

https://dspace.org/

Black clinical psychologists' experiences of race in psychodynamic psychotherapy.

Mbele, Zamokuhle

2012-02-14
http://hdl.handle.net/10539/11305

Downloaded from a DSpace repository. https://dspace.org/

Black Clinical Psychologists' Experiences of Race

In Psychodynamic Psychotherapy

A research report submitted in fulfillment of the requirement for the degree

Master of Arts in Clinical Psychology

In the faculty of Humanities at the
University of the Witwatersrand, Johannesburg

October 2010

By:

Zamokuhle Mbele

Supervisor:

Renate Gericke

Declaration

I declare that this research report is my own, unaided work. It is submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

Signed this _____ day of _____ 2010.

_____

Zamokuhle Mbele

Abstract

From colonial and post-colonial periods to apartheid and post-apartheid contemporary South Africa, South Africa's history has highlighted the salience of race and racial identity in its society. The profession and discipline of psychology in South Africa has paid limited attention to the role of race in psychotherapy, particularly for racially diverse therapeutic dyads and for black clients and black therapists. This may be informed by the historical exclusion of black and other non-white South Africans from the profession and its services for many years.

The aim of this study was to explore black clinical psychologists' experiences of race; with racially similar and dissimilar dyads. Three central concepts to psychodynamic psychotherapy namely; the working alliance, transference and countertransference, were identified as areas of particular interest in the study. The study investigated how the clinicians understood these concepts to be influenced by race within the clinical space. The research design used for this study was qualitative. The research method used was semi-structured interviews with seven black clinical psychologists in Johannesburg, South Africa. Thematic content analysis was used to elicit themes from the interviews.

The findings from the interviews can be summarized under four themes. The theme of *Race in the room* refers to instances when participants interpreted race to be present in the therapeutic encounter in different ways, and how this may facilitate or hinder the working alliance at times. *Transference and Countertransference* addressed the clinician's experiences of transference and countertransference related to race. The theme of *Assumptions*; is informed by the clinician's experiences with working with their own assumptions in the room as well as their clients' assumption in the room. These assumptions were found to have some influence on the working alliance. Lastly *Language* spoke to the clinicians' understanding of language as a facilitator or obstacle when work with both racially similar and racially dissimilar clients.

In conclusion, black clinical psychologists were found to experience race as present in the room most of the time. The race in the room seemed to influence the clinician's experiences of transference, countertransference and the working alliance. Difficulties and struggles related to race which frustrate the working alliance exist in unique ways when working with black and non-black clients. Race was also occasionally experienced as a facilitator in the therapeutic process, with both black and non-black clients.

Acknowledgments

All the glory to God and the holy trinity for continued support and strength in the completion of this dissertation.

I would like to acknowledge my family; my mother, sister, *brothers* and late father. Thank you for your encouragement, support and occasional distractions which in hindsight was often exactly what I needed.

I would like to recognize the invaluable contributions of those who helped me at different times during this research. In particular I would like to acknowledge my research supervisor Renate Gericke for her immense input in the production of this dissertation and my growth in it. I would like to extend my gratitude to Dr. Brett Bowman for his contribution to the development of this research topic. I would also like to thank Dr. Kgamadi Kometsi for helping me think throughout the process. I want to recognize the research participants for their extended contribution and assistance and for new bonds made. All of your efforts are appreciated.

Lastly I would like to acknowledge my close colleagues, when my sanity was being compromised you were there.

Table of contents

Abstract 3

Acknowledgments 4

Chapter 1: Introduction 7

1. Introduction 7

1.1. Aims 9

1.2. Rationale 10

1.2.1. Psychology and literature on race 10

Chapter 2: Literature review 14

2.1. Contextualizing psychology and South Africa 14

2.1.1. Working with definitions of Race 15

2.2. Race and psychotherapy 17

2.2.1. Racial identity and psychotherapy 18

2.2.2. The universality of psychoanalysis 20

2.2.3. Cross-Cultural Language Issues 21

2.3. Psychodynamic theory and Race 22

2.3.1. Transference and the working alliance 22

2.4. Working with Race in therapy 27

2.4.1. Transferences, the working alliance and race 28

2.4.2. Race and assumptions 28

2.4.3. Black clients in psychotherapy 29

2.4.4. Therapists' perspectives 30

2.4.4.1. A blank screen 36

2.5. Conclusion 36

Chapter 3: Methodology 37

3.1. Research design 37

3.1.1. Research framework 37

3.2. Research questions 38

3.3. Sample 38

3.4. Research procedure 39

3.5. Analysis 39

3.6. Ethical Consideration 40

3.7. Self reflexivity 42

Chapter 4: Results 46

4.1. Introduction 46

4.2. Race in the room 46
4.2.1. Ambivalence – whether material is race related or not 46
4.2.1.1. Subtle race related communications 47
4.2.1.2. Questions on professional competence 48
4.2.2. Race censoring in response to trauma 50
4.2.3. Complexity of interracial dyads: Ethnicity, Class, Social background 50
4.2.4. Expected segregation facilitating trust, openness and the working alliance in clients 51
4.3. Transference and countertransference 53
4.3.1. Transference objects and enactments 53
4.3.2. Countertransference 55
4.3.3. Politics of psychodynamic psychotherapy 56
4.3.3.1. Particular pressures and difficulties on maintaining a psychodynamic frame with black clients 57
4.3.3.2. Cultural constructs in the room 58
4.3.3.3. Black perceptions psychotherapy 59
4.4. Assumptions 59
4.4.1. Assumptions of understanding 60
4.4.1.1. Expectations of understanding 61
4.4.2. Assumptions of misunderstanding 63
4.5. Language 63
Chapter 5: Discussion 67
5.1. Introduction 67
5.2. Race in the room 67
5.3. Transference and Countertransference 75
5.3.1. Countertransference 80
5.3.1.1. Race and the psychodynamic frame 82
5.4. Assumptions 86
5.5. Language 89
5.6. Conclusion 92
Chapter 6: Limitations of the research and Recommendations 96
Reference List 98
Appendices 108

Chapter 1: Introduction

1. Introduction

South Africa is a particularly racially charged society, largely due to the country's history in which race was systematically engineered over many years to be "deeply embedded in South African society" (Nair, 2008, p. 23). Not only were the country's laws and legislative policies developed and maintained to perpetually reinstate the race divide, but they were also regularly modified to become more overt and blatant in their intentions and to find ways to further divide the society according to race. This 'divide and rule' was micro-managed by several acts and and with legislation to ensure that racial contact was minimal and almost only functional, contraventions of these edicts were punishable by laws such as detention without trial and a systematic indefinite imprisonment (Nair, 2008; Stevens, 2003).

These historically informed politics of race have invariably informed and influenced the construction of racial identity in contemporary South Africa. South African's social discourse pregnant with articulations of race based entitlements is testament to the visceral nature of racial identity and how it has social and inter-group implications. The racial divisions in the new South Africa have largely been informed by a split in social opinion and social discourse which are often polarized racially, with the media readily fuelling these perceptions (Potgieter & Moleko, 2002). What is relevant for this study is the salience of racial identity and its role in social and didactic interactions such as those often found in psychotherapy. Bekker (2001, p. 17) notes that "in South Africa, it (race) was important and pernicious in our apartheid past, and is still clearly a major issue in our present". Similarly the possible role of race in psychotherapy should be investigated.

This dissertation focuses on the clinicians' experiences of psychotherapy; with both racially like and racially dislike clients, and how they have experienced and interpreted race as emerging during these experiences. The importance of the therapist-client relationship has been well recognized by most schools of psychotherapy. In particular psychodynamic clinicians and scholars have contributed to the understanding of the dimensions and dynamics of race in the therapeutic relationship (Carter, 1995). Recent scholars in the fraternity of psychodynamic psychotherapy and theory have also recognized and vocalized that psychoanalysis was inaccessible to a bigger section of the population, including "those who were thought to be less intelligent and not sufficiently verbal, those who could not devote sufficient time to treatment, or

could not afford treatment" (Carter, 1995, p. 19). These latter exclusion criteria meant that "people of colour (or black people) were often judged unsuitable for psychoanalysis and many other psychodynamic approaches" (Carter, 1995, p. 19). As a result the profession and discipline of psychotherapy and psychology, has been considered reserved for white people or inaccessible to black therapists.

This dissertation aims to access and investigate how race, which has been a salient feature in South Africa's history and still continues to be in contemporary South Africa, has potentially manifested in the therapy room, as subjectively reported by black psychotherapists. The use of race here has been loosely defined by the author and rests mostly on the therapists' idiosyncratic experience and understanding of the concept. The study endeavoured to access subjective experiences relative to a contentious issue in South Africa, namely race. It was therefore felt by the author that prescribing a working definition for race in the study may foreclose some experiences and undermine the phenomenological and interpretavist stance associated to the research method as discussed in the methodology section. While the complexity of the concept is discussed later in the dissertation, an operational definition for participants was avoided.

While a definition of race was not prescribed for the participants involved in this study, the researcher defines black as particular to the black *Bantu* South African. Most of the literature reviewed refers to 'black', or 'black South Africans' as homogenously including the Coloured and Indian population, when referring to 'black' South Africans in this paper, the author intends being particular to the black Africans.

In this sense, the author makes it clear that reference to *black* psychologists, students and other groups and individuals, excludes those historically considered Coloured, Indian and Asians. In other words, this study is only concerned with looking at black Africans. To provide some justification for this, historically, Coloured and Indian South Africans have enjoyed better access to psychological services and psychological training programs (Bowman, Seedat, Duncan & Burrows, 2006), given the racial gradations of the past (Erasmus, 2001) which located black Africans at the bottom of the racial ladder. Therefore, it is the *black* Africans who have been the most marginalized and underrepresented within the discipline and profession of psychology in South Africa.

Secondly, Nair (2008) reported differences of opinion and perceptions with regards to the role of race in their experiences as intern psychologists between 'non-white' participants (Black,

Coloured and Indian). The differences are significant enough to suggest the necessity to specify the target group within the historical 'non-white' racial category, especially considering the limitations of this study (which are discussed in a different section of this paper). Thirdly discourses on South African racial identities have perpetually homogenized the 'non-white' racial groups. Not specifying that this study will be concerned exclusively with black therapists would be perpetuating this homogenization.

One of the foreseeable risks with conducting a study such as this one is the imminent criticism that researching according to racial identities reinscribes racial differences. However, due to the primacy of racial identity in South Africa, racial differences are not only inevitable and unavoidable, but they cannot be attributed solely as due to active engagement with the topic and relative discourses. Additionally, it is worth quoting Nair (2008, p. 88) here who articulates the importance of grappling with race and racial classification in contemporary South Africa;

> It is surprising that we do not speak more often or openly about the internalized experiences. Perhaps we avoid talking about that which is painful in the hope that it would eventually go away. However, we cannot assume that the internalized experiences will ameliorate, only because legislation has changed. As psychology teachers, we cannot heal that which we cannot name.

Echoing similar sentiments are Bowman, Seedat, Duncan & Burrows (2006, pp. 99-100)

> How does the researcher attempt to deracialise without referring to the category of race? […] we may need to concede to the need to use the category for progressive and possibly even liberating purposes. Stated differently, our racialising means may just paradoxically justify deracialising ends.

What is relevant for this study, is the salience of racial identity and its role in social and inevitably dyadic interactions, or as Bekker (2001, p. 17) articulates; "in South Africa, it (race) was important and pernicious in our apartheid past, and is still clearly a major issue in our present".

1.1. Aims

This study aims to explore the experiences of race; of black practicing clinical psychologists within the therapeutic encounter. Specifically, the study aims to explore these experiences through unpacking clinicians' experiences of the working alliance, transference and countertransference when working with racially similar and racially dissimilar clients. The study will be interested in whether race has been experienced as a theme when working within and between races by black clinical psychologist, within the clinical space.

1.2. Rationale

In South Africa, black therapists often work within what has historically been considered a 'white' profession. Psychology in South Africa has largely been reserved for white South Africans, through historical systems of apartheid as well as through contemporary forms of systematic marginalization and discrimination (Stevens, 2003). While research from Europe and America has been conducted to explore some aspects of the influence of race on the therapeutic space (see Matsumoto & Juang, 2004 for example), little has been done in South Africa, both empirically and theoretically, to assess this intuitively obvious proponent of psychotherapy. This absence is concerning considering the salience of race in the South African society.

Classic and contemporary psychoanalytic theory's understanding of race has been largely limited to an interrogation of racism (Dalal, 2001; Gelso & Mohr, 2001). However, elements of these discussions have their place within the discussion concerning race and psychotherapy as well as in particular, transference and countertransference as theoretically and empirically fundamental to psychoanalytic theory and to the psychotherapeutic relationship (Dalal, 2001; Gelso & Mohr, 2001; Holmes, 1999; Lowe, 2008; Morgan, 2008; White, 1994).

Empirical research has indicated that transference and countertransference can and often do act as moderating and mediating factors of the working alliance (Gelso & Mohr, 2001; Schachter and Butts, 1968). Research, indicates that racially matched and racially mismatched therapeutic dyads have significantly different results between them (Tang & Gardner; 1999). Particularly, racially matched therapeutic dyads yield better results vis-à-vis the working alliance and transference (as experienced by both the therapist and client) (Kozuki & Kennedy; 2004). Perhaps not surprisingly then, racial mismatched therapeutic dyads produce less positive results regarding the therapeutic alliance and transference (Maphosa, 2003).

1.2.1. Psychology and literature on race

It has become commonly accepted within the fraternity of psychology, especially in South Africa, that there is a significant lack of theory and literature on race, the development of racial identity and their cumulative and respective influence on psychotherapy and psychology generally (Carter, 1995; Strous & Eagle, 2004). This acknowledgement has inspired academics and professionals within the profession and discipline of psychology to either produce some knowledge themselves or highlight the plight for such knowledge production in contemporary

South Africa (see Ahmed & Pillay, 2004; Nair, 2008; Seedat, 1997; Strous & Eagle, 2004; Suffla & Seedat, 2004 for example).

The critique of psychology as actively and passively supporting the political administration has been relatively well articulated in post-apartheid South African academia. Particularly, it is psychology's silence about and non-confrontation of apartheid policies and practices (Nicholas & Cooper, 1990), class (Stevens, 2001), gender (Seedat, 1997) and race (race and training) (Duncan et al., 1997; Pillay & Kramers, 2003; Seedat, 1993) which have been noted. Stevens (1993) notes how the lack of knowledge production was an invariable support of "stereotypical notions of 'race' and therefore, also oppressive social relations in South Africa" (p. 190).

Several studies and research have since been undertaken to accurately investigate the underrepresentation in knowledge production relative to black South Africa in post-apartheid South Africa. Duncan, van Niekerk and Townsend (2004) examined the authorship trends in the South African Journal of Psychology (SAJP) after 1994. The authors "query the extent to which any consequential shifts have occurred in authorship patterns in South African psychology post-1994" and conclude that while there was an increase in the representation of black authors in the SAJP between 1994 and 2004, there is a notable absence of "sustained and strategic interventions aimed at expanding the authorship base in South African psychology, black authors will continue to occupy marginal positions within the profession" (Suffla & Seedat, 2004, p. 516).

This study would contribute to the scarcity of literature on race and particularly the black race in psychological academic literature, in South Africa. While it has been well documented that psychology in South Africa during apartheid was notably passive and silent in the literature produced, it is the opinion of the author that this descriptive work has merely reflected past inadequacies and failed to proactively produce informative and progressive literature. Little work in contemporary psychology in South Africa has redressed the literacy shortage, both in terms of authorship and in content. One of the central aims of this study is therefore to create literature by black people concerning black people.

Carter (1995 cited in Strous & Eagle, 2004) puts forward that the scantiness of reflection on race in both therapy and identity development has contributed to the lack of insight on the part of the mental health professionals with regard to the salience of race in therapeutic interactions. Nair, (2008), Spainierman and Heppner (2004), and Swartz (2007) address how replete the literature around race and its relationship with psychotherapy is, with the cost occurring in the therapeutic

encounter, specifically when therapists do not acknowledge, name or invite discussions about race. Nair (2008) notes the irony that "whilst many therapists are still engaging in debates and challenges about seeing themselves in racial terms, many clients are unambiguous in identifying therapists racially" (p. 80). Instead of ignoring the salience of racial identity within the therapeutic encounter, the encounter could be significantly strengthened and treatment outcomes improved by having open discussions about race (Burkard, Knox, Groen, Perez, & Hess, 2006; Cardemil & Battle, 2003).

The following presents an overview of the chapters included in this dissertation.

Chapter 1 briefly locates the study within South Africa's history by acknowledging the salience of race in the country's history. The chapter suggests that race may then be an influential factor to consider when working within therapeutic dyads, as recognized by some psychodynamic literature. An overview of the focus of the dissertation is provided. The author comments on the exclusive use of the racial category *black* as used for the purpose of this dissertation. The latter part of the chapter presents the aims of the dissertation and provides a rationale for the study. The rationale explores the role of race in the history of South Africa's psychology as a profession and a discipline and suggests that race can be thought to have an influence on some central concepts of psychodynamic psychotherapy. Lastly a discussion on the paucity of literature by black South Africans; in psychology in South Africa is highlighted.

Chapter 2 reviews some relevant literature to this dissertation. The chapter begins by contextualizing the research through a discussion of the development of the profession of psychology in an Apartheid South Africa. The definition of race is discussed and suggested for this dissertation. The chapter includes a review of some international and South African empirical literature exploring the role and influence of race on psychotherapy. The chapter follows an engagement of some central concepts to psychodynamic psychotherapy; including transference, countertransference and the working alliance; and how race can be pervasive to these.

Chapter 3 outlines the methodology followed and the research framework for this qualitative research. The nature of sample, procedure followed while conducting this research and analysis method used are also outlined. Reflexivity as well as general ethical considerations are included in this chapter.

In **Chapter 4** results are presented from a thematic content analysis used to extrapolate relevant themes from interviews conducted. These results are have four main themes; which include

material related to how race emerges in the room, how clinicians work with transference and countertransference associated with race, how clinicians work with race related assumptions in the room and the use of language in the room.

Chapter 5 discusses the results and their relevance to the literature reviewed.

Chapter 6 summarizes some main arguments made, concludes some central thoughts and observations. The limitations of the study and recommendations are made.

Chapter 2: Literature review

2.1. Contextualizing psychology and South Africa

Trends in psychology in South Africa have largely reflected and/or can be paralleled closely with the socio-political climate throughout most of South Africa's history. For one, the discipline and profession of psychology has been criticized for failing to act against procedures which oppressed the black population by being passive to these injustices (Painter & Terre Blanche, 2004); and accused of actively abetting some of the discriminations by being accomplices to policies of dehumanization, unethical acts such as the use of race and culturally biased tests (Stevens, 2003; Duncan, & de la Rey, 2000; Louw & Foster, 1991).

The statutory structures representing psychology in South Africa and their development can also be used to mirror and reflect the political landscape of the time. For example, the formation of the first professional body in psychology was established in 1948 (Louw, 2002; Louw & Foster, 1991), which coincided with the law of Apartheid being enforced in South Africa as a result of the National Party (NP) being instated as the ruling party (Hammond, Clayton & Arnold, 2009). In the late 1950's, shortly after the policy of apartheid had been introduced, the South African Psychology Association (SAPA), objected "to the membership of a black psychologist" and garnered support from the then prime minister Hendrik Verwoerd (who himself was a psychologist) for this objection (Painter & Terre Blanche, 2004, p. 524).

In the year 2000, six years into the democracy, 90% of all psychologists registered with the Health Professions Counsel of South Africa (HPCSA) were white while 80% of registered interns where also white (HPCSA, 2010). In the same year, the Psychological Society of South Africa (PsychSSA) and the Professional Board for Psychology took an active stance to redress this inequity by "encouraging training institutions to review their selection criteria and procedures in order to broaden access for students from previously disadvantaged backgrounds" (Mayekiso *et al.*, 2004, p. 659). Later during the same year, the Professional Board of Psychology set targets that by the year 2004 the admission to graduate programs for training clinical psychologists should be at least 50% black student and 50% white students, and that there should be a marked increase in the admission of Black students by 2010 (Painter & Terre Blanche, 2004).

While there has been legislative change to encourage the training and registration of black psychologists in the new South Africa in a bid to address and redress the inequalities from the apartheid period, these changes have not yet been legitimized vis-à-vis the framework within which the profession and discipline still operate (Stevens, 2001). Early psychology failed to develop contextually relevant psychological tools and technologies such as intelligence tests and other assessment materials (Foxcroft & Roodt, 2005; Louw, 1997). Similarly, the profession operated strongly under ideological and theoretical models which were imported and superimposed onto a South African context, with evident incongruence between theoretical paradigms and context of application (Ahmed & Pillay, 2004; Stevens, 2003).

An additional pressure for black psychologists in contemporary South Africa is the complexity of race which has been inherited from the past. While psychological intervention, psychotherapy and counseling are increasingly becoming accessible to some black South Africans (Eagle & Strous, 2004; Painter & Terre Blanch, 2004), the profession is still used largely by middle class white South Africans (Eagle & Strous, 2004). Therefore not only is there a racial stratum, but there also exists a class stratum which often renders it an option only for middle class white South Africans. When working in such an intimate and therapeutic space; as is preferably the case with counseling and clinical psychologists and their clients, race is invariably a confounding variable (Matsumoto & Juang, 2004). This latter point is perhaps more appropriate and relative when considering South Africa and its history pregnant with racial tension.

2.1.1. Working with definitions of Race

Race is a contested concept or construct in most literature. Betancourt & López (1993, p. 630) found that on average most "scholars and pollsters often use the concepts of culture interchangeably with race, ethnicity, or nationality" which created an interpretative problem as well as an issue of standardization across studies. Scholarly debates on the concept range from an acknowledgement of the usefulness of understanding race as 'partly contextual', understanding it as taxonomy for biological difference, to a deeply critical approach subject to its functionality. Other debates around race include discussions on whether race is objectively constructed, subjectively interpreted and/or inheritable, even when not hereditary (See Smedley, 1993 for example).

The earliest use of race was associated with a biological taxonomy for humans based on an assumption that a group had shared genetic heritage evidenced in physical characteristics

(Guthrie, 1976; Johnson, 1990, cited in Carter, 1995). Tobias (1972, cited in Kometsi, 2007, p. 41) perpetuates the idea that race is a concept borrowed from biology. He holds that "it refers to animals, birds and plants, which helps bring about order in otherwise meaningless human variation". This biological understanding of race has since been rejected and considered reductive as it does not consider the social and political elements inherent. Similarly other characteristics such as skin colour, physical characteristic and language are often used as indicative and descriptive of race in different contexts around the world and throughout time.

The more contemporary shifts in understanding race were more immersed in a social construction of race. Carter (1995, p. 15) suggests a definition of race as "a concept that refers to a *presumed* classification of all human groups on the basis of *visible physical traits or phenotype and behavioural differences*", where ranking of these groups is also presumed (emphasis original). Carter adds that socio-politically race is defined 'as a socio-political designation in which individuals are assigned to a particular racial group based on presumed biological or visible characteristics'. The latter proposed definitions however is more useful in describing how race is used, its functionality; namely that of classification. The definition therefore may not be sufficient in giving a definition of what race *is*. These definitions can also be seen as deductive from their utility in a society with more than one race.

Omi and Winant (2002) dispel the idea that race can be defined from either polarity and instead suggest that race be seen as "an unstable, decentered complex of social meanings which are subject to constant transformation by political struggle" (Kometsi, 2007, p. 42). Their definition acknowledges an inherent biologically based human characteristic while also pointing out that the "specific features that are selected for the purposes of racial signification are embedded in social and historical processes" (Kometsi, 2007, p. 42). They therefore suggest that "Race is a concept which signifies and symbolizes social conflicts and interests by referring to different types of human bodies" (Omi & Winant, 2002, p. 125). This critical understanding of race seems to suggest that no one definition would be sufficient due to the complexity of the construct as a definition cannot be static and universal but instead would need to be contextual.

Therefore a more relative understanding of race as suggested by Smedley's definition may be a problematic construct in this case. For the purpose of this study race may be understood in a similar construct as suggested below. This following definition is neither all inclusive nor considerate of the existing variance, interracial and *intra*racial sub-cultures. (Smedley, 1993, p. 22, cited in Carter, 2995)

> It [Race] was the cultural invention of arbitrary meaning applied to what appeared to be natural divisions within the human species. The meaning has social value but no intrinsic relationship to the biological diversity itself. Race has a reality created in the human mind, not a reflection of objective truths

Appiah (1992) validates this relative use and understanding of race which neither claims universal applicability, nor limits itself to a specific cohort, time period, functionality or social discipline or ideology. Appiah refers to this position as 'contextualism', which views race as "socially constructed, historically malleable, culturally contextual, and produced through learned perceptual practice" (p. 270).

2.2. Race and psychotherapy

Psychotherapy has differing and varying perspectives informed by specific theoretical frameworks and fundamental positions. It would be useful therefore to specify one psychotherapy framework or perspective within which this study is positioned. For the purpose of this study, the psychotherapy orientation and perspective chosen is a psychodynamic psychotherapy. Attempting a thorough definition for this perspective would require a historical contextualization of the theorists, intra-fraternity differences and a discussion on the ideology which informs it. The limitations of this study prevent the author from such a rigorous engagement. However a succinct definition will be provided for clarify the position.

When formulating a definition within such limitations there is usually a vulnerability which the author faces, that of being accused of being reductionist and concise. It must be noted that an undisputable and thorough definition is not the intention here. The definition of psychodynamic psychotherapy for the purpose of this study will draw on the work of Kozuki and Kennedy (2004). Therefore psychodynamic psychotherapy will be used in this dissertation as a collective term for "nonbehavioural, noncognitive, interpersonal-oriented therapy based on principles of psychoanalysis and focused on the influence of past experiences on present behaviours" (p. 30). This also includes short-term supportive counseling.

Smedley (1993, cited in Carter, 1995, p. 11) strongly advocates for the unavoidable and contaminating role of race as a barrier in psychotherapy. Smedley sees race as more of a 'divider' than sociocultural background, ethnic groups, and social class. The United States of America is given as an example of how race, despite the assumption of cultural similarities to the 'outsider', obfuscates the internal relations between Americans. The salience of race in South Africa and within the South African population may be evident from the discussion above. It

would be fitting therefore to assume that race should and would play an influential if not critical role in therapy for South Africans, especially when considering possible cross cultural therapeutic dyads. Most of the literature interrogating multicultural studies of psychotherapy is limited to the United States of America (Maphosa, 2003), however the principle concepts and ideas may be useful for this study.

Psychotherapy is a process which begins formally when a client seeks therapy (Matsumoto & Juang, 2004). This act of 'seeking therapy' has also been found to be racially and culturally influenced. Sue (1977) for example conducted research into differences in ethnic utilization of standard mental health services in the Seattle area and found lower rates of utilization by Asian Americans and Native Americans than European Americans and African Americans. A similar study, (Sue, 1991) produced comparable results. While not differentiating for within group variability, Leong & Lau (2001) concluded that Asian Americans are characterized by extremely low levels of seeking treatment for mental health issues (Matsumoto & Juang, 2004). Broman (1996) and Snowden (2001) account for the apprehension in African American's tendency to seek therapy by drawing attention to their (African Americans) autonomous and self-reliant culture where individuals are encouraged to "rely on their own willpower to confront problems […] and to 'tough out' difficult situations" (Matsumoto & Juang, 2004, p. 371). Additionally, less specific reasons that ethnic, cultural and 'racial minorities' use for underutilization of mental health services include stigma and mistrust of other races (Matsumoto & Juang, 2004; Primm, Lima, & Rowe, 1996; Uba, 1994).

Research in America has indicated for many years now that "culturally diverse clients prefer to see therapist who are similar to them in cultural backgrounds and gender" (Matsumoto & Juang, 2004, p. 375). Atkinson, Ponce, & Martinez (1984), concluded from their study that similarity of worldviews and attitudes to treatment between client and therapist may be more important than ethnic similarity. Similar results by Ponterotto, Alexander and Hinkston (1988) suggested that African Americans who identified strongly with African American culture preferred an ethnically similar therapist.

2.2.1. Racial identity and psychotherapy

The field of counselling psychology has a large body of literature suggesting that all humans go through a process of developing a sense of racial or ethnic identity (see Sue & Sue, 1990 for example), the theme of which "is that individuals at different stages of identity development assign different degrees of importance to the concept of race/ethnicity" (Cardemil & Battle,

2003, p. 281). In this case, racial identity would be important to consider because black clients at different stages are likely to have different opinions and beliefs regarding working with racially dissimilar therapists. Furthermore, the therapist's own stage of identity development may affect how s/he approaches these issues with clients (Helms & Cook, 1999; Sue & Sue, 1990 cited in Cardemil & Battle, 2003).

Acculturation "refers to the gradual physical, biological, cultural, and psychological changes that take place in individuals and groups when contact between two cultural groups takes place" (Chun, Organista, & Marı´n, 2003, cited in Cardemil & Battle, 2003, p. 282). When a population and its individuals move into an area occupied by an existing dominant culture, the new group often feels the pressure to conform and accommodate to the dominant culture's way of life by abandoning or undermining their own cultural practices (Berry & Kim, 1988; Chun et al., 2003). In America these concepts of acculturation have been applied to racial minority groups (including black Americans) interacting with the larger American Caucasian culture (see Anderson, 1991 for example).

A number of theorists have proposed models and instruments of acculturation in an attempt to capture and quantify individuals' level of acculturation. Berry and Kim (1988) have defined four models of acculturation including;

> Integration (both the individual's own culture and the dominant culture are valued), assimilation (the dominant culture is valued, but the individual's original culture is devalued), separation (the individual's original culture is valued, and dominant culture is devalued), and marginalization (both the individual's original culture and the dominant culture are devalued).

It is possible to consider how racial identity development and acculturation may be a variable in psychotherapy. Sue and Sue (1990) suggest that black clients in the conformity stage of identity development may prefer white therapists, since they view them as more competent than black therapists. Individuals in the resistance and immersion stage may prefer a non-white therapist since they may think that some of their psychological problems are results of oppression and racism by white people. Clients who have fully integrated elements of different cultures may be more comfortable with a therapist of any race, while clients who have undermined the dominant culture may insist on a racially similar therapist. These useful ways of looking at racial identity and its relationship to culture have encourage research considering how these variables may interact with each other (Chun et al., 2003; Ponterotto, Casas, Suzuki, & Alexander, 2001; cited in Cardemil & Battle, 2003).

2.2.2. The universality of psychoanalysis

Several authors have attempted to dispel the idea that psychotherapy is strictly the same for every race and culture in the world by arguing for these differences from their experiences of therapy with different races. Kenedy (1952) for example noted that Whites' and Blacks' transference phenomena are distinctly different. He suggested that "the initial transference in a White patient can be either positive or negative […] [T]he Negro patient in our culture…enters treatment with fear, suspicion, and distrust of the therapist, whether the therapist be Negro or White" (p. 313). A debate about the universality and applicability of psychoanalysis in South Africa has to consider Sachs's *Black Hamlet*. *Black Hamlet*, now a seminal and canonised literary text and case study in the investigation of the genesis of psychoanalysis in South Africa, is a useful reference in contextualising psychoanalysis in South Africa. Sachs, a Lithuanian Jew, sets to test whether psychoanalysis can be done on black *native* South Africans by attempting an analysis on *John* Chavafambira.

Sachs's hypothesis begins with his psychological observations at an African Mental Hospital, where he discovered that "the manifestation of insanity, in its form, content, origin, and causation are identical in both natives and Europeans" (Sachs, 1937, p. 71). This observation leads Sachs to wonder and hypothesise that if the "mind in its normal state were not also the same" for black South Africans as White South Africans. Sachs then uses psychoanalysis as a tool for testing his hypothesis, acknowledging that the universality of psychoanalysis was also being tested here. More specifically, Sachs was testing the applicability of psychoanalysis for a black South African population.

For Crewe (2001) "Black Hamlet reveals a situation in which Western psychotherapy is not merely compromised by political forces but is always on the verge of being overwhelmed and displaced by them" (p.416). He also accuses Sachs for trying to "inscribe the South African native subject in the colonial global imaginary of 1930s psychoanalysis" where if one considers the colonial history and re-enactment of Sachs's endeavour "the attempt increasingly seems like one in which an ill-fitting template is imposed on political and cultural realities it cannot encompass" (p. 418). Therefore *Black Hamlet* becomes both "self-problematizing and assimilable to postcolonial critiques of a colonizing psychoanalysis" (p. 418). Similarly Bloom notes Sachs's inconsideration of the socio-political landscape which South Africa found itself by observing that "in a society as passionately politicised as South Africa was (and is still?), it is

immensely difficult to disentangle the influence of the political on the personal in psychoanalysis" (Bloom, 2004, p. 38)

In "revealing the mind of a Negro", Sachs concludes the universal validity of psychoanalysis and "confers full human recognition on his subject" (Crew, 2001, p. 420). Whether Sachs achieves an accurate test of his hypothesis and whether his initial and revised findings and conclusions are valid for either one of his aims has been contended (Crew, 2001). What may be useful to look at for this dissertation are what the fundamental difficulties are that confront Sachs and what that may mean for psychoanalysis in South Africa today.

In *Black Hamlet* Sachs excuses the non-conventional use of psychoanalysis with *John* by stating reasons why prescriptions such as the *frame* were not employed. What is interesting to note is the insinuation that one cannot therefore employ an analytic frame with its rigorous conventions and still 'manage' or practice psychoanalysis in South Africa. This assumption is at this point a hypothesis, since it has not been tested or explored. What can be thought about though are the reasons why this has not been attempted, or if it has, why no successful reports have been written up, at least none as resounding as *Black Hamlet*. It is possible that perhaps it is unlikely to employ a strict analytic frame of practice on 'the black mind'. The counterintuitive practices to *black* nature which are familiar to *Western* ideology are at the heart of psychoanalysis.

2.2.3. Cross-Cultural Language Issues

Kozuki and Kennedy (2004) stress the importance of bearing in mind cross-cultural language issues in psychotherapy. They suggest that it is only through language "combined with nonverbal cues interpreted by the therapist, can meanings that the client would like to communicate with the therapist be conveyed" (p. 36). A paradox of language and psychotherapy with racially and culturally dissimilar therapeutic dyads may reside in the culturally bound nature of most human experiences which are expressed in equally culturally embedded languages (Kozuki & Kennedy, 2004). Psychotherapy often requires a 'western-type dialogue' which would mean that for clients not from Western culture, language would create a deficit and would need to be negotiated.

Kozuki and Kennedy note the real challenge of language in psychodynamic psychotherapy in expressing visceral experiences;

> Simple miscommunication can be a source of confusion when more than one language is used. In addition, the most subtle parts of psychodynamic psychotherapy, such as client fantasies and early childhood experiences, are embodied in the language that was used at

the time of those experiences (Connolly, 2002; Movahedi, 1996). Representing those experiences in a different language can be difficult, as can free association (a psychoanalytic concept also utilized in psychodynamic therapies to extract implicit memories by having the client verbalize to the therapist whatever comes to mind).

In South Africa, one may expect these challenges to be perpetuated by the diversity in language and culture which exists. There are eleven recognised official languages, which themselves have different inflections, dialects and are often localised for particular niche communities. In addition to that, the politics of language in South Africa's history often mean language also represents power symbolisms (Painter, 2006) which may further complicate psychotherapy.

2.3. Psychodynamic theory and Race

There has been a relatively recent trend within the academic realm of psychology and the professional practice of psychology to investigate and openly discuss how sociocultural constructs of race/ethnicity and sexual orientation influence the therapy process, (Gelso & Mohr, 2001), this trend has been echoed more faintly within psychoanalytic theory *and* race or psychoanalytic theory *of* race. Dalal, one of the more active members of the psychoanalytic community investigating the relationship between race and psychoanalytic theory (see Dalal, 1997a, 1997b, 1998, 2001, 2002 for example), remarks on the paucity of literature written concerning race and psychoanalytic theory, by noting that "there is not one paper to be found written on the topic [of race and psychoanalysis] by a British psychoanalyst" (Dalal, 2001, p. 58).

Race has often been considered by the analytic theoretical frame as a symptom or an "*effect* and expression of internal psychological dynamics and not as a latent issue" (Dalal, 2001, p. 45). This avoidance to both address race from a critical perspective and to view race as a central and latent agenda in psychoanalytic theory and psychoanalytic psychotherapy is noted by Morgan (2008), as counterintuitive considering that "we are rarely reluctant to talk and think about other matters that seem to be unspeakable, and we assume that harm is being done not only to the part that is not being spoken about or to, but also to the one who is silent" (p. 35).

2.3.1. Transference and the working alliance

Sigmund Freud's psychoanalytic theory significantly informed psychoanalytic treatment. Psychodynamic psychotherapy owes much of its fundamental influence from Freud's psychoanalytic theory (Carter, 1995). At the root of both these treatments, though used and configured differently, are the concepts of transference and countertransference. The theory

sought to uncover unconscious conflicts using transference from the client and the therapist's countertransference (Carter, 1995), positioning these two latter constructs as central to both forms of treatment. Early psychoanalysis work has deemed transference and countertransference (see Freud, 1905; 1910; 1959 for example) as well as the working alliance (see Greenson, 1967 for example) as pivotal in therapy. Discussions of these constructs as mutually exclusive yet indivorceable have been prevalent during the last two decades (Gelso & Mohr, 2001). A brief working definition for the working alliance, transference, and countertransference will follow, these will be supplemented by respective discussions for an operational definition.

Despite the importance placed on transference and countertransference when working within a psychoanalytic orientation, no consensual definition of these constructs exists. However Gelso and Mohr (2001) argue, while transference could present as the most controversial construct in psychotherapy, it remains a vital aspect of successful therapy. Gelso and Mohr (2001, p. 53), drawing on the works of Greenson (1967), Fromm-Reichman (1950) and Orange, Atwood and Stolorow (1997), suggest a comprehensive definition for transference as

> The client's experience of the therapists that is shaped by the client's own psychological structures and past, and involves displacement, onto the therapist, of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships […] although the client's experience of the therapist is shaped by the client's structures and past, the therapist does contribute something to this experience […] in essence all transferences are co-created by therapist and client

The challenge with attempting to give a definition of transference is one which often arises when attempting to define an experiential process. Equally problematic are the contextual differences which hinder a static and universal definition for transference and countertransference. This issue pertains to the different understandings of transference across psychoanalytic theories. While the predominant understandings of transference in contemporary psychoanalytic theory consider transference and, countertransference as useful and progressive in the therapeutic relationship, this was previously challenged.

The classical Freudian view of countertransference as "the analyst's transference to the patient" (p. 348, Winnicontt, 1994) positioned countertransference as negative. Freud understood countertransference as "an obstacle to psychoanalytic work that was based on the analyst's unconscious perception of the patient as a figure from the analyst's past" (Winnicott, 1994, p. 348). This understanding of countertransference as inevitably problematic and unrelated to the analysand's transference has since been challenged. Countertransference, generally described as

the therapist's emotional reactions and issues resulting from the client's transference, is seen as inevitable (Gelso & Mohr, 2001). Heimann, (1950) showed the use of countertransference as an important tool for psychoanalysis and differentiated this from pathological countertransference response. Winnicott was leading in changing this understanding of countertransference by suggesting an objective countertransference. Therefore Winnicott (1994) suggested that objective countertransference is "an understandable and 'normal' reaction to the patient's actual personality and behavior" (Winnicott, 1994, p. 348).

Money-Kyrle (1956, cited in Winnicott, 1994) interrogates the idea of negative or pathological countertransference by showing how the "therapist's own experience of the patient's projections may be linked to the analyst's own internal reactions to the material" (35). As an example, Money Kyrle (1956, cited in Winnicott, 1994) shows how in a particularly difficult phase of an analysis, the client's possible projections of an incompetent self become mixed-up with the therapist's internal feelings of professional incompetence. This latter example is the process of countertransference, where the projections or transference of the client evokes feelings from the analyst. To further address the dialectics of positive and negative transference, Money-Kyrle (1956, cited in Winnicott) notes a hypothetical encounter where the analyst feels disturbed during an analysis. She suggests that it is likely that the feeling(s) have been unconsciously contributed by the patient. In this situation three factors need to be considered "first, the analyst's emotional disturbance, for he may have to deal with this silently in himself before he can disengage himself sufficiently to understand the other two; then the patients part in bringing it about; and finally, its effect on him" (p. 361). It is at this point of the countertransference that if the analyst is insightful of the transference and the feelings it has induced in him/herself then "all three factors may be sorted out in a matter of seconds, and then indeed the counter-transference is functioning as a delicate receiving apparatus" (Money-Kyrle, 1956, p. 361 cited in Winicott, 1994, p. 35). However, an inability to recognize this will be counterproductive in therapy.

Strous (2001) notes that an understanding of transference and countertransference draws attention most psychological interventions and therapeutic relationships in particular do not occur objectively in a vacuum. Instead psychotherapy must be acknowledged as occurring "within the context of client and therapist constructions of reality and meaning" (p. 87). It is expected therefore that South Africa's unique social realities may emerge in therapeutic process and specifically inform transferantial and countertransferantial experiences.

Similar to the concept of transference and countertransference, working alliance can be traced to early psychoanalytic work, including Freud (1905; 1958 cited in Gelso & Mohr, 2001) and Greenson (1967). However, unlike with transference and countertransference, there has not been as much attention devoted to the working alliance in contemporary psychoanalytic/psychodynamic theory. Gelos and Carter, (1994); Gelso and Hayes, (1998) provide the following definition for the working alliance; "the joining together of the reasonable self or ego of the client and the therapist's analyzing or 'therapizing' self ego for the purpose of the work" (this definition relies on the psychoanalytic concept of the split ego). Bodin (1979 cited in Gelso & Mohr, 2001) notes that when the working alliance is sound, the therapist and client tend to have a solid working bond, agree on the goal of treatment and the tasks needed to accomplish those goals.

Literature suggests that the alliance has a significant positive impact on the outcomes of brief and longer term psychotherapy (Martin, Garske & Davis, 2000 cited in Gelso & Mohr, 2001). While the working alliance and transference have reciprocal impacts on one another, there appears to be a bias towards the working alliance as a prerequisite for any transference. However, once both established, they are dependent. For example, when transference dissipates, a working alliance based on transference also tends to erode (Geslo & Mohr, 2001). It is therefore evident that a healthy working alliance is necessary for effective psychoanalytic therapy. However, the working alliance seems to be influenced by the match or mismatch of the racial dyad (Strous & Eagle, 2004), in other words, race may influences the development of a working alliance and invariably, transference.

Generally, transference has a positive effect when it is combined with insight on the client's part; yet, in the absence of client insight, transference can have adverse effects (Gelso & Mohr, 2001). While transference is expressed between a client and their therapist in the current relationship, it is rooted in experiences and relationships outside the therapeutic encounter. This suggests that transference will inevitably and invariably be loaded and not value-free, and may be informed by personal attitudes and values, including stereotypes (Holmes, 1999). White (1994) sees racial stereotypes as inevitably 'moderating' the transference. This is the case, according to White (1994), even when the therapeutic dyad is enhanced by a racial match as the client may feel that the therapist shares his/her racial stereotypes about others, and therefore does not need much elaboration or clarification. Alternatively the client may feel insecure and incongruent with the therapist when the client's stereotypes are being challenged by the therapeutic relationship.

2.4. Working with Race in therapy

Socio-political change in psychology geared at making the profession more accessible to the diverse and previously marginalised populations has its implications. One of them includes the recognition that the ability to conduct effective psychotherapy with these diverse populations should and is becoming increasingly recognised in South Africa. Tang and Gardner (1999) point to an inconsistency by observing that disregarding gender in psychoanalysis is unthinkable, yet often race and cultural factors are not acknowledged, understood, or analyzed within the clinical setting. There is an importance and necessity of integrating issues of race and ethnicity into the field of psychology, through encouraging engaging discourse to these and related issues in most clinical training programs, developing guidelines for therapist competency when working with racially diverse clients, as well as funding professional meetings aimed at identifying ways to promote sensitivity to diversity in psychology (APA, Committee on Accreditation, 2002; APA, 1993; McGuire, 1999; cited in Cardemil & Battle, 2003).

While most therapists recognise the importance of knowing one's own cultural and racial assumptions and core beliefs, many therapists still battle to incorporate this into therapy with racially diverse clients, in a useful and facilitative way (Cardemil & Battle, 2003). Cardemil and Battle suggest that having an open dialogue about race in the room between therapists and clients by demonstrating a willingness to engage, is one way therapists can achieve this. This can therefore strengthen the alliance and improve the treatment process (Cardemil & Battle, 2003).

Cardemil and Battle (2003) observe that there may be different reasons why therapists may battle with conversation on race with their clients. These reasons may include feelings of discomfort with having these conversations due to the emotive nature of the topic, concerns about being unintentionally offensive, and concern over the relevance and appropriateness to initiate these conversations. Some clients may feel comfortable to broach these issues, while others may have as many anxieties about addressing the issue as the therapist may have.

When clients and therapists engage in these issues, there is often no prescribed way of doing so, with differences in the number of times the issue is discussed, the intensity of the conversation, the space and attention afforded to the discussion and whether it is discussed once off or frequently (Cardemil & Battle, 2003). These variables are often informed by a number of factors including the client's level of trust in the therapist, the therapists comfort and openness on this issue and salience of race in the environment and context within which the therapy occurs (Cardemil & Battle, 2003).

2.4.1. Transferences, the working alliance and race

Research indicates that race moderates transference and countertransference, given the influence of both the client's race and the therapist's race. Schachter and Butts (1968, cited in White 1994, p. 91) present an example of the interaction between race and racial stereotypes, and transference and countertransference;

> Butts' patient was a white male presenting with problems of premature ejaculation and fear of marriage. He endowed his black male analyst with a racial stereotype – that of the black man as a sexual athlete. The white analysand thus hoped magically to attain sexual potency from his black analyst. This racial stereotype foreshadowed the developing positive transference on the analyst as 'an omniscient, benevolent superman who magically infused his strength into the frail, anemic patient

In this particular case, the racial stereotype is obvious and has influenced the transference between the therapist and the analysand.

Gelso and Mohr (2001, p. 64) note how "Sometimes these transferences are subtle" however it is apparent that these "cultural and culturally reinforced transference" will emerge. What may be useful in this and other related cases is the importance to address the issues of the transference. Morgan (2008, p. 45) notes that because of the possible guilt, anxiety or distress attached to the transferences and projections, the client may find themselves 'working hard' to avoid bringing them openly in the room, and they may be "swiftly suppressed even as they surface in the mind". Thus it seems that the literature, the clients and professionals in the room, are all working hard to avoid talking about race in a country with a history that indicates we have all been made painfully aware of race and difference.

In his paper *Black and White Thinking*, Altman (2000) presents a discussion of how he as a white Jewish analyst has experienced the tension brought into the room by the analytic third of race. The analytic third, which is understood as a proverbial third subject in the room, is created by the intersubjectivity of the client and the analyst "in which the patient and analyst are both created anew within their interaction" (Altman, 2000, p. 598). The concept of the analytic third (see Ogden, 1994 for discussion) suggests that the subjective experiences, within the room, are embedded in the historical experiences and contexts, outside the immediacy of the room, which then enact themselves as another subject in addition to the analyst and the analysand, invariably mediating and/or moderate the therapeutic encounter.

Straker (2006, p. 731), suggests that the analytic third is a "manifestation in the consultation room of a noxious social discourse" which is *performed*, invariable to the conscious knowledge of either the analyst or the analysand. Straker admits two agendas in her discussion of the analytic third, that firstly; it is crucial for psychoanalysis [and psychoanalysts] to "develop concepts to give voice to what it has traditionally silenced, specifically, the effects of the social and the political on the constitution and continual reinvention of the subject". Secondly; "the symbolic order and the shared understandings which become possible through language play a large part [...] in processing and containing traumatic effects". Lastly; Straker sees the possibility of the language which articulates the social as it lives itself out in the personal, modifying; over time noxious social discourses such as racism and homophobia, present and active in social fields and therefore, "clinical practice contributing to the political" (Straker, 2000, p. 732). Several clinical cases are presented which demonstrate the presence and effects of the analytic third with the therapeutic encounter, and suggest their inevitability.

While this theoretical concept has several implications on the quality of the therapy, it appears that several tendencies are important in understanding the effects on transference, countertransference and the working alliance. Firstly, the therapist will unavoidably have tranferencial experiences which oscillate between positive and negative, mostly in response to the clients' transference. However it appears that the analytic third suggest the presence of an unprovoked and inevitable countertransference existing objectively, due to the intersubjectivety of the two subjects. In other words, this transference would not exist objectively outside the presence of the two subjects and their social, and socially constructed historical contexts. Secondly; this analytic third; which is heavily influenced by the visceral presence of race (Altman, 2000), can also dictate the course of the therapeutic experience, for both the therapists and the client.

2.4.2. Race and assumptions

As noted more elaborately elsewhere in this paper, literature on the possibly enhancing effects of different and same racial dyads emerged in the late 1960's (see Schachter & Butts, 1968; Jones, 1985 for example). This was also marked by the shift in psychoanalysis from understanding the analyst as a neutral blank screen, towards an acknowledgment and assessment of the role of the analyst in active and participatory in the therapeutic process (Comas-Diaz & Jacobsen, 1991; Tang & Gardner, 1999). Since then, most of the literature incorporating the analyst in the process and looking particularly at race and the phenomena of transference and countertransference; has limited itself to the difficulties brought into the analytic situation in racially dissimilar

therapeutic dyads (Comas-Diaz & Jacobsen, 1991). Little substantive literature has been produced which critically and thoroughly engages with the backgrounds of both analyst and client in the therapeutic process.

Psychotherapy training from different orientations usually encourages the suspension of assumptions and preconceptions of clients. Likewise assumptions about a clients racial and ethnic identity and their past experiences relative to this, may lead to misunderstandings which have the potential to compromise the therapy process. Occasionally therapists may make incorrect assumptions with good intentions which end-up compromising the therapeutic relationship (Comas-Diaz & Jacobsen, 1991). Cardemil and Battle (2003) recommend that clinicians directly ask their clients how they identify their race/ethnicity and recognise that clients may also be different from other members of their racial group.

Tang and Gardner (1999) have proposed some positions on the role of backgrounds and the assumptions these may introduce in therapy processes. They note that '[w]hen therapist and patient come from similar backgrounds, there are certain shared assumptions by both individuals about their culture [which] include those values and ego ideals that are taught, aspired to, and modeled from early on' (p. 12). They continue to contend that the more similar the experiences, backgrounds, histories and cultures shared between therapist and client, the fewer challenges to shared assumptions regarding appropriate behaviors and responses to situations.

There is recognition that in racially dissimilar therapeutic dyads, the dissimilarities may threaten the process of therapy and result in therapeutic difficulties and premature terminations. Therapeutic difficulties may "occur when the patient holds a particular culture-specific value, and the therapist understands and interprets this as a resistance" (Tang & Gardner, 1999, p. 13). In these situations, the client may be left feeling misunderstood by the therapist and in dissonance with what may be appropriate in his/her own culture and race, and what is in question in the therapy (Tang & Gardner, 1999).

2.4.3. Black clients in psychotherapy

Some black clients in particular may be uncertain what to expect from the process of therapy (Marsella & Pedersen, 1986) as a result of limited previous exposure to psychotherapy. For many black clients, their expectations of psychotherapy are that the therapist will ask them questions and give them corrections (Maphosa, 2003). Overall black clients have been perceived

as preferring a directive, active and structured approach to psychotherapy (Marsella & Pedersen, 1986; Maphosa, 2003; Sue, 1977; Sue 1981).

Many black clients often attend psychotherapy believing that they will "be able to obtain advice about a specific matter" or seeking something concrete and tangible from therapy (Maphosa, 2003). Often psychotherapy and specifically psychodynamic psychotherapy would take a historical approach to the presenting problem which may be experienced by some black clients in this case as unhelpful and frustrating (Maphosa, 2003; Sue, 1981). As a result many black clients show lower attendance in therapy and usually terminate prematurely more often than white clients (Maphosa, 2003).

Black clients also often seek psychotherapy in reaction to a stressor or distressing event, they therefore often present for psychotherapy looking for relief from acute stress. These clients are also more likely to perceive the therapist as an expert with the necessary knowledge, skills, experience, training and tools to actively help them and solve their problems (Vontress, 1981 cited in Maphosa, 2003; sue 1981). These presentations of black clients as impassive in psychotherapy, perpetuates the perception of psychotherapy being arcane to many black people (Strous, 2001).

Jones (1991, cited in Maphosa, 2003, p. 19) identifies racial mismatching in therapeutic dyads as one of the hindrances in establishing an optimal working relationship for black clients. Maphosa (2003, p. 19) suggests that "client/counsellor same-race pairs would reduce the range of possible issues encountered" in therapeutic relationships. She qualifies this latter statement on the premise that black therapists and black clients may share racial issues which are therefore not expected to impede the therapeutic process. However Ridley (1995) notes that black therapists like their white counterparts are also usually only trained to work with white clients, thereby limiting their theoretical and practical knowledge that may facilitate working with black clients.

2.4.4. Therapists' perspectives

One of the less highlighted considerations in discussions on backgrounds and assumptions in therapy processes; is the therapist's own assumptions about their clients' backgrounds and that relationship with their own background (Comas-Diaz & Jacobsen, 1991; Kozuki & Kennedy, 2004). Tang and Gardner note that "It is only when confronted with someone of a different culture who is assumed to have dissimilar experiences that one is forced to confront one's own" (1999; p.6).

Recent attempts have been made to understand the therapeutic encounter from the view of the therapist. Due to the inter-relational aspect of therapy, therapists themselves have been shown to have '*between races*' differences of client preference and perceived effectiveness. Matsumoto and Juang (2004, p. 376) cite a study which interrogated this relationship from the perspective of the therapist;

> In one such study (Russell, Fujino, Sue, Cheung, & Snowden, 1996), for example, the records of thousands of African, Asian, Mexican, and European American outpatient clients […] were examined for ethnic match with their therapist […] a black therapist-black client dyad or Chinese therapist-Chinese client dyad was considered an ethnic match. However, for Asian Americans, a Chinese therapist –Japanese client was not a match. Results indicated that ethnically matched therapist tended to judge clients to have higher mental functioning than did mismatched therapist […] thus, how the therapist perceived the client differed according to weather the therapist was of the client's ethnic group or not.

While this study is important in understanding the influence of race on the client-therapist relationship especially from the consideration of the therapist, it is merely descriptive and does little to interrogate experiential aspects of the didactic relationship from the therapist's perspective.

Tang and Gardner (1999) advocate for the idea that for some black clients, having a black therapist may be important for openness in the therapeutic process;

> Just as a female patient may not feel comfortable revealing certain things to a male therapist, but willingly and eagerly shares them with a female therapist, so, too, do our "disenfranchised" majority patients express things to us (p. 14)

Some assumptions which may arise when working in dyads where the therapists and client are black; include an assumption that the therapists may know what it is like to be disadvantaged and disenfranchised, which the client maybe be familiar with. Therefore in some instances the client's identification with the therapist's racial background may allow him/her to incorporate aspects of the therapist in a useful and creative way which may facilitate the working alliance (Comas-Diaz & Jacobsen, 1991; Shonfeld-Ringel, 2001).

Tang, a Chinese clinician in America, draws on personal experience as evidence for the facilitative role of racially similar therapy dyads;

> When the therapist and patient are from the same cultural background, there is an assumption about shared meaning and experience. As one young Asian woman put it, "You are the first person I have seen who looks like me." Although we came from vastly different geographical locations, she felt that I (Tang) would more readily understand the role of women in a predominantly Chinese family (Tang & Gardner, 1999, p. 18).
>
> In the beginning phase of treatment of Asian patients, for example, I am likely to be sensitive to the difficulty many Asians have in expressing their feelings. In some Asian cultures, to express one's feelings is, in fact, seen as selfish and is highly discouraged. Furthermore, the voicing of "morbid thoughts" is understood to be a contributing factor to becoming mentally ill. Because the relationship is of paramount importance, I am more tolerant of questions that may sound personal to some, since I understand that they represent an attempt to form a relationship and that this requires some sense of connectedness, whether through family ties, or through some common background experience. This may include something as superficial as knowledge of an area in China, or even a special restaurant (Tang & Gardner, 1999, p. 18).

It is not uncommon for clients to express anxieties about being misunderstood, often through asking the therapist if what they are saying makes sense (Kozuki & Kennedy, 2004). Sometimes clients may directly ask if the therapist understands what they mean and what they are saying (Tang & Gardner, 1999). However when the cultural identity is shared between client and therapist, the client may have a greater readiness to believe that the therapist understands them, with a positive transference emerging more quickly (Comas-Diaz & Jacobsen, 1991; Shonfeld-Ringel, 2001; Tang & Gardner, 1999).

However, perceived similarities in background with racially similar dyads can also present as a resistance to true exploration of the client (Tang & Gardner, 1999).

> It is not uncommon for a Chinese patient to state confidently, "You know what Chinese families are like," as if this obviates the patient's responsibility to describe his or her own history [...] There are also times when I will learn that a Chinese patient opted to go elsewhere because she or he feared that I would share too many of the cultural values from which the patient was trying to escape.

Some racially marginal clinicians have reported that in their work with clients from racially similar background, several things became clear particular related to countertransference (Kozuki & Kennedy, 2004; Shonfeld-Ringel, 2001). One of them includes the sense of relief, at least in appearance, clients felt at the thought of being treated by someone perceived to be from a racially similar background. There was a belief that because of their ability to identify with racially similar clients, they could be more helpful to them, "that there are certain powerful life experiences that can better equip one to be more accurately empathic" (Tang & Gardner,1999, p. 18).

Some clinicians have also noted the pressures which came with a sense of responsibility for these clients, which were extracurricular to that of usual therapy relationships. The clinicians would also often find themselves being required to draw on intimate knowledge of their own experience as a racially marginal member of the population (Shonfeld-Ringel, 2001). Clinicians reported that they may be more likely to act out on their countertransference with racially similar clients, especially when the clinician identified closely with the clients experiences. As a result, clinicians are more likely to go-the-extra-mile for these clients (Comas-Diaz & Jacobsen, 1991). When reflecting on these countertransference acting-outs, Tang and Gardner (2003) note that possible reason for this countertransference may be their feelings that some experiences were related to their own "often painful experiences of having been misunderstood, and wanting to protect our patients from similar occurrences" (p.16).

It is apparent that with shared assumptions, there is a danger of questions going unasked which may result and foster a mutual resistance against looking at some material. Nevertheless, common experiences between client and therapist may foster a sense of shared meanings and can enhance the therapeutic relationship. In these instances the therapist has the ability to make the client feel truly and authentically understood and can avoid the pitfalls of misunderstanding communications that have culturally embedded meanings.

The studies discussed above have been a product of research done in America and with Americans. Notwithstanding the scarcity of such research in South Africa, Strous and Eagle (2004) have contributed to this area of research. Additionally, their study is relevant because it is conducted from the perspective of the therapist, engaging with the therapeutic alliance from the orientation of the therapist. Amongst other discussions, the study critically probes the therapeutic alliance by dealing with issues which overtly and covertly influence and moderate the transference and countertransference phenomena which are critical to the process of therapy. The

study also examines the personal views and beliefs held by the therapists who "may either facilitate or hinder counseling" (Strous & Eagles, 204, p. 26).

The findings and discussion of the study include an analysis of the *pro-client*; *anti-client* and *ambivalence and negotiation themes*. The anti-client themes will be briefly discussed here. The anti-client position was characterized by a counsellor experiencing antagonistic or unhelpful feelings towards counseling a racially different client. Generally this portion was informed by a central theme of 'Whiteness' where therapists perpetually define reality according to their own ideologies and an ideology which their clients are expected to share or accommodate. This ideology is embedded in the belief that white culture is superior and normative and black culture is 'different and inferior'. The findings from the sample included sub-themes which understood black people as; violent, sexist (sexism and violence often related especially with reference to women abuse), 'less-than-civilized', unduly entitled and overly expectant. Research participants also noted their mistrust, anxieties, and concerns about power, differences and unwillingness to work with black clients.

Results from the pro-client position reflected the themes of receptivity and progressive constructive attitudes towards therapy with racially mismatched clients. These themes "included notions of equality in diversity, consultative participation, flexibility, healing and feelings of confidence in interracial psychotherapy" (Strous & Eagle, 2004, p. 41). Overall, several ideas where expressed within this theme, including the idea that white therapists acknowledged their possible blindspots when working with black and other racially different clients, and the occasional need to either consult fellow professionals or refer on particular issues. In addition, the therapists' willingness to acknowledge their clients' backgrounds and contexts without; generalizing, stereotyping or attaching the stigmas which exist with these acknowledgements. Instead the participants reminded themselves to work with the individual as *an individual*. Lastly, the acknowledgement of the power dynamics prescribed by the socio-historical context within which they operate (Strous & Eagle, 2004).

The *ambivalence and negotiation* theme was as a result of responses which oscillated on the continuum of the pro-client and anti-client continuum. The therapists' views within this theme were generalized as unresolved and negotiating between the pro and anti-client respectively, as well as not being succinct or clear enough to be accurately classified as either pro-client or ant-client and having contradictions within them.

In another study Nair (2008) engages with the role of race in training psychologists and in psychotherapy. Nair (2008, p. 167) draws the following conclusions;

> The colour of the clients' white skin reportedly has the potential of emotionally destabilizing the trainee and may affect therapeutic competence. The internalized racism associated with being of a colour is elicited in some cross-racial dyads, resulting in feelings of intimidation, fear, low self worth, anger, critical self consciousness and questionable expertise. In contrast, according to trainees, when they see clients of the same race, their racial identity facilitates feelings of comfort, rapport and safety for both client and therapist.

Both studies are pioneering in producing literature which orientates itself from the perspective of the therapist. However it is important to note that both studies have predominantly investigated or focused on the experiences of white psychotherapists and not black psychotherapists, perpetuating the gap in literature representing blacks and their experiences.

2.4.4.1. A blank screen

The challenges faced by minority therapists however extend to other races. For example, the black clinician as a person of colour belonging to a different culture 'is more than just a blank screen, and his or her colour will pull forth a rich variety of projections and stereotypes' (Tang & Gardner, 1999, p. 12) from the non-black client (Shonfeld-Ringel, 2001). These fantasies may be similar to those a male analyst may evoke in female clients, or a female analyst in their male clients.

Negative transference from a client is both mandatory and useful in psychotherapy. Black therapists however may occasionally have to deal with derogatory and insulting comments which may be socially unacceptable and remain therapeutic in their response (Tang & Gardner, 1999). The clients too may be faced with the dilemma of free expression and censoring. For example some thoughts and comments from non-black clients may be tinged with racism, making it uncomfortable for the therapists, but also for the client of a different race to feel free enough to express. The client may have anxieties about damaging and harming the analyst, which may be linked to the greater social power most clients of dominant cultures have (Tang & Gardner, 1999). These negative feelings projected onto the black therapist may also induce feelings of guilt and concern about destroying the therapist (Tang & Gardner, 1999).

In their observations, Tang and Gardner (1999) acknowledge that minority therapists may be more sensitive to the reactions of their non-black clients to the identity of the therapist. As a result the minority therapist is likely to be hyperalert and more aware of statements and sentiments that bear possible tones of racism or bigotry. Gardner suggests an example of a client who came in for the first session and proceeded to inspect his qualifications which were hanging on the wall. In this case Gardner was not certain how much he should attribute this test of competence to his race. In other words, he was aware of two or more possible explanations, one of them being that the client walked in, saw that he was black and wanted assurances that the services are accredited. The other explanation draws on clinical observations and suggestive of the clients character; possibly including obsessional needs or an inclination to rely on external validation. Whatever the reason for the client's behaviour, it seems for the therapist it introduced another layer to the therapeutic relationship or heralded the presence of the analytic third as discussed by Straker (2006).

2.5. Conclusion

The literature review has focused on the role of race in psychotherapy and psychodynamic psychotherapy in particular; internationally and in South Africa. The literature contextualised the dissertation by tracking the socio-political history of psychology in South Africa. A working definition for race was problematized and suggested. The salience of race in psychotherapy, both internationally and in South Africa, was explored by looking at some of the relevant research. Three central concepts to the study; transference, countertransference and the working alliance, were defined and briefly discussed in terms of their importance to the therapeutic relationship and process.

The universality of psychoanalysis and psychotherapy and its applicability to a wider South African context was briefly discussed. Race and its role in the dyadic relationship was explored and literature on racial identity and its possible influence on therapeutic relationships was also looked at. Race and its relationship with transference, countertransference and the working alliance were briefly discussed. Lastly, the influence of perceived shared backgrounds and the assumptions which these perceptions bring with them to therapy was also explored.

Chapter 3: Methodology

3.1. Research design

This research is positioned within a qualitative methodology. While certain aspects of the work can be represented from a quantitative frame, it is the aspects of the work which cannot be understood and appreciated from a quantitative frame which this study is concerned, more specifically subjective experiences.

Qualitative research allows for extensive consideration of personal meanings, as well as historical contextualization (Burman, 2001). Additionally qualitative research is considered to be best suited to research aimed at "exploring the lived experiences and worldviews of participants. The lived experience include the socio-political contexts of participants, making this method a popular choice for the study of race, gender, class" as well as the implication of interactions between these latter concepts (Burman, 2001; Tolman & Brydon-Miller, 2001 cited in Nair, 2008, p. 90). Therefore a qualitative approach was the most useful and appropriate approach considering the aims, framework and questions of this study.

3.1.1. Research framework

One of the more articulated concerns about working within a qualitative methodology is the unaccountable validity of the work, since it relies on interpretations and interpretations are inevitably subjective (Tappan, 2001). Considering the interpretive nature of this study, the reflexivity of conducting the study and the necessity to contextualize the experience to be shared, and the theoretical framework underpinning the methodology is an 'interpretative' or hermeneutic approach to psychological theory. The hermeneutic approach, largely advanced by Dilthey (1976; 1977), has contributed considerably to research in the social sciences with a methodology which allows for the interpretation of written texts, recorded interview narratives, verbal communication and "other social phenomena as if they were texts to be interpreted" (Dilthey, 1976; Tappan, 2001, p.10).

It is particularly the ability to firmly contextualize the individual that made Dilthey's (1976; 1977) hermeneutics appropriate for this study. It is the historical, environmental and psychological frames which are indivorceable from an individual's lived experiences which require this integrative approach. Equally, interpretations of an individual have to consider the

historical and psychological contexts which invariably influence the lived experiences for both the researched and the researcher (Tappan, 2001).

3.2. Research questions

1. How is race experienced when working within the therapeutic space by black clinical psychologists?
2. What are the differences, if any, in working with racially similar versus dissimilar clients?
3. How is race played out within the therapeutic encounter, especially through the transference, countertransference and working alliance?

3.3. Sample

The sample was comprised of 7 black practicing clinical psychologists. The criteria for the participants to be eligible for consideration was as follows;

- Participants needed to be registered as a clinical psychologist with the Health Professions Council of South Africa (HPCSA)
- The clinicians needed to be actively practicing or providing psychotherapy (full-time or part-time), or must not have been out of practice for 12 months or longer
- The participants needed to self identify as black and must have been historically considered black (Coloured and Indian were not included)
- The participants needed to be South African
- The participants needed to have been working in South Africa for a minimum of three years[1]

All participants interviewed for this study met all of the above criteria. An additional specification was made which required all participants to have had a psychodynamic orientated professional training. The latter specification was necessary because of the constructs being referred to in the research questions (that is working alliance, transference and countertransference). Given the limited number of black clinical psychologists, the sample is more vulnerable to be identified. Due to these considerations of the sample little further information will be given in a bid to increase participant anonymity.

[1] This is to ensure that the therapist has adequately experienced working within the South African context

3.4. Research procedure

Upon receiving ethics clearance, the researcher used convenient and purposive sampling strategies to contact candidates. Snowball sampling was the primary method used to recruitment candidates for the study. There exists a close community of black practicing clinical psychologists in Johannesburg South Africa (often for referral purposes), which was accessed through referrals between their members. In other words some candidates' details were forwarded to the researcher by research participants for purposes of the research interview. Candidates were approached individually to participate. Once it was established that the individuals met the above prescribed criteria, they were formally requested to participate in the study. All participants were contacted telephonically and informed about the study. Once candidates indicated their interest to participate, a participant information sheet (Appendix A) was forwarded to them for their familiarization with the study. A follow-up call was made to setup an interview convenient to the participants. At this point participants were also invited to clarify and address any concerns ahead of signing the participant consent form (Appendix B) the participant consent form for the interview to be recorded and for the recording to be transcribed (Appendix C). Five of the interviews were conducted at the participants' offices, one interview was conducted at the airport, and one interview was conducted at the home of one of the participants.

During the interview, which lasted approximately one hour on average, the participants were asked open ended questions in a semi-structured interview (see appendix D for interview schedule). All interviews were recorded and transcribed by the primary researcher. None of the transcripts have been attached as per ethical discussion and requirement, however all transcripts and recordings have been kept and will be stored for five years, after which they will be destroyed.

3.5. Analysis

A thematic content analysis was conducted for analysis. A thematic content analysis involves the grouping of themes followed by "an attempt to trace the internal shape of experiential awareness", referred to as 'phenomenological immediacy' (Parker, 2005. p. 99). The six classic phases of thematic content analysis (Gunaratnam, 2003) were employed in this case, beginning with:

a. **Familiarizing oneself with the data.** In this case, the researcher become familiar with the data collected. Fortunately the limited number (7 narratives) allowed for rapid immersion.

b. **Generating initial codes**. Next the researcher generated initial codes, where interesting and reoccurring features across the data set were coded and patterns discerned.

c. **Refining the codes**. This leads to the third step where the researcher collected all data relevant to each theme identified in step two.

d. **Checking for contradiction and consistency**. Step four required the researcher to review the themes categorized in step three, looking for consistency between steps one and two.

e. **Finalization of themes**. Step five entailed identifying the 'essence' of what each theme was by refining and defining the themes and 'determining what aspect of the data each theme captures' (Braun & Clark, 2006, 3, p. 92; Gunarratnam, 2003).

f. **Write up**. Lastly, the researcher produced a discussion section based on these themes.

3.6. Ethical Consideration

Ethical considerations have often been subject to differing views and opinions within the social sciences, and perhaps especially so when working with psychology related subjects (Burke, Harper, Rudnick & Kruger, 2007; Canadian Psychological Association, 2000). In recent years however, ethical considerations have taken more of a central role than has been in the past (Scherrer, Louw & Móller, 2002; Pope, 1992). The notion of 'subjects first' has been afforded more importance and attention for all research. Similarly, the specificity and phenomenal nature of most research and concerned subjects has also been a point of debate (Gunaratnam, 2004). In other words, while general and universal ethical guidelines have often been prescribed and expected for all research studies and projects, there has been a shift towards appreciating the idiosyncrasies of each research project and the peculiarity which should follow in the ethical considerations and application.

This research project endeavored to recognize and employ the long existing and universally prescribed ethical considerations, but was nevertheless particular to the distinctiveness and uniqueness of the study. Particular ethical considerations were highlighted necessarily over others. For example; the sample used is a unique and easily recognizable sample. The community of practicing black clinical psychologists in Johannesburg South Africa is small and easily apparent should anyone want to investigate them. Therefore the participant's identity had to be considerably protected from public knowledge (especially considering the ethical consideration of the importance of a clinical psychologists' reputation and therefore viability to

practice) as well as from each other. The size of the sample also increased the likelihood of recognition if insufficient anonymity steps were not taken.

As mentioned above, anonymity and confidentiality of the participants was an important consideration for the sample concerned. For anonymity purposes, all distinguishing detail about the participant was disguised or removed throughout the research process. Demographic information was changed or withheld, place of work was also withheld and removed during the process of transcription. Full transcripts will not be published with the dissertation. Names were replaced with *Interviewee 1* to *7* in the transcription and in the report. All steps were taken to ensure confidentiality beyond the knowledge of the researcher. Confidentially was guaranteed through the following steps; the recorded interviews were only accessed by the primary researcher, only the primary researcher transcribed the interview recordings, the recordings are locked in a cupboard only the researcher can access and will be kept securely for two years if publication arises or five years if publication does not arise and will be destroyed thereafter. Additionally, the participants were given the option to withdraw their participation and therefore recorded and transcribed material at any point before the dissertation is published. The latter steps were taken to ensure third party anonymity, and confidentiality was communicated to the participants (see Appendix B).

This study was interested in the experiences of the therapists, however, confidential information about the clients/patients and the identity of clients/patients (clients and patients of the therapists participating) were likely to be compromised in discussions during the interviews. The researcher was aware that only the therapists' consent was given. Therefore, the researcher informed the participants that any information about their clients' identity or other confidential information should not be discussed during the interview or at any other time. As an additional precautionary measure, the researcher requested that research participants use pseudonyms if they cannot avoid referring to a patient/client. Additionally, during the analysis and write-up of the research, the researcher removed any and all information which may have compromised the participants' clients' identity and/or anonymity, this was also communicated to the participant ahead of the interview and was available in the participant information sheet.

While accounting personal experiences related to race may be distressing for some individuals, the current sample was not necessarily considered a vulnerable group. Appropriate steps for their post-interview debriefing were however taken by making suitable numbers available. Informed

consent as a requirement for ethical practice was required from the participants. The participants were not coerced, neither physically or psychologically, into agreement to participate.

It was explained to the participants that their participation in the study is completely voluntary and that they reserve the right to withdraw from the study at anytime for any reason by; refusing to participate, stopping the interview should they feel uncomfortable, or withdrawing their interviewed and transcribed material, without being questioned or coerced to recommit to the research. The participant information sheet referred the participants to debriefing and counseling available at the Emthonjeni Centre at the University of the Witwatersrand, Johannesburg or FAMSA at minimal cost or Life Line at no cost, in order to minimize the potential distress that the participant may have experienced. This precautionary measure ensured that participation in the research was not experienced as personally or professionally harmful to the participants.

3.7. Self reflexivity

Research within the social sciences and humanities has been consistently criticised for lacking positivist empirical rigor (Bhavani & Haraway, 1994; Tolman & Brydon-Miller, 2001). Qualitative research in particular is usually informed and grounded within an interpretaivist approach. This approach is often dependent on the subjective values and attitudes, motivation and intention of the researcher, and interpretations made by the researcher. Additionally, the qualitative approach conducted within psychology, highlights the pivotal role of the researcher (Tolman & Brydon-Miller, 2001). The above observations have lead many within the academic fraternity to argue that research within the social sciences and qualitative research specifically is inextricably bound with the personal dimensions, a personal bias and concerns of the researcher (Bhavani & Haraway, 1994; Tolman & Brydon-Miller, 2001).

The researcher's own subjectivity and reflexivity is reflected in the intention of the researcher, the research process, the outcome of the research and how this is presented (Bhavani & Haraway, 1994). This is even more the case with research focusing on visceral and emotive topics such as race (Tolman & Brydon-Miller, 2001). While this personal involvement has been argued to invariably taint the research process, instead, an "awareness of the inevitability of this influence allows researchers to guard against undue biases that may direct processes in favour of the researchers' needs, but also makes explicit a level of complexity and challenge which may be hidden in other research forms" (Nair, 2008, p. 1). The researcher therefore acknowledges his due influence on the research process, and the possibility of collusion with the participants.

However, through reflexivity the researcher hopes to curtail inadvertent or intentional contamination of the research findings.

An equally important issue to be borne in mind when conducting psychological research is the requirement that one knows one's self, and one's position within the research process. Psychology often promotes insight and reflexivity among those who make use of the services, however, the American Psychology Association also prescribes that psychologists have sufficient self insight in practice and in research. Particularly relevant to the research process, is the necessity of being sensitive to the differences and similarities between the researcher and the researched. An awareness of these differences and similarities allow clinicians to have the necessary 'openness and flexibility' for accurate assessment, diagnosis and treatment (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006, cited in Nair, 2008, p. 184).

It is therefore important to locate myself as the researcher within this study as that in itself has informed the research topic. I am a black South African male, whose experiences of race have been mostly from the transitional period into the 'new South Africa' and in a democratic South Africa. My long standing interest in race relations and racial identity, as well as personal difficulties experienced during my undergraduate and post graduate studies in psychology, including my current training in clinical psychology, have been the main impetus for exploring this topic and discourse. Most of the difficulties experienced were informed by the experience of being in the racial minority as one of a few black students, and more so black males students, during my studies in psychology. I am currently the only black male in my current Masters of Arts in Clinical Psychology class. As a result, this context often incited significant affect with emotions vacillating between insecurity, shame and ambivalence towards the profession and discipline, as well as pride, omnipotence, pressure and enthusiasm to provide a service to a marginal group which I represent. Additionally, my anticipation and fantasies about working as a black clinical psychologist in a profession which I have perceived as mostly reserved for non-black South Africans has deeply influenced and motivated me to engage with this topic.

During the research process I had various experiences and thoughts which I understood as informed by my blackness and my subjectively. One such experience was particularly noted through a reflection on the process of writing up the report. The researcher became aware of the perceived pressures to accurately represent the participants' experiences in the report write-up, as I may be misunderstood as 'speaking on their behalf'. Nair (2008) cites how these feelings of responsibility and accountable for one's race as a person of colour are referred to as the "burden

of representation' carried by 'minoritized subjects" (Mercer, cited in Burnam, 1994, p. 157). This experience of representing one's race in the work produced can be thought about in the context of the paucity of literature and material concerned with blackness and psychology in South Africa, and the pressures which may be felt when producing novel material.

Since the researcher was working with an underrepresented sample population, he often experienced the task of accurately representing the sample in the work produced as a burden. Most research participants were excited and eager to participate in the research; often indicating personal interest and vicarious investment in the topic. I was often confronted with praise from the research participants regarding exploring an under research area and requests from them for a copy of the final research report. The accumulative effect of this for me was a rising pressure to represent the participants accurately as well as produce a research report which matches their expectations for the research. In addition, other sources are also perceived to be invested in the outcome of the research. Moreover, I have also had to battle with the perceived pressure of speaking on behalf of all black clinical psychologists in training, considering the very limited literature available to validate or dispute the findings of this research. These perceived pressures were initially a block to writing the research report and had to be noted, and processed, by the researcher in order to produce an authentic report. The researcher therefore had to be aware of the possibility of other voices speaking to the research in a manner that was experienced as unintentionally unconstructive.

Another difficulty experienced by the researcher during the analysis was limiting it to data that was only produced 'on record'. During the interviews the participants would often engage in 'off the record' discussions, both related and unrelated to the research topic. It was difficult to exclude and not be influenced by 'off the record' data which is related to the topic. The researcher had to be aware of the potential of these discussions to inevitably inform how the researcher reads the transcripts, and writes up the report which had to be consciously guarded against. It is therefore important to note that the discussion and analysis was only informed by the voices which emerged from within the confines of the research interview.

Finally, it is felt that acknowledging my subjective position will not disadvantage the process but instead enhance it. It has been argued that the subjective experience is indivorceable from qualitative and interpretative research and this has been illustrated in this study in particular, it is the "recognition of the salience of the subjective position of the researcher [which] enhances rather than detracts from academic rigour and credibility, understanding where and how the

researcher is located in the research endeavour provides the reader with a context within which to evaluate the research product" (Holt, 2003; Humprey, 2005; Suzuki et al, 2005; Williams, 1991, cited in Nair, 2008, p. 9).

Chapter 4: Results

4.1. Introduction

The transcripts were subjected to a thematic content analysis and the following themes arose. Four major themes were identified including; *Race in the Room, Transference and Countertransference, Assumptions, Language*. For each theme, relevant subthemes were also identified. In qualitative research, the validity of thematic content analysis is reliant on cogent argument illustrated by supportive data (Strous, 2001). Therefore extracts from interviews are quoted throughout. However, in the interest of brevity and clarity, non-essential, non-fluencies and repetitions in typescripts insignificant to particular analysed themes have been removed from the quotes. Three ellipses indicate these omissions.

4.2. Race in the room

This theme primarily emerged from a particular question within the interview schedule, but was also informed by general responses to most questions from the interview schedule. This theme is essential to the research as it identified particular and general instances where black clinicians perceived race, in variant forms and degrees of clarity; to be present in the room subjectively. Most of the subthemes in this theme are informed by subjective experiences of the clinicians understanding of the client explicit or surreptitious reference to race. These include; *Ambivalence – whether material is race related or not, Race censoring in response to trauma, Complexity of interracial dyads: ethnicity, class, social background* and *Expected (ongoing) segregation facilitating trust, openness and the working alliance in clients.* These themes may speak to the facilitative value or hindrance race may have on the working alliance.

4.2.1. Ambivalence – whether material is race related or not

This subtheme represents instances where participants were uncertain if any of their encounters and experiences with clients were indeed race related. What is significant to note within this subtheme is the general and constant awareness of race as a possible variable for the therapeutic process. In most instances as indicated by selected extracts, the participants are uncertain whether the presentations of material can be understood as challenges usually present in any and most therapeutic encounters, or whether it has been informed by race, both their own race and/or that of their client.

> **Interviewee 4:** *And I've had some really powerful experiences and sometimes you don't know how much of it has to do with race and sometimes with the material in therapeutic*

context. But over a period of time that become a lot more transparent and you start working with what is the real issue. And sometimes, I mean I remember this one particular incident with a family, it was family therapy and I really felt like the buffer of the one family members aggression and I don't know if I had been of a particular race if that would have been any different. And if I was a similar race would the anger have been directed towards that particular individual in a destructive way. So I don't know, there's a fine fine balance between how much of that is about race and how much of that is about just general material happening in the room.

Interviewee 6: *And sometimes it also, it can frustrate the therapeutic space where people all of a sudden because you are black things are gonna be done in a way that is not as profession as it would be if maybe...so like I was saying I wasn't sure if that particular client was doing that because I was black and therefore I needed to be...but for me it was inappropriate and I'm not sure if I had been white, whether they would have done the same.*

Interviewee 4: *I would go in there being aware that black people and therapy dah dah dah. Then again there would be issues of boundaries. I remember one specific client, where a person could call and, because its in our nature, well not our nature, I'd like to think that generally black people, I think this is a stereotype but in any case there is a sense that black people are sociable and all that. This person would call and ask about their son, so I wasn't sure if maybe that was part of her own dynamic or part of her being black and therefore okay, they wouldn't understand the boundaries because if somebody is helping you...so I don't know to what extent it was a racial thing that because we are both black I should understand that.*

4.2.1.1. Subtle race related communications

The following comments have two distinctions. Questions whether material presented by the client was related to race or usual therapeutic encounters were still evident here. However additional to those questions; the participants were both certain of the reference to race; as well as the subtlety with which race was being referred to and being presented.

Interviewee 4: *Race is very subtle and it takes a while to be able to figure out if there is any dynamics at play around race [...] I think most of the time it [race] usually*

confrontation at the beginning and the questions around so who are you, its very subtle, never really pronounced.

Interviewee 7: *And I can't name it specifically, nothing was ever named, but its just a feeling of being spoken to as if you are a child and being hugged at the end of the session and being infantilised.*

Interviewee 4: *You know for me working dynamically is sometimes uniquely different from when you can name race for what it is, but as I said most times race is often subtle finds a subtle expression in the room, and would need longer term therapy to be able to work with it properly.*

Three participants' comments were specific to the role which the subtle expression of race may have particularly influenced the clients' openness and trust of the therapeutic process and of the therapists in some instances. In these instances, race was still not clearly the identified independent variable.

Interviewee 5: *Also in terms of trust factors, it takes a bit of time because, I think race still plays a huge role in therapy than we realise. It takes a bit of time before they trust the process [...] and I found that there was such caution around issues around race and background and stuff like that. And it was getting to me because it disturbs the level of trust that could be there in the process.*

Interviewee 1: *Issues of openness come into play. Sort of openness or lack of openness and trust issues, and what a person really believes about a non-white or an African person, whether they believe that they will get the services that they really need.*

Interviewee 4: *And I suppose the interesting bit is its more around the trust issue you know it takes a lot of time sometimes I find, actually it goes either way, either [white] people go in too deeply, or it takes a while for them to get into an intimate space in therapy.*

4.2.1.2. Questions on professional competence

The following comments represent instances where participants may have felt that their professional competence as a clinical psychologist was being brought into question by the client. Relevant here is the way in which the participants are uncertain whether this is due to or related

to their race and/or that of the client, or whether once again these are usual experiences to be expected at the beginning of most therapeutic processes.

> **Interviewee 2**: *So initially I asked myself whether this is a race issue or is this a issue of any client who walks through the doors and sees a therapist and questions their competence [...] I think like many other clients they (white clients) do question your competence, but that happens with black clients as well. Look I mean with a black client I think for me, my experience is that I've never had to worry about them questioning my competence on race, I've always said, when there are questions raised I've always thought its about my competence as a clinician, but I've found with other races I have to question; are these issues around competence as a clinician or is it also interracial issues that are coming up here and like I say, my experience is if its competence issues, usually in the first two session they are kind of there but once the person settles then they go away.*

> **Interviewee 7:** *There is a sense that you've got to prove yourself definitely a sense that you have to sound clever, you've got to make the interpretation, you've got to hold them, you have to give them stuff to hold them so that they can come back. Where as you don't get that with black clients [...] with white people its very different, its about your competency that's being pushed rather than your language. I think that with Indian clients the dynamic is similar, but there is much more of a sense of being undermined, much more a sense of being undermined.*

> **Interviewee 3:** *But they (white clients) will put you on the spot, put the therapist on the spot and want to demonstrate how much they know, who has told them what and what the internet says and what the books say. And they will want to know what your input is and what your answers are. So they do tend to hide behind that attitude.*

Two participants identified the context or environment within which clients were seen as eliciting race related material which may have been speaking to their competence as a clinical psychologist. In one instance race was more explicitly referred too.

> **Interviewee 4:** *Where those issues (of race) would come up it would be in a corporate environment where people are forced to come in and there you would find some of the dynamics you would have to deal with.*

Interviewee 7: *I mean I have had like a racist client telling 'what do I know what do I think I can tell her' and that was in community setting where they were allocated a therapist they did not have that choice to have that therapist and they were blatantly racist asking what do I know [...] she stood up and said she was gonna get out of here because did not want to speak to a black therapist.*

4.2.2.Race censoring in response to trauma

These two comments represent instances where participants recognised how race was an evident factor when working with trauma and trauma victims. In this case it was felt that the race of the clinician hindered the client from speaking openly about the race of the perpetrators who were often also black.

Interviewee 4: *And also more difficult when working with trauma when someone wants to say 'two black guys came up to me' it would be two...guys' and so they would hesitate around me and sensor it. So it would be interesting how race is not named with some people, it would be very silent and naming it means you shame it.*

Interviewee 5: *Another thing will be things around trauma that people want to be careful around, I mean even saying that the person got in and the person had a dark completion, they become careful with saying those things, its almost like you have to give them permission to do that and if you don't do that it leaves a lot of chance of what it will do over time, so you have to speak about it because its not easy for both parties; it brings a lot of stuff.*

4.2.3.Complexity of interracial dyads: Ethnicity, Class, Social background

These quotes represent views from some participants that working with racially like clients presented *intra*racial dynamics. Elements such as ethnicity, class and social background in particular are identified here as further dynamics when working within a black racial dyad. Participants note how they often have to be mindful of these latter elements as they influence the working alliance and other constructs which inform the working alliance.

Interviewee 1: *A black person is not the same as the other black person [...] the level of education is also huge it plays a huge role between the therapist and the client how the person presents themselves and how from a cultural background, how they feel.*

Interviewee 2: *I mean let me give you a typical example, you'd have guys who come from the younger generation who have been brought up in middle class families, went to Model C schools and I don't necessarily have a similar experience to them. So, let me use a concrete example I think that will illustrate the point nicely. I had a young [black] lady who was about 21 22 then; middle class background, studied multiracially, was brought up mainly in your suburbia not in the township although she had some experiences of township, experiences in terms of when we communicate you'd just assume certain things in terms of culture, and she speaks English predominantly, although she's Zulu.*

Interviewee 6: *But either than that I think there was those, I mean but I guess its part of the frame of the relationship to the point where consciously I had intellectualised to say okay that's part of the limitations, even if I were to see a black person, they would have to be Tswana then I'm not that ethnic group [...] but its not as simple as that because then there would be an issue of ethnicity, you know where because I speak Xhosa, my first language, somebody else, even if they were Xhosa speaking, you would find that there would be an idea that oh okay we can speak.*

4.2.4. Expected segregation facilitating trust, openness and the working alliance in clients

The following four participants reported how they understood how some racially dissimilar clients where more forthcoming of themselves and in the therapeutic process, as a result of an assumed racial, cultural and social distance between the client and the therapist. Here participants feel that they are experienced as so *other* by their clients; which facilitates the client's ability to be expressive and cooperative with the process.

Interviewee 7: *There was a client I had and it was very interesting, it was a white Jewish male, a rabbi in his sixties. And at the time, I was around my early 20 and I'm a black female Christian women. There was stuff that came up about him being gay and blah blah blah, I don't believe that that would have come up in another setting. I think the othering made it so safe for that man to be able to come out and bring his information to the fore [...] I also think that the other side of it can be that you can be so different that you are safe because there is no ways, there was never a threat that I*

would no anyone, that I would be in his community, I was just so other that he could go and tell me his fantasies about boys and things and stuff like that.

Interviewee 5: *And another thing I found with white patients is that they are reassured of confidentiality. Its assumed that our lives won't meet outside of here. And I don't know how I feel about that sometimes but it is assumed that confidentiality is there [...] so its an element that I'm being understood by someone outside my culture.*

Interviewee 4: *The one who goes in too quickly obviously because I'm seen as other so I'm not part of someone's world, I'm not white I'm not Coloured I'm not Indian. Therefore I'm not part of their social reference because therapy can be conceived to be part of social reference [...] also they feel safe enough to go to that space quickly because you are not part of my world [...] but it has also been fascinating for me how sometimes I've been seen as the safer option because I'm not part of their social reference.*

One participant expressed how black clients' perceptions of proximity to the therapist, as a black therapist, sometimes hindered openness and trust.

Interviewee 5: *I think one of the things that come up in black black relationships is that, there are certain instances that require one too uhm, one of the things that people would do before they even come is to find out who they are going to see and basically by just saying your name it basically tells what race/nationality you belong to, so in black black relationships it would be issue around concerns about confidentiality in some way that you might know someone I know, you know that kind of thing. Or we might meet in a social environment something like that and also there will be concerns around, a lot of times class also plays a role [...] what makes it hard is that most black clients are concerned by confidentiality, its not even funny.*

4.3. Transference and countertransference

The subthemes identified here represent one of the major constructs with which the research is concerned. Several ideas are included here, all of which speak to the experiences of transference and countertransference as subjectively understood and experienced by the participants. While the participants were limited from speaking to transference material as experienced by the clients, they did refer to instances where they understood the material to be related or indicative of transference. Additionally participants also made reference to their own countertransference in

particular situations and as general reactions and experiences. This theme includes the following subthemes; *Transference objects and enactments, Countertransference* and *Politics of psychodynamic psychotherapy*. This theme was mostly informed by responses to particular questions in the interview schedule as well as other responses to related questions.

4.3.1. Transference objects and enactments

The following three comments represent some participants' view that clients would occasionally enact different transferantial objects in response to working with them as black clinicians.

Interviewee 3: *Otherwise those that have been somehow given an ultimatum to attend therapy will take you as an extension of their boss, if their boss is black then you fall in the same line of fire. So if they left them attacking then they will come in attacking as well.*

Interviewee 3: *Other [black] people will want you to occupy that victim role that they have found themselves in. And others will attack the language that you use when you introduce yourself to say 'are these things they're for whites only?' and what and what and what, later on you'll find that they have had problems with non-black people or with white people.*

Interviewee 4: The *other extreme would be around guilt around the history of the country, which they would sometimes have an over apologetic sense around ownership of that stuff.*

Interviewee 5: *I worked with somebody for quite a while and I couldn't understand why they sung praises of me, about my work. And it was quite interesting because it was getting to a point where because I'm trying to ensure that I don't get praises anymore I will, and I'm talking across borders like you are wearing something as plain as this. They will have to see it as completely wonderful and I'll be, it will be awkward for be because I'll consciously try to get something that is as plain as possible so I don't have that kind of thing. But over time I realised that this person is responding to the fact that their partner had a relationship, an affair with somebody, in their eyes my age and black. And that came out a long time, and it was that kind of stuff that made me realise that actually the major part of this picture has to do with me and my race.*

In some cases the participants spoke about instances where the transference enactment was more overt in the room.

> **Interviewee 7:** *I mean I have had like a racist client telling 'what do I know what do I think I can tell her' and that was in community setting where they were allocated a therapist they did not have that choice to have that therapist and they were blatantly racist asking what do I know. And it really took me aback and I tried to work with it in that room and say well this is what we have. And so it was the age and the race, there was an older white woman in the room, and she blatantly, she stood up and said she was gonna get out of here because did not want to speak to a black therapist.*

Three participants specifically mentioned instances where the transference was related to trauma material.

> **Interviewee 3:** *And for the clients who have been traumatised or going through post traumatic stress disorder, and you find that the perpetrators have been black fellows so they also tend to be quite racist or their remarks also tend to be quite racist because also if you think of the dynamics that happen when people rob or when people mug, its a violent and aggressive thing so language also gets spoken in there and they will also bring that and come and explain that in there.*

> **Interviewee 5:** *If somebody is coming for trauma debriefing remember, unfortunately it will be trauma debriefing out of somebody of a black race having attacked them. Now I'll be like the object in the picture now in that either they come in and attack terribly, or they come in and want to put the face that I like all black people and I like you and I don't understand how this happened. So its something that we try to put into consciousness but its not that easy, its almost automatic in that space. So what is important is to explore if this is something that they have always had or if its due to the trauma. Because its different for someone to say, I can't understand why I'm responding like this because you're a black therapist, from somebody who clearly indicates their history with some reservations about different nationalities so you can pick it up from the way the person is unsettled or settled from the start. Then after a while its almost like you represent something else like somebody will have had an issue with somebody else and you almost take that place and for them to address that issue you become the object.*

Interviewee 7: *And particularly with trauma, you see it so many many times with trauma because the, unfortunately, highly likely what's gonna happen is that its normally black people that have done this crime now their sitting across a black therapist having this conversation and they are goanna have to divorce you out of them, or split you out of this group of mad men, serial killers, and pour out their hearts to you, so they do have to split to some extent to have a really relationship. And sometimes you have to hold onto all those emotions.*

4.3.2.Countertransference

In the following comments participants are reflecting and reporting their countertransference in a variety of situations. Feelings of disempowerment and being attacked came up as some of the prevalent themes.

Interviewee 4: *For me where I make differences and the struggle sometimes is, its about, when race is an issue, when the focus is on race I felt it in being disempowered and almost paralysed in a therapeutic context. And when one is not aware of the countertransference then that can also be paralysing.*

Interviewee 5: *But there is something that I need to work with before I place myself in that position, I needed to be okay with whatever, if I'm attacked; which is not so easy because I needed to go back and reflect on what this person is going through before I actually sit with my own feelings around that, so I needed to work with that and I had help, a bit from colleagues and ya, I had help.*

Some participants were explicit about feeling that they need to remain neutral and not act on their countertransference.

Interviewee 7: *And its difficult because you cannot confront the racism because that is not the platform to confront the racism, there are difficulties around looking at it and understanding whatever their dynamic is. 'You know how they are, I can't look at them anymore', and no offense to you, I'm not talking about you I'm talking about, you know them them, and I don't know how you deal with the tension in the room, you suppose to what? And you have to swallow it, there is no way you can say, what do you mean by them? Because then you're bring your own shit into the room, you have to hold on to your shit and facilitate their process.*

Interviewee 1: *Especially in South Africa there are always events from time to time. Where the evening before on the news you hear that a certain white person shot a black person for no apparent reason, then the next morning you are sitting down with a white a client, where do you place yourself in that position. So your countertransference issues automatically become invasive, so you need to position yourself in a neutral position and really think about that, what you can do.*

Some participants also expressed some countertransferantial pressures to deliver and 'act' when working with black clients particularly.

Interviewee 3: *The countertransference, some of the stories that you hear from the patients are quite upsetting some of them are quite severe, and in cases like those is where you find yourself as a therapist having to stand up and saying obtain one two three in terms of legal issues or legal matters, legal protection and you find yourself writing referral letters, small notes and you give that to a patients as an object to say 'hold onto this, I know that its hard, try and remind yourself when you go to that meeting' because some of them you know some of them you know racial issues do come from work and you find that they are being attacked at work but its, when you look into their story you find issues of race and racism. So countertransference comes in there where the therapists will find himself playing rescuer. And with that one its hard to wait for a time when you can interpret it. So practically I am pushed to be as practical as possible, especially when there is a risk to any of the people involved then latter on to start to interpret.*

Interviewee 7: *The major stuff, or my stuff is that, comparative to white clients, with black clients you feel much more of a sense of being a fraud in a way, I think that there is an expectation that you gonna give them something tangible to take away with them. And I think it also comes from a bit, I suppose this view may shift a little bit it depends on what client you're seeing, but I think that you often feel like you wanna give someone something tangible to walk away with.*

4.3.3.Politics of psychodynamic psychotherapy

The following extracts vary slightly, however their principle concern is similar. Here the participants commonly spoke to the complexity of working within a psychodynamic frame for psychotherapy, as well as the difficulties and challenges they encounter. These subjective

experiences did present an aggregate which occasionally problematised psychodynamic psychotherapy within a South African context.

4.3.3.1. Particular pressures and difficulties on maintaining a psychodynamic frame with black clients

A significant majority of participants reported experiencing some difficulties on maintaining a psychodynamic frame when working with some black clients. The following extracts express general challenges experienced, as well as specific examples and instances where participants felt that the *frame* was being tested. In most cases the participants are making use of their reflections and understanding of countertransference to surmise this pressure.

> **Interviewee 2:** *Majority of black people are crisis orientated, crisis intervention that lasted no more than six sessions. And you had to be, and I found that with a lot of them you had to very concrete around certain boundaries but also doing activities. I found, a lot of people still have that notion that they've come to, they call you a doctor, so they have to carry away something physically, and its not about the carrying away of that emotional containment.*

> **Interviewee 4:** *And so at times with some black clients I would be pushed not to do dynamic therapy, referencing a lot of dynamic work as a base but also be more supportive in therapy and maybe more directive.*

> **Interviewee 5:** *And with black client there is pressure to explain more before you even go too far and I think you are gonna let them down terribly if you don't actually announce your space from the start. Because if I allow that space to carry on where someone expects me to tell them what to do, they are gonna be walking out with such disappointments of why did I even do that.*

> **Interviewee 4:** *And you get obstacles around commitment; I find that a lot of black people struggle to commit to therapy, a lot of late cancellations. Other obstacles would be, sometimes people struggle to understand why they have to pay for therapy [...] but when you are trained dynamically, to make sense of the fact that they don't pay [...] and the fact is that psychodynamic training is still very bourgeois.*

4.3.3.2. Cultural constructs in the room

The following clinicians note how they sometimes feel like intuitive and internalised social constructs and cultural practices and values, are incompatible with psychodynamic psychotherapy. These participants note how this can present a difficulty when they are brought into the room purposefully or furtively through mostly learnt behaviour and expectations.

> **Interviewee 2:** *I think when you are sitting with an elderly person; you want to accord them that necessary respect and I think a lot of us struggle with coming to terms with that, and that's a black thing.*

> **Interviewee 5:** *And I started doing this when I was 22/23, so it took me a couple of years before I got settled into working with somebody my mother's age and calling them by their first name, and obviously if I bring in the element of mama'whoever or sisi'whoever for me it feels like you're already doing something to the relationship. Because it already limits me in terms of what I can and what I can't say. So as much as I check with people that can I call you by this, or how would you like me to call you most of the time. So if somebody is significantly older, I'll check with them how they would like me to refer to them [...] so you must engage with these things so it doesn't compromise the working relationship. I think sometimes once you get into a space where I can't call you by your name; sometimes it does make it hard for them to hear what you have to say because there is that element of 'my child or niece'. But you do have to keep it in mind that that person may be thinking of it.*

> **Interviewee 7:** *I find it exceptionally hard because I think that it is very counter intuitive not to touch and not to communicate and not speak, Zulu or whatever; and you can its just that sometimes the therapeutic language is a little bit different to master when you're speaking Zulu [...] so I'm very aware of saying 'hello mama ndice'lu hlalepansti', I'm very aware of that because I'm kind of, if someone speaks to them in Zulu then I will facilitate and carry on doing it that way, I certainly will and if someone is more comfortable and puts a bit of Zulu here and there, its fine, but I'm defiantly not the person who is initiating that.*

4.3.3.3. Black perceptions psychotherapy

Four of the participants interviewed mentioned how psychotherapy and psychodynamic psychotherapy was often perceived as inaccessible to many black people and communities. Additionally; participants also expressed how the profession as a whole has not been socially constructed to be appealing to black people and black communities.

> **Interviewee 1:** *Ya, based on some misconceptions or a lack of a clear image about the profession. People think that when you go to a psychologist you go to a white person, or you are likely to see a white person. So it can come with a surprise element when you see a black psychologist. So people usually become surprised, they thought that I will be white. People are more familiar with black social workers but not black psychologists. I would ascribe that to the image of the profession itself, how the public sees the profession.*

> **Interviewee 5:** *Counselling is still seen like a western thing so unfortunately that means that somebody will come with a perception that your thinking will imply that you judge somebody who stays with her parents after 37 differently kind of thing [...] because people think of it as a western thing sometimes they'll come with a perception that what you're going to, how you're going to think about their situation will imply that you see it as something they need to do differently, like, this is quite interesting because most time when men come up there is already that feeling that I'm in the wrong space, so it has to be a desperate situation for them to be there. So the resistance will be around, I am being put in a place where I have to consider counselling not that its my choice [...] you know psychodynamic therapy is sometimes very different to your usual counselling.*

> **Interviewee 7:** *A lot of comes from a sense that...everyone is foreign to this world, me and that black client, so were coming into a western construct and we're moving into this western world in a way and we are relating in a way that isn't I suppose normal for us, but we've both chosen that.*

4.4. Assumptions

This theme and subthemes represent the comments made by all participants related to their view and understanding of how and when clients brought or made the use of assumptions during the therapeutic process. The two subthemes present include *Assumptions of understanding*, where

participants refer to assumptions that the clients, and occasionally the participants themselves, often bring with them when working with a black psychotherapist. The second subtheme; *Assumptions of misunderstanding*, contains assumptions where the clients perceived or anticipate some misunderstandings based on the race of the participant and the assumed background which they come from.

4.4.1. Assumptions of understanding

The following four participants are speaking generally to how assumptions can come up in therapy. These comments include both assumptions from the participants as well as those brought by the clients.

> **Interviewee 2:** *With racially like clients you have a sense of people's backgrounds.*

> **Interviewee 5:** *But I also find that, what I think happens with them is that initially they almost want to check if you understand their words in the way that they do and most times I'm in a place that is predominantly Afrikaans, and if you look at this place it is predominantly Afrikaans, middle class, young.*

> **Interviewee 3:** *When you do come across those people who are willing to work with you, they bring a lot of stuff in the room and they expect you right away to, especially also in relation to race they have high expectation that you will relate and some of them out rightly phrase it 'as black people' or 'as a black person you must understand' or they assume that as a black person you must have gone through this yourself.*

Some participants saw the assumptions of understanding as having a facilitative role in the therapeutic process and for the working alliance.

> **Interviewee 1:** *When a client would really like to feel that you understand the dynamics of their daily lives. You just take it in a surface level and they would very much appreciate that. And they find it easier if they see a black therapist, a black client seeing a black therapist they think they'll easily understand where they come from and what are they're issues and all of those details.*

Interviewee 4: *There is an assumption that you can understand and therefore it creates the alliance or strengthens the alliance more than anything, and I think that's where some of my success stories come from.*

Interviewee 2: *And that aids the therapeutic alliance too much, hugely. It strengthens the therapeutic relationships. Its easier for a client to be seen from their experiences, to be seen by someone who immediately understands what they are talking about or immediately understands them from their back ground. Because a client needs to feel understood, not to think that they have been understood. So its easier or better when they get there as soon as possible, you can get that connection, that this person understands what is my problem. And you see the problem in psychology is different, its not just a physical problem like in medicine. The psychological problem with the client will involve the environment, it will involve the background and all of that so yes. So it sort of strengthens the working relationship when the client believes that by seeing a black therapist the may share or know a problem*

4.4.1.1. Expectations of understanding

The comments present here refer to the participants' view that some black clients enter therapy with an expectation to have material understood because of the racial black dyad. Participants here are making reference to the way that some black clients take it for granted that material will be understood or known by the therapist because s/he is also black and the presumption that they (client and clinician) share some commonality in their background.

Interviewee 6: *For me its quite lazy to say simply because one is black, therefore there is gonna be, yes being black, for other people makes they think okay 'he's a brother', but I'm saying to you that even if you break that down, I may be black then I meet someone who speaks Shangaan or Venda, I don't know much about those cultures, so if the patient says they want to see a black person for whatever reason, for me its fine, I find that its got these added dimensions of 'ya well, you should be more understanding'.*

Interviewee 2: *So I would need to clarify sometimes by saying this is my sense of what is happening, I just need to make sure we are on the same page on this particular things because you might assume that I'm a black male and therefore we see eye to eye on this particular issue, and that might not necessarily be the case.*

Interviewee 5: *To challenge it takes a long time and takes a lot of patients because sometimes people use the race card inappropriately, they just pull it out. And its assumed that you'll actually understand and embrace it based on the fact that you're black. I suppose where it works fairly okay, I don't know if it should be considered okay, but when somebody tells you something related to their culture like this is what my family did this is what they had to pay for their damages, you things like that, its assumed that they don't have to go into how it was done, they can just tell you the bigger picture they don't have to tell you the large part of it. And its never the same how things are done in different families so its almost like you have to show curiosity in terms of how they make sense of that, what it means, it means different things to different people, so there are assumptions of that kind.*

Interviewee 7: *Very much with the 'you know how we are', that kind of very, when they are trying to facilitate some kind of understanding of their experience, so they try pull you into it, with 'you know how we are, you know how our men are, you know how our children are' so that kind of over identification because of your race [...] I think that, it serves as a hindrance because I always feel like there is an expectation that I'm gonna understand them. And you can't have that understanding you can't say 'that's how we are, you know how we are', because we doesn't mean anything for me or you, it doesn't help understand you better, we could be very different, you construct of what a man is and my construct of what a man is not the same [...] I've also got to come in here and be what I'm suppose to be, the blank slate, and you can't do that it you're pulling in and you're we'ing and us'ing that kind of stuff.*

Two participants spoke about working with their own assumptions with clients.

Interviewee 1: *Because I've been exposed to such a variant of clients, from time to time I have to put my own assumptions aside because as a therapist we need to remind ourselves always that the client is a unique person not anyone is the same as any other person.*

Interviewee 2: *Sometimes its not even that clear cut because you assume that uho darkie then the majority of black people will have similar circumstances, but its not*

necessarily the case [...] so I have certain things about culture that I would assume that she knows, so make a particular interpretation assuming that within the cultural context she'd understand and to her it was like okay, what this does not resonate with her. So the assumption of culture can cause a problem.

4.4.2. Assumptions of misunderstanding

The comments which follow address cases where often the participants' clients assumed and expected that the participants would not understand them because it is presumed by the client that they come from different background. In some cases the participants are referring to the clients' idea that the clinician would not fully understand them.

Interviewee 4: *For example if it comes up it will usually be like 'I'm Indian and I'm having such a challenge at work and you won't really understand what its like to be Indian because you're black', you know the kind of struggle that someone would be facing in that particular moment or just would be personalised.*

Interviewee 1: *So sometimes the client will assume that you won't fully conceptualise or understand their problem, because their context is different.*

Interviewee 2: *I mean obviously the assumption that we come from different races, cultural groupings, I find that they can be a bit inhibiting because I want to understand symbols of these things [...] for example the other cultures I know very little. I once worked with a Muslim man, and the difficulties of not knowing Islam and what it entails about certain things. A little thing like for example, at some point I had forgotten and said lets set up an appointment on Friday at 14:30, but Friday is mosc and he comes out around 14:00 so he's likely not to make it for 14:30. So that's a little thing but it can be major in terms of the working alliance and that relationship.*

4.5. Language

These themes refers to the role of language in therapeutic encounters. In the following comments, participants mostly understand language as an influential and significant variable when working in both racially like and dislike dyads. In both cases of racially like and dislike, language is seen to have a unique influence.

Interviewee 1: *The issue of language, you know with us South Africans, its a huge huge thing since our work is conducted in the medium of language [...] there are many languages out there and so the issue if the language plays a very important role in how the client interacts. Therapy is the domain of motions and how emotions are expressed verbally and non-verbally and how the client feels you as a therapist is in connection with their language and the way they communicate. That issue of the language needs more exploration from the profession. In South Africa there are officially eleven languages; but there are actually many languages, there are many forms of a language. There is the lingo language, township language...everywhere there is a language.*

Interviewee 6: *But then again you can find that we use English so as much as I said language, because its middle class people most of the time that would come and consult you find that we speak English or even if its a person who speaks any other language either than Xhosa, they would still be happy that I'm black but its quite complex.*

Interviewee 5: *So if someone is seeing themselves and really in so many ways is in a middle class or higher class, they will present themselves differently for example speak in English while knowing that we both speak Sotho or we both speak Zulu [...] I think it comes back to language, so they present themselves in a certain way in terms of language, but it wouldn't necessarily compromise their way of thinking about me.*

One participant understood language as facilitative to the working alliance and therapeutic process when both clinician and client use the same language.

Interviewee 5: *Sometimes language makes it better, when somebody is able to say it in their language. I find that even somebody who comes in with the perception that because its a Western thing they speak in English, when there is that punch line, when there is something important that they need to say, they revert immediately to their language and almost like that creates such a connection in that moment because you're thinking 'I can understand'. And there are some words which are not easy to translate by the way, so you can actually immediately connect with that person in that space, either in excitement or out of just being furious, they elaborate something in their language then you actually connect much better and I think that's very helpful.*

Some participants refereed to language as presenting some hindrances, difficulties and limitations when working in the room with clients.

> **Interviewee 2:** *Certain symbols or use of language can be a bit difficult and you make certain assumptions. I'll give you a typical example, a lot of black folk when they speak in the township lingo they say 'I'm sure so and so is there' and they are meaning actually that they are not sure but there is a possibility. And I have to be consistently thinking when I use a certain phrase and I think am I using them in the appropriate sense or in the township lingo. And so I will think if I used it appropriately in my mind, because I thought I reflected this but actually I reflected something else something different. And so that can be a bit challenging.*

> **Interviewee 6:** *But you see there are other limitations, for example, something as basic as language, we are trained in English, we read all these things in English, but at times when you want to express yourself, you would prefer to use your language. I mean there I thing that I could say; where English would lose meaning like when you say intliziyo yam Ib'hlungu you can't say my heart is sore.*

> **Interviewee 5:** *Language again, I don't speak English in the perfect sense of the word, so from my side I'm cautious of the words that I use with white clients more than in other spaces, because the whole work is about words so ya. It compromises sensitive communication, not in the sense that you can't say something its in the sense of how you say it and the way you actually want to have it received in a particular way and not have it misinterpreted.*

Participants also spoke about the challenges with working with a psychodynamic language.

> **Interviewee 1:** *It won't be useful if the way I think and the way I speak doesn't link with the client. If I speak a Freudian language to someone who didn't go to school, I don't think to will be helpful for that person.*

> **Interviewee 6:** *So I wouldn't necessarily say that its difficult but I think psychology obviously if you're talking purely from your Freudian or any specific modality, I don't see how it could work because for me there are issues around language as I was saying*

I think I find the language that I use, even when you make an interpretation or a reflective interpretation, whatever form of intervention...I mean I have had to adapt it I have had to develop my language with the client that would be comfortable. I mean some clients would have maybe a township background so you find that the nature of their way of expressing their emotions or thoughts or their relationships has a lot of township lingo [...] so for me issues of language, even English because if you think about psychology you have English, you have the professional psychological jargon of the training and within that you have the terminology and its almost like a three tiered thing so obviously I don't use any of that in its purest form I use it in relation to the person.

Interviewee 7: *And the translation is lost and the effectiveness is lost I think, in some instances. Especially when you're doing dynamic work, when you're doing other kind of work then it might be much easier, but you try do psychodynamics in Zulu, good luck. Because I think it just gets diluted.*

Chapter 5: Discussion

5.1. Introduction

This study aimed to explore the experiences of race; of black practicing clinical psychologists within the therapeutic encounter. Specifically, the study aimed to probe the roles of the working alliance, transference and countertransference, and how these three constructs which are central to psychoanalytic psychotherapy; were mediated, moderated, and influenced by working between and within races. The study was interested in whether race has been experienced as a latent or manifest variable when working with similar and/or different races, by black clinical psychologist, within the clinical space. Since this was intended as an explorative study no formal hypothesis or expectations were suggested. This chapter will cover four main themes, including; *Race in the room*, *Transference and Countertransference, Assumptions* and *Language.*

Yi (1998) notes that in his experience for racially dislike or like dyads in which both participants are members of a racial minority, race becomes a salient issue more often than not. In South Africa, black therapists or clients are in the racial majority, however one can consider them to be statistically in the minority for psychotherapy and in psychology as a profession and therefore understand black clinical psychologists as minorities when considered within that context. Where applicable the discussion will therefore consider minority therapists when referred to in the literature in relation to black clinical psychologists.

5.2. Race in the room

Responses in this theme were prompted by a particular question in the interview schedule, but also emerged indirectly in responses to other questions. This theme represents instances where clinicians make sense of experiences in the room as possibly related to race. A significant response pattern under this theme was the uncertainty on whether particular and general issues were related to race or not. Nevertheless it is the recurrent questioning of race relatedness which the participants experience and report which is significant. In other words, it is the fact that the participants experience race as a possible explanation for material and as a factor they have to grapple with, associated with being a black clinician. Participants' responses also pointed to instances when they felt that race was indeed in the room in very subtle ways. The ways that race was experienced to have been brought in to the room, both by clients and by the clinicians themselves may speak to the facilitative value or hindrance race may have on the working alliance.

The general idea which drives this theme is the conviction by most therapists that race is always alive in the room. This corroborates Smedley's assertion that race has an unavoidable contaminant role in psychotherapy. Smedley (1993) and Carter (1995) emphasise the importance of race and racial identity, and its ever-present influence in psychotherapy. What will be discussed later is the hypersensitivity to race and racial issues most black clinicians may experience. It may be useful, in understanding the participants' responses to appreciate the hyperawareness that most black clinicians may have as a result of *being black in the world* which often positions blackness as marginal, *other* and different. Therefore it may be understandable that black clinicians may be more likely to see race in the room than their non-black counterparts.

Participants reported their difficulties of discerning whether certain material in the room was race related or not. It became clear that black clinicians are occasionally questioning how much race is being brought into the room, both as a result of their race and the race of the client. There seemed to be recognition that in both instances of the client's race, and that of the clinician being considered as a source for eliciting race material, there was an acknowledgment of the social and historical associations as well. Participants refereed to their struggles of having to sift out whether the clients' presentations, resistance, defenses, attacks and other examples of material which may be expected in therapeutic process, were based on or informed by race or not. Black clinicians therefore report being aware of the possibility of their race in the therapeutic process, often in maters which may hinder or present challenges to the therapeutic alliance or therapeutic process.

Most participants report not knowing whether particular experiences would have taken place or occurred differently if they were not a black clinical psychologist in the room. Black clinicians therefore seem to constantly wonder if what is happening is being induced, moderated, mediated or is a direct result of and reaction to their race. These questions were often reported when participants had *powerful* experiences. By this, participants were referring to therapeutic experiences which were momentous and/or highlighted in the course of the therapy process. Other examples included less significant and more inconsequential, expected and mandatory experiences such as terminations, different transferences and challenges to the therapy process. Nevertheless black clinicians seem to be aware of their race in these experiences as well and question whether there is a link between race and these events.

Most black clinicians seem to experience race as an additional factor to think about in therapy. This variable may make it more difficult for them to make therapeutic understanding of what is happening in the room because it is often experienced as unaccounted for and difficult to access objectively. Black clinicians may be more sensitive to race and therefore not certain how much of the material they should interpret as race related. There seems to be a constant double guessing of their interpretations of race related material and possible self-criticism and awareness of interpreting race in material. This awareness seems to be a site of anxiety for black clinical psychologists and also appears to result in some insecurity about their ability to interpret the situation and material in the room. Some black clinicians then use the '*if I was white*' test, where they question if whatever the client has brought, said or presented, would have been so if they were a white clinician. As a result black clinicians may occasionally compare themselves to their non-black counterparts in a quest to understand clinically relevant material.

Clinicians' experience of ambivalence and uncertainty about the material in psychotherapy is common for most clinicians across the racial divides. However, it seems apparent that what black clinicians also have to consider when trying to make sense of these ambiguities and uncertainties is the possibility that race is present and playing a role in the room, all the time. In other words, whether the material is or is not related to race, black clinicians seem to be more open to the possibility that is may be present. Black clinicians may therefore entertain the presence and role of race when some things in the process are unclear, more than non-black clinicians.

Further material reported by black clinical psychologists related to the intermittent subtlety that race emerges in the room. There were instances where participants were both certain of the reference to race as well as the subtlety with which race was being referred to and being presented. In some cases, participants were more certain of the presence of race in the room, however they noted how it emerged in very subtle ways. Participants deduced race or racial material form indirect communications and presentations. This was consistent with Gelso and Mohr's observation discussed in the literature that "Sometimes these transferences are subtle" however it is apparent that these "cultural and culturally reinforced transference" will emerge (2001, p. 64).

Participants may therefore be aware of how race and race related material is not obvious in its presentation in some instances, and how they have to surmise or infer the racial and race reference as presented by some clients. They report that it is often hard to name or qualify their summation and that material is indeed related to race when it is subtle, but that most of it was intuitive and subjective interpretations. Examples of this differed between participants, however they reported that questions of race usually present themselves at the beginning of the therapy in different forms.

The consequences and effects of these subtle racial expressions were not explored. However what was mentioned by some participants was how they may sometimes moderate the clients' openness and trust of the clinician and the therapeutic process. In most cases trust and openness issues were understood as the manifestation of the subtle racial material. Black clinicians therefore attributed some non-black clients' lack of trust and openness to the racial inconsistency in the therapeutic dyad. Clinicians were often aware that trust and openness issues are common in many therapies, but felt that race played a role in some instances with non-black clients' lack of trust in them and the therapy process. One participant suggested that non-black clients would react in one of two ways to black clinicians, either trusting and opening up too much, or being resistant to trusting and opening up to the black clinician. Therefore participants understood this as a subtle expression of race.

As mentioned in the literature, Comas-Diaz and Jacobsen, (1991), Kozuki and Kennedy, (2004), and Tang and Gardner (1999) observe that minority therapists may be more susceptible to seeing the race in the room. Particularly, minority therapists may be more sensitive to interpreting their client's reaction as a reaction of their identity as a non-black therapist. The findings from the interviews confirm this literature and suggest that black clinicians are more likely to interpret communications as race related communications. In addition, black clinicians may also be more likely to pick-up nuanced or surreptitious material which is racially motivated in the therapy room.

Specific subtle race communications by clients in the room included questions of professional competence. Participants referred to instances where they interpreted that their professional competence was being questioned by the client. This was understood as having been done so because of their race as a black clinical psychologist.

Once again most participants report that this usually manifests at the beginning of most therapeutic relationships. In some cases clinicians felt that questions of their competence happens with both black and non-black clients. Therefore at times this happens, regardless of the race of the client, but due to the race of the clinician. Some clinicians acknowledged that this latter point applies to most clients irrespective of their race, but that there may be more of a pattern of non-black clients questioning their competence, than with black clients.

There was therefore a sense that black clinicians cannot deliver as a good a service in the profession perhaps as compared to their non-black colleagues. This was associated with a sense of being undermined in their capacity as a black psychologist and the belief that they are not competent in their skills. A few participants mentioned that they had to prove their competence with some participants, before the process of therapy continued or consistently throughout the therapy. How this was done was not explored fully with participants. Participants alluded the shame and insecure feelings induced by these perceptions and interpretations. These feelings have been reported and theorized in related literature and studies discussed above (Comas-Diaz & Jacobsen, 1991; Kozuki & Kennedy, 2004; Shofeld-Ringel, 2001, Sue, 1998). In their literature, these former authors have observed and suggested that minority therapists' ability to perform skills in their professional capacity may be undermined and undervalued by clients and colleagues. These findings are therefore congruent with the literature.

Once again Tang and Gardner's (1999) observation that black clinicians may be more sensitive to race related material may be applicable here. This is not to suggest that black clinicians are more likely to attribute mandatory therapeutic material to race and racial tensions, rather, that black clinicians are more acute to the race in the room. In other words, black clinicians may be more willing to interpret the situation material in the room as being informed by race as they are more capable of noticing when race subtly emerges in instances such as competence. What may also be important to know is that black clinicians may also be thinking more about race in the room than possibly their non-black colleagues. This is a difficult hypothesis to consider since there is little literature to draw from.

This content about questions about black clinicians' professional competency being questioned was relayed by Gardner (Tang & Gardner, 1999). Gardner notes how in one particular situation, he was uncertain whether a client who scrutinised his qualifications on the wall during their first session, was also questioning his professional competence. What is notable is the fact Gardner

was aware of attributing this act of professional enquiry to the fact that he was a black clinician in the room. It seems as though whenever questions around professional competence do come up in therapy black clinicians are likely to consider their race as the source of doubt.

When reflecting on the way race came up the room, participants frequently mentioned trauma as vehicle through which it was either directly or indirectly being brought forth. Participants mentioned how when working with trauma victims, which were all most always non-black in the examples used, the race of the perpetrator was often black. Participants reported that their clients would censor themselves when speaking about their perpetrators.

Participants noted how this is a challenge because the client would therefore initially feel that they cannot speak openly and freely, which is countertherapeutic. The clients' feelings of discomfort are noted by the clinician and understood as being induced or provoked by the clinician's race. These are essentially examples of when race is in the room through silence or expurgating it from the discourse. Some participants noted that this was an uncomfortable situation for them as well.

It is important to bear in mind the literature which recognizes that the black clinician is not a blank screen and that his/her colour will evoke reactions from the client. This is especially the case with non-black clients (Shofeld-Ringel, 2001, Sue, 1998). The literature recognised that when the non-black client's thoughts are loaded with racially derogatory material, or material which may be perceived as potentially damaging to the black clinician, the client may feel uncomfortable and be faced with a dilemma of free expression or censoring. In this case the victims of traumas where usually non-black according to the participants. As a result of sitting across a black therapist the non-black clients may feel uncomfortable to bring-up the race of the perpetrators who are also usually black as reported by participants. Therefore the non-black clients avoid this potentially uncomfortable situation by censoring themselves.

Similarly, Tang and Gardner (1999) discuss the anxieties some non-black clients may feel about potentially destroying or damaging the black clinician if they engage with their rage with the perpetrators, with which the black clinician has been associated. The non-black client's omnipotence and fantasies of his/her potential to do harm is linked with the social power which most non-black clients possess in most societies (Tang & Gardner, 1999). Consequently the non-black client's omnipotence makes them think that they could destroy the clinician with the

projections of rage since the race of the clinician evokes transference, making the black clinician an object for re-enactment. The non-black client experiences anxiety, concern and guilt for these fantasies, and censors him/herself as a result (Tang & Gardner, 1999).

A majority of the participants reflected on the complexities that often arise when working in a racially similar dyad. These complexities therefore refer to the specific and general challenges, considerations and issues which they have become aware of and need to keep in mind when working with black clients. What was evident from the interviews was the fact that participants felt that they need to be mindful of their black clients' race and their own race as a black clinician in the room. These elements were seen to influence the working alliance in a variant of ways.

The distinction or uniqueness of each black person is important to black clinicians. They felt that they needed to clarify how different black people are and how often black dyads in therapy carry with them their own difference. These *intra*racial differences create unique complexities for psychotherapy. Participants felt that while clients and clinician may both be black, other elements which play a role in the quality of the working alliance include; level of education, language, cultural and ethnic group with which the client affiliates and identifies, social and geographic background and economic status.

While it is better recognised that there is a paucity of literature on psychotherapeutic work with black clients in South Africa, one can surmise the dearth of literature which engages with within-black differences and similarities in South African psychology. With that said, it is also possible to know that while race is a salient feature for an individual's identity, it is not the only marker of social identity. Class and social status is a growing identity for many black South Africans in contemporary South Africa (Durrheim & Mtose, 2006). In South Africa's pre and post-colonial historically, as well as during apartheid, ethnicity was considered a more accurate and prominent social reference for an individual's identity than race was (within the black race) (Bowman, Duncan & Stevens, 2006). Therefore it is possible to imagine that the residual impact of the latter social identity marker (ethnicity) and the growing importance of the former identity marker (class and social status); may present within race differences.

It may also be useful to think that black people are more likely to discern between non-black people. In this case, black clinicians may have been more likely to report within black

differences in psychotherapy than perhaps non-black clinicians would have been able to. Unfortunately because of the scarcity of the literature, this hypothesis is hard to accurately either substantiate or dispute.

Working with racially different clients was noted to have a facilitative role on the working alliance with some clients. According to the participants some clients interpret the racial difference as indicative or telling of a perceived racial distance and social distance. Therefore these clients are understood as being more open and forthcoming of themselves to the clinician because the client is thought to be so *other* and different that clients are more expressive and open in the therapy process.

According to the participants, it was the *othering* of the clinician which makes them a safer option. The clinician in this case is other by their race, by the virtue of belonging to a different race to the client. It can be thought that the client must be employing an internalised cognitive difference between him/herself and the black clinician. Therefore this *othering* is experienced as safer because the clinician will never be part of the client's world and community, therefore confidentiality is assumed. The effect of perceived proximity to one's social reference and community was noted by one participant who reported that some black clients may be more opaque because they feel that the black clinician may have access to their immediate environment, and therefore confidentiality is not guaranteed.

Literature suggests that clients of racially similar therapeutic dyads are likely to be more open in the therapy process (Matsumoto & Juang, 2004; Sue, 1977; Sue 1981). These clients are likely to experience the racial similarity in the therapeutic dyad as facilitative of openness and disclosure. This hypothesis is based on the idea that the black client feels more comfortable with the black clinician and assumes that they can better relate and more accurately understand where they are coming from. However this was not reported by the participants. Instead; the participants reported that some non-black clients experience the perceived racial distance between them as facilitative of openness and disclosure.

Understanding these findings may require some speculation. For example, from the participants' exerts it sounds as though the clients were more likely to reveal aspects and information about themselves to the distant, *other* clinician, which they may have found difficult to do with *the same* clinician. While this may be common in psychotherapy, it seems as though the clinician's

distance in fantasy, creates a safe space into which the client can project and fill with material otherwise unprocessed. Because the clinician is so *other*, the client recognises how different they are. Therefore the client may feel safer to explore and volunteer information which may usually be too shameful to discuss with other like members of a community. As a result the client may feel less confronted with the meanings and implications of what has been discussed or brought and is required to feel less, guilt, shame and remorse. Since there in limited literature it is hard to substantiate or dispute this.

The clients could also be having a defensive reaction to the situation. They may be more open and forthcoming with material because they are experiencing anxieties about disclosing to the unknown *other.* In other words, parallel with the literature which suggests that racial likeness in therapeutic dyads may facilitate openness (Maphosa, 2006; Matsumoto & Juang, 2004; Sue, 1977; Sue 1981), perhaps racially different therapeutic dyads discourage openness because of the concerns and discomfort the client may feel. However, in accordance with the literature which suggests that clients may be concerned about hurting and insulting their therapists, they may therefore present in a defended way which means that they are more forthcoming. This may be a reaction formation defense where the opposite of what the individual experiencing is acted out because the individual is uncomfortable with acknowledging the true core anxieties. Javier and Rendon ((1995) and Holmes (1992; 1999) have suggested that these defenses may be expected when working in racially dissimilar therapeutic dyads.

5.3. Transference and Countertransference

The subthemes identified here represent one of the major constructs with which the research is concerned. Several ideas are included here, all of which speak to the experiences of transference and countertransference as subjectively understood and experienced by the participants. While the participants were limited in speaking to transference material as experienced by the clients, they did refer to instances where they understood the material to be related or indicative of transference. Additionally participants also made reference to their own countertransference in particular situations and as general reactions and experiences. This theme includes the following subthemes; *Transference objects and enactments, Countertransference* and *Politics of psychodynamic psychotherapy*. This theme was mostly informed by responses to particular questions in the interview schedule as well as other responses.

South Africa's social reality of a race conscious society (Stevens, Swart & Franchi, 2006; Terre Blanche, 2006) was evident in participants' experiences on transference and countertransference. What is useful to note here is how these experiences are informed by the meaning which the clinicians attach to the transference, which is subjective and interpretative. The objectivity of racial influence and content may be arguable; however it is the subjective meanings which inform these experiences which constructs the meaning. The experiences therefore may have been experienced differently in a socially and historically different society to South Africa, but it is this particularly racially aware and preoccupied society which then taints understandings of transference and countertransference. Therefore social and socio-political factors unique to a South African society are experienced as influential in experiences and understandings of transference and countertransference as was suggested by literature.

Participants reported that their clients would occasionally enact different transferantial objects in response to working with them as black clinicians. In selected extracts participants understood the transference as related to their race and to the clients' identification of them as a black clinician. Here the clinicians either became extension of a clients' previously experienced black object relation, or the client unconsciously experiences the clinician as a representation of another black person or black people, onto whom they project unresolved feelings and thoughts and/or re-enact that previous relationship.

As discussed in the literature, transference can be thought to the client's inappropriate and displaced feelings, drives, attitudes, fantasies and defenses towards the clinician which originate from other and earlier relationships (Greenson, 1967; Gelso & Mohr 2001). Therefore in these cases the client, both racially like and dislike, would interact with the clinician as informed by a previous significant relationship with another black person. In other words the clinician was experienced by the client as a black person from a previous relationship, the significance of which is determined by different but often conflictual contexts. The clinicians particularly felt that the transference was informed and elicited by their race, unique therefore to working with black clinicians.

The relationships which were the source of the transference were different and particular to each of the clinician's clients. Often for non-black clients the source of these relationships varied from specific black individuals such as black bosses and superiors from work environments and black perpetrators and attackers, to more generalised, group or patterns of relationships such as

historical relationships between black South Africans and non-black South Africans. In transference associated with the former category, the clients were often experienced as attacking the clinician and antagonising of the clinician. The attacks on the clinicians were understood by the clinicians as a reenactment by the client of a previous relationship with another black person where the clinician, in the therapy room, assumed the identity of another black person related to the client. The transference in the latter category seemed to be informed more by feelings such as guilt, remorse and other anxieties which the client felt as a result of associating the black clinician with other disenfranchised, perpetrated and oppressed black South Africans, both during apartheid and as a result of Apartheid.

In selected cases, the participants reported race related transference from black clients. This transference was mostly informed by an identification of the black clinician with a *white* profession. Therefore the clinician in this instance may have been associated with other or another black person who was antagonised, through their role as a professional, or specifically in a profession perceived for white people. It must be noted that more participants reported on race related transference with non-black clients than with black clients. This skewing in results may be as a result of participants being more sensitive to interpreting transference from racially dislike clients as race related than that of racially like clients.

Yi (1998) notes that racial minority therapists are more aware and cognisant of race and its impact in therapy than white therapists. For example, in a case where in a therapy conducted by a black male therapist with a white female patient, the black clinician "insisted that they look at the race relationship between them over her repeated statements that race was not her main issue. The heightened salience of race for racial minority individuals may be a function of their attention to both overt and subtle racial inequalities represented pervasively at societal and cultural levels" (Yi, 1998, p. 14).

As noted in chapter two, transference is considered fundamental in psychoanalytic and psychodynamic psychotherapies. It is in the understanding and interpretation of the client's transference that the analyst does most of the work of the treatment (Greenson, 1967; Gelso & Mohr, 2001; Yi, 1998). It is therefore important to an analytically and dynamically trained therapist, as was the case for all the participants in this study, to be aware of the transference. Discussions of race related transference in the psychoanalytic literature have been infrequent (Yi, 1998), and often limited to Freudian or Kleinian perspectives positioning the concurrence of

these two constructs as either "a manifestation of intrapsychic conflicts or projection of unwanted mental content onto the racial other" (p. 1). A large portion of the literature concerned with race and transference, however, has had a polarised presentation, either understanding the race as a hindrance to transference (see Bernard, 1953 & Fischer, 1971 for example) or in demonstrate the usefulness of race in elucidating and facilitating transference (see Goldberg, Myers, & Zeifman, 1974; Schachter & Butts, 1968 for example) (Holmes, 1992).

None of the participants interviewed explicitly presented the race related transference and countertransference as a limitation or hindrance, nor did they understand it as a facilitative factor to the transference. Instead the participants seem to present the racial transference as inevitable or invariable. What was evident is how the therapists tried to understand the transference as informing the therapeutic process. Three models in the relevant literature explore an explanation of race related transference which include; the intrapsychic drive model, the Kleinnian-contemporary Kleinian model and the intersubjective view (Tan, 1993; Yi, 1998).

For the intrapsychic drive model the black race is positioned as a symbol of libidinal and aggressive instincts. Authors in this school of thought have focused on whether race was a "conduit of libidinal and aggressive impulses and whether transference of these impulses could be established across racial barriers" consistent with classical Freudian orientation (Yi, 1998, p. 4). Yi criticises this school and the position which informs it for ignoring the many other possible meanings attached to race and for not considering that transference is co-constructed by analyst and client. The participants interviewed all seemed to account for their role in the transference by acknowledging, often implicitly, that the client's transference was evoked by their (the clinician's) race. The participants' recognition and account of their race therefore voids this model of understanding race related transference.

The Kleinian-contemporary Klein conceptualization of race related transference uses the Kleinian concepts of projection and projective identification to understand race related transference in therapy (Altman, 1995; Tan, 1993). For Altman the *other* race provides the client with a "not me" (cited in Yi, 1998, p. 8) into which s/he can "project unwanted psychic content, such as aggression, which is then introjected by the other racial category of people" (p. 8). Race is used as a focus for the back and forth oscillation of projective identification which takes place in interracial therapy. This model is useful in attempting to understand the aggressive transference reported by most participants from non-black clients. It recognises that the therapist

has a role to play in the client's transference as was acknowledged and owned by the participants. Additionally, it can be considered to match with a South African understanding of race relation where the black race was consistently positioned as the other through legislation and structural institutions.

Using this model may be problematic when trying to account for race related transference with racially like clients. It may be argued however that because the black clinician is operating within a profession long understood to be reserved for white South African's, that they too are now identified as the *other* by their clients. It may also be complex when trying to understand the race related transferences which invokes feelings of guilt in non-black clients. Clinicians may be experiencing this as a projective identification, where they are holding the feelings for the client, which the client is as overwhelming, unbearable or unable to contain themselves. Literature from Javier and Rendon, (1995) suggests the likelihood of this in racially dissimilar psychotherapies.

The intersubjective conceptualisation of race related transference, which is the more recent of the three models, hold the view that the therapist is not neutral and objective, but instead "operates out of a subjective reality that may or may not be similar to the subjective world of the client but that nevertheless has much influence on the therapeutic process" (Yi, 1998, p. 11). From this school of thought, the race related transference is co-created by the subjectivities of the therapist and the client (Hoffman, 1992; Yi, 1998).

For these 'intersubjectivists' a broad array of meanings that race may bring in therapy is considered, including particular consideration to the larger societal and cultural milieu in which race relations are shaped (Yi, 1998). This may be useful in understanding the race related transference which is associated to South Africa's history of a racially conscious society, such as examples where non-black clients were thought to have guilt and shame transference when working with black clinicians, and when black clients attacked the therapists for working in a historically white profession. Similarly one may consider the current social and socio-political dispensations, and account for some of the non-black clients' attacks on the black clinician, as a possible expression of general discontent which may be felt by many non-black South Africans. However this remains an unsupported hypothesis.

With the intersubjective position, when the therapist's race evokes an intense negative reaction, as was the case with most non-white clients, this can also be understood as race being

constructed and interpreted in “such a way as to activate fear of repetition of some aspects of the patient's painful experiences with caregivers” (Yi, 1998, p. 14). While with the Kleinian model, where the client’s negative reaction or attack is likely to be understood as a defensive projection of inherent aggression or hostility, the intersubjective position emphasizes “developmental elements underlying the negative reaction, the assumption being that understanding and a gentle articulation of the patient's fears would result in the patient's feeling understood and would bring forth the patient's developmental yearnings” (p. 14). Therefore the clinician may still use an attack understood to be informed by a race related transference for interpretative value on intrapsychic infantile material.

This model may therefore be more useful in understanding the race related transference as presented by the participants in interviews as it recognises the role of the clinician in the transference and acknowledges intrapsychic material and influence. The two previously discussed classically oriented models are likely to understand race related transference as related to aggressive and libidinal drives and partially or fully ignore the meaning and reality of race and its subjective construct. The intersubjective models however “entertains a much broader array of possible meanings, mindful of the person's unique history and of the psychological makeup of the intersubjective milieu that might have given rise to the patient's unique take on race” (Yi, 1998, p. 13).

5.3.1. Countertransference

When participants reflected and reported their countertransference in a variety of situations, feelings of disempowerment and being attacked came up as some of the prevalent themes. Most participants were articulate about their struggles with some of the countertransference they experienced, mostly when working with both black and non-black clients, but in both instances it was their race as a black clinician to which they attributed as the source of these struggles.

Participants reported a variance of countertransference most of which was associated with being disempowered, attacked, uncomfortable and paralysed in the face of these feelings. At times the transference was evoke through more explicit and overt material, while at other times it was as a result of more surreptitious material as is often the case with transference. What is particularly informative to this study is how the participants understood this countertransference to be race related. In other words; participants reported that this race related countertransference was particular to their situation as a black clinician.

Some participants noted how they had to be mindful about not reacting and being neutral in the face of some strong race related countertransference, which was occasionally a challenge for them, especially when the participants felt that the countertransference was informed by some racist element or discourse from their clients. A couple of participants highlighted how race related material from social discourse may also emerge in the therapeutic process, of which they also had to be mindful of.

Participants were also specific that black clients evoke a particular countertransference which involved pressures to deliver and perform in the therapy. The countertransference with many black clients according to the participants made them feel like they had to work more in the therapy either because they identified with the client's struggles as a black person, or because they felt that they needed to be more directive and active in therapy.

In a bid to expand the idea that countertransference is not always pathological and that the clinician's responses may have a realistic response to the client's behavior, thoughts and emotion, Racker developed the concept of transference. Racker (1957) proposed the term 'complimentary countertransference', which is similar to the idea of projective identification, in which the therapist inadvertently identifies with or experiences emotions and feelings of significant and internalised people in the client's past and are projected onto the therapist in the room. Racker further introduced the term 'concordant countertransference' (cited in Strous, 2001), which refers to the clinician's identification with the client's self-representation.

In the case of the participants' countertransferantial responses involving attacks, discomfort and paralysis, it is possible that for the clients a projective identification may have been employed and that what the participants were experiencing was a countertransference. In other words, the therapists were identifying with and/or experiencing feelings of being attacked which may have rendered the client feeling disempowered and paralysed. Particular to transferences related to trauma victims and victims of violence, as reported by most participants, clients may have experienced literal attacks which would also have resulted in real feelings of disempowerment. Therefore one may surmise that the clients were projecting those feelings into the clinician.

It is possible to speculate on the role of the race of the clinician in the former situation. One possibility is that the clients, often non-black, could not own the feelings evoked by being

attacked by black people in the presence of a black therapist because of the concern of retaliating towards the clinician. They (non-black clients) therefore project the feelings onto the therapist to prevent a violent retaliation.

Another speculation could understand the projection as an attack. In this instance the client may be projecting the feelings into the therapist in a fantasy to attack and disempower his/her attackers. Here the concept of concordant countertransference is also useful in an understanding as it positions the clinicians as identifying with the client's self-representation of an attacked victim by a black person, which the clinician identifies with. For Strous (2001) concordant countertransference feelings are useful for both the therapist and the client because "they enable an understanding of patients' inarticulate experiences" (p. 94). Racker (1957) saw the process of concordant identification as the clinician's identification with the patients which may be conscious or unconscious but difficult for the patient to verbalise. This process and function is therefore analogous to empathetic attunement.

Countertransference pathology is a reminder that clinicians, despite their professional training, will also have 'human' reactions and failures (Ivey, 1992). In cases where therapists reported that they were aware of their negative or pathological countertransference in response to some racial attacks on them or racist remarks, this is also a reminder of their mortality. What is useful for the therapists is their awareness and openness to these countertransferences because clinicians' 'awareness of their own and of their clients' intrapsychic and interpersonal dynamics are critical if deleterious countertransference reactions are to be positively harnessed' (Strous, 2001, p. 97). Hamiliton (1992) also notes that the idea that the clinician may have an active intention to influence or imply their subjectivity in the process of therapy even while adopting a neutral and interpretative stance, furthers the idea that the clinician 'is always an active presence, even when he or she is quiet' (p. 163).

5.3.1.1. Race and the psychodynamic frame

All the participants spoke to the complexities and challenges of working within the prescribed frames of a psychodynamic psychotherapy. As mentioned elsewhere in the report, all of the participants interviewed have a psychodynamic training background and therefore often commented on how an application of this orientation in practice had its difficulties. Of particular interest to this dissertation was how participants understood these difficulties as having a racial theme to them, which will be discussed bellow. Overall the participants were presenting the

problems they have encountered with the application of psychodynamic psychotherapy and critically questioning whether one can apply a psychodynamic approach to psychotherapy in South Africa without considering and negotiating the two, since it was often felt by them that there is some disparity.

One of the noted themes from participants related to how they experienced the pressures and difficulties of maintaining a psychodynamic frame with black clients. The challenges experienced and expressed by participants related to persistent pressures placed on maintaining a psychodynamic frame with its prescribed conventions for psychotherapy. In most cases the participants made use of their reflections and understanding of countertransference to surmise this pressure they felt and the collusions they were being pulled into by their black clients. In most cases the participants were also clear or suggestive that these challenges were not experienced when working with non-black clients.

Several particular examples as well as general comments were given and made regarding how the participant experienced challenges to the frame. Specific examples given included an understanding of black clients as being *crisis orientated* in their presentation for psychotherapy and expectation of the intervention in psychotherapy. Therefore therapy often lasted no more than six sessions. Black clients were also reported to seek more direction from the therapist and expected the clinician to be more instructive in therapy. Participants reported that they felt that the client was expecting them to *give them something* and/or be more active in therapy by telling the client what to do, or giving them advice and their opinion. Other challenges presented by black clients according to the participants; included black clients' struggles with commitment to the consistent attendance required in psychodynamic psychotherapy, strict observation of time frames, and regular and diligent payment of invoices.

The literature discussed notes how black clients often seek psychotherapy in reaction to a stressor and attend psychotherapy looking for relief from acute stress. Their responsive motivation to seeking therapy means that many clients are also uncertain what to expect from the process of therapy (Marsella & Pedersen, 1986) and as a result expect the clinician to be more directive, active and structured in therapy (Maphosa, 2003; Marsella & Pedersen, 1986; Maphosa, 2003; Sue, 1977; Sue 1981). In therapy; black clients usually perceive the therapist as an expert to help them and resolve their problems (Vontress, 1981 cited in Maphosa, 2003; sue 1981). Psychodynamic psychotherapy would take a historical approach to the presenting

problem which may be experienced by some black clients in this case as unhelpful and frustrating (Maphosa, 2003; Sue, 1981). This may also be why many black clients show lower attendance in therapy and usually terminate prematurely more often than white clients (Maphosa, 2003).

These findings were therefore consistent with the literature presented and the previous studies of Maphosa (2003) and confirm some of the conclusions of Strous (2001). There have been few other similar studies in South Africa however it is useful to note that in both previous cases these reports and conclusions were based on a sample of non-black therapists. Additionally, other such international studies also often use white therapist-black client dyads. These results confirm those reports but are unique by using a black-therapist and black-client dyad. This may also be reflecting the difficulties Sachs (1996) encountered when testing the applicability of psychoanalysis on a South African.

Some participants vocalised how they understood cultural constructs to occasionally emerge in the room with black clients. Participants experienced how when working with black clients, social and socially constructed cultural norms, values, expectations and other *ways of being black in the world,* which were often expected and practiced outside the room, would be brought into the room. The participants were expressing their difficulties and the complexity of dealing with intuitive and internalised social constructs and cultural practices and values, which they would often observe in social settings outside that prescribed by a psychodynamic psychotherapy. Notable was how they therefore experienced these formally mentioned constructs as incompatible with psychodynamic psychotherapy.

Participants also spoke about how these constructs are brought into the room both purposefully and furtively through mostly learnt behaviour and expectations by participants. In these cases it would often be with black clients that they would have these experiences, but more useful to note is the fact that it is their race and position as a black clinician which would insight these experiences.

Specifically, participants referred to age as one of the constructs which they had to deal with at times. Related to this was how the participants would have to be thoughtful about how they refer to and address some of their black clients. For example, participants expressed how the in a different social setting, they may have, and be expected to, refer to older clients not by their first

names or prefix their names in order to accord respect or recognise their age differences. Similarly how clients would refer to them had comparable dynamics in the room. Other constructs which may arise included the language to speak, the manner of communication, greetings and touching in particular instances. Most clients recognised how this has implications for the working alliance.

Moore and Leafgren (1990) noted that the therapist needs to have "an appreciation of African cultures and its role in shaping the development of Black clients" (cited in Maphosa, 2003, p, 17), and therefore be aware of their own and the clients' culture and social background (Lago & Thompson, 1996). It was noted that this is due to the influence of society on the therapeutic process and in the therapy room (Holdstock, 1981; Lago & Thompson, 1996; Maphosa, 2003). The participants in this study demonstrated this awareness, and also demonstrated the importance of how these social constructs may be in opposition to a psychodynamic way of practicing, in its formal requirement. This suggests that the longstanding idea that psychodynamic psychotherapy may not be easily applicable in a South African context, or if it is, the incompatibility of the two need serious consideration.

Strous (2001) and Maphosa (2003) consider an aspect of some black clients' passivity in the therapy and black people's general reluctance and resistance to psychotherapy as a considered option. One of the proposals suggests that psychotherapy and psychology are often considered to belong to and rooted in a *white* European world view. Black clients are considered as coming from and sometimes operating within a black world view, which it then different to that of the therapist. Therefore black clients may be "objectified as deviating from Eurocentric norms and as therefore unready to participate in the therapeutic system. The presentation of blacks as unresponsive to therapy adds to a constructed notion of psychotherapy as alien and mystifying to blacks" (Strous, 2001 cited in Maphosa, 2003, p. 12). Therefore this view does not assume that black clients are the 'problem', nor does it see the contracts of psychodynamic psychotherapy as inconsiderate or antagonising. Instead, it acknowledges the divergence of two world views which need to be considered and accounted for in these unique situations.

Black clients' perception of psychotherapy was a theme which surfaced with some participants. Four participants specifically mentioned how they had experienced psychotherapy and psychodynamic psychotherapy were often perceived as inaccessible to many black people and communities. The participants had deduced this feedback they received with their clients in the

room, and the feedback they received as a clinician in society. While the latter source of their deductions is useful to note, it falls outside the limitations of the analysis of this study which is the therapeutic room, it will therefore not be engaged with.

Some of the challenges experienced in this area included how participants have had to deal with clients 'not expecting to see a black psychologist' when they enter a therapy room or assuming that the clinician belongs to a different health care service such as social work. Other participants mentioned how most black clients had misconceptions about the role and practice of a clinical psychologist and how some black clients may think that as a clinician certain practices would be foreign or judged by the clinician because they are operating within a 'western' profession.

The literature acknowledged that historical constructions of the profession of psychology usually positioned it as a service reserved for non-black South Africans (see Bowman, Seedat, Duncan & Burrows, 2006; Eagle & Strous, 2004; Painter & Terre Blanch, 2004 for example). Nevertheless the profession is still used largely by middle class white South Africans (Eagle & Strous, 2004), and considered inaccessible by black South Africans (Bowman, *et al.,* 2006). Therefore the perceptions some of the black clients may have, as reported by the participants, can be understood as having been socially constructed and internalised for many years. These realities of access to mental healthcare for black South Africans may be shifting in contemporary South Africa (Bowman, *et al.,* 2006), however the *perception* still seems prevalent.

5.4. Assumptions

All the participants in the study spoke to the assumptions which often emerged in the room and throughout the therapeutic process. The assumptions relevant here were those which constellated around and were informed by race. Most of these emerging issues were directed by the race of the clinician and were being brought by the clients. Some participants noted their active contribution and spoke about assumptions they themselves may have held, also either because of their own race in relations to the client, or the clients race relative to theirs. In both cases these assumptions were either of understandings or misunderstandings. It is also useful to note that the assumptions were understood by the participants and can be interpreted as being informed by perceived backgrounds, of the client and of the clinician.

Participants noted how assumptions surface in the therapy room. These assumptions were from both the participants and their clients. Clients and participants occasionally brought assumptions into the room of an understanding between each other. What these assumptions usually result in is a level of unspoken and unaddressed material and information.

These assumptions varied between participants and included examples where participants expressed how they may have a sense of their clients' background based on their racial match. The assumption expressed here is that because the client and the clinician are both black, the clinician will know something about the clients' background. Similarly, clients would also bring into the room their assumption that the clinician has an idea of their background based on the fact that the clinician is black. Participants expressed their observation that often non-black clients would have fantasies about whether the clinician will understand their background.

These findings were consistent with much of the literature review that addressed assumptions and backgrounds between therapeutic dyads. Participants were reporting that the assumptions held by some of their black clients were that because the therapists shares the race of them, they have a similar background and would therefore be able to empathise better with them and better conceptualise their perspective. This was suggested in the literature by Tang and Gardner (1999). The findings concur with the research which suggests that "culturally diverse clients prefer to see therapist who are similar to them in cultural backgrounds and gender" (Matsumoto & Juang, 2004, p. 375). It is therefore also possible to hypothesise that non-black clients may have anxieties about black clinicians not understanding and/or empathising with them because of a perception that they do not share a background.

Some participants were clear in the perception and understanding that the assumptions of understanding can be useful and facilitative for the therapy process and the working alliance. These understandings are informed by the client's opinion that the clinician would be able to better and more authentically understand them because the clinician understands where they come from. This perception was seen as helpful by some participants at times, because it was understood as strengthening the working alliance and the therapeutic relationship. These findings concur with Tang and Gardner (1999) who agree that in a racially similar therapeutic dyad, the assumption of a similar background is useful for the therapeutic process.

Participants commented on their perception that some black clients enter therapy with expectations that the clinician will understand them and some of their presentations because both the client and the clinician are black. The clinician is therefore expected to understand the client and know the clients' background and current environment because s/he (clinician) is also black. When the clinician is expected to know and understand the client and some of the material brought to therapy, and that not brought to therapy by the client, a lot of material remains unattended to and unresolved which can be countertherapeutic. These expectations are therefore understood as hindrances to the therapy.

Some participants expressed the difficulties in addressing the expectations the clients had about them, which required them know and understand unspoken material. Some of these difficulties included the feeling that some clients may misinterpret this as a distancing of the two by the clinician. Other difficulties include the pressure to understand with little curiosity and exploration because the clinician is expected to know and understand intuitively. Some of these expectations to understand and to know which are brought by the clients are often based on the assumption of sameness and homogenous makeup between black people. The assumption is that backgrounds, environment and experiences of black people would be similar or the same for all black people.

The clients therefore seem to have an over identification with the clinician which is informed by their racial likeness. The separateness and subjective experiences and interpretations of the clinician as another black person in the room are not considered, and therefore is a fantasy of a merger between the two. Some participants were aware of the need to be mindful of their expectations and assumptions, recognising that they needed to put them aside but also engage with them.

These findings were in line with most of the literature which note the over identification clients working in a racially like therapeutic dyad may have. The clinicians were also aware and mindful of the dangers these assumptions may have, particularly the potential of leaving material unaddressed. In these cases, as suggested by the literature the clinician is therefore expected to draw on intimate knowledge of their own experience as a black person in the world, which is burdensome and possibly countertherapeutic.

Participants were aware of instances where there would be assumptions and expectations of misunderstandings; mostly from their non-white clients. In the latter case; it was often understood by the participants that their racial difference with some of their non-black clients would be interpreted by the client as indicative of different and would therefore hinder the therapeutic process. The participants felt that the client was wary that they would not be fully understood by the clinician, and therefore perhaps doubted the clinician's ability to be appropriately and accurately empathetic, supportive and/or containing.

The examples given by the participants were similar and pointed to the specific difficulties some non-black clients may have with the racial difference between themselves and the clinician, as interpreted by participants. Most of the challenge faced related to questions around perspective taking and the ability of a racially dissimilar clinician to imagine and understand the client's process and circumstances. Participants felt that the clients would imagine them to have a limited understanding of them because there may be ways of experiencing which are inherent and viscerally indivorceable from their race, and at times specifically because the clinician is black.

As noted by Kozuki & Kennedy (2004) in the literature, it is not uncommon for clients to express anxieties about being misunderstood, especially when the dyad is racially dissimilar. In the same way as a client would have a greater readiness to believe that the therapist understands them when the client and therapist share an identity, when they do not, this too may result in the client being uncertain about being understood.

5.5. Language

Language in the therapeutic encounter was discussed by all the participants in the study. Participants were mostly aware of language as an influential variable when working in both racially like and dislike dyads. The participants' view on language as a variable varied, however most participants thought of language as a barrier to the working alliance. Some participants were neutral to whether it was facilitative or a hindrance but merely recognised its salience. One participant understood language as facilitative in the working alliance. Some of the participants in the latter category also understood language as being used by some black clients as solidifying their status as a *middle class* black South African. In this way, some black clients would use English in therapy for the purpose of social distinction.

Another subtle difference in the way participants understood language was the intensity or level to which language was influential. For most participants; they reported and reflected on language with an assumption that psychotherapy is normally conducted in English and that when or if they conducted psychotherapy in another language, this was a deviation. Participants either alluded to this, or they clearly stated that these were their understanding of psychotherapy. It might be useful for the reader to know that all the participants were trained in English, none of the participants acknowledge English as a first language and that the interviews were all conducted in English.

Participants' reporting of language was often meshed with their reference to race. In other words, participants would use language interchangeably with race at times, or refer to language in the context of answering or referring to a race related question. Additionally; the between and within language differences were also used in an interchangeable manner with between and within race differences. This resulted in the distinction of race related meanings and identification of the theme of language, being left to the subjective interpretation of the author.

Otto (1945) states the obvious perhaps that talking "is the very instrument of psychoanalysis" (cited in Krapf, 1955, p. 348). Krapf (1955) warns against the mistake of considering only *what* the patients says and ignoring *how* the patient has spoken. Therefore the form of linguistic expression should be considered just as worthy of psychoanalytic research as content material (Krapf, 1955). Participants in this study recognise the importance of language and its role in psychotherapy, and perhaps unwittingly advocate for the investigation and production of language as a variable in psychotherapy in South Africa. One participant in particular explicitly expressed what he felt was the immanent need to consider the dearth of investigation to the role of language in South African psychotherapy.

One may be able to speculate on the apparent shortage of exploration if this topic in South African psychology. As discussed in the literature; the history of psychology in the country as often reserved and operated by white South Africans can be thought about as an influential factor. Fundamentally; there is discursive recognition of the systematic marginalisation of the profession through catering and accommodating mostly only white South Africans. Black South Africans therefore had little access to both the profession of psychology and the services of the profession (Stevens, 2003; Duncan, & de la Rey, 2000; Louw & Foster, 1991). Therefore in apartheid South Africa language barriers may not have been encountered as often as they are in

contemporary South Africa. When they were encountered, there may have been little motivation to address these situations.

The understanding of language as a hindrance was also informed by a recognition of the eleven different official languages in the country, and several other unofficial languages. This was often the first point of reference to the complexities of working with languages in a multiracial South Africa. Dialects and colloquialisms were also identified as a further complication to working with different races and cultures by participants. Colloquialisms and dialects were also seen as particular difficulties when working with black clients. Participants reported that black clients occasionally brought different and niche vernacular to psychotherapy, often with the assumption that as a black clinician, they too would invariably understand it.

Krapf (1955, p. 349) asserts that "the common denominator of the motivations that underlie the choice of language in polyglot psychoanalysis is in general a tendency to avoid anxiety". He suggests that any person is likely to use the language that "in a particular situation is least likely to provoke a feeling of anxiety or, conversely, most likely to give him a feeling of security". While Krapf is particular referring to psychotherapeutic use of language here, he suggests that this may even be generalisable to most situations in which that individual may be subjected to stress. It may therefore be possible to think that clients' use of language and personal and subjective language is motivated by their intent to reduce anxiety in the therapeutic situation, especially in a psychoanalytic psychotherapy whose techniques is the "is the provocation of play and counterplay between the arousal and the alleviation of anxiety" (p. 351). Edith (1949) also suggests that the use of a first language may also be understood as a way to revert to a more visceral mode to communicate for the client.

The most significant understandings of language as a hindrance related to the participants' concern and recognition that some meaning of material may be distorted when translated into English when working with racially dissimilar and similar clients. Here participants' disquiet was specifically that clients' intrapsychic world would be misrepresented. Most participants felt that this translation did not work. Some participants expressed their frustration with the difficulties they have had with translations, indicating the preference to use their mother language, and a compromise in sensitive communication when they had to resort to the use of English.

Kohut (1959) argued against the absolute role and importance of spoken language for attunement and understanding between therapists and client. In his paper; *Introspection, Empathy, and Psychoanalysis,* Kohut notes that psychoanalytic listening is different from other forms of listening. Psychoanalytic listening, "allowed for an imaginary attunement to the mental position of the patient" (Krapf, 1955). Therefore 'vicarious introspection' and 'empathy' are the only tools necessary for the analyst to listen with. Therefore in this stance, the theory would suggest that the participants are placing too much emphasis on language and are therefore out of tune with their clients. Unlike Kohut (1959), Lacan (1968) was more interested in the actual use of words and would have therefore justified the participants' view that a misunderstanding or not fully appreciating the language may hinder the therapeutic relationship and process. Kozuki and Kennedy (2004) noted that people who struggle with English or do not have English as a first language, may experience difficulties when trying to express some visceral experiences in psychotherapy.

An additional issue around translation of language related to the frustration and discontent of translating psychodynamic language into an indigenous South African language. Participants expressed their views that some psychodynamic and/or psychotherapeutic jargon and terminology would be inappropriate to use for some of the population in South Africa, and that would be counter-therapeutic and present as a hindrance to the working alliance.

Once again there is limited literature on the effects of psychoanalytic language and jargon and its effects of the therapeutic process. It seems that most black clinicians recognise the need to be mindful of the use of psychotherapeutic and psychoanalytic language in therapy where clients are unfamiliar and uncomfortable with it. Participants suggest that the clinician needs to be accommodating through awareness that most of the South African population may not appreciate psychodynamic and psychotherapeutic language.

5.6. Conclusion

This study aimed to explore the experiences of race; of black practicing clinical psychologists within the therapeutic encounter. Specifically, the study aimed to probe the roles of the working alliance, transference and countertransference, and how these three construct which are central to

psychodynamic psychotherapy; are mediated, moderated, and influenced by working between and within races. Most of the themes and understandings from the interviewees concurred with the literature on racially diverse and similar psychotherapy related to transference, countertransference and the working alliance. However in some cases there was data which highlighted the paucity and absence of literature in South Africa which considers the role of race within the therapeutic space.

Interviewees reported experiencing race, both their own and that of their clients, as a manifest variable which often influences their overall experiences in the room. In particular, race was also noted to taint the clinician's engagement and understanding with the client, irrespective of the race of the client. It was noted by most clinicians that different racial groups influence these experiences differently. Transference, countertransference and the working alliance with clients were also subjectively experienced to be influenced by the race of the clinician and/or the race and racial identity of their clients. Once again this was often subject to the two different racial categories in this study, namely black and non-black.

From the interviews in is apparent that race is experienced as present in the room by black clinical psychologists. Most of the responses referred to the ambiguity of the presentation of race in the room and how clinicians are often uncertain as to whether clients' material and presentations are race related or not. In this case clinicians are often bringing the race into the room through their meaning making of by considering race as a possible explanation or way of understanding. Clinicians often wonder how much of a client's presentation is in response to or evoked by their race as a black clinician in the room. Participants' responses also pointed to instances when they felt that race was indeed in the room through subtle and subliminal communications.

Overall these findings corroborates Smedley's (1993) assertion that race has an unavoidable contaminant role in psychotherapy. Carter (1995) has highlighted and stressed the importance of race and racial identity, and its ever-present influence in psychotherapy.

As was suggested by the literature, race was experienced to have a significant role in the clinicians experience and understanding of transference and countertransference in the room. In most cases, the clinicians became an extension of a previous or past object. This enactment though was evoked by the clinician's race. In the countertransference, participants noted that

their aggregate feelings were informed by disempowerment when working with non-black clients and pressures to deliver and be more active and directive when working with black clients. Interviewees reported their struggles with marinating a psychodynamic frame when working with most clients. These findings agreed with most of the literature by; Altman (2000), Hamiliton (1992), Maphosa, (2003), Nair (2004), Racker (1957), Schachter and Butts (1968), Straker (2006) and Strous (2001).

Interviewees reported in their experiences of working with clients' assumptions and expectations in therapy which were based on the clinician's race and the race of the client relative to the clinician. Most of the assumptions were brought by clients however some assumptions were brought by the clinician. These assumptions usually included the consideration of the clinician's background or the client's background in relations to the clinician. In most cases these assumptions were either of understandings or misunderstandings. These findings were mostly consistent with the literature on assumptions and backgrounds (Maphosa; 2006; Matsumoto & Juang, 2004; Tang and Gardner 1999).

These uses of assumptions where experienced as both facilitative to the working alliance as well as a hindrance at times. For assumptions of misunderstandings; it was mostly non-black clients' anxieties that the black clinician would not fully understand the client because the clinician may not be able to conceptualize them due to an assumption of differing backgrounds. Some black clients expected the clinician to understand them and their background because they assumed that the clinician would have a similar background as well, as a result some content and material would be unaddressed. In both cases the clinicians understood these assumptions as a hindrance to the working alliance. Assumptions worked as a facilitative factor when some black clients felt more comfortable by assuming that the clinician would understand them better because they shared a similar racial background.

Lastly; interviewees refereed to the use of language and their experiences of language use in the therapeutic process. Some participants understood language as facilitative to the working alliance while others saw language as a hindrance to the working alliance. In instance when participants saw language as hindrance would often be when they were working with non-black clients and the client would use a different language to the clinician. Other instances would be when the clinician is working with a black client but would feel the pressure to use English as a

medium. Language was experienced as a facilitator when participants would work with black clients and be able use a vernacular language with that client.

While this study managed to address most of the aims, it also highlighted the necessity for further research and literature production in psychology in South Africa. Sine this study endeavored to explore experiences, few distinct questions were answered. Instead the conclusion of the study suggests that there are many more issues to be explored in a more focused way with the intention to produce more definitive and direct findings and conclusions. Now that this study has suggested that black clinicians do experience race in a variety of ways in the therapeutic encounter, there is also the necessity to produce literature which informs and understanding of these experiences.

Chapter 6: Limitations of the research and Recommendations

One of the fundamental limitations of this study is the research design employed. While a qualitative approach and interpretavist framework were most appropriate and suitable to addressing the aims of this research study, the weaknesses have been well articulated with the fraternity of research. The study is therefore limited in its empirical rigor. In line with qualitative research methods, the study focused on seven non-independently sampled participants. The participants are not fully representative of the population of black clinical psychologists in South Africa. Therefore the findings and conclusions from the study cannot be generalised to the whole population.

A study which would be more extensive and diverse in its sampling would manage to capture more of an essence of black psychologists' experience of race and would also be more representative and therefore generalisable. Furthermore; a bigger sample may also be able to account for different experiences of race as they are constructed and understood differently in different parts of the country.

This study may have homogenised the population of black clinical psychologists and not considered the possible and probable variance which exists between black clinical psychologists. A study researching a bigger more representative study may also be useful in accounting for the variance between black clinical psychologists. Three particular variables may be useful to account for, namely; sex, ethnic identity and context of practice. In the same way, a study which distinguishes and focuses on one racial client population may also be useful in contributing to a better understanding of an aggregate presentation for client racial groups.

The researcher acknowledges that the aims of the study and the research questions in the interview schedule are based on an assumption that black clinical psychologists would invariably experience race as an independent and isolated construct. The study was therefore based on a

suggestive approach. The questions were however open-ended and phrased not lead the participants to answer in any particular way.

The researcher also recognises the complexity of researching only black clinical psychologist about their experiences on race and not including other non-black clinical psychologists in the study. This is both exclusionary and possibly discriminatory, and does not consider possible variance or consistency in experiences of race. This latter point may have made the research stronger or disputed the notion, on which this research is therefore based, that black clinical psychologists' experience of race is significantly different enough to constitute the need for distinction.

A study including a mixed population may be useful in understanding whether these findings are particular to black clinical psychologists, or whether they are common to most clinical psychologists irrespective of their race.

Future research may add value by an in-depth exploration of specific psychodynamic concepts such as transference or countertransference, or the working alliance. This research was limited in examining and investigating the influence of race on and with those constructs.

Reference List

Ahmed, R., & Pillay, A. L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology. 34(4)* (pp. 630-656).

Appiah, K. A. (1992*). In my father's house – Africa in the philosophy of culture*. Oxford: Oxford University Press

Atkinson, D. R., Ponce, F. Q., & Martinez, F. M. (1984). Effects of ethnic, sex, and attitude similarity on counsellor credibility. *Journal of counseling psychology, 31 (40)*

Bekker, S. (2001). Identity and ethnicity. In Bekker, S., Dodds, M., & Khosa, M. M.(2001)(Eds.), *Shifting African identities* (Vol. II, pp. 1-6). Pretoria: Human Sciences Research Council.

Betancourt, H., & López, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, Vol. 48, No. 6, pp. 629-637.

Bloom, L. (2004). "Black Hamlet": A Psychoanalyst Destrangers a Stranger. *PINS 30* (pp. 35-41).

Bowman, B., Seedat, M., Duncan, N. & Burrows, S. (2006). 'Race' Social Transformation and Redress in the South African Social and Health Sciences. In Stevens, G., Franchi, V. & Swart, T. (2006)(Eds.). *A Race against Time: Psychology and challenges to Deracialisation in South Africa*. Pretoria: Unisa Press.

Brems, C. (2000). *Dealing with Challenges in psychotherapy and Counselling*. United States of America: Wordsworth Thomson.

Broman, C. L. (1996). Coping with personal problems. In Neighbors, W. H., & Jackson, J. S. (1996)(Eds.). *Mental health in America.* Thousand Oaks, CA: Sage.

Burkard, A. W., Knox, S., Groen, M., Perez, M., & Hess, S. A. (2006). European American therapist self-disclosure in cross-cultural counseling. *Journal of Counseling Psychology. 53*(1), (pp. 15-25).

Cardermil, E.V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional psychology Research and Practice, 34(3),* (pp. 278-286).

Carter, R. T. (1995). Pioneers of Multicultural Counseling: An interview with Janet E. Helms. *Journal of Multicultural Counseling and Development,* 23 (pp. 73-86).

Clark, L. (2001). But what colour white: The white psyche in post-apartheid South Africa, Unpublished paper presented at *The C. G. Jung centre public lecture series, Cape Town.*

Comas-Diaz, L. & Jacobsen, F. M., (1991). Ethnocultural Transference and Countertransference in the Therapeutic Dyad. *American Orthopsychiatric Association, Inc. 61* (3) (pp. 392-402).

Crewe, J. (2001). Black Hamlet: Psychoanalysis on Trial in South Africa. *Porter Institute for Poetics and Semiotics. 22* (2) (pp. 413-434).

Dala, F. (2001). Inside and outside: a review of psychoanalytic renderings of difference, racism and prejudice. *Psychoanalytic Studies, 3*(1), (pp. 43-66).

Dithey, W (1977). *Descriptive psychology and historical understanding*. Belgium: Martinus nijhoff the hague.

Duncan, N., & de la Rey, C. (2000). Racism: A psychological perspective. Paper presented at the South African Human rights Commission National Conference on Racism 2000, Sandton, South Africa, 30 August-02 September 2000.

Duncan, N., van Niekerk, A., & Townsend, L. (2004). Following apartheid: authorship trends. *South African Journal of Psychology, 34* (4), (pp. 553-575).

Durrhiem, K. (2005). Socio-spatial practice and racial transformations in a changing South Africa. *South African Journal of Psychology. 35(3)* (pp. 444-459).

Durrheim, K. and Mokeki, M. (1997). Race and relevance: A content analysis of the South African Journal of Psychology. *South African Journal of Psychology, 4* (4).

Erasmus, Z. (2001). Introduction: Reimagining coloured identities in post-apartheid South Africa. In Z. Erasmus (Ed). *Coloured by history shaped place – New perspectives on coloured identities in Cape Town*. Cape Town: Kwela Books.

Foxcroft, C., & Roodt, G. (2005). *An introduction to psychological assessment in the South African context* (2nd Edition). Cape Town: Oxford University Press

Fromm-Reichman, F. (1950). *Principles of intensive psychotherapy.* Chicago, IL: University of Chicago Press.

Gelos, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of counseling psychology, 41* (pp. 296-306).

Gelso, C. J., & Hayes, J. A. (1998). The management of countertransference. In Norcoss, J. (Ed.) (1998). *A guide to psychotherapy relationships that work.* Oxford: Oxford University Press.

Gelso, C. J., & Mohr, J. J. (2001). The working alliance and the transference/countertransference relationship: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists. *Applied &? Preventive Psychology, 10* (pp. 51-68).

Goldberg, E., Myers, W., Zeifman, S. (1974) Some observations on three interracial analyses *International Journal of Psychoanalysis 55* (pp.495-500).

Greenson, R. R. (1967). *The technique and practice of psychoanalysis, (Vol. 1)*. New York: International University Press.

Gunaratnam, Y. (2003). *Researching 'Race' and Ethnicity: Methods, knowledge and power*. London: Sage Publications.

Hamilton, N. G. (Ed.) (1992). *From Inner Resources. New Directions in Object Relations Psychotherapy.* Northvale N. J.: Jason Aronson.

Hammond, T., Clayton, B. M., & Arnold, P. J. (2009). South Africa's transition from apartheid: The role of professional closure in the experiences of black chartered accountants. *Accounting organizations and Society, 34* (2009), (pp. 705-721).

Holdstock, T. (1981). Psychology in South Africa Belongs to the Colonial Era: Arrogance or Ignorance? *South African Journal of Psychology 11* (pp. 123-129).

Holmes, D. E. (1992). Race and Transference in Psychoanalysis and Psychotherapy. The *International Journal of Psychoanalysis. 73* (pp.1-11).

Holmes, D. E. (1999). Race and countertransference: Two "blind spots" in psychoanalytic perception. *Journal of Applied psychoanalytic Studies, 1*(4), (pp. 319-332).

Hoffman, I. Z. (1992). Some Practical Implications of a Social-Constructivist View of the Psychoanalytic Situation *Psychoanalytic Dialogue 2* (pp. 287-304).

Hook, D., Mkhize, N., Kiguwa, P. and Collins, A. (2002). *Critical psychology.* Lansdowne: UCT Press.

Ivey, G. (1992). Countertransference Pathology in South African Psychotherapy. *Psychoanalytic Psychotherapy in South Africa, Spring* (pp. 31—45).

Javier, R. A., Rendon, M. (1995). The Ethnic Unconscious and Its Role in Transference, Resistance, and Countertransference: An Introduction. *Psychoanalytic Psychology 12* (pp 513-520).

Krapf, E.E. (1955). The Choice of Language in Polyglot Psychoanalysis. *The Psychoanalytic Quarterly*. *24* (pp. 343-357).

Kohut, H. (1959). Introspection, Empathy, and Psychoanalysis. *Journal of American Psychoanalysis Association 7* (pp. 459-483)

Kometsi, K. J. (2007). *Coloured Subjectivities and black Africanness.* Johannesburg: University of the Witwatersrand.

Kozuki, Y. & Kennedy, M. G. (2004). Cultural Incommensurability in Psychodynamic Psychotherapy in Western and Japanese Traditions. *Journal of Nursing Scholarship*. *36* (1) (pp. 30-38).

Lacan, J. (1968). *Speech and Language in Psychoanalysis*. Baltimore: Johns Hopkins University Press.

Lago, C. & Thompson, J. (1996). *A Model for Counseling Asian Americans*. In P. B. Pedersen, J. G. Draguns, W. L. Lonner, & J. E. Trimble (Eds.). *Counseling Across Cultures* (3rd Ed.). Honolulu: University of Hawaii Press.

Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to providing effecting mental health services to Asian Americans. *Mental Health Services Research*, 3 (4).

Louw, D. (1997). *Intelligence*. In Louw, D, A., & Edwards, D. J. A. (1997). (1997) Eds.). *Psychology; an introduction for students in South Africa* (2nd Edition). Cape Town: Heinemann.

Louw-Potgieter, J., & Foster, D. (Eds.) (1991). *Social Psychology in South Africa.* Johannesburg: Lexicon Publishers.

Maphosa, M. J. (2003). *Black Clients' Personal Experiences of Therapy Having Benn in Therapy with a White Female Therapist or Counsellor.* Johannesburg: University of the Witwatersrand.

Marsella, J. & Pedersen, P. B. (1986). *Cross Cultural Counseling Psychotherapy.* New York: Pergamon Press.

Matsumoto, D. & Juang, L. (2004). *Culture and Psychology (3rd Edition).* United States of America: Thomson Wordsworth.

Mayekiso, T., Strydom, F., Jithoo, V., & Katz, L. (2004). Creating new capacity through postgraduate selection. *South African Journal of Psychology. 34(4)* (pp. 657-671).

Merret, C. (1994). *A culture of censorship: secrecy and intellectual repression in South Africa.* United States of America: David Phillip Publishers (Pty) Ltd.

Moore, D. Leafgren, F. (1990). *Men in Conflict: Problem Solving Strategies and Interventions for Men.* USA: American Association for Counseling and Development.

Morgan, H. (2008). Issues of 'race' in psychoanalytic psychotherapy: Whose problem is it anyway? *British Journal of psychotherapy, 24*(1), (pp. 34-49).

Nair, S. (2008). *Psychologists and race: Exploring the identities of South African trainee clinical psychologists with reference to working in multiracial contexts.* Stellenbosch University.

Nicholas, L. J., & Cooper, S. (Eds.) (1990). *Psychology and apartheid.* Johannesburg: Vision publications.

Omi, M. & Winant, H. (2002). Racial formation. In P. Essed & D. T. Goldberg (Eds.). *Race critical theories*. Oxford: Blackwell Publishers.

Orange, D., Atwood G., & Stolorow, R. (1997). *Working Intersubjectivity: Contexualism in psychoanalytic practice.* Hillsdale, NJ: Analytic Press.

Painter, D. & Baldwin, R. (2004). 'They all speak your language anyway...': Language and racism in a South African school. *South African Journal of Psychology. 34(1)* (p. 24).

Painter, D., & Terre Blanch, M. (2004). Critical psychology in South Africa: Looking back and looking ahead. *South African Journal of Psychology. 34(4)* (pp. 520-543).

Parker, I. (2005). *Qualitative psychology: Introducing radical research.* New York: Open University Press.

Pillay, A. L. and Kramers, A. L. (2003). South African clinical psychology, employment (in)equity and the "brain drain". *South African Journal Psychology, 33*(1), 52–60.

Pillay, Y. G. and Petersen, I. (1996). Current practice patterns of clinical and counselling psychologists and their attitudes to transforming mental health policies in South Africa. *South African Journal of Psychology, 26*, 76–80.

Ponterotto, J. G., Alexander, C. M., & Hinkston, J. A. (1988). Afro-American preferences for counsellor characteristics: A replication and extension. *Journal of Counseling psychology*, 35 (2)

Potgieter, C. A., & Moleko, A. (2002). Surprise!!! It is not easy to be black woman academic at a historically white South African university. *Research and Methodology, 2* (pp. 1-7).

Primm, A. B., Lima, B. R., & Rowe, C. L. (1996). Cultural and ethnic sensitivity. In Breakey, W. R. (1996)(Ed.). *integrated mental health services: Modern community psychiatry.* New York: Oxford University Press.

Racker, H. (1957). The Meaning and Uses of Countertransference. *Psychoanalytic Quarterly 26* (pp. 303-357).

Ridley, C. R. (1995). *Overcoming Unintentional Racism in Counseling and Therapy.* London: SAGE Publications.

Sachs, W. (1996). *Black Hamlet.* Baltimore & London: The Johns Hopkins University Press.

Schachter, J. S., & Butts, H. F. (1968). Transference and Countertransference in Interracial Analyses. *Journal of American Psychoanalysis Association. 16* (pp.792-808).

Schieff, L., Tredoux, C., Dixon, J. & Finchilescu, G, (2005). Patterns of racial segregation university residence dining-halls. *South African Journal of Psychology. 35(3)* (pp. 433-443)

Seedat, M. (1997). The Guest for Liberatory Psychology. *South African Journal of Psychology. 24* (4) (pp.261-270).

Seeknig, J., & Nattrass, N. (2006). *Class, race, and inequality in South Africa*. Pietermaritzburg: University of Kwazulu-Natal Press.

Shonfeld-Ringel, S. (2001). A Re-Conceptualization of the Working Alliance in Cross-Cultural Practice with Non-Western Clients: Integrating Relational Perspectives and Multicultural Theories. *Clinical Social Work Journal*. *29* (1) (pp. 53-63).

Smedley, A. (1993). *Race in North America: Origin and evolution of a World view.* Boulder, CO: Western Press.

Snowden, L. R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research,* 3.

Stevens, G. (2001). Racism and cultural imperialism in training of black clinical psychologists in South Africa: Identity, ambiguity and dilemmas of praxis. In Duncan, N. Van Niekerk, A., de la Rey, C., & Seedat, M. (Eds.) (2001). *Race, racism, knowledge production and psychology in South Africa.* New York: Science Publishers.

Stevens, G. (2003). Academic representations of 'race' and racism in psychology: Knowledge production, historical context and dialectics in transitional South Africa. *International Journal of Intercultural Relations. 27(2003)* (pp. 189-207).

Strous, M. (2001). *Therapists' Self Talk in Interracial Counseling Contexts. Doctoral Dissertation.* Johannesburg: University of the Witwatersrand.

Strous, M., & Eagle, G., (2004). Anti-client and pro-client positions in interracial psychotherapy. *South African Journal of Psychology. 34(1)* (pp. 25-54).

Sue, S. (1977). Community mental health services to minority groups: some optimism, some pessimism. *American Psychologist*, 32.

Sue, D. W. & Sue, D. (1981). *Counseling the Culturally Different. Theory and Practice.* New York: Wiley.

Sue, D. W. & Sue, D. (1990). *Counseling the Culturally Different. Theory and Practice.* New York: Wiley.

Sue, S. (1998). In Search of Cultural Competence in Psychotherapy and Counseling. *American Psychological Association, Inc. 53* (4) (pp. 440-448).

Suffla, S., & Seedat, M. (2004). How has psychology fared over ten years of democracy? Achievements, challenges and questions. *South African Journal of Psychology. 34(4)* (pp. 513-519).

Swart, L. (1998). *Culture and mental health: A Southern African view.* Cape Town: Oxford University Press.

Tan, R. (1993). Racism and similarity: Paranoid-schizoid structures. *British Journal of Psychotherapy, 10* (pp. 33-43).

Tang, N.M., & Gardner, J. (1999). Race, Culture, and Psychotherapy: Transference to Minority Therapists. *The Psychoanalytic Quarterly 68* (pp.1-20).

Tappan, M. B. (2001). Minding the gap. Positivism, psychology, and the politics of qualitative methods. In Tolman, D. L., & Brydon-Miller, M. (Eds.) (2001). *From subject to subjectivities. A handbook of interpretative and participatory methods.* New York: New York University.

Uba, L. (1994). *Asian Americans: Personality patterns, identity and mental health*. New York: Guilford Press

Vontress, C. E. (1981). Racal Differences: Impediments to Rapport. *Journal of Counseling psychology 1* (pp. 7-13).

White, J. C. (1994). The impact of race and ethnicity on transference and countertransference in combined individual/group therapy. *Gruop, 18*(2), (pp. 89-99).

Wilson, R. A. (2001). *The Politics of Truth and Reconciliation in South Africa: Legitimizing the Post-Apartheid Sate.* Cambridge: Cambridge University Press.

Winnicott, D. W. (1994). Hate in the Countertransference. *Journal of Psychotherapy Practice and Research, 3* (4), (pp. 348-356).

Yi, K. Y. (1998). Transference and Race: An Intersubjective Conceptualization. *Psychoanalytic Psychology. 15* (pp.245-261).

Appendices

Appendix A: PARTICIPANT INFORMATION SHEET

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

Good day;

My name is Zamo Mbele, I am a psychology student at the University of the Witwatersrand, currently completing my Master of Arts in Clinical Psychology. I am currently conducting research for my study as a requirement for obtaining my Masters degree.

My study aims to explore the experiences of race for black practicing clinical psychologists working in post-apartheid South Africa. The study aims to access and investigate how race, which has been a salient feature in South Africa's history and still continues to be in contemporary South Africa, can be or has been manifested into the therapy room. The questions will be aimed at investigating the role of race for black therapists practicing in a predominantly and historically white profession, which has been known to cater largely for white clients.

Specific to the therapeutic encounter, the study aims to probe the roles of the working alliance, transference and countertransference, and how these three constructs which are central to psychoanalytic psychotherapy; are mediated, moderated, and influenced by working between races.

I am inviting you to participate in my study. You can indicate your intention to participate by signing the participant information sheet (Appendix B). Your participation will involve an interview conducted at a time and place of your convenience and should last on average of 60 minutes. The interview will be recorded and transcribed upon you signing the participant consent

form for the interview to be recorded and transcribed (Appendix C). This study is interested in your experiences as the therapists and therefore requests that any information which may compromise the anonymity of your clients and the confidentiality of anything discussed during and outside your therapy session, be avoided during the interview process. The researcher will also go to extended measures to ensure their anonymity and confidentiality during the analysis and write-up by removing anything which may compromise this.

Please also note that you may refuse to participate without any penalty, stop the interview at any point should you feel uncomfortable and withdraw your recorded and transcribed material from the study at any point in future. There are no benefits attached to participating in this research, nor are there any penalties for refusing to participate. Should you feel any discomfort as a result of this study, counseling at a nominal fee will be available from the Emthonjeni Centre at the University of the Witwatersrand, or at no cost through Life Line, or FAMSA, whose numbers will be made available to you.

Steps will be taken to ensure your anonymity, however this cannot be guaranteed considering the size and nature of the sample. Transcripts will only be read by the primary researcher and his supervisor, Renate Gericke, but your identity will also be protected from her. Where participants request that only the researcher has access to a transcript, this will be respected. Steps will be taken to ensure your confidentiality, which is guaranteed. The digital records of the interviews will be kept in password protected laptop of the primary researcher. The recorded interviews will only be accessed by the primary researcher, only the primary researcher will transcribe the recordings. The recordings will be deleted after transcription, and the transcripts will be locked away in a filing cabinet of the primary researcher at his home until they are destroyed (between two and five years). Additionally, the participants can choose to withdraw their recorded and transcribed material at any point before the dissertation is published.

Anonymity and confidentiality of the participants is an important consideration for the sample group concerned. For anonymity purposes, any distinguishing detail about you will be disguised or removed throughout the research process. Demographic information (except gender) will be distorted or withheld, place of work will also be withheld and removed during the process of transcription should it and any other identifying information surface. Should you agree to participate, you will be asked to use pseudonyms when referring to your clients during the interview. Pseudonyms will also be used in the transcripts and in the final report.

The results from this interview will be written up in my dissertation which is a partial requirement for the completion of my Master of Arts in Clinical Psychology degree. Once this dissertation has been published you can access it through the library catalogue of journals on www.wits.ac.za/library. Alternatively you can request a copy of the dissertation findings from me via email, and an abridged version will be made available to you.

If you have any questions about the project, please feel free to contact me or my supervisor, Renate Gericke on the e-mail addresses or telephone numbers provided below.

Regards;

Zamo Mbele, (Researcher)
E-Mail zamoms@webmail.co.za

Renate Gericke, (Research Supervisor and Clinical psychologist)
Tel: 011 717 4555
E-Mail: renate.gericke@wits.ac.za

Families South Africa (Johannesburg):	(011) 892 – 4272/3/6
Life Line (Johannesburg):	(011) 728 – 1347
Emthonjeni Center (Wits):	(011) 717 – 1000

Appendix B: CONSENT TO PARTICIPATE

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559

I,_____, have read the participant information (Appendix A) and consent to participating in the study aimed at *Exploring the experiences of race among black clinical psychologists in the therapeutic setting; The working alliance, Transference and Countertransference.* In so doing, I understand that:

a. My participation in the study is voluntary
b. I may withdraw from the study at any time by instructing the researcher to withdraw all of my elicited material.
c. I may refuse to answer any specific question/s.
d. I understand that direct quotations from the interview may be used during the write-up of the report.
e. Steps will be taken to ensure my anonymity, however this cannot be guaranteed considering the size and nature of the sample.
f. Steps will be taken to ensure confidentiality, which is guaranteed.
g. Steps will be taken to ensure the confidentiality and anonymity of my clients.
h. I can request an abridged version of the findings of this study once completed from the researcher.
i. Transcripts will only be read by the primary researcher and his supervisor, Renate Gericke, but my identity will also be protected from her. I may request that only the researcher has access to my transcript, and this will be respected.
j. I understand that the dissertation write-up of this study may also be published.
k. I understand that there are no benefits attached to participating in this research, nor are there any penalties for refusing to participate.
l. There are also no perceived risks in participating, however I am aware of the counseling services which have been recommened whould I experience any distress as a result of participating.

Signed:

Date:

Appendix C: CONSENT FOR INTERVIEW TO BE RECORDED AND TRANSCRIBED

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559

I, _____, after having read the participant information sheet consent to my interview to be recorded and transcribed. I understand that should I so desire, the audio recording of the interview can be deleted after it has been transcribed. This transcription of the recording will be kept safe and secure for five years after which period it will be destroyed. Step will be taken to protect my identity, by the use of pseudonyms and limiting the access of transcript from the interview.

Signed: _____

Date: _____

Appendix D: INTERVIEW SCHEDULE

Introducing purpose of interview

My study aims to explore the experiences of race for black practicing clinical psychologists working in post-apartheid South Africa. The study aims to access and investigate how race can or has manifested into the therapy room.

Interview Questions:

1. Demographics question;

1.1. Age

1.2. Gender

1.3. Years in practice

1.4. Approximate number of black clients

1.5. Approximate number of white clines

2. What are your experiences of working with racially like and unlike clients? (please provide examples, including transference and countertransference issues)
3. When, if at all, does race become a theme in the therapy and how is it dealt with?
4. Are there circumstances when you becomes more aware of your race?

   4.1. How is this understood?
5. Are you aware of particular resistances and obstacles, or facilitative and factors encountered when working in a racially matched dyad?
6. Are you aware of particular resistances and obstacles, or facilitative and factors encountered when working in a racially unmatched dyad?
7. To what extent and in what ways does race influences an effective therapeutic relationship, if at all?