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'AT LEAST I GET A GLIMPSE': SOUTH AFRICAN PATIENTS' PERSPECTIVES ON GETTING TO KNOW THEIR THERAPISTS

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The process of psychotherapy invites the patient to explore their mind and the mind of the other but does so in the context of a therapeutic relationship in which the therapist is at least partly unknown. This article explores how patients, unbeknown to their therapist, explore clues that may disclose some knowledge about their therapists. One route towards exploring the unknown is through the therapist's social identities. The article presents an analysis of interviews conducted with 11 patients attending a free clinic in Johannesburg, South Africa. Their process of exploring the therapist and encountering the unknown, and wondering about whether their therapist can know them, is presented. The therapist's social identities offer a 'glimpse' into the therapist's mind. The article offers an alternative way of approaching inadvertent self-disclosure and invites therapists to be aware of their patients' explorations of them that may remain unknown to therapists. Social identity offers a potential vehicle for alienation but also for connection.

KEYWORDS: PATIENT PERSPECTIVES, SOCIAL IDENTITY, PSYCHOTHERAPY, QUALITATIVE PSYCHOANALYTIC METHOD

INTRODUCTION

A patient entering psychotherapy is confronted with a paradox. On the one hand, being invited to embark on the most intimate of relationships, the patient experiences a closeness unlike that in everyday relationships. On the other hand, this most intimate relationship is undertaken by a stranger. As the patient comes to know this stranger, she is repeatedly confronted, by the nature of the therapeutic situation, with the limits of her knowledge about her therapist. The person she is so intimately close to remains, at some level, always a stranger.

The paradox, it could be argued, is compounded by the mechanisms through which therapeutic change takes place. Theories of mentalization, based on observations between mothers and infants, posit that psychotherapy works by helping patients to better understand their own minds and the minds of others (Fonagy

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et al., 2018). Yet in a situation where the patient is actively encouraged to discover the mind of self and other, the therapist's mind remains at least partly inaccessible to the patient, no matter how much the therapist shares with the patient. Enjoined to discover the mind of the other, the patient confronts the limits of their understanding of the therapist's mind. In the context of psychoanalytic therapy where therapist self-disclosure is seen in some quarters as anathema, despite considerable challenges to this idea, the patient also potentially confronts the therapeutic rule that the therapist's mind is, at least to some extent, off-limits.

This article explores what this paradox might feel like for patients, and how they use cues about the therapist's social identity to try to solve the mystery of their therapist's strangeness. The article is based on interviews conducted with Black[1] South African patients from diverse backgrounds attending a free psychotherapy clinic in Johannesburg, South Africa. The clinic is staffed by trainee clinical psychologists who also occupy diverse social identities. The purpose of the study was to explore patients' perspectives of their therapists and their therapeutic experience and also, given the distinct diversity that characterizes South African society together with a history of oppression (Pillay & Nyandeni, 2021; Swartz, 2006), to explore how the social identities of therapist and patient occupied the therapeutic space. Rich descriptions of patients' experiences of therapy are underrepresented in psychological research (Long et al., 2022; Elliott, 2008, 2010; Fuertes & Nutt Williams, 2017; Levitt et al., 2016; Roussos, 2013; Safran, 2013) and even more so in psychoanalytic writing. The question of what patients make of us and how they come to know us is as much a mystery for therapists as for patients. Listening to the patient in this way enriches our understanding of the therapeutic process.

This article focuses on a preoccupation that spontaneously punctuated patient interviews, with getting to know the person of the therapist. Wilfred Bion's (e.g., Bion, 1962) theory of knowledge is helpful here: he describes meaningful psychological knowledge as always in process, never attained or fixed. What matters is *getting to know* rather than knowing. This process, heavily laden with patients' fantasies about their therapists, is explored. For Winnicott (1971), fantasy and reality are in paradoxical relationship. The object is simultaneously created and found. In *getting to know* the therapist, patients both create and find the other. The article then explores one particular route through which the patient can potentially know and feel known by the therapist: through the network of their similar and different social identities, be those in terms of gender, culture, religion, sexual orientation, class or racial identity. Mobilizing social identity becomes a way of solving or complexifying the mystery of the therapeutic relationship.

IMPLICIT, INADVERTENT DISCLOSURE AND SOCIAL IDENTITY

The issue of therapist disclosure has been hotly debated in psychoanalytic circles and has been characterized as a topic that polarizes (Kronner & Northcut, 2015). The focus of this article is not on self-disclosure as a technique, but rather on how the patient surmises possible information about the therapist through inadvertent

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identity-based cues. For this reason, debates about self-disclosure will not be repeated here (but see Richards, 2018); suffice to say that the intersubjective turn in psychoanalysis has launched a significant challenge on the classical psychoanalytic position that the therapist should be neutral and anonymous (Kronner & Northcut, 2015). The idea of analytic neutrality—that a therapist can be a 'blank slate', unknown to the patient—is generally recognized as impossible to achieve (Knox & Hill, 2003; Peterson, 2002) and highly problematic. Brenman-Pick goes so far as to say that, if we are not affected by the patient, this 'would represent not neutrality but falseness or imperviousness' (Brenman Pick, 1985, p.165). Similarly, Loewald (1960) stresses that to be (re)discovered by the patient, the analyst must be available. The patient's 'new discovery of objects' may thereby facilitate transformation.

The potential for self-disclosure to have strong positive therapeutic impact has been demonstrated (Long et al., 2020; Knox & Hill, 2003), but self-disclosure may always contain an element of enactment (Smith & Tang, 2006). The therapist may never be sure of the extent to which a self-disclosure is countertransferential and the extent to which it is a considered move to offer themselves for a 'new discovery of objects' (Loewald, 1960, p.18). It is helpful to briefly explore this debate in order to turn to the question of the ways in which the patient may make meaning of inadvertent or implicit 'clues' offered by the therapist and in the therapeutic exchange.

Despite the apparent move towards acceptance of therapist self-disclosure as an inevitable and potentially helpful part of the therapeutic exchange, self-disclosure remains an uncomfortable topic (Kuchuck, 2009, 2018). A PEPweb search for the term 'self-disclosure' in the title results in only four articles since 2018. While this may indicate that the debate has subsided, it is very possibly a result of the insolubility of the dilemma that clinicians face. Indeed, Richards (2018) has described a trend over time towards 'somewhat more self-disclosure', a very different statement to the immersion in self-disclosure implied by the relational turn.

The ambivalence of this statement is echoed across contemporary psychotherapeutic and psychoanalytic literature. This literature clearly situates therapist self-disclosure as a potentially powerful and important tool: the idea of the blank slate has been roundly discredited. When reading between the lines, however, another message sometimes surfaces in self-disclosure literature. The benefits of self-disclosure are often placed in the context of danger. For example, Brody's (2013) article is entitled 'Entering night country'; Bredesen's (2020) is called 'slipping into self-disclosure' and Brody's work (Brody, 2021) is sub-titled 'swimming in dark places'. An interesting study exploring therapists' varied (positive and negative) responses to self-disclosure is entitled 'when in doubt, sit quietly' (Pinto-Coelho et al., 2018). Of all the responses explored, it is doubt that occupies the title. Within the nuances of the debate of self-disclosure, then, tropes of night, dark, slipping and doubt haunt discussion.

This link between self-disclosure and danger is potentially felt by therapists themselves. Knox and Hill (2003), for example, show how therapists often experience

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internal struggles about whether or not to disclose, sitting with a feeling that they may be doing something forbidden. Kuchuck (Kuchuck, 2009; Kuchuck, 2018) outlines how the narcissistic needs of the therapist are inevitably aroused in the context of self-disclosure and that this may prompt shame and a consequent reluctance to explore. The therapist's shame thereby forecloses engagement. Interestingly, while Knox and Hill (2003) found that self-disclosure was the least frequently reported technique used by therapists (but was experienced as strongly therapeutic), Peterson (2002) found that 60% of clients reported that their therapists self-disclosed. In other words, while therapists report that it is rarely used, clients report much more frequent self-disclosure. This may point towards the shame therapists experience in divulging their use of self-disclosure against the backdrop of the spectral 'blank slate', as well as the inevitability of self-disclosure in the therapeutic relationship. It has been suggested that even Freud experienced this ambivalence, using self-disclosure far more often than his theory advocated (Peterson, 2002; Richards, 2018).

Much of this discussion is in the context of intentional self-disclosure. If intentional self-disclosure is shaming for the therapist (Kuchuck, 2009, 2018), one wonders whether unintentional self-disclosure, outside of the therapist's control, may be more so. The literature tends to focus largely on intentional self-disclosure, but it has been suggested that unintentional self-disclosure may be particularly impactful for patients: either as a startling revelation or alternatively as intrusive, disturbing or exposing (Gody, 1996). We may also disclose a great deal about ourselves from our way of being in the world, for example the photographs in our offices, our gender, wedding rings or other jewellery (Kronner & Northcut, 2015) or even what appears when we are googled (Richards, 2018) or when we are in our Zoom window (Brody, 2021). Brody (2021) offers an interesting account of working online through the pandemic, where therapist and client share the knowledge that they are both living an unprecedented time together, probably working from home and being aware of this but not necessarily talking about this shared experience. For Brody (2021), this shared experience holds the potential for something significant to be shared in the context of the bigger unknown of the pandemic. The reverse, it seems, must also be possible: that inadvertent self-disclosure highlights what is unknown and unshared between therapist and patient.

Many of the social identities we carry hold the potential to reveal something about ourselves. Smith and Tang (2006) distinguish between innate and visible identities (such as racial identity or gender), innate invisible identities (such as sexual orientation or social class) and acquired or achieved identities (such as political affiliation, religion or marital status). We carry all of these identities and the potential for the interaction of identities between therapist and client is significant. While Smith and Tang mark certain identities as visible, it could be argued that we inhabit all of the above identities in our bodies, and thus potentially inadvertently disclose them to our watchful clients. Religion, for example, can sometimes be inferred (even if incorrectly) through a person's name or dress and political affiliation through a grimace or disapproving look. It also matters whether identities are shared or different between client and therapist. Sunderani and Moodley (2020) observe

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that disclosure is more comfortable in the context of similarity of social identities, with difference being more strongly linked to silence. It is likely also the case, however, that disclosure may be more shaming in the face of shared social identities, which so often go along with assumptions of shared moral judgements.

A number of authors have, however, noted that the debate about therapist self-disclosure in the context of social identities of oppression must take on different contours. For example, it is one matter to disclose that one is married in a heterosexual relationship (i.e. inhabiting a normative identity) and quite another to disclose that one is gay (i.e. inhabiting an identity that has been the target of prejudice). Kronner and Northcut (2015) argue that for gay clients and therapists, disclosure may be a crucial way of addressing clients' experiences of discrimination. Leary (1997) argues in the context of race that, because we potentially wear racial identity on our skin, silence may be collusive and talking about race may sometimes be the only way to enter a psychoanalytic encounter. In feminist therapeutic approaches, self-disclosure equalizes power (Peterson, 2002). Disclosure of social identities may then hold the possibility of strengthening the therapeutic relationship, validating the role of oppression in clients' lives and, importantly, helping therapists to acknowledge their own biases and prejudices (Sunderani & Moodley, 2020). While such disclosure may deepen the therapeutic process (Leary, 1997), however, the effects cannot be understood to be simply positive. The self-disclosure of social identities may also be a source of pain (Kronner & Northcut, 2015) or be felt as intrusive (Bredesen, 2020). Inadvertent revelations can powerfully affect treatment both positively and negatively, and sometimes patients simply do not want to know (Smith & Tang, 2006). What is not known about the other is also a source of speculation and fantasy (Smith & Tang, 2006); social identities, particularly marginalized ones, provide fertile soil for imagination. Similarly, the pull towards self-disclosure in relation to marginalization may be an enactment of a fantasy for mutual recognition (Bredesen, 2020). Conversely, non-disclosure may not necessarily indicate power imbalance or avoiding experiences of oppression: there are many ways in which the therapist can respond to the patient. It therefore matters that the conversation is deepened and sustained rather than named and left. The effects of disclosure are not always in the therapist's control or even awareness. As this article will demonstrate, clients observe and speculate about their therapists in ways beyond therapists' disclosure and beyond therapists' appreciation. From the client's perspective, the therapist potentially discloses all the time, and the therapist may be unaware of the assumptions a client is making.

METHOD

Study design

Although there is a substantial body of psychotherapy research exploring client perspectives, little of this research focuses on rich descriptions of the lived experiences of clients (Elliott, 2008, 2010; Fuertes & Nutt Williams, 2017; Levitt et al., 2016; Roussos, 2013; Safran, 2013), let alone the inner worlds of clients. This qualitative

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study utilized a psychoanalytic interview-based approach because of its ability to explore not only what clients said about their therapists and therapeutic experiences but also what was difficult to articulate or remained unsaid (Frosh & Saville Young, 2008), where anxieties, fantasies, hopes and fears resided (Hollway & Jefferson, 2013; Holmes, 2013) and what was manifest as well as latent (Stamenova & Hinshelwood, 2018). This approach was preferred to a thematically based approach because of its ability to access what is less easy to articulate. The broader study included both therapists and clients; this article focuses on the method used to conduct client interviews.

Participants

Participants were clients attending a free clinic in Johannesburg, South Africa. South Africa's public healthcare system is severely under-resourced, with most psychologists offering therapy in their own private practice settings. Access to psychotherapy is therefore extremely limited and often comes with long waiting lists. Because this clinic is a university training clinic, it is able to offer both brief-term (16 session) and long-term therapy to clients. It is therefore an uncommon resource in comparison to public systems which can often only offer basic outpatient treatment with a very limited number of sessions (usually far fewer than the 16 sessions offered at the university clinic). Clients from diverse backgrounds are therefore offered depth therapy. This makes it an ideal location to explore the psychotherapy experiences of clients who do not have the luxury of access to private services.

Clients were invited to volunteer to participate in the study. In total, 11 clients volunteered to be interviewed for the study. Clients ranged in age from 20s to 60s. Ten clients were African and one client was Indian. Thanks to the legacy of apartheid, social class and racial category are highly correlated: patients at this clinic are largely Black, and this is reflected in this smaller sample. Ten clients were female, and two were male. This skewed gender presentation is also reflected in the larger group of patients attending the clinic. Masculinity is highly associated with strength in South Africa, as elsewhere, and this makes help-seeking more complicated for men than for women.

Procedure

Ethics clearance was obtained from the Human Research Ethic Committee (Non-medical) of the University of the Witwatersrand before the study began. Participants who volunteered to participate could choose to withdraw from the study or to refrain from answering particular questions. They were also assured that their identities would be protected through the use of pseudonyms (hence the use of letters rather than names in this article) and thick disguise. Interviews were conducted on the university campus in a private office in close proximity to the therapy clinic and generally lasted around 60 min. They were transcribed verbatim.

Following psychoanalytic interviewing guidelines (e.g., Hollway & Jefferson, 2013; Kvale, 1999), the interview style was open enough to allow for

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unexpected associations or directions to emerge. Each interview was loosely structured around an initial exploration of the therapeutic relationship followed by an exploration of the social identities that emerged as salient in the interviews. This order allowed for significant issues connected to social identity to emerge spontaneously before being more directly explored. The third phase of each interview was reflective, exploring participants' experiences of the interview itself (Berman & Long, 2022). Questions were phrased broadly, allowing participants to choose the direction they wished to explore (for example, the first question was 'What has therapy been like for you? How has it felt to be in therapy?'). The planned interview schedule did not include specific questions related to what clients knew (or did not know) about their therapists, although a question about the therapist's explicit self-disclosure was included. This preoccupation of the client's knowledge of the therapist spontaneously emerged in all interviews and therefore became a point of analysis.

Data analysis

Analysis was guided by the principles of psychoanalytic interview analysis (e.g., Cartwright, 2004; Hollway & Jefferson, 2013; Holmes, 2014, 2017). Such analysis operates at a number of levels simultaneously. Interview data were analysed for preoccupations that emerged in interviews, particularly those coloured by anxiety (Hollway & Jefferson, 2013) as well as by what was left unsaid or partially said. The focus of the article was driven by an analysis of what was emergent, surprising or unexpected in interview material (Cartwright, 2004; Frosh & Saville Young, 2008; Holmes, 2013). Attention was also paid to relational dynamics and to participants' fantasies of self and other. Because the study was not only interested in the internal world but also in how social identity shapes experiences of psychotherapy, the links between the internal and social world were identified (Hollway & Jefferson, 2013). Because one theme that emerged concerned clients' attempts to get to know their therapists, Bion's theory was explicitly used to analyse the data. In this way, analysis could identify what was felt to be unknown or unknowable, how participants attempted to get to know their therapists and what the process was of exploring the mind of the other. This latter focus was facilitated by the method of analysing shifts and contradictions through a participant's interview material and what this might say about the ambivalence of knowledge.

RESULTS

The unknown therapist

While the explicit focus of interview discussion was about patients' experiences of therapy and the therapeutic relationship, questions about the person of the therapist spontaneously arose for all participants. D, for example, raised the question in response to the first interview question about her experience of therapy, saying 'At first obviously, I felt very uncomfortable you know, having to share my problems

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with somebody that I don't know'. Participants grappled with the dilemma of the therapist as unknown to them and yet somehow known. E's comment illustrates the process of grasping for what is familiar in the unfamiliar:

> I find her to be a soft, kind person I, I get the impression. But I don't know her as a person. The only relationship I have with her is in that room, you see. [*Interviewer: What do you like most about her?*] Uh, there's something about the way she looks that appeals to me but I don't know what it is. But I think I see a, a kindness in her, I don't know what it is, I can't actually pinpoint it. But there is something. When I go home sometimes I do think about her hair, about her face, and I'm drawn to it.

E knows something about her therapist, and while she references it to her therapist's physical appearance, it is clear that she is searching for something more substantial that she cannot pinpoint. This knowledge, however, is in the context of the unknown: 'I don't know her as a person'. Participants frequently voiced curiosity about their therapists in ways that underscored an absence of relational knowledge of their therapist. F, for example:

> Sometimes I ask myself well, 'who are you?' But she is true you know. But sometimes she makes examples about her as well, just for me to have a picture, you know, but she doesn't talk about herself which is, I wish one day I could have a cup of tea and you know, but she she, I feel the trueness of her, I think the connection comes from there.

F feels connected to her therapist but her question, 'who are you?', remains as a haunting presence, along with a wish for a more mutual relationship. F keenly notices that her therapist does not talk about herself, leaving F wanting to explore her more than is permitted by the therapeutic relationship.

This sense of the therapist as a stranger and yet not altogether strange held the potential to feel puzzling. When asked what she finds difficult about therapy, J says:

> I think the difficult part is when you are starting to get used to the person and she's becoming like a sister, she's becoming like a friend and even sometimes you develop some feelings or, or, something like that. So ja because uh, it's kind of like a stranger that got to know you even, deeper, if I can say.

J comments on her developing process of coming to know her therapist. Strikingly, it is through the process of coming to know her own mind, and her own feelings about her therapist, that she simultaneously comes to know her therapist and comes up against the feeling that her therapist is a stranger. F echoes this strange dilemma:

> What's strange, but I don't think it's negative, it's very strange, not knowing that person and wishing to say, 'who are you?'. Because we have connected, we have smiled to each other, but I don't know you, you know me, so. You know.

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The strangeness is in the unevenness of knowing one another. Poetically, she ends her reflection with 'you know', making a plea for shared knowledge between herself and the interviewer about how little she knows about her therapist. A little later in F's interview, she makes the link between this strange knowledge she has of her therapist and the fact that 'you don't even know what's going on in [the therapist's] mind'. F's therapist's mind is a mystery to her and she sits with a sense of territory that is not open for her to explore.

Some participants described a process of trying to explore this forbidden territory in therapy. Although most participants were in therapy for the first time and from a socio-cultural location that is not necessarily familiar with psychotherapy (Long, 2022), the 'rules' of therapy were understood. B mentioned several times in his interview that he would like to ask his therapist personal questions, but 'I don't know if it's allowed'. The pressure of this question left the interviewer feeling an urgent need not only to answer the question but also to reassure the patient, indicating perhaps the urgency of the question in B's own mind. K described her experience of asking her therapist a personal question in therapy:

> I remember a couple of times I would ask her if she has a father. And ja there's not even once has she responded to that. She never responded. But in a good way. I think it was very good. [*Interviewer: Were you asking if she could understand something about your experience?*]. Ja. And also wanting to know if she really does relate or her just doing her job. But I think it was just me being selfish, and me being me, and me being a patient you know. Ja I can say.

B's search for knowledge about her therapist is thwarted, and B says this feels good (albeit perhaps ambivalently). Exploring what it is that she wanted to know, it becomes clear that the question is about the authenticity of her therapist's connection with her. She wants access to knowledge about her therapist so that she can come to know something about herself. In the moment of voicing this, she feels selfish and greedy, as if she is intruding upon her therapist, transgressing the rules.

Part of the search for knowledge about the therapist, then, involves the question not only of whether the patient knows the therapist but also whether the therapist knows the patient. For some patients, the possibility of posing this question was vehemently denied. L, for example, insisted that her therapist 'understands whatever I tell her', that there was no possible area of misunderstanding in her therapist's mind. H, misunderstanding a question about whether the therapist had ever disclosed anything about herself, answered:

> No. No, no, no. I never experienced that, so. Everything that she would bring up, I would sort of like resonate or you know, something, it always touched something, even things that I was not aware of, you know, sort of like such things that were hidden. But nothing, yes, nothing different from what she, her intention was.

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The responses of L and H, in their adamance, suggest an underlying anxiety about the possibility that the therapist does not fully understand the patient, an anxiety which of course has basis, since it is impossible to fully understand another. Other participants grappled more fully with this question. G's vacillation between feelings of being known and being unknown at different points in her interview illustrates the ambivalence that comes with the possibility of being known by the therapist. In an early comment, she stresses that her therapist 'can understand you, like maybe a person, the same person who is listening to you has been through what you have been through and somehow they managed to go out of it and they decided they must talk to people'. She finds her therapist's motivation in her fantasy of her therapist's pain and expresses complete understanding. A little later, she says that 'at least I understand him and he understands me' but stresses that 'I wouldn't call it a relationship. I would call it an exchange between a patient and a doctor'. What was first expressed as complete understanding is now expressed as an exchange. Yet later in the interview, her fantasy of his motivations falls apart: 'I don't know him, I just know him because he is my therapist. So I don't know what makes him be there'. Towards the end of the interview, her hope that her therapist can know her is undermined by her feeling of being too damaged to be known:

> I am in my own world; they are in their own world. I think he's in his own world, I am in my own world which is the world of misery and ja. … You guys you don't have problems and if you do they are minor not like mine, let me just put it like that.

What starts off as an assertion of understanding unravels around a fear that the mind of the other is so different, so undamaged, as to be utterly foreign—in another 'world'. The contradictions through G's interview underscore not only the fear that the therapist does not know the patient but also that the patient is unknowable. The search to know and be known by the other is one that is inevitably partial and unattainable.

Getting a glimpse: Coming to know the therapist through their social identities

The primary way in which participants speculated about their therapists during interviews, attempting to get to know something about them, was through appraisal of their therapists' social identities. In F's words, this allowed a 'glimpse' into unknowable territory:

> At least I get a glimpse of her, a glimpse of her for a bit, like aww she's married, aww great, aww she has a husband, aww great, so I get a small glimpse even if I don't get more cos I can't ask about her.

F carefully observes her therapist and finds some indication, perhaps a wedding ring, that her therapist is married and heterosexual. This offers F not only some information about her therapist but also the fantasy, unconfirmed in reality, that her therapist is normative and happy.

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Sometimes patients found idiosyncratic information about their therapists that allowed them to place them in a similar social group. In the process of discussing how little she knows about her therapist and how scary that feels, J remembers something that she does know about her therapist:

> Oh yea, uh one time I walked into my therapy session and my, my phone was on and the music was playing, was playing loud and I was listening to, OneRepublic, yea OneRepublic, so the artist OneRepublic, and she asked me if I'm listening to OneRepublic and ja that kind of said to me oh you also listen to OneRepublic. [*Interviewer: She knows it's OneRepublic*]. Ja [laughs]. So that was, 'Oh okay, cool'. [*Interviewer: And what did that mean to you?*]. Um for me, oh okay, oh my therapist also listens to this music. So I don't know. Instead of listening to good music, I dunno. But ja it really—It wasn't just something that passed by. It was something that I thought about.

The therapist's unintentional disclosure was significant for J in ways that the therapist would never know, and which J never discussed in therapy, indicating something of the therapist's resonance with J's own tastes and sensibilities. Their shared recognition of OneRepublic felt to J to be a glimpse into her therapist's private world.

A also discovered an idiosyncratic moment of resonance with her therapist when her therapist came to the session wearing a football jersey of the team A supported. A described that it 'actually made me happy, it made me very happy', and went on to discuss how she 'doesn't know much' about her therapist:

> I can only deduce I guess, you know, that at an intellectual level, race, culture, uh educational background, cause I don't know what her family background is or anything. [*Interviewer: The football thing, it was significant for you?*] It was significant. I found it, it was actually um, the basis of me opening up a very important, I guess segment of my experience.

A went on to explain in some length the significance of the football jersey and how her therapist wearing it opened an unexpected area of exploration in therapy. It is striking that her recollection of the football jersey, which represents a disclosure about the therapist, then serves as a reminder of how little A knows about her therapist. She describes trying to deduce something about her therapist based on her social identities but it is only the football jersey that makes the therapist more known. As J above discovered a point of connection (through music) in the context of the unknown, so A is reminded of the unknown in the context of a point of connection (through a football jersey).

Perhaps unsurprisingly, deductions about social identities often focused on observable socio-political identities such as gender or racial identity. E, for example, expressed relief that her therapist is a woman because this meant for E that her therapist would understand her better. Her explanation of why this might be drew heavily on typical social associations with womanhood:

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> I don't know, I look at, a woman is built differently to a man, even emotionally. And a woman I feel understands a woman better because of our physio, uh, how we are built, our DNA or our genes or whatever.

This point of reference offered E a sense of certainty: her therapist's social identity made her feel more known to E. G was also comforted that her therapist was a woman, but this reflection opened up consideration of her other social identities:

> The fact that we are both woman I think made it more easier for me to open up. Um but. I don't know what her religious orientation is, I don't know what her sexual orientation is. I actually don't know much about her other than what we discuss about in therapy. So I guess you can look at it as a one-way relationship in the sense that I think she knows more about me than I know about her, other than the fact that she's [racial group] and she's doing her Masters in Psychology. I don't know much about her. Um at all ja. [*Interviewer: And what's that like for you?*] Um. It's. Initially I had a problem with that, initially, um because I felt, how could I be talking to you about everything and I know nothing about you but then I realised it actually makes it more easier for me to open up to her because then the fact that I don't know what her religious affiliation is or her sexual orientation or, or whatever um I don't know—if she's judging me, I don't know in what context or what basis she is judging me, or making her judgements. So you know to me it was okay.

One sees in the interview a similar process to what G describes in therapy: she is initially uncertain and disconcerted that she does not know her therapist's social identities but then feels relieved that she is not burdened with information that may make her wonder how she is being judged. This relief is coloured, however, by an anxiety about how the therapist, situated in her own social identities, may judge her as the patient. This process helps us to appreciate the complexity of knowing about one's therapist, particularly in the realm of social identities, which are potentially linked to biases and judgements about the other. It is disconcerting to both know and not know one's therapist, and social identities offer both a reassuring compass and a fear of misunderstanding.

In the quote above, G makes a point of stating that she knows the racial group to which her therapist belongs. This gives her some certainty amidst the uncertainty about her religion or sexual orientation. Racial and cultural identities offer a similar site for potential understanding and misunderstanding. D describes telling her therapist about a dream:

> What she did was she showed quite a lot of respect for that to say that as much as she's [one religion] and I'm [another religion] you know, she didn't like take it as meaning to say that we need to disregard it. You know like, we spoke about it and she asked me what do you think about this, the fact that it's like this, how do you feel about it? You know like she showed that respect to say that, I respect your culture or your belief or whatsoever.

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D's therapist's respect for her cultural beliefs made an impression on D and helped her to feel closer to her therapist. In this case, she surmised her therapist's religious beliefs from assumptions about her racial category. Her therapist's belonging to a particular racial group offered her a feeling of certainty about her therapist, although she was guessing at her therapist's religious beliefs, thereby making her feel understood and known by her therapist.

In contrast to this certainty, B expressed frustration at one point in his interview about his uncertain knowledge:

> Eh that's why I said to you, Carol, I don't even know the guy. I don't even know how old is he, whether he's Sotho, Tswana. I don't know his eh, language, whether he's speaking Sotho, Zulu, I don't know his age, I don't know about his family, I don't know about him, I don't know what is he's studying. I don't know, why he chose to be a therapist.

B's frustration is expressed as a seeking out of some kind of knowledge about his unknown therapist. B immediately turns to his cultural knowledge of his therapist in order to find some familiar coordinates, but his sense of the unknown therapist grows. Towards the end of his interview, B proclaimed that he was going to ask his therapist about himself: 'I'll change the therapy. I'll be the therapist, he'll be a client [both laugh]'. Our shared laughter points to the power relations he wishes to uproot, leaving him in control and the therapist uncertain and on the spot. Perhaps because social identities are potentially more guessable and are associated with assumptions and stereotypes, they offer not only a way of understanding the therapist but also potentially a way of subverting the therapeutic relationship. J similarly expressed a wish towards the end of her interview to get to know her therapist more fully 'even though maybe she hasn't had any difficulties'. J's fear that her therapist has not had difficulties means her therapist can potentially not understand her, and this is the risk of getting to know the therapist. Unintentional or imagined disclosures about the therapist's social identities are deeply linked to being understood.

CONCLUSION

If therapy can be understood as about helping our patients to mentalize—to better understand their mind and the mind of the other—we perhaps do not always appreciate the mystery of the context in which this process takes place. This article has explored patients' fascination with the process of getting to know the therapist and has demonstrated that the mind of the therapist is a preoccupying mystery to patients. Questions about the therapist's identity, in this study, were also linked to burning questions about whether the therapist can understand the patient: whether the therapist's mind is able to come to know the mind of the other. Patients watchfully observed therapists to glean clues about the therapist's judgement of them. Importantly, this preoccupation was seldom spoken about in therapy. Patients in this study all felt that it was difficult to voice, and so the person of the therapist often remains as a question in the mind of the patient.

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The question arises: why may this have been difficult to voice? A possible answer lies in the paradox of the therapeutic relationship: the relationship is fundamentally asymmetrical, and there are important reasons for the therapist to remain at least partly unknown to the patient. Yet the point of therapy is to make space for the patient's curiosity, fantasies and questions. Therapy simultaneously occupies the fundamentally unknown and the process of getting to know. It is clear that this is a paradox that patients actively grapple with. While there may be space for the patient's curiosity, there is something about the person of the therapist that *feels* off-limits, or at least out of reach. In this sense, perhaps, the therapeutic relationship participates in Bion's 'O': the ultimate unknown and undiscoverable about self and other.

Patients' reflections on their therapy are, of course, situated in the context of a research interview. Although participation was entirely voluntary and it was stressed that therapists would not be told of what patients said, all of the participants were at pains to convey to the interviewer how much they valued their therapists. Participants were less worried about getting their therapists in trouble and more concerned to convey the specialness of their therapists. Although this may not have resulted in an 'accurate' representation of their therapists as internal objects, it does convey something of the process of idealization. It is significant that this idealization interacted in interviews with a view of participant and therapist as differentiated and in dialogue with one another. This move from merger to differentiation is an important part of the process of *getting to know*.

Winnicott's (1971) notion of paradox is helpful here. For Winnicott, the therapeutic space occupies an intermediate area between reality and fantasy. One can never resolve a paradox by pinning down reality. The therapist is simultaneously real and not-real, fantasy and not-fantasy, to the patient. In Sandler's (1990) terms, the patient actualizes the therapist into reality whilst suspending the distinction between fantasy and reality. Similarly, the therapist and patient can never truly come to know one another. Indeed, patients in this study voiced ambivalence about knowing their therapists more fully, as alluring as this was. It is important for therapists to understand that it is likely their patients are preoccupied by fantasies of who they are but not to try to eliminate these fantasies. Equally, it is important for therapists to appreciate the complexity of the patient's process, much of which remains unknown to the therapist's mind. As the therapist is a stranger to the patient, so too is the patient a stranger to the therapist. This strangeness may be disturbing, but it is also creative. Winnicott (1965) captures this dialectic in his concept of the incommunicado self: that private core that is 'a true isolate' and, somewhat like Bion's 'O', wholly unknowable. The incommunicado self-engages in 'a sophisticated game of hide-and-seek in which it is joy to be hidden but disaster not to be found' (p.186). In this context, the urgent need to communicate coexists with 'a still more urgent need not to be found' (p.185). Holding the intermediate area of playing in mind offers a different perspective on the question of how the patient comes to know, and be known by, the therapist. This study has highlighted that the person of the therapist occupies a central position in the mind of the patient, who is likely to speculate from any

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available clues. Rather than merely an inconvenient inevitability, inadvertent self-disclosure operates relationally to keep the patient both connected and disconnected from the therapist.

It is striking that social identity offered a primary vehicle for trying to get to know the person of the therapist. Social identities promised a window into what remained private. The context of South Africa, with its history of oppression connected to social identities (racial but also gendered identities) is likely to have shaped the curiosity of these patients, and this curiosity may be different in different contexts. However, the curiosity and its links to the unknown are likely to express themselves in different contexts too. In some ways, the South African context spotlights the ways in which patients use social identities to get to know their therapists. The importance of self-disclosure in the context of oppression is not only a way of validating oppression (Kronner & Northcut, 2015; Leary, 1997; Sunderani & Moodley, 2020) but preoccupies the therapeutic relationship. What patients surmised about their therapists (correctly or incorrectly) was not only often comforting to patients but also highlighted the ambivalence of the relationship. In this way, social identity holds potential as a vehicle for alienation or for connection, offering a bridge over the strangeness. This may open up spaces for exploration, if not resolution, of this paradox and its meanings in the social world.

DATA AVAILABILITY STATEMENT

Data are not available.

ENDNOTE

1. The term 'Black' is used in South Africa to designate the disadvantaged groups identified in the Apartheid era: African, Indian and Coloured. These terms are retained in this article because of their continued use. It is important to acknowledge, however, that such racial categories are problematically categorized, fluid rather than fixed and socially constructed.

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