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Possibilities and challenges of psychodynamic therapy in a South African community setting

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Possibilities and challenges of psychodynamic therapy in a South African community setting

A research report submitted in partial fulfilment of the requirement of the degree

Masters of Arts in Clinical Psychology

In the Faculty of Humanities, School of Human and Community Development, at the

University of the Witwatersrand, Johannesburg

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Declaration

I declare that this research report is my own, unaided work. It is submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology in the Department of Psychology, School of Human and Community Development, at the University of the Witwatersrand. It has not been submitted for any other degree or examination at this institution

_____ _____

Alexander Oosthuysen Date

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Chapter 1: Introduction

Psychoanalysis has a long history of critique. Fonagy (2003), for example, points out that John Watson, in 1930, predicted the demise of psychoanalysis within 20 years. In the second decade of the 21st Century, however, psychoanalytic theory and practice remains strong, as evidenced by the many books and journals dedicated to the profession. Critics of psychoanalysis, amongst other things, often point out the limits of a profession designed "as an expensive treatment for the worried well" (Lemma & Patrick, 2010, p.6). Although from the beginning of the history of psychoanalysis there was interest in providing psychoanalytic services in community contexts (for example Freud's free clinics) (Danto, 1998), the focus has indeed been on inevitably expensive long term intervention. More recently, however, there has been increasing interest in applying psychoanalysis outside of the traditional consultation room, both locally (e.g. Kruger, 2012; Long, 2012; Smith, 2013) and abroad (e.g. Altman, 1993; Altman, 2010; Harper, 1999; Lemma & Patrick, 2010).

In the South African context, psychoanalytic practice has a long history dating back as far as 1946 with Wulf Sachs who helped establish the Johannesburg Child Guidance Clinic (Miller, 1999). This clinic focused on assessment, long term individual play therapy and psychiatric social work with parents (Miller, 1999). Sachs, along with support of professionals such as Ernest Jones, also attempted to create a branch of the International Psychoanalytic Association (IPA) in South Africa (Miller, 1999). Historically there was limited psychoanalytic training in the country (Gillespie, 1992), with the exception of Jungian analytic training (Swartz, 2007b), although applied psychoanalytic practice has since expanded. Due to the country's unique Apartheid history, there has been increased interest in applying psychoanalysis in a context which differs from the affluent Western society in which the theory was developed. Outside of the traditional one-on-one therapeutic setting, practitioners have been inspired to apply psychoanalytic theory and practice in diverse community contexts and in different formats. New areas of practice as well as new methods have emerged, along with an interest in applying psychodynamic therapy in contextually relevant ways. Some of this applied work has been published, but much of this work is not documented (Long, 2012). Published work in South Africa tends to explore particular foci, for example applying countertransference to trauma in the South African context (Moosa, 1992), with very little scholarly work addressing the broader question of the experience of applying psychoanalytic theory and practice to South Africa. These published works are also

often written about from the subjective experience of a single therapist, drawing on examples of their own clinical practice, rather than offering multiple perspectives of therapists working psychoanalytically in South Africa.

1.1 Aim

This research aims to explore experiences of practicing psychodynamic therapy in non-traditional settings within the South African context, from the subjective perspective of practitioners currently or previously engaged in such work. By interviewing professionals faced with questions regarding how to apply psychoanalysis in innovative, relevant and accessible ways to the diverse South African population, it is hoped that richer insight can be obtained concerning how the theory is interpreted by the practitioners, what it is felt to offer the field of mental health in South Africa, as well as its limits in this context. The research also aims to understand the way practitioners relate to, and understand, the work on a personal level. The aim of this research is therefore to map the experience of practitioners, in order to extrapolate possible points of interest for the field of psychoanalysis in South Africa.

1.2 Rationale

There is a small but growing body of writing concerned with the application of psychoanalytic work in the South African context. This work often tends to focus, however, on specific aspects of psychoanalytic theory, application of psychoanalytic theory to specific cases, the personal experiences of a single psychotherapist, or a combination of the above. Issues that have been explored include, for example, abuse and mental disabilities (Sinason, 2001), object relation theory in the treatment of trauma (Eagle & Watts, 2001), attachment theory and self-mutilation (Smith, 2001), feelings of shame in therapy (Kruger, 2012), the psychotherapist's experience of the 'other' (Swartz, 2007b), and the therapist's struggle with voice (Swartz, 2007a). This research proposes to examine the personal experiences of therapists working within the South African community context and to explore their perceptions of this approach, as well as specific theoretical ideas that guide application. In this way, the experiences of several practitioners, rather than singular voices, may be explored in order to examine the practice of psychodynamic community work in South Africa.

The availability of mental health services in community contexts is often limited, described in 1999 for example as 'dismal' (Miller, 1999). A community service year is now mandatory for

clinical psychologists, but many practitioners do not work in this context and instead pursue ventures in the private sector. Lack of community involvement may be one of the reasons that new policies are now being proposed.

National Healthcare Insurance (NHI) is in the planning stages and aims to offer access to health care, including mental health care, for all South Africans (Smith, 2013). This will hopefully include increasing the number of psychologists in the public sector, with an emphasis on short term diversity sensitive interventions (Smith, 2013). Therapists who practice psychoanalytically informed therapy will need to adapt their methods to best fit the public sector and a diversity of clients with limited access to resources (Smith, 2013). A shift in the thinking of universities, as well as in already practising professionals, in how they will adapt to these new demands will also be needed (Smith, 2013). There is increasing interest in psychodynamic orientated work in the community (Smith, 2013) and psychoanalytically informed thinking is on the rise in South Africa since the fall of apartheid (Swartz, 2007a; Swartz, 2007b). The research presented in this report is timeous given the increased interest in the application and efficacy of psychodynamic therapy in this context.

The focus of this research within a South African community context allows for an examination of the application of psychoanalytic thought in a different setting from the Western, affluent and liberal society of the theory's origin (Walls, 2004). Themes such as torture, extreme violence, poverty, repeated loss, rape survivors, criminals and political refugees (Eagle, Haynes & Long, 2007), as well as racial conflict, multiple traumatisation and secondary trauma (Eagle & Watts, 2001) are endemic to this context. Working in the South African context also involves issues of inequality, reparation, reconciliation, diversity and trauma (Smith, 2013). The context in which these practitioners immerse themselves is notoriously uncontaining (Padfield, 2013), and traumatic events, including infanticide, occur in close proximity (both physically and psychically) to the practitioners (Gubb, 2010). Psychoanalysis, therefore, is often not practiced in its purest form but is rather adapted to the needs of the community (Eagle et al., 2007). This research therefore aims to offer insight into the subjective experiences of community psychodynamic practitioners in their adjustment of frame, and the possibilities and challenges offered by this approach, through the inclusion of several South African therapists' voices, to help illuminate the field.

1.3 Outline of chapters

The current chapter is an introduction to the aims and rational of the research as well as an orientation to work later presented. The second chapter focuses on an overview of relevant literature. Areas of literature that are explored include, what the underpinnings of psychodynamic work which classify it as a modality are, current debates in the field, a definition of what is meant by community practice and the unique feel of this work. Psychodynamic concepts affected by the South African context are also explored. These were seen to be: internalised voices that effect practice, the frame and otherness.

The methodological structure of the research is discussed in Chapter 3. Research questions, the qualitative approach as well as sampling and participant information are highlighted. The method of data collection and thematic analysis, as set out by Braun and Clark (2006), are examined. The importance of reflexivity and its essential nature is mentioned as well as ethical limitations are discussed. The findings that stemmed from the thematic analysis are set out in Chapter four: the experiences of working in the unfamiliar, the often jarring environment and how shocking this can be emerged in the analysis. My experience as a researcher is also examined as a means of understanding the less overt underlying communication in the interviews. The internalised voices and how each participant grappled with their own relationship to the modality is then further explored. Important topics such as an adjustment of the therapeutic frame and difficult feelings of otherness and othering are then foregrounded.

Finally Chapter five examines the findings of the research in comparison to existing literature in order to better comprehend and deepen understanding. The importance of a practitioner's "ability to think" in this context is highlighted. A need to be able to keep a thinking mind under very difficult circumstances is better understood in terms of Bion's (1959) theory of thinking. The limitations of the study as well as insights for future research are also considered.

Chapter 2: Literature review

An extensive review of literature was conducted in order to better understand what is meant by, and the underpinnings of, the model of psychodynamic psychotherapy. Once the importance of psychodynamic therapy is clarified, the limitations of this method will be explored. In understanding the limitations of, and debates around the method, the shortcomings and complicated nature of its application are highlighted. Community practice is then discussed and defined as it is essential to understand the distinction of this context from more traditional psychoanalytic settings, and the potential impacts of this. Psychodynamic psychotherapeutic application is then examined in a South African context and important factors relevant to this are discussed. Within the South African community context three important sub headings developed out of the literature. These are, the internalised voices experienced by therapists in relation to their approach, the large effects of the context on specific ideas of frame, as well as the difficult experience of 'otherness' in the context.

2.1 Underpinnings of psychodynamic therapy

Psychodynamic[1] approaches arose from the pioneering work of Sigmund Freud (Corey, 2009). While Freud is seen as the founder and leader of the initial psychoanalytic movement, many theorists helped shape the modality in its early development and have been developing it ever since (Watts, 2004). While it is not feasible to give an account of all the important authors and the seminal works they have contributed, a few examples include Melanie Klein's ideas of projective identification; Robert Fairbairn's ego defence operations; Wilfred Bion's containment theory; Donald Winnicott and the good enough mother; Otto Kernberg's ability to create new works through existing theory; Carl Jung's work on the collective unconscious; as well as Hienz Kohut and the Self-Psychology Movement (Watts, 2004). This is not a representative sample of key psychoanalytic authors; moreover the singular concept linked to each author does not represent the true breadth, width and depth that must be attributed to their writings.

Psychoanalysis ushered in a new way of thinking about the human condition, one that was in stark contrast to the notions of 'higher conscious' and 'noble thinking' that was generally

[1] The term psychodynamic is used to refer to psychodynamic, psychoanalytic as well as psychoanalytically informed schools of thought. These terms will be used interchangeably.

believed before its introduction. This shift in thinking has been likened to the impact of Darwinian thought (Lazarus & Kruger, 2004). Psychoanalytic thought was affected by both World Wars and the horrific experience of soldiers during the birth of this method. Concepts brought to the fore by psychoanalysis include: a layer of experience and motivation that exists below conscious thought, irrational behaviour in neurosis, expressed meaning in pathological symptoms that are beyond obvious observation, the importance of the impact of childhood on later development, and the effects of psychic forces on the development of the personality (Watts, 2004) The term 'psychodynamic' is now applied to any form of psychological thought or therapy that has its roots in the psychoanalytic approach (Lieper & Maltby, 2004).

Modern psychodynamic thought has deviated from classical psychoanalysis and the original works of Freud, a move said to be predicted by Freud himself (Lieper & Maltby, 2004). This deviation has given rise to many different schools of psychoanalytic thought, many of whose forerunners are listed above. These different schools may disagree on the exact nature of the foundation of the theory but do agree on certain general assumptions (Watts, 2004). For example the importance of childhood development is a widely held point of consensus. However authors such as Melanie Klein stress the importance of the child's inner world, while others such as Donald Winnicott emphasise the relationship between the child and mother (Watts, 2004). Many authors have stressed the importance of different theoretical concepts in childhood experience (Bion 1959, Freud, 1924; Klein, 1923; Fonagy & Target, 2003; Winnicott, 1941).

The focus on pathological and non-pathological childhood experience, and the role of this in developing the mind and personality, gives rise to the next important underlying concept of psychoanalysis - the unconscious. The unconscious is seen to be present from birth and can never be fully brought into our awareness (Watts, 2004). This is because it is repressed through various defences due to its unacceptable and unbearable nature. The unconscious can only be seen in its daily repetitions and is thought to explain the irrational decisions made by individuals. These are decisions such as a repetition of self-defeating behaviours, and the choice of a partner that resembles an individual's relationships with parents (Watts, 2004).

Psychoanalytic practice explores the unconscious, the feelings, drives and defences it houses, and how this affects adaptation, behaviour, emotion and conscious thought (Fonagy & Target, 2003). Psychopathologies may develop if these are environmentally maladaptive, for

example, the over reliance on a defence mechanism or a relational structure based on childhood trauma and pathological attachment figures (Fonagy & Target, 2003; Shedler, 2010). The unconscious is covertly present in client's communications and can be brought to awareness through a linking of life events, analysis of transference (Fonagy & Target, 2003), and exploring resistance in patients (Shedler, 2010). This is all done in a holding and containing environment (Fonagy & Target, 2003), allowing clients to express painful and unconscious emotions in an effort to break self-repeating cycles (Shedler, 2010).

2.2 Debates about the relevance of psychodynamic interventions

There has been much debate about the advantageous, as well as limiting, aspects of psychodynamic theory. It is important to note that conflicting debates within an academic discipline does not necessarily discredit it in any way (Louw & Edwards, 1995). There are often conflicting theories in medicine as well as law, and these are two of the oldest and most respected academic disciplines (Louw & Edwards, 1995). Textbooks prescribed to students of psychology typically include an introductory list of these debates but do not always convey a full understanding of psychoanalysis. Many sources of information offer contradicting viewpoints of the merits or limits of psychoanalysis. For example, a video lecture at Yale University asserts that psychoanalytic techniques are not very widely used, as shorter more effective techniques are now preferred (YaleCourses, 2008). This video suggests that Freud now belongs to history rather than psychotherapy, although the importance of Freud's work to the creation of psychotherapy is emphasised (YaleCourses, 2008). The video does not acknowledge the wide variety of work that is taking place internationally.

Psychoanalysis has been critiqued for a number of reasons. For example, it has been argued that psychodynamic therapy often surprises individuals who expect professionals to be far more directive, similar to that of a doctor (Corey, 2009), and who may find the emphasis on self-exploration to be contrary to cultural norms of blind faith and acceptance.

Walls (2004) writes that psychoanalytic theory has, since Freud, been aware of the influence of culture on the method, but that the theory remains influenced by the liberal western society in which it was developed. Psychoanalysis has, however, become increasingly concerned with taking issues such as culture, class, gender, race, and sexual orientation into account (Walls, 2004). Relational psychoanalytic theories, in particular, emphasise the social and cultural effects on the unconscious (Walls, 2004). It is ironic that psychoanalysis is now thought of as a theory that excludes and discriminates against cultural groups, as the founding

authors of psychoanalysis were Jewish in notoriously anti-semitic 19th century Vienna (Watts, 2004). The question of the cultural relevance of Freud's psychoanalysis ranges back to those issues raised by students of Marxism in pre-Hitler Germany. Marxists believed that Freud's 'experiments' were completed in private practice, for a monetary fee, in a capitalist society and thus only had an understanding of the bourgeois (Langer, 1989).

The scientific base of psychoanalysis has also been critiqued (Meyer, Moore & Viljoen 2008). The lack of empirical evidence, the vagueness of methods and theory, and the difficulty of subjecting the theory to empirical testing have all been raised (Meyer et al., 2008). The contested empirical evidence of psychoanalysis is addressed by Shedler (2010). Meta-analysis on research into the efficacy of psychodynamic research has shown that psychodynamic therapy has empirically provable positive outcomes. Some research has suggested that psychodynamic therapy may even result in more desirable outcomes in general, and in relation to specific disorders, for example personality disorders (Shedler, 2010).

Other studies have also shown the benefits of long term psychotherapy. Long term psychodynamic treatment is seen as beneficial in mental disorders, such as personality disorders, when compared to more short term treatments (Gabbard, 2010). These results have been seen to be stable over time based on repeated meta-analysis of cases. This is not to suggest that short term psychodynamic psychotherapy is not beneficial. Short term psychodynamic interventions have been shown to significantly aid recovery when compared to 'no treatment' controls, and has been shown beneficial in a number of disorders (Lewis, Dennerstein & Gibbs, 2008). Short term psychodynamic psychotherapy has shown positive treatment results for depression, generalized anxiety disorder, panic disorder and some personality disorders (Lewis et al., 2008). Research has also shown longer lasting results of treatment, with follow up research showing that positive changes in client functioning are maintained longer after psychodynamic treatment in comparison to shorter term methods (Shedler, 2010). The empirical evidence that has been published on the efficacy of different forms of psychoanalytic treatments with different disorders is staggering, to the point that a complete summary here would be beyond the scope of the paper (see, for example, de Maat, de Jonghe, Schoevers, & Dekker (2009); Fonagy, Roth, & Higgitt (2005); Levy & Ablon (2009); Midgley & Kennedy (2011); and Verheul & Herbrink (2007)).

While some have criticised the psychoanalytic model as being the antithesis of the biomedical model, the theory has been growing in its incorporation of neuroscience (Altman, 1997). Recent psychoanalytic work in attachment theory is congruent with neuroscience findings on the impact of right brain learning and what has been termed 'relational knowing' in infants (Bain, Rosenbaum, Frost & Esterhuizen, 2012). Some authors such as Mallo and Mintz (2013) urge that the mostly medical orientated training of psychopharmacology should include a more integrated approach and understand that, in light of current evidence, the psychological aspect of psychopharmacology is equally important to a patient's recovery.

Watts (2004) argues that psychoanalysis should be critiqued for its downfalls as this allows for the theory to grow, but that the dated argument of empirical evidence does not take into account the current state of psychoanalytic research. Shedler (2010) proposes that one possible reason for the perception that psychoanalysis lacks evidence is because of its exclusionary and insular history. This may have resulted in researchers and practitioners from other orientations welcoming research on new methods, in comparison to the aloof nature of the psychoanalytic school, and overlooking empirical support for psychoanalysis (Shedler, 2010).

Despite many critiques, psychoanalytic approaches offer distinct advantages. For example, psychoanalytic therapists are required to attend their own therapy, which allows for deeper understanding of themselves (Corey, 2009). The breadth of the theory allows for debates to occur and the theory to grow (Lieper & Maltby, 2004).

Psychoanalytic theory itself is far from homogenous and consists of many strands. For example, ego psychology focuses on the psychosocial development of defence mechanisms, object relations theory focuses on the internalisations resulting from interactions with others, and self-psychology examines how one creates a sense of self through the use of relationships (Corey, 2009). Debates therefore exist within psychoanalysis, for example concerning the creation of the ego or the nature of the unconscious (Meyer et al., 2008). This lack of homogeny, while generating many debates, is not necessarily viewed as a shortcoming. Sey (1998) suggests that it might be because of these debates that research into the clinical validity of the method is still growing.

The application of psychoanalysis to social issues also generates debate. Kovel (1980 as cited by Walls, 2004), for example, argues that psychoanalytic thought encourages psychological explanations of symptoms, rather than understanding the roots of distress in social, political

and economic suffering. In contrast, John Forrester (as cited by Sey, 1998) argued that psychoanalysis has the power to re-write the future and break a social cycle of trauma and pain, a very important aspect in the South African context. Psychoanalysis has been increasing the level of societal theory intertwined with its practice, seen in an increasing amount of feminist theories with a psychoanalytic orientation (Altman, 1997). The cultural relevance of psychoanalysis is an important issue in relation to the South African context (Eaton & Louw, 2000).

Psychodynamic therapy aims to go beyond the alleviation of acute symptoms and seeks to develop internal resources that promote growth (Shedler, 2010). Limited research has been done on the benefits of psychoanalysis, beyond the elevation of, or absence of, symptoms and the ability to create health. However limited studies do suggest some promising possibilities of psychodynamic therapy, although it is too early to draw any conclusions at this point (Shedler, 2010).

2.3 Psychoanalytic community practice

> *It is possible to foresee that the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery; ... institutions and out-patient clinics will be appointed, so that men ... women ... children ... may be made capable ... of efficient work. Such treatments will be free* (Freud, 1919, p. 167 as cited by Altman, 2006, p. 1409).

Public work has been prevalent since psychoanalysis was founded, as can be seen in the quotation above. Freud instituted clinics offering free treatment in 10 cities across 7 countries (Altman, 2006). This generosity extended as many analysts with differing levels of expertise would take on at least one free case within the clinic. Alternatively they would dedicate some of their income from private practice towards the maintenance of these clinics. During this time many other prominent analysts, including Freud's own daughter, were offering analytic assistance in different contexts, such as in an educational setting for the poor (Altman, 2006).

This was seen as a very large task as the implementation of mass psychoanalysis was difficult. Atman (2006) describes this as 'mass-produced, streamlined, analysis' similar to the production and architecture of the period. The need to adjust the concepts of psychoanalysis was clear. "Between 1918 and 1938 psychoanalysis was neither impractical for working

people, nor rigidly structured, nor luxurious in length" (Danto as cited by Altman, 2006, p. 2). The need to adapt psychoanalysis to fit the crowded, under-resourced, environment was essential.

A better understanding of what is meant by 'community practice' is generated through a discussion of the community service year required of certain health care professionals. A year of community work for South African clinical psychologists was introduced in 2003, following the example of other health care professionals such as doctors and dentists, as discussed by Pillay and Harvey (2006). Community work was introduced in the hope of addressing problems of accessibility of mental health services in rural areas. It also aimed to combat the effects of skilled labour migration which deprives the country's work force of these services. Various institutions were involved in community placement in order to promote accessible mental health care services in areas with an identified need. These institutions involved general hospitals, psychiatric hospitals, military and university institutions (Pillay & Harvey, 2006). Clinical work in the community is not limited to these settings, as work is also done in a community context within non-government organisations (NGOs), such as the Red Cross, and in community health clinics. Pillay and Harvey (2006) state how almost two thirds of community psychologists placements were within general state hospitals, which is seen to be a positive step towards more accessible health care in South Africa. This is particularly important as these institutions notoriously lacked mental health resources in the past.

The community context is also represented in international literature. The implementation of psychoanalytic psychotherapies in poor communities has been seen around the world, including in Europe (Jacoby, 1983, as cited by Altman, 1993), South America (Langer, 1989), as well as in North America (Altman, 1993). In this setting the discipline is faced with setbacks namely: requests for more active help, missed sessions, as well as a need for 'bread-and-butter issues' such as food and housing (Altman, 1993, p. 36). The difficult choices which must be made in this context are highlighted in two case studies presented by Altman (1993). The first is one in which a patient requests a forwarding of documentation in order to apply for a social service grant after only attending a single therapy session. The other is a case in which a patient would like an extra slip to allow transportation to and from the clinic for her two brothers who accompany her for protection, one of whom is a known drug user. The difficulty of making these decisions, which do not present in private practice, in a

context in which the motives and meanings behind actions are often unclear, is highlighted here.

Altman (1993) describes the deprivation in a New York public hospital. The patients ranged from second generation immigrants of Irish and Italian descent, to immigrants from Puerto Rico, the Caribbean as well as various African countries. This created a vibrant cultural community. Many of the more mobile middle class inhabitants had moved to the suburbs after the creation of a highway through the area, which also subsequently split the community creating a "wrong side of the tracks" scenario (Altman, 1993 p. 31). The lack of jobs and resources as well as a large percentage of school dropouts resulted in lower, if not the lowest, socioeconomic rung presenting in this setting. The population was plagued by teenage pregnancy, single female headed households, substance abuse and a high level of HIV infection. Administrative issues are also clear in this setting which range from the availably of funding from the Medicare (medical aid), or the feeling that help is only sought out in times of emergency. These issues highlight the difficulty of practicing in this context as the problems faced by the community are often dire. Due to administrative issues or urgency of the patients' situation (emergency help seeking) it is difficult to be able to effectively apply psychodynamic methods.

Altman (1993) states that while work with lower socioeconomic groups has often been questioned in terms of its relevance, and the "analysability" (Altman, 1993, p.29) of patients, it is the author's experience that the work is relevant. The gap between public-private or affluent-poor patients should be bridged as there is "a polarity in psychoanalysis between work with the poor in public clinics and work with the well-to-do in private practice" (Altman, 1993, pp. 32-33).

Pine (1985, as cited by Altman 1993) is a predominantly ego psychology driven theorist who has worked in the public sector. Pine described the important difficulties in adapting one's methods in such a troubled setting. There may be a temptation in such difficult settings to focus on support to the exclusion of insight. Pine emphasises the importance of not splitting interpretation oriented therapy and supportive therapy, as it is required that interpretations are made in a supportive environment, often after transference anxieties have lowered. The support one offers in this setting is seen as particularly important due to the lack of support from other facets of the patients' lives. This is what Pine refers to as "striking while the iron

is cold" to ensure transference interpretations are not punitive (1985, as cited by Altman 1993).

Altman (1993) describes how Pine (1985) adapts the therapeutic work by challenging ideas of therapeutic purity and rigor in order to help those previously unreached to gain mental insight. This was done by basing the intervention model largely on a parent-child therapeutic model in which the reliability, non-judgmental stance, and the ability to recognise and name feelings are all seen as important. This provides the opportunity for potential curative interventions, with a more welcoming and less frustrating attitude (Altman, 1993).

These examples given from different community applications are important in understanding what is encompassed under the definition of "community practice". The community context is seen as separate from private practice (Altman, 1993). The distance from the norms of private practice and feelings of unsafety in this setting is felt in an "on the ground" sense of work. This feeling seems to be common and is telling of the divide. A sense of being at the coalface of theory adaptation is clear in writings of this type of work - regardless of the actual physical surroundings.

Altman, Bonovitz, Dunn and Kandall (2008) illustrate what is meant by an 'on the ground' feeling in community work, regardless of one's physical surroundings. The project set up by these authors was one in which foster children were seen in an open ended therapeutic relationship by a clinician in their own private offices (as opposed to government institutions). It was felt that this would allow the clinicians to be continuously available to the children, rather than only for the duration of training, as most free clinics employed training therapists. Altman et al. (2008, p.15) state "We imagined we could be free of the constraints that limit and thwart conventional efforts" which is telling of the belief that in the changed setting the limitations would be diverted. This was later found to be optimistic. Thus the nature of the patient's background and circumstance impacts the therapist, regardless of the place of practice.

Therapists' feelings of difference from the socioeconomic struggles of the children were clear. The potential patients seemed to devalue the service, would often terminate without notice, guardians struggled at times to bring the children, and there were many false starts to therapy (Altman et al., 2008). Enthusiastic therapists were met with rejection from un-wanting children, mirroring the abandonment experienced by the children in relation to their parents. This adds credence to the description of community work as not only defined by the

context, but by the difference from private patients felt in the work. The experience of the therapists highlights the internal difficulties that are experienced within this population. Extreme deprivation from not only physical safety and monetary gains, but also emotional safety, affects containing and mirroring, as well as the lack of a secure attachment base which is often experienced. This impacts the therapeutic space in a powerful way.

Altman et al. (2008) described the difficulty of being faced with trying aspects of this kind of work. This includes the complete lack of control in the children's lives that would result in sudden terminations after periods of meaningful therapy, as well as the difficulty of working with the projective identification and attachment styles of children in such dire circumstances.

Feelings of otherness are also common in this context. Altman (1993) describes feelings of being "other" from the client base in terms of socioeconomic status, and while this is an important aspect of difference it is not the only one. Race is a socially constructed concept that cannot be separated from the norms of society. The colour of one's skin exists on a continuum and the labels associated to it are manmade (Altman, 2000). For example, in 19th century Vienna Jews were considered black, whereas today they would be labelled as white. Around the world, belonging to cultural groups, religions and nations has allowed individuals and groups to create boundaries of "me", "like-me" and "not-me". The sense of safety that comes from these boundaries also creates a fascination with the perceived "not-me" or "other". This creates a dichotomy or hierarchy infused with power dynamics (Foucault, 1980, as cited by Altman, 2000). This goes as far as separating the 'civilized' or First World nations who encouraged and developed a scientific epistemology during the age of enlightenment, as superior to the less developed 'Third World'. This thinking highlights the tendency to separate into specific groups on an individual, social, and societal level across the globe. Divides in society are a part of daily life and are meaningful not only on a social level but are often internalised in labels of 'black', 'white', 'Christian' and 'Native American' (Altman, 2000).

These differences are tied to our physical being and create unconscious preconceptions within ourselves. "If we do not confront such feelings in ourselves, we do not stand a chance of being able to process such interactions therapeutically, in words and in action" (Altman, 2000, p. 599). While not advocating for full therapist disclosure on racial beliefs, Altman (2000) stresses the importance of being able to discuss this in the room. If these feelings are

denied it is similar to a denial of our own bad objects creating a blockage to a whole object depressive position understanding of a patient, thus leaving only parts of the patient visible to the clinician (Altman, 2000).

In denial of these aspects many would argue that racism is dead in North America. Altman (2000) feels that in a denial of its existence racism is driven underground and this gives rise to other debates that are equally separating. These include debates on affirmative action, immigration policy, and what the official language of a country should be.

In summary, the 'community context' is an environment in which individuals often feel that they are practicing the modality in a starkly different manner to the one it was created for. This can involve strongly feeling the divide that Altman (1993) describes as existing between the ideals and rigor of middle class private practice, and the adjusted practice needed in the public, or community setting. A sense of unpredictability exists where there is great poverty and where concrete interventions such as food and medical care are needed, and substance abuse, trauma, and neglect are commonplace. This also then creates a stark divide between the therapist and patient - often in terms of socioeconomic and education level, class as well as race and racial ideas. It is this sense of the work, a sense of being on the ground and at the coalface that is referred to as community practice.

2.4 Psychodynamic therapy in South Africa

Psychology in South Africa has a troubled history similar to the nation itself. When psychology was introduced to the country during colonisation, it functioned from a Western perspective which alienated South African cultures (Nsamenang, 2007). Psychological testing was also unethically used to create a false grounding for apartheid systems (Nsamenang, 2007). Contemporary psychology in South Africa has adjusted many of its previously unethical methods. Louw and Edwards (1995) wrote soon after the fall of apartheid that South African psychology was in need of more non-western centred research and technique creation, cross cultural adaptation of measures and methods, as well as inclusion of diverse cultures within the profession. Whilst some improvement has resulted in a more diverse and culturally sensitive profession today, these imperatives remain important.

There is limited exploration of the history of psychoanalysis in South Africa (Swartz, 2007b). There are historical accounts of South African analysts training outside the country prior to World War II. This has been attributed to the absence of formal analytic training institutions

in South Africa. Furthermore many professionals left the country in protest against apartheid (Swartz, 2007b). Gillespie (1992) tells of her experience of being a training analyst in 1940's South Africa when Wulf Sachs was the only practicing analyst in the country, and the challenges that came with the development of an analytic society where one had not existed. There are, however, also some psychoanalytically oriented writings originating from South Africa during the apartheid era. For example, Pye (1957) discusses the application of dream analysis to clients from different ethnic backgrounds. Pye (1957) gives an interesting perspective of apartheid South Africa through examining how members of different cultures all felt innately entitled to the land, as well as how contrasting forces created an ego dilemma through exposure to opposing cultural worlds. Pye (1957) discussed an example of a black man who had been forced to integrate into the racially biased business world, as well as the conflict within Afrikaans men who were raised by black domestic workers. Pye (1957) goes as far as to claim that these social conflicts may disturb the foundations of the unconscious and in turn put the ego in jeopardy. Thirty seven years before the first democratic elections Pye (1957, p. 177) described South Africa as a "country of opportunity, a country of self-preservation, and a country that calls for leadership and healing".

Pye's assertion remains relevant today. Although apartheid has fallen, its effects can still be felt, and the reconstruction of the economic, political and psychological functions of the country are very complex matters (Sey, 1998). According to Sey (1998) and Miller (1999) the country must address its long history of trauma. While the Truth and Reconciliation Commission has helped in this process, this trauma is also present on an individual level and manifests in therapy, as many people have lived traumatic experiences under the oppression of apartheid and in post-apartheid South Africa.

In order to explore literature about the challenges of applied psychoanalytic therapy in the South African context, three themes will be explored below. These themes have been chosen because they were dominant themes to be found in the interviews conducted for this research. First, the theme of the 'internalised voices' of theory and supervision is explored. Second, the implications of the frame for work in applied settings is interrogated. Third, given the ever-presence of diversity in the South African context, the impact of otherness on the therapeutic encounter is surveyed.

2.4.1 Internalised voices

Practitioners personally relate to, and internalise, theory, supervisors and theoretical texts. The concept of such 'internalised voices' may explain how all of this experience filters into their eventual approach and way of thinking in the room. There are many important dynamics that can affect this, such as the South African context and the therapists' own life experiences. These voices can at times be defensively used or adaptive and may be either punitive or malleable (Long, in press). This complicated process is essential to address in the understanding of how theory is uniquely applied.

Until very recently, few fully qualified psychoanalysts practiced in South Africa and psychoanalytic training did not exist (Swartz, 2007a). This has resulted in psychoanalytically oriented therapists in South Africa having often felt inadequate in comparison to their international colleagues because of a lack of pure training and the lack of opportunity to enter a formal analysis (Swartz, 2013). On the one hand, Swartz (2007a) argues that South African practitioners have often tended to imitate their international colleagues exactly. On the other hand, however, the psychoanalytic community in South Africa, including therapists in practice and university members, has been described as robust despite these challenges (Swartz, 2007b).

Swartz (2007b) examines what may prevent South African psychologists from finding a voice, i.e. representing psychoanalysis in both speech and writing in a way that truly reflects the theory and their unique experience (Swartz, 2007b). She notes how many South African practitioners feel their practice to be lacking in relation to their Western counterparts, resulting in a reluctance to speak out due to fear of ridicule, a backlash because of their deviation from orthodox approaches, and unquestioning acceptance towards visiting psychoanalysts (Swartz, 2007b). Many current debates in the South African psychoanalytic community mirror international debates, such as concerns over training requirements (Swartz, 2007b). The existence of a feeling of inferiority to the traditionally trained analyst could form a type of superego that polices and judges the adaptation of work. Internalisation and use of theory may happen at this micro or at a macro level.

Long (in press) examines the use of projective identification by training psychotherapists in the supervision context. Long (in press) uses Winnicott's terms, 'object relating' and 'object use', to describe the defensive and insightful application of theory. She highlights the importance of the internalisation of a theoretical stance as an idiosyncratically internalised

object. Theory, in many contexts, may be internalised and related to or used in idiosyncratic ways. The importance of supervision to training therapists is also clear in the writings of Long (in press). Supervision is seen as a place in which new therapists can express their concerns and so find their own voice (Kaufman, 2006, as cited by Long, in press).

Being able to discover one's own voice as a therapist is important. Greenberg (1986) writes of the divide between theory and practice. Theory by nature is public. In order to contribute to growing discussion thoughts must be written, spoken and debated. This, in Greenberg's (1986) view, is in contrast to that of practice, which is by nature private. The way the method is applied in analysis is understood by the analyst, integrated within their own experience and filtered through their personality giving the outcome a uniqueness specific to the therapist. Sandler (1983) states that each practitioner holds theory, at least pre-consciously, in their mind. This is not to suggest that individual methods without theoretical basis are acceptable, but that a 'by the book' practice is not applicable in certain psychotherapeutic settings (Greenberg, 1986).

Sandler (1983) further describes how psychoanalytic thought can be viewed in two ways. The first would be a position of rigor, that theory is a complex jigsaw puzzle that must be homogeneous in its application and understanding. This view would see any deviation from the founding texts or overlapping contradictory theories as something that must be adjusted to remove the blemish created. A second viewpoint as described by Sandler (1983) is that the theory can be viewed as a way of thinking that has been developing organically since its birth, that the ever growing theory which "possesses elasticity, is pliable in its usage, having a whole spectrum of context-dependent meanings" (pg. 35). This is an important point when coupled with Greenberg's (1986) ideas as well as the internalised use of theory discussed by Long (in press). This could suggest that a personal understanding of the theory as a whole may be internalised and at times exist as rigorous and/or malleable. This internalisation could be seen to relate to how the practitioner would experience the work, which can at times be protective and giving, and at others harsh and punitive. It could be this openness to adaption that may explain the divide between the work in private practice and the public sector described by Altman (1993) as discussed above.

Gubb (2010) provides an example of internalisation, which provides a clear understanding of the distinction between the community context and the ideals of private practice. Gubb vividly recollects the experience of working in a South African government hospital where a

patient brutally beat her infant child to death on the floor, and was later beat to death herself by her fellow patients in reaction to this. Gubb (2010) also described the experience of repeated para-suicide evaluations. This rather vivid traumatising image is telling of the difficult context in which the practitioners work. The shocking nature of this is clear and Gubb (2010) describes her attempt to make sense of the large number of borderline traits she was seeing in this population in comparison to others. Gubb's (2010) examination of "The State as a borderline mother", the article's title, can be seen as a theoretical formulation of the environment, that is used in a constructive manner to better understand the context. Other examples include 'attachment theory' based parent-infant workshops as described by Bain et al. (2012). In these workshops therapists were faced with difficulty in consistent participation in the group, and at times had negative countertransferential reaction to the participants. It is described how an analytic understanding of these difficulties, as well as an analysis of the limited time available in the context, allowed the difficulty in participation levels to be addressed. Bain et al. (2012) describes how theory can be used both to defend against, and to make sense of, loss in public health environments.

2.4.2 The frame

The frame is an important concept in psychoanalytic literature and has been commented on by many authors. Authors such as Quindoz (1992) feel that the set standards of the frame should be emphasised in training, and adherence to this should be a requirement of the International Psychoanalytical Association (IPA). Quindoz (1992) named the Spatial, Temporal, and Financial facets of the frame as important. The spatial aspect implies that there are only two parties alone in an undisturbed room, one the patient who is lying down and the other is the analyst sitting behind them. The temporal aspect is specified at several years of four to five weekly 45-50 minute fixed scheduled sessions with breaks only occurring when agreed upon or beyond one's control. Financially, sessions must be paid for by the patient even if these sessions are missed. Quindoz (1992) also emphasises the importance of having no relation to the patient outside of therapy, and no contact with third parties in the patient's life.

Böhm (2004), who writes on aspects of the frame from the perspective of a private clinician in a European country, describes some aspects of the frame:

> *First, there is the setting - the office, the sound-proof room, the modest decor, the switched off telephone, the non-self-revealing furniture and the "routine procedures",*

> *and then there are other parts, like: time, length and frequency of sessions, responsibility for sessions, fees, and finally the analyst's attitude: the absence of censorship, the fundamental rule of free association, the use of the couch, the total privacy and confidentiality, the relative anonymity of the analyst, the use of neutral interventions and the rule of abstinence.* Böhm (2004, p. 2).

The South African Psychoanalytic Confederation (SAPC) emphasise the psychoanalytic frame's structural features, which include time and place, fees as well as breaks (Silove, Schon, Berg, Green, & Levy, 2011). It contains a professional relationship which cannot be blurred. The importance of being able to address termination as well as having a plan in place for the analyst's death, along with the importance of maintaining a frame in the supervisory relationship, are clear in this definition (Silove et al., 2011).

Community practitioners are often faced with questions and challenges in their practise which may call for a deviation from these orthodox norms of practice. Examples such as the merit of their actual work, the possibility of greater benefit coming from practical aid such as feeding schemes, ethical concerns about giving long term therapy while waiting lists only increase, and the use of Eurocentric theories in African settings are common in this context (Miller, 1999). Difficult questions such as the possibility of re-traumatisation as a result of allowing an underprivileged child access to toys in play therapy, and then not allowing them to take these toys home, also arise (Miller, 1999). Kruger (2012, p 23) writes of her experience of breaking the frame by having contact with a patient outside of the therapeutic relationship after therapy had terminated, describing negotiating this within herself - "Being a conscientious psychotherapist, I think: the frame, the frame, the frame" - and how difficult the management of this is, in these impoverished communities.

Lisa Padfield (2013) writes of her experience in her government sanctioned community service year. She describes her difficulty in functioning as a therapist in this under-resourced environment. Rooms were often too small and cramped with very little comfort. At times these rooms were not even available due to over scheduling and emergencies. The referral resources were scarce or informal as only one referral letter was received in the entire year, with many patients not even knowing what a psychologist does. Faced with problems of extreme poverty and violence and seeing patients for an average of 2.4 sessions, Padfield (2013 p. 79) described how the frame is affected:

As more aspects of the psychoanalytic frame are relinquished in consequence of under-resourcing, for example in clinics where not even the same room is guaranteed from one session to the next, it becomes increasingly important for the therapist to hold the frame in mind.

Being able to keep a frame in mind is further discussed by Padfield as containing several key aspects which are all important but have difficulties in their implementation. Empathic immersion, feeling truly attuned to somebody, can be infringed upon by feelings of otherness. Padfield (2013) emphasises the use of the therapist as a self-object, highlighting the importance of the therapist's containment and mirroring function in community contexts. In this way the therapist comes to embody the frame. The link between psychic space and physical space is important and the creation of an individually reserved space in an otherwise overcrowded clinic is unconsciously extremely powerful. Privacy is key, and being able to create a private space in impoverished communities where many patients do not even have their own beds is of clear importance to the work. Privacy is difficult to maintain due to the staggering numbers of people these clinics receive. The establishment of a set appointment time which cannot be disrupted is foreign, and while of obvious benefit to the client, can be administratively problematic. Outside the profession this importance is neither understood, nor valued, and so it is difficult in these strained environments to get the administrative staff to assist. Padfield advocates the importance of valuing appointment times despite these challenges. The final recommendation made by Padfield (2013) concerns consistency: being able to be there for a patient in a consistent manner after a lifetime of unpredictability, lack of safety and extreme trauma is seen as instrumental.

Padfield's (2013) description of an internalised frame has some overlapping key elements; such as confidentiality and consistency of the space; with more traditional understandings of the frame. The contrasts are also clear between Böhm's (2004) setting when juxtaposed with Padfield (2013): the sound-proof room versus a prefabricated structure; the modest décor and non-self-revealing furniture versus at times not having a room and having to give therapy in a shipment container; and the use of neutral interventions versus the use of direct breathing exercises and social placement programmes. Padfield (2013, p. 87) states "modification is not a choice, it is imperative".

Padfield's (2013) essential argument is that the psychoanalytic concept of the frame, if modified and held flexibly, can be of enormous value when working in community clinics.

While Böhm (2004) writes from the context of private analysis in Europe, and his concrete descriptions of the frame are clearly not relevant to community contexts, he offers some conceptual arguments concerning the frame that offer broader applicability. One of these concerns the distinction between the external and internal frame. The less obvious internal frame is conceptualised in relation to the reactions of the therapist based on their own personal experiences, beliefs and countertransference. This internal frame adds another dimension to the already important external observable frame. This frame is established in different ways based on the fluid nature of the practitioner's internalisation of principles. Internal frame breaks can be enacted when a clinician has identified with a particular aspect of the client's dynamic and allows their own wants, needs and desires to affect the therapeutic space.

The frame is also described as less tangible by Tuckett (2005), who suggests that the frame consist of three components. The participant-observation frame involves being able to emotionally experience and be aware of the process but not necessarily act on it, while remaining in a relationship with the patient. Second is the conceptual frame: being able to conceptualise the experience and work in the transference and countertransference. The third frame is that of the interventional frame, seen as one's ability to implement an intervention informed by the participant-observer as well as the conceptual frame.

The relevance of Böhm's (2004) and Tuckett's (2005) work to the South African context is perhaps less in relation to the external frame, and more in terms of the therapist's ability to hold the internal frame, and the importance of thinking about one's actions and feelings. The ability to be able to work with internal and external frame breaks is essential to Böhm's (2004) thinking. The question he feels should be posed in relation to frame breaks is: "What could have been touched within yourself by what you experienced in relationship to me and my frame break?" (Böhm, 2004, p.3). This question allows for the effect of the break to be interpreted in a unique and experiential way for the patient and the therapist, allowing the break and the transferential feeling this evokes to be worked through.

The importance of knowing oneself and being able to think about not only the space of the frame, but one's role in it, is expressed strongly by both Padfield (2013) and Böhm (2004). This is very important in a setting so marked by the social context that affects the way one is interpreted in the room, working in a post-apartheid South Africa.

2.4.3 Otherness and othering

Psychoanalytic psychotherapists, as well as trainees working in community settings, often face particular challenges related to the difference between their (usually middle class) lives and the lives of their patients - who may also belong to different ethnic or language groups. One of the more concrete difficulties is the language divide. The language spoken by the clinician is often not the same as the home language of the patient. In a profession where the spoken word is described as the "tools of our trade" (Esprey, 2013, p. 41), therapy across the language divide is placed at a disadvantage. This is not only because of concrete linguistic differences but also because language is used in therapy to convey unconscious or less obvious communications.

Eagle et al. (2007) examine the experiences of psychology Masters trainees working in a community setting, exploring how supervision can foster growth. They also examine the implications of what they term "the unfamiliar" (Eagle et al. 2007), a concept closely related to otherness and difference. The unfamiliar relates to being faced with experiences that are outside the student therapist's normal comfort zone and includes issues such as abuse, extreme poverty and even torture (Eagle et al. 2007). These experiences are often outside the normal range of therapists' experiences, as the long and expensive training required to qualify as a psychotherapist means that many students come from middle to upper class backgrounds, and do not have similar lived experiences (Eagle et al. 2007). Swartz (2007a) writes of her personal experience with difference, how her white skin marks the privilege afforded under the apartheid era and the suffering that this protected her from. She reflects on how she learnt to dismiss the suffering of others seen daily on the city streets and how all of this difference resulted in her being disconnected from some of South Africa's population (Swartz, 2007a). Therapists live in a social context and that social context therefore lives in the therapist. Understanding this is imperative to working in the South African context (Lazurus & Kruger, 2012).

The experience of one's marked difference in the therapeutic encounter, based on the communication of one's skin, is further elaborated by Swartz (2013). Swartz (2013) discusses the tense nature of the South African context as a consequence of a shared history of racial segregation, dividing citizens and creating lines of poverty, class and unearned privilege. Butler (1997, as cited in Straker, 2006) describes how stereotyped injurious slurs draw the attention to one's label as a social being. This can leave one feeling as though the words have

entered one's body, thereby repeating historical pain and clearly differentiated power relationships. The impact of difference is imperative to understand in a country so marked by segregation that the communication of racial assumptions and difference is already made before the first words are spoken (Swartz, 2013). The difficulty of being able to address these feelings is mentioned by Esprey (2013) who describes how it was originally easier for her to engage with the topic of race while studying abroad, compared to the difficulty of being able to address these painful internalised racial states in the heated South African context.

Kruger (2012) discusses shame as stemming from similar awareness of otherness. She explores her own experience of shame and guilt about her comfortable middle class life in juxtaposition to the struggles of her clients and how this feeling is exaggerated in newly practicing therapists. She describes her shameful feelings of helplessness at the severity of clients' social and contextual issues. Swartz (2013) discusses how these feelings of shame, dominant power relations and difference can create a barrier to empathy. It is common, she argues, for mistuned, ruptured or turbulent therapeutic relationships to be blamed on racist origins, and because of the complicated nature of these interactions therapeutic impasses are created. These impasses and overwhelming dynamics can affect the ability of the analyst to think in the room, described by Straker (2006) as the anti-analytic third. Swartz (2013) sees the manifestation of this in the room as two subjectivities in the room that are now separately scrutinizing each other.

The impasse that may be created by otherness has therefore been described by different authors, and the importance of being able to work with otherness is clear. The healing ability of being able to directly address and name the difference that has created the impasse (Straker, 2006), being able to discuss the difference and stay empathetically attuned to the commonality of the underlying human experience (Swartz, 2013), and addressing the ever present elephant in the room (Esprey, 2013) are all described as potentially transformative. Straker (2006) vividly describes this transformative potential:

> *[T]hat even while performing racism, or any other "ism" for that matter, some possibility of transformation exists, even as such performativity is inevitable and potentially shaming. Knowing this possibility of transformation and knowing that a particular unacceptable performance experienced as emanating from within me is also a particular instantiation of the more general desire of the Other allows me more freedom and hope in relation to it (p. 745).*

Transformative work in the face of otherness has been theorised as not only inevitable but essential in the mature mutual recognition of the other in the subjective relationship (Benjamin, 1990 as cited by Swartz, 2013). Unashamed curiosity, reflection and engagement remain long standing pillars of psychoanalysis and are needed to be able to address otherness in a reformative way (Swartz, 2013). The increasing acknowledgement of difference in the literature is telling of its inevitability in therapeutic work (Esprey, 2013).

In summary, several themes run through the literature exploring the state of psychoanalysis in South Africa. Therapists' struggles with a uniquely South African voice as well as a lack of pure training can be seen to be interlinked, as many therapists may feel inferior to their international counterparts. Questions of adaptation in the face of shocking poverty, abuse and physical interventions beyond the scope of the psychodynamic frame are raised and need to be answered repeatedly. Experiences of otherness, encounters with the unfamiliar, and shame are central to the South African experience. These experiences are related to the country's troubled past and illuminate the continuing effects of apartheid in the now democratic South Africa.

Chapter 3: Method

3.1 Research questions

The overarching question of this research is:

> *What are the subjective experiences of psychodynamic psychotherapists working in community settings?*

Due the inductive nature of the research, specific questions were created and refined inductively from the research data namely:

> *What is the interplay between the South African context and the psychodynamic approach?*
>
> *How may the researcher's experience of participating in the research shed light on this interplay?*
>
> *How is the frame understood within this interplay?*
>
> *How are experiences of otherness understood?*

3.2 Research approach

This study aims to better understand the subjective experiences of individuals who practice psychodynamic psychotherapy in the South African community context. A deep understanding of the personal recollections and experiences of these individuals is placed above any need to categorise, quantify or test a hypothesis around the applicability of the theory in the context. It is because of this individual focus that a qualitative method of analysis was chosen. Qualitative analysis allows for deeper and richer descriptions of individuals' views on issues and a subjective understanding of the world around them (Nieuwenhuis, 2010). The emphasis on the subjective understanding is clear as the focus is on individual experiences (Howitt, 2010).

It is for these reasons that this method is felt to best suit the research question. The individual participants each had a uniquely important view on the work, and at times would overlap not only in experience but also in understanding. Staying close to the subjective truth of each participant was important. The experiences and emotions communicated in the interviews were powerful and personally meaningful. The importance of the subjective experience of the

participants cannot be understated, as it was these experiences that served as the raw data that the research aimed to understand. The root of the research being focused on subjective understandings also promotes the use of qualitative analysis. This is characteristic of the qualitative method which strives to describe the experiences of an individual, group or context (Babbie & Mouton, 1998). For Willig (2001), qualitative research is important in prioritising the "quality and texture of experience, rather than … the identification of cause–effect relationships" (Willig, 2001, p. 9). Therefore, the depth provided by qualitative analysis was required to better understand the uniquely personal experiences of the participants.

The personal stories of the participants were gained using a semi-structured interview administered in a one-on-one, face-to-face setting. The freedom for adaptation that comes with a semi-structured interview was beneficial. In entering the interview it was never clear what information would arise. The unique experience of each participant made the interview content unpredictable at times. The semi-structured interview was felt to be flexible enough to allow for exploration of these unforeseen lines of discussion, but also remained structured enough to allow the researcher to focus the discussion and not stray from the topic.

Thematic analysis as discussed by Braun and Clarke (2006) was implemented in order to analyse the data. This method allows for overarching shared experiences to be analysed, placed into themes and discussed. Sarantakos (2005) described this as allowing the common threads of experience to be identified within the interviews.

The role of the researcher was important in the data collection and analysis. As I intend practicing in this modality in the future it is important to remain cognisant of my feelings towards the work. At all times personal feelings were taken into account and worked with internally and if need be, expressed and discussed with my supervisor, Professor Carol Long. The researcher's subjective experiences were also felt to allow for sources information on what was being communicated in the interview.

3.3 Sampling

A non-probability purposive expert snowball sampling method was used. Expert sampling was chosen to ensure the inclusion of participants with suitable knowledge of psychodynamic thinking as well as adequate experience in the community context (Palys, 2008). In order for participants to be included in the study the following criteria had to be met: 1) they were

willing to volunteer for the study; 2) they identified themselves as practising within a psychodynamic orientation; 3) they had practiced in some professional capacity for at least 3 years in a community context. Community setting is defined as being any context outside the traditional private practice/ private hospital contexts. These include non-government organisations, public hospitals, as well as community clinics in impoverished areas. It is in these settings that the difference between private practice and the reality of the community context is highlighted. Professional capacity refers to having any form of psychological role, for example supervisory or therapeutic, in this environment.

The reason for including only therapists who have been practicing for over three years in this setting, as opposed to focusing on those in community service - which would have provided logistically easier access - is due to the wealth of experience that the time in the setting has generated. The initial year of community service is the practitioner's first professional year outside a training environment (Reid, 2001). The growth experienced in one's community year is felt to be transformative, with 90% of psychologists reporting increased confidence in this year (Pillay & Harvey 2006). Therefore it is felt that the professionals in this year may not yet have developed a deep understanding of psychodynamic community practices, when compared to their more experienced colleagues.

Snowball sampling allowed for the network of therapists who meet the abovementioned criteria to be accessed with relative ease (Maree & Pietersen, 2010). Psychodynamic psychotherapists in the community context are scarce as the mental health care system is notoriously under-staffed and poorly funded. The clinicians who practice in this modality often belong to similar networks. This can either take to form of reading groups, training programmes, or even professional communications and referral systems. The limited number of practitioners who meet the criteria, as well as the common networks between them made the snowball method the best suited sampling strategy (Atkinson & Flint, 2001).

Teaching staff of the MA Clinical Psychology programme at the University of the Witwatersrand were approached for referrals to initial participants. The active involvement of staff in the psychodynamic community allowed for easy access into the network of psychodynamic therapists. The referral system was then further expanded as therapists known to the researcher in a professional capacity, outside of the staff team, also provided initial participant referrals. The initial interviewees were then asked for further participants who

they felt would be of value to the study. This chain of referrals is characteristic of the snowball method (Maree & Pietersen, 2010).

To protect confidentiality the names of the participants could not be shared amongst respondents. This resulted in many overlapping referrals as the participants would often refer the researcher to possible participants who had either been approached or already interviewed. This highlights the close knit and limited number of clinicians who meet the inclusion criteria.

From this process 6 participants were identified. While the initial sampling aim set six as the minimum number of participants needed, the information gained was felt to be of adequate depth and saturation was reached after six interviews. Six participants allowed for the experiences to be varied enough that many different perspectives were gained, but at the same time still feasible within the limitations of this study.

3.4 Participants

The participants consisted of two males and four females varying in age. The cultural diversity included one black and five white participants. Due to the small nature of the psychodynamic community and the high possibility of overlapping memberships in reading groups and organisations the participants will all be referred to as female in this report in order to further protect confidentiality.

The experiences of the participants varied. Some were initially trained in the psychodynamic approach while others had chosen the modality later in life, some had obtained PhDs in psychology while others also had been initially trained in disciplines other than psychology. The community experience also differed, with certain practitioners taking part in the mandatory community year, while others trained before this was introduced. Certain participants functioned as therapists within community settings, while others took on supervisory or case management roles. Due to the varying ages some had experience of community work under apartheid, while others did not. While several participants were currently very active in community work, other participants had been more so in the past.

This diversity of participants benefitted the research as it allowed for many different subjective experiences to be explored and discussed from varying points of reference.

3.5 Data Collection

A semi-structured interview was conducted in a one on one setting with all participants. Qualitative interviews facilitated a deeper understanding of the individual's subjective world, provided untold stories a voice in participants' own words, and created a connection between the interviewing parties (Kvale, 2006). These advantages were of benefit to the data collection, as experiences and recollections of community practice was the main focus of the research, as well as being congruent with the qualitative research approach.

A semi-structured interview was chosen as it allowed for openness, flexibility and reflexivity (Nieuwenhuis, 2010) by the participants. The flexibility allowed for the examination of unexpected areas of interest that arose during the interviews. Louise-Barriball and While (1994) state that the advantages of probing in a semi-structured interview include: being able to clarify information that seems unclear, allowing for an explanation that requires the use of memory in greater detail, and the examination of interesting and relevant issues unexpectedly raised by participants. This was seen as important to the interview process as there were many times when the participants presented unexpected thoughts and information. Probing questions allowed these lines of thought to be unpacked and elaborated upon so that the unique experience of the participant could be accurately conveyed.

Face to face interviews allowed for body language and other non-verbal cues to be noted and elaborated upon (Opdenakker, 2006). The advantage of the researcher being in the room for the interview was that emotions could be experienced by both parties in the discussion. The importance of tone and facial expression, as well as the internal feeling of the researcher in the room, cannot be underestimated. The information gained was essential to garnering a full understanding of what was happening in the room, and what was being conveyed in the interview.

The interview schedule (see Appendix A) was created based on the aim of the research. At all times throughout the interviews participants were encouraged to use case examples as these were felt to best clarify the internal thought process. The interviews initially began with a direct question around the exact nature of participants' work. This allowed for a better understanding of individual frames of reference. Questions then focused on the personal understanding and internalisation a psychoanalytic approach, both in the way it was practiced and the reasons they continue to use the method. The South African context was discussed in terms of its more general effects on the work, as well as the response felt from the population the clinician had been working with. Experiences of otherness and the frame were also

discussed. Finally the personal experienced possibilities and shortcomings, as well as the clinician's view of this psychoanalytic modality in comparison to others, were explored. Once the interview was completed participants were asked if they felt there was more information that should be added, that the schedule had possibly missed. Less than half of the participants added information that they felt the interview had missed, often adding a reiteration of previous important points rather than a new topic. In conclusion the participants were asked if they required any more information from the researcher.

Once these interviews were complete, the data was transcribed verbatim in what Clandinin and Connelly (2000, as cited in Creswell, 2007) referred to as "field texts".

3.6 Data analysis

The research was inductively analysed and research driven, rather than being informed through a specific theoretical lens. The experience of the participants was felt to be important and primary, rather than a specific psychodynamic understanding of what was occurring in interviews. Verbatim transcriptions underwent thematic analysis in order to identify underlying themes. The thematic analysis followed a realist method, which aims to report on the meanings, experiences and specific reality of the participants (Braun & Clarke, 2006). Thematic analysis is one of the most widely used methods of qualitative analysis and is able to provide rich, detailed and complex analysis of data (Braun & Clarke, 2006).

In order to conduct thematic analysis appropriately the steps set out by Braun and Clark (2006) were adhered to. The work of Braun and Clark (2006) was chosen because of its wide usage - despite its relatively recent publication, it is a very highly cited article. The electronic academic database Google scholar shows over 6500 articles have cited Braun and Clark at the time of writing. The different phases as set out by Braun and Clarke (2006) are described in Table 1 below.

Table 1:

Number	Name	Description
Phase 1	Familiarising yourself with the data.	Involved active reading, searching for meaning and repeated readings to become comfortable and familiar with the full range of data collected. Verbatim transcriptions of the data.
Phase 2	Generating initial	More specific codes in the data are created which allow for

	codes.	easy reference to specific segments. These were not the same as themes which are broader and may encompass many different codes.
Phase 3	Searching for themes.	Codes created in the previous step were examined to find connections or overarching theme. This was the first step in which some basic themes start to take shape.
Phase 4	Reviewing themes.	Themes were refined into viable and non-viable options. This was done by examining the coding which created the theme as well as examining themes in relation to the entire data set.
Phase 5	Defining and naming themes.	Final themes were refined so that the story of each comes across in an interesting way. Themes must have clear boundaries that define them, and names should be considered.
Phase 6	Producing the report.	Themes were conveyed in a final report, which utilises extracts from the data set in the form of quotations, and highlights the important findings.

While these steps were implemented they did not follow a strict, set pattern of analysis, but rather followed a more fluid, flexible and cyclical pattern in which analysis occurred throughout many different stages of data collection. Braun and Clarke (2006) specify that the phases listed in their steps are not linear nor are they to be adhered to in a strict sense. This rigid application would limit the method's flexibility, robbing thematic analysis of one of its main advantages.

The analysis of the research was done in a continuous fashion. Often directly after the interview the feelings as well as pivotal moments in the discussion seemed clear in the mind of the researcher and were then noted. Later, during the transcription of the interviews by the researcher, a familiarity with the information was gained. This process was invaluable to the understanding of the data as it allowed the research to be repeatedly examined. It was during this stage that main themes began to emerge - many in line with important points that were experienced in the room. Steps 1 through 4 of Braun and Clarke (2006) were influential at this stage in the analysis.

Preliminary themes were then developed as discussed in Steps 4 and 5. This was done by the researcher and it is important to note that the creation of themes was the responsibility of the

researcher (Janesick, 2000). The decision of what constitutes a theme is left to the researcher's judgment (Braun & Clarke, 2006). Themes were therefore created in a theoretically driven manner, in relation to the research question (Braun & Clarke, 2006). In order to ensure that the themes were created in an ethical and accurate manner, the process of naming and boundary creation was discussed with the supervisor. This process was done in a cyclical way throughout the research as more data was added. An actual step by step process is described here to better illustrate the method used, while the fluid nature is important to note.

During the data analysis it is important that validity, often referred to as trustworthiness, must be ensured (Sarantakos, 2005). In order to ensure the quality of the data, internal and external consistency was examined. External consistency involves checking results with writings on similar topics (Bryman, 2004). External validity was examined by comparing results to pre-existing work on psychodynamic community practice. Internal consistency was ensured by analysing all the data collected to assess if final reported conclusions were accurate and plausible (Bryman, 2004).

The concept of internal validity is congruent with the writing of Elliott, Fischer, and Rennie, (1999) in terms of standards for good qualitative research. The importance of providing credibility checks was utilised in what Elliott et al. (1999) refer to as an "additional analytic auditor" (pg. 222). The role of an analytic auditor was fulfilled at times by the research supervisor's independent assessment of the data analysis, which helped to ensure a match between data gathered and the results drawn out of this.

Elliott et al. (1999) also examines the importance of grounding the results in examples. This is important as it allows for the link between what the participant discussed in the interview, and the researcher's understanding, to be made. To ensure that this link is communicated properly, direct quotes will be used. Participants were informed of this before the initial interview and identifying information was changed if it was presented in the quotes. This was important, amongst other reasons, to ensure that an ethical approach to the information was followed.

3.7 Reflexivity

> *Qualitative researchers accept that it is impossible to set aside one's own perspective totally (and do not claim to). Nevertheless, they believe that their self-reflective*

> *attempts to `bracket' existing theory and their own values allow them to understand and represent their informants' experiences and actions more adequately than would be otherwise possible* (Elliott et al. 1999, p. 216).

A researcher has an impact on the research they conduct (Gilgun, 2010), highlighting the importance of self-awareness and reflexivity. In order to ensure a high standard of qualitative research the researcher's role in the research process cannot be denied (Elliott et al. 1999).

The University of the Witwatersrand's clinical psychology programme has a psychodynamic inclination which often results in graduates practicing in this framework. This means that I was trained and will practice psychodynamically, as well as be involved in a community service year. This results in a personal investment in the research, of which I remained mindful, allowing myself to be open to the results as they were presented. Being mindful of my wishes was important, as the more one is aware of one's inner world the more its representations in actions can be identified. Denial of this would have resulted in unknowingly contaminating the work.

My wants and needs regarding the theory have been important during the process of data collection and analysis. When this subject was chosen I lacked a psychodynamic background and was a novice in terms of the theory. My feelings towards the theory have changed throughout the transformative year, partly due to my persistent exposure to theoretical structures, as well as my implementation of the method. This highlights my experience as being tied to the research topic. While my familiarity with the theory has increased, it is minimal in comparison to that of my participants whose practical experience led them to have clear views of the work, unlike myself.

My personal experiences in the interviews were very informative in terms of the results. Feelings of being (at times) familiar with the theory, while still being separate from the experience, allowed for an informative dynamic in the interviews. My lack of practical experience is what was felt to have prevented my thoughts from colliding with those of the participants. As my stance is still being formed, I was more in tune with what was being offered. Directly after the interviews I would experience new feelings towards the modality. Interviewees would often bring me into the discussion during the interviews. This would include both direct references and questions about my thoughts, beliefs and understanding. At other times indirect references were made to "my generation" or research in general, and on occasion this seemed likely to be a reference to myself or my research. This would leave me

feeling either energised by the method or disheartened by it, at times feeling like a naïve student and at others like a competent researcher. This all seemed to be strongly affected by the content of the interview. It is this important internal dynamic that led to a wealth of information which may not have been present otherwise, and is discussed in the "researcher in the interview" section of the next chapter.

Gilgun (2010) states that to attain reflexivity it is important to write, reflect, and discuss during the process. Reflections on my writing, emotions, and inner conflicts have therefore been incorporated into the different stages of the research and have been explicitly included in the analysis of interviews in the following chapter.

3.8 Ethics

The ethical standards of the University of the Witwatersrand as well as the ethical code of the Professional Board of Psychology were strictly adhered to. This involved ensuring that participants were fully informed of the nature, goals and confidentiality measures taken in the research, in order to ensure adequate informed consent was obtained (Allan, 2011). A written participant information sheet (see Appendix B) was given to all participants in advance, in order to enable them to give informed consent on the day of the interview (see Appendix C).

Specific consent was obtained for the use of the audio recording device (see Appendix D), as recordings were used, and then later transcribed. Participants were informed of the storage of these recordings as well as who had access to them (Allan, 2011). The recordings were kept on a secure hard drive which only the researcher had access to, and the participants were made aware of this. The participants are aware that the recordings will be kept for two years post research completion, in the event any further analysis is needed, and will thereafter be destroyed.

Confidentiality was ensured and respected (Allan, 2011). The snowball sampling method used in the research creates specific confidentiality issues. Some initial participants were contacted via the University of the Witwatersrand staff. This resulted in a common thread among some participants. Personal contact between members was also clear in the repeated referral sources and membership to organisations. This connection, and ethical concern, is common in participants when snowball sampling is used (Neuman, 2000). The research supervisor is also a lecturer at the university and an active member of the psychodynamic community and therefore may know the participants. This increased the importance of strict

confidentiality measures at all times, as neither the supervisor nor the fellow participants were made aware of the identities of the participants in the study. Transcriptions do not include participants' names or any other information that may compromise their identity. The names of participants are only known to the researcher. While the participants' identities are kept confidential, direct quotations are included in the research report. Participants were made aware of this and consent was obtained.

The interviews included and encouraged discussion of the participants' actual practice. Participants drew upon actual experiences that took place within their therapeutic practice. The interaction between client and therapist is confidential and this was respected at all times (Allan, 2011). Participants were informed that should they inadvertently reveal confidential information in interviews confidentiality of any relevant parties will be respected in the transcriptions and in the final report. Identifying information that presented in this way was changed to protect parties involved.

It was conveyed to participants that the aim of the research is not to evaluate their application of the theory in practice but rather to understand their experience of it. Participants were told that if during the interview any omission of, or indications towards, bad practice arose these would not be reported as it is not the focal point of the study. This was included in the participant information sheet (Appendix B) and was hoped to reduce anxieties allowing for a more accurate representation of their practice. Participants were informed that transcriptions would undergo thematic content analysis in order to discover underlying common themes.

The semi-structured interviewing process has its own ethical implications as it can be used to gain access to privileged information and lead subjects to give desired responses, all under the guise of a friendly equal relationship (Kvale, 2006). Power relations were examined to ensure that interviewing was conducted in an ethical manner.

The participants were made aware of their right to decline the invitation to be involved in the research without any repercussions, and were also free to stop the interview at any time or decline to answer any question (Allan, 2011). Participants were made aware that the research forms part of a dissertation for the university, and that a copy of the final report will be available on the World Wide Web.

Benefits and risk to the participants were important to consider (Allan, 2011). Although there were no direct benefits to participation, the results of the study may inform participants'

practice and the process of discussing their work in interviews may have been perceived as beneficial to participants. There were no direct risks anticipated or encountered in participation in the study.

Chapter 4: Findings

The findings of this research are presented in five sections. The results of the research highlighted what appeared to be dichotomies which therapists grapple with in their work. This was experienced in the interplay between the South African *context and the application of the theory* in the setting. The *researcher's own experience*, as presented below, is felt to be crucial to understanding the results. I would, at times, feel the internal conflict or struggles that were being expressed in the room, highlighted in my own personal relation to theory and practice. It is this informative experience which led to reflexivity being presented in this chapter rather than as separate to the findings. The way in which *supervision and psychoanalytic theory was internalised* by participants also shed light on a deeper understanding of their experiences of psychoanalytic community work. The *frame* was also an important topic highlighted in the interviews, with almost all participants mentioning it as a seminal concept. It was interesting to note that the frame was simultaneously one of the most problematic concepts to maintain. *Otherness* as experienced by the participants was also seen as seminal to understanding the context, but again exists in a struggle between its obvious presence and the difficulty in addressing it.

4.1 The experience of working psychodynamically in community contexts

A dominant theme to have emerged from research interviews centred around participants' descriptions of working in community settings. This section explores how these visceral and powerful descriptions were presented and how, in response to the sometimes horrifying experiences of working in community settings, participants grappled with working psychodynamically. Quotations from interviews are used to illustrate the active grappling that took place, with participants deeply questioning the applicability of a psychodynamic approach to the setting. Participants simultaneously expressed how psychodynamic theory and practice offers an important way of making sense, and helping practitioners to think and reflect in the face of overwhelming concrete difficulties.

All participants commented on their experiences of working in community contexts, often with reference to the nature of cases seen and the impact of the setting on both the work and the therapist. Ms. J[2], for example, comments:

[2] Female pseudonyms are used throughout to ensure confidentiality

The poverty for me was shocking, the magnitude of problems was shocking, you could see somebody about a rape and it turns out they had a dreadful, had terrible things happening and one can barely imagine how one can survive (Ms. J).

The levels of despair that one sees in the community setting range from crippling poverty to toddler rape. These problems are very different from those experienced in middle class suburban life, which many therapists have been exposed to. Ms. B described her experience as follows

I was also just being literally transported into another world (Ms. J).

Feelings of being transported and being out of place are clear and telling of an unfamiliarity that is present for most practitioners that practice in the community. This is often spoken about in a way that evoked feelings of being unsafe. Practitioners experienced a sense of entering an environment in which one does not have the protection of distance. This is described by Ms. B:

You know where they talk about I don't have food, or I'm in whatever distressing situation, it's not just thinking or imagining it, it combines with the experience of actually witnessing and seeing it, and seeing it that I think makes it difficult (Ms. B).

Being faced with poverty and despair, and often being actual witness to the suffering as one drives into these unfamiliar, impoverished areas is enough to feel unworldly. The stories participants heard were described at times as horrific:

[a supervisee] was counselling someone who had to bury her husband alive, and she said the horror of this, she was overcome by the horror of this, and what enabled her to sit with the horror of this was her countertransference (Ms. M).

The difficulty of hearing these recollections are repeatedly described as evoking a feeling of "horror" while countertransference is seen as the useful and protective application of the theory. Often it was suggested that the theory provided comfort and protection from the context. It was also noted that while the theory can be protective in this context, it is felt that one cannot work in a conventional method as problems in theoretical application due to logistical reasons were common. This is highlighted in the quotation below:

How does the context affect it? It affects it hugely. In all the community contexts where people can't get there on time, can't come regularly, haven't got enough money to feed themselves let alone get a taxi to come to therapy (Ms. J).

The lack of resources needed to do the work seems to affect not only getting somebody into the room, but actually having a room, having a space, and being able to keep the space available. Experiences of this are described:

People pitch up an hour into the group, and you can't turn them away, and all the kinds of things you say "oh yes this is how we do it" doesn't work like that. So you got to really often rethink and see how you can accommodate the kind of work that you are doing without getting too worried about the frame (Ms. V).

You know there's no privacy (Ms. V).

So they might, counselling might happen under a tree (Ms. M).

Even once a person is in the room, the work often seems difficult as there is no privacy and interruptions are common. The need to be able to work without being "too worried about the frame" is essential as the frame is repeatedly infringed upon, which is discussed in greater detail below. The modality is also unfamiliar to most people, as explained by Ms. Z:

I think psychoanalysis often does not get the South African context, and I think the South African context does not get psychoanalysis. It's like this vague conceptive view improving yourself……. People recognise trauma in this country so trauma debriefing, Cognitive Behaviour Therapy [CBT] and that kind of stuff is very well regarded - get in, fix it, move on (Ms. Z).

This leads to the question of how one practices the psychodynamic model, which is not focused on a "get in, fix it, move on" method, and adapt when faced with this attitude? It is obvious that circumstances plagued by 'poverty' and 'despair' described as 'horrific' and 'appalling', even 'traumatising', would benefit from psychotherapeutic interventions. The context is also clearly under-resourced and the possibilities to implement important classical psychodynamic ideas, such as frame, seem difficult and even impossible at times. The question of how one works in this context is clear. Is this even relevant? This question is described by Ms. Z:

How is this going to help this child who lives in the squatter camp who has been abducted, held captive and raped continuously for three days by three men - and the mother's destitute, what are you going to do for this child? And then it's a fair question frankly, how are we going to help in that context, what are we doing? (Ms. Z).

The ideas of how to help those in such dire circumstances highlights the difficult nature of the cases in the community context, as well as a feeling of helplessness in the face of what seems to be insurmountable trauma. This is then further clouded with concerns about the reach:

[Speaking to private practitioners] I tell them "tell me how we're relevant, tell me how me sitting here, they are in these conditions, that one child comes here for four years of psychotherapy and I've got 40 000 if not 4 000 000 who need help". So the answer would be rather do a little bit of therapy well than a lot of therapy badly. Ok fair enough, but then we accept its ability to reach the mass of South Africa is limited (Ms. Z).

Faced with the traumatic reality of the context creating feelings of despair and insignificance the question of why this modality is useful becomes apparent. How does psychotherapy and psychodynamic thought make a difference and reach an overwhelming number of people who need mental care, in a limited amount of time, and with an adjusted frame? Is this method really important or feasible in the country, is it truly applicable? The answers given by participants show great significance, a huge need, and a strong belief in the relevance of the theory - making a counterpoint to the previous statements. Examples include the healing power of understanding:

I think the missing link in our current South African dilemma actually is psychology, is a deep psychoanalytic understanding of the illness in this country post-apartheid that we all experience (Ms. A).

The depth that this theory provides:

It's going much deeper we all know that, but somehow it's like sort of painting on a canvas but being able to think psychoanalytically allows one to really bring out so much more so the picture it becomes much richer, much more meaningful, much deeper, and I think for me that's the biggest benefit of working in this way (Ms. V).

The recognition of going beyond a simple addressing of needs and solutions, being able to understand what this person may need beyond the obvious:

> *I think concrete solutions are really helpful when you are poor - you need water, sanitation, and food and jobs. So working in that context those needs can attack one's capacity to reflect and think and still feel that we as a profession have something really valuable, not secondary, but absolutely essential, absolutely essential, central to this country (Ms. A).*

This highlights the importance of what psychodynamic psychotherapy may mean in this context and to the country at large. There is an ability to look past what may be needed on a concrete level, while not denying its importance, and find a deeper meaning in an individual experience, explained by Ms. V:

> *[speaking of a HIV positive adherence workshop for adolescents] there was a fact that the medication didn't taste very nice. It's really embarrassing if you've got to take the medication in front of somebody else and when you go on school trips and that sort of thing. And at the end of the discussion the observation that was made was, well perhaps part of the difficulty in being adherent to treatment has to do with the fact that there are blockages, emotional blockages. And in the course of this intervention none of that was addressed so there was no discussion about what it might be that was getting in the way of taking the medication. It was the more sort of concrete stuff around the taste and the time (Ms. V.)*

This shows thinking beyond the concrete. The medication does taste bad, and it is embarrassing, but it is also the only way to live a healthy life. Yet adherence is still an issue. Psychoanalytic understanding was thought to allow a better understanding of these types of conflicts that seem to make little logical sense. The ability to understand the deeper implications of this depends on the creation of a reflective space.

> *I do understand it's very difficult to go back to one's environment where things haven't changed. You might have had a safe space for a while but you're still going back to grinding poverty or stigma or violence or alcohol abuse or whatever it may be. But then one's got to be cognisant of that and mindful of that. But on the other hand I do think there are very few spaces available for people without medical aid for a space to*

explore some of the things that have shaped their experience of life and how that may be impacting their own ability to function (Ms. V).

This shows an awareness of the difficulties of the context, as well as the experienced benefits of the model in the idea of creating a reflective space. The ability for the theory to create a space for not only reflection, but for caring that may not have been experienced before, was also felt to be a positive contribution:

It's just true about the relationship and it's someone who week after week for 5 sessions, where you never had anyone, before you've gone to the clinic to get your meds, you're shunted along, you're kept waiting. Suddenly to have the experience of someone there interested in you and try, you know and just listening … it can be an experience that has never been felt by the patient (Ms. J).

Interviewees highlighted the country's extreme trauma and the difficulties that people living in those conditions face, even in their basic needs for survival such as safety and food. Interviews also highlighted the experienced subjective possibilities of the approach, as expressed by the practitioners. The ability to create space, uncover deeper meaning, attempt to understand the individual as unique in their development and personality, understand the effects of the past, and show care and respect rather than superiority and superficial solutions in the room are all seen to be valuable aspects of practice stemming from personal experience as practitioners.

The difficulties of the context and how this differs from what one might see working in a different setting has been highlighted above. It can also be seen that psychodynamic psychotherapy is felt to be able to offer varying degrees of help from the perspective of the practitioners. This creates a contradiction of how the two should meet: how the context which is felt not to "get" the theory and a theory that is felt not to "get" the context can come together in a way that is mutually beneficial. This question was be answered differently by different practitioners. How individuals adapted the theory to the setting was influenced by what the theory meant to those individuals.

4.2 The researcher in the interview

My experience in the research provided me with an understanding of the below-the-surface communication, a feeling that comes from the subjective, relational experience of being in the room for the interview. These were feelings related to my changing ideas towards the

research and towards myself as someone in the process of learning both psychoanalytic psychotherapy and community practice. It often felt that I either doubted my role as a future therapist, or I was excited by it. This experience of notable conflicting emotions and thoughts was informative and potentially mirroring of the participants' own internal relation to the approach and the voices that they felt guided their work.

As the researcher, my distinct feelings and beliefs were at times addressed and directly questioned in the interviews:

What made you choose this? (Ms. V).

Before we go to the next question I want to ask you a question… How do you understand psychoanalytic thinking? (Ms. Z).

What do you do when you leave, what are you going to do? (Ms. Z).

Do you like this way of working? (Ms. J).

This seemed to affect what I felt in the interviews. When I was actually brought in it highlighted my involvement and investment in psychodynamic work. The questions above are in relation to my thoughts and transferential experience to the research topic. I experienced being brought into the room differently by different participants. I would at times feel that as a novice therapist, still in the early stage of development, I did not have the right to contribute to the interview. I would at times preface my thoughts with statements such as:

From my limited experience.

I mean I am hearing a lot in my limited psychological language, so you work more in the intersubjective ideas, when people are in a relationship?

My repeated mention of "limited" shows anxiety around engaging with my ideas. Feelings of incompetence plagued these moments. I feared my "limited" understanding would be apparent. This was sometimes expressed relationally and I could see that I was treated as a student in the room.

Ms. Z: But anti-Bion, remember what Bion said? What did he say?

Interviewer: Memory and desire

Ms. Z: Correct: no memory no desire

Being able to answer questions such as this paradoxically put me at ease rather than making me feel as though I was being interrogated. This speaks to my experience, that I was comfortable being the student. I was fearful of the mass of theory ahead of me and as long as everybody was conscious of my incompetence then the work could continue. This is in contrast to other moments where I felt I was treated more as a colleague where my thoughts and feelings were asked to be expressed in the room. Ms. J, for example, asked me "Do you like this way of working?". The shift between feeling like an incompetent student and feeling like I had something to offer was very informative. It was telling of my feelings towards the theory, and possibly my participant's as well. I felt at times that the theory was insurmountable, the method was complicated and difficult to use, especially in this setting. At other times I felt as though I understood the issues at a base level, and was able to engage with my knowledge in a way that resonated with my understanding of why it is important - although more anxiety provoking.

The shifts between positive and negative experiences in the room were recurrent. I felt the relevance of my research was questioned at times; sometimes I had the sense that my questions were not as important to my participants as I felt they were. For example in Ms. B's response to one of my questions:

> *It's you need to get the job done, and maybe at some stage in a few years' time there will be a surplus of psychologists [then] those are issues and debates we can get into but I don't know right now. If somebody is a therapist and they have been trained a particular way and they're coming and they can do the work and come, all of that (Ms. B).*

At this point, the topic of conversation was directed at the need for greater acceptance of any help that the community receives, as there is a real shortage of mental health workers, which is a realistic worry. At the time I felt it was directed at my question on the topic. I felt that I was working on the wrong idea and was very disheartened by my research. It appeared that perhaps in the broad field of community health, my micro-study was asking the wrong questions and looking at insignificant information. Was I asking the wrong questions? The feelings of guilt that my question was simply to get research done and obtain my master's degree were clear. I felt transparent and shameful in that moment. I was un-energised to carry on with the research.

However, at other times I felt that my questions and research was rather well received and considered to be meaningful. For example:

> *How do we spread psychological services to the people who really need it the most in this country, which are the poor, the desperate, the miserable? How do we take this thing out of the consulting room? But that is again not an inherent problem with the model I don't think, I think it's a problem in how we apply it and we don't have enough research, so we need your generation (Ms. A).*

This comment on the need for my generation to be doing research energised me, making me feel that I was contributing. I felt that I was adding to the collective information. I was now doing what, in my mind, I was supposed to do and this allowed me to feel like the research itself was meaningful. This represents a large focus on my feelings of contribution, how I was adding to the work and it was meaningful. The feelings of not being able to contribute were again contrasted with feeling of importance.

My age was often brought into question as in the previous statement with the mention of my 'generation'. The questions of my age and the changing face of the work were often addressed:

> *I don't think any of us are free of our history. And I don't think even your generation can be, although your generation will generally say "we're different, we wish you wouldn't talk so much about race" or "we just get on in class" or whatever. And so that's true you have had a different experience which I envy but at the same time I do believe that until we actually address some of the difficulties of the past psychologically, as well the fact that the structural poverty still manifests, and clearly our government I think suffers from a repetition compulsion in a way, I mean in a way they just keep on repeating (Ms. A).*

The ability to be able to draw on my experience of race is clear in this statement, that maybe my generation's big issue to be addressed would not be the struggle against a fascist government based on segregation. Maybe my generation has to address the aftermath that is still felt to be "repeating", such as structural poverty. Inherent in this is not losing sight of the past but being able to see beyond the black/white divide, to the current issues evident today. This highlights the need to develop our own way of thinking based on our lived experience

This is on the side but I do think you know maybe your generation won't inherit this, I hope not, but our generation inherited a sort of colonial mentality, a kind of inferiority that everything good comes from the Tavistock. That we can't think for ourselves (Ms. A).

Participants therefore expressed their opinions about how I (my generation) will experience the theory, how I will be able to integrate theory and if the superego of the Tavistock will still loom overhead. This mention of being able to think again left me with a positive transferential experience. I felt that I could pick up this torch of research and help carry forward the work of psychodynamic psychotherapy in the South African context. At other times feelings towards the theory were questioned and I was unsure about what I felt regarding the theory.

I believe also that our young people, this is a challenge to you that you don't have to answer, but I believe many of our young therapists don't even believe in long term therapy. Lots of the young therapists I speak to say we need to rethink the way we are doing things because we don't have the luxury. Some of our therapists, some of our young therapist students go into therapy only because we tell them they have to, because it's part of their training, they didn't choose to. So therapy is part of your training, therapy is not an internalised belief structure (Ms. Z).

This statement made me question myself. I am not from a psychodynamic background and the conflicts I had been experiencing had, at times, made me question my feelings towards my work. I felt that possibly I was one of these "young therapists" who had not internalised the work and who may be seen as a fraud completing a Master's degree for selfish reasons. Could I 'rethink' the way things are done in a uniquely South African context, free from the superego of the Tavistock? Or was I simply going to create a semblance of psychodynamic thought, a type of directive therapy, and try to label it 'psychodynamic' because I had not internalised it?

This is yet again another conflict in my experience and one that is seen to be vital to the understanding of the interviews. I attributed my conflicting shifts to my inexperience. As an inexperienced therapist, new to the model at the time of writing, I have had just a year of intense exposure to psychoanalytic theory and practice. This is in contrast to the participants who had at least 6 years of experience. This left me malleable to the ideas of others, as I have not established a firm grounding myself.

Although my shifts described in this section can be understood in relation to my experience and my dynamics, the quotations demonstrate how participants joined me in these shifts and positioned me in particular ways. There may therefore have been an unspoken dynamic in the interviews linked to the feelings, projections and internalisation of psychoanalytic practice in a community setting. I may have been experiencing something similar to the participants. At times they experienced the theory as giving and useful, and at others the punitive superego would prevent free thought. This is an important theme that runs through the findings. Experiences of conflict are often evident in thinking about psychodynamic ideas, and can fluctuate in the same interview repeatedly. These can exist between feeling that the theory provides an empowering sense of depth and understanding which is at its best transformative and reparative, and feelings of repression, ridicule, orthodox practice and punitive superegos that block thought and condemn adaptation.

4.3 Internalised voices

The internalised supervisor and internalised theory is an important theme that emerged throughout the interviews. This was often seen in the way participants would describe why exactly they used a psychoanalytic approach, Ms. M, for example, simply and definitively stated:

> *I believe in it (Ms. M).*

Her statement highlights the personal meaning of this approach for her. The ability to be able to practice in a modality that was personally meaningful was important to professional development:

> *So you know discovering all those ideas and I read very widely actually before I went [to university]. So I suppose it was a kind of gradual, more and more it made sense to me particularly people like Winnicott at the time, then I discovered Klein who I didn't understand a word of it, I remember trying to do a presentation on the paranoid schizoid position and not being able to even read even 3 pages of it. But I would have to say Klein's become my, I think Klein's fantastic now (Ms. J).*

The theory making "sense to me" again shows the importance of one's own experience towards theory. The acknowledgment of the difficult entrance to the way of working suggests the barriers that may exist, but the benefit of later finding the work 'fantastic' shows an

internalisation of the work. The theory is also felt to offer a lens to understand the human condition:

> *It just made so much sense to me, so much of what people experience in childhood and I suppose I'm talking more psychoanalytically than anything else but so much of what is experienced shapes the way in which we respond or think or view what happens in your life. And yes I absolutely agree that a systems point of view, you know, what's happening in the here and now, obviously has an effect and an impact on you as well. For me it was very powerful to think about the difficulties we experience, or people can experience from that point of view, so it was a personal thing (Ms. V).*

While the theory was internalised and its applicability was clear to participants, there was an acknowledgement that the field of psychology is one of many modalities, as seen above in reference to systems theory, which the participant was also familiar with. It was clear that many practitioners would draw on many different theories, using psychodynamic theory as the base, and at times questioned their work based on traditional methods of practice. In this way practitioners grappled with being fully invested in the theory but having to adapt and change to the context.

The extent that this tension was dealt with, and the ability of the practitioner to negotiate this, depended on their relationship with the theory, the voices they had internalised, and the limits or liberties this created. For example:

> *I have the voice of lecturers and how you've been taught. You have to realise that what I have been taught and what I am sitting with they are two very different things. So in some ways I feel like you know it's all good and well to learn things in the textbook and to read about things but you know being in the context and actually having to do it is very different (Ms. B).*

The mention of lecturer's voices in one's head, reciting teachings irrelevant to the context one works in, is telling of an internalisation. The difficulty of being in the real world which is very separate from the 'textbook' is also highlighted, and the need is expressed for an adaption away from strict traditional principles. Conflict occurs between using a theory that is personally meaningful, but feeling like certain internalised 'voices' are ill suited to the context. The participant's feelings around their adaptation of a psychoanalytic approach was brought into question:

Well I don't think I was drawn into the method, I think that the context sort of draws you into its own method which you learn, I mean I studied through [university] and I mean what you are taught is long term psychodynamic work and so you're taught to work with one particular model and then you go out and you realise that what you are taught and the context within which you learn and you work that they are two very different things. So in a way it's like you have to adjust what you have been taught and try and make it work with the context or where you are. So that's what it's had to be. I've been taught to work long term, and then you come into a context where you can't do long term work. I mean even if you were seeing, like people who see people in private practice I don't imagine, and certainly medical aids don't afford you know, the luxury of seeing patients on a long term basis, they pay for a certain number of sessions and I guess that applies even here (Ms. B).

This quotation highlights some of the ways in which long term psychotherapy is felt to be inappropriate for the context. The mention of being trained in long term therapy and then coming into an environment where this cannot be practiced signifies a feeling of division between the previous mention of "lecturer's voices" and the work one is faced with. There also seems to be anger in being ill equipped which may result in questioning the application of this theory in private practice as well. The acceptance of one's approach can at times be doubted in the discussion of its appropriateness in the next quotation, as seen in the repeated mention of "maybe" and "I guess":

Well I don't know any other lens, this is the only tool I've been given you know so I guess in a sense, I can't say this is certainly better than another sort of method of looking at it but for me this is what works, it helps me understand things, not just from what I am being told, but I guess what's not being said and all the other factors. I guess it also does influence just how direct I can be, you know. Because like I said to think about 'cause it's looking at the past and how maybe early relationships and you know I guess in thinking about that then I might, I might be able to maybe be directive or not be directive and I guess be more sensitive to what I can say and how much can I say because I'm thinking a lot more ahead, and thinking about the dynamics and what's playing, and thinking about the transference and the countertransference and its working in all of those, so I still work with all of that which is maybe quite helpful and ja just maybe what I might be doing is maybe different (Ms. B).

This participant questions, but also affirms, the usefulness of a psychoanalytic approach in a community context: it "helps me understand things". The uncertainty in the above statement, evident in the use of 'maybe' and 'I guess', is telling of an uncertainty in the way the theory is thought about. It is possible that the internalised psychodynamic voices are judgmental of Ms. B's personal adaptation of the technique. This indicates a difference between finding the theory useful, and doubting its adaptation. There is a distinction between noting the 'different' nature of one's work and the necessary, yet possibly non-psychodynamic adaptations, while important core aspects are valued, such as the past, unspoken communication, a non-directive approach and countertransference. While still able to engage with the benefits of the theory, the following statement is not as clear on the definite positive internalisation of the theory as other statements:

> *I suppose what to say is that interesting I mean stimulating, for me you can hear, I mean I am an advocate, I find it very interesting, I can talk for ages as you can see (Ms. J).*

The different feelings towards the work is emphasised here. Wanting to 'advocate' for the theory and to find it 'stimulating' experienced by one respondent contrasted to another feeling: "I can't say this is certainly better then another sort of method of looking at it, but for me this is what works" (Ms. B). While both practitioners are experienced therapists who undoubtedly benefit their clients, it would seem that the feelings they have towards the theory differs at times.

The importance of actual supervision, as well as one's own therapy, was mentioned by almost all participants. Participants described an internalised supervisor, integrated with the self, who provides theoretical understanding.

> *In the work that I started doing I was supervised by psychoanalytically based people, my personal therapy was psychoanalytically based. I mean the person who I was in 10 years of therapy with, she was psychoanalytically trained so a lot of what I learned, I learned in my therapy, and the supervision and the way of thinking about my cases. The people I went on to work with were predominantly psychoanalytically based and trained as well. So it wasn't by choice frankly. Now it [where I work] is, is psychoanalytic… so all of our case conferences etc. are all based in psychoanalytic thinking, but we do recognise that that's not everything, you know there are times when we step out of that and we say look, the mother has taken this child and run onto the*

street and is selling her, I am not going to sit with her in the room and discuss her motivations for doing that, I need to protect the child (Ms. Z).

Ms. Z positions herself in relation to supervisors, her therapist and colleagues, stressing that over time she made a choice to align with psychoanalytic thinking. Towards the end of this extract, however, she offers an example which seems to evoke a punitive internalised supervisor. She understands the concrete protection of a child who is being sold into prostitution by the mother as going against the traditional psychodynamic ideas - that one must keep the frame and work purely in the mental sphere. It is evident that breaking of the frame by offering concrete solutions or breeching confidentiality is seen to be incongruent with the rigidity of the theory. The difficulty of being able to negotiate this type of situation, which seems common in the context, while still being able to call the work psychodynamic introduces a difficult internal debate. How does one remain responsive to context but maintain a way of working in line with psychodynamic principles? The rigidity of the psychodynamic principles in practice was experienced by Ms. A:

I don't think it's a method itself, I think in psychoanalysis internationally and then particularly here because of colonialism we do suffer from a kind of superego hang up. Where if you are not orthodox you're not cool and you shouldn't be in the reading group… And I think that it really stops thinking. I think you have to be able say your work that "this is what I did" and not have people ridicule and laugh and criticise. Because unless we can do that, unless we can get to a real trust and honesty between ourselves as colleagues, but that's not the method itself, it's the way people use it. And frankly all religions do that. And we have to really guard against psychoanalysis becoming, psychodynamic becoming, a religion and I think that great minds like Barnaby, Mark Solms really have helped shake things up here because I think there was a danger of a colonial orthodox, of being more British than the British in a way (Ms. A).

Ms. A directly describes theory as an internalised superego. If a practitioner does not practice in an orthodox way they are not seen as 'cool' and will be rejected from the reading groups, which is damaging as this process prevents thinking. The participant is clear that this is not inherent in the theory: "but that's not the method itself, it's the way people use it". She feels there is a need for a more accepting psychodynamic community of practitioners, and that we should value the South African context rather than be "more British than the British". The

latter, she feels, leads to feelings of inadequacy and over-compensation. The internalisation of the theory is affected by both feelings of inadequacy resulting from the context, and from the fear that the practitioner community will ridicule dissenters. There is an acknowledgment of the need to find freedom from this:

> *Because I think you know Klein and Freud, their great freedom is that they didn't have somebody else's superego on their back and they could think really freely. Now some of the things they did, like Melanie Klein analysing her own daughter, we wouldn't do that today. But she still had the freedom to explore that and find out why we couldn't do that today. If we translate that to now I think that we also have to give ourselves the permission to think somewhat freely while doing no harm. You know there's certain basics we must adhere to….. one constantly integrates the frame and says "when is it important", so your patient that came late, are you still going to see him for the 10 minutes or are you maybe going to go over knowing that he caught five taxis to get to you. I mean certainly in community settings some of my students have agonised "can I give this child a sandwich"- yes you can give the child a sandwich because the child's really hungry and he is not going to think straight in the therapy session if he hasn't had a sandwich, and yes you see him putting some in his pockets to take home to his little brothers and sisters (Ms. A).*

Ms. A stresses the importance of being able to break away from a theoretical superego. The need to be able to adjust the frame to one's context and be able to feed a hungry child is evident. The saddening idea of having to sit in a room with a starving child and not giving them food - as it is against an internal belief structure - provides a very clear picture of the difficulty of managing "somebody else's superegos on their back". There is also an acknowledgement that therapeutic practice should not be boundary-less as there are ethical lines, but certainly one should be allowed freedom to bend and adapt to the context. The way that the theory is felt to impact a practitioner is also discussed by Ms. J:

> *If you idealise the therapist and you do the training - and of course you split - if you're a good Kleinian baby you know either you might find yourself having a very positive transference to the training because it's sort of part of your positive transference to your therapist… And of course you may or may not know but you will learn as you go along but positive transference is always negative transference so if you idealise something there is always going to be a devaluating of it (Ms. J).*

Ms. J feels that the internalisation of theory has transferential elements which possibly affect how it is internalised. The reference to transference, stemming from one's transference to one's own therapist, suggests how one's personal life affects one's internalisation and in turn application. This may suggest that the way one views the theory changes during the course of a career as "positive transference is always negative transference so if you idealise something there is always going to be a devaluating of it". The practitioner's relation to theory is fluid rather than static. During the interview process, some participants would change from valuing and devaluing the theory during the same interview.

Ms. Z feels that an inauthentic internalisation of theory will be apparent:

> *You do need to make any model that you work in, whether it be gestalt or psychotherapy, and you choose Klein vs. Winnicott, and you choose Freud vs. whoever, you do need to internalise it because if you're not authentic they will get that you are not genuine or authentic, particularly children. They will immediately know that you are not genuine or authentic, so you try and keep the frame to please the supervisors rather than be genuine in the room with the person. You are not real and that's the end of the relationship, and as a result I don't believe you are going to do anything of relevance (Ms. Z).*

It is to the detriment of the client, Ms. Z states, if a therapist is not truly integrated with theory and simply acts to "please the supervisors". The work must have meaning to the practitioner and the patient. The way theory is experienced will impact the way one thinks about other key factors such as the frame and experiences of otherness.

4.4 The frame

The frame is seen as one of the most seminal and useful theoretical concepts in psychoanalytic theory. In the context of community work, therapists simultaneously valued in and felt it to be difficult or, at times, impossible to implement. Participants spent time in interviews negotiating what a "frame" is in a community context and how it should be held despite lack of contextual support, as it is often the therapist who has to embody and convey the frame.

The participants experienced the fundamental psychodynamic idea of the frame as very important. The frame was repeatedly mentioned as fundamental to technique:

Well I think frame was very important, that's what I tried to instil. That was probably the first and most important thing that we tried to instil [as supervisors]. That it's a 50 minute hour, so there's a time frame and a special frame. Even, so that I don't think I even need to expand on that (Ms. M).

The direct and matter of fact tone that the frame is the "most important thing" highlights the essential nature of the frame to practitioners. While the interview schedule contained a question directly addressing the frame, each participant raised the issue before this question was reached. In response to the first question of the interview, "Can you tell me about your work?", Ms. Z said:

You find that the external world interceded on your therapeutic frame in a very serious way because a lot of what I, your confidentiality and all of that is irrelevant because the law supersedes it and requires you to break confidentiality under certain circumstances (Ms. Z).

This early mention of the frame suggests its significance. Ms. Z also introduces the challenges to the frame in a community context, for example breaking confidentiality. While this is an important issue, it is one of many that were mentioned in interviews. The ability to hold the frame in a community context was seen as difficult, almost impossible:

So I think it does [affect the frame] in any therapy. I mean like structural things for example, I mean you try and like limit as much of the external factors, you know you try and keep to the frame as much as you can, but there are also… [those] beyond one's control, so you try to limit them but also try to work with them. It's actually quite interesting, it's like you've… I feel like I get to apply psychodynamic practice you know to a context within which it was not designed or thought about, so ja, so it maybe it's, I don't know, it might be seen as sort of diluting, or being less psychodynamic but I think it's me sort of making psychodynamic work for the context I'm in (Ms. B).

Wanting to limit external factors, while acknowledging the inevitably of frame breaks is important. It is also telling that ideas of the internalised supervisor, as discussed above, arise when Ms. B questions if the way she works dilutes and diminishes the method, rather than just adjusting it. Knowing that frame breaks will exist and being able to think and work in this context is described as 'interesting'. The frame was described as essential by many participants.

It's hard to get [medical and administrative staff] to understand what is important. Ensuring you can terminate, ensuring you have a space that is private and safe, and you know it's the same space, you know I've been in a situation where I have run a support group with kids who are HIV positive and adolescents and we've always used the same space, and one day I've arrived and somebody else has taken the space over and they said "no the xyz from the Department of Health are here and you can't have it today" .....Without any real appreciation of what that might mean to the kids, and the children notice it. It's as if we're saying "well you're not terribly important really, where you are does not matter, we can move you about, the adults are more important, the Department of Health is more important, but you know you - doesn't matter (Ms. V).

The description of lack of support and understanding from medical and management staff within the clinics highlights the difficulty in ensuring that the frame is maintained in its traditional sense and the importance of being able to address the feelings evoked by frame breaks. It is important to be able to think about the frame and what it might mean to the children. The communication of their own unimportance is used as an example of the breaks and the impact that these have. Although breaks are inevitable, attempts to construct a frame have been thought about in unique ways by the participants.

Ms. V describes how she used to create her own space and frame by carrying three "magical objects" with her. These included a while tissue box, a Peru cloth and a clock. She describes how these three objects allowed for consistency of the space even if the therapy was being done outdoors: wherever she was, these objects were placed in the therapeutic space. The usefulness of these objects as consistent factors in a setting where very little is guaranteed was expressed by Ms. V. The difficulty of trying to create boundaries and safety in an "uncontaining" environment was experienced by both the therapist and the client. Ms. V also acknowledged the feeling of safety these objects offered her personally - a "security blanket" to the therapist at a very "unwieldy time".

A less concrete aspect of the frame was consistency. Having a space available for an individual at a set time and date was seen as very important in communicating an exclusive therapeutic focus on an individual client. Ms. Z describes the importance of being able to create a space with boundaries in order to facilitate the psychic space needed for therapy.

So it really is about, because I don't think that, you know what it is, you talk about the frame, the same time, the same room, the consistency etc….but for me the frame is to say "I will, when it comes time for you to be here, I will drop everything, I will drop my cell phone, I will not look at my watch once, I will not look out the window, I will attend to you and only you, for 45-50 minutes, I will talk about whatever it is that you bring to me (Ms. Z).

The frame for Ms. Z offers a way of focusing on the client creating their own space.

Being able to hold an internal frame inside one's self is felt to be strongly linked to one's experience with the internalised voices of supervisors and theory and therefore can at times be punitive:

I also think that one can idealise the frame…I mean there's some people who will go into the experiences in hospitals and clinics after the training and say I can't work under these conditions I can't do psychodynamic psychotherapy because it's not real - I can't do it in a ward, I can't do it outside …. There's an external frame that one can make do, so like I describe my things which are partly for me but I do think that if one's got an idea, a concept of a frame in one's self, also it doesn't have to just be a tangible thing… I do think it could be an internal situation (Ms. J).

Ms. J goes on to discuss how the frame can be too rigid and thereby not facilitate projection or allow the connection needed for a psychic exchange. Conversely, if there are not boundaries the space becomes unpredictable, unsafe and uncontained. The ability to be able to think about the frame and its breaks, as well as decide how to hold the frame internally, is seen as essential to the work. Being able to not only hold a therapeutic frame, but to create it by embodying the frame, is felt to be an extremely important experience for the therapeutic work with the client. By saying "but I also think that one can idealise the frame, one can say I can't work", Ms. J underscores the link between how theory is internalised and how one works with the frame. If one idealises it, or experiences it in a punitive manner, an internalised barrier is created inside the clinician themselves; the "internal situation" is affected. The frame can be experienced as idealised and punitive:

I don't think [the context] should [affect the frame] because our frame is sort of almost quite sacred to us. And being able to hold a frame is very important, even in my private practice I break rules about the frame. I would like to think it's not ethical breaks… but

at the same time I think some people can stick to orthodoxy too strictly and that drives me completely mental (Ms. A).

Orthodoxy comes into question here as Ms. A seems to suggest, at times, clinicians may over-identify with theory. She contrasts the usefulness of the frame as a live concept with a strict, orthodox approach that she feels is unhelpful, to the extent that the idealised frame, in its rigidity, is enough to drive Ms. A "mental". Ms. J also stresses the helpfulness of being able to break the frame when the context requires, but still having the confidence that internally the space is safe.

I think there is often huge projection and I think one can blame things like the frame or use it defensively as an excuse not to think, so it's acting out rather than actually thinking - which is our job (Ms. J).

Ms. J highlights the importance of thinking rather than using theory defensively. This ability to think within the frame, she feels, is vital in the community setting: thinking is described as "our job". By simply blaming the frame, the practitioner may refuse to think outside of what they have been taught, or to adapt. Psychoanalytic theory, for Ms. J, potentially offers a thinking space the ability to look beyond the obvious:

It's the lining of Freud's theory that the most insignificant thing is the most significant, all of those ideas, you know, that you don't just take something at face value, you think about it and say I wonder what that means (Ms. J).

Ms. Z also alludes to the therapeutic importance of a certain state, which she describes not as a way of 'thinking' (as does Ms. J) but as being present:

But for me a lot of it is about being present, about having a certain mind set and mindfulness around the fact that, I work almost entirely with children so also to put that in context, to be present and to understand that their behaviour is communicating something, and assist them to talk out instead of act out (Ms. Z).

Being present in the therapeutic space and being able to think about the client is understood to be extremely important and implies a way of being in the room. For Ms. Z, while at times the frame will be broken and the work may require a directive intervention such as food or child care interventions, the ability to think about meaning and underlying communication is essential - and must never be sacrificed. The ability to think psychoanalytically while

working in a way that may not appear to be in line with conventional practice was repeatedly discussed by participants:

> *Well even the [projects that on a face level are not psychodynamic e.g. more directive and group focused] are maintaining a mindful way of being and how people enact and re-enact … attachment I keep at the base of my mind at all times (Ms. Z).*

> *I will be thinking psychoanalytically, I will be thinking as I am talking to them this person's response… where does this thinking come from. Let's think about what's been happening to you, how have your experiences been (Ms. V).*

> *So the purely, it's not about eclecticism, for me it's about a way of thinking, the way you think and the way you help other people think, less than very specific techniques (Ms. Z).*

The importance of being able to think psychoanalytically was discussed approvingly by all of the participants. This was often contrasted to a perceived threat that if one does not use strict psychodynamic techniques, one's therapeutic work will be met with ridicule and negative attention. Often the use of other techniques, while still thinking psychodynamically, was described as being discouraged by the community of psychoanalytic psychotherapists:

> *I know that eclectic approaches are frowned on, and I was quite eclectic in my practice, and I think new therapists sometimes bring in a bit of this, a bit of that, and I don't think that it's always a bad thing. I think there are horses for courses, I think there are times when you need to adopt a certain approach (Ms. V).*

Ms. V suggests that at times interventions may be needed that are not purely psychodynamic. However all participants expressed the value of being able to maintain a mindful awareness of what the implementation of these techniques means on a psychodynamic level. The allowance to think outside the frame, the freedom to do so and the difficulty in experiencing this as either right or wrong, explains the way participants differently internalised psychoanalytic theory.

4.5 Otherness and othering

It emerged through interviews that being placed in the position of the "other" or feeling as though one is othering another is uncomfortable situation for the therapist, as it is often difficult to talk about the resultant divide. This difficulty is worsened by the racialised history

of the country, in which lines of separation have created painful divides of poverty and privilege. While it is a difficult topic to engage with it is one that cannot be denied and must be explored. Otherness was seen as important topic in the interviews. The initial responses to the question directly addressing this topic were markedly different to the more direct responses received on other questions. When the question was asked, interviewees invariably hesitated before responding. For example:

Well otherness in what sense? (Ms. B).

Otherness in terms of male-female, colour? (Ms. M).

Just help me understand your understanding of it (Ms. Z).

You're obviously talking about race but you're just talking about the 'other' (Ms. J).

Reversal of the question, often putting the focus back on the interviewer, was telling of the difficulty of talking about otherness. The emotional tone in the room was an indication of what was being communicated in the answers: sometimes there was a sense that the participant was aware of their own otherness and seemed confused by the question as there were so many types of other they could be. At other times the question was perceived as loaded and accusatory. In this way the question possibly signified an experience of otherness in the actual interviewing context. Race was often discussed in relation to otherness, as can be seen in Ms. J's comment that "you're obviously talking about race but you're just talking about other".

Race affects practice in community settings on a number of levels, including in terms of language:

In the therapeutic context in community setting I recognised sometimes I have been stuck in the sticks where I have run my workshop in English because I am monolingual largely, I have tried really hard to learn Zulu and have picked up some Tswana but I'm lousy..... But at lunch time people will then break into their own language and then I am kind of sitting there feeling a bit odd, so I go for a walk (Ms. A).

Language is an issue; because a lot of the kids they work with have limited English so you know to use big fancy interpretations sometimes just is lost frankly (Ms. Z).

The language barrier in the community is a very real hurdle that is tied to the racial divide. While language can be taught and is a concrete barrier there are more abstract differences which cannot be simply learnt or overcome.

> *I think that initially I was very conscious of it and very aware of it and felt that I, given my sort of privileged background, really shouldn't be intruding, giving the kind of advice, becoming involved with people the way that I was. It felt wrong, it didn't sit very comfortably. I felt often very alienated, I don't know if that's the right word, but I would often be told, "it's not our culture". Which was a sort of massive put down because what it was really saying is "you don't understand us". I would make a comment or observe something or suggest something and I would be told it's not our culture, so I think that feeling of otherness was often very present (Ms. V).*

The feeling that one is "put down" for not being the same culture is an important part of the internal experience described by Ms. V. The feeling of being very aware of one's own "privileged background" was repeated in the interviews; feelings that because of this the other's culture could be less easily understood because it is far removed from one's own culture.

Working not only with difference, but in *South Africa* also held meaning for participants.

> *I suppose, you know I think, what, in South Africa one's continually face to face with it, I mean it's been how the country's been. I mean it's all about difference and otherness and denial of that… I mean apartheid was based on that you are not the same. But of course you know it's a fear of, well we are the same, but there's also the opposite that you are different and I don't like that, so it's sort of a paradox (Ms. J).*

Because of the specificity of the South African context, Ms. J describes, clinicians are "face to face" with otherness and what otherness signifies in a society that has been so damaging, linked to a history of the rigid enforcement of ideas that "you are not the same". The continuing effects of apartheid were experienced by the participants and at times they were hesitant to discuss this:

> *Some of my colleagues who are black say they have experienced this where black patients don't want to go to a black clinician, they would rather go to a white clinician for whatever reason...maybe they believe that white clinicians are going to be able to offer them more...it's probably a hangover from apartheid days (Ms. V).*

The legacy of apartheid is described here, evident in the perception that a white clinician may be expected to offer a better service. This is strongly contrasted to the feelings of inadequacy that a clinician feels, as can be seen in thoughts of Ms. V "can I really help, can I really make a difference, can I really understand this person enough to be able to work with them and think with them" are dealt with, emphasising the experience of otherness in both parties. The value of being able to address and discuss with the client is seen as important as one must be "sensitive" and "aware" of this in order to help and "make a difference". The difficulty experienced is seen in the response of Ms. B when asked how these differences are felt on a personal level

> *Um… Just I don't know it's more, maybe, I don't know, I guess I don't really think about it. I haven't really thought about it ja, I don't know, I haven't really thought about it, its, maybe. I haven't really thought about it and how I feel about it, but I do know that in some ways it's the thing that protects me maybe. Maybe that's my wall not having to think about it because I mean it makes it a lot easier for me to do the work, and maybe that's an aspect of me just not thinking about that consciously ja (Ms. B).*

Ms. B's difficulty in thinking about otherness is evident in the repeated usage of "I don't know". Not thinking is easier: "it's the thing that protects me maybe". Ms. B reflects that avoidance and the protection this provides can make it "a lot easier to do the work". Ms. B's extract communicates how impactful and overpowering these emotions can be. The negative feelings that otherness can evoke is discussed by Ms. J:

> *So it's white guilt… But I think it's not anymore for me so much about a kind of black or white issue to race issue but it's also just about the differentiation in wealth and accessibility and I, because I believe that psychodynamic psychotherapy or the way of thinking is invaluable to everyone, I feel most people don't have access to it, and that for me, so I don't know if it's I mean there's some guilt in that.*

Feelings of guilt related to otherness are shown here while the changing nature of the guilt is also expressed. The divide between the "black or white issue" is felt to be changing. As the country grows as a democracy the divide is felt too in living conditions and socioeconomic status. Feelings of guilt are also highlighted in that the participant wants to do more, a feeling of guilt around one's limited reach into lower socioeconomic classes, who often lack access to psychological services. The feelings that otherness evokes are often very difficult to think about.

There's always difference and I suppose at times one can collapse that and sort of say well actually you know I deeply understand someone, whoever they are, gender, colour, age, situation….I think in general one can be defended against otherness. One would rather say "no I'm colour-blind, I'm this and that" and of course this has its own set of problems. It means that one is denying the idea of being alone and separate which is another concept going back to the beginning to the key concepts, ideas around separation and separating out, just as basic tenets of why I think psychodynamic psychotherapy is interesting because a lot of it is around separation, and the fear of separation and the resistance to separation. I guess that one can feel very, I think it's quite difficult unconsciously sometimes to accept that in fact you are the left out one (Ms. J).

The difficulty in being "the left out one" is telling of the negative emotions associated with being other and the desire to be the same. A denial of difference and feeling that one is "colour-blind" is seen to be accompanied by its own limitations, that it is in fact a defensive denial against difference. Ms. J mentions theory as potentially helpful in allowing for the difficulty of facing difference and the emotional reaction of clinicians to be examined. Hopefully too this will lead to understanding in terms of why separation and identification are so difficult. In this discussion the inclination to deny the difference is expressed, yet the importance of addressing it in order to overcome it is also highlighted. For Ms. J, then, difference itself is not necessarily a barrier to understanding, but denial is as damaging as difference to the therapeutic encounter.

The idea of difference also highlights the similarities.

Over time [my sense of insurmountable difference has] decreased and I do remember sort of at the end of the community internship talking about how we all have feelings and there are things that really matter to us and that in that respect we're not that different from one another. We'll all hurt, we'll all cry, we'll all get angry. I think that that's an understanding that has stood me in good stead, because I was thinking how can I do this work because how can I possibly be helping people to understand more of themselves when I am not part of this environment. I have never lived in a situation where I am scared that somebody will break in and injure me and my family or whatever the circumstances may be, or one might be worried about putting the next loaf of bread on the table, it's something that was never part of my experience. But it's

understanding the feelings and the challenges, my patients helped me to understand a lot, I think that feeling of otherness is there. And I think it's something that depending on who I'm working with, I put out there and say look, you know, you and I are different colours or different creeds or whatever it may be, how do you feel about that, which can be incredibly useful in some situations, but it's there, it's certainly there (Ms. V).

The ability to be able to address and name the difference, being able to bring it into the room is seen as therapeutic. The other important aspect is an awareness that while difference is very clear to individuals so is the acknowledgement that similarities do exist: "we'll all hurt, we'll all cry, we'll all get angry". The awareness of the commonality of experience is important as there must be recognition of the human experience, behind the ideas of otherness, that allows for a connection to be made. This is in contrast to the idea of otherness as a separator; the need to address the difference allows the commonality to be highlighted and thus the whole person to be acknowledged.

The ability to be able to learn from one's patients is suggestive of the possibility of positive dynamics otherness can create or engender:

I sometimes have a sense of, I suppose guilt, around how terribly terribly poor these people are that I work with, I mean destitute to the point where they have no food. But they come here to try and feel better. So I'm humbled and I'm honoured that they even bother to come speak to me. I am incredibly incredibly humbled and I try work from a point of absolute compassion because they teach me more than I teach them frankly. So I'm very very aware that I get a lot out of the people I interact with as well, my learning has been extraordinary so I treat it with great respect and recognise that I will be affected by this, and I will want to jump in and feed them and give them money and take them home and whatever the case is but I can't do any of that cause that really starts setting up a whole other dynamic, which is why the frame is also sometimes useful, but you run a group for children here, you have to feed them, it's just the way it is otherwise they can't think (Ms. Z).

Feelings of guilt are noted here but these are turned into admiration. Ms. Z experiences the possibility of being able to connect through negative emotions and difference. She highlights the importance of being aware of difference and being able to learn from it. Being able to be aware of what one might feel - such as an urge to "give them money" - is important, taking

into consideration aspects of the frame, and being able to know when this is not acceptable (e.g. to "take them home") and when this is a needed intervention ("you have to feed them otherwise they can't think"). Knowing that one cannot feed one's clients and take pity on them, but then actually feeding some clients when appropriate is an important contrast. This represents the ability to think about otherness and what one is enacting. The desire to take a person home to feed and clothe them may be driven by a saviour fantasy, as well as a way of alleviating guilt. One's ability to be sensitive to the environment and the ability to think in an integrated theoretical way, to draw out what feelings of otherness are evoking within one's self is essential.

The ability to think and reflect is represented in all five themes above. This involves the ability to think about the application of one's method in a context that it may not have been designed for, how the important concept of the frame may be held in unconventional ways or may be held internally, how thinking about otherness with a client is important to their own therapy, and finally how one's thinking is affected by an internal supervisory or theoretical voice.

Chapter 5: Discussion

This research aimed to illuminate the subjective experiences of therapists practicing psychodynamic therapy in a contrasting context to the theory's origins and orthodox settings. The effects of the context, the benefits and shortcomings in the work, as well as specific topics of the frame and otherness were explored. The way in which therapists adjusted to the context, both in general and in specific terms, as well as what aspects were key in their decision making process were important.

It is important to understand the difficulties faced in the South African community. The different advantages as well as shortcomings that the theory was felt to provide are informative to the struggles of those working in this context. The importance of internalised theoretical and supervisory voices were also clear, in assisting to create a therapist's thinking mind. Specific focus must be placed on otherness and the frame, two concepts clearly highlighted in the literature, also points which the participants themselves found to be important.

5.1 The experience of working psychodynamically in a community context

The experience of working in the community context seemed to be characterised by a struggle between feelings of despair and feelings of the great need for the work. Feelings of horror and secondary trauma were experienced by the therapists interviewed. Working in a situation where concrete problems such as the lack of food and medication are common, where therapy is experienced as strange and impractical, created repeated difficulties for clinicians. The contrast to this is that the practitioners have a belief in the curative, transferential and healing abilities that their practice offers. The government healthcare system is often overrun with patients in emergency situations, who need help but are swiftly moved along the process, with little regard for their own individuality or needs. The difficulties in implementing psychoanalytic psychotherapy are often logistical, namely those of time and place, as well as for more personal reasons in which the nature of the work (e.g. starving children) leaves the therapist feeling helpless. Having a space in which clients are free to express themselves is a different experience and one that will hopefully help patients to function better in a dysfunctional system. While the nature of the cases seen, as well as the application of therapy is difficult in the community context, participants see this kind of therapeutic work as worthwhile and very much needed. Working in a community context is

experienced as a struggle between the difficulty of implementation and the vast need for, and belief in, the benefits of psychoanalytic psychotherapy.

The experiences of community practitioners described in this research are in line with the experiences found in research done in other settings. For example Altman (1993) describes how working in communities from the lowest socioeconomic rung, who are faced with "bread and butter problems", can leave therapist feeling helpless and wanting to provide more concrete solutions. Padfield (2013), like the participants in this study, describes difficulties of assuring patient arrivals and dealing with unexpected terminations. The benefits and possibilities of working in a psychodynamically oriented approach, and what this may offer patients, is expressed by other authors who works in this context including Altman (1993), Bain et al. (2012), Kruger (2012) and Padfield (2013).

Participants highlighted the difficulty of adjusting to working differently in a community context. Often practitioners feel unprepared, uncared for and uncontained in this environment. This highlights the importance of supervision, and the need for adequate training before assuming a position in the community. This is vital in order to have the relevant skills base and support needed to do appropriate work.

5.2 Internalised voices

The influence of internalised supervisory and theoretical voices arose as a repeated theme in the interviews and affected different aspects of application. Every aspect of theoretical application was affected by the way in which individual practitioners experienced the theory. Participants' experiences of theory can be summarised as a struggle between two poles: one in which psychoanalytic theory was experienced as giving and adaptable, and the other in which it was experienced as rigid and withholding. Practitioners frequently expressed concerns about being judged for unorthodox practice. It was clear that at any given time, the practitioners could relate to either side of the two poles, indicating that personal relationships to theory are fluid in relation to different aspects of therapeutic work.

It was repeatedly noted that conventional practice is not felt to be applicable in the South African community context. It was suggested that practitioners who experienced the internalised voices of supervisors, theory, or textbooks as being strict in its application, would feel discouraged in implementation. At times seemed that participants felt that those who adhered to traditional applications of psychoanalysis would judge any adaptation they

undertook disparagingly. At other times the flexibility afforded within this modality was felt to be one of its main advantages. The ability to think and formulate psychodynamically while possibly working in a more directive manner was often expressed as the basis of one's flexible approach. The depth and understanding of patients that a psychoanalytic way of thinking provided was felt to be invaluable. Being able to internalise the voices that guide one's practice was described by participants to be crucial to an authentic way of working. This genuine relationship with theory was experienced as vital to building a relationship with patients, while a belief in one's own work was important for the maintenance of personal wellbeing. There was a recognition that many of the disadvantages of the work were in the application of the method, rather than in the method itself - once again highlighting the personal nature of practice.

The importance of internalised theory is highlighted by Greenberg (1986) who describes how the application of theory is subjective and private in its actual implementation. Personality and life experiences are felt to impact the way in which therapists are able to relate to the theory (Greenberg, 1986). Long (in press) notes that theory can be utilised either helpfully or defensively. This explains how therapists who relate to the theory in personal, private, ways are then able to use this as either a defence or a useful technique.

The two ways in which theoretical voices were internalised in this study – defensively or productively – are similar to that described by Sandler (1983) regarding ways that psychoanalysis can be interpreted: one as a complex jigsaw puzzle that must be orthodox in its application, the other as an adaptive and malleable way of thinking. These voices are felt to push and pull the practitioner into doing what they believe to be theoretically correct.

The internalised voices, as discussed by the participants, were seen to be generated from many different sources, including reading groups, studies at university, one's own reading, one's own therapist and, influentially, one's supervisors. The importance of supervision for therapists has been discussed by many authors (e.g. Watkins, 2013). Sarnat (2012) explains that while supervision is a very important part of psychodynamic psychotherapy training there are still debates between supervisors as to what a "good" psychotherapist does according to the differing schools of thought. This is thought to affect the way in which a therapist internalises supervisory voices. If the supervisor finds value in a different school of thought, or applies rigid methods, it may affect the way a supervisee internalises the supervisor's voice and therefore influences their own practice later in life. It is therefore

important that supervision offers a safe space to discuss the work, and an acknowledgement within this space that adaptation is key. Being able to understand how one works in the community, while maintaining a psychodynamic thought process is vital in order to allow basic psychoanalytic assumptions, such as the importance of a unconscious life and the developmental effects of childhood (Watts, 2004), to be expressed and applied in non-traditional approaches.

5.3 The frame

The frame was simultaneously understood by participants as one of the most important concepts in community work as well as the theoretical construct most affected by a community environment. Holding a frame is difficult within this setting but every participant emphasised how important the creation of a frame is, and how a thinking space must be fostered.

The parameters or logistics of the frame, which include consistency in time and place, become affected and at times impossible to maintain. The sheer volumes of patients that community institutions receive, coupled with underfunding, results in a limited number of available rooms. Most participants discussed the difficulty of no longer having a room available to them because other services have commandeered the office for that day. Therapy settings ranged from what was described as abandoned churches, makeshift shelters, to shipment containers and even under a tree. The effects of the frame come not only due to clinic resources but also the common problems faced within the community population. Often patients will not have the resources to pay for transportation to the clinics, or the public transport system in South Africa leaves them wanting. Employers are also often hesitant to give the patients the time off work to attend therapy, or the patients may themselves not believe that therapy could help. It is therefore common for sessions to be missed and therapy to be disrupted and terminated. It was also clear that if one denies that the frame must be adapted it is unethical for the patient. In this context poverty and despair are common, often the frame is broken as a starving child is fed before the session. Abuse is another common concern, meaning the confidentiality limits of the frame come into question, as legally, practitioners must report child abuse. Practitioners felt it would be unethical not to consider these aspects, for example if the child is not fed or the abuse is not reported, and the frame is felt to supersede the client needs. At all times the importance of understanding and thinking about frame adjustments were expressed.

Many participants described psychotherapy in a community setting as unpredictable. Given this unpredictability, it was felt that holding a therapeutic attitude and frame of mind was essential. While the creation of the frame was essential, the ways in which this was done were unique. Some would carry "magical objects" that they felt would provide consistency such as a tissue box, a particular cloth and a clock; while others would feel that their presence allows for some form of consistency, in this way 'embodying' the frame. There were also less observable ways in which a frame was preserved, including being completely client focused and emphasising and fostering an exploratory attitude. Clinicians discussed practices of paying full attention to the client and refusing any interruptions, thus communicating the importance of the space to the patient. The ability to hold a psychic space, in which the client has the ability to express themselves in a safe space, was seen as essential. A recurring theme was the importance of creating some sort of space which would foster thinking in both the therapist and the patient.

As noted the traditional frame, as discussed for example by Quindoz (1992) and Böhm (2004), is not feasible in this context. If one works in a setting where the same room cannot even be guaranteed, requirements of modest décor or a couch for the patent to lie on are impossible to obtain. The experiences described by Padfield (2013) are congruent with those discussed by participants, as the unpredictability of the context meant that a clinician must adapt her work to fit the context. The importance of an internal understanding of what the frame means is closely related to discussions of the frame by Tuckett (2005) and Böhm (2004). Both these authors discuss different aspects of being able to hold an internal frame, whether this is specific to ways a client is formulated and thought about (Tuckett, 2005), or the way that a therapist must be able to separate their own experience from that of their patients (Böhm, 2004). The frame, as an internal situation that fosters psychic space in which two parties can think, is essential to working in an environment in which there is no guarantee of an external frame.

The internalised holding of a frame is important in the application of work in the community. It should be stressed that when the external frame is jeopardised, the internal frame can be maintained. This would subvert counterarguments in which clinicians "blame" the frame by asserting that it is impossible to work psychoanalytically in a community context. The concept of an internalised frame opens possibilities of doing meaningful work in under-resourced communities.

5.4 Otherness and othering

Otherness is a very common feeling in South Africa. The country has a history of separating "me" and "not-me" through its own institutional policies. The extensive training required of psychotherapists often means that practitioners come from upper to middle class backgrounds, and thus working in impoverished communities means working in contexts that are markedly different for practitioners. The difficulties in discussing otherness and how it is managed in the room was clear in the interviews.

When the question of otherness was addressed, it would often change the emotional tone of the interview, adding tension. Participants often reversed the question back onto the interviewer rather than answering directly. It would seem that being the 'other' is an uncomfortable position for the practitioners to be in and to discuss. Otherness was often felt to limit the ability of the therapists to relate to their clients, sometimes in concrete ways such as through language differences, as well as in more subjective ways. There was often reference to the changing nature of otherness within the South African context, for example from divisions of black and white to class divisions.

While the cultural barriers were discussed in-depth, the importance of being able to address difference was also raised. If the difference could be brought into therapeutic discussion and addressed, participants felt, then otherness could be understood and consequently become a potential catalyst for therapeutic change. In understanding the difference between the two "others" in the room, a better understanding of the meaning of "other" - specific to the patient - is explored. This allows for the patients and therapist to relate to each other in a much more integrated sense. Participants also often spoke about how, after the initial otherness was experienced, an underlying similarity came to the fore. Feelings of similarity were felt to be powerful, allowing clinicians to work with an underlying commonality and a sense that the cultural or economic divide could be overcome.

The initial difficulty therapists often experience in engaging with otherness is discussed by Esprey (2013) who described how addressing race was easier done outside of South Africa, rather than while still immersed in the setting. The research interviews were at times held in the offices of the therapists and they were therefore fully absorbed in the context. This possibly added to the initial hesitation in engaging with discussions of otherness. The communicating of one's racial history and past privilege in the embodiment of race was also expressed by the participants, which is in line with the writings of Swartz (2007a; 2007b).

This often evoked feelings of shame and guilt (Kruger, 2012). Both the difficulties expressed in working with otherness, and the possibility for transformation that this creates, is represented in the literature. Being able to think about difference and address it as it appears in the room is transformative and allows more scope for therapeutic work to be done (Straker, 2006; Swartz, 2013)

The importance of thinking about one's own otherness and addressing it with clients is clear. Otherness is heated and uncomfortable, especially in a community setting, and possesses the potential to create rifts if not addressed. It is therefore essential to the working relationship to be able to address the difference with an open curiosity to allow the impasse to be overcome. It is important to be aware of one's feelings of race and difference and to understand one's boundaries and their relationship to separation and difference. It is for this reason that a clinician's personal psychotherapy is important when working with otherness.

5.5 The broader ability to think

The themes above were all dominant in interviews and to some degree interlinked with a particular way of working, namely the ability to think in the room. Thinking was addressed several times in the interviews. Sometimes it was mentioned that it is the goal of psychotherapy to be able to "think out and not act out", or thinking was referred to as "our job", stressing the importance of the ability to think. Thinking in a community context is at times seen as difficult. The circumstances which the patients come from and will return to are dire, often lacking in basic needs. The ability to be able to think about what a particular individual may need from psychotherapy beyond the obvious concrete solutions may often be jeopardised.

Thinking about the – holding the frame in mind – was another dominant theme in interviews. This ability to think was often discussed in relation to difficult-to-negotiate situations, for example in relation to debate about whether or not to feed patients. The ability to think of these dynamics is essential as stepping outside of the frame may often be required in order to behave ethically. An understanding of the benefits, transferences as well as the power dynamics created in this enactment must be taken into account. It would seem that the common idea was that, not only must a thinking space be created for the patient, but the therapist must be able to think about their own adaptation. This must be done through a psychodynamic lens to negotiate the effects of this, and explore what it might mean to the dyad.

The ability to think about otherness is similarly crucial. While this is possibly one of the most difficult subjects to discuss, as demonstrated in the way interviewees responded during interviews, it is also one of the most important. Issues of race and difference are central to South African life. Being able to highlight the starkness of difference or, as one participant said, "put it out there… you and I are different colours or different creeds or whatever it may be, how do you feel about that", was described by participants as incredibly useful and essential to a therapeutic relationship. The ability to ask this question and think about it is seen as imperative to understanding the other. The ability to be able to think in the room about race while experiencing feelings of separation, shame, guilt and loneliness can be a difficult but essential task.

The internalised voices of the theory/textbook/supervisor also affect the ability to think. The way in which these voices are internalised affects later thinking and understanding. An argument may be made that it is these internalised voices that actually promote one's ability to think. The theory of thinking as stated by Bion (1959) is useful. In a therapist's unfamiliar experience in a community setting experiences of difference can create an uncontaining experience. This exact phrase "uncontaining" was often descriptively used by participants. These uncontained feelings are then taken to supervision or formulated theoretically or discussed in a reading group so they can then be given back to the therapist after being understood through this auxiliary alpha function. This may mean that a therapist's analytic thinking mind is influenced by their own experience of theoretical understanding - creating their own thinking apparatus (Bion, 1959). This highlights that it is not the theory itself that may inhibit an individual's ability to think but rather their own experience and internalisation of it.

5.6 Limitations of the research and implications for future research

The research was limited in its scope. The small sample size as well as the homogeneity of the setting (all therapists worked in Gauteng) means that the generalizability of the study is limited. Future research is encouraged to include a wider breadth of sampling with a larger group of participants. This would add breadth to understandings of psychoanalytic practice in community contexts.

The analysis largely focused on the subjective understandings of people involved in psychoanalytically oriented therapeutic practice in the community. The views of private practitioners, or those disapproving of adaptation of psychoanalysis to community work, were not explored. While some of the participants interviewed had experience in private practice, their community work may have meant that they would not represent the views of private practitioners. Feelings of being judged by private practitioners or more 'purely' psychoanalytic therapists, therefore, cannot be fully substantiated, as there are many subjective factors which may influence feelings of acceptance. It is recommended that future studies could explore how those who practice psychoanalysis, in a 'purer' sense, feel regarding the adaptation of its methods.

The issue of why certain work seems to have more punitive aspects to it than others should be explored in future studies. This research focused on what this internalisation has meant for individual application of psychodynamic psychotherapy. The exact process of how these are internalised, and why, was not explored and should be addressed in future studies.

5.7 Conclusion

The aim of the research was to better understand the experiences of those who practice applied psychodynamic psychotherapy in the South African community context, in the hopes to of illuminating an area of work that has often been kept in the dark. Although more authors are writing about such work, the challenges and possibilities remain relatively undocumented. It is apparent from this research that the application of psychoanalytic psychotherapy in community settings involves considerable adjustment in comparison to psychoanalytic psychotherapy in more privileged contexts. The logistical problems faced in community settings mean limited space for therapy, a lack of supportive structures, as well as lack of community understanding.

It is also apparent from this research that this kind of therapeutic practice has considerable psychic impact on practitioners. The unsettling nature of the work and feelings of difference can be traumatic and horrifying at times. Otherness became highlighted not only in terms of a racial divide, but also in relation to difference in upbringing and life experience, at times evoking guilt and shame. It is essential, yet difficult and uncomfortable to address these feelings and dynamics.

Perhaps the core issue to have emerged from this research regards the importance of a particular kind of thinking space for therapists, through which an internalised frame, internalised theory and internalised sense of difference and similarity can be held. It is the ability to think flexibly and creatively that also helps therapists to tolerate the difficulty of their work.

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Appendix A

Interview schedule

As the interviews will be done in a semi structured manner the following schedule must be viewed as a structural skeleton which will guide the questioning, as interviews may be directed in an unforeseen direction by the participant. Questions will be followed with request for practical examples and usually end with questions of "anything else" in order to ensure that participants have discussed the topic fully.

- Tell me about your work.
- What makes the work psychodynamic for you?
- What drew you into working with this method?
- How would you say the South African context affects your work?
- How do the people you work with respond to the psychodynamic approach?
- How would you say working in this context affects the therapeutic frame?
- What are your own personal experiences with "otherness" in the therapeutic context?
- What would you say are the benefits or advantages are when working with this method in your experience?
- What would you say are the challenges or short comings when working with this method in your experience?
- What are your thoughts on psychodynamic therapy in comparison to other methods (e.g. CBT) when applied in the community context?

Appendix B

Participant Information Sheet

Dear potential research participant

I am a current M.A. Clinical Psychology Masters student at the University of the Witwatersrand conducting research towards my dissertation. My research aims to better understand the perspectives and experiences of psychodynamically oriented therapists working in a community context. Through this research the subjective experienced possibilities and challenges of practicing in this context may be better understood. The research will involve interviews which will be qualitatively analysed.

I would like to invite you to take part in the study. I have been referred to you by one of your peers because you have experience working therapeutically in a community context and your experience may present a meaningful contribution to this study. The research involves a semi-structured interview that should take between one to one and a half hours to complete. I would like to ask your permission to tape record the interview, which will then be transcribed verbatim. Your personal information will be treated with the utmost respect and care. Confidentiality will be ensured through the changing of any identifiable features in the transcriptions and final report. Your real name will not be used. Access to the original recordings will be restricted to the researcher and will be kept for two years in a password protected file, after which it will be destroyed. While your identity will be kept confidential direct quotes will be used in order to illustrate specific findings. The purpose of the study is to understand your experience of the theory not to evaluate it, and therefore any indication of "bad practice" will remain confidential and not be reported on.

There are no anticipated risks to you should you decide to participate in this research. While the research has no direct benefits, it is hoped that the research will contribute to a better understanding of psychoanalytic practice in community contexts.

Participation in the research is voluntary and there will be no repercussions to you should you decide not to participate in the study. If at any point during the interview you feel that you would no longer like to continue, or that you would not like to answer a question, please feel free to voice this concern and withdraw. Your withdrawal will not result in any negative repercussions for you. The final report will form part of a Wits dissertation and may also be published. A summary of the results will be sent to you once the research is complete.

Feel free to contact me or my research supervisor should you have any queries or concerns.

Yours sincerely

Alexander Oosthuysen

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Supervisor: Prof Carol Long (Tel 011 717 4510 or email carol.long@wits.ac.za).

Appendix C

Consent

I…….. agree to participate in the study conducted by Alexander Oosthuysen.

I understand that:

- My identity will be kept confidential at all times and that any identifiable features will be excluded from the final report and transcription
- There are no direct benefits to me in participating in this research
- While risks are not expected, the researcher will be available for contact if any personal concerns do occur
- My involvement in the research is completely voluntary
- I have the right to withdraw, or not answer questions, at any point without fear of negative repercussions
- Direct quotes will be used in the final report

Date ……..

Signature ……

Appendix D

Recording Consent

I …… agree to have the interview conducted by Alexander Oosthuysen tape recorded. I understand that verbatim transcriptions will be made of the tape recording.

I understand that:

- My identity will be kept confidential and any identifiable features will be disguised
- The tape of my interview will only be available to researcher
- The tape of my interview will be kept in a password-protected file which will be destroyed two years after completion of the study

Date ……..

Signature ……