to develop a sense of self-reliance and independence. She was able to consider her future rather than being caught in the past and was able to say "I can speak out, not as shy anymore…I can start a topic on my own, not just answer questions…I have more confidence…I know feel I am a totally different person to a year ago where I didn't want to exist anymore…I am pleased that someone showed me there was more to life than sitting on your hands and feeling sorry for yourself ".

<u>Difficulties encountered in the analytic process.</u>

Participant Three's strong need for support was manifest in the transference. The therapist was aware that if he did not provide this support the participant would withdraw and become angry and quiet as she did with her family. It was therefore difficult to offer interpretations that may have challenged the participant as such interpretations would be experienced as rejection. The therapist often felt caught between meeting the supportive needs of the participant and offering constructive interpretations to further the analytic process. The therapist maintained consistent levels of empathy for all the participants. At times, however, when participants were suffering high degrees of emotional distress, he found himself offering overt statements of sympathy, which were generally well received. In spite of this the therapist was aware that his efforts to make the participant feel better were not necessarily constructive. These spontaneous acts were considered by the therapist to be deviations from the analytic attitude in that they obstructed the participant from experiencing the full depth of their own despair. By intervening with statements of sympathy the therapist was effectively foreclosing the possibility of not only a deeper emotional experience but also the simultaneous emergence of conscious meanings that may have arisen from these affect-laden moments in the therapeutic process.

The main challenge to the analytic process with Participant One lay in her attempts to encourage the therapist to react to her with the negativity she believed she deserved. In order to safeguard the evolution of the analytic process the therapist had to avoid reacting to these challenges.

Participant Two's main challenge to the analytic process was her strong desire for unqualified affirmation of her persona from the therapist. This was an unconscious attempt to deny incongruent parts of her psyche, which she felt to be unacceptable.

Adaptations used by the therapist in the unfolding of the analytic process.

One significant adaptation to the analytic process involved the therapist's having to learn to be sensitive to the idiom participants used to express their relationships with significant others, particularly family members. It emerged that there was a strong cultural component to their interpretations of and expectations of their families' behaviour towards themselves. Participants often used a material idiom to describe inter-relationships. A sense of financial obligations and material reciprocity within the family was central to describing and understanding emotional transactions. Familial interactions were characterised by the sharing of resources which appeared to be simultaneously material and emotional. Difficulties and problems that occurred amongst family members were discussed on this level in therapy, rather than on an internal emotional level. Participants therefore located problems on this external frame and the therapist needed to adapt to this idiom. He had to recognise that the participants were very attuned to this external framework of understanding and discussing emotions. In the analytic process participants are encouraged to focus on their internal response to events. The therapist found that these participants tended to return to their familiar idiom in order to discuss emotional difficulties. It was only after considerable time that the participants were able to speak of their internal world of emotions in relation to such difficulties. Part of the therapist's adaptations involved assisting the participants in separating out feelings that belonged to the individual self from feelings that derived from the collective self.

Was the analytic process successful overall.

All three participants had been sent away from home at an early age and all had problematic relationships with their mothers and complex feelings concerning their fathers. They were all aware that their current life difficulties were based fundamentally in their earlier life experiences. It became particularly clear that being separated from the original family at an early age had left each of the three with profound feelings of insecurity around their identity formation, which had been compensated for through different responses. The participants were able to recognise the need to speak about these earlier experiences and to engage with their feelings in this regard.

During the course of the therapeutic process all three participants developed many clear insights into the feelings that lay behind their current behaviour patterns. This without exception left them feeling more empowered and in control. It was also noted that while all three participants had initially presented with strong depressive feelings, these ameliorated considerably during the course of therapy.

6.4: Generative Uncertainty

Generative uncertainty involves an attitude of inquiry that aims to overcome any attempt on the part of the therapist to maintain fixed ideas and certainties in the therapeutic encounter which could compromise the emergence of understandings that may exist beyond such fixed perspectives. The therapist needs consciously to be aware of a natural inclination to place material into "safe" or "convenient" packages of interpretation, especially when such material is ambiguous. By packaging material into conventional theoretical units predetermined from previous sessions other creative possibilities potentially useful in understanding the participant may be left out. Fixed perspectives give rise to static understandings that are contrary to the fluidity of conscious exploration. By not placing material into safe packages but maintaining a sense of ambiguity a certain degree of constructive tension will exist for both the therapist and the participant. This tension is a necessary pre-condition for the promotion of self-discovery. The criteria used to judge whether generative uncertainty was effective in this study included the following. These criteria provided a basic framework for evaluation and discussion.

Criteria used to judge the effectiveness of generative uncertainty.

1. Was the therapist able to resist the demands from the participants to align with their own neurotically fixed understandings?

2. Was the therapist able consciously to resist the impulse to fit the participants' communications into fixed and established meaning units?

3. To what extent did the therapist refer to his own experience, previous experience of the participant or theoretical concepts to understand communications?

4. Was the therapist's attempt to maintain ambiguity frustrating for the participants and counterproductive?

Participants' responsiveness to the use of generative uncertainty.

All three participants displayed strong neurotic certainties. Participant One believed that she would always be let down and rejected; Participant Two believed that she was not particularly likeable and needed to compensate for this by upholding a social front; Participant Three believed strongly that her family disliked her and that she was ultimately a victim. Especially in the case of

Participant One and Three, neurotic certainty persisted through to session forty. The therapist often found it difficult to maintain the analytic balance of generative uncertainty without being pulled into the participants' need to have their neurotic certainties confirmed. On the whole the therapist was able to resist these demands, although at times he recognised that he was drawn into their perceptions of their worlds. However, at no stage did he intentionally side with these perceptions although with Participant Three he was aware of losing his analytic balance more frequently. With Participant Three there were times when the therapist caught himself accepting the participant's own rendition of her "uncaring mother". The participant described one instance where her mother had made contact with her when she was living away from home. Given that this is what she purportedly desired the therapist was surprised that the participant responded with suspiciousness rather than being pleased. In this case the therapist's expectations of how the participant should respond reflected his own unacknowledged emotional involvement in the relationship between the participant and her mother.

In session twenty-one Participant Two described a dream that superficially appeared to conform to her underlying fear of discarding her persona and coming to terms with her real self. Instead of intervening the therapist allowed the participant to discuss her own interpretation of this dream which ultimately took her to discussing her issues concerning trust which she had been unable to articulate previously. This was seen as an example of how the therapist's suspension of fixed meaning units and apriori interpretation allowed for the emergence of unexpected material.

The therapist was very conscious of his need to resist using pre-conceived interpretations and preconceived theoretical constructs in each new session. However, the tendency to interpret new actions based on an understanding of old patterns was strong. This was the case particularly when fixed certainties held by all three participants appeared to persist from one session to the next. An example of this was evident with Participant Three. In this case the participant was describing her actions in relation to an ex-employer. The therapist felt that the participant had unconsciously manipulated herself into the victim role of being fired rather than appearing as the initiator of walking out of a job that she did not want. This understanding was based on previous experiences of the participant's preference for the victim role.

One overarching certainty held by the therapist related to his inclination to interpret each participant's movement towards individuality and independence as a positive development. This orientation derived directly from his western values, his own personal experience and his theoretical orientation.

The ambiguity aroused by the stance of generative uncertainty was generally productive with all three participants. This productiveness was in part because neurotic needs were not being played into. However, in one instance Participant One found this tension to be too high and accused the therapist of "not understanding her". Participant Three did not cope well with this sustained ambiguity and the therapist had on occasion to relax this stance and reassure the participant. This was particularly the case when she showed extreme emotion and despair.

Difficulties encountered in using the stance of generative uncertainty.

The therapist was aware of having to monitor his interpretations very closely. Symbols and associated meanings that would normally be taken for granted needed to be re-thought and alternative meanings assigned from within the cultural context of the participant. The therapist realised that he needed a reasonable degree of knowledge of his participants' cultural backgrounds in order to make valid interpretations of their symbolic frameworks. This knowledge of the participants' culture was important not only in understanding to what extent they adhered to these standards, but also to what extent they had shifted away from their cultural norms. The most obvious example in this regard was Participant Two's attitude to the death of her father. The therapist found it difficult to understand whether her lack of expressed emotion was due to her stated belief that her father was "still around" in that he had joined the omnipresent ancestors and was therefore not lost to her, or whether this lack of emotion was due to her inability to engage with her real feelings. Other symbols that required careful reflection included various rituals and ceremonies such as Participant Three wishing to sacrifice a goat to placate her deceased aunt's spirit and Participant Two's choice to submit herself to the authority of the family values by undergoing a purging process.

The therapist noticed that whilst attempting to generate deeper insights on certain themes he at times asked the participants to reflect back on issues that had been raised in previous sessions. Frequently these links were not easily assimilated, with participants often not seeing the relevance of the link. The lack of importance ascribed to self-reflection and an associated lack of understanding of habitual patterns of personal behaviour at times frustrated the therapist to the point where he occasionally attempted to shortcut this process of understanding by asking direct questions and breaking out of the stance of generative uncertainty. These attempts were almost always unsuccessful. In one instance when the therapist attempted to generate an insight he was aware that the participant felt compelled to play into what she believed would please the therapist. It was clear that such deviations from the stance of generative uncertainty failed to aid the therapeutic process.

It became increasingly clear as therapy progressed that all three participants had some measure of difficulty with self-reflection. The therapist came to realise that whilst all three participants were becoming more oriented towards the concept of individual self-reflection it was not a valued tool in the collective self. In fact self-reflection was antagonistic to the cohesion of a collective self, not serving the purpose or goals of community living. In terms of generative uncertainty the participants experienced difficulty in making links and drawing parallels between patterns of behaviour when such understandings required a great deal of self-reflection and a distancing from the collective self. Participants were therefore frequently perplexed with questions and requests that demanded a high level of self-reflection. In such cases these requests served to disrupt rather than promote further insight. The collective self also lead participants to be more reliant on the therapist for a level of support, guidance and counsel which did not always fit comfortably into the parameters of the analytic attitude and frame. The participants at times experienced difficulty with the therapist's attempts rigorously to maintain this therapeutic gap.

Adaptations used by the therapist in maintaining the stance of generative uncertainty.

One adaptation that was necessary in the context of generative uncertainty related to the therapist's need for constant internal evaluation of his use of standard symbolic constructs that were not necessarily appropriate to the participants' cultural foundation. This required constant evaluation and re-evaluation of constructs that the therapist would normally have taken for granted with many of his western patients.

As has been discussed the participants showed a far greater need of support from the therapist than he commonly found to be the case with most of his western patients. All three participants felt significantly disconnected from their family of origin. The extent of this disconnection and the need for closer union was felt strongly in the therapeutic relationship. The therapist was therefore prompted to revise his own certainties concerning western notions of independence and needed rather to see this call for support in terms of the interdependent, inter-related matrix of the collective self that was fundamental to each participant. The therapist discovered early in the process that a refusal to meet these supportive needs was generally counter-productive. Through the stance of generative uncertainty he was able to generate new perspectives beyond his own fixed assumptions and beliefs concerning self-containment. He was able to appreciate that 'disconnectedness' from the family, the community and the ancestors represents something far more significant in the cultural milieu of his participants than it does in a western system. By adopting this understanding it became clearer to the therapist why a judicious display of support was stimulating rather than inhibiting to the therapeutic process.

Difficulties, especially in the earlier sessions, with self-reflection and the placing of individual thoughts, values and opinions above those of the collective framework needed to be acknowledged by the therapist. He found that participants were able to move to a more individual interpretation of their feelings and problems but this required repeated intervention in terms of placing some pressure on participants to articulate how they personally felt about their situation.

An evaluation of the overall effectiveness of generative uncertainty.

The therapist found this stance to be extremely beneficial within a cross-cultural context where idioms, symbols and pre-occupations could not be taken for granted or analysed by the therapist using his conventional (western) understandings. Generative uncertainty afforded the therapist a powerful means of allowing symbols to unfold within the meaning context of the participants' own cultural framework. It also allowed for the therapist's re-interpretation of these symbols as the participants' use of them changed through the course of therapy. An example of such a changing symbol requiring re-evaluation on the part of therapist was the issue of dependency needs. Western assumptions on dependency differed markedly from participants' collective values around this issue. Generative uncertainty assisted the therapist in understanding the way his participants experienced dependences and allowed him to overcome his own assumptions.

6.5: Neutrality

Neutrality involves maintaining a self-reflective position of balance that avoids the attraction of siding with the participant's self-critical judgements, defences or desires. By siding with the participant's views, opinions or beliefs the therapist would automatically fulfil the unconscious transference needs of the participant and would in turn prevent a conscious exploration of these needs. Contrary to general opinion, neutrality does not imply a lack of concern and feeling for the participant: rather it is out of concern for the participant's treatment that neutrality is exercised. The therapist needs constantly to check his own moral and ideological beliefs about the participant's behaviour and opinions to ensure that they do not distort or hinder the process of making conscious what was previously unconscious. Non-neutral statements from the therapist serve to block the very purpose of therapy and can be disempowering for the participant. For instance if the therapist were to agree with a participant's consciously stated negative feelings towards a significant other, this would make it difficult for the participant to explore her less conscious positive feelings in this regard. The criteria used to judge whether neutrality was effective in this study included the following. These criteria provided a basic framework for evaluation and discussion.

Criteria used to judge the effectiveness of neutrality.

1) Was the therapist able to remain equidistant from the participant's id, ego and superego, thereby maintaining a necessary potential space between himself and the participant.

2) Was the therapist able to maintain a consistent position of self-reflection, checking his own moral and ideological beliefs and feelings about the participant's thoughts, fantasies and actions.

3) Was the therapist able to achieve a level of "optimal frustration" by maintaining a concerned interest in the participant without becoming neurotically involved.

4) Did the participants in any way show an awareness of and response to the therapist's use of neutrality.

Participants' responsiveness to the use of neutrality.

Participant One ascribed much of her emotional difficulties to central others in her life. She spoke a great deal about the conflicts and fears she held with regard to her mother, a series of boyfriends and also her son. In these discussions she vacillated between the extremes of self-blame and external blame. It was evident that she desired the therapist to affirm her judgement of herself as the aggrieved and not the aggressor. The therapist was put under considerable pressure to side with her and sympathise with her. At the same time the participant's refusal to accept her own part in her emotional difficulties aroused negative feelings in the therapist which he had to work hard to control. The therapist had internally to negotiate his own understandings that while the participant aroused feelings of sympathy for her situation also aroused disapproval at her attitude and behaviour, especially towards her son.

Participant Two also desired the therapist to affirm her social perception of herself. The therapist was aware from early in the therapeutic process that not only was this persona false but that the participant too realised this inherent falseness. However, he did not confront her on this or make negative assumptions, but instead debated internally as to why the participant was so fearful of being herself.

The therapist's internal responses to Participant Three's experience of herself as unloved, unlovable and victimised were complex. Whilst he rationally recognised that the participant's account of herself was strongly located in a profound belief in herself as a victim, he at times found it difficult to maintain an adequate distance from this belief and at times found himself inclined to interpret her statements as if her account of events was factually (and not just emotionally) true. That is, he found it extremely difficult to withhold judgement from her family whom she blamed for her distress.

Participant Three also presented the therapist with a challenge in terms of listing a set of priorities as a means of solving her problems which to the therapist's perceptions were inappropriate. It was particularly difficult to judge these priorities as a number of them were culturally determined and seemed irrational to the therapist. Again he had to struggle to withhold judgement.

Difficulties encountered in using the stance of neutrality.

One central theme that emerged in the therapist's negotiation of neutrality related to the participants constantly presenting the therapist with a culturally different set of values for which the therapist had no frame of reference. The stance of neutrality does not imply a complete avoidance of judgements, rather it is about accepting that the therapist will indeed make judgements but will simultaneously be aware of and will internally debate with these judgements. In this cross-cultural context the therapist was often uncertain whether his judgements were appropriate or not as his knowledge of the cultural significance of actions and the values stimulating them was lacking. This affected his internal understanding of the participant. In other words he could only use his own framework of reality to judge the participants, as he did not have full access to their cultural framework.

The therapist found that on a number of occasions he had strong feelings aroused by the participants' revelations both of events which they had had to endure and by behaviours they manifested towards others. These feelings were both strongly positive and strongly negative. On all such occasions he had to struggle to maintain neutrality. This was especially the case where cultural differences clouded his ability to interpret such events or behaviours within his usual framework of reference.

Adaptations used by the therapist in maintaining the stance of neutrality.

The therapist found that it was only by remaining rigorously neutral that he was able to move towards a fuller understanding of his participants' concerns, especially those expressed in terms of a cultural idiom. It was sometimes the case that the therapist would find himself initially moved to strong feelings by a statement from the participants deriving from a particular cultural belief, attitude or event, such as Participant Three's statement that "incest was accepted in Black rural communities". In such cases the therapist was required to exercise extreme vigilance and internal evaluation with his own belief system in order to determine the appropriate level of response to such statements.

Following from the above, an adaptation that the therapist did find necessary was the active need to learn more about the cultural milieu of his participants. Although neutrality implies remaining equidistant from the participant's id, ego and superego, and relating more to her emotional experience rather than to her factual experience, the therapist found that in dealing with superego needs, cultural issues were significantly represented and he had to be able to identify these so as to work with them.

Was the use of neutrality successful overall.

With all three participants the therapist's maintenance of neutrality opened up a therapeutic space in which the participants came to feel ready to acknowledge their inner conflicts and to verbalise these to the therapist. The participants indicated that they had a sense of the therapist's willingness to understand all aspects of their personality and behaviour and of his lack of negative judgement.

This was particularly apparent with Participant Two. Initially she was intent on having the therapist agree with her desired perception of herself and responded to the therapeutic process in a way which she felt would please him, rather than reflecting her real feelings. It was very clear that in encountering the neutral stance of the therapist, the participant felt able to be more honest and real. She realised that he would not respond negatively or superficially to the inner dissonances which she generally preferred not to reveal as she saw them as reflections of an imperfection and weakness.

A neutral atmosphere allowed the participants to discuss cultural beliefs, superstitions and understandings which they had previously suppressed and felt embarrassed of in a western cultural context. By the therapist's maintenance of neutrality the participants were themselves able to examine and accept their own beliefs and emotions in a non-judgemental framework.

From the above analysis it can be seen that the therapist was able to meet the criteria needed for the successful implementation of neutrality and overall it was a useful and productive stance. The therapist's constant self-checking and self-evaluating which is central to neutrality was extremely useful in this cross-cultural setting in that these ensured that nothing was taken for granted.

6.6: Abstinence

Abstinence involves the withholding of any overt expression on the part of the therapist whether it be sympathy, flattery, judgement or any other feeling. For this to be successful the therapist must be very aware of his feelings so as to guard against their inappropriate expression. The

reason for this is that any attempt to express emotions regarding the patients issues would allow premature closure on such issues, providing the patient with an external rather than an internal solution and thereby preventing a full exploration of such feelings. The criteria used to judge whether abstinence was effective in this study included the following. These criteria provided a basic framework for evaluation and discussion.

<u>Criteria used to judge the effectiveness of abstinence.</u>

1) Was the therapist was able to refrain from overt demonstration of his emotions while still maintaining a level of "concerned understanding"?

2) Did premature closure take place at any stage because of the therapist's own anxiety or need to meet the wishes and demands of the participant?

3) Did the therapist's overt expression of feeling interfere with the transference process?

4) Did the therapist's refusal to express overt emotion alienate or in any way affect the participant counter-productively?

<u>Discussion of the use of abstinence for three participants.</u>

All three participants attempted to manipulate the therapist into confirming their own beliefs about themselves. In Participant One this took the form of overtly provoking the therapist into confirming her view of herself as unlovable and unworthy. She unconsciously attempted to manoeuvre the therapist into a position where he would hold negative feelings towards her: for instance she frequently told the therapist that he was not helping her. By his abstaining from becoming angry or judgemental the participant's neurotic certainties remained unconfirmed. This left the participant in a position where she was forced to confront the feelings that she was attempting to avoid. Abstinence for Participant One was particularly important as she was overtly seeking condemnation from the therapist to justify her belief that everyone ultimately rejected her.

Participant Three displayed overt emotionality, thus provoking the therapist into feelings of sympathy from which he had at times difficulty in abstaining. She perceived herself as an innocent victim and needed the therapist to confirm this through expressions of compassion and support. As was the case with Participant One, the therapist's abstaining from directly meeting these needs forced the participant to explore the validity and reasons for this self-perception.

Participant Two was not as emotionally provocative as Participants One and Three. However, she covertly requested the therapist to affirm her as a likeable and valuable person. Often when asked a question she would reply in a manner that she believed would please the therapist, thereby eliciting liking and praise. The therapist was aware that many of the participant's statements were

directed towards pleasing him as a way of maintaining her perception of herself as an agreeable person. By his not succumbing to this need and by refraining from offering positive affirmations in such instances she was tentatively encouraged to relax the use of this persona.

Participant Two also made constant reference to the negative feelings she held towards her brother. In most instances the therapist felt that the participant was asking the therapist to agree with and support her position. The therapist abstained from doing so and found that as the therapy unfolded this abstinence eventually gave rise to a revelation on the part of the participant that she was in fact jealous of her brother. It was clear that if the therapist had colluded with her initial opinion this insight would not have been achieved in later sessions.

Difficulties encountered in using the stance of abstinence.

The therapist often found himself confronted with material that was very provocative, often causing strong emotions. In certain instances it was difficult for him not to express these emotions. This was particularly the case when participants described events and situations outside of the therapist's cultural frame of reference. The therapist often asked for further clarification on such issues in order to understand his own anxiety and to respond appropriately within the participant's cultural framework.

The therapist found that abstinence on the level of transferential issues was relatively easy to maintain. He was for the most part able to recognise and work with participants' unconscious attempts to provoke him into conforming to their transference needs. However, participants sometimes related experiences and events that were culturally based. In such cases the therapist had great difficulty in assessing the appropriate degree of abstinence or involvement with the participants' emotions relating to such experiences.

The therapist recognised in all three participants strong feelings of rejection and abandonment and was over-responsive at times to the call for support. This over-responsiveness generally took place at times when participants were deeply overcome by feelings of loss and grief for extended periods in the session. At such times the therapist offered verbal statements of sympathy such as "I feel very sorry for you". Participants generally found such statements soothing and were able to regain a sense of emotional control. The therapist recognised that a failure to provide support in these instances was in fact disruptive to the therapeutic alliance in that participants tended to withdraw and feel let down. Whilst such interventions could be construed as distorting the transference, it was also recognised that such a sacrifice was at times necessary in order to preserve the therapeutic relationship. Any attempts at remaining aloof and distant would not only

have been going against the principle of abstinence but would also have been seriously anti-therapeutic for all three participants. The therapist found that the participants required a degree of emotional involvement at all times. His difficulty lay in attenuating this involvement so as to create a balance between providing emotional containment without closing the transferential gap.

Adaptations used by the therapist in maintaining the stance of abstinence.

A central theme throughout the process of therapy related to the participants' clear need for an active response in times of high emotional strain. All three participants presented with problems of feeling undervalued and worthless and were in strong need of affirmation and support. The therapist's withholding of sympathy and support were found to be counterproductive on a number of occasions. Realising this, the therapist was more ready to demonstrate sympathy with their various predicaments.

As mentioned earlier, during the course of this study a full appreciation of the concept of connectedness in traditional African culture emerged. Hewson (1998) points out that disconnectedness in most African cosmologies is the primary cause for profound suffering, which is why most traditional healing treatments are aimed at restoring connectedness. The participants in this study all felt historically cut off from their family and community. This desire for connectedness displayed itself in the therapeutic relationship through a concrete need for emotional and other forms of support. The analytic attitude was not able to accommodate the full extent of this need and adaptations were necessary. With all three patients requiring a higher level of support than is generally found with western patients it became clear to the therapist that the analytic attitude - which carries western assumptions of independence and separateness – needs to be adapted on this score if it is to be appropriate across culture.

Abstinence required the therapist to be very closely attentive to his internal thoughts and assumptions in order for him to recognise whether these were personal bias or not, before acting on these ideas.

Was the use of abstinence successful overall.

The therapist found it difficult to adhere to the strict criteria for abstinence. He noticed that when participants placed a stronger emphasis on their collective values, then abstinence was more difficult to maintain. Although on most occasions he was able to adhere to the principle of abstinence there were occasions where he deliberately chose to break out of this stance. Overall the stance was successful and necessary but there were definite instances where it was either inappropriate or impossible to maintain.

The tension that came with abstaining from sympathising or colluding with the participant was high in some instances and lower in others. The therapist had constantly to monitor this tension so as to be sure it did not develop to a level of anxiety that would in fact be counter-productive and hinder the process of self-discovery. With one participant in particular (Participant Three) it was necessary to intervene and break out of the stance of abstinence more frequently than with the other two participants. This was seen as a necessary measure to safeguard the analytic relationship.

It was interesting to note that when abstinence was maintained, and tension deliberately created, there emerged in the space between participant and therapist a new idea, concept or attitude. In such cases it was felt that abstinence had achieved its objective.

6.7: Countertransference Receptivity

Post-positivistic understandings of human relatedness acknowledge that communication between the participant and the therapist occurs on conscious and unconscious levels. In order for the therapist to understand his participant fully it is necessary for him to be responsive and open to the different ways in which the participant may unconsciously manipulate him into playing out roles that represent the internal object world of the participant. Countertransference receptivity refers to the therapist's willingness to allow the participant's unconscious communications to speak through his own experience. Conscious recognition of these roles on the part of the therapist may only emerge once the role has been acted out and neutrality lost. The reception of meanings from the participant will also be coloured by the therapist's own unresolved complexes which are bound to distort and interfere with his understanding of what the participant is telling him. The criteria used to judge whether countertransference receptivity was effective in this study included the following. These criteria provided a basic framework for evaluation and discussion.

Criteria used to judge the effectiveness of countertransference receptivity.

1. Was the therapist aware of the transference identities participants ascribed to him?
2. To what extent did the therapist become lost in the participant's experience and enact identities without being consciously aware of doing so?
3. To what extent was the therapist's understanding of the participant's unconscious dynamics enhanced through countertransference receptivity?
4. To what extent was it possible to explore with the participant the meanings that emerged from the therapist's countertransference receptivity?

Participants' response to the use of countertransference receptivity.

With Participant One the therapist was acutely responsive to the role the participant was transferentially expecting of him. By being aware of the feelings and thoughts evoked within himself the therapist was able to gain a deep understanding of the participant's internal world. The participant spoke at length about her relationships with men and described the repetitive cycles of suspicion, argument and withdrawal that characterised such relationships. It became clear that these dynamics were a compromise against her dependent needs that conflicted strongly with her fears of rejection, which were an echo of her childhood experiences of abandonment by both her mother and her father. The participant unconsciously attempted to provoke the therapist into enacting the same cycle by constantly testing him. This was understood as an attempt to ascertain whether the therapist was strong enough to contain her dependence and caring enough not to reject her. The therapist's feelings of anger, frustration, ambivalence and compassion alerted him to the nature of her transferential need and he recognised the very strong control he had to give to his role in order to contain the therapeutic environment and allow the participant the space to surrender herself and work through her fears of vulnerability. With Participant One the countertransference tension was very high and the therapist was aware that were he not sufficiently receptive to the participant's transferential needs the entire therapeutic process would be at risk of becoming simply another repetition of her original childhood trauma.

In contrast to Participant One, the clarity of Participant Two's transferential need was not so strongly manifest from the outset. The therapist perceived in the initial stages of therapy that a principle motivation on the participant's part was to encourage the therapist to affirm and accept her persona as a true reflection of herself. The therapist noted that even while the participant was speaking of emotionally charged events, there was a significant lack of emotionality in the relating of these events. The therapist was initially puzzled and felt uncertain of the personal impact of these events on the participant; he thus began to recognise the extent to which the participant was persona-identified. However, through maintaining all the elements of the analytic attitude the participant was compelled to recognise the inadequacy of this persona in the therapeutic setting. She began to feel sufficiently contained enough to allow the more fundamental aspects of herself to emerge. As the therapy progressed the therapist became increasingly aware of his own emotional experience and took this to be a measure of how the participant was becoming more emotionally engaged with herself. The therapist recognised that the participant was beginning to allow the therapist to respond more to her feeling-self rather than to her safe persona. With time the participant's expression of emotion became more prominent. She expressed strong feelings of anger and frustration which were directed towards significant others in her world. The therapist understood that many of these feelings where in fact projections

of her own anger and frustration at herself which derived from her inability to let go of the safety of her persona. The therapeutic interaction subsequently became more informative and meaningful as the participant was able to express the deeper vulnerabilities that lay beyond her persona: these included aspects of her collective self.

From the outset Participant Three displayed a high degree of emotion that the therapist was acutely responsive to. The therapist responded to her account of extreme loss, betrayal and abandonment with feelings of compassion and a desire to comfort her. The therapist was aware that in the transference there was an inherent need for the participant to see herself as the vulnerable child/victim and for the therapist to be a protective loving mother. Whilst the therapist did show a level of compassion that extended beyond the usual analytic parameters, he was also aware that by indulging this emotion too fully he would be perpetuating the participant's notion of herself as a helpless victim. He recognised that it was important to be responsive to her extreme distress but also to encourage her to use her own resources and move beyond her sense of helplessness.

In the course of therapy the therapist was aware through his own feelings of confusion that the participant's sense of identity was profoundly unconsolidated. The repetitive need to find concrete answers to the circumstances surrounding her birth, including her birth date and true surname, were indications of her desperate need to establish a concrete sense of belonging and understanding of herself as a family member. This need to belong and be cared for were both expressions of an ultimate need for acceptance and love which represented her principle dynamic and countered her current feelings of abandonment and betrayal.

With Participant Three the therapist's level of countertransference receptivity was high largely because of the participant's strongly expressed emotion. Whilst the therapist had no difficulty from the outset in establishing the transferential role required of him, it was resoluteness that represented the main challenge with this participant.

Difficulties encountered in using the stance of countertransference receptivity.
The therapist felt that of all the elements of the analytic attitude countertransference receptivity was least affected by cultural factors. Unconscious communications through the transference/countertransference composition appeared to transcend some of the difficulties that were encountered with other aspects of the analytic stance. Through careful monitoring of his personal countertransference the therapist was able to gain a greater appreciation of the cultural differences between himself and the participants. Whilst he was able to contain his feelings with

regard to rites of passage, practices and rituals which often involved the slaughtering of animals, he found it more difficult to negotiate feelings related to the authoritarian, patriarchal norms of the participants' culture. In such instances the therapist was forced to re-consider his own values of individualism against those of communalism involving hierarchical networks of order with women being placed in a sub-ordinate position. There were instances in which the therapist became aware of the extent to which his own upbringing had instilled in him stereotyped views and prejudiced thought-patterns. This was particularly the case in relation to so-called irrational beliefs that exist in Black culture, as well as stereotypes relating to crime and physical aggression. His own in-built view that western systems are more superior to non-western systems was also brought to the fore. However, the framework of the analytic attitude provided sufficient latitude for the therapist to self-reflect on these personal views. This process of monitoring his personal countertransference and internally negotiating his western beliefs facilitated a level of heightened insight and personal growth that greatly enhanced his acceptance of difference.

Adaptations used in maintaining the stance of countertransference receptivity.

The therapist found that very little adaptation was required in maintaining the stance of countertransference receptivity. By being responsive, open and constantly aware of his own feelings and thoughts in relation to the participants, there were significant developments in his understanding of all three participants. There was no obvious indication that specific modifications or adaptations could have enhanced what was achieved by this stance.

Was the use of countertransference receptivity successful overall.

Through self-relating and being aware of his own experience the therapist felt he was able to gain strong insights into the transferential needs and internal world of all three participants. Early life experiences were strongly present in the therapeutic encounter and he was well aware of how each participant enacted through transference usage the familiar roles and experiences of childhood.

6.8: Resoluteness

The analytic situation is characterised by many unsettling factors for both the therapist and the patient. Both are participants in a process that requires letting go of securities and facing uncertainties. The process of confronting resistances and allowing unconscious elements, which were previously unacceptable to the ego, to emerge into consciousness requires courage on the part of the patient and the therapist. However, in order for change to be effected in the container of the therapeutic encounter a certain level of regression, anxiety and frustration is required. The therapeutic encounter is therefore by nature charged with energy, tension and fear and the

therapist is constantly having to monitor his own and the patient's anxiety. It is a natural inclination from both sides to attempt to close the gap and escape this anxiety. Patients do this by trying to manipulate the therapist into responding in ways that are familiar and safe. Therapists attempt to overcome their anxieties by hiding behind fixed assumptions, offering sympathy, giving advice and avoiding uncomfortable feelings. Resoluteness refers to the disciplined maintenance of this tension in the service of treatment goals, trusting that the analytic process will teleologically unfold without having to be directed. The unfolding of this process requires the therapist and the patient to become mutually involved in the emotional aspect of the transference. The transference cannot simply be explained away intellectually; rather it has to be "lived through" with the therapist. The criteria used to judge whether resoluteness was effective in this study included the following. These criteria provided a basic framework for evaluation and discussion.

Criteria used to judge the overall effectiveness of resoluteness.

1. To what extent was the therapist resolutely able to contain his own anxieties in the face of uncertainty?

2. How did the participants respond when the therapist lost his ability to maintain resoluteness?

3. How did participants respond to the atmosphere created by the stance of resoluteness?

4. Did the maintenance of resoluteness retard or promote the unfolding of psychological insight?

Participants' response to the use of resoluteness.

All three participants held strongly fixed neurotic certainties to which they returned repeatedly. Each participant expressed these fixed certainties differently. Participant One went through repetitive cycles with each new relationship and repeatedly returned to the level of somatic symptoms, especially in times of emotional distress. Participant Two felt safe in returning to a series of on-the-surface understandings and resisted engaging with the deeper meanings. Participant Three was caught up in considerable psychological pain as a result of her early childhood trauma: this pain governed most of her choices in her current life, but she was unable to perceive this or move past it.

Initially the therapist found these repetitions extremely frustrating. He attempted to promote insight and understanding by challenging the participants to recognise their repetitive patterns of thought and behaviour. On one occasion with Participant Two the therapist tried to impose insight; the participant proceeded to deny the interpretation, thereby indicating that she was not

yet ready to receive such an interpretation into consciousness. The therapist realised that his efforts to hasten the process derived merely from his own need to escape the frustration that he often felt when participants repeatedly remained with the same theme from session to session. However, he came to realise that such attempts on his part served only to distract the participants and delay the natural progression of the session. By using resoluteness and by maintaining it in the face of his own frustrations the therapist was able to understand the underlying need for these certainties in all three cases. For this reason he did not try to force insight but instead aimed at maintaining the tension that would propel them towards their own insights in their own time. By maintaining this analytic balance all three participants progressed towards very important insights in their own time.

Difficulties encountered in using the stance of resoluteness.

Resoluteness was at times interrupted by cultural factors. The therapist found that the maintenance of resoluteness in a cross-cultural setting was far more complex than he had experienced in a western cultural setting. He was aware of a series of needs on the part of the participants which he was initially unable to comprehend fully as these needs related more to the collective values of the participants rather than their western values of individualism. All three participants viewed the therapist as an authority figure or "elder" from whom they could request advice in times of difficulty. In such cases the therapist found it uncomfortable to be asked for, but simultaneously have to refrain from, giving advice. He was not always able to maintain this position and at times succumbed to advice-giving. This only occurred in times of extreme difficulty and distress when it appeared more therapeutic to console the participant rather than to refrain from advice.

The therapist often found himself in a position of ambiguity and uncertainty with regard to cultural meanings. At times he was unsure whether his internal responses to the communications of participants were appropriate to their cultural values. In such cases he found himself entertaining interpretations that simultaneously related to a western set of values and to a traditional cultural set of values. This fluidity of possible understandings was at times difficult for him to maintain and required a high degree of resoluteness. However, he generally found that by abstaining from any immediate interpretation the full meaning of the communication from the participant's internal world emerged with time.

Adaptations used by the therapist in maintaining the stance of resoluteness.

Part of the difficulty the therapist expected to encounter related to the participants' unfamiliarity with a vocabulary and modes of thought needed for introspection. He initially envisaged that one

adaptation that might be useful in maintaining resoluteness would be to educate participants with concepts, words and structures in which to think and express feelings and thereby arrive more rapidly and concisely at a deeper understanding of their emotional issues. An example of this was when the therapist explained the concept "persona" to Participant Two in order to help her discuss her use of a social front in interpersonal contexts. Initially she rejected the idea, but used the word several sessions later when she had come to her own understanding of how she adopted such a social front in relation to others. The therapist realised that the participants would learn and understand introspective concepts in their own time and that he had resolutely to give them this time.

In general the therapist noted that no real adaptations to the concept of resoluteness were necessary. All attempts to adapt resoluteness to his participants' perceived needs proved unsuccessful and counterproductive to their actual needs.

<u>Was the use of resoluteness successful overall.</u>

For the most part resoluteness worked very well. The therapist noticed that his initial response to the participant's perceived "stuckness" was to try and dislodge them from their fixed certainties. After recognising that this was unsuccessful he made every effort to contain his frustrations. This gave rise to a much fuller understanding of the depth and pervasiveness of each participant's condition. It served to alert the therapist to understanding the participants in ways that were previously clouded by his own frustration. The intensity with which participants held on to certain concepts, particularly with Participant One and Three, was proportionate to the intensity of the trauma they had experienced through their childhood abandonment. The need to remain with these concepts reflected the level of importance these themes carried in their current lives and the level of repeated attention such concepts required before participants were able to move on.

CHAPTER SEVEN: DISCUSSION

7.1: Context of Discussion

Introduction.

This study aims to make a contribution to the ongoing debate that has followed on from the Psychoanalytic Trust Conference held in Cape Town in March 1998. This conference represented a turning point for psychoanalytic thought and practice in South Africa. At this conference important questions were placed on the table concerning the relevancy, effectiveness and appropriateness of psychoanalytic work in post-apartheid South Africa. Certain critics (*Cape Times* article 26/09/02) have implied that psychoanalytic psychotherapy is not a suitable treatment modality for the vast majority of South Africans. The assertion has been tabled that this approach is an inadequate model of treatment for the psychological concerns of the poor as it is imbued with the western-centric cultural values of a White middle-class society.

Whilst it is fully acknowledged that financial status currently precludes the vast majority of South Africans from accessing psychoanalytic treatment, it is also true to say that previous economic imbalances along racial lines are currently being addressed and many Black South Africans are now expressing interest in western treatment resources for their psychological concerns. It is also true that traditional African forms of psychosocial treatment rely on collectivist action-oriented treatment procedures, which are contradicted by the western/individualist insight-oriented approaches to treatment. However, due to the fact that South African society is in a process of rapid social transition this study cannot support the perception that the practice of psychoanalytic theory is irrelevant to a new and developing South Africa whose people are increasingly adopting western ideals.

In order to examine these contentions more closely, the practical application of psychoanalytic psychotherapy to non-western individuals was explored. The analytic attitude as described by Ivey (1999) was applied to a specific cross-cultural context involving three Black South African women from an urban environment.

The **research question** under exploration in this study was:

- How does the therapist and each participant under study make use of the conceptual and practical framework of psychoanalytic psychotherapy comprising the analytic attitude and its counterparts the analytic task, process and setting?

The study **propositions** underlying this research question were:

- The conceptual and practical framework of psychoanalytic psychotherapy in its current form is inappropriate to non-western urban-dwelling individuals.
- The conceptual and practical framework of psychoanalytic psychotherapy requires modification in order to meet the cross-cultural needs of non-western urban-dwelling individuals.

In terms of the research question and its related propositions above the usefulness of psychoanalytic psychotherapy in a cross-cultural setting was explored using a case study method that focused on the analytic attitude, which incorporates the basic underlying framework through which psychoanalytic psychotherapy is practiced. The central focus of the study comprised the therapeutic dyad, involving the therapist and participant. The way in which each responded to the elements of the analytic attitude and its counterparts the task, process and setting was closely examined.

Foci of discussion.

In order to facilitate a comprehensive discussion of the findings it was decided to organise the material into five areas of focus that emerged naturally from the study. These five areas include:

- A) Discussion of the use of the analytic attitude in this study,
- B) Discussion of the use of psychoanalytic theory in this study,
- C) Discussion of relevant cultural factors that emerged in this study,
- D) Discussion of new pathways for psychological treatment in South Africa, and
- E) Discussion of the use of a case study methodology in this study.

This discussion is located in the material and theoretical stances outlined in the first three sections of this study. It takes into account the current use of psychoanalytic practice in South Africa and discusses the potential for further application and research.

7.2: Discussion of the Use of the Analytic Attitude in this Study

7.2.1: Study Findings

Analytic setting.

The maintenance of a secure analytic frame was for the most part uncomplicated. All three participants readily accepted the constraints and conditions of the analytic setting: this involved a one-on-one relationship with an older White male of a different cultural background; the

understanding that they were expected to divulge intimate thoughts, feelings, and beliefs without equal disclosure on the part of the therapist; and the concept that despite a high degree of emotional intimacy, this was a professional relationship that was bounded by time, space and financial commitment, demarcated by a set of relationship rules, and could not extend beyond the therapy room. The therapist was well aware that such a relationship would to some extent be felt as unnatural by any participant in psychoanalytic psychotherapy; he expected that individuals coming from the tradition of a collective self would have even more difficulty in adapting. The expectation that participants from a different cultural background would have to be educated into the nature, the expectations and the parameters of this form of treatment was unfounded. All three participants appeared entirely comfortable with this framework of treatment and no serious difficulties were encountered with the analytic setting.

As with all the elements of the analytic attitude the therapist had to be very clear about rigorously maintaining the parameters of the setting. Despite a general adherence to these parameters, the frustrations of such a setting for the collective component of each participant's sense of self were evident to the therapist. Participants occasionally expected the therapist to intervene in matters outside the therapy room, for instance in social, familial and occupational matters. However, the therapist was at all times able to maintain the boundaries without disruption to the therapeutic process.

Analytic task.

The analytic task involves providing a setting in which participants are able to think about and speak of their concerns. It was noted that participants entered the process at a high level of emotional engagement. Each participant was well aware of a strong emotional dimension to the difficulties and issues troubling her, and each appeared to be quite clear about the goals she wanted to achieve in therapy. This acknowledgement served to assist the therapist's task in that all three participants were already in the process of trying to access and think about their feelings. However, they initially had difficulty in articulating thoughts and feelings around emotional issues. By maintaining the elements of the analytic attitude the therapist was able to facilitate exploration of these emotional issues on two levels. The one level was in enabling the participants to explore ways of expressing these feelings; the other was in providing the analytic space in which to explore resistances, thereby confronting and integrating repressed material. This material was ego-dystonic and was therefore resisted or avoided initially. The therapist successfully sustained his task in establishing a setting of "concerned understanding" that was non-judgemental, with no expectations, no intrusive display of emotion on his part and which

showed a trust in each participant. The participants were thus able to achieve their own insights that increased conscious awareness of previously denied aspects of themselves.

Analytic process.

The analytic process refers to the maintenance of the analytic task and setting in such a way that participants achieve insights and acknowledgements of aspects of self that were previously resisted or not understood. The process is the product of participant and therapist working mutually to give rise to a third entity that transcends both of their individual contributions. Using these criteria to judge the analytic process, the outcomes achieved in these therapy processes reflected an acceptable measure of success. All three participants initially perceived themselves as victims of circumstance and partially powerless to take control and change their situation. Through the analytic process, all three were capable of recognising their own responsibility in the alleviation or maintenance of their difficulties, and further showed that they were able to recognise ways of redefining their concept of self, thereby accepting their degree of autonomy in changing their situation.

The therapist was able to create and maintain an interactive space between himself and the participant in which new insights were acknowledged and expanded upon. This interactive space reflected movement from resistance to negotiation. Initially participants were fixed in their neurotic certainties and unwilling to change underlying belief systems: they resisted input from the therapist and opportunities to explore the symptoms associated with their neurotic certainties. In the safety of the space provided in the therapeutic setting as part of the therapist's task, participants were able to negotiate beyond the margins of these fixed certainties.

Generative uncertainty.

The attitude of generative uncertainty was found to be particularly useful in the context of cross-cultural psychotherapy as it provided a mental attitude through which meaning could be considered from the point of view of the participant rather than the therapist. In this study the therapist was aware that the cultural meanings of certain symbols were not immediately available to him. Any attempt on his part to assign meaning from his own cultural background would have been potentially misleading or prone to over-simplification. By focusing on the participant in the here-and-now, without giving precedence to pre-conceived ideas, the therapist was able to adopt a relativist approach which encourages an attitude of open-mindedness that moves beyond the framework of theoretical knowledge; he was thus able to assimilate from context some insight into the meanings which participants assigned to various ideas and symbols.

Another challenge that emerged in the attitude of generative uncertainty related to the fact that participants were by culture inclined to look externally - to their community - for the answers to their questions and their difficulties, rather than search for such answers within themselves. Similarly in the therapeutic encounter they often looked to the therapist to provide answers. Generative uncertainty, rather than providing guidance, provides ambiguity; rather than providing answers, encourages further questionings; and rather than providing assurance provides uncertainty. Participants were therefore often thrown back on themselves and encouraged to generate their own solutions, understandings and answers. This position of focusing within went against a general inclination to search for meaning in the collective.

Neutrality.

Whilst generative uncertainty is about staying with the participant in the here-and-now, maintaining a stance of ambiguity and allowing her to search for her own potential meanings, neutrality relates more to what the therapist is thinking and feeling about the participant, and his attempts to work out potential meanings embedded in his own experience of her. In this study the therapist found that he was constantly negotiating internally with his own desire for understanding by searching for a theoretical "home" for the data that emerged. Neutrality requires the therapist to remain equidistant from the id, ego and superego. An appreciation of the different cultural configurations of id, ego and superego was necessary in order for this stance to be effective. The therapist was aware that his western background pre-disposed him towards a particular understanding of this structural model of the psyche. Unlike the pattern in western culture, superego needs were not necessarily the main regulator of behaviour: instead the ego ideal of the community with its reciprocities and hierarchical relationships was more likely to influence conduct. Similarly the western notion of the individual ego at the centre of consciousness had to be re-thought in terms of the participatory nature of the individual within a collective ego.

Neutrality was an aspect of the analytic attitude that required rigorous attention and consistent internal negotiation on the part of the therapist. The active practice of neutrality was particularly relevant with material of a cross-cultural nature. There were times when the therapist found that he was unsure whether certain material and stated beliefs that arose in the sessions were appropriate or in fact aberrant. Often if such material was placed into a western framework it would be considered aberrant; however, when placed into a non-western framework it was entirely appropriate. The therapist was required to shift between these modalities in order to reach his own understandings. The answers to such questions were often unclear and the therapist was forced to sit with the ambiguity of not knowing. In the context of cross-cultural psychotherapy

neutrality afforded the therapist recourse to a space of internal negotiation that was crucial to the unfolding of the analytic process. It allowed the therapist to hold thoughts, feelings and judgements, to question, organise and differentiate these impulses into their appropriate frames of understanding.

Abstinence.

Abstinence was the element of the analytic attitude with which participants experienced most difficulty. It was through the stance of abstinence that the collective aspect of the expanding self in all three participants was most obvious to the therapist. These collective needs required of the therapist that he assume a position of authority. This transference need of perceiving the therapist as an "elder" presented some difficulty for the participants, especially when he abstained from assuming this role. The therapist's efforts not to close the transference gap by falling into this role forced participants to consider themselves as their own authority. This role caused some tension as participants appeared uncomfortable in assuming this position and furthermore they initially found it difficult to verbalise their needs when forced back on their internal resources. This difficulty was not due to an inherent failure on the part of the participants but rather that their collective value system placed little emphasis on independent self-evaluation.

Participants tended to place their emotional welfare in the hands of the therapist. They openly asked for advice, support and guidance; efforts on the part of the therapist to resist these requests were at times disruptive to the therapeutic alliance as participants experienced difficulty in accommodating to this shift.

The need for support both in and out of the therapy room was best understood in terms of a central dynamic that was present for all three participants. This dynamic related to strong feelings of separateness and alienation arising out of a perceived lack of connectedness to the family of origin. The attempts to elicit support from the therapist were in effect a compensation for these feelings of separateness. The therapist's awareness of these strong feelings and needs challenged his position of abstinence. It became clear that some modification to this aspect of the analytic attitude were necessary.

Another challenge to abstinence presented itself in the manner in which participants elicited sympathy from the therapist through displaying high degrees of emotionality. This was understood in a cultural framework that places an emphasis on expressed rather than introverted displays of emotional experience.

In order to safeguard the therapeutic relationship, the therapist initially gave in moderately to such needs. However, with time this became less and less necessary. This modification to the practice of abstinence was recognised as a necessary adaptation to the analytic attitude that arose in direct response to the participants' cultural backgrounds. "Concerned understanding", the key concept in the stance of abstinence, was not enough for all three participants in the initial part of the therapy process: they required a stronger level of support. In spite of this adaptation, abstinence remained a very necessary part in the therapeutic process and served its purpose in that by the end of 40 sessions of therapy all three participants were expressing a much higher degree of self-evaluation than they had been able to do previously.

<u>Countertransference receptivity.</u>

Countertransference and transference communications occur on an unconscious level. The therapist found that he was able to identify and respond to such unconscious communications with relative ease. Although participants initially experienced difficulty with consciously reflecting and discussing their emotions, their unconscious feelings were more discernable. Through a rigorous awareness of his own emotional responses the therapist was able to identify the ways in which participants manipulated him into transference usage and identified the roles that they required of him. Countertransference receptivity allowed the therapist to be responsive to the emergence of unconscious archetypal meanings that went beyond the overlays of culture and associated cultural images of expression. The meanings emerging from such communications transcended the complications of cultural difference that occurred in other aspects of the analytic attitude. Ritual, rites of passage, bewitchment beliefs and the presence of ancestors were archetypal frameworks that were constantly evident throughout the therapy processes. The therapist could recognise these entities on one level as archetypal and transcending specific culture; he was, however, also aware that these entities had for the participants a far more immediate and less esoteric reality. The impact of these beliefs was not, in fact, problematic. While certain practices raised countertransferential feelings, the therapist was careful in his assessment of these and was able to internalise his response. An example of this was Participant Two's attitudes to her father's death which she saw not as a removal but as a translation of their relationship.

 The therapist found that he was able to develop a strong sense of each participant's internal object world. Understandings that emerged through this level of communication rose above the limitations of language and conscious self-reflection. Transference and countertransference communication contributed significantly to the analytic process as it provided access to meanings that were less accessible through conscious communication.

Personal countertransference factors that emerged were largely based on cultural difference. The therapist was aware of many personal feelings relating to prejudice and stereotype, inculcated through his own experience of growing up as a White individual in Apartheid South Africa. Furthermore, his own cultural views of individualism were strongly challenged by the established norms of collective belief concerning sex role stereotypes, male dominance, authoritarianism and other values that place the community before the individual. By being receptive to these internal cues and working with them the therapist was able further to develop his own cultural sensitivity and acceptance of difference.

Resoluteness.

Resoluteness allows for resilience and faith on the part of the therapist that even if he loses his way in the cultural differences a stance of consistency will ultimately ensure a re-balance. Working cross-culturally inevitably raises ambiguities and anxieties in the therapist that may not occur in other settings. An attitude of resoluteness was particularly useful in this context as it provided the therapist with the assurance that the feelings of discomfort and tension that arose from his own uncertainty would ultimately contribute to the process in so far as he was able to endure such feelings. In the initial part of therapy all three participants showed a strong tendency to concretise and externalise the source of their difficulties. Furthermore, difficulties with language, verbal expression of emotions, and internal self-reflection left the therapist with feelings of doubt concerning the progress of therapy. The therapist found that in the cross-cultural context of this study he was unable to rely on the usual signposts and guidelines to gauge the progress of therapy which he had access to in a more western setting. Symbols, events, behaviours and conscious reasonings that would be taken for granted with western patients could not be taken for granted in this setting. As a result the therapist was more frequently faced with the "unknown". He could not be certain of his participants' reactions and was at times unable to gauge whether the analytic attitude was in fact serving its purpose optimally. When participants repeatedly returned to the same themes from session to session he was unsure whether this was in fact due to a specific failure on the part of the analytic attitude or whether it was a measure of the depth of the participants' neurosis. In the face of such uncertainty the therapist was required resolutely to trust that his continued use of all elements of the analytic attitude would ultimately be beneficial and effective and that the process would unfold in its own time.

7.2.2: Summary of the Effectiveness of the Analytic Attitude in this Study.

In a close analysis of the therapeutic dyad and the units of analysis, it was found that participants did not show much difficulty in adapting to the analytic stance. In the three cases under study the

analytic attitude was found to be both useful and effective. The findings of this study therefore refute the initial propositions that this framework, namely the analytic attitude and its counterparts the task, process and setting, require extensive modification and adjustment in order to meet the cross-cultural needs of this particular group. It was generally found that no serious problems were encountered. In fact this study showed that when used rigorously the analytic attitude provided a way of working that was effective not only as a treatment frame, but also as a framework for the ongoing revision of psychodynamic theory.

By adhering to the basic ground rules implicit in the analytic setting, it was possible for the therapist to sustain a therapeutic environment through which the analytic process could unfold. All three participants showed that they were able to develop insights and endure the concomitant emotionality that gives rise to change. Debilitating depressive conditions lifted and significant behaviour change occurred. Furthermore all three participants remained in therapy for over a period of two years, well beyond the 40 sessions included in this thesis. In this sense the analytic task of assisting participants towards increased psychological insight was deemed successful.

During the course of therapy the concept of generative uncertainty represented an area of intense negotiation with all three participants, who initially showed a strong inclination to hold on to their neurotic certainties. These certainties often derived from a collective-self need to locate the source and solution of emotional difficulty in the external world rather than the internal world. The stance of neutrality - whilst requiring some modification - was particularly useful in this cross-cultural setting. It had to be exercised more rigorously than in a more western based setting as the therapist was compelled repeatedly to check and re-check his own western-based assumptions against the culturally specific meanings of his participants' experiences. However, it provided the therapist with an internal space, a place for negotiating and differentiating cultural meanings from his taken-for-granted western mindset.

Most aspects of the analytic attitude proved adequate for the cultural context to which it was applied; abstinence was an element which required overt modification, especially in the initial part of therapy. The degree of emotionality in the early stages of each participant's therapy process was extremely high; consequently a strong need for emotional support required the therapist temporarily to suspend his position of abstinence by offering appropriate compassionate responses that went beyond concerned understanding. Abstinence requires the therapist to abstain from action although not from feeling. Overt utterances of sympathy should therefore not be made. However, considering the cultural context of the participants in this study, which primes them to seek direct external and practical support for their emotional difficulties, a failure to

provide overt support was at times interpreted as a failure of understanding and care. It became clear through the course of the study that the abstinence element of the analytic attitude strongly reflects a western ideal that promotes insight, self-determination and validation on an individualised level. This stance was contradicted by the collective need inherent in all three participants for connectedness to the family, community and ancestors which is sought through external validation.

This modification to a more active demonstration of sympathy and understanding, mainly expressed through utterances, was in part driven by the strong emotional displays to which the therapist was subjected. This was understood as culture-appropriate in that the therapist became sensitised to the fact that internal suffering in individuals of collective culture tends to be expressed more overtly than in a conventional western setting, and seeks a more overt response.

In a cross-cultural setting a therapist is faced with many doubts and anxieties generated through "not knowing". Such anxieties were significantly higher in this non-western setting as the therapist was aware of his own lack of knowledge of the cultural framework of his participants. A stance of resoluteness provided a frame in which such anxieties could be contained throughout the process. Countertransference receptivity added a dimension to the analytic process that was very useful when working across culture in that it offered a level of unconscious communication and understanding that transcended some of the constraints encountered on the level of conscious communication present with other elements of the analytic attitude, such as difficulties with language.

The results of this study therefore serve to reinforce an understanding that, if used in the correct way, the analytic attitude - as described by Ivey (1999) - represents a relativist/constructivist approach that is highly successful in different cultural contexts. It encompasses a frame for treatment that does not impose judgement or direction but rather aims to provide a secure environment within which the unique meaning world of the participant can emerge. It offers a framework that not only allows the therapist to be sensitive to cultural difference, but also allows for such differences to be processed. The analytic attitude is by definition an attitude of self-reflection on the part of the therapist that contains inherent checks and balances to ensure that he is mindful of his own pre-suppositions and assumptions. Such a framework is very appropriate to cross-cultural work, where a high degree of vigilance is required to avoid universalistic judgements. In this study it was found that the various elements of the analytic attitude offer the psychoanalytic psychotherapist a sophisticated tool with which to monitor, evaluate and observe

his own and his participant's conscious and unconscious processes: it allowed the therapist to not only listen to his participants but also to listen to himself.

<u>Therapeutic gain as a measure of effectiveness</u>

All the subjects in this study experienced trauma in childhood and early adulthood. A common theme related to the fact that all three participants were separated from their parents in childhood. Participant one was sent to a child minder, participant two was sent to a White middle class boarding school and participant three was sent to live with her aunt in the Transkei. Feelings of separation were further exacerbated by the fact that all the participants had fathers who were physically or emotionally absent and mothers with whom they experienced complicated relationships. Feelings of abandonment, rejection and neglect were therefore presented as prominent themes. During the course of therapy participants were able to recognise the impact of these earlier experiences on their current level of emotional and inter-personal functioning. Neglect in childhood had left them with identity concerns, feelings of mistrust, inferiority and low self worth. As a way of compensating for feelings of low self-worth Participant One placed a strong emphasis on academic achievement and a constant search for the love that she felt deprived of. Participant Two compensated for such feelings by trying to gain acceptance through developing a "likeable" persona. Participant Three compensated by desperately searching for concrete evidence to establish a sense of identity and a sense of belonging.

During the course of therapy all three participants were able to recognise that the prism through which they viewed the world was strongly constructed around defences and ways of coping that had served a purpose in childhood but were no longer necessary in adulthood. In fact these defensive coping styles, which were organised around the protection of painful feelings of hurt and neglect, were responsible for all three participants feeling that their current difficulties were caused by others. Over time all three participants were able to shift away from "blaming" and feeling "let down" by others towards a more fluid understanding of how their own issues with trust, abandonment and rejection influenced their expectations of others.

In the process of therapy participants were also able to recognise the conflict they experienced between their western values of individualism and their traditional collective values. A strong need to be independent was frustrated by a simultaneous need to belong to the family and to conform to family expectations. These ambivalences were evident in the transference and were interpreted. Subsequently, all three participants were able to relax their defences and move towards an acceptance of their dependent needs. An acknowledgment of these previously unfulfilled needs for love and acceptance facilitated the transition from a position of conflict

towards a position of reconciliation with principal others and family members. These external reparations reflected a level of consolidation in each participant's interior world. As a result all three participants stated that they felt more empowered and more in control of their life circumstances.

7.2.3: The Analytic Attitude as a Relational Two-Person Model

The analytic attitude used in this study is that drawn from Ivey's 1999 paper *Thoughts on the "analytic attitude"*. This model reflects the relational two-person model of psychoanalysis that is in keeping with postmodern developments in psychotherapy. It is important to note that the analytic attitude has over time adapted to accommodate new theoretical and clinical insights with changing epistemologies. The classic analytic model of psychoanalysis that derives from a 19th century Vienna reflected the scientific ethos of the time. The scientist's task was to observe the patient's mind from a distance in the same way that he would approach any other phenomenon in the natural sciences. Freud's Drive Theory understood the entire basis of emotional difficulty and neurotic symptoms to be located intrapsychically within the patient. Such conditions were the result of internal conflict over instinctual impulses. Given this understanding pathogenesis was best understood through the therapist's remaining distant (Altman, 1995), in that such a position allowed him objectively to observe and interpret these intrapsychic processes: the scientist's subjective reactions were seen as a hindrance to this method of observation and every effort was made to avoid "contamination", by remaining outside the field of study. This classical psychoanalytic perspective was fundamentally orientated towards a one-person model. Psychological freedom was understood to have been achieved in as far as the patient became consciously aware of his unconscious impulses and conflicts. This one-person theoretical model strongly informed the way in which psychoanalysis was practised through the analytic attitude and its related techniques.

The analytic attitude as it was used at this time reflected this dominant positivistic epistemology. A position of anonymity, distance, refraining from gratification, and being reserved, was consistent with the positivist worldview. The therapist's interventions were confined to interpretation, which was not seen as an interpersonal act but rather as a way of informing the patient of the workings of his unconscious. Transference wishes facilitated through the frustration created by abstinence and anonymity provided the basis for such interpretations. The presence of the therapist was not seen as relating in any real way to the patient's reactions.

It is the assertion of this study that many of the criticisms surrounding the usefulness of psychoanalytic psychotherapy in a South African cross-cultural context derive from

misunderstandings of how the analytic attitude is currently used. Practitioners often have a tendency to view psychoanalytic psychotherapy as an approach that promotes a cold and detached stance towards the patient. Such a perception is more in keeping with a classical one-person model than the relational two-person model used in this study. This perception generally does not take into account that the theoretical understandings and practical techniques of psychoanalytic work have moved far beyond a one-person model. Whilst it is true that certain aspects of the classical stance have been maintained and the inevitable elements of dualism still exist, it is no longer possible to understand the concepts of abstinence, transference and neutrality today in the same way that it was described in the classical model. Transference for instance is not seen as emerging in isolation to the influence of the analyst, and countertransference is now given equal importance to transference. The inter-subjectivity of the encounter is emphasised; and the interpersonal processes of projection, projective identification and unconscious communication go far beyond the polarised understandings of the therapeutic encounter that belong to a classical mindset. Altman (1995) describes this development as the relational two-person model. He proposes that such a model offers a dyadic (rather than individual) perspective of the encounter incorporating a much deeper and broader understanding of the process. He states, "Contemporary relational theory seeks an integration of one and two-person models, of intrapsychic and interpersonal dimensions of the analytic situation" (Altman, 1995, p. 56).

7.2.4: The Analytic Attitude in Post-Apartheid South Africa

This study maintains that the analytic attitude deriving directly from the classical positivistic model is inappropriate and unable to access the nuances of cross-cultural work in South Africa. This is largely because the strict dualisms of the classical model imposed a universalistic framework that perpetuated a belief in the possibility of an objective, unbiased observer. In doing so it was unable to assimilate cultural differences or reflect on its own cultural assumptions. Working from within a classic model therapists were not encouraged to reformulate psychodynamic theory or even to question their own interpretations or role in the therapy process. For instance, in this paradigm feelings arising in the patient that relate to race, social, class, gender and power issues would be reduced to an intrapsychic level and would be understood in terms of a drive defence model of conflict. However, in a two-person model such feelings would incorporate the interactions about both the therapist's and the patient's subjectivities thereby providing a much broader set of meanings that relate to the cultural beliefs, attitudes and symbolic understandings of both participants. This use of the analytic attitude, situated in a postmodernist relational paradigm, is therefore far more suitable to cross-cultural therapeutic work.

As stated above the framework of the analytic attitude used in this study reflects a postmodernist epistemology, which is increasingly relational, moving away from the old traditions and beliefs. However, it must be recognised that the nature of this model still maintains some aspects of the dualistic structure. So long as western society promotes the individual, psychotherapy must reflect this fact. The postmodernist stance recognises that it is impossible fully to separate "self" and "other": the self will always interpret the other through its own biases. However, the therapist, although aware of the impossibility of being unaffected by his patient, will still attempt to provide a neutral setting and interpretive framework to further his patient's insights. The most important development in postmodernist psychotherapy is the therapist's recognition of his own thoughts, feelings, beliefs and interactions affecting his interpretations and attitude to his patient. The analytic attitude as it is used in this study provides a means for the therapist to reflect constantly on his own role as well as on the participant's responses within a two-person relational dyad. The relational model encourages the therapist to be aware of the impact of his own race, culture, gender and social class on the therapy process in ways that were not recognised as important in the one-person model.

However, it is also important to point out that in order for the analytic attitude to be used successfully it is necessary for clinicians to recognise its limitations. Psychoanalytic psychotherapy in both theory and practice derives from and is strongly situated in the social context from which it emerged. Not only does it reflect the dualisms of western thought such as self/other and subject/object but it also reflects the dominant principle of individuation in western culture through the precepts of differentiation, self-actualisation and transformation.

The entire framework of the analytic attitude and its theoretical backdrop is located within the framework of individualism. The analytic setting relies on a boundaried one-to-one relationship. Within this relationship pressure is placed on the subject to take responsibility and individual control for personal fantasies, thoughts, feelings, attitudes, behaviours and actions. Such an approach reflects the value that western society places on independent self-control, self-analysis, self-determination and self-reliance as a measure of good psychological health. Furthermore the analytic attitude operates on a principle of differentiation. For instance the transference-countertransference continuum is inherently about working out what belongs to the therapist and what to the subject. The entire process of the analytic attitude and its ground rules aim constantly to enforce a sense of differentiation so as to create a potential space for meaning to emerge. Abstinence, neutrality and generative uncertainty aim to ensure that the therapist does not identify too closely with the subject's internal world, refrains from closing the gap between both parties by offering advice or reassurance and in Ivey's words "not just tolerates ambiguity but actively

courts it" (1999, p. 7). This emphasis on differentiation causes a necessary state of tension and frustration with all subjects of western mindset but is particularly difficult for subjects who have an inherent collective self where the boundaries of self and object may not be as clearly delineated. As Ulmer (2003) states, "illness [in traditional collective culture] is addressed by [an entire] family approaching a healer, and would never be the concern of only one person" (p. 66). Not only is the one-to one treatment setting bounded by confidentiality an unfamiliar one, but also the level of personal responsibility enforced through differentiation goes against traditional directive-and-advice-giving styles of treatment.

As is suggested by the above there exist historical, political, social, race and gender concerns which are implicit in the practice and theory of psychoanalytic psychotherapy in South Africa. This study shows that the practice of psychoanalytic psychotherapy across culture is to some extent constrained by these parameters and if this approach is to be used effectively in a non-western setting it needs critically to re-examine these powerfully embedded social constructs. When referring to the practical use of psychodynamic theory in South Africa Swartz states that "Psychodynamic theory as a body of knowledge is universalising rather than context sensitive" (1999, p. 45).

In spite of these limitations this study shows that the analytic attitude situated in a relational model offers a framework through which these deeply rooted understandings can be challenged. As stated by Kareem and Littlewood (1992) "Intercultural therapy should never be allowed to become some specialised psychotherapy, to be targeted at Black people, but simply therapy which takes into account these issues" (p. 12). The analytic attitude therefore provides a frame-work that can assist clinicians in their ongoing attempts to develop culturally sensitive understandings. These new understandings will contribute towards challenging and ultimately revising the universalistic and etic[5] approaches that have previously been so prominent in the application of psychological treatment models across culture in South Africa. This study therefore supports the view proposed by Kim and Berry (1993) that a derived etic is both desirable and possible when working in a specific cross-cultural context. Further it proposes that the analytic attitude provides an excellent framework through which these derived etics can emerge, thereby informing and adapting existing psychoanalytic theory to the cultural context in question.

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[5] See Chapter Three page 57

The therapist was very aware from the outset of this study of the therapeutic challenge offered by having Black female participants who had all grown up in Apartheid South Africa. Initially the therapist was concerned about the fact that he was attempting cross-cultural psychoanalytic therapy. He was aware of his own complexities and sensitivities around issues of race, culture and ethnicity. Similarly, he expected that his participants would carry feelings and attitudes, conscious or unconscious, about the fact that he was White and a South African male. His main goal, therefore, in the initial stages was to establish a therapeutic alliance. That these three participants had chosen to attend therapy with a White male was considered significant from the outset and had implications for the therapeutic alliance.

As therapy progressed it became clear that all three participants were willing to maintain a satisfactory alliance and that the expected issues above were less intrusive than had initially been anticipated. The analytic attitude, with its emphasis on self-reflection for both parties, allowed the therapist room to encounter and work with his own personal counter-transference relating to race, culture and ethnicity. No overt concerns were raised by the participants on a political, social or gender level. The therapist was, however, aware that his maleness was culturally significant to the participants on an unconscious level in that he was incorporated into the collective structure involving "elders" and male dominance.

The therapist found that in his interaction with the participants that none of them seemed concerned with his "Whiteness"; they were more concerned with his cultural difference rather than his racial difference. While it is impossible to judge how much of an impact this factor might have had on an unconscious level, at no stage did it intrude overtly into the therapy process – despite the therapist's expectation that it would. It was evident that all three participants showed a strong awareness of cultural differences and verbalised this in a variety of ways. Participant One said "It is a cultural issue – you won't understand"; Participant Two claimed that she felt shy in speaking of cultural beliefs as she felt the therapist would "laugh at her", and Participant Three tried to educate the therapist about certain aspects of her culture, such as saying "In my culture a woman is expected to be a wife and a worker by my age".

The most obvious challenge to the success of the therapy for these three participants was the therapist's lack of in-depth knowledge of their culture. The analytic attitude allowed the therapist to perceive his lack in this regard, and he was therefore able to address it by reading literature on the topic. The therapist considered the implication of Black therapists working with Black patients in that such a relationship would be free of many of the cultural factors that emerged in

this study. However, his reading of the literature suggests that there may be many other dynamics in such a relationship (Palmer, 2002).

7.2.5: The Analytic Attitude as a Research Tool

Not only does the analytic attitude as used in this study provide a framework through which individuals can be understood in their own context, but it also offers a very sophisticated strategy of enquiry for ongoing research to those clinicians practicing psychoanalytic psychotherapy across culture.

As stated above the modifications required of the analytic attitude in this setting were minimal. If used correctly this approach proved to be highly capable of dealing with alternative cultural settings. The use of the analytic attitude in this study revealed two important considerations, Firstly it provided a sophisticated, open and disciplined framework of observation into the unique "meaning world" of each participant, her values and her cultural background. Secondly, by gaining access into this world the therapist was able to recognise not only the innappropriacy of his western-based assumptions of psychological health and development but more importantly the adequacies and inadequacies of psychodynamic theory in such a setting. The universalising and culture specific nature of development and conflict theory in psychoanalysis were strongly evident. In spite of this there were certain fundamental principles of psychodynamic theory that were relevant, but it was clear that these theoretical assumptions needed to be de-contextualised out of the culture of individualism and re-contextualised into a culture of collectivism for their full meaning to emerge.

7.3: Discussion of the use of Psychoanalytic Psychotherapy theory in this Study

The purpose of this study was limited to focussing on the applicability of psychoanalytic psychotherapy to a particular emerging group of South African women. In order to research this applicability this study focused on the analytic attitude, which represents the framework through which psychoanalytic psychotherapy is practised. However, the analytic attitude incorporates a particular mindset that involves not only an "attitude" but also a theoretical framework that underpins such an attitude. Whilst it is beyond the scope of this thesis to make recommendations on how the central concepts of psychoanalysis need to be adjusted, it is important to point out where certain such concepts arose that may need to be modified and re-contextualised within the cultural framework that it is being applied to.

Western-centric understandings concerning the healthy development of an individual who moves from symbiotic unity towards separation and individuation are deeply embedded in

psychoanalytic theory. The healthy development of ego resources, superego regulators for behaviour and an independent identity are expected to occur at specific age-appropriate levels. Similarly pre-oedipal anxieties and the passage of the Oedipus for boys and girls are expected to follow universal patterns. These concepts clearly reflect specific western values such as individual ego autonomy. They do not take into account kinship patterns existing in collective communities that place autonomy in the hands of elders who often exist at the centre of group consciousness and fulfil an ego function for this group. Kinship rules incorporating family expectations and hierarchical layers of authority (often patriarchal) are significantly different to western notions of family (Ulmer, 2003). Similarly spiritual beliefs and a reverence for ancestors incorporating rituals that mediate constantly between the living and the "living dead" are not well reflected in western notions of psychology. In such cultures disease, illness and misfortune are construed very differently and are often understood as a failure in kinship and ancestor relations and are treated accordingly. Whilst it is true to say that many of these traditional understandings have undergone considerable transformation, it is also true to say that they exist as a reference point in the collective element of self for most Black South Africans regardless of whether they belong to traditional societies or have adopted a more western lifestyle. Therefore, when applying psychoanalytic concepts across culture these understandings need to be re-contextualised into existing theoretical standards that accommodate psychological development in the context of family, kinship, and spiritual belief.

During the course of this study it became clear that the cultural specificity of psychoanalytic theory requires ongoing revision in order to be truly reflective of the needs of the cultural group that it is being applied to. Bracero (1994) states that such modifications to theory need to take into account the fundamental definitions of selfhood, experience of self in time, and values around separation-individuation that are specific to western middle class culture.

Challenging the central tenets of psychoanalytic theory is a necessary but difficult task. In the context of ongoing clinical training and research in South Africa Swartz states:

> To ask trainees not only to master psychodynamic theory sufficiently to be able to do a competent formulation, but also to modify that theory to take account of non-western values, might seem to be a tall order at this point in our history. However, it may also be the kind of challenge which will free us from the colonial past, and put us into a more fluid and enlivening relationship to psychodynamic knowledge (Swartz, 1999, p. 46).

Having established that certain psychodynamic formulations need to be revised, the question of whether psychoanalytic theory is able to accommodate such changes is raised. As stated earlier,

psychoanalytic theory is fundamentally mutable and flexible. Psychoanalytic theory was born out of a multicultural, multilingual environment and in fact has always shown a strong capacity to adapt to the social needs of society. Contrary to certain beliefs psychoanalytic theory has never been a static monolithic philosophy, it is flexible and is able to incorporate cultural difference to good effect. Whilst the necessary revisions to such theory cannot be attended to overnight the analytic attitude offers clinicians a way of checking and re-checking established theory and challenging universalistic assumptions with what happens in actual experience and, over time, suggesting changes.

This study supports the view that a universalistic approach to understanding and treating individuals across culture is inseparable from the social history of South Africa. As social transformation occurs there is an increased need to be critical of the taken for granted assumptions that previously obscured cultural difference. Efforts to reformulate the universalistic assumptions and theoretical understandings that belonged to a colonial mindset have been undertaken In fact psychoanalytically informed programmes are becoming well established in many cross-cultural community programmes (Swartz, 1999).

7.4: Discussion of Cultural Factors Emerging from this Study

As South Africa emerges out of its colonialist and apartheid past so the cultural identity of many South Africans is shifting and changing. As stated by Kareem and Littlewood (1992) cultural identity is not a fixed entity: "it is a dynamic re-creation by each generation, a complex and shifting set of accommodations, identifications, explicit resistances and re-workings" (p. 8). However, unlike many other multi-cultural societies, the natural process of social change in South Africa was deliberately skewed. Segregation was effected through legislation that enforced the continuation of separate identities along racial lines. Non-White individuals were encouraged to maintain a traditional way of life and were denied access to western political, educational and economic institutions. This apartheid system ensured that strong divisions were maintained between racial groups; hence many groups still live traditional rural lives, maintain strong collective values and speak only their mother tongue. As a result many South Africans are only recently emerging into a society that models itself on the western principles of democracy and places the emphasis on the individual. A new political dispensation that is structured in terms of a liberal western constitution and a bill of rights that protects the individual has had a strong impact on individual self-perception. Individuals are expected to take responsibility for their education, welfare and health through free economic enterprise, the legal system and educational and health care structures, all of which emphasise the rights of the individual (Ulmer, 2003). Similarly, other influences such as media and advertising have also contributed to these changing self-

perceptions. As a result it is becoming increasingly less appropriate to discuss South African culture in terms of the binary opposites of western and non-western.

In South Africa there is now a vast emerging group of individuals, especially amongst urban communities, who can now be construed in terms of an expanding self that incorporates traditional-collective and western-individual values simultaneously. A good example of this blend of values is reflected through changes that have taken place on the level of spirituality where elements of traditional ancestral belief and Christian belief are interwoven through Zionist churches that incorporate the Christian Holy Ghost and the ancestors into one interactive unit (Ulmer, 2003). This blending of traditional collective values and western individual values in terms of spiritual need is also occurring on the level of psychological need and different treatment structures are being sought that reflect these changing psychological needs. As South Africans continue to reformulate their cultural identities along these lines so issues concerning class, gender, health, status and power are also being reformulated. Similarly, the pathways followed for health care reflect shifting perceptions of health, illness and treatment. Any form of psychotherapy practiced in South Africa has to acknowledge the powerful historical connotations of the past and needs to accommodate the enormous social and psychological changes that are currently underway.

7.4.1: The Expanding Self

The participants who participated in this study represent a group of individuals that can be psychologically construed in terms of an expanding self. This emerging group is different to both the western and traditional groups and treatment strategies need to take this into account. The theoretical and practical aspects of psychoanalytic psychotherapy that are applicable to a western group are not wholly applicable to this emerging group and require certain adjustments. This study revealed that specific aspects of the participants' collective selves did not accord well with the analytic attitude and some modifications were necessary. These individuals have adopted the western values of individuation but unlike the western group they bring into the analytic setting an inherent learnt collective structure that was inculcated from birth. If psychoanalytic psychotherapy as practised in South Africa ignores this inherent structure then it will commit the error of universalising a western treatment strategy to a group that is in fact moderately different and requires different strategies for treatment. The tendency to overlook differences and to believe that all people are the same can therefore be counter-productive to developing appropriate strategies for treatment (Gibson, Swartz, & Sandenbergh, 2002).

The very fact that individuals in this group are using this form of treatment indicates that their needs are changing and, as in other areas of their lives, they are adopting western structures that reflect these changing needs. They actively sought out a western treatment modality that reflected their need to find personal solutions rather than collective/familial solutions for their difficulties. Psychoanalytic psychotherapy is a well accepted and widely used treatment strategy for western middle class individuals. It is not a useful strategy of treatment for individuals who are configured purely in terms of a collective traditional self as it is based on a set of expectations antithetical to traditional structures for healing, which do not place much emphasis on individual autonomy in the healing process.

7.4.2: Discussion of New Pathways for Treatment in South Africa

It is therefore not the contention of this study that psychoanalytic psychotherapy is readily adaptable for all groups. If the analytic attitude derives from western notions of the individualised self then it could be argued that it is only really suitable to those individuals who are adopting western values of individualisation. In this study the therapist was aware that he was working within the paradigm of the 'individualised self' drawn from his own culture and his theoretical training. However, he was also aware that all three participants wanted to work within this paradigm. In fact all three participants felt strongly about their own individuality and were grappling with a negotiation between the collective/familial demands of their cultural background versus their individual needs of self-determination. As mentioned previously, it became apparent through the process of this study that the 'collective self' in its traditional form is not suitable to the analytic attitude, which demands a high degree of self/other differentiation expressed through a learnt capacity to be self reflective: an ability to stand back and express feelings, thoughts and opinions deriving from a set of individual values, ideas and beliefs.

This research study highlights the fact that there is a growing need for a type of therapy that meets the needs of individuals who find themselves between the traditional (collective) world and the western (individual) world. As has been shown in this study when individuals from this group are faced with specific emotional difficulties they are beginning to recognise that the solutions to such difficulties cannot always be alleviated through traditional modalities of treatment. For this reason an increasing number of Black South Africans are seeking out other forms of treatment that coincide more closely with their western values and are more likely to place the emphasis on internal individual solutions rather than external collective solutions. In other instances these individuals also find that there are specific life problems that cannot be adequately addressed through the western treatment structures of psychotherapy and in such cases they may

concurrently choose to use traditional modalities of treatment, such as consulting the ancestors through a traditional healer.

7.4.3: Working across Culture

As Buhrmann (1984) states:

> It is so self-evident and yet it must be stressed: no one can understand, respect fully or enter the inner world of another, be that other a person of his own culture or from another culture, without knowing the history of his people and their world-view, or how that person experiences and interprets personal and historical events (p. 24).

Whilst this statement is true, it is also true to recognise when working cross-culturally that differences do exist and that in spite of good intentions there will always be things that divide people (Gibson et al., 2002). Practitioners in South Africa may tend to be especially uncomfortable with the notion of difference because historically "ideas about difference" have been used to oppress and subjugate people (ibid). Recognising the possibility of difference is not the same as using difference as a weapon against people. As Kareem (1978, cited in Kareem and Littlewood, 1992) states, psychotherapy must take into consideration the whole person's life: it cannot deny consideration of his race, culture, gender, or social values. Racial differences between therapist and patient must also be considered, although it is acknowledged that such differences can be counter-therapeutic when they are institutionalised in systems of power. Kareem provides the following definition of intercultural psychotherapy:

> A form of dynamic psychotherapy that takes into account the whole being of the patient – not only the individual concepts and constructs as presented to the therapist, but also the patient's communal life experience in the world – both past and present. The very fact of being from another culture involves both conscious and unconscious assumptions, both in the patient and the therapist. I believe that for the successful outcome of therapy it is essential to address these conscious and unconscious assumptions from the beginning (cited in Kareem and Littlewood, 1992, p. 14).

7.4.4: The Analytic Attitude as a Culture-Sensitive and Sensitising Tool

The importance of initially accepting that differences do exist and then processing these differences is paramount. In this study the therapist had to acknowledge his own concerns about his difference as a White therapist working with Black participants. He had to take into account, not only his identity as a post-apartheid White South African, but also his education, upbringing and his own western beliefs that would consciously or unconsciously affect the way in which he worked with his patients. Being a White therapist and from another culture had its obvious drawbacks, mostly relating to a lack of knowledge about cultural norms, and the perceived political legacy of being South African. However, this distance at times had a positive effect in

that it seemed easier for participants to discuss certain issues that would be considered taboo, or at the very least difficult to discuss with someone from their own culture. This sentiment was verbalised by Participant Two when she said, "It's easier to talk to some-one who's not from my culture [about these issues]". The therapist recognised that by his belonging to a different culture the participants felt they would not be judged from within their culture, as he was not a part of it. This made communication on certain themes easier. The analytic attitude afforded a space for these acknowledgements of difference to be absorbed through the concept of neutrality. Furthermore the analytic attitude was able to accommodate what is referred to in (Gibson, 2002) as "cultural countertransference – which involves a collection of feelings about culture and difference that practitioners may hold towards the people they work with; and cultural transference – the way in which subjects react to practitioners" (p. 86).

Gibson et al. (2002) introduce the concept of a "working misunderstanding" which derives from anthropological insights concerning working across culture. This concept maintains that it is not necessary to aim at complete understanding when working across culture - in fact this is not possible. The best that can be achieved is to recognise that differences exist and that for both parties such a relationship will always be imperfect. As Gibson states, "It is all right not to know – any process of counselling is a process of discovery for both the client and the counsellor" (p. 87). In terms of the analytic attitude this concept is well established. In fact the idea of balancing the tension of on the one hand "not knowing" and on the other "concerned understanding" is central to the analytic attitude. Together these concepts reflect the notion of a "working misunderstanding" which has as its basis a recognition of the inherent difficulties of working across culture but also the value of such a relationship within these limitations. Whilst the analytic attitude provides an "attitude" of openness, which makes way for a necessarily unobstructed view of the individual, it is also important to recognise that such a view can never achieve a full understanding of the other.

In this study the therapist found that there were instances when he did not understand his participants' reactions and communications. For example the therapist's understanding of death from the cultural perspective of Participant Two was incorrect. His expectations around her emotional response towards the death of her father were western based. He made specific misinterpretations which arose from his attempt to apply universal validity to his western concept of death. Similarly the therapist's approach to dreams from a symbolic perspective was insufficient as participants tended to see their dreams in a more literal framework. For example when Participant Two dreamt about her deceased father, she understood this as an actual visit from her father. Abstinence, neutrality and resoluteness afforded the space to internally negotiate

these instances on an ongoing basis. Generally the culturally specific meaning of such reactions emerged with time and insight was assisted through having a basic knowledge of concepts such as universalism, individualism, dualism and collectivism. This knowledge of different conceptualisations of self and the participant's attempts to negotiate an individualised self with its concomitant expectations assisted the process enormously. A basic understanding of the cosmology, especially the role of ancestors, the place of the individual, the literal meaning of dreams, and the tendency to objectify internal objects in the external world was extremely useful to the process. This study demonstrates that such basic knowledge should be a part of the training of all individuals working cross-culturally for two reasons: firstly it assists the therapist to challenge his own individualistic assumptions and secondly it enhances his understanding of some of the choices, goals, tensions and conflicts that he is bound to witness in his patients.

7.4.5: Language and Communication

From the outset of therapy participants were able to access feelings and emotions with relative ease. However, as English second language speakers they were not always able to articulate these feelings and find the appropriate words to describe their inner experience. Whilst some of the subtle nuances may have been lost, in general it was felt that language differences were not an obstruction to communication. Participants were rarely at a loss for a word and the underlying sense of meaning always emerged in spite of language constraints. At times the therapist found himself being stimulated into offering different word options if participants were at a loss. Generally participants would pick up on one of the words offered and would internalise the word, often using it later. Whilst the therapist recognised that his introjections created the possibility for a distortion of underlying meaning of the participant's experience, he also recognised that it was at times necessary in that it brought some relief to the participant and assisted the flow of conscious expression.

The therapist realised the importance of attempting to understand the way in which the participant was using a word. Rather than adopting a prescriptivist/universalist position, which maintains that there is a fixed universal meaning to a word, he was encouraged to take a more relativist position, focusing on the particular usage of a word for each participant.

The fact that English was a second language for the participants of this study was therefore an important consideration. In a setting involving first language speakers the therapist would be inclined to place more emphasis on the choice of the word. This would be based on his understanding that certain words carry specific meanings and that the choice of one word may deliberately be carrying connotations that the choice of another word would exclude. In a second

language setting it was not possible to place the same emphasis on the word itself. Rather than listening to meaning encapsulated in word choice the therapist had to place the emphasis on meaning that was transmitted through other forms of communication, particularly the affective exchange.

7.5: Teaching and Training in Cross-Cultural Psychotherapy

Swartz, (1999) states that psychodynamic teaching and training in South Africa has historically been associated with White institutions. As a result most clinicians working in a psychodynamic oriented framework tend to be White. Furthermore these clinicians almost exclusively establish themselves in practices that serve a White middle class population - which is precisely the population that psychodynamic theories assume as the norm (ibid). In the recent past therapists were not compelled to encounter the needs of the greater population, therefore there was little incentive to challenge ethnocentric and classist assumptions that characterise the theory and practice of psychodynamic treatment. As transformation has occurred in South Africa there is an increasing pressure to revise this stance. Swartz states that much of the literature on psychodynamic thinking assumes a uniform model of the development of the unconscious, of conflict and of defence. She states further that, "one of the benefits of working in a culturally diverse country is that there is ample opportunity to challenge those values which conflict with the cultures of our patients, and to modify theory where necessary" (1999, p. 46).

The therapist in this study was a White South African male who was working with Black South African females. Certain factors became evident to the therapist during the course of this study that could be useful for other therapists working under similar cross-cultural circumstances. An important factor was that cross-cultural work requires considerable conscious effort. When working with a patient of the same cultural background, education, socio-economic status and cultural heritage there is an element of shared meaning that can be taken for granted. In the cross-cultural setting nothing can be taken for granted and the therapist is required constantly to assess and re-assess his own responses and those of his patient. The cultural and historical differences that currently exist between a White therapist and a Black patient in South Africa are significant and must not be understated. It is only through having a full appreciation of these differences - historical, cultural, socio-economic and political - that the therapy can proceed. Denying such differences would only serve to obscure the very attitude of openness that the analytic attitude attempts to achieve.

The therapist became acutely aware of the importance of critically evaluating the tools of treatment. An appreciation of the concepts of individualism and dualism and the way in which

these concepts inform the theory and practice of psychoanalytic work was extremely beneficial. Furthermore, it was important to have an understanding of the cultural worldview of the patients he was working with. The single most important understanding which assisted the therapy process enormously related to the way in which "self" is configured in traditional communal living. An appreciation of the fundamental fact that in a collective culture the group, its needs, goals and expectations are more important than the individual's needs and aspirations assisted the therapist with a much deeper understanding of concerns relating to reciprocity, hierarchy, dependency, accepted roles and family expectations that participants brought with them into the therapeutic encounter. This configuration of self is strongly reflected through language. For instance in the Xhosa language the expression "Umtu Ngumntu Ngabantu" can be literally translated as: "a person is a person through (or because of) other people" (Ulmer, 2003). The inherent need to maintain a sense of identity that was community and family based was present in all three participants despite the fact that they were also aspiring towards a sense of individual autonomy. The need to belong to the family, and to maintain strong links most often through material assistance and financial support, became clearer to the therapist when considered in terms of the collective self. Identity is powerfully related to belonging. The immense fear and lack of meaning that comes with severing family ties through increased urbanisation and translocation was represented as a central concern for all three participants.

By understanding that participants had been born into patriarchal systems where the expression of individual needs, especially for women, are generally subordinated to the needs of the group, it became much easier to understand why participants sometimes found difficulty in expressing certain emotions, such as anger to parents (which would generally not be tolerated in traditional households). Furthermore it became easier to understand why participants succumbed without question to certain rituals and expectations that were enforced on them by elders. Most importantly, however, such an understanding alerted the therapist to the intense difficulty that participants were experiencing by adopting western values of self-determination. These values often existed in direct opposition to the learnt principles of their collective upbringing. It also became clear to the therapist that the subject/object boundaries that are taken for granted in western culture such as life and death, self and other, individual opinion versus group opinion were not as strongly delineated. The principle of subject-object unity in collective culture giving rise to a group ego identity explained why the participants at times found it difficult to express and verbally articulate inner thoughts, opinions and feelings. Whilst all three participants had become sufficiently individualised to stand back and express themselves from the position of an individual ego identity this new emphasis was learnt rather than inculcated from birth. A strong understanding of the internal negotiations and conflicts inherent in this configuration of self - the

expanding self - which included both collective and individual elements, was of paramount importance to the therapy process.

It has become increasingly evident that the use of psychoanalytic models for treatment across culture in South Africa is often viewed with suspicion. As stated at the outset of this study, the couch - and by implication, psychoanalysis - is viewed as an inappropriate tool for helping the previously disadvantaged deal with their problems (*Cape Times* article 26/09/02). Such an opinion is held not only by professional bodies who inform psychological practice but also by individual practitioners who, for their own unconscious reasons, may hold particular transferential beliefs towards the analytic attitude itself, seeing it for instance as comprising a set of rules representing a punitive superego (Ivey, 1999) or a controlling parent. On the contrary the therapist found that a full grasp of the concepts incorporated in the analytic attitude when used as a two-person model, such as neutrality, generative uncertainty et cetera, allowed for a form of treatment that transcended many of the boundaries and constraints of other psychological approaches. However, he also recognised that in order to maximise the benefit of this approach cross-culturally it was necessary for practitioners to have a full grasp of the relational quality of these concepts and the way in which technique has developed beyond the classical one-person model belonging to a positivist epistemology. It is only through a full appreciation of the inter-subjectivity and relativity of this approach as well as its internal checking mechanisms for overcoming a natural inclination towards universalising that the full benefit of this framework for cross-cultural work in South Africa can be realised.

7.6: Discussion of the Use of a Case Study Methodology in this Research

The aim of this study was to examine how the therapist and each participant under study makes use of the conceptual and practical framework of psychoanalytic psychotherapy comprising the analytic attitude and its counterparts the analytic task, process and setting. The case study approach served to provide a unique insight into the relational aspect of the therapeutic dyad. Ironically, the very focus of enquiry, the analytic attitude itself, assisted the research process both in that it was not only the focus of enquiry but also the means of implementing the enquiry. The particular use of this qualitative method from the standpoint of a postmodernist epistemology provided the researcher with a framework that allowed for a more substantial and unbiased access to the material under study. It also provided a way of overcoming some of the shortcomings of similar case-based studies conducted in the past.

An important concern in this study related to establishing the legitimacy of the research. Case studies have often been criticised for lacking confirmability – that is, rigorous controls against

researcher bias. As stated by Edwards (1998, p. 61), "Enthusiasm for a particular interpretation or desire to make a particular point can lead to writing case synopses that are distorted by the aims and assumptions of the writer". This point is further emphasised in Edwards (1998) who points out that whilst the brilliant and pioneering psychotherapy case studies of Freud served as the foundation for the development of psychoanalytic theory, studies such as these have been criticised for lacking validity in terms of bias and selection effects that detract from the genuineness of the data collected. This study uses a postmodernist perspective which offers a critical epistemology that aims at developing new ways of seeing, interpreting, arguing and writing. It is mindful of the bias inherent in all representations of research data and by acknowledging these concerns it alerts the researcher to the difficulties that are involved with any form of qualitative investigation. These difficulties include the almost impossible task of claiming objectivity when reporting events, and the difficulties involved in developing a set of criteria to evaluate the legitimacy of the results. An awareness of these concerns (referred to as the crisis of representation and the crisis of legitimation) has allowed the researcher to ensure that the research design included measures of control in an attempt to overcome, as far as possible, these potential threats to credibility through observer bias.

By situating the study within a postmodern framework the researcher was in a better position to decide on the most suitable research design. It also provided him with the awareness that there is no single design which has precedence over any other. He was not constrained by a need to situate the study in any particular paradigm, but was free to utilise guidelines for data collection that evolved from a postmodernist position, such as incorporating verbatim material from the participants, as well as his own personal responses, into the data collection. In the data analysis he was able to incorporate a more disciplined approach, drawn from a more scientific mindset. Further, when evaluating the emergent data the researcher was not obliged to adhere to the conventional positivist standards for establishing study credibility - such as validity and reliability - but rather, by not laying any claim for absolute objectivity, was able to use other more realistic measures to ensure that the study was trustworthy, disciplined and rigorous.

The aim of the study was not primarily to generalise to a physical population but rather to a theoretical body of psychoanalytic knowledge on the analytic attitude. The transferability or generalisability of the research findings depended on the level of credibility achieved in this study. The researcher used a number of methods to ensure credibility. Triangulation involved of collecting data on the therapist's experience as well as on the participant's experience and verbatim responses. Further it was of the utmost importance to contain this study within the parameters of the elements of the analytic attitude which comprised the principle focus and to

apply these parameters to each step of the processes of data collection, data analysis and data interpretation (Edwards, 1998). Other methods of establishing credibility involved attempts to be rigorous by outlining a protocol for procedure and ensuring that the data collection did not incorporate extraneous or selective information. This was enacted through a process termed data reduction which was a measure to safeguard against over-generalisation of the material. This method of data reduction also allowed the large quantity of data to be organised into manageable units within the elements of the analytic attitude.

This study does not lay claim to the findings being directly representative nor does it claim that a similar study would draw the exact replicable conclusions. However, it does claim that the findings within the study can be reproduced and are therefore dependable. This dependability and thus legitimacy of results are substantial enough to add to and further inform a general body of theoretical knowledge on the analytic attitude.

By using Ivey's (1999) model of the analytic attitude, applying it to a particular cross-cultural setting and using strong measures to control for credibility, it follows that the results obtained can be used to inform new theoretical perspectives on this attitude. The response of the therapist and the participants to the analytic attitude is generalisable to similar situations of cross-cultural psychoanalytic psychotherapy. This study has demonstrated that Black South African individuals in a state of cultural transition are not constrained by cultural or language considerations in gaining benefit from the use of psychoanalytic psychotherapy conducted from within a two-person model.

7.7: Limitations of the Study

This study aims to overcome an objective modernistic understanding of the "other" by focusing rather on a process that incorporates both subject and object. However, the researcher experienced some difficulty in attempting to transcend terminology that is characteristic of a modernistic mindset. This was due to the fact that features of dualism are so embedded in western culture that language itself reflects this subject/object duality. Words such as "effectiveness" and "determine" are used throughout this study. Whilst it was well acknowledged that such terms are inappropriate to a postmodern mindset it was felt that in order to communicate the findings of this study to a research community these language constraints were unavoidable.

From a postmodernist position of doubt the entire study was situated within the double crisis of legitimation and representation. This could be construed as a limitation in that it raised concerns of biased reporting when making connections between the text and the world being written about.

The researcher was well aware that he was simultaneously enacting two roles in this study: the role of therapist and the role of the researcher. The researcher/therapist was an intrinsic part not only of the data collection but also of the data itself. Given that the data collection procedure was situated in a postmodern framework the researcher felt comfortable with these two roles in that he felt no compulsion to position himself as an objective observer. In fact a postmodern position of enquiry would claim that it is impossible for any researcher to be thoroughly objective.

However, the tension that did exist related more to the credibility of the data that was selected. The decision to include or exclude data was strongly influenced by the researcher's judgement and experience. For instance, the therapist's awareness of his own ability or inability to maintain an analytic balance as well as his capacity to monitor participants' responses to the analytic attitude were strongly dependent on his understanding of the analytic attitude. Despite the fact that the therapist/researcher was well acquainted with the analytic attitude, it could still be argued that the information chosen would reflect the researcher's own bias and level of proficiency. The quality of the information gathered was therefore directly proportionate to the researcher's ability, knowledge and experience. Whilst this created a tension and concern for the study, there were certain measures that could be implemented to increase credibility. Efforts to establish that the findings of the study could be confirmed by similar studies relied more on the data itself rather than on the objectivity of the researcher. By constantly referring to and quoting the verbatim responses of each participant, the quality of the data was allowed to speak for itself. Furthermore, the data collection was enacted through a research design that was delineated by clear parameters which served to increase dependability.

A general fault and central criticism of case based research is that it generates vast amounts of unnecessary information. It was stated from the outset of this study that the data collection procedure would be structured to avoid the pitfall of including all the information generated by 120 sessions of therapy for three separate dyads. By exercising what Edwards (1990) refers to as data reduction the researcher limited the data collection to information that was relevant to the research question and its propositions. Data collection was organised around the principle units of analysis and focused on issues that related to the eight elements of the analytic attitude. An outline of the exact procedures for how the data was collected was therefore paramount in order to establish that the data was dependable. This meant that the researcher was required to place a strong emphasis on the research design. In an effort to maximise dependability the researcher went to considerable lengths to explain exactly how the data would be chosen. At the beginning of the individual case reports the researcher provided an outline of the main features of each element of the attitude to remind the reader of the central points that would be focused on.

Furthermore, a set of criteria was generated for each element to assist the researcher in selecting relevant information. These measures served to increase the credibility of the study by attempting to overcome researcher bias in as far as this is possible for any study.

Further research in South Africa that focuses on a rapidly emerging group of Black individuals who are beginning to use western psychotherapy as a treatment choice will have to be completed before a substantial derived etic can be established that is representative.

7.8: Conclusion

This study recognises that psychoanalytic theory and technique is in a constant process of change and adaptation. In the evolution of psychoanalytic practice two important paradigm shifts have occurred: the change from a drive-reduction model to a relational model and the shift from positivism to constructivism. This shift to constructivism requires the use of a relational system in which experience is continually and mutually shaped (Stolorow et al, 1994). Furthermore, this shift represents a deconstruction of the objective-subjective dichotomy, leading to the creation of a world of mutual influence and constructed meaning (Rubin, 1997).

The model of the analytic attitude used in this study strongly reflects the spirit of these new developments. The therapist in this system recognised that his participation in the process had a continuous effect on his understanding of himself and the participant. This study suggests that the practice of psychoanalytic psychotherapy from this postmodern position represents a suitable framework for treatment in the context of cross-cultural work in South Africa. The intersubjective and relational quality of this system is able to assimilate the difficulties and demands of working across culture. Furthermore, this position, which is by nature sceptical and critical, affords a way of challenging the constraints of a universalist mindset that has dominated treatment in psychology and psychiatry in South Africa.

Since the ending of apartheid there is a large emerging group of Black South Africans who can be construed psychologically in terms of an *expanding self*. Clinicians working cross-culturally with this emerging group need to adopt a critical postmodern stance towards the way in which they practice psychoanalytic psychotherapy. It is not possible to ignore the differences and assume that the same treatment strategies that are applicable to a White middle class community will be effective with this group. Furthermore it is not possible to exclude the historical, political and economic context from which this group has emerged. In fact this study shows that clinicians working in this context need to be acutely aware of their own taken-for-granted assumptions and need also a basic knowledge of the concepts of individualism and dualism and the way in which

these concepts inform the theory and practice of psychoanalytic work. It is also important for clinicians to have some understanding of the cultural worldview of their patients and the way in which "self" is configured in traditional communal living.

The analytic attitude used in this study as described by Ivey (1999) conforms to a relational/-constructivist paradigm. The participants and the therapist responded well to this model and no extensive modifications were required. However, certain adjustments to the stance of abstinence were necessary and high degree of critical self-evaluation and constant re-checking was required on the part of the therapist through neutrality.

This study recognises that the relational model emphasises the creation of a shared subjectivity, which represents an attempt to overcome the objective/subjective dichotomy. However, it also recognises that elements of dualism are strongly present in the general use of psychoanalytic theory and practice. Although current changes in psychoanalysis point to a shift from positivism to constructivism, it would be short sighted to conclude that this shift is absolute (Rubin, 1997). It must be emphasised that the analytic attitude still reflects the standards, myths and western-centric beliefs from which it has derived. Individualism is at the centre of this framework and more importantly the theoretical backdrop is strongly informed by western notions of dualism. It must be acknowledged that whilst the analytic attitude reflects dualistic structures it simultaneously affords a way of overcoming these constraints through offering a working strategy that lends itself to the continued revision of basic psychoanalytic concepts. In this sense it allows for the development of new psychoanalytic meanings that are derived through de-contextualising original concepts from their western mindset and re-contextualising these concepts into the cultural patternings of the group under study.

This study showed that if used correctly the analytic attitude allows for cultural difference to be absorbed into the treatment encounter to good effect. It lends itself to overcoming gender, race, ethnic, cultural and historical factors and it provides space for necessary self-evaluation on the part of the therapist. In fact this study shows that contrary to certain beliefs psychoanalytic psychotherapy conducted within a relational model proved to be an effective and valid treatment approach for a group of urbanised English-speaking Black female individuals between the ages of 25-35.

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APPENDICES

Appendix 1

<u>CONSENT FORM</u>

Name:………………………………………………………………………………………………

Date of birth:……..…………………………………………………………………………..

Occupation:…………………………………………………………………………………...

Level of education attained:…………..………………………………………………

Matric English:………………………………………………………………………………

Address:…………………………………………………………………………………………

Contact Numbers:………………………………………………………………………...

_____

I………………………………………………….**hereby agree to participate in the research project of Mr G.F.H. Read entitled** *Psychoanalytic Psychotherapy and the Analytic Attitude: A Cross-Cultural Case Study Approach.*

I am aware of the following:
- **I am aware that my psychotherapy treatment takes precedence over my participation in this research study. If I choose to withdraw from the study this decision will in no way affect the course of my psychotherapy treatment.**

- **I am aware that I can withdraw from this study at any stage if I choose to discontinue participating.**

- **I am aware that this research project comprises a PhD thesis, which will be printed and held in the Library of the University of Pretoria.**

- **I am aware that I have the right to peruse a draft copy of this thesis and to request the withdrawal of any information that I feel is too sensitive.**

- **I am aware that all efforts will be maintained to exclude identifying data from this research study.**

I agree to the following:
- **That all records; interviews, assessments, note taking and information gathered during the course of the psychotherapy process may be used for the purpose of research.**

- **That the results of this research may be used for the purpose of a PhD thesis through the University of Pretoria.**

- **That the results of this research may also be used for printing, publication and teaching purposes.**

- **I am over the age of 21 and therefore able to take full responsibility for my own consent to participate in this research.**

I understand all the details pertaining to this research study and agree to the above conditions.

Signed………………………………………………………………………………………
Date………………………………………………………………………………………

Appendix 2

LETTER OF INTRODUCTION

Research Thesis: Psychoanalytic Psychotherapy and the Analytic Attitude: A Cross-Cultural Case Study Approach

This research will be conducted by Mr Gary Read who is a registered clinical psychologist (Practice Number: 8632472) for the purpose of a thesis, which will be submitted in partial fulfilment for the requirements of a PhD (psychotherapy) degree under supervision of the department of psychology, University of Pretoria.

To prospective subjects participating in this research study

It is important to state clearly to all those subjects who choose to participate in this research project that all information gathered during the data collection process will be treated with the utmost confidentiality and anonymity. Subjects will be asked to provide written consent for the use of their data on the understanding that all identifying data such as names, places and events will be removed before print. Subjects will be in control of the data that is included in this project and will have the right to remove any information that they feel may be identifying or unsuitable for print.

Yours sincerely
Gary Read

Acknowledgement of receipt

Participant name

Signed

Appendix 3

<u>Acceptance Form</u>
<u>Subject Perusal of Completed Dissertation and Acceptance of Content</u>

- **I hereby acknowledge that a completed version of this study has been perused by me**

- **I have considered the contents of this study and am satisfied with all attempts to maintain the anonymity of the participants**

- **I hereby provide consent for the publication of this material in the form of a University dissertation.**

Name………………………………….

Signed…………………………………

Date…………………………………