

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 transference 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 transference 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 transference 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 transference 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 were participants able to engage emotionally with their latent insights?

Participants' responsiveness to the use of the analytic process.

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 transference 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 provocational 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 unquestioning. 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”.

Difficulties encountered in the analytic process.

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.

Criteria used to judge the effectiveness of abstinence.

- 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?

Discussion of the use of abstinence for three participants.

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 transference 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 transference 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 transference 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 transference 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 transference 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 were 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 transference 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.

Was the use of resoluteness successful overall.

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.